Is primary health care capable of addressing frailty?

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An 86-year-old lady presents to her primary care physician for a regular follow-up. She visits her physicians every three months for follow-up of her hypertension and high cholesterol. She mentions that she feels too tired lately. After a quick review, the practitioner reassures her, explaining that the symptoms are part of usual aging and sends her back home. Two days later, the lady falls at home and suffers a hip fracture. On reviewing her chart by the geriatric liaison team in the hospital, in Tripoli, Lebanon it becomes clear that the patient never received a comprehensive geriatric assessment and has the criteria of a frailty syndrome. It is clear that her primary care physician was not sensitive or well equipped to deal with this geriatric syndrome.

One of the century's major achievements is the continued increase in life expectancy. However, the additional years of life do not always correspond to years of healthy life, which may result in an increase in frailty [1]. Early detection of the condition is critical for assisting older adults in regaining function and avoiding the negative consequences associated with frailty [2]. Despite the critical nature of diagnosing frailty, there is no conclusive evidence or consensus regarding whether routine screening should be implemented in primary care. A variety of screening and assessment instruments have been developed from a biopsychosocial perspective, with frailty defined as a dynamic state caused by

deficiencies in any of the physical, psychological, or social domains that contribute to health [3].

Frailty should be identified and addressed through the use of a comprehensive and integrated approach to care. To accomplish this goal, primary health care (PHC) must serve as the fulcrum around which care is delivered, not just to the old and frail, but to all individuals, by emphasizing a life-course and patient-centered approach centered on integrated, community-based care [4]. Personnel in primary health should be trained to address frailty not just clinically, but also in a societal context. Additionally, health professionals should contribute to community-based frailty education and training, promoting community-based interventions that assist older adults and their caregivers in preventing and managing frailty.

Frailty is becoming more prevalent. Around 10% of people over the age of 65 and 25–50% of those over the age of 85 are frail. There is an immediate need to develop a primary care assessment instrument that is considered the gold standard for assessment. Frailty phenotype [5], Short Physical Performance Battery (SPPB) [4] and Edmonton frail scale are some suggestions [4]. There is a need to develop educational strategies to educate health care professionals at all levels about frailty prevention and management. There are few publications that discuss the evidence for and viability of educational/training programs for frailty prevention and/or management [6].

To address the growing epidemic of frailty, health care planners (worldwide) are refocusing their health care workforce capacities. Thus, increasing awareness, knowledge, and skills among a diverse group of professionals involved in the social and medical care of older adults is critical for developing an efficient and effective integrated frailty prevention approach (FPA) [3]. Physicians, nurses, and other medical personnel should be trained in recognizing pre- and frailty symptoms and implementing evidence-based interventions for prevention and management [7]. Only a few studies have been conducted to determine the efficacy of education and training programs for health care professionals addressing older adults' functional abilities in a variety of care settings

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[8–11]. There is a dearth of evidence supporting education and training of health professionals in the field of frailty prevention and management [8–11].

Frailty and pre-frailty identification, and frailty prevention are critical components of future health care needs in this context. Certain European countries, such as Ireland, have already recognized this need and established national educational strategies to prepare the health care workforce for the growing demand for skills in elder care [12]. A recent paper [13] was published by an expert group of geriatricians. In this paper, geriatricians from across Europe discuss the role and competencies of medical doctors in providing care to older adults in a variety of care settings. Prevention at all levels of public health is a critical component that future medical doctors must possess to meet the demands created by European citizens' increased life expectancy.

The development of health systems requires a multifaceted approach aimed at addressing resource shortages and training and retraining sufficient personnel to meet the needs of the elderly population [14]. Training health care professionals on new clinical entities adds another layer of complexity, as it requires not only financial reallocation but also a shift in mentality. In general, health professional education and training are critical for ensuring high-quality care across all care settings [15].

Macdonald et al. [16] conducted a meta-analysis to determine the efficacy of primary care interventions for physical frailty in community-dwelling adults aged 60+ and provided an up-to-date review of the literature in this area. They concluded that exercise, either alone or in combination with nutrition supplementation or education, as well as comprehensive geriatric assessment, may help to reduce physical frailty. Individual-level factors and the availability of health system resources will almost certainly dictate the configuration of future interventions [16]. Whereas Travers et al. [17] conducted a systematic review of primary care frailty interventions. There were 925 studies that met the search criteria, but only 46 were included. They emphasized that as frailty prevalence increases, recommendations for routine frailty screening in general practice are increasing. In 2017, England made frailty identification a contractual requirement [17].

