

Assessing “What Matters Most” among Hospitalized Older Adults using a Geriatric Consult Service

Alexander Wen

The University of Texas Health Science Center at Houston

Megan Hatcher

The University of Texas Health Science Center at Houston

Dasom Kim

The University of Texas Health Science Center at Houston

Dana Giza

dana.giza@uth.tmc.edu

The University of Texas Health Science Center at Houston

Min Ji Kwak

The University of Texas Health Science Center at Houston

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Abstract

Background

The 4M's framework was created to help standardize and improve care for the geriatric population who often face poor outcomes. What matters is an essential part of the 4M's framework that has been shown to have the lowest rate of assessment in the inpatient setting. Our study assesses the frequency, documentation, and content of what matters assessments by a geriatric consult service.

Methods

Our study includes patients who were 65 or older at time of admission who received a geriatric consult service at Memorial Hermann Hospital from January 1, 2025, to May 31, 2025. We conducted a retrospective chart review and descriptive analysis to assess the frequency of "What Matters" assessments. We also conducted an inductive thematic analysis on the content of "What Matters" documentation.

Results

Out of 110 total patients seen by the geriatric consult service, 62.7% had what matters assessed. There were no statistically significant differences in demographics, medical history, or hospital course for patients with and without what matters assessed. The four themes we found for "What Matters" content in order of most prevalent to least is: Maintaining Independence and Function, Social Connections, Maintaining Health and Well Being, and Spirituality.

Conclusions

We did not find an increased rate of assessment of "What Matters" by a geriatric consult service. Although documentation identified patient values, no entries translated those values into actionable care plans or included realistic, measurable goals. We developed a conceptual model connecting the different themes identified in our qualitative analysis that can be used to guide what matters assessments. In addition to more thorough "What Matters" assessments, use of structured, validated tools, such as Patient Priorities Care (PPC) and Goal Attainment Scaling (GAS), is necessary to ensure that these assessments are translated into practical, actionable goals.

Background

According to US census data, the population of people in the U.S. who are 65 or older continues to grow at an ever-increasing rate, with 15.5 million older adults added between 2010 and 2020. ¹ Furthermore, the geriatric population commonly experiences numerous chronic medical conditions, cognitive and

physical decline, and complex psychosocial issues. As a result, the geriatric population often has poor outcomes, including frequent inpatient hospitalizations, emergency center visits, and skilled nursing facility stays.^{1,2} To address these unique challenges faced by geriatric patients, the John A Hartford Foundation launched a nationwide initiative, the Age-Friendly Health System (AFHS) 4M care framework. This framework consists of assessing What Matters, Medications, Mobility, and Mentation of geriatric patients.¹

What matters, one of the 4M's of the AFHS model, is considered the essential part, as other Ms should be assessed and acted on to allow the individuals to promote what matters to them.² Assessing what matters has proven to be the most difficult aspect of the 4M framework to implement in the inpatient setting, with multiple large-scale studies finding it with the lowest frequency of assessment.^{5,6} A large-scale qualitative study examining challenges with 4M implementation found that healthcare workers reported difficulties eliciting meaningful conversations with geriatric patients about what matters that translated into actionable goals. Healthcare workers also experienced uncertainty about how best to document what matters and how it extends beyond advanced care planning, health directives, and patient goals.⁵

When what matters is not adequately assessed, older adults are more likely to receive care that is misaligned with their goals, leading to poorer outcomes and reduced patient satisfaction. With specialized training in identifying what matters most to older adults, geriatric consult teams are uniquely equipped to assess what matters and implement care changes that benefit patients significantly.

Our study aims to evaluate the current practice of an inpatient geriatric consult service in assessing what matters most to hospitalized geriatric patients. We assessed how often the "What Matters" component of the 4M's model was assessed and documented by a geriatric consult service in the inpatient setting of an academic tertiary hospital. We also conducted a qualitative analysis on "What Matters" documentation to better understand the priorities, values, and goals expressed by hospitalized geriatric patients.

