The Journal of Frailty & Aging 15 (2026) 100146

Contents lists available at ScienceDirect

The Journal of Frailty & Aging

journal homepage: www.elsevier.com/locate/tjfa

Brief Report

# Implementation of a best practice advisory alert for inpatient frailty screening and intervention: A pilot quality improvement program

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ARTICLE INFO

*Keywords:*
Frailty
Screening
Inpatient
Best practice advisory
Electronic health records

ABSTRACT

*Background:* Frailty is highly prevalent in hospitalized older adults and predicts adverse health outcomes but remains under-recognized. Manual screening tools previously employed were challenging in high-volume settings and reliant on individuals' knowledge on frailty. With the development of electronic health records (EHRs), there is a potential to automate screening for frailty in hospitalized older adults. We introduce a quality improvement initiative that utilizes an EHR-automated Best Practice Advisory (BPA) alert to identify inpatients who may benefit from geriatric intervention and encourage timely Geriatric referral to a Mobile Frailty Intervention Team (MFIT).

*Methods:* MFIT was piloted at Woodlands Hospital, an integrated acute and community hospital in Singapore. BPA was automatically triggered to encourage referral to MFIT if any of the following criteria were met a) Clinical Frailty Scale (CFS) $\geq 7$ b) CFS 5–6 with presence of either of cognitive impairment / high falls risk / high readmission risk c) Age $\geq 60$ with presence of delirium, regardless of CFS status. The MFIT team conducted Comprehensive Geriatric Assessments (CGA) as part of routine review with the diagnosed geriatric syndromes and discharge dispositions recorded.

*Results:* On MFIT review, 81.3 % ($N = 248$) of patients referred had a geriatric syndrome and 68.5 % ($N = 209$) had multiple syndromes. MFIT further identified syndromes which may be neglected during acute admission such as underlying dementia (87 %, $N = 83$), osteoporosis (13.4 %, $N = 41$) and urinary incontinence (9.8 %, $N = 30$). MFIT also provided discharge recommendations which were adhered to in 79.2 % ($N = 232$) of patients. 32.8 % ($N = 100$) were given specialized outpatient clinic follow-up with Geriatric medicine, suggesting the potential to divert patients from away from primary care services and unplanned readmissions. Further studies are needed to investigate whether this transition effectively optimizes resource allocation.

*Conclusion:* A CFS-based BPA alert may be feasible in providing an automated and scalable method to identify hospitalized older adults with frailty that would benefit from timely geriatric intervention.

## Key points

- This report presents a quality improvement initiative that pilots the use an Electronic Healthcare Records (EHR) based Best Practice Advisory (BPA) alert, as a scalable and automated screening tool to identify hospitalized older adults with frailty who may benefit from geriatric intervention and encourage timely referral to a Mobile Frailty Intervention Team (MFIT).
- Most older adults referred to MFIT were diagnosed with multiple geriatric syndromes such as underlying dementia, osteoporosis and urinary continence which may otherwise have been neglected during an acute admission.
- MFIT also assisted with discharge planning and provided new follow-ups to specialized Geriatric clinics, suggesting the potential to divert patients away from primary care services and unplanned readmissions. Further studies, however, is warranted to investigate impact of this transition on resource allocation.
- Clinical Frailty Score-based BPA alert may be feasible as an automated and scalable screening tool to identify hospitalized older adults with frailty who may benefit from geriatric intervention.

**Why does this paper matter?**

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https://doi.org/10.1016/j.tjfa.2026.100146
Received 22 December 2025; Received in revised form 27 February 2026; Accepted 2 March 2026
Available online 21 March 2026

With the high prevalence of frailty in hospitalized older adults, there is a pragmatic need for an automated and scalable process of frailty screening. This paper explores the feasibility of using a best practice advisory alert, triggered automatically using electronic health records information, in identifying hospitalized older adults with frailty that would benefit from geriatric intervention.

