

## Failing to Focus on Healthy Aging: A Frailty of Our Discipline?

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The academic geriatrics community has provided outstanding leadership in addressing frailty and complexity in older adults, but a minority of older adults are frail. Although resources to treat older adults are limited, and it is appropriate to focus clinical efforts on those with frailty and multimorbidity, there is also important expertise that can be brought to bear on the health of ALL older adults. A review of the literature suggests that attention to healthy or successful aging has failed to keep pace with the focus on frailty. By providing leadership to promote successful aging, the quality of life of older adults across the spectrum can be improved and transitions to frailty reduced. The template that leaders have established in understanding frailty—defining and operationalizing it, understanding outcomes, identifying pathophysiology—can be used as an approach to successful aging. Several community-based programs have been successful in promoting successful aging. These are potentially highly scalable and could have a substantial effect on the aging population, but their essential components need to be better understood. The geriatrics community is uniquely positioned to take on this role. This is a critical time to work together to make the lives of all older adults as healthy and fulfilling as possible. *J Am Geriatr Soc* 63:1459–1462, 2015.

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The academic geriatrics community has provided superb leadership in addressing frailty and complexity in older adults, but this narrow focus has come at a cost of paying less attention to the needs of a large group of older adults who are not yet frail and who want to preserve high levels of health and vigor for as long as possible.

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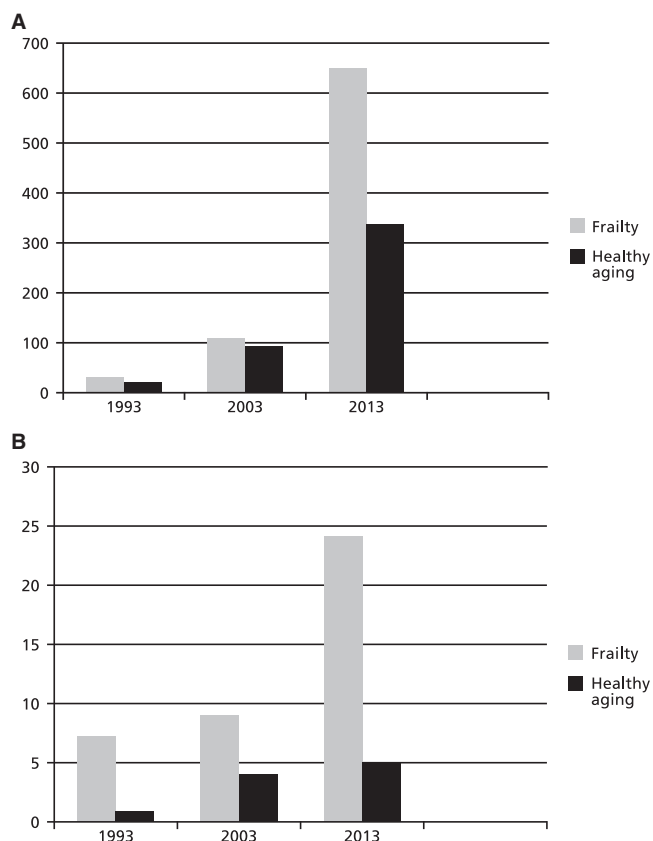
ble. The successful approach of defining the challenges, understanding the processes, and disseminating information provides an excellent framework for addressing healthy aging. It is time to broaden the vision, learn from successes, and add this new focus to efforts to improve health and quality of life across the spectrum of all older Americans.

The past 2 decades have witnessed tremendous strides in understanding frailty. Although there is still work to be done, important progress has been made in defining frailty as a clinical entity,<sup>1,2</sup> understanding its implications for care and outcomes,<sup>3,4</sup> and recognizing some of the dysregulations that occur as individuals become frail.<sup>5,6</sup> Because of the work of academic geriatricians, gerontologists, and others, tools for measuring frailty are available, and the concept of frailty is more routinely incorporated into clinical decision-making. The term “frailist” has been recently coined, and many geriatricians self-identify as having expertise in recognizing and caring for individuals who are frail.

The growth in literature related to frailty reflects this interest. A recent Medline search (completed on December 9, 2014) showed that the number of references using frailty as a key word grew from 28 in 1993 to 108 in 2003 to 650 in 2013, more than a 20-fold difference in 20 years (Figure 1A). In the *Journal of the American Geriatrics Society*, the number of manuscripts with frailty as a key word grew from seven to nine to 24, respectively (Figure 1B). In contrast, the literature on healthy or successful aging has not kept pace (Figure 1A, B).