Kotsani et al. [18] emphasized the importance of educating the primary care team about frailty through a brief training course that can significantly improve PHC professional attitudes and practices regarding frailty. Regardless of the significance of their study, it is critical to emphasize the importance of increasing the knowledge of PHC team members regarding major aging issues through continuous CME and CPD programs addressing major geriatric issues. There is a need to be more proactive in our frailty education. We need to set the agenda so that frailty is no longer viewed as a natural byproduct of aging. Consider it as a clinical

constellation that, when recognized, prompts the physician to consider the following: “This older person is vulnerable and requires a comprehensive geriatric assessment”. If physicians caring for patients as the one described above were educated about major geriatric issues, they would have handled the patient differently and maybe avoided hip fracture. Some of the methodology that a primary care provider can resort to include:

1 Formal education. There is a need for medical schools, both undergraduate and graduate, to place a premium on frailty education. The BGS's response to this knowledge gap is to formalize undergraduate curriculum content on frailty and to place all foundation and core medical training doctors under the supervision of a geriatrician for a period of dedicated training.

2 Theoretical instruction alone is insufficient. While teaching theory is one thing, this does not guarantee that the learner will take this knowledge and apply it in practice. Theoretical education about frailty must be supplemented by coordinated clinical exposure. A critical component of frailty education is equipping learners with the skills necessary to manage frail patients once they are identified. Additionally, addressing learners' attitudes toward old, frail patients is critical for progress, but extremely difficult. Developing learning outcomes that adequately address attitudes requires thought; determining how these can be assessed and how attitudinal change can be quantified adds another layer of complexity. Perhaps interspersing frailty education with patient and public involvement is one approach—patients have the potential to be far more powerful educators than we do!

3 Innovative education There is a requirement for innovation, creativity, and stimulation. At the moment, in a digitally connected world where an incredible amount of information is available at the click of a mouse, clinically relevant online medical updates may be a means of reaching, motivating, and teaching junior learners. With this in mind, consider short, focused video podcasts, such as the Mini-GEMs (Geriatric E-learning Modules) recently described in the BGS newsletter. These are hosted on YouTube and are open to the public.

4 Ensuring that we explain to junior what it means when we refer to an older person as frail.

5 Explaining why comprehensive geriatric assessment is necessary. Perhaps junior doctors who have a better grasp of what frailty is will be more receptive to the fact that these patients are walking a physiological tightrope.

6 It is critical to emphasize that simply teaching how to manage frailty in primary care is insufficient.

7 Models We must ensure that primary care has the capacity to care for older patients. This must be focused on increasing the educational level of the multidisciplinary team that is responsible for the elderly. This can be

accomplished in a variety of ways, including the successful models of continuous education established by The European Academy for Ageing Medicine (EAMA) in Europe and the Middle East Academy for Ageing Medicine (MEAMA) in the Middle East and North Africa.

8 Age-friendly primary health care Services will have to be oriented around the needs of older people rather than around the needs of the services themselves. It is important to move from disease-focused approach toward care that aims to enhance older people's intrinsic capacity over their life course.

Abbasi and colleagues advocate for frailty case finding in primary care in a linked article [19]. However, the absence of consensus on a clinical definition or tool for detecting frailty, as well as a lack of evidence regarding the clinical utility of its detection, continue to be significant barriers to identifying and managing frailty in primary care. Costs and potential harms associated with routine clinical use of frailty tools should also be considered. Costs associated with screening for frailty in primary care are unlikely to translate into improved clinical outcomes in the absence of a clear definition and evidence for clinical decision-making. Additionally, patient perspectives have been largely ignored in frailty research. Patients over the age of 65 have expressed disagreement with researchers' frailty definitions and object to being labeled as "frail" [20, 21]. Screening for frailty may have a detrimental effect on patients if it stigmatizes them. Without the involvement of older patients in future research and development of clinical decision-making aids related to frailty, it will be impossible to conduct future research and develop clinical decision-making aids related to frailty (22).

Age-related frailty, disability, and pain are major concerns for our society and health and care systems. Care delivery that is efficient and responsive to individual needs and social circumstances is an unavoidable responsibility for policymakers and management teams. In the scientific literature, there is a significant knowledge gap regarding education and training of health care workers in the prevention and management of frailty. Additional research is necessary to determine the most effective educational strategies for health professionals to prevent and manage frailty.

However, the issue of frailty is not addressed systematically in the primary healthcare (PHC) network, possibly due to a lack of consensus on the most appropriate instruments for detecting its presence among PHC patients, or because reports on the effectiveness of interventions in this area frequently originate in areas other than PHC, or because the necessary resources are not available. Frailty case finding in primary care is complicated by time constraints, a diversity of care providers, and an abundance of tools available. Despite the feasibility of the recommended case finding tools, acceptance varied according to provider role and was higher for tools that required minimal clinic interruption,

few resources, and added benefit (e.g., stratify risk, enhance understanding of frailty).

I believe that additional research is necessary before we can determine the most effective strategies for improving the primary health care team's ability to detect frailty and how that research can be leveraged to improve frailty-related clinical and public health practice. Additionally, research is necessary to prioritize intervention targets and to identify novel teaching methods. Nonetheless, the present work established critical foundations for future research.

Declarations

Conflict of interest There are no conflicts of interest to be declared.

Ethical approval This article does not contain any studies with human participants or animals performed by any of the authors.

Informed consent For this Type of study formal consent is not required.

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