## 1. Introduction

Frailty is defined as a dynamic state of health which involves the gradual loss of physiological in-built reserves and increases the vulnerability of older adults to adverse health-related outcomes [1]. Frailty is common in hospitalized older adults with prevalence up to 79.6 % for moderate to severe frailty and this is estimated to be up to 4 times higher as compared to community dwelling older adults [2]. Frailty status on admission predicts a range of adverse outcomes, including falls, delirium, pressure ulcers, and mortality [3,4]. However, frailty remains under-recognized [5] as there is a lack of an effective framework for its identification in an inpatient setting. Recognizing frailty timely would allow for interventions, including tailored exercise programs, nutritional support and targeted comprehensive geriatric assessment. These may slow the progression of frailty, improve function and facilitate transition back into community [6].

Currently, there is a lack of routine and systematic assessment of frailty in patients admitted into acute hospitals with many receiving disease-based models of care instead of integrated and patient-centric care with an emphasis on functional ability as an important outcome [7]. Frailty identification in most settings still relies largely on 'end of the bed' assessments with a low utilization of validated assessment tools [8]. Barriers to implementation of a frailty screening program includes a lack of consensus on definition of frailty and lack of formalized care pathways after frailty screening [9]. Locally, the Framework for Inpatient care of the Frail Elderly (FIFE) [8] was formulated in 2014 to design a system of care that reaches out to frail older patients in non-geriatrics specialty wards. It consisted of a mobile geriatrics team where ward nurses were paired with a geriatric specialty nurse / advanced practice nurse (APN) and supported by a geriatric medicine physician. Initial identification of at-risk older patients with frailty would be carried out manually by ward nurses using a structured screening template and this triggers comprehensive geriatric assessment by a specialty-nurse/APN followed by recommendations for intervention from a geriatrician. This was however challenging in a high-volume setting as it is laborious and reliant on individual nurses' knowledge on frailty care [10]. Hence there is a need to better define frailty and implement a standardized tool to ensure consistent outcomes.

With the development of advanced electronic health records (EHRs) systems, there is now the potential to leverage structured EHR data to bypass manual screening processes. EHR notifications in the form of Best Practice Advisory (BPA) alerts have been used in areas such as recruitment for a hospital-at-home program [11] and identifying those who would benefit from early Advance Care Planning [12]. The usage of BPA alerts has shown promising results in an emergency department setting for identification of older adults at risk of delirium [13]. There is potential for utilization of EHR data to create an automated and scalable workflow for timely frailty identification and intervention to improve outcomes.

In this report, we introduce the Mobile Frailty Intervention Team (MFIT) program, a geriatrician-led qualitive improvement initiative that aims to provide timely geriatric assessment and intervention to frail hospitalized older adults outside of geriatric care wards. In this program, we took a novel approach of utilizing available EHR data to automatically identify hospitalized frail older adults who would benefit from an inpatient frailty assessment and trigger a BPA alert to encourage referral by the primary inpatient care team to our MFIT program. We present the preliminary outcomes from this program, including its impact on identification of Geriatric Syndromes and on discharge disposition.

## 2. Methods

### 2.1. Setting up MFIT

The MFIT program was piloted in Woodlands Health (WH), a 1000-bedded integrated acute and community hospital based in the north of Singapore that started operations in 2024, currently operating at 460 bed capacity with plans for gradual expansion. As part of building a frailty ready-healthcare system, one of the initiatives introduced in WH was frailty screening using Clinical Frailty Scale (CFS) [14]. This is done by ED nurses for all patients aged $\geq$ 60 years old upon presentation to ED. CFS was chosen as it has been validated in previous studies for use in ED setting [15] with good inter-rater reliability between nurses and clinicians [16]. Locally, CFS is also the tool of choice for frailty screening and segmentation, as recommended by National Frailty Workgroup 2023 [17]. In addition, patients are assessed for fall risk using the Johns Hopkins Fall Risk Assessment Tool (JHFAT) [18] and screened for cognitive impairment using the 4AT [19] score by inpatient ward nurses upon admission to the ward. Both JHFAT and 4AT were selected to be easily administered and retains reliability and validity as a screening tool when done by non-specialist staff including nurses [18,19]. Data will be entered into EPIC [20], the main EHR system used in WH, to facilitate automated screening for at-risk older adults who may need frailty intervention.

