ANNOUNCER:  
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.

MATTHEW BRANDENBURG:  
Today we are joined by Dr Susy Stark, Professor of Occupational Therapy at Washington University in St Louis, and a truly renowned researcher. Thank you for being on the show today, Susy.

SUSY STARK:  
Matt, thanks for inviting me. I'm really happy to be here to talk to you. It's been a while. So, it's really good to hear your voice.

MATTHEW BRANDENBURG:  
Thank you. I appreciate that. In January of this year, 2022, you presented a grand round session for the Learning Health Systems Rehabilitation Research Network, also known as LeaRRn, about environmental interventions for fall prevention, which was titled 'Designing Complex Behavioral Interventions for Implementation'. Before we discuss this topic today, could you briefly explain what LeaRRn is?

SUSY STARK:  
Sure, I'm happy to. I had to understand what LeaRRn was myself. So, it's a collaboration of some university, Brown University, Boston University, the University of Pittsburgh, and they work together to establish the Center on Health services, training, and research, which has been called CoHSTAR, which was funded initially by the Foundation for physical therapy. LeaRRn's mission is really near and dear to my heart, and I hope to a lot of OTs in the community, it's to improve the quality and value of rehabilitation. They foster stakeholder-partnered research, so community-engaged research, and they use the learning health system. So, they look at the data that we're already collecting, as part of clinical care, to see if it can inform how we can do a better job of providing care. Some of the focus they have it's really on optimizing implementation and best practices for rehabilitation. And so that's something I'm very interested in as a researcher, is how can we help therapists be better and more effective at their jobs.

So, I was honored to speak with them. And I think your listeners should definitely visit their website. They archive all of their talks and resources, they have a great training program, and they recently have even gotten support from the American Occupational Therapy Foundation so that occupational therapists can be involved as well. So, it's a terrific faculty and a terrific group. I encourage your listeners to explore LeaRRn's website.

MATTHEW BRANDENBURG:  
Absolutely. Thank you so much. And LeaRRn does sound amazing. And I'll be sure to include a link to the LeaRRn website in our episode description, so everybody can check that out. Again, before we jump into the specifics of this presentation, I wanted to ask about some of your background as well. what really motivates you to conduct and synthesize research and evidence related specifically to fall prevention?

SUSY STARK:  
So, I am very interested. It's like fall prevention is one of my greatest passions. And I began this line of inquiry after I was asked by one of my community partners to give a talk on fall prevention, and (INAUDIBLE) another talk in fall prevention, I better do a little bit of exploration. I was really stunned when I started doing the research to realize what a huge public health concern falls were for older adults. So, I guess, it's depending on which data that you look at. It's 25 to 30% of older adults aged 65 or older fall every year. Your chance of falling increases with every additional risk factor you add to the mix. So, if you have no risk factors, you have a 25% chance of falling. If you have three or four risk factors, you have like an 80% chance of falling in a one-year period of time. And those folks that are at high risk of falling, those are the folks that a lot of our occupational therapists meet and treat and get to interact with on a daily basis. So, fall prevention became really, really important to me.

And what I found was, you didn't have a lot of really useful, ready-to-hit-the-road intervention that occupational therapists can deliver right out of the box. Physical therapists do a great job with some of the exercise programs that have been developed over the years. But a lot of the research that had been done in occupational therapy interventions, which are really focused on home hazard removal programs had been done in other countries and we didn't really have the health systems in place here in the US to support that kind of intervention. So, that's why I began my home hazard removal of fall prevention line of inquiry (INAUDIBLE).

MATTHEW BRANDENBURG:  
That's wonderful. Thank you for providing that background. It really kind of paints a picture of how big fall prevention is as an issue and how important it is to address. How would you describe the evidence linking a person's environment to the risk of falling?

SUSY STARK:  
So, it's pretty stunning. About half of falls are attributed to environmental hazards alone. So, we characterize our fall risk, or people falling because of intrinsic factors. They might have had syncope or they lost consciousness. They might suddenly fall, or was it kind of a behavioral activity? Were they climbing up a ladder that maybe they didn't have the strength to climb up? Or was it an environmental cause? Was it a slippery floor or a stair that didn't have a handrail? And when we look at the causes of falls, about half of those are caused by environmental hazards alone, not because of something in the person that you might try to change but because of the way the environment is constructed. So, that speaks to me as an OT interested in the environment. The other thing we know is that about half of falls occur in the home. So, it makes sense because older adults spend a lot more time at home than they do out in the community when compared to when they were working-age adults. But to me as an OT, the home looks like a pretty appealing place to design an intervention to reduce environmental barriers.

