There are two main objectives for these sessions.

- The debriefing session should provide an opportunity to discuss how these results are used clinically (i.e., our interpretation of the patient’s functional and cognitive status and what we would recommend if Mr./Mrs. Gerhard were to be discharged home). In addition, this discussion should serve to reinforce the value and importance of performing geriatric functional assessment. We expect the house officers to understand the concepts of impaired mobility and cognition – our job is to reinforce the use of the data they’ve collected from the encounter as a method of documenting impairment.

- The debriefing should also provide an opportunity for house officers to discuss attitudes towards older adults, and how this may impact their communication with older patients.

This SPI encounter is fairly new, having first been delivered to house officers in 2003. We are interested in constructive student feedback directed toward its improvement.

After the learners have completed the SPI encounter and the survey of impairments, gather them around a table in a conference room. The debriefing session should take about 30 minutes. Please take some brief notes to summarize their feedback and send these to James Jensen and Karen Hall (fax: 761-7489; VAMC GRECC, Box 2399).

**Objective 1: Solicit constructive feedback.** (up to 10 minutes)

1. Ask for general feedback. “How was the experience for you?” or “What did you think of the experience?” Note responses below:

   Allows the learners to “blow off steam”. They are often performance-conscious and this general question is crucial to allow them to voice (and therefore handle) any anxieties or emotions around the experience.

   The faculty member responses should be very open-ended, eliciting further feelings and general responses and reactions. Specific issues should be noted for later reference, but usually should not be followed up at this first phase.
Solicit general reactions from any who do not spontaneously offer them.

2. Ask “What aspects of the experience were most helpful to you?” Note responses below:

   This question is still relatively open-ended and solicitous (as opposed to instructional, which should occur later when it does occur). Let a few respondents answer first, noting the answers. If appropriate, follow them up with a few “reinforcing” questions or comments to help them translate their experience into clinical practice. Solicit comments from those who have not spoken.

3. Ask “What aspects of the experience didn’t work for you?”

   This will elicit complaints and feedback, and is also generally open-ended and solicitous. Follow-up on them with questions a. and b.:

   a. Elicit what the problem was.

   b. Identify aspects of the experience that we should consider changing
Objective 2: Clinical Interpretation of the Data (10-15 minutes)

1. Ask “Do you have any questions about how the assessments are carried out, or how to interpret the results?”

   After you address learners’ specific concerns, look for opportunities to emphasize (perhaps by formulating them as questions rather than didactic statements) some key aspects of the assessment methods:

   a. **All ADLs are important.** Minimum performance is to ask all 6 areas. The SPs generally give feedback that the learner should have asked more in-depth questions. Generally, reassure learners that the main point is to think and ask about all six functions.

   b. Among IADLs, **medications, grocery shopping, and meal preparation** should be queried by all physicians’. Other IADLs will be more context-specific.

   c. For the Timed Up and Go, mention that it really requires **10 feet** of room. Most learners do not open the door to do the complete exam. This is not necessarily bad in this case, where the patient requires > 20 seconds just to get up, walk and few steps, turn around, and sit back down.

   d. Review how the Mini-Cog is **scored**, and **what to do with negative** (generally proceed on the assumption that the patient does not have significant cognitive impairment) or **positive** (further evaluation, perhaps starting with the MMSE and consideration of depression and delirium.)

   e. The 2-question depression screener is most useful to **rule OUT depression** if patient answers “no” to both questions (sensitivity 95-100%). Its specificity is limited, however (57% in one study), so patients who answer “yes” to either question should undergo some sort of additional evaluation, as appropriate to the level and type of learner. Recent practice guidelines published by the UMMC Clinical Care Guidelines Committee (June 28, 2004) recommends the two question screener as the initial quick screen for depression.

   (http://www.med.umich.edu/i/oca/practiceguides/depress/depress04.pdf)

2. (Optional) Ask “What impairments did you think this patient has?”
3. Discuss how the results from these screening tests are applied in clinical practice.

Some examples to provide include:

a. Above age 80, 30-40% of community-dwelling patients have significant cognitive impairment, often unrecognized.

b. Cognitive impairment is a strong predictor of delirium.

c. About 5% of patients above 65 suffer from major depressive illness, but about 30% of patients with medical illnesses suffer from clinically significant major or minor depression.

d. When a patient is identified who has had a fall, no further evaluation is indicated if:
   a) the circumstances of the fall are not worrisome (e.g., tripped on a rug or curb rather than sudden palpitations and collapse), b) the patient has fallen only once, and c) the Timed Up and Go is under 10 seconds.

Finally, conclude the session. Ask if anyone has any final questions.

**Thank the learners for their time.**

Be sure everyone has handed in the two evaluation forms to the LRC administrator: the first is the learner’s clinical interpretation of the SP’s impairments; the second is the learner feedback about the encounter itself.