### 2.2. Inclusion and exclusion criteria

MFIT inclusion criteria are as follows: A) CFS $\geq$ 7, B) CFS 5–6 with presence of either of cognitive impairment (4AT score 1-3) / high falls risk (JHRAT $>$ 13) / high EPIC readmission risk ($\geq$ 30 %), C) Age $\geq$60 with presence of delirium (4AT score of $\geq$ 4), regardless of CFS status. (Supplementary Figure 1)

The EPIC unplanned readmission risk model [21] is a proprietary predictive algorithm embedded within the EPIC EHR system. It predicts the risk of an all-cause unplanned readmission within 30 days following index hospital discharge. High readmission risk in frail patients is often a symptom of underlying functional decline, presence of unevaluated geriatric syndromes and reflect gaps in social support which MFIT could help address.

Exclusion criteria include critically ill patients under the Dangerously ill patient (DIL) list or those admitted in the Intensive care / High dependency unit / Acute Assessment Unit where achieving stabilization would take priority. We also excluded patients admitted under palliative medicine or frail care wards (which are already run by Geriatricians) and those who have been reviewed by a Geriatrician (either as an inpatient Geriatric Consult or under Geriatric Liaison Services) to prevent duplication of care. Patients in the Short Stay Unit or Community Hospital wards were also excluded.

For patients who fulfilled MFIT criteria, EPIC would trigger a BPA alert to inform the primary inpatient care team to consider placing a consult order. If the primary team accepts the BPA trigger and places the consult order, the patient would then be reviewed by the MFIT team. (Supplementary Figure 1)

### 2.3. MFIT intervention

MFIT team conducts comprehensive geriatric assessments and evaluates for cognitive impairment, recurrent falls, urinary incontinence and osteoporosis. The MFIT team also provides expertise in managing medical-functional issues such as postural hypotension, behavioral issues related to dementia/delirium, dysphagia with malnutrition, and polypharmacy. Furthermore, MFIT provides geriatric expertise on utilization of suitable home, center-based services or transitional services such as hospital-at-home initiatives to smoothen the discharge planning

process. With each review, the team endeavors to start discharge planning from the point of admission, with early initiation of caregiver training, home modifications and procurement of equipment if needed. MFIT aligns with the national goal of providing value-driven care [22], by aiming to reduce length of stay, readmission and reduce overall cost to the system.

All patients under MFIT service will be reviewed by a Geriatric trained clinician (senior resident grade or above)/APN with overall supervision by a Consultant Geriatrician, who may physically review the case if deemed necessary.

### 2.4. Data collection

Baseline demographics including age, gender, CFS scores were available through EPIC EHR. For each patient, the type of geriatric syndrome present on review was recorded as part of routine documentation by the MFIT team. Labelling of a new diagnosis of these conditions (eg newly diagnosed dementia, osteoporosis and urinary incontinence) was done by the MFIT clinician as part of routine care based on review of available clinical information. Through a retrospective and systematic review of MFIT clinical notes manually by our authors, the number of Geriatric syndromes present on initial MFIT review and newly diagnosed geriatric syndromes were derived. Discharge disposition was also tracked and classified into those who were discharged home with community services, back to community, back to nursing home, to transitional care services such as hospital-at-home, or those who needed institutionalization. The number of patients with new outpatient Geriatric medicine follow-up were also identified. (Table 1)

## 3. Results

### 3.1. Baseline demographics, reason for referral

307 patients were referred into MFIT program between May 2024 to July 2025. 2 patients were triaged for subacute admission hence excluded from data collection. The remaining 305 patients had an average age of 80.5 years, with age range between 64 to 104 years old. 68.5 % (N=209) were mild-moderately frail (CFS 5 to 6). A small number of pre-frail patients (12.5 %, N=38) were recruited on a case-by-case basis due to presence of geriatric syndromes that may benefit from intervention. The most common reasons for referral were cognitive impairment, followed by high falls risk and delirium. (Table 2)

### 3.2. Identification of geriatric syndromes

81.3 % ($N$ = 248) of patients referred into MFIT had a geriatric syndrome present on initial review, with delirium and behavioral and psychological symptoms of dementia (BPSD) being the most common. 68.5 % ($N$ = 209) had ≥ 2 Geriatric syndromes. (Supplementary Fig. 2)

