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Infusing an occupational perspective into chronic disease management: a manual for occupational therapists

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INFUSING AN OCCUPATIONAL PERSPECTIVE INTO CHRONIC DISEASE MANAGEMENT: A MANUAL FOR OCCUPATIONAL THERAPISTS

by

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Master of Occupational Therapy, University of North Dakota, 2015

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This Scholarly Project Paper, submitted by Katelyn Mari and Abby Wicklund in partial fulfillment of the requirement for the Degree of Master of Occupational Therapy from the University of North Dakota, has been read by the Faculty Advisor under whom the work has been done and is hereby approved.

Signature of Faculty Advisor

Date
PERMISSION

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Infusing an Occupational Perspective into Chronic Disease Management: A Manual for Occupational Therapists

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ABSTRACT

Problem: In 2014, the National Council on Aging reported that almost 92% of older adults were affected by a chronic condition and 77% of these individuals had at least two chronic conditions. In addition, chronic disease is responsible for 75% of United States health care spending. Ironically, only 1% of health care dollars are spent on public education and other efforts to reduce the incidence of chronic disease.

Purpose: The purpose of this scholarly project was to provide a framework for occupational therapists to deliver effective treatment for individuals with chronic disease. Due to the longevity of chronic disease, encouraging clients to self-manage their condition is important.

Methodology: An extensive literature review was conducted on the impact of chronic disease on individuals and effective strategies to self-manage chronic disease. The literature review was completed using reliable databases and journal articles to ensure relevant information was obtained. During the literature review, it was evident there is limited research discussing the role of occupational therapy in relation to chronic disease. Upon completion of the literature review, a manual was produced to outline the role of occupational therapy in chronic disease management. The Occupational Adaptation (OA) model was used as a theoretical base to guide the development of this manual. The sections are organized as follows: Part I contains information related to assessing individuals readiness for change and strategies to advance them through the change
process. Part II is consistent with the person component of the OA model and contains three sections discussing cognitive, psychosocial, and sensorimotor components and how to address each of these areas. This section contains information for therapists as well as handouts for clients. Part III contains post-intervention evaluations for both the client and the therapist to assess their satisfaction with the therapeutic process.

**Conclusion:** The purpose of this scholarly project and resulting manual was to provide a guide identifying the role of occupational therapy in chronic disease self-management. The product was written for both the occupational therapist and the client to provide an intervention framework for chronic disease self-management. The goal of this manual is to develop relative mastery within the client and allow them to participate in occupations important to them. In addition, the manual aims to change a client’s internal adaptive response to facilitate more adaptive responses to novel situations in the future, thus helping them manage their chronic disease more effectively.
CHAPTER I

INTRODUCTION

According to the Center for Managing Chronic Disease (2011), chronic disease is defined as “a long-lasting condition that can be controlled but not cured”. The National Council on Aging (2014) reported that almost 92% of older adults were affected by a chronic condition and 77% of these individuals had at least two chronic conditions. In addition, four of these conditions, specifically heart disease, cancer, cerebral vascular accident (CVA), and diabetes, are responsible for almost two-thirds of the deaths in the United States each year (National Council on Aging, 2014). The high incidence of chronic disease in this country comes at a cost. The National Council on Aging (2014) states chronic disease is responsible for 75% of United States healthcare spending. Ironically, only 1% of health care dollars are spent on public education and other efforts to reduce the incidence of chronic disease and to improve the health of United States (US) citizens.

A number of factors have contributed to the high incidence of chronic disease in the US (Coleman & Newton, 2005). An increase in life expectancy, combined with cultural and environmental risk factors including smoking, unhealthy eating, sedentary lifestyles, and air pollution, are a few factors contributing to the chronic disease epidemic. Coleman and Newton (2005) also highlighted the fact that individuals with chronic diseases such as depression, diabetes, hypertension, asthma, and congestive heart
failure are not treated adequately leading to worsening of their condition. The authors explained that this is often magnified by comorbidities present.

