SPEAKER:  
You're listening to Everyday Evidence presented by the American Occupational Therapy Association, helping the occupational therapy practitioner apply evidence to practice. Here's your host, Matt Brandenburg.

MATT BRANDENBURG:  
Today we are joined by Susan Fasoli. Susan, thank you so much for sharing your knowledge and expertise on the show with us today.

SUSAN FASOLI:  
Thanks, Matt. I'm glad to be here.

MATT BRANDENBURG:  
Yeah, I've been really looking forward to our conversation and to learn from you. You are a legend in occupational therapy, if you don't mind me saying. In addition to being an active member of the American Occupational Therapy Association, as well as the American Congress of Rehabilitation Medicine, you're a professor emerita of occupational therapy at MGH Institute of Health Professions where you've conducted published and disseminated research related to robot-assisted therapy and cognitive skills training, the importance of interprofessional collaboration, and what will be the main focus of our interview today - the Rehabilitation Treatment Specification System. Susan, you've done so much within the profession, what motivated you to focus your practice and scholarship on these diverse areas?

SUSAN FASOLI:  
Well, thanks, Matt. Really, I think that these areas are not as diverse as they may seem. I've always had an interest in identifying ways to improve treatment outcomes for people after stroke. And during my entire professional life, I've truly appreciated collaborating with colleagues across disciplines, knowing that we all bring unique skills and experience to our clients and our patients. My postgraduate training at BU and at MIT gave me the opportunity to learn ways to measure whether a person's ability to use their affected arm and hand after stroke was related to their use of compensatory strategies, or true recovery of motor abilities. The years that I spent engaged in robot-assisted therapy research in reading the results of other large robot therapy studies caused me to realize that we really needed to do a better job at teaching individuals how to carry over the movement gains that we saw during therapy sessions during everyday tasks. During a pilot study, I integrated cognitive strategy training with robot therapy sessions in a home program and found that the Rehabilitation Treatment Specification System, or RTSS as we call it, to be very helpful for breaking down these different aspects of treatment.

It helped to guide my thinking about how to set up the parameters of the robot games, and to better design targeted home programs that were individualized and based on clients' performance and needs.

MATT BRANDENBURG:  
I think that is such a wonderful example of letting a question or a research interest guide your actions, and it growing so much to where now it's the development of an entire model. And I love how you mentioned all these areas of practice are so connected within occupational therapy. And why do you feel it's important for OT professionals to contribute to the advancement, development and use of theory-driven interventions like you have done throughout your career?

SUSAN FASOLI:  
I've been an OT for many years, and I've seen how the advances in research and the use of theory-driven interventions can inform clinical practice, and, I think, yield better outcomes. It's important that OT professionals continue to advance the science of occupational therapy. This hopefully will contribute to new and effective ways, I think, of providing rehabilitative care and provide evidence to insurers or payers of the value that OTs bring to a person's ability to return to valued occupations and life roles after disabling event. So I think that advancement is really essential to our practice.

MATT BRANDENBURG:  
I love that, it truly is. And there's so many ways that occupational therapy can increase its scope and impact. You present about the Rehabilitation Treatment Specification System nationally at different conferences. Most recently, I believe, at the American Congress of Rehabilitation Medicine. And included in your presentations, you talk about the black box of rehabilitation, can you tell us today what is the black box of rehabilitation?

SUSAN FASOLI:  
The term black box of rehab was coined to describe a dilemma that we've faced for years. Rehab therapy is a complex. OTs work with clients to address a wide range of treatment goals. We provide a variety of treatments, some that are more successful than others, but often these treatments are not well-defined and it can be challenging to describe the essential elements. I think that this impacts our ability to know what pRTSS of our therapy worked and what didn't work. So this barrier to examining the specific effects of our treatments is what's called the black box. It's not enough to know that OTs spent an hour on ADL training, or that the PT worked on gait training for two hours. It's how that therapy was delivered, what cues or assistance was provided that's really essential to our understanding of treatment effectiveness.

MATT BRANDENBURG:  
I love that answer. It makes me think in OT education, I feel like a big step for students is learning to understand and be able to articulate what occupational therapy is and what our role as an OT is. But then from a clinician standpoint, we still need to advance that knowledge to a point where we can articulate what our treatments entail and what our interventions entail. And I wanna ask you, how can clear specification of the content and process of occupational therapy interventions benefit overall practice, research and education?