27 % ($N$ = 83) had newly diagnosed dementia, 13.4 % ($N$ = 41) had newly diagnosed osteoporosis while 9.8 % ($N$ = 30) had newly diagnosed urinary incontinence. MFIT also provided specialist geriatrics input in management of recurrent falls ($N$ = 79, 25.7 %) and delirium ($N$ = 175, 57.0 %). For 23.6 % ($N$ = 72), MFIT also provided support acute medical management e.g. postural hypotension, hyponatremia, blood pressure control and anemia, for patients from non-medical specialties. (Table 3)

**Table 1**
Baseline demographics, clinical frailty scores and presence of inclusion criteria.

| Baseline Characteristics (Total $N$ = 305) | | |
|---|---|---|
| Age – years, mean (SD) | 80.5 (8.20) | |
| Gender – Male ( %) | 146 (47.9 %) | |
| CFS Score 3 to 4, N ( %) | 38 (12.5 %) | |
| CFS Score 5 to 6, N ( %) | 209 (68.5 %) | |
| | Presence of Cognitive impairment | 151 (72.9 %) |
| | Presence of High falls risk | 102 (48.8 %) |
| | Presence of High Epic Readmission risk | 50 (23.9 %) |
| CFS Score >/= 7, N ( %) | 58 (19 %) | |

Abbreviations: CFS – Clinical Frailty Scale, SD- Standard deviation.

**Table 2**
Number and type of Geriatric Syndromes present on referral to MFIT followed by number and type of geriatric syndromes identified among the patients recruited into MFIT.

| Type of Geriatric Syndromes present on referral to MFIT | |
|---|---|
| Presence of Cognitive impairment, N ( %) | 216 (70.8 %) |
| Presence of Delirium, N ( %) | 150 (49.2 %) |
| High falls risk, N ( %) | 135 (44.3 %) |
| High readmission risk, N ( %) | 83 (27.2 %) |
| **Geriatric Syndromes identified by MFIT** | |
| At least 1 Geriatric syndrome, N ( %) identified | 248 (81.3 %) |
| Newly diagnosed dementia, N ( %) | 83 (27.0 %) |
| Newly diagnosed osteoporosis, N ( %) | 41 (13.4 %) |
| Newly diagnosed urinary incontinence, N ( %) | 30 (9.8 %) |
| Delirium, N ( %) | 175 (57.0 %) |
| BPSD or titration of psychotropics, N ( %) | 156 (50.8 %) |
| Recurrent falls, N ( %) | 79 (25.7 %) |
| Acute medical management, N ( %) | 72 (23.6 %) |

### 3.3. Impact on discharge disposition

58.3 % ($N$ = 176) were recommended for discharge back home with community services while 15.2 % ($N$ = 46) were recommended for transfer to community hospital prior to discharge home. 67.1 % of patients ($N$ = 100) had a new Geriatric medicine follow-up on discharge. A minority 4.0 %, ($N$ = 12) were recommended for placement in nursing home while 3.6 % ($N$ = 11) was recommended for hospital-at-home service (H2H). 79.2 % ($N$ = 232) of patients had a final disposition which was in alignment with MFIT recommendations. For those who did not have final disposition aligned with MFIT recommendations, reasons included family/patient's preferences ($N$ = 14) such as being keen for early discharge or declining outpatient follow-up, discharge to community hospital (CH) ($N$ = 16) e.g. need for a longer course of rehab, discharge to a transitional care facility (TCF) ($N$ = 5) e.g. to await helper, or due to demise during inpatient stay ($N$ = 4). Locally, TCFs were first set-up to house COVID-19 patients to relieve bed-crunch in acute hospitals. Today, they are run in partnership between the Ministry of Health Singapore and private healthcare providers to care for patients from public hospital who are stable and require time for long-term care arrangements to be established.