Due to the complexity and chronicity of chronic disease, motivating individuals to self-manage their own condition is a primary goal of the healthcare system (Richardson et al., 2014). The goal of self-management is to empower individuals to take charge of their own health and well-being, in an attempt to reduce their dependence on the US healthcare system and thus reduce costs. One such program, the Chronic Disease Self-Management Program (CDSMP), outlines a framework for implementing a program to educate individuals with chronic disease on how to manage their condition (Lorig et al., 1999). The CDSMP is currently considered the ‘gold standard’ for chronic disease self-management in the US. This program is delivered in a small group setting and addresses issues related to managing pain and fatigue, medication management, exercise, communicating with family and friends, nutrition, problem solving, and goal setting (Ory et al., 2013). According to the National Council on Aging (2014), the CDSMP results in measureable improvements in the health and quality of life of individuals with chronic disease. In addition, it has been found that this program decreases health care utilization by lowering the number of emergency room visits and hospitalizations for this population (Ory et al., 2013).

Although numerous healthcare professionals are involved in chronic disease management, occupational therapists have had less of a voice on this topic and appear to be unrecognized currently as a viable contributor. The literature supporting occupational therapy involvement in chronic disease self-management is presently limited. However, due to the global impact chronic disease can have on an individual, occupational
therapists have an opportunity to play a significant role in the treatment of this population (DeRosa, 2013). The profession’s focus on client-centered care, occupational engagement, and holistic treatment puts occupational therapists in a promising position to get involved. Client’s relationships with their healthcare provider must be productive to ensure clients are getting what they need to manage their chronic disease and occupational therapists pride themselves on their ability to promote therapeutic relationships (DeRosa, 2013).

The purpose of this scholarly project was to develop a guide for occupational therapists to use for the treatment of individuals with chronic disease. This guide is intended for occupational therapists working with adults experiencing one or more chronic diseases. The guide is structured using the framework provided by the Occupational Adaptation frame of reference to highlight the importance of the client in the disease self-management process (Schkade & Schultz, 1992). The main sections of this clinical guide include information related to the following: assessment of a client’s readiness for change; motivational interviewing skills; an occupational therapy needs assessment; development of the occupational profile; assessment tools appropriate for this population; occupational therapy interventions to address cognitive, psychosocial, and sensorimotor client factors affected by chronic disease; and post-intervention questionnaires for both the client and the therapist. Also, links to additional resources are provided in the manual to encourage clinicians to seek more information on issues relative to their client.

Within this guide, there are several reproducible handouts to utilize as an additional form of learning for clients. The handouts encourage an interactive,
collaborative relationship between the therapist and client and should be used at the discretion of each unique therapist. Handouts may be modified for clients with the author’s permission to address their specific needs and ensure they match the literacy level of each unique client.

To facilitate the organization and fluidity of this clinical guide, the Occupational Adaptation (OA) frame of reference was utilized (Schkade & Schultz, 1992). This model focuses on the interactive processes between a person and his or her occupational environment across their lifespan. OA considers an individual’s desire for mastery based on internal role expectations and the natural demand for mastery created by the environment (Schkade & Schultz, 1992). This interaction between the individual and his or her environment creates a press for mastery. This press for mastery is what results in an adaptive response from an individual (Schkade & Schultz, 1992). This response is based on an individual’s ability to recognize the need for change and adaptation capacity to meet the demands of the environment and achieve mastery. Consequently, the client is the agent of change within the OA frame of reference (Schkade & Schultz, 1992). This forms a key connection to the self-management approach to health management.

According to OA, function is evident when an individual is able to participate in an occupation within their desired environment with a sense of relative mastery and accomplishment (Cole & Tufano, 2008). Disability is evident when an individual is unable to participate in occupation due to a decreased ability to readily produce an adaptive response (Cole & Tufano, 2008). Depending on a person’s ability or inability to produce an adaptive response, individuals may seek services from occupational therapy or other health care professionals. The role of the occupational therapist is to develop
skills within the client to enable him or her to adaptively and independently respond to novel situations in the future.