Methods

Study Design:

We conducted a retrospective mixed-methods study. We conducted a retrospective chart review to determine how often the "What Matters" component of the 4Ms model was assessed and documented by the geriatric consult service in the inpatient setting. We also identified patient demographics. In parallel, we conducted a qualitative analysis of consultation notes to examine the key priorities expressed by hospitalized older adults. The study included patients 65 or older at the time of admission who received a geriatric consult service at Memorial Hermann Hospital from January 1, 2025, to May 31, 2025. The University of Texas at Houston Institutional Review Board approved this study.

Outcome Measures:

Outcome Measures:

We collected the following demographic information for each patient: age, sex, ethnicity, and race. We collected the following information on patient hospital course and medical history: number of days since admission until consultation, admission to intensive care unit (ICU), reason for geriatric consult, reason for hospital admission, primary team, presence of comorbidities (hypertension, diabetes mellitus, cancer, heart failure, coronary artery disease, peripheral artery disease, dementia, and chronic kidney disease), frailty, and polypharmacy (≥ 5 medications on admission). Quantitative measures included the frequency with which the “What Matters” domain was documented in the medical chart.

Analysis:

We conducted descriptive analysis to assess the frequency of assessment of “What Matters” among patients who were seen by the geriatric consult service. We conducted an inductive thematic analysis of “What Matters” documentation to understand themes and priorities expressed by hospitalized older adults. Two reviewers (AW and MH) independently coded the data manually and iteratively refined them into themes through consensus. Patients were allowed to be represented in multiple themes.

Counts and percentages for each theme are reported, and noteworthy quotes from patients have been included. Figures and statistics were generated via StataNow/SE 19.5 (T test, Chi square test, Fischer test) and the Venn diagram was generated using DeepVenn (Supplemental S2).⁸

Results

Quantitative analysis

In total, there were 110 patients with 62.7% of patients having what matters assessed. Of note, 9 patients counted in the not assessed group were documented to be unable to be assessed due to various reasons, such as altered mental status and being non-cooperative. The average age was 80.2 ± 7.9 years, with 60% of patients being female. 54.5% were of the white race, and 45.5% were non-white races. On average, patients had a median stay of 4 days, with most patients having the medicine team as their primary team (81.7%) and just over half of patients being admitted to the ICU (57.4%). Most patients were consulted for delirium (34.6%) and geriatric assessment (32.7%). There were no statistically significant differences in demographics, medical history, or hospital course for patients with and without what matters assessed. The characteristic with the most significant difference between patients who had what matters assessed and those who didn't was “reason for consult” (p value 0.07).

Table 1
Demographic Characteristics of the Study Population and Frequency of “What Matters” assessment

Characteristic		Overall Number (%) (N = 110)	What Matters Assessed group (%) (n = 69)	What Matters Not Assessed group (%) (n = 41)	p- value
Age (mean, (SD))		80.2 ± (7.9)	80.6 ± (8.2)	79.6 ± (7.4)	0.53
Sex	Female	66 (60.0%)	41 (59.4%)	25 (61.0%)	0.87
	Male	44 (40.0%)	28 (40.6%)	16 (39.0%)	
Ethnicity	Hispanic	18 (16.4%)	9 (13.0%)	9 (22.0%)	0.40
	Not Hispanic	91 (82.7%)	59 (85.5%)	32 (78.0%)	
	Unknown	1 (0.9%)	1 (1.4%)		
Race	White	60 (54.5%)	41 (59.4%)	21 (51.2%)	0.81
	Black/African American	21 (19.1%)	14 (20.3%) 5 (7.2%)	7 (17.1%) 4 (9.8%)	
	Asian	9 (8.2%)	12 (17.4%)	9 (22.0%)	
	Other	20 (18.2%)			
Median number of days until geriatric consult (IQR)		4 (2–8)	5 (2–6)	4 (2–8)	0.73
ICU admission	Yes	63 (57.3%)	43 (62.3%)	20 (48.8%)	0.17
	No	47 (42.7%)	26 (37.7%)	21 (51.2%)	