Yet frail individuals are a minority of older adults. Studies of prevalence vary substantially depending on the population. In the Cardiovascular Health Study, which evaluated community-dwelling individuals with an average age of 73, the prevalence was 6.3%.<sup>7</sup> In the Women’s Health and Aging Study, which examined the one-third most-disabled women living in the community, prevalence was much higher, at 28%, but still accounted for only one-fourth of the population.<sup>8</sup> In the former study population, 45.3% had one or two frailty criteria (prefrail), and 48.3% had none. Whereas individuals with prefrailty have important opportunities for preventive efforts directed at limiting the transition to frailty, those who have no frailty criteria may benefit from a focus on promoting successful aging.

We are currently at a demographic tipping point. Beginning in 2011, the first of the baby boomers turned



**Figure 1.** (A) Medline publications with frailty and healthy or successful aging as key words, 1993–2013. (B) *Journal of the American Geriatrics Society* publications with frailty and healthy or successful aging as key words, 1993–2013.

65, and 10,000 turn 65 every day in the United States. Until recently, the rates of disability in later life appear to have been declining,<sup>9</sup> although those trends may be plateauing or even reversing.<sup>10</sup> There is evidence that the rate of disability in adults aged 18 to 59 increased from the 1980s through the 1990s (the group currently aging into the older adult population). This rise in disability is felt to be due in part to declining activity levels and growing rates of obesity, which raises the risk of multimorbidity, including diabetes mellitus, hypertension, coronary artery disease, and hyperlipidemia.

This trend in primary risk factors is ominous. Data from the National Health and Nutrition Examination Survey (NHANES) from 1988–1994 were recently compared with data from 2009–10. The number of individuals reporting a completely sedentary lifestyle (no physical activity) increased from 19.1% to 51.7% in women and from 11.4% to 43.5% in men. Average body mass index increased in all age and ethnic subgroups.<sup>11</sup> The 2014 edition of the American Health Rankings reported that 29.5% of U.S. adults were obese, a 7.0% increase from 2013.<sup>12</sup> Most ominous is that 9.6% of adults have diabetes mellitus, more than double the number from 20 years ago. The presence of multimorbidity puts individuals at risk of functional decline and the onset of frailty. From an individual and a systems perspective, it is critical that the geriatrics community lend its voice to framing large-scale interventions to limit these transitions.

In many ways, the baby boom generation is an ideal group in which to develop prevention efforts aimed at healthy, or successful, aging. Individuals from this generation are known for their interest in health and physical fitness and their desire to be active participants in their own health care. As members of the information age, they tend to be proactive and self-motivated. It seems appropriate not only to target prevention efforts toward older adults with chronic medical conditions and the near frail, but also to take a more-active role in promoting and educating successful aging to middle-aged and older individuals with preserved function and few or no comorbidities.

To have a meaningful effect, a standard definition of successful aging needs to be developed. Different groups in the scientific community (biomedical and psychosocial experts) and the general public define successful aging differently.<sup>13</sup> The most widely used approach may be the biomedical model, which defines successful aging as absence of disease, maintenance of physical and cognitive functioning, and active engagement.<sup>14</sup> The endpoint of avoiding disease altogether in the biomedical model makes this definition unrealistic for most older adults,<sup>15</sup> although delay in onset has certainly been shown to be feasible.<sup>16</sup> The psychosocial viewpoint deemphasizes the disease-avoidance element and focuses more on general life satisfaction, social functioning, and psychological resources of support when defining successful aging.<sup>17</sup> Finally, the general public often thinks of successful aging as a combination of spirituality, positive coping, freedom, comfort resources, relationships, independence, and beneficial contribution to society.<sup>18</sup>

The recent approach to defining frailty provides a model of how a consensus definition of successful aging might be attained. Frailty, for example, is defined as a syndrome of decreased physiological reserve and resistance to stressors, which results in increased vulnerability to poor health outcomes, worsening mobility and disability, hospitalizations, and death.<sup>1</sup> Frailty involves multiple physiological systems and different phenotypes; nonetheless, progress has been made in adopting a consensus definition that links clinical observations to physiological processes. Similarly, a consensus in defining successful aging can be achieved that also links clinical observations with physiological processes. The potential for translational research on successful aging would be greatly advanced as a result. Successful aging could be characterized as a counterbalance to frailty. For example, it can be defined as good physiological reserves to maintain full functional ability and resist stressors and changes, which results in greater resistance to poor health outcomes.

Is tackling the goal of healthy or successful aging a task that the geriatrics community can take on? Many have argued that resources for addressing the needs of older adults are limited. There are currently just over 7,000 board-certified geriatricians practicing in the United States.<sup>19</sup> There are approximately 40 million older adults in this country.<sup>20</sup> This translates to 5,700 older adults for every geriatrician, and demographic characteristics indicate that this ratio will increase over the decades to come.

As has been noted,<sup>21</sup> the geriatrics personnel to provide medical care for all older adults is not available. There is growing consensus that the individuals who need

geriatric care the most are very elderly adults, medically complex individuals, frail individuals, and functionally impaired individuals.<sup>22</sup> From a clinical standpoint, it makes perfect sense to continue to limit the provision of services to people with the greatest need, but from a societal and systems standpoint, it is a recipe for disaster.

