PROVIDER SELF-ASSESSMENT

PURPOSE: To help individual providers, interdisciplinary teams or departments evaluate how consistently they deliver care aligned with the 4Ms while integrating dementia-capable practices across any care setting.

INSTRUCTIONS: For each statement, check the option that best reflects your current practice.

Scale: 3 = Always | 2 = Sometimes | 1 = Never

WHAT MATTERS

	Always (3)	Sometimes (2)	Never (1)
I ask older adults what matters most to them regarding health goals, routines and preferred daily activities.	☐	☐	☐
I document "What Matters" and make it visible to all team members across care transitions.	☐	☐	☐
I include caregivers or healthcare proxies in goal setting when patients have cognitive impairment.	☐	☐	☐
I adapt care plans to align with the person's life story, sensory preferences and cognitive stage.	☐	☐	☐
I revisit "What Matters" when health status or cognition changes.	☐	☐	☐
Subtotal (out of 15): _____			

MEDICATION

	Always (3)	Sometimes (2)	Never (1)
I review all medications for appropriateness using Beers or STOPP/START criteria.	☐	☐	☐
I assess for cognitive side effects or anticholinergic burden in people living with ADRD.	☐	☐	☐
I avoid or deprescribe sedatives/antipsychotics unless clearly indicated.	☐	☐	☐
I communicate medication changes clearly with caregivers and next providers.	☐	☐	☐
I explore non-drug alternatives for behavioral or sleep issues before prescribing.	☐	☐	☐
Subtotal (out of 15): _____			

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MENTATION

	Always (3)	Sometimes (2)	Never (1)
I screen for cognitive change and depression using validated tools (AD8, PHQ-2/9).	☐	☐	☐
I recognize and manage delirium risk factors (pain, infection, dehydration, medications, environment).	☐	☐	☐
I tailor communication to cognitive level (simple sentences, calm tone, orientation cues).	☐	☐	☐
I provide education and community resources to caregivers after identifying cognitive decline.	☐	☐	☐
I coordinate with other clinicians for diagnostic work-up or follow-up on suspected dementia.	☐	☐	☐
Subtotal (out of 15): _____			

MOBILITY

	Always (3)	Sometimes (2)	Never (1)
I assess fall and mobility risk using simple tests (TUG, gait observation) at each visit or shift.	☐	☐	☐
I promote safe movement and independence, even during acute illness or hospitalization.	☐	☐	☐
I address wandering or unsafe ambulation behaviors in people living with ADRD through environmental or staffing solutions.	☐	☐	☐
I involve physical, occupational and speech-language pathologists when functional or cognitive changes affect mobility.	☐	☐	☐
I teach caregivers mobility and fall-prevention techniques for home or community settings.	☐	☐	☐
Subtotal (out of 15): _____			

TOTAL SCORE (out of 60): _____

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SCORING MATRIX AND INTERPRETATION

Score range	Performance category	Interpretation	Recommended focus
50+	**Consistently Age-Friendly and dementia-capable**	Practices are well integrated and documented.	Share workflows; mentor peers; pursue formal Age-Friendly Health System or dementia-capable recognition.
38-49	**Solid foundation – targeted improvement needed**	Core practices are in place but inconsistently applied or documented.	Identify lowest-scoring M; refine workflow reliability and handoffs.
25-37	**Developing – inconsistent practice**	Awareness is present but not systematic.	Begin QI cycle: select one M, pilot a standard process, measure improvement.
Less than 25	**Needs improvement**	Age-Friendly and dementia-capable elements are largely absent.	Start with foundational education and a single M (What Matters). Pair with coaching or champion support.

USING THE RESULTS

1. Interpret patterns, not just scores

- Look for your lowest-scoring M – that's your priority focus.
- Aggregate team results quarterly to reveal systemic barriers (e.g., lack of screening prompts).

2. Translate into action

- Less than 25: Start with one M and basic education.
- 25-37: Standardize one reliable workflow.
- 38-49: Strengthen documentation and consistency.
- 50+: Model and spread best practices.

3. Use in QI and learning

- Discuss one domain monthly at huddles.
- Set measurable targets ("Increase cognitive screening to 80% in six months").
- Track correlation with patient outcomes (falls, readmissions, satisfaction).

4. Integrate into training

- Embed in onboarding, annual competencies and cross-disciplinary education.
- Pair with short scenario-based learning on ADRD care communication.

5. Align with organizational goals

- Link low-scoring M's to QI or accreditation projects (e.g., AFHS, Geriatric Emergency Department Accreditation).
- Share high-scoring units in newsletters or recognition programs.

6. Celebrate progress

- Highlight incremental wins ("all caregivers now documented").
- Capture patient and caregiver stories showing 4Ms in action.

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