If half the falls are environmentally caused, and half of those falls are threat in the home, the skill set that we as OTs have to modify the environment suddenly becomes pretty important.

MATTHEW BRANDENBURG:  
Absolutely. I'm glad you would emphasize that last point of how OT practitioners are kind of uniquely poised to address the environmental factors of clients. Is there anything else you'd like to say about how important that is for OT practitioners to address and include in what they do with the people they work with?

SUSY STARK:  
Absolutely. So, I think it's really important for all OTs to remember that new home modifications are not a specialty practice. This is a tool that we all have in our OT toolbox. And I, when I teach students here at Washington University, I try to make sure they know that understanding how to modify somebody's home, whether they're coming home from post-rehab from a stroke, or if you're trying to make sure they do not have a fall in the community. Home modifications are one of those things that we are so good at because we understand personal environment best because we understand (UNKNOWN) model. And we are so well-versed in task analysis and in compensatory strategy. Those are skills that every OT needs to be taking into the field and understanding how to apply them to fall prevention is really important because of the statistics that I told you.

MATTHEW BRANDENBURG:  
Absolutely. And I do understand how that can be intimidating for a practitioner to do to really begin applying those skills of home modification. But you're so right. All practitioners and even students once they're completing their programs are poised with these skills to be able to make recommendations. That can be impactful.

SUSY STARK:  
And to me, I don't know about you Matt, but I became an OT because I wanted to help people get back to their lives or maintain the lives that they have that was so important to them. And I don't know very many people who live their life in an OT clinic. So, we want to make sure that the places that we're helping people live their lives are actually the places they want to be. So, to me as a community-based practitioner, I love being in people's homes and getting to know them and it makes perfect sense to me. I love being able to see the problems before my very eyes. It's actually a lot easier to figure out how to address your treatment plan when you're there in the context that's giving people trouble versus trying to guess what it might look like (INAUDIBLE). So, personally, I'll take a home visit any day.

MATTHEW BRANDENBURG:  
I love that. I love that. Home visits, where the rubber meets the road.

SUSY STARK:  
Exactly.

MATTHEW BRANDENBURG:  
Susy, in your presentation you discussed the idea of 'designing for implementation'. Can you describe what this approach is?

SUSY STARK:  
Sure. Yes. I came to occupational therapy first as a clinician and I found, when I was in the field practicing, that I would get frustrated with these amazing interventions that have been developed and demonstrated efficacy in clinical trials that were almost impossible for me to implement as a clinician. And there were lots of reasons. Maybe the intervention was designed in a way that didn't fit within my setting. Maybe the clients that I was serving, it wasn't palatable to them - what the intervention offered wasn't what they were willing to accept. But these barriers to implementation stuck with me as I started creating interventions that I hoped would impact practice. So, I early on had a fantastic mentor named Ross Bramson from Washington University who's an expert in dissemination research, and he taught me about designing for dissemination. And I applied those concepts to designing for implementing a new clinical intervention. And so I started about identifying what the potential barriers to providing.

In this case, it was a home hazard removal program might be, and how we might overcome them. So, it's designing from the beginning, before we even do any efficacy or testing or research on this intervention, making sure the therapist wanted it, the therapists could deliver it within their scope of practice, the older adults that I was interested in serving found it palatable, and that there was an agency and a funding source that would actually make delivering the intervention possible. So, designing smart from the beginning before we even put it into a testing mode is what I'm talking about.

MATTHEW BRANDENBURG:  
I love that. And in your presentation, you mentioned the efficacy-to-effectiveness gap and really emphasized how designing for implementation and the way you just described can minimize that gap. What can an OT practitioner do to really apply this approach and decrease that efficacy-to-effectiveness gap in what they do?