SUSAN FASOLI:  
Matt, I think that clear specification of OT interventions can help us to eliminate this black box by providing a method that clinicians, researchers, and educators can use to better articulate what the treatments are that they're administering and why. So it's the what and the why that's really important. I think specification can help researchers to better plan experimental treatments and to more precisely, examine and measure the results of their interventions.

MATT BRANDENBURG:  
I love that, and the why it's so important. And I'm so glad that you're here with us today to hopefully explain a little bit of the how practitioners can reach that point to where we're comfortable articulating the what, articulating the why. So let's dive into it. Susan, what is the Rehabilitation Treatment Specification System?

SUSAN FASOLI:  
The Rehabilitation Treatment Specification System, or RTSS as we call it, was developed and refined by an interprofessional team of rehab professionals over more than the last ten years. It's a systematic framework that we use to describe and quantify rehabilitation treatments based on a person's or clinician's treatment theory about the how or why that treatment is expected to work. In OT, we have a lot of treatment theories that guide our clinical decision-making when we plan a client's course of treatment.

MATT BRANDENBURG:  
What's the way you hope that the RTSS gets used? Are you hoping that clinicians can use this framework or this system to eliminate that black box of rehabilitation?

SUSAN FASOLI:  
Yes, I do to at least address what happens in that black box. Oftentimes, I think our documentation doesn't address or describe what it is that we actually do in therapy. I can say that I do ADL training or self-care training, but it's the way that I deliver it that's really important, that's gonna make my treatment either more or less effective than another clinicians treatment. So the better we can describe what we actually do in therapy, the more we'll understand what's inside that black box and hopefully the more effective will be in figuring out what the effects of our treatment may be.

MATT BRANDENBURG:  
Absolutely I love that. The RTSS is a wonderful support and framework. What are some of the key concepts and components of the RTSS that can help practitioners to achieve that goal?

SUSAN FASOLI:  
A key concept of the RTSS is that every treatment is guided by the clinicians treatment theory. So the treatment theory is really their hypothesis or their prediction about why and how the treatment provided will be effective. There are many sources of treatment theory, examples include well-established theories within each profession, like the model of human occupation or the task-oriented approach in occupational therapy, as well as there's a lot of less formal theories that are derived from a clinician's own practice and experience. In some cases, our treatment theory might turn out wrong, but having a hypothesis about why or how a specific treatment will work is important to figuring out how to make it more effective.

MATT BRANDENBURG:  
I love that. So the treatment theory is very important in following the RTSS or in the process of the RTSS. What about enablement theory - what's the relationship between treatment theory and enablement theory, and how does the RTSS distinguish between the two?

SUSAN FASOLI:  
That's a good question. So as I said, treatment theory is really a statement of how a treatment is supposed to work. So treatment theory guides my thinking about cause and effect - what ingredients will I provide based on my client's abilities to effect a specific target during treatment. So for a client with NS, that direct target could be improved independence or toilet transfers, or increased ability to use energy conservation techniques during hot beverage prep. Enablement theory, on the other hand, considers how different impairments, personal factors, and activity or participation limitations may causally be related to one another. So OTs use enablement theory when they make decisions about what underlying abilities are needed for successful performance. But enablement theory does not tell them how to change those abilities for a given client. Enablement theory is important when selecting the more downstream aims of treatment which is similar to our long-term goals in OT. So these aims may or may not change indirectly as a result of our treatment.

So depending on the client's level of functioning, these aims could be things like returning to driving or managing a weekly schedule of daily tasks to reduce fatigue. So for my client with NS, I may address the treatment targets of improved independence with toileting and use of energy conservation techniques to help her achieve her aims of independent self-care and home management abilities. However, there are many other targets that I'll likely need to address during our RT sessions for her to reach these treatment aims. So I guess in conclusion about that, in OT practice, treatment theory and enablement theory really complement each other. Treatment theory guides our decisions about what ingredients will affect the desired target or the immediate effect of our treatment. Enablement theory helps us to predict what targets are needed to be achieved to have a meaningful impact on our clients aims for therapy. So it makes sense?

MATT BRANDENBURG:  
That makes such clear sense, and it's beautiful to hear you describe that and really break down and provide clear terms and definitions as a way of explaining clinical reasoning, and the process that each occupational therapy practitioner goes through when conducting an evaluation or implementing the OT process. It's starting to click for me how the RTSS is a way to quantify and express this process of clinical reasoning that can be a little nebulous and tough to always put words to, I believe.