Characteristic		Overall Number (%) (N = 110)	What Matters Assessed group (%) (n = 69)	What Matters Not Assessed group (%) (n = 41)	p- value
Reason for consult	Geriatric assessment	36 (32.7%)	26 (37.7%)	10 (24.4%)	0.07
	Delirium	38 (34.6%)	18 (26.1%)	20 (48.8%)	
	Goals of care discussion	4 (3.6%)	4 (5.8%)	4 (9.8%)	
	Polypharmacy	8 (7.3%)	4 (5.8%)	7 (17.1%)	
	Other	24 (21.8%)	17 (24.6%)		
Reason for admission	Medical	90 (81.8%)	58 (84.1%)	32 (78.0%)	0.46
	Surgical	19 (17.3%)	10 (14.5%)	9 (22.0%)	
	Others	1 (0.9%)	1 (1.4%)		
Primary Team	Medicine	90 (81.7%)	58 (84.1%)	32 (78.0%)	0.46
	Surgery	19 (17.3%)	10 (14.5%)	9 (22.0%)	
	Others	1 (0.9%)	1 (1.4%)		
Comorbidities	Hypertension	93 (84.5%)	61 (88.4%)	32 (78.0%)	0.15
	DM	47 (42.7%)	32 (46.4%)	15 (36.6%)	0.32
	Cancer	17 (15.5%)	10 (14.5%)	7 (17.1%)	0.72
	Heart failure	33 (47.8%)	16 (39.0%)	0.37	
	Coronary artery disease	23 (33.3%)	11 (26.8%)	0.48	
	Peripheral artery disease	49 (44.5%)	4 (5.8%)	5 (12.2%)	0.24
	Dementia	34 (30.9%)	9 (13.0%)	8 (19.5%)	0.36
	Chronic kidney disease	9 (8.2%)	17 (24.6%)	13 (31.7%)	0.42
		17 (15.5%)			
		30 (27.3%)			

Characteristic		Overall Number (%) (N = 110)	What Matters Assessed group (%) (n = 69)	What Matters Not Assessed group (%) (n = 41)	p- value
Frailty	Yes	41 (37.3%)	28 (40.6%)	13 (31.7%)	0.49
	No		27 (39.1%)	16 (39.0%)	
	Unknown	43 (39.1%)	14 (20.3%)	12 (29.3%)	
		26 (23.6%)			
Polypharmacy (≥ 5 meds)		93 (84.5%)	58 (84.1%)	35 (85.4%)	0.85

Qualitative analysis

Among those assessed for “What Matters”, 65 patients were included in the thematic analysis; 4 patients who only had advance directives in their documentation, and all patients in the not assessed group were excluded. We identified four recurring themes in the documentation (Table 2). We also found that there were overlaps among the themes in the documentation, and those overlaps were shown in the Venn diagram (Supplemental S2).

Table 2
Themes identified from qualitative analysis of “What Matters” documentation and percentage of patients for each theme. (allowed overlaps)

Themes	N (%)
Maintaining independence and function	27 (41.5%)
Social connections	25 (38.4%)
Maintaining health and well-being	22 (33.8%)
Spirituality	2 (3.1%)

Maintaining independence and function

The most frequently reported priority for patients was to regain their sense of independence and functioning. For most patients, this meant leaving the hospital and going back to either their home, assisted living facility, or nursing home. Patients reported wanting to return to doing the things that bring them joy and purpose such as watching TV, listening to music, work, and walking their dog. Motivation to return to their normal level of functioning was related to wish to not be a burden to others.

Example documentations:

“being home alone, watching TV and listening to music (he has multiple boxes of records of his favorite music and consider them very important)” [P1]

“high function of life and not being a burden on any one” [P2]

“Maintaining patient's dignity and independence. His work gives him a sense of purpose.” [P3]

“She was very independent prior to this fx so goal is to help her regain her walking and independence.”[P4]

Social Connections

The second most frequently reported priority for patients was maintaining social connections with family, friends, pets, and others. Patients reported wanting to be able to spend quality time with their loved ones through activities such as sharing a meal together.

Examples documentations:

“Family and social connections; Pt loves people and family. She would like to go out and shop and be with family and friends” [P4]

“would like for him to be able to sit at a table and participate in a family meal.” [P5]

Maintaining Health and Wellbeing

The third most frequently reported priority for patients was maintaining health and wellbeing. Patients reported wanting to reduce symptoms such as shortness of breath, pain, and sleep disturbances so that they could be more comfortable, maintain their functional independence, and maximize their quality of life.