SUSY STARK:  
I think that's a great question. I think a lot of that gap is dependent on how we as researchers get the information to the practitioner. So, making sure, like I said, that interventions can be adapted and delivered with the same level of fidelity and efficacy as they were tested in the kind of the research phase. So, that's partially our responsibility. But I think clinicians have a couple of roles to play. One, they should have a say and an opinion as a stakeholder about what the intervention should look like as it's being built. So, I think it's a great opportunity for clinicians that are out there to join the research team as an expert in being a clinician and understanding the context in which you practice. It's a gift to share that knowledge with researchers because you want to make sure that the researchers are developing programs and projects that are gonna work for you. That's one way. On the other end, once there is efficacy in intervention, figuring out how to adapt it well and with fidelity to the intention of how the intervention was to be delivered.

So, making sure you understand what is the theory behind an intervention. If interventionists know, if OTs know the theory behind an intervention, they're really, really good at figuring out how to aim that intervention in the right direction if there is an answer to their question in the manual that was provided to them. So, making sure you understand the heart and soul of what that intervention is supposed to do and then figuring out how to adapt it appropriately. So, maybe you're working in another city, or maybe you're working in a rural community and that's not the population the intervention was initially tested on. Letting you know that you're in a very intervention kind of target that will help you adapt what was put out in the literature to make sure you can deliver it. That's what I think occupational therapists do - trust themselves, they'll be good at it.

MATTHEW BRANDENBURG:  
Trust themselves. I love that. That's such an encouraging and empowering message to our listeners. And it might take a little bit of effort in expanding your knowledge on those theories backing these interventions, but it'll pay off in the long run for so many clients and for a whole career of practice.

SUSY STARK:  
I agree. I fully agree. The other thing is just go ahead and contact those researchers if you have questions. I think it's a gift to them to let them know if you're using their intervention and how well it's working for you. I think that helps those researchers build better products for you. You as an OT can think of yourself as a consumer that can have important marketing information that feeds back to researchers. It will be nothing if we didn't have a really good therapist in the field to deliver what we've invented.

MATTHEW BRANDENBURG:  
I love that perspective. Thank you, Susy. What is the home hazard removal program? How did this really come about and what really sparked your interest in developing this type of intervention?

SUSY STARK:  
So, the Home Hazard Removal Program is a fall prevention intervention designed, just as the name implies, to identify and remove home hazards in the homes of older adults who are at high risk of falling. So, we built this intervention based on Lindy Clemson's amazing work. Lindy is an Australian occupational therapist who developed the Westmead Home Safety Assessment. And that's the assessment that is used in HARP. What we did that was a little different than Lindy's work, is we kind of expanded the intervention description. And we were really explicit about what elements were required as part of the intervention. So, the Westmead is a good assessment part of it but also making sure that we describe those active ingredients and the essential ingredients to the intervention that we felt were critical for its effectiveness. So, for example, it's theoretically based. So, it's based on a person environment, that theory that we explicitly described. So, for the very reason I said, so therapists who are in the field and don't have an answer to a weird question, because there's always an exception to everything when you're an OT.

There's so many. You've seen one, you've seen one experiences (INAUDIBLE). But understanding theoretically what to do is first. So, we teach the theory that we use. The other elements are basically a competence-first model - so how you remove barriers in the home using that theory. Plus the secret ingredient that I think OTs are not very explicit about that we use all the time in our clinical practice, is strategy training. We don't just remove barriers in the home. Like we don't just put a handrail in. But we teach people how to use the handrail safely, and when they should use it. We teach people to turn the light on before they walk down the stairs and use the handrail which is different than just putting a handrail in and walking out the door. Anybody can add a handrail, but it's the therapist that understands how the older adults using the handrail in the stairway and the lighting that makes it safer for the older adults. So, making sure that we recognize those two elements to the intervention, removing the hazard, and then also teaching people the effective strategies to be safe at home.

We also felt there were other secret ingredients that OTs do use on a daily basis, but aren't really captured in any of the evidence that we've seen before. So, there were things like shared decision-making, which we call client-centeredness, which gives older adults - we empower them to decide what changes they wanna make in their home. So, many of us know there's a lot of ways to change the height of a toilet. So, we can add a little lift under the toilet seat, we can add a raised toilet seat on top of the seat, we can put in a new ADA-accessible height toilet. But allowing older adults to choose which modification they want in their home sometimes improves the likelihood that they're gonna keep using the modifications that we suggest. So, shared decision-making or client-centeredness, teaching people what they can expect with the types of modifications we have empowers older adults. We also use motivational interviewing. So, we don't tell people, you must pick up your (UNKNOWN). We allow people to sort out on their own using scripts and algorithms for motivational interviewing, how to make decisions about what changes they're gonna make in their homes.