Individuals with chronic disease are faced with many new challenges that may create a desire for mastery. These individuals may not be able to engage in activities the same way they have in the past, as they may no longer be able to meet the demands of the environment due to internal factors related to their chronic disease. It is this interaction that produces a press for mastery and encourages the individual to adapt. Enabling individuals to master this adaptation process on their own is the focus of chronic disease self-management. The goal of the occupational therapist under this model is to facilitate the client to be his or her own agent of change in the future.

To be consistent with the OA framework, this clinical guide starts with information addressing a client’s readiness for change, as well as a needs assessment and other evaluation tools to build an occupational profile. This will allow the therapist to assess the person, their environment, their desire for mastery, and their current internal adaptation ability. The next section of the manual focuses on the person and, in congruence with the OA model, includes cognitive, psychosocial, and sensorimotor factors related to chronic disease. The OT practitioner is provided with information about how each factor is related to chronic disease, intervention ideas, and handouts for clients. All materials were developed by the authors themselves or modified from existing materials within the public domain. The goal of this section is to address multiple facets of the client and how they are contributing to the individual’s ability to manage their chronic disease.
The ultimate goal of this clinical manual is to facilitate individuals with chronic disease to achieve relative mastery in daily occupations across multiple contexts. By utilizing this clinical guide, occupational therapists will implement occupation-based, client-centered practice for individuals with chronic disease. Due to the large impact chronic disease can have on an individual’s life, it is important to consider client factors, as well as factors external to the client to help them in achieving relative mastery. This guide provides the necessary guidance for occupational therapists when providing intervention for individuals with chronic disease. In addition, it provides resources for clients to encourage positive change and adaptations to manage their chronic disease.

The following chapters of this scholarly project are put together following the OT process (AOTA, 2014) and clinical reasoning to facilitate its implementation into clinical practice. Chapter II provides an overview of the literature review and highlights existing support for individuals with chronic disease as well as its impact on society. Chapter III details the activities involved in the literature review and the production of this clinical manual. Chapter IV contains the product, entitled Infusing Occupational Perspective into Chronic Disease Management: A Manual for Occupational Therapists, with useful information and resources for OT’s to facilitate chronic disease self-management with their clients. Chapter V summarizes the purpose, limitations, and strengths of this clinical manual.
CHAPTER II

REVIEW OF LITERATURE

Chronic disease is defined as “a long-lasting condition that can be controlled but not cured” by The Center for Managing Chronic Disease (Center for Managing Chronic Disease, 2011). According to the Centers for Disease Control and Prevention, chronic disease is the single leading cause of death and disability in the United States and accounts for 70% of deaths in this country (Center for Managing Chronic Disease, 2011). Quite apparently, chronic disease is a massive issue in this country. Chronic disease includes conditions such as asthma, diabetes, stroke, obesity, chronic obstructive pulmonary disease, heart disease, arthritis, and cancer. According to DeRosa (2013), Americans are experiencing a shift in health care needs; rather than acute needs, individuals are requiring ongoing care for chronic conditions. This has a large financial impact on the health care system as individuals affected by disease utilize more health care services and have an increased use of prescription medications (O’Toole, Connolly, & Smith, 2013). Further investigation into chronic disease and development of programs and treatment strategies to help these individuals is warranted.

Several programs have been developed to address chronic disease self-management techniques. Research studies have been conducted on providing caregivers education on chronic disease and incorporating them into the treatment process for individuals who have a chronic disease. Healthcare professionals also need to be
educated on chronic disease management, as well as utilize a variety of approaches to meet the needs of each patient. Occupational performance is impacted when an individual has a chronic disease, which supports the need for occupational therapist involvement. Continuing to engage in meaningful occupations is highly valued for individuals who have a chronic disease.

