NEW OLD AGE

What Geriatric Emergency Departments Do Differently

These specialized units can help keep older patients out of the hospital, lower their health care costs and more.

Credit...Bianca Bagnarelli

By Paula Span – The New York Times

July 25, 2026

It had been a rough few months. Cynthia Tompkins was hospitalized in May for osteomyelitis, a bone infection, then spent six weeks in a rehabilitation facility. “It was a struggle,” she said. “I didn’t bounce back too well.”

Ms. Tompkins returned to her home in San Diego, but she was still taking antibiotics, along with a host of other drugs for diabetes, pain and blood clots. The deaths of her husband the previous year and her closest friend more recently had sapped her spirits.

In early July, a new symptom appeared: violent vomiting three times within about 24 hours. “I was so depleted,” she said. “I got weaker and weaker.” A friend who was visiting her called an ambulance.

“It’s the last place you think you want to go, the E.R.,” said Ms. Tompkins, 75, a retired teacher and family program director. She anticipated spending hours on an uncomfortable stretcher in a chilly hallway. Arriving at the emergency department at U.C. San Diego Health in La Jolla early in the morning, “I was in a knot,” she said.

But the place upended Ms. Tompkins’s expectations. Since 2022, this and every other adult E.R. in San Diego has been accredited as a geriatric emergency department, redesigned to address the specific risks and needs of older patients. It’s an approach, recent studies show, that can reduce hospital admissions and deaths among older adults and lower costs.

“They took me right to a room,” Ms. Tompkins said. She was transferred to a gurney with a thicker mattress to prevent bedsores and given blankets. “I got an I.V. right away because I needed fluids,” she said.

She was pleased that the small, curtained room, with sound-absorbing walls to lower the cacophony of emergency care, had a cushioned chair for her friend, who would stay with her, and a window looking out on trees.

The window served a medical purpose, too. Patients “can see whether it’s day or night,” said Denise Valenzuela, the geriatric emergency nurse assigned to Ms. Tompkins. “It prevents delirium,” the sudden change in mental status that can arise in hospitalized older patients and increase dementia risk.

Before long, “I just felt a calmness,” Ms. Tompkins said. “I felt, I’m where I need to be right now.”

Since 2017, the American College of Emergency Physicians has accredited 624 such geriatric emergency departments across the United States, including 73 in Veterans Affairs medical centers. “A fairly exponential rate of growth,” said Dr. Kevin Biese, the emergency doctor who directs the Geriatric Emergency Department Collaborative.

Few of these units are restricted to older patients. Instead, like the E.R. in La Jolla, they serve all ages but incorporate senior-friendly practices and protocols in an environment aimed at staving off disorientation, falls and other elder hazards. They’re classified from Level 1, for those fulfilling the highest number of criteria, to Level 3.

Adults 75 and older visit the emergency room at a higher rate than any other age group except infants: 76 visits per 100 people in 2022. Yet standard emergency care "wasn't correctly designed for the needs of older adults," Dr. Biese said.

The mission of a traditional E.R. is to speedily identify the central problem and either fix it or admit the patient to the hospital for ongoing care. "We ask, 'What's your chief complaint?'" Dr. Biese said. "You fell down the stairs and broke your leg."

Older patients rarely arrive with a single ailment, however. Like Ms. Tompkins, most contend with several chronic conditions, take multiple prescriptions and need a variety of tests and assessments. Trained geriatric emergency teams focus not only on the broken leg but on determining what caused the fall, and how to prevent another one.

"An emergency department doesn't routinely screen for delirium" and cognitive impairment, said Dr. Ula Hwang, an emergency doctor and researcher at N.Y.U. Langone Health. "But it's one of the first things geriatric emergency departments will do," along with a careful review of all the patient's medications.

Geriatric E.R.'s also try to counter sensory impairment, another contributor to delirium, by distributing reading glasses and sound amplifying devices. They dim glaring lights and offer eye masks and ear plugs to promote sleep. If Ms. Tompkins had forgotten her walker, the unit would have lent her one.

These E.R.'s also aim to address a rising concern in emergency departments: hours or even days spent "boarding," when admitted patients wait for open beds before they can leave the E.R.

"Prolonged boarding has increased among older adults," said Dr. Cameron Gettel, an emergency doctor and researcher at the Yale School of Medicine, referring to waits that last over three hours. He is a co-author of a study on the topic in Health Affairs Scholar.

Spending more time boarding isn't merely uncomfortable or inconvenient. Researchers studied patients 75 and older in emergency departments across France. They found that those kept there overnight before moving to an inpatient ward had a higher in-hospital mortality rate (15.7 percent) than those admitted to a ward before midnight (11.1 percent). Overnight boarding was associated with more falls and infections, too.

What geriatric emergency staff prefer, however, is to help patients avoid hospitalization altogether. "Admission may not be the best thing for an older adult," Dr. Hwang said. "It might be the worst."

Hospital patients, she said, are exposed to infections, staff errors and the rapid deconditioning that accompanies days spent in bed. All pose a greater threat to older patients.

Previous studies have found reduced admissions from geriatric emergency departments, but most of those studies involved one or two hospitals. Now, Dr. Hwang and her team have used nationwide data from the federal Health and Retirement Study and Medicare claims for nearly 4,600 adults over age 65, comparing those treated in geriatric emergency departments with a matched group seen in standard E.R.'s.

The differences were stark: Patients in the geriatric units had a 39 percent lower likelihood of hospital admission and a 38 percent reduction in mortality over 30 days. The geriatric E.R.'s also saved Medicare up to about $3,000 a visit, according to an earlier study Dr. Hwang led.

So having more than 600 accredited geriatric emergency departments nationwide represents both great strides and — in a country with more than 5,000 emergency departments — missed opportunities, Dr. Biese said.

"I'd encourage people to ask why their hospitals don't have an accredited G.E.D.," he added. "We should demand that."

In La Jolla, Ms. Tompkins began feeling stronger. The intravenous fluids supplied anti-nausea medication and corrected the electrolyte abnormalities that her lab work revealed. She was able to sip water and juice and eat a few graham crackers.

A battery of other screens and scans found no serious concerns. After completing a geriatric assessment, Ms. Valenzuela, the nurse, suspected Ms. Tompkins hadn't been eating well and was taking medications on a mostly empty stomach.

By about 6 p.m., Ms. Tompkins and her doctor agreed she could return home. She left the hospital with numbers to call for further help, and several staff members checked in by phone to see how she was doing.

Better, was her answer. "They took care of the whole me and put me on the right track," Ms. Tompkins said. "I'm progressing. It's slow, but I'm OK."

The New Old Age is produced through a partnership with KFF Health News.