We find that this strategy increase the likelihood that older adults will participate fully in the program and also will stay and will have high adherence to the interventions for those plans. So, our intervention manual for HARP explicitly describes all of these strategies that we deploy. So, it gives therapists a really good tool to deliver the intervention no matter where they have to go in the US, north, south, east or west, rural, urban, it gives them the strategies that we think are critical and important to be effective. So, that's the piece that we've added on to HARP that gives it a little more rigor in terms of understanding what the therapy did, but also more guidance for the therapists in the field to be the really good therapist they are. We give them the guardrails so they know what's possible, and they make it happen with their creative, amazing OT brain.

MATTHEW BRANDENBURG:  
I love that. And in hearing you describe the HARP program, and it truly does sound amazing. What did you find in clinical trials of HARP looking at its effectiveness?

SUSY STARK:  
So, HARP was able to reduce the number of falls in the treatment group versus the control group, which was usual care. And these were... We looked at over 300 older adults who were getting services from an Area Agency on Aging. We took anybody that got services from this program that was worried about falling or had a previous fall, we accepted them in the intervention, and we randomized to them to a treatment group or to a control group. And the control group got any usual care, including fall prevention education, and whatever the Area Agency on Aging typically delivered. The treatment group got HARP. And HARP occurs over two to three initial sessions. The first session, we do the Westmead home safety walkthrough, and we have scripts for how to use the Westmead and use the motivational interviewing together so that older adults can help identify their own problems and resolve those problems. And then we come in over a couple of series of visits to make sure that modifications are installed.

In this study, we installed them for the older adults, but therapists delivering this could use any typical service that they might use, like within the Area Agency on Aging, (INAUDIBLE) service, etc. And then we went back in after about six months to see how people were doing. We just did a phone follow-up. If they needed another visit, we went in to see them. And that was HARP. And we followed people for 12 months. And we counted the number of falls. Every month, people would mark down their falls on a fall calendar, and we would check on them monthly and verify if a fall happened, yes or no, if they told us a fall happened. And we found at the end of this study, the treatment group had 40% fewer falls (INAUDIBLE), which was a pretty remarkable number of falls to prevent. And so that was a big finding for HARP. Now, we didn't have any difference in the number of actual people who fell. So, the risk of any falls in the home were little less than HARP but about the same that's not statistically significant.

But the number of falls, the overall risk of falling was much lower for the treatment group. And then we also did something that was interesting. We wanted to know what the health care costs would be between these two groups. So, we asked them every month in addition to 'did you have a fall', we also asked them, what health care services have you received this month? We found we could track those or any type of health care service that the older adult received. We found that there was a remarkable health cost savings for - so almost for every dollar spent on HARP, there was a $2.11 cent return on investment or cost savings that we had for the HARP participants. So, not only were we able to make older adults safer in their homes and hopefully able to live independently at home longer, we were actually able to save the healthcare system valuable healthcare dollars. So, it's important. We think it's important.

MATTHEW BRANDENBURG:  
Absolutely, those are amazing outcomes of 40% decrease is huge and that sounds like a great return on investment as well with the HARP program. I know you mentioned the HARP manual earlier. In your presentation, you also mentioned a Clinical Practice Guide as kind of tools to address barriers to implementation of HARP and evidence-based interventions for clinicians. Can you talk to us about these two a little more specifically, how can they be used to assist practitioners in making recommendations to their clients?

SUSY STARK:  
Sure. So, the HARP manual is available and if people can visit our website - I bet you'll put up a link for that, and they can order the manual. And we actually just we're launching this spring or this summer. We will have a training program for HARP that we're gonna test, like a video-based program in didactic training programs. So, if anyone wants to sign up for any of those potential training programs, we'll make sure we have a link on our website. So, interested participants can do that. But we are going to try our best to make sure that the field of OT is ready to deliver HARP because I think there's a lot of interest in HARP now from the Department of Housing and Urban Development and other agencies are interested in how to implement HARP. So, we wanna make sure we have enough OTs. That's (INAUDIBLE). But you're right, we also have an implementation guide that we put together that will help community agencies that want to figure out how to deliver HARP in their own agency - how they can do that.