SUSAN FASOLI:  
Absolutely. Thanks.

MATT BRANDENBURG:  
So this clinical reasoning begins through treatment theory, enablement theory, aims and goal setting. And we get to treatment, how is treatment defined and what are the different components of treatment within the RTSS.

SUSAN FASOLI:  
So a clinician's theory or treatment theory will guide their decisions about three elements that comprise a treatment component in the RTSS. These elements of a treatment component are the ingredients the clinician selects or provides a client, the proposed mechanism of action which is why or how the treatment is expected to work in the target or direct change in function that's expected. So a very familiar and basic example is a target of increased bicep strength. The ingredients would include repetitive practice of bicep curls and use of a weighted barbell. In this example, we know that the mechanism of action, in other words how the treatment is expected to work is the physiological changes that happen in the muscle fibers that result from this resistance training. These changes enable improved force generation or strength which is the target of intervention. So the aims are those more downstream goals of a course of treatment that are predicted by enablement theory, as we talked about previously.

The aims may or may not change indirectly as a result of the treatment, so depending on the client's level of functioning, these aims could be things like returning to work or managing a weekly schedule of daily tasks to reduce fatigue.

MATT BRANDENBURG:  
I love that the RTSS flows so smoothly. I can't find the right word for it but it flows in a way that really, I think, can assist practitioners and students who are learning the importance of clinical reasoning to develop their own clinical reasoning and to identify aims from the very beginning and ensure that each of their treatments are addressing what's important to the client and helping them reach their goals. When applying the RTSS, what are some recommendations that you could give to clinicians to help them select client-centered targets and ingredients that are being used in their treatments?

SUSAN FASOLI:  
I'd suggest that OTs use the RTSS framework in their activity analysis skills to identify and select the targets and ingredients that they will implement during therapy. By specifying the direct targets and ingredients that they'll administer prior to each treatment session, I think that their interventions will become more intentional, client-centered, and hopefully more effective.

MATT BRANDENBURG:  
What a beautiful goal. I think everybody wants to provide care in that way. There's a number of treatment groupings defined in the RTSS, just three of them. You mentioned the physiological grouping, I believe it was with your example of building bicep strength. What are the other treatment groupings, and how should practitioners be trying to understand these groupings to inform and guide their interventions?

SUSAN FASOLI:  
That's a great question, Matt. The RTSS was organized to place all rehabilitation treatments into three treatment groups, and each of these treatment groups is mutually exclusive with regard to their targets and their mechanisms of action. So these three groups are labeled organ functions, skills and habits and representations. The organ functions, targets, addresses, changes in organs and organ systems, and those targets could include things like muscle strength, spasticity, edema, limb deficiencies, et cetera. Skills and habits targets address the development of skills and habits, usually through repeated practice. Examples include ADLs, IADLs and dexterous hand use, functional mobility, vocational skills, et cetera. Representations targets include changes in knowledge, changes in attitudes and beliefs, or facilitating volition or engagement in therapy. Clinical examples of representations targets and ingredients include patient education, counseling, and addressing motivation. So I think that the treatment groupings are helpful when thinking specifically about what needs to change and what ingredients the clinician will select based on the client's abilities.

During a single treatment session, we might provide education to increase knowledge about the importance of doing a home exercise program, and those are representations, ingredients, and targets. In addition to perhaps providing supervised practice to improve the client's ability to perform those prescribed exercises correctly, which is really a skills and habit target. I know that the treatment groupings have enabled me as a clinician, as a researcher, to better articulate what I'm targeting during therapy and to help my client achieve his or her goals.

MATT BRANDENBURG:  
I love that. It sounds like such a valuable framework and a great tool to help practitioners do exactly what you just explained, to articulate what the purpose behind each intervention is, how it's gonna help someone reach their aims, and also to approach treatment and intervention with a correct understanding or a correct approach that's evidence-informed. And how would you say that the RTSS encourages or enables practitioners to address the development of skills and habits during their intervention?

