Frailty in Older Adults

TO THE EDITOR: In their review article, Kim and Rockwood (Aug. 8 issue)[1] provide an extensive discussion of frailty in older adults. To this contribution, we suggest adding consideration of the basic anthropometric, mutually independent indexes — body-mass index (BMI), which adjusts weight for height, and a body-shape index (ABSI, also abbreviated BSI), which adjusts waist circumference for height and weight. The ABSI has been well established as a predictor for the risk of death[2] and, in combination with the BMI, has shown associations with muscle strength and mass in general populations.[3,4] Beyond that, the ABSI has recently been found to be a longitudinal predictor for the 10-year incidence of frailty in a late middle-aged cohort.[5] The preliminary evidence supports further evaluation of these simple indicators for clinical use.

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TO THE EDITOR: The article by Kim and Rockwood meticulously delineates a comprehensive review of the frailty syndrome, including its biologic underpinnings, assessment methods, and clinical management. However, the authors have overlooked the psychosocial aspects of frailty management, including the need for social support to combat feelings of loneliness and depressive symptoms.

For instance, a low level of social engagement may exacerbate an individual's state of frailty, whereas effective social interventions could potentially ameliorate the physiological and psychological health of older adults. Consequently, future research should integrate psychosocial factors into a multidimensional model for the assessment of frailty.[1,2]

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TO THE EDITOR: The review by Kim and Rockwood offers a valuable overview of frailty and its biology, screening, and interventions. We applaud their interdisciplinary approach and recommendations, including the involvement of occupational and physical therapists in promoting functional recovery among those with frailty. However, the critical role rehabilitation plays in preventing functional decline in the prefrail stage warrants additional consideration.

A recent meta-analysis[1] identified the benefits of physical activity for frail and prefrail persons, which emphasizes the need for professional involvement in exercise prescription. Physical and occupational therapists have expertise in exercise prescription for both high-risk groups. In addition, such therapists have expertise in fostering meaningful social engagement,[2] guiding environmental adaptations,[2] managing medications,[3] prescribing mobility devices and training patients in their use,[4] and facilitating independence[2,4] — all critical factors in frailty prevention. Finally, these therapists are well positioned to screen for frailty-related needs to support timely intervention. Too often, patients are re-

ferred to rehabilitation only after major functional decline.

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TO THE EDITOR: We appreciate the review of frailty in older adults and the recommendation that a comprehensive geriatric assessment should include a core evidence-based management strategy to address frailty. This recommendation is useful but difficult to implement, given the facility-focused configuration of health care delivery and shortages in the geriatrics workforce in the United States. For persons with ambulatory frailty, comprehensive geriatric assessment is essentially inaccessible because of the scarcity of geriatricians; it is an even greater challenge for the millions of homebound persons. In our recent survey of 514,188 Medicare Advantage beneficiaries, we found that 22% were homebound, a percentage that rose to 50% among frail older persons.[1] Frail older adults often lack access to office-based primary care or comprehensive geriatric assessment[2]; only 12% of homebound persons receive home-based primary care.[3]

This lack of access to interventions to address frailty is particularly disturbing in the context of value-based care, given that approximately 50% of preventable Medicare costs are incurred by frail older adults.[4] Policymakers, health systems, and society stand to gain by incentivizing the expansion of the geriatrics workforce and focusing their efforts on the care of homebound older adults.

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THE AUTHORS REPLY: Krakauer and Krakauer highlight the correlation between body-mass index, a body-shape index, and the relationship of both scales with muscle strength and mass and the risk of frailty.[1] Although we agree that body composition is indeed a risk factor for frailty, we emphasize that these measures alone are insufficient for diagnosing frailty because of the multidimensional nature of this condition.

Zheng and Yang underscore the importance of psychosocial and environmental factors in the treatment of frailty, a point with which we fully agree. As mentioned in our review, patient- and family-centered care (including maintaining daily routines in familiar surroundings, preserving social connections, and mobilizing resources) can enhance quality of life and mitigate the negative health effects of frailty.[2] The assessment of psychosocial factors and the surrounding environment should be an integral part of care for older adults at risk for frailty.

Canter and Evans emphasize the critical role of occupational and physical therapists in promoting independence among older adults. Such professionals not only prescribe exercise programs but also deliver interventions such as environmental adaptations, mobility-device training, assistance with medication management, and support and education for caregivers. These services are essential for those at risk for frailty.[3]

Leff and colleagues raise a critical issue regarding the challenges of delivering comprehensive geriatric assessments within the current facility-focused U.S. health care system, particularly for homebound frail older adults who are at high risk for increased health care use but lack access to home-based primary care or geriatricians.[4] We agree that the shortage of geriatricians and limited availability of patient-centered care models pose substantial barriers. Expanding the geriatrics workforce and training clinicians to deliver high-quality, patient-centered care are high priorities for the U.S. health care system and are crucial steps in addressing the needs of homebound older adults.

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Since publication of the article, the authors report no further potential conflict of interest.

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