Examples documentations:

“Reduce SOB so that he can enjoy more activities and be more mobile” [P6]

“Return to rehab to get stronger...to prolong life as long as he still has any cognitive function left and to God's plans for him.” [P7]

Spirituality:

There were only two documentations of spirituality. One states, “Belief in God and Son Jesus Christ” [P8] and the other states “Spiritual Health” [P9].

Discussion

In our study, we assessed the frequency of assessment of what matters among hospitalized older adults who were consulted for geriatric service. We found that a geriatric consult service had similar rates of “What Matters” assessment compared to other services. In our study, 62.7% of patients had what matters assessed. One study with over 90% of its patients coming from the general inpatient setting without a geriatric consult or ACE unit stay had 65.5% adherence to what matters assessment.⁵ Another study found 67% adherence to what matters assessment in the ACE unit.⁴ Notably, 100% of patients consulted for goals of care discussion had what matters assessed and the reason for geriatric consult was the characteristic with the most significant difference between the patients with and without what matters assessed (p value: 0.07), indicating good compliance when emphasized.

Notably 22.0% of the patients who did not have what matters assessed were unable to be assessed for various reasons such as altered mental status and unwillingness to cooperate. It is likely that more patients without documentation of what matters assessment were not assessed because their condition didn’t allow it. Documentation of why assessing what matters was not possible is important to distinguish between implementation failure and barriers at the patient level.

Despite the presence of a note template, “What Matters” documentation in our study was often vague and lacked specificity (e.g., brief statements such as “family,” “my 3 kids,” “health,” “get better”). While documentation in our study identified what matters most, no entries translated those values into actionable care plans or included realistic, measurable goals. These findings indicate the need for more thorough assessment of what matters and the use of validated tools to help connect values to the care plan.

We derived a theoretical model of how the different themes of “What Matters” relate to one another based on their frequencies and overlaps (Fig. 1). At its core, patients prioritize maintaining health and well-being, which supports quality of life by reducing disease burden, pain, and discomfort while also enabling purpose through independence, function, and social connections. In addition, some patients derive a sense of purpose independent of health through spirituality. This framework can help clinicians structure conversations by first addressing health and well-being, then exploring impacts on comfort and quality of life as well as functional and social roles. Finally, clinicians can consider the role of spirituality in patients’ sense of purpose.

After thorough assessment of what matters, providers can utilize validated models such as patient priority care (PPC) to align the care plan with a patient's health priorities and goals.^{6,7} Providers can then assess attainment of these goals by using validated tools such as goal attainment scaling (GAS).^{8–10} Incorporation of both the PPC and GAS will help bridge the gap between identifying patient values and operationalizing them into specific, actionable care plans.

Our study has several limitations to consider. First, our study was limited to a single site which could limit the generalizability of findings. Secondly, our sample size is small, which could decrease the

statistical significance of findings. Third, we didn't include those who geriatric consult service was not provided, which limits generalizability. Lastly, we relied on the documentation by the physicians, and therefore, we were unable to capture the patient's perspective on the "what matters" assessment.

Conclusion:

Overall, our findings suggest that a geriatric consult service is a promising strategy for increasing the frequency of "What Matters" assessments. However, greater emphasis on provider training and the use of structured, validated tools, such as PPC and GAS, is necessary to ensure that these assessments are translated into practical, actionable goals. Our study also highlights the importance of thorough documentation, including not only a patient's stated values but also how these values inform the care plan, as well as clear documentation when assessments cannot be completed. To address these gaps, we recommend the implementation of more comprehensive note templates that guide providers through "What Matters" discussions and incorporate tools like PPC and GAS, ultimately facilitating more patient-centered care and improving outcomes for older adults.

Declarations

Acknowledgements

Ethics approval and consent to participate

This study was approved by the Institutional Review Board (IRB) of The University of Texas Health Science Center at Houston (UTHealth Houston). All study procedures were conducted in accordance with the ethical standards of the institutional research committee and the Declaration of Helsinki. As this was a retrospective study involving existing data, the requirement for informed consent was waived by the Institutional Review Board.