SUSAN FASOLI:  
Well, I think OTs are pretty good in addressing activities of daily living and instrumental activities of daily living skills and habits during treatment. But one concern that I've had is we've become more fully embraced and occupation-based treatments. So I'm not sure that we're always provide the right treatment ingredients to address those underlying functions that impede performance. For example, I've been guilty myself of thinking that I'm effectively working on several different targets during a treatment to improve upper body dressing. I think that I'm addressing things well, like figure ground skills when I'm asking a patient to locate the sleeve opening before putting on their shirt. We're sequencing to place their weaker arm into the sleeve first, or addressing fine motor skills when attempting to button five buttons. But the RTSS has helped me to realize that if fine motor skills are what's impeding my client's ability to complete the stressing task, then I'm not providing a sufficient dose of practice to improve their coordination.

I think the RTSS Its framework, combined with good activity analysis skills, is really helpful when addressing not only the development of skilled occupations, but also in specifying the underlying targets like limited strength or coordination, et cetera, and intentionally providing sufficient dose in rules for progression when using occupation-based tasks.

MATT BRANDENBURG:  
I love that, Susan. This framework is so practical. I think it's such a pleasure to hear you describe its implications and how it can be applied to achieve all these wonderful outcomes. How can implementing and following the RTSS improve interprofessional practice and communication across rehabilitation settings and maybe specifically during transitions of care?

SUSAN FASOLI:  
Well, I think when OTs clearly specify which treatment targets to address during an ADL task, such as, say, improved balance skills or improved sequencing during a tub transfer practice, that the covering therapist will be better able to administer more consistent and better-focused treatment session. Interprofessional use of the RTSS provides a common language, I think, and comprehensive descriptions of treatment components that improves communication across disciplines. I think this can facilitate a more holistic approach when addressing impairments that affect all disciplines, and these could be things like limited problem-solving or impulsivity or impaired procedural memory that affect treatment by occupational therapists, physical therapists and speech-language pathologists.

MATT BRANDENBURG:  
I think it's so important to, like you mentioned previously, identify that connection between what we're doing and why we're doing it. And if you're practicing OT, I'm sure you've had an experience where you receive a referral or are working with someone with a previous plan of care, and you look back to see what they were working on. And maybe those interventions, to use your example from earlier, are just upper body dressing. And you're like, well, what about this is difficult? And then it slows down the improvement that this patient can achieve because now you have to go back and you have to do your own activity analysis and really assess to find what is causing the breakdown and why was their previous therapist working on this skill. So I think using the RTSS can really help improve that transition of care. And like you said, help us to be on the same page and help patients even more.

SUSAN FASOLI:  
Exactly, Matt. I think that's a great summary, thanks.

MATT BRANDENBURG:  
How could clinicians implement RTSS concepts within their own settings to make clinical reasoning more explicit?

SUSAN FASOLI:  
I know that OTs are thoughtful when they're planning and implementing treatments for their clients. And I think that the RTSS is really helpful for clearly specifying the targets that are addressed during a given treatment session. And for evaluating whether those ingredients that were provided were or were not effective, the RTSS facilitates questions like, well, was the dose of practice sufficient to improve performance? Do I have a plan for how I will progress therapy to ensure continued progress towards targets and aims? How might my client's lack of motivation or volition impact their engagement in therapy? And how might I address this specifically during my sessions? So I think that when clinicians need to articulate their treatment theory or rationale for selecting targets and ingredients, I think their clinical reasoning is enhanced and I believe that patient outcomes will improve. Certainly, the RTSS framework can help clinicians to clearly communicate the what and the why of treatments to their clients and families or caregivers, as we've mentioned before.

MATT BRANDENBURG:  
I love that. I think that skill is so important to quality occupational therapy practice, and I love that this framework helps clinicians to develop that. Could you share a case study or a clinical example, even a personal example of how you've seen the RTSS be implemented to achieve improved health outcomes?

SUSAN FASOLI:  
Sure. I can share an example from my clinical and research experience with robot-assisted therapy and cognitive strategy training. When working with a 60 year old male who had moderate impairments and upper extremity motor coordination, strength, and grasp more than six months after stroke, I found that the RTSS was helpful for selecting treatment targets and explaining my rationale for the robot therapy exercises that he practiced. My initial ingredients, targets, actually, were to improve his range of motion and coordination during reaching activities, and I used the Amyl Spring Exoskeleton during treatment. The ingredients included assistance from the Amyl, increasing the workspace in which he needed to reach to improve range, and systematically reducing the amount of assistance that was provided by the robot as he gained control. To improve his control of shoulder, elbow and wrist motions, I progressed the robot games, which were the ingredients to require increased control of into joint coordination at the same time.