**Specific Chronic Disease Management Programming**

Due to an increase in the prevalence of chronic disease, effectively managing chronic disease(s) has received an increasing amount of attention in recent years (Cooper & McCarter, 2014; Cramm et al., 2014; Heng, Tham, Eng, Ling, & Menon, 2013; Melchior et al., 2014; Morrin, Britten, Davachi, & Knight, 2013; Ory et al., 2013; Schulman-Green et al., 2012). Authors of these articles are from many different professional and educational backgrounds and focus on many unique facets of management of chronic disease. The areas of disease management considered most important for managing chronic disease include educating individuals about community resources, improving individual’s self-efficacy, constructing care plans with individualized goals and action plans, problem-solving or decision making, pain and fatigue management, medication management, nutrition education, exercise implementation, sleep management, use of cognitive symptom management techniques, and managing fear, anger, and depression (Cooper & McCarter, 2014; Cramm et al., 2014; Lorig, Ritter, Pifer, 2014; Melchior et al., 2014; Ory et al., 2013). In an article by Kurien (2014), additional areas for managing a chronic disease were identified including relaxation strategies, emotional regulation, positive thinking, preventing falls or increasing balance, planning for the future, and communication skills. Each of these topics...
areas are important to address on an individual basis in order to achieve desired outcomes in managing chronic disease for each unique individual.

One evidence-based program addressing many of these areas is the Chronic Disease Self-Management Program (CDSMP); individuals at the School of Medicine at Stanford University developed this program (Lorig et al., 1999). The university received a research grant to develop and assess a community-based program that would be useful for individuals with chronic disease. With this grant and the work of multiple professionals, the CDSMP was developed (Lorig et al. 1999; Melchior et al., 2014; Ory et al., 2013).

The CDSMP is a workshop designed to promote and encourage individuals with chronic disease to participate more fully in everyday life (Lorig et al. 1999; Melchior et al., 2014; Ory et al., 2013). This program lasts from four to six weeks, depending on what the organization determines, and consists of two and a half hour classes that take place once a week. Workshop sessions are offered at community centers, churches, libraries, hospitals, nursing homes, and health clinics. Class sizes range from 10-15 participants; group leaders act as facilitators rather than lecturers to encourage member participation during discussion (Lorig et al. 1999; Melchior et al., 2014; & Ory et al., 2013).

Topics covered by the CDSMP include techniques to deal with fatigue and pain, the importance of exercise, medication management, communicating effectively with family, friends, and healthcare professionals, nutrition, and effective decision making (Melchior et al., 2014). The components of the CDSMP found to be most helpful for healthcare professionals included an emphasis on patient responsibility, structured care plans, educational materials, reflection on the client’s situation, and community resources
In 1999, Lorig et al. designed a study to evaluate the effectiveness of the CDSMP over a six-month period. The authors evaluated the effectiveness of the program through assessing health behaviors and health status of individuals before and after implementation of the program. Results indicated participants were engaging in more health promoting behaviors and were utilizing health care services less frequently as indicated by a decrease in the number of hospital visits (Lorig et al., 1999).

In another research study on the CDSMP, researchers aimed to determine the short-term effectiveness of the program specifically related to its ability to improve individual’s self-efficacy related to multiple areas of disease management, decrease perceived role limitations, and increase time spent exercising (Melchior et al., 2014). This workshop was implemented once a week for four weeks and addressed topics characteristic of the CDSMP. Outcome questionnaires focused on health behavior outcomes related to exercise type and frequency, as well as self-efficacy outcomes related to an individual’s confidence in themselves and their ability to manage their disease. Results indicated significant improvements were made in individual’s self-efficacy and time spent walking. These results are congruent with findings from other studies, and if sustained, can potentially reduce the utilization of healthcare services over time and reduce costs (Melchior et al., 2014).

A further study on the CDSMP program aimed to evaluate how implementation of the program changed health outcomes, lifestyle behaviors, and the frequency of health care utilization over a six-month period (Ory et al., 2013). The authors utilized a pretest and posttest design with a number of outcome measures to thoroughly assess lifestyle
changes resulting from program participation. This study supported the use of the CDSMP in chronic disease management. Specifically, authors found participants reported decreased activity limitations and depressive symptoms, increased communication with their physician, and decreased the number of emergency room visits and hospitalizations. This suggested an improvement in quality of life for these individuals, as well as a decrease in health care utilization and costs (Ory et al., 2013).