Consent for publication

The study was approved by the Institutional Review Board with a waiver of informed consent. No clinical trial number is applicable to this study. Clinical documentation was retrospectively reviewed and de-identified prior to analysis. Representative excerpts from the medical record were paraphrased to minimize the possibility of patient identification.

Competing Interests

The authors declare no conflicts of interest.

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No funding as used in this study.

Author Contribution

AW: Study conceptualization and design, data collection, data analysis, including inductive thematic analysis coding, manuscript drafting. MH: Inductive thematic analysis coding. DK: Figure creation and statistical analysis. DG: Supervision and revision of manuscript writing. MK: Study conceptualization and design, supervision and revision of manuscript writing.

Acknowledgement

Not Applicable

Data Availability

The datasets generated and/or analyzed during the current study are not publicly available because they contain information collected from human participants and are maintained in a secure onedrive database at The University of Texas Health Science Center at Houston (UTHealth Houston). De-identified data supporting the findings of this study may be made available from the corresponding author upon reasonable request and in accordance with institutional policies and applicable regulatory requirements.

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Figures

Figure 1. Relationship between What Matters Themes

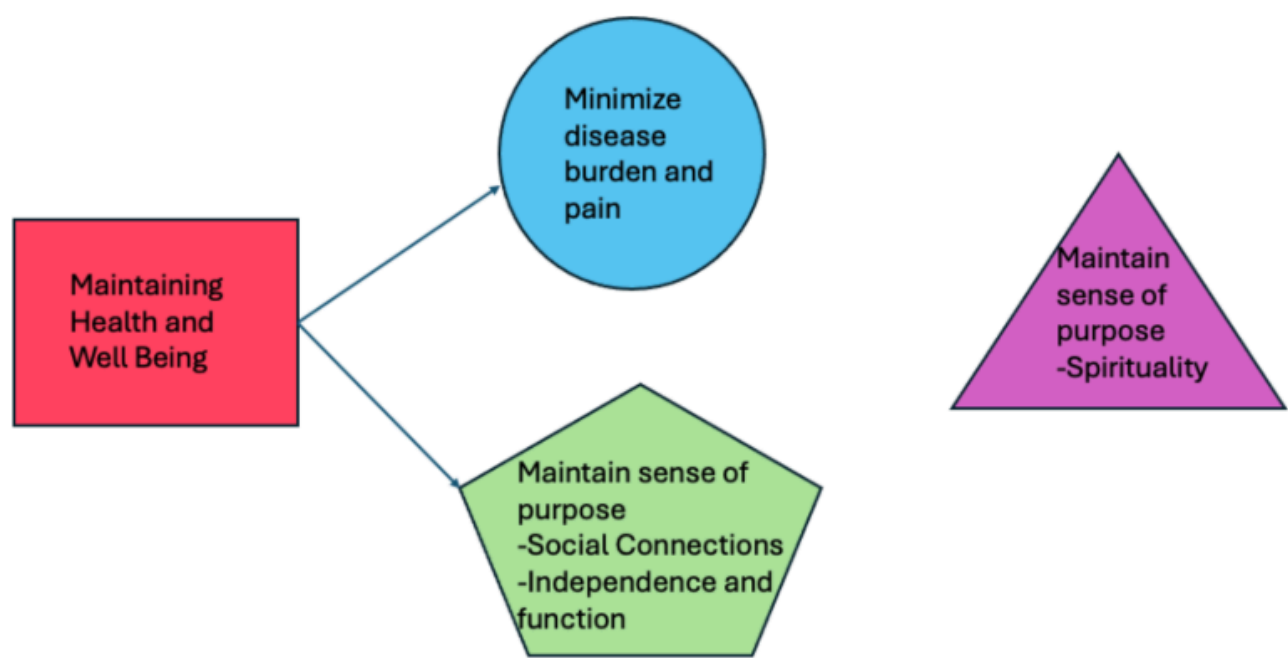


Figure 1

Relationship between What Matters Themes

Supplementary Files

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- [WMSupplemental.docx](#)