To address the target of improved grasp and release, I chose robot games that involved grasping, transporting, and releasing items that were shown on the computer screen. And together we identified tasks that he wanted to complete at home to enhance the carryover of robot practice motions to everyday activities. The cognitive strategy training was another ingredient directed toward the target of improving its ability to identify impediments when trying to use his weaker arm and hand during a desired task, and implementing one or two strategies like self stretching or changing his body position to improve his performance. The RTSS really helped me to better plan his treatment options and to change the ingredients I provided when not successful. He expressed how helpful this combined treatment approach was, and was able to describe the challenges and benefits of each aspect of treatment. He was fun to hear that months later, he had returned to golf and was well able to use his stroke-affected arm and hand during valued daily activities.

MATT BRANDENBURG:  
That is amazing, Susan. That is just such a perfect example of the OT process and really high-quality OT intervention. Of course, thank you for sharing and thank you for all the work you've put into the RTSS, because developing that clinical reasoning and developing the clinical expertise to continue refining and improving intervention to help people reach those outcomes can be really difficult and it can be challenging for a lot of clinicians. So I'm just stoked about the RTSS, I wanna start using it in my practice. How could you say that the RTSS can be integrated into interprofessional education to promote the development of student clinical reasoning?

SUSAN FASOLI:  
These are a number of OT, PT, and speech-language pathology programs across the US, Canada and now the UK that are integrating the RTSS into their curricula and clinical training programs. So it's exciting to see this advancement. Generally speaking, the RTSS has been integrated into foundational courses that introduce students to OT theories. It's been used in practice-based courses that provide instruction and activity analysis and treatment planning and clinical decision-making, and also in evidence-based treatment courses in PT and speech-language pathology. At the MGH Institute of Health Professions where I've taught, I've used the RTSS to teach students to more clearly articulate their treatment targets and ingredients, and to link these to the treatment theories about why or how they think their ingredients may be successful, so it really helps to promote clinical reasoning. We've used written case scenarios, simulations, and video observations as practice methods across these academic programs.

And some rehab clinicians have used the RTSS when mentoring students, most rehab in Philadelphia is an excellent example. Their approach guides clinicians to explicitly describe their treatment theory and choice of targets and ingredients to students, to other therapists, patients, and caregivers. And finally, I know that research has shown that clinical reasoning skills become more tacit or implicit as clinicians establish practice-based experience and expertise. The RTSS, I think, provides an important structure and framework to help these experienced clinicians, more clearly articulate their clinical reasoning to students and to new practitioners, and I think it helps them to become more effective educators.

MATT BRANDENBURG:  
Absolutely. And I can't help but think that, as you say, becoming better educators, educating at a high quality, I imagine the same is true in a clinical setting where as articulating to your patient or the people that you're working with, the connection between what you're doing and why it's important and how it relates to their goals has got to improve buy-in and motivation for the client. And I would guess in these educational settings it's improving buy-in amongst the students as well.

SUSAN FASOLI:  
Exactly. And really helping them to break down these treatments that they're reading about in their textbooks or seeing during a lecture to really break those treatments down into definable and describable parts

MATT BRANDENBURG:  
I love it. And that's such a skill, and it takes practice. And it's wonderful to have frameworks like this to help develop that skill. And how would you recommend researchers specifically could use the RTSS to inform the design and dissemination of the work that they're doing?

SUSAN FASOLI:  
That's a great question, Matt. Jared Vanston, who's a PhD speech-language pathologist affiliated with Harvard Medical School and Mass General Hospital, was the first author on an article that was published in the Archives of Physical Medicine Rehab back in 2019. And I think that this article well addressed your question. In this special communication, he and others described ways that the RTSS could improve the design, reporting, and replication of rehabilitation research by guiding researchers to explicitly state their hypothesized treatment targets and ingredients. They demonstrated how RTSS theory-based specification is more detailed and ideally, more helpful to researchers and clinicians than the tidier checklist that's commonly used to describe research interventions. I truly think that the RTSS has advantages for both research design and for the translation of research treatments to clinical practice.

MATT BRANDENBURG:  
I love that, making research more accessible, consumable, and applicable to the reader, consumer of research. That's a wonderful application of the RTSS. What additional recommendations would you give to students and practitioners to help improve their clinical reasoning?