Kurien (2014) described another chronic disease management program, the Expert Patients Programme (EPP). The goal of this program was to help individuals with chronic disease manage his or her own symptoms, treatment, and to help each individual live a healthier life. This program was licensed at Stanford University in California and has been modified in the United Kingdom for individuals with a chronic disease. The program’s focus is on increasing the individual’s confidence or self-efficacy to self-manage his or her chronic disease in everyday life. Motivation is a key aspect of this program, focusing on each individual using the skills they already possess, but also learning new skills and utilizing outside resources to help manage their chronic disease (Kurien, 2014). The EPP is free to participants and takes place one time per week for six weeks. Each class session takes two and a half hours with one rest break. The instructors of this program are individuals who are managing a chronic disease in their own lives and are able to teach from personal experiences. The class size ranges from 12-16 participants with varying chronic diseases. Topic areas are similar to the CDSMP and include relaxation, healthy eating, weight management, fitness and exercise, pain management, fatigue, managing medications, and communication skills (Kurien, 2014, pp. 31).
Another important disease management strategy was addressed by Cramm et al. (2014) and focused on developing individual care plans with goals unique to each person. The authors focused specifically on increasing physical activity and smoking cessation among individuals with chronic disease. The authors found that participation in a disease management program which included individual plans and goals was helpful in increasing physical health activities and decreasing the smoking frequency of participants (Cramm et al., 2014).

**Caregiver Responsibility**

There is a strong impact on family members and caregivers of individuals with a chronic disease. Zayas, Wisniewski, and Kennedy (2013) found that family members helping individuals with chronic disease include children, spouses, and other informal helpers such as a friend, neighbor, or other relative. Further research found that women, who were about 73 years old, were more likely to be the caretaker for a male who had the chronic disease (Masters et al., 2013). Caregivers and family members are important to the well-being of individuals with chronic disease (Lowe & McBride-Henry, 2012). Unsurprisingly, research has shown there is a tendency for individuals with chronic disease to rely on family to care for them (Zayas et al., 2013). Fisher et al. (2007) found that individuals who have a chronic disease feel family members are one of the only individuals they can trust and depend on to be there for them through the hardships. In addition, individuals with chronic disease feel family members are the only ones who can fully understand the difficulties they are going through. This indicates a need for healthcare professionals to include family members throughout the entire treatment planning process (Zayas et al., 2013).
Every role in the family can be altered when an individual is diagnosed with a chronic disease. Arestedt, Persson, and Benzein (2014) recommend healthcare professionals learn to facilitate families’ awareness of changing family patterns and help members adjust to new roles if necessary. An important factor to consider when shifting roles in a family member is sharing the responsibility of caretaking among all family members to decrease stress levels for all people involved (Arestedt et al., 2014). During the time when roles are altered, relationships could become stronger or weaker as a result of the ongoing needs of the individual with a chronic disease (Arestedt et al., 2014). The authors found positive effects on chronic disease management for each individual when the focus shifted from the individual with the chronic disease to the family as a whole unit.

The traditional role of caregivers can be altered by having daughters and sons or the extended family as caregivers for the family member with a chronic disease (Zayas et al., 2013). When roles have changed, finding balance between being a caretaker and a family member is important in maintaining relationships within the family (Arestedt et al., 2014). Not only is it important for a family member to have a healthcare professional to communicate with during the time of changing roles, a family member can also have a significant role of communicator between the client with the chronic disease and the healthcare professional (Masters et al., 2013). For example, communication barriers could be present if the individual with chronic disease does not understand the healthcare professional or if the family member with a chronic disease speaks a different language. Therefore, cultural considerations are also important in the chronic disease management process.
When managing a chronic disease, Zayas et al. (2013) found including family members in the treatment planning process and having an early conversation about the issues of caregiving will normalize this topic for families and likely lead to better outcomes. Involving family members in conversations with the client and actively involving them in care will not only help family members better understand the illness, but will also allow the family members to feel like a valuable member of the treatment team (Arestedt et al., 2014). The responsibilities of a caregiver may change and include daily household chores, managing appointments, medication management, physical assistance with bathing, dressing, and mobility, and providing adequate supervision for the individual with a chronic disease (Masters et al., 2013). Effective communication was a leading factor for family members and individuals with chronic disease to better understand each other, as well as enhance the overall well being of the whole family (Masters et al., 2013). When families are communicating with each other, it is important to avoid talking solely about the chronic illness, as this seems to keep families focused on only the chronic disease and not other components of the individual (Arestedt et al., 2014). Caregiver education is extremely important for families managing a chronic disease and this can be provided by a healthcare professional.