Setting aside for a moment the human costs of an increasing prevalence of frailty with the changing demographic and lifestyle trends, the financial cost to society is substantial. Frail older adults need disproportionate amounts of care across the continuum, including inpatient, outpatient, and long-term care.<sup>23</sup> If nothing is done to delay the onset of frailty, multimorbidity, and functional decline, clinical and financial resources will be drained, further limiting the ability to provide care across the spectrum.

There are many recent examples of the ability of the geriatrics community to leverage its resources to create meaningful change. Through research, educational efforts, and program development funded by the National Institutes of Health and private foundations such as the John A. Hartford and Donald W. Reynolds Foundations, care for older adults has changed in a variety of medical disciplines such as in oncology, the surgical subspecialties, and emergency medicine. The key to changing care is vision, determination, organization, and leadership.

A survey by the Task Force on the Future of Geriatric Medicine identified preventive gerontology as an area of special expertise of geriatricians,<sup>22</sup> yet if the frailest individuals are solely focused on, opportunities for prevention are minimized. The concept of “squaring the curve”—of limiting morbidity at the end of life—has been a central tenet of geriatrics for decades,<sup>24</sup> and despite this, the literature is failing to keep pace with this concept. In 2013, there were half as many articles that had “successful aging” or “healthy aging” as key words, compared to those focused on frailty (338 vs 650) in Medline, and in the *Journal of the American Geriatrics Society*, there were only one-fifth (5 vs 24) (Figures 1A, B).

There is danger of letting resources dictate goals. What is the goal in geriatrics? The authors would suggest that it is to make the lives of ALL older adults as healthy and fulfilling as possible and to ensure that all individuals have an opportunity to experience their best possible health for as long as possible. As such, it is not enough to provide clinical care to those who can most benefit from the field’s expertise. As others have stressed, leadership is needed to “develop, practice, evaluate and disseminate the principles of geriatrics.”<sup>22</sup>

Expertise in the realms of frailty, disability, and complexity and of transitions to these states informs understanding of those who are not there yet. By understanding risk factors, as well as the outcomes of these states once they are established, geriatricians have important voices to lend to the discussion of optimizing health for older adults. Who better to take the lead in promoting lifestyle changes that will reduce the burden of frailty, cognitive loss and comorbid chronic illness?

It has been noted in an editorial on geriatric leadership that “working harder in the present system is unlikely to result in any long-term substantive change.”<sup>25</sup> The academic geriatrics community should provide leadership

for a novel robust “Social Epidemic” designed to reduce risk factors, to enable a future older age less perturbed by frailty, less likely to bankrupt the healthcare system, and more likely to promote dignity in aging for future generations. In his book *The Tipping Point*, Malcom Gladwell described the mechanics of extraordinary social change (epidemics). Geriatricians have many of the qualities that lead to successful social epidemics. First, they are connectors. They interact regularly with people in the aging world at all levels—more so than any other professional group. They are at the same time content experts—mavens—and successful salesmen, skilled at advocacy with department chairs, funding organizations, and advocacy groups.

How might this challenge be undertaken while still providing the highest-quality care to the existing older adult population? Intent and interest would have to be declared. This could be in the form of a policy paper or more likely a public declaration of what is intended. Participants would be characteristically inclusive and invite other aging societies to join. The American Geriatrics Society (AGS) and the *Journal* would be the public face.

The work could be leveraged by identifying needs of potential partners. For example, the Centers for Medicare and Medicaid Services inaugurated a preventive program in 2011, the Annual Wellness Visit and the Personalized Prevention Plan. This program provides a fee structure for primary care providers to delineate a preventive program for new Medicare beneficiaries along with a written preventive program and yearly check-ins. There are no copayments, and the programs are open to all new beneficiaries. Only approximately 6% of beneficiaries avail themselves of this service.<sup>26</sup>

There are successful examples of community-based approaches to optimizing health and aging, but these need to be understood better, including their key elements and their generalizability. Community projects based on the Blue Zones principles<sup>27</sup> have led to wide-scale improvements in activity level, weight loss, nutrition, and downstream outcomes such as longer life expectancy and lower health-care costs. The Experience Corps, which brings together older volunteers and students in city public schools, has helped to boost students’ academic success while preventing physical, cognitive, and psychological disability of older adults. Some AGS members are working with a nonprofit community-based advocacy organization in Boston, the Community Catalyst, aimed at enhancing geriatrics knowledge of consumers in five states. These are all potentially highly scalable programs.

This challenge provides an important opportunity for members of the geriatrics community to demonstrate their scientific, organizational, and leadership skills. Collaborative efforts between geriatrics, communities, and individuals will set the stage for developing a healthier society for all to age well and successfully. The time is right to meet this opportunity together!

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