So, we've put together some tips and guides for delivering it, for example, in apartment building for older adults in your apartments, and how you might go about offering HARP, for everything from gaining engagement from the older adults to getting them to think about their own fall risks. We have some cool activities like fall prevention bingo that we recommend that are also available on our website to, in a fun way, engage older adults to learn about falls. So, they will be willing to listen to occupational therapists who are interested in delivering fall prevention intervention through HARP, all the way to tips for making sure that you engage an occupational therapist as part of your team to deliver the intervention. And that's all available in our (INAUDIBLE).

MATTHEW BRANDENBURG:  
Awesome. And I'll be sure to link your website so all our listeners can check out that training program, and that implementation guide and see some of these fun things like fall prevention bingo as well.

SUSY STARK:  
So, it's a fun thing to do on a Thursday night with your family. And we have a Zoom version. So, don't worry if your family's stretched out across the country, you can still engage your app phone in fall prevention bingo if you're interested.

MATTHEW BRANDENBURG:  
There we go. Who doesn't love catching up with (UNKNOWN) Thursday? Can we talk a little bit more about some of these barriers? What are some of the... You've mentioned a few but what barriers to implementing interventions with older adults exist? And how would you recommend practitioners make sure they're being addressed?

SUSY STARK:  
Oh, sure. So, we never develop a new intervention. I think there's barriers. I kind of just find them. I like context, as you, Matt. So, the first barrier for me is setting. So, I think about what about the setting that I'm working in would prevent me from delivering this intervention. So, sometimes the barriers might be, it's not an intervention that's offered typically in this setting. So, what can you do? And in this case, we overcame the barrier by finding a community partner. I'd like to encourage occupational therapists to not only think about working in rehabilitation settings but think about non-traditional places like Area Agencies on Aging. I think those are pretty amazing places to work to deliver these novel interventions. Another barrier might be cost. So, making sure that you can fit your intervention into whatever payment structure is available for the setting that you're in. Other potential barriers might be making sure that there are evidence for the population that you have.

Maybe we tested HARP in a staple of urban, underserved communities, but maybe you need to consider what population you're working with and what are the different barriers that they might have. And would this still work in the community that you might be interested in? So, I think about 'setting barriers'. Then I think about provider barriers. So, as OTs, do we have the set of tools that we need in order to deliver the interventions in HARP? We did things. We've been working on this for a long time. So, we developed lots of tools to help therapists. We wanted to make sure that the novice therapists who are just graduating and getting ready to spread their OT wings could think and practice like seasoned therapists. So, we created like a clinical reasoning guide that's part of our implementation manual. We created a clinical decision analysis forms. So, it was kind of led therapists who hadn't done (UNKNOWN) like this before through the process that seasoned therapists use. We applied a theory in very concrete way to help their pursuit through how they might deliver the intervention.

So, we tried to provide them with all the tools that they needed in order to be successful for the intervention, for example. So, we were worried about fidelity for the therapist A deliver it like therapist B, deliver it like therapist C. So, we would still see those amazing returns and reductions in fall risk. And so, we created these HARP manual and we're hoping that this training will help get anybody that's interested in delivering HARP ready to deliver it successfully. So, we're trying to break down barriers that providers or occupational therapists might experience. When I think about barriers from the older adult perspective, a lot of older adults, like many of us, don't think falls will ever happen to them. And they have a hard time imagining why they might need this intervention. It's hard to get people to engage in prevention. So, education and outreach. So, we created fall prevention bingo to overcome the barrier of getting older adults to think about what their fall risk might actually be and why it might be smart to think ahead of time of what the home hazard removal program might (INAUDIBLE) them.

So, creating tools like that, that would help us engage older adults. Then making sure that we've designed the intervention itself to be super durable. So, we wanted to make sure we went with an opt-out model. So, we teach therapists, when they provide interventions, that they should start with architectural modifications. You can always, as we know, compensate for functional loss by providing modifications like a grab rail, or maybe adaptive equipment that you can bring into the home or take out of the home like a reacher, or assistance. You can ask someone to help you. But the most durable of those is architectural meditation. So, we teach the therapists that learn HARP, start with architectural modifications if you can because it's a lot harder to not do something if it's screwed into the wall. If there's a handrail, there people who are more likely to use it. So, thinking about intervention barriers like that, we used evidence-based approaches. So, this is a complex intervention. But we took elements that already existed and were really comfortable and familiar to therapists, like motivational interviewing or client-centeredness, and built them into the intervention so they would feel really comfortable and confident delivering the intervention.