As part of caregiver education, healthcare professionals are encouraged to provide families with resources about caregiving services (Zayas et al., 2013). Caregivers often need encouragement to utilize resources and formal supports to enhance both the quality of life of the individual with a chronic disease, as well as their caregiver (Zayas et al., 2013). In a research study conducted by Masters et al. (2014), healthcare professionals who provided families with information about the chronic disease and community
resources were found to be more helpful for families. In addition, this information provided families with a new perspective on activities in which they could participate. According to this study, healthcare professionals should not assume they know what an individual needs. There are many barriers to receiving adequate care and it is important practitioners’ provide clients with the education and services useful to them. It is important for healthcare professionals to assess client needs on an individual basis (Zayas et al., 2013).

Another study discussed the family systems nursing (FSN) theory when addressing the importance of caregiver involvement in intervention. The FSN theory supports a dynamic and interactional approach in which nurses and families are working together throughout the disease management process and learning from each other (Arestedt et al., 2014). Caregivers are not only educated by healthcare professionals, but are also educated by the individuals with chronic disease, as they are the true experts on the details of their illness (Towle & Goldolphin, 2011). Caregiver education is an important factor to consider in the process of chronic disease management.

**Importance of Educating Healthcare Professionals**

Along with caregiver education, there are many other facets to consider to effectively support individuals with chronic disease. One of these is education of the healthcare professionals to provide for the needs of individuals with chronic disease, including how to support them in the community (Cooper & McCarter, 2014; Heng et al., 2013). In a research study conducted by Lake and Staiger (2010), the authors discussed how many healthcare professionals did not receive training on self-management techniques and felt as if they were working in a foreign area of practice. Healthcare
professionals who had received self-management training utilized a small portion of the key elements of self-management education due to feeling confident only in a limited number of subject areas (Lake & Staiger, 2010). In one study, authors found educating nurses on chronic disease self-management techniques increased patients’ self-efficacy scores (Cooper & McCarter, 2014). In addition, individuals benefited from knowing about community resources where they could obtain support. This also fostered building collaborative relationships, which was shown to be motivating to individuals (Cooper & McCarter, 2014). Another study by Cordova et al., 2014 identified that individuals with chronic disease felt uneducated about their condition and how to manage it on their own. They pointed out the importance of keeping communication open between the client and the professional so the client feels they are getting his or her needs met effectively (Cordova et al., 2014).

Heng et al. 2013 further highlighted the need for healthcare professionals to become educated on chronic disease self-management in order to offer the most effective support to their clients. When healthcare professionals had received adequate education, they could offer more specific information to their clients, therefore improving the health outcomes for individuals with chronic disease (Cooper & McCarter, 2014; Heng et al., 2013). Providing healthcare professionals with adequate education will be beneficial to a patient’s chronic disease self-management success.

**Therapeutic Approaches to Chronic Disease Self-Management**

Also identified in the literature on chronic disease management is the importance of considering the therapeutic approach being utilized when addressing the client and providing intervention (Morrin et al., 2013; Schulman-Green et al., 2012). Morrin et al.
2013 highlighted the importance of a holistic approach to disease management rather than a fragmented one. They identified the importance of considering the person and their context rather than focusing on the disease itself. This approach, they found, led to a significant improvement in clinical outcomes and a decrease in health care utilization (Morrin et al., 2013).