## 4. Discussion

Given the high prevalence of frailty in our hospitalized older adults,

**Table 3**
Recommended discharge disposition of patients recruited into MFIT program and proportion whose final disposition was as per MFIT recommendation.

| Recommended discharge disposition | |
|---|---|
| Home ± community services | 176 (58.3 %) |
| New geriatric medicine clinic follow-up | 100 (67.1 %) |
| Transfer to community hospital then home | 46 (15.2 %) |
| Discharged back to nursing home | 27 (8.9 %) |
| Discharged to Hospital-at-Home | 11 (3.6 %) |
| New nursing home placement (or interim placement to await nursing home) | 12 (4.0 %) |
| Others | 30 (9.9 %) |
| **Final disposition as per MFIT** | 232 (79.2 %) |

Abbreviation: MFIT – Mobile Frailty Intervention Team.

this study attempts to address the pragmatic need for an automated and scalable tool to conduct frailty screening by introducing the use of a CFS-based EHR-automated BPA trigger. 68.5 % of patients had multiple geriatric syndromes present upon MFIT review. MFIT also newly identified syndromes such as underlying dementia, osteoporosis or urinary incontinence which are often overlooked during an acute admission [23, 24] and provided specialist input for management of existing geriatric syndromes such as recurrent falls and delirium which was present in more than half of patients reviewed. This suggests that a multi-criteria BPA based on CFS may be feasible in directing limited geriatric specialist resources towards patients who would benefit from a comprehensive geriatric assessment [25]. The use of a CFS-based criterion also strengthens future scalability, given the emerging literature demonstrating simplified approaches to CFS scoring, such self-rating scales, with promising results on diagnostic and predictive performance [15].

MFIT also assisted with discharge planning as shown by the adherence rate of 79.2 % to MFIT's disposition recommendations reflecting the close partnership MFIT has with various referring specialties. Reasons for non-adherence to recommendations were in-part attributed to contextual factors. As an integrated acute and community hospital, our acute and subacute teams collaborate closely to right-site patients to appropriate acuity settings in a timely manner, which may explain the proportion of patients who were transferred to CH if a longer course of rehabilitation is needed. Operational considerations such as the need to preserve acute bed capacity also explain why some patients may be transferred to TCFs while awaiting nursing home placement or to CH if they require longer rehabilitation.

The number of new geriatric medicine follow-ups suggests potential for our intervention program to establish a longitudinal care relationship, shifting the burden of post-discharge follow-up away from primary care clinics or unplanned readmissions [26]. However further studies are needed to investigate whether this transition effectively optimizes resource allocation.

There are, however, some limitations. If implemented in silo, a BPA triggered intervention program may make it easier to simply trigger an onward referral. Given that frailty is increasingly prevalent, there is a need to upskill the entire healthcare workforce to be frailty-ready [27]. If paired with relevant training programs, MFIT may serve to provide exposure to geriatric principles of care and present the opportunity for cross-disciplinary upskilling.

As a quality improvement initiative, this study also has inherent methodological limitations such as the absence of a comparative group, descriptive nature of patient-level data and lack of longitudinal outcomes. However, given the novel use of EHR-based BPA as a frailty screening tool and lack of existing literature, this study provides insight on its feasibility and may serve to inform the design of future clinical trials to investigate the efficacy of this model.

## 5. Conclusion

A CFS-based EHR-automated BPA alert may be a feasible and scalable tool to conduct broad-based frailty screening in hospitalized older adults, to identify those who would benefit from timely frailty intervention and facilitate post-discharge transition into the community.

## CRediT authorship contribution statement

**A.P. Chew, T.L. Tan, Z.Y. Koh, H. Tan**: Conceptualization, **J.A. Abengana**: Data curation, **L.M. Teo**: Writing-original draft, **Z.Y. Tan, H. Tan**: Writing-review & editing.

We would like to thank the patients who participated in the MFIT program and staff of Woodlands Health Geriatric Medicine Department and Woodlands Health Nursing for their support in running this intervention program.

## Declaration of use of generative AI

The author declares no usage of generative AI and AI-assisted technologies in scientific writing and in figures and images.

## Data statement

The data that support the findings of this study are available from the corresponding author, LM Teo, upon reasonable request.

## Funding

The authors have no funding sources to report.

## Ethical approval

This program evaluation was exempted from IRB review.

## Disclosures

The author has no funding sources to report. The findings in this report have not been previously published.

## Declaration of competing interest

On behalf of all authors, the corresponding author states that there is no conflict of interest.

## Acknowledgements

The corresponding author affirms that everyone who contributed significantly to this work has been listed, and all contributors have been consented to be named in this article.

## Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.tjfa.2026.100146.

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