We know therapists are really creative, and that they find lots of unique situations. So, we created ways in the intervention that you could tailor in a standardized way so that you could offer the intervention the same way to people as the intervention that always like (INAUDIBLE) between two different interventions. So, we tried to build all of those kinds of support in the therapist to deliver the intervention in an effective way. That's what I mean by barriers and overcoming them.

MATTHEW BRANDENBURG:  
Of course, and I love that. From a practitioner's perspective, it sounds amazing to have all these types of supports built-in. And it sounds like it really makes the intervention easier to provide on the practitioner and easier to learn to be effective at providing.

SUSY STARK:  
I hope that works that way.

MATTHEW BRANDENBURG:  
We'll get back to our interview right after this quick message. You all know, we really try to make research more consumable and applicable on everyday evidence. But did you know that just one minute of your time could help us to improve the show, improve the resources the American Occupational Therapy Association provides for practitioners, and improve the application of evidence to practice within our whole field? Please take our one-minute survey. It's only three questions. And you can find the link in this and every episode's description, and support the AOTA and continued efforts to improve our podcasts and to improve the translation of research to practice. Now back to the interview. And you mentioned the durability of interventions. I saw in your presentation that the adherence rate for HARP is 90% or above, even after 12 months for the clients who are receiving this type of intervention. What else do you attribute such a high carryover rate to?

SUSY STARK:  
So, I think a couple of things. I think number one, therapists, we don't do anything that people don't want us to do. So, they come to the decision as part of the HARP process that this is the right intervention for them. So, I think there's something about making that decision that I'm going to do this and it's my decision. That gives (INAUDIBLE). That's really important. And then like I said, we've structured the intervention in a way that we try to make it as durable as possible while it's there. So, it's really hard not to use your grab bar or your automatic lights that come on when you get up at night if it's just gonna happen passively. You really have to opt-out. You have to say to yourself, I'm not gonna hold on to that grab bar. And it seems like a silly choice that someone made because that's the choice that they made was to put in the grab bar. So, we do have remarkably high adherence. Usually, people will quit using an intervention because they built enough strength, or they might have moved, but we don't find that people, once we use this approach to the client center, we don't find abandon their technology or their environmental modifications pretty often.

MATTHEW BRANDENBURG:  
Perfect. You've already given so many awesome recommendations here. I can't thank you enough. I wanna give you a scenario now, though. Let's say I just purchased the HARP manual and going through training and wanna start implementing these client-centered and effective fall prevention interventions. What recommendations would you give to me or a practitioner in the same situation?

SUSY STARK:  
So, I think you're on the right track with this, firstly. Get yourself some training so you feel comfortable and get the manuals and you know what to do. Then build a community network of partners - so a place to deliver the intervention. So, whether it's an area agency on aging, it might be a community, the type of independent living center, and there's so many places we know where older adults are living, a naturally occurring retirement community. There's lots of agencies that serve older adults that are really, really hoping to have an OT to deliver these interventions. So, find a community partner because that can give you access to the older adults that you want to serve. And then jump right in. You'll need to find a community partner that's deliver that intervention, so some type of handyman or contractor. There's lots and lots of different choices for finding those partners. So, if you may be part of community agency, they might already have that network in place, where there's always rebuilding together in those great resources on AOTA's website to find contractors who're HARP certified that can help you deliver the intervention per the HARP manual to help you make it all happen.

I think that would be like my biggest thrill if this took off and it was to get therapists out there preventing falls. It makes a (INAUDIBLE) difference in the world. That would be very exciting.

MATTHEW BRANDENBURG:  
And it sounds so possible and so attainable for people to do. Could you share a case study or personal story or experience of when you've seen HAARP or another fall prevention intervention lead to a positive outcome for a client?

SUSY STARK:  
Sure. So, Raman, one of my favorite research participants who, I guess, was pretty amazing to me that when you open the eyes of a person that's living in their bed and hasn't been out of their home for a while, and is at high risk for falling, and you can come in and help them understand that it's possible to emerge from your bed, hop back into a wheelchair or to pick up an assistive device, and you can re-engage. So, it can be anything as simple as going to a library to read books with a community again, or to go back to church. Those are the things that are super impactful for me when somebody can overcome the fear of leaving and re engage in their community. That is super impactful for me. It's also pretty cool when I meet people who have had a fall and are worried about falling, but just don't have an idea of the possibilities of what life could look like. We met a woman named Jane - and I think I talked about her in (UNKNOWN) network, who had an amputation of her leg and would have to put her leg on every day.