Schulman-Green et al. (2012) discussed another approach to chronic disease management that focused on intervention as a dynamic process rather than a linear one. Conducting a review of evidence, they concluded behavioral, emotional, and cognitive factors play a role in managing a chronic disease and these factors change across time. This information addresses the importance of meeting a client where they are at a specific point in time, while understanding that their needs will fluctuate throughout their life. Authors also highlighted the importance of inter-professional communication when dealing with chronic disease as different professional areas have unique skills and perspectives to offer an individual (Schulman-Green et al., 2012).

Kurien (2013) further described the importance of healthcare professionals keeping the focus of each treatment session on the client. They recommend that when working with clients, healthcare professionals be aware of meeting each of the client’s individual needs and allowing the client to have a voice in his or her own care. There are many different ways to more effectively meet the needs of individuals with chronic disease including: treating the patient as a person before a patient with a disease; providing services that are easily accessible; providing adequate information about medications; communicating in a way the patient can understand; and offering programs...
about self-management led by individuals who have a chronic disease themselves (Kurien, 2013).

Another therapeutic technique found to be effective was a coaching technique (Howard & Ceci, 2012). Coaching is a technique where healthcare professionals utilize their listening skills, question the client, and paraphrase what the client is saying to help determine what the individual needs. Motivational interviewing and motivational techniques are another aspect of coaching to help an individual reach his or her desired goal. Within this approach, healthcare professionals focus on how the individual can decide how to use the information provided to them, thus making their own choices to achieve the best results. The health care professionals also step down from their role as an expert and let the patient be the expert by having a larger voice in the care plan to make the process more client-centered (Howard & Ceci, 2012).

Another therapeutic approach for treatment of individuals with chronic disease was discussed by DeRosa (2013). Taking an occupational therapy perspective, this approach highlights the self-management components of coping with chronic disease; specifically, how to prepare a client for change and help him or her see change is within them and not within the healthcare professional (DeRosa, 2013). The author indicated the importance of remembering the client is an expert on his or her own chronic condition. Practitioners are there to act as facilitators and a resource person instead of telling their client what they should and should not do. The author highlights four motivational interviewing strategies to assist the practitioner in facilitating the client to realize changes they are willing to make in their own lives. These strategies include: asking open-ended questions; providing affirmation and empathy; utilizing reflective listening and
developing discrepancy; and summarizing what is heard. DeRosa highlights the importance of adapting to the conversation instead of offering solutions and telling the client how to fix their condition. It is important for the client to realize the need for change on their own; the practitioner can facilitate this process by utilizing motivational interviewing strategies and therapeutic use of self (DeRosa, 2013). Having multiple approaches for a healthcare professional to choose from will allow the professional to best meet the needs of each patient.

**Chronic Disease and its Impact on Occupation**

When an individual with chronic disease starts to experience symptoms of his or her chronic disease, there may be changes in his or her ability to perform everyday occupations (White, Lentin, Farnworth, 2013). Occupations can be defined as “the daily activities in which people engage” (American Occupational Therapy Association, 2014, S6). When an individual has a chronic disease, occupations may be negatively impacted by physical and psychological distress.

Physical distress can inhibit an individual from engaging in everyday occupations. For example, chronic pain has been found to increase emotional distress, which may also lead to increased sadness and even depression in individuals with chronic disease (Fisher et al., 2007). Physical pain experienced on a daily basis may lead to other challenges such as a decreased level of confidence to self-manage chronic disease and a decreased quality of life (Zayas et al., 2013).

A psychological factor that may be impacted by chronic disease is self-esteem. Self-esteem can be negatively affected by decreased participation in physical and social activities (Pinquart, 2012). A decrease in self-esteem can lead to other complications or
exacerbation of chronic disease symptoms in the future for many individuals (Pinquart, 2012). To successfully manage a chronic disease, an individual needs to maintain a positive attitude and outlook (Lowe & McBride-Henry, 2012). When individuals are able to maintain a positive outlook about their life with chronic disease, they will be more willing to participate in various meaningful occupations (Lowe & McