GERIATRIC 5MS	ASSESSMENT	MANAGEMENT	EDUCATIONAL OBJECTIVES
WHAT MATTERS 	☐ Ask the patient: "What matters most to you?" ☐ Ask about Advance Care Plan ☐ ADL / IADLs for function ☐ Estimate life span	• Align health care goals with what matters to patient • Document ACP in EMR and educate patient on Advance Care Planning • Address support for functional impairments with ADL / IADLs • Use lifespan to know when to transition to comfort care	• Identify functional limitations in older adults and their remedies • Use lifespan determinations to avoid futile care or ageism • Record and manage older adult's health care goals • Help older adults and families understand functional versus absolute lifespans • Ensure treatment decisions reflect patient priorities
MOBILITY 	☐ Fall screen: If any falls reported, do Timed Up & Go ☐ Check for sarcopenia & assistive devices ☐ Assess transfers, gait and speed (fall risk if <1 m/s) ☐ Ask if patient does resistance training?	• PT referral if fall risk • Set daily mobility goals • Avoid sedentariness • Twice / week strength training • Rx high protein diet (1.2-1.5 g/kg daily)	• Recognize fall risk and prevent it • Understand the dangers of sedentariness • Be able to appropriately prescribe assistive devices • Understand how to consult and collaborate with PT and OT
MEDICATION 	☐ Review Beers Criteria ☐ Identify high-risk or unnecessary meds ☐ Screen for polypharmacy	• Consider symptoms as a drug side effect before adding new Rx • Deprescribe or lower Rx dose • Avoid Benadryl- containing OTCs • Avoid prescribing cascades	• Identify potentially inappropriate medications for older adults • Perform a medication reconciliation that prioritizes cognitive and physical safety • Counsel patients and caregivers on safer alternatives and deprescribing
MENTATION 	Screen the Geri 3D's: ☐ Dementia —> Mini-Cog ☐ Depression —> PHQ2 ☐ Delirium —> CAM	• If Mini-Cog positive, do SLUMS to stage dementia and treat • If PHQ2+, do PHQ9 to stage and treat • If CAM+, use DELIRIUM mnemonic to find the cause	• Conduct assessments of cognition and mental health • Differentiate between delirium, dementia, and depression • Initiate care strategies for cognitive impairment and caregiver training • Apply pharmacological and non-pharmacological interventions
MULTI-COMPLEXITY 	☐ Check if frail ☐ Check Social Determinants of Health (SDOH) ☐ Screen for elder neglect ☐ Evaluate self-efficacy / caregiver status	• Educate on self-management of chronic conditions • Manage frailty • Consult ePrognosis for remaining life expectancy • Use social work and community resources for SDOH • Use team - based care	• Recognize atypical manifestations of common diseases • Navigate SDOH as barriers to optimal health • Know the hazards of hospitalization • Collaborate and use team-based care