



Editorial

Frailty as the Main Target for Community Health Services

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Frailty is defined as a vulnerable state in older adults that results in various adverse outcomes, including poor quality of life, falls, fractures, hospitalizations, nursing home admissions and increased mortality.¹⁻⁵ Frailty is also considered to be a “pre-disability” state that can potentially be reversed, and this feature warrants community-based intervention programs. In this issue of *Aging Medicine and Healthcare*, Jiang et al. reported the prevalence and contributing factor of frailty from the perspective of the community hospital in Singapore.⁶ The study reported high prevalence of frailty in both inpatient (45.6%) and outpatient (53.1%) settings as assessed by the FRAIL scale. Among the components of FRAIL, incapacity of resistance and ambulation were the most common factors contributing to frailty in both settings. As this was a cross-sectional study, the authors were not able to report the clinical outcomes of these pre-frail/frail patients. However, they hypothesized that patients with different components of frailty may have different long-term outcomes.

A previous study proposed that frailty may consist of different sub-types, including mobility, non-mobility and inactivity.⁷ Mobility-type frailty was found to pose a greater risk for mortality in a community-based sample. A recent report that looked at the Japanese longitudinal aging cohort data confirmed the development of the above-mentioned subtypes of frailty.⁸ And similar to the previous study from Taiwan, patients with mobility-type frailty were found to be at greater risk for multimorbidity and cognitive declines. A previous report in residential care setting found that underweight pre-frail/frail older adults had higher burden and complexity of care.⁹ While these reports echoed the findings of Jiang et al., they also provide insight into the at-risk populations in Singapore’s communities.⁶

Although frailty is a well-established concept that identifies older adults at risk of adverse health outcomes, clinicians practicing Precision Medicine need to identify its subtypes.¹⁰ Mobility-type frailty differs from other subtypes in its demographic characteristics, laboratory data, functional performance, and many others, suggesting the underlying etiology may lie in the neuromusculoskeletal systems. In contrast, the non-mobility type of frailty is more likely to be cardiometabolic in origin and be associated with depressive mood.⁷ A brain imaging study identified structural deficits in the gray matter of cerebellum in mobility-type frailty, further supporting the notion that frailty

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subtypes have distinct pathophysiology.^{11,12} Jiang et al. used the FRAIL questionnaire to define frailty in their study, while most other studies reported to date have taken the phenotypic approach to physical frailty.⁶ The diagnostic accuracy of FRAIL has been validated in the literature, and many similarities in the diagnostic components exist.

Given the high prevalence of frailty in inpatient and outpatient settings in the community hospital, community health services for community-dwelling older adults should target frailty in combination with management of chronic conditions. Jiang, et al. reported a higher prevalence of frailty in community hospitals than in community-dwelling older adults, suggesting that older people with health care needs were at higher risk for frailty.^{6,13} An integrated multidomain intervention may be necessary for community-dwelling older adults with different conditions.¹⁴ Adding frailty as one of the main targets to promote healthy aging may also improve healthcare system efficiency because frail patients generally have higher health resource use.¹⁵

An integrated care platform that encompasses both disease management and functional ability may be the optimal healthcare model for older people. Adding frailty prevention and intervention in the community health service system may hold the key to success in healthy aging.

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