SUSAN FASOLI:  
I'd suggest being a good consumer and evaluator of research evidence to determine whether and how you might integrate a successful research intervention into your clinical reasoning process. The RTSS can be helpful when identifying targets, downstream aims, and treatment ingredients provided during the study, and when determining whether it's feasible to translate that research treatment to clinical care. It's not an easy process because many researchers don't explicitly state the number of repetitions or how the ingredients are progressed, or their rationale for selecting outcome measures. The RTSS framework can help clinicians to improve the content and process of their treatments, I think, not only by facilitating the review of the research literature, but also explicitly applying a theory-based approach to their clinical reasoning. It makes their rationale for treatment explicit and direct.

MATT BRANDENBURG:  
I love that, Susan. I think everyone within the field of OT has heard the phrase, it depends when we have clinical reasoning questions or questions about interventions. There's always this it depends. And the RTSS sounds like it's taking the it depends to be it depends on what and it depends on why - what's the why behind the it depends? These are the factors that go into it. So it's making things more clear and more explicit in a way that's still client-centered and individually focused. I don't know if that makes sense.

SUSAN FASOLI:  
Yeah, it does, sure.

MATT BRANDENBURG:  
So I love this tool. This is so fun for me, learning about this tool from you. What further studies or research is needed to really continue advancing the application of the RTSS?

SUSAN FASOLI:  
Well, we're actually in the middle of a scoping review to identify published studies that have used the RTSS to specify rehabilitation treatments. And have found more than 50 so far that applied the RTSS to a variety of interventions for persons with aphasia, traumatic brain injuries, and stroke. One OT example that comes to mind is recently accepted manuscript that used the RTSS to retrospectively examine treatment targets and ingredients of a behavioral treatment for women diagnosed with breast cancer and compare them to the control intervention. It was interesting because this analysis was really instrumental in identifying common elements of these two interventions, the experimental treatment and the control, and was helpful in refining the conceptual model in preparation for future research. I think that going forward, studies that measure how the RTSS affects clinical reasoning by students and clinicians will help to guide initiatives to advance the use of this theory-based approach in both academic and clinical education settings.

So I look forward to engaging in and seeing those studies in the future.

MATT BRANDENBURG:  
Absolutely. We're we're gonna have to have another interview so we can review some of those outcomes and directions as they are being conducted.

SUSAN FASOLI:  
Sounds great.

MATT BRANDENBURG:  
Susan, what additional resources or certifications related to the RTSS would you recommend to our listeners who want to learn more?

SUSAN FASOLI:  
Well, Matt, there are no current certifications required to use the RTSS in clinical practice or education. But there are a lot of resources that have been developed with colleagues from ACRM, which again, is the American Congress of Rehabilitation Medicine. Listeners can go to the ACRM website, which is acrm.org and can search the ACRM communities for the Rehabilitation Treatment Specification Networking Group, or RTS-NG. On the networking group front page, there's a lot of information about RTSS's task forces, ways to connect or submit in RTSS question, lists of resources, including links to published articles and to our soon-to-be-published second edition of the RTSS specification manual. And also has links to RTSS webinars that we've done with ACRM. The annual ACRM conference also includes an entire track of presentations about the RTSS. And always, listeners can reach out to me at my email address at sfasoli@mghihp.edu for more Information.

MATT BRANDENBURG:  
Thank you so much, Susan. I'll be sure to include links to those resources in our episode description.

SUSAN FASOLI:  
Awesome. Thanks.

MATT BRANDENBURG:  
We end every episode of our show with the Golden Nugget segment, and I ask one last question to really sum it up and send a message home with our listener, Susan, if you could share one piece of advice or one recommendation with them, what would it be?

SUSAN FASOLI:  
I would say that learning a new approach to describe your treatments takes practice, and don't let the RTSS terminology deter you from giving it a try. I think that our practitioners or listeners will find that having to explain the rationale that underlies your treatments may be a challenge, but it's an important one to overcome. I know that the RTSS has honed my clinical reasoning skills and ability to teach clinical decision-making to my students, and I certainly hope that listeners will have the same experience.

MATT BRANDENBURG:  
I hope so too, Susan, and I just can't thank you enough for your time and for sharing this wonderful information and your expertise with us today.

SUSAN FASOLI:  
Thanks so much, Matt, for inviting me to do this podcast. It's been a great treat. So thanks.

MATT BRANDENBURG:  
Absolutely, the RTSS rocks.

SPEAKER:  
Thanks for listening to Everyday Evidence. Tune in next time for more evidence-based practice, insights, and applications. (UPBEAT MUSIC).