But her clothing was located in the guest bedroom because she couldn't get into her own closet because her walker was too wide. And she didn't really have an idea of what would happen if she fell because she was hopping naked through her house chatting with a walker trying to get to her clothes. And when we showed her that, all we had to do was take off the door of her closet and turn the wheels inside on her walker, and she could get right in there and wouldn't have to hop through her house naked with a big picture window anymore. I mean, when she's like crying with happiness that her life was gonna be different and better, that to me is being impactful. And I know all your OT students out there knew exactly what to do for the home modifications for Jane to make it possible for her to be safe in her home. So, it's possible for all of us to make this difference for older adults. This is pretty cool when you can lift the wheels to the inside of the walker and change people's lives. It's a pretty good thing.

So, I hope your listeners will consider joining us in delivering.

MATTHEW BRANDENBURG:  
Absolutely. Thank you so much for sharing that example. I'm gonna be sure to link the presentation that you gave with LeaRRn, as well as the HARP website. Are there any other resources or places where you'd like our listeners to be able to find more information related to what we've discussed?

SUSY STARK:  
Sure. I think the CDC's website is really, really exceptional. And then the National Council on Aging also has lots of great resources for fall prevention. So, those are two places I would start for folks that are just new to fall prevention and want to learn more. I also love USC, University of Southern California's home modification network. They have a really, really fine web page with lots of up-to-date evidence and resources that I highly recommend. The other intervention that we didn't talk about that occupational therapists might be interested in, there are a couple that I wanna mention that OTs might wanna learn about. One is called LiFE. And that was created by Lindy Clemson, the OT I mentioned from Australia, which is building an exercise program into your daily activities. So, instead of going to an exercise class, LiFE helps build the key evidence-based exercises that will build strength and balance to prevent falls into daily tasks. It's just a cool intervention that OTs are so.... It speaks to us all of how we should build our lives.

You do your deep knee bends while you're brushing your teeth, or you do a tandem walk as you're walking down the hallway every day. And it's a really cool way to build exercise (INAUDIBLE). I love LiFE. The other is stepping on a Matter of Balance. Are both on educational programs reduce fear of falling and falls. It teaches people about their fall risk. And OTs can volunteer in their communities to deliver one element of that class. There's always a home modification element to those courses, or you could partner with them to maybe even deliver some of these interventions. So, OTs should take a look at those two interventions as well as LiFE. I wanted to make sure we didn't just talk about home hazard removal, which I think is super cool, but the range of home prevention interventions that OTs could deliver.

MATTHEW BRANDENBURG:  
Yeah, absolutely. Thank you for those additional recommendations as well. I'm so excited with how much awesome information and support we have in this episode for our listeners. And now we've come to the last question, Susy. This is our golden nugget segment. If you could give one piece of advice or one recommendation to our listeners, what would you say?

SUSY STARK:  
Always, always, always ask your research participant or your patient, or your client what's important to them first.

MATTHEW BRANDENBURG:  
I love that. I love that. How do you think including that question in everything you do can impact quality of care?

SUSY STARK:  
I think that it will always guide you to where you should start. Whether it's your research project, your treatment plan, or your new program. Knowing what matters to people is the critical piece to beginning to be a good therapist.

MATTHEW BRANDENBURG:  
That's perfect. That's wonderful advice. The critical piece to being a good therapist and the critical piece to developing that connection with someone to be able to make a meaningful impact in their lives as well.

SUSY STARK:  
I agree.

MATTHEW BRANDENBURG:  
Awesome. Well, thank you so much for your time today, Susy. It's been a pleasure to have you on the show.

SUSY STARK:  
Thanks. It's been great to talk to you. I hope we have lots of folks that have lots of questions. I'm always available to answer them. Please tell them to reach out.

MATTHEW BRANDENBURG:  
Absolutely. We will. Thank you again.

SUSY STARK:  
Thanks, Matt.

ANNOUNCER:  
Thanks for listening to Everyday Evidence. Tune in next time for more evidence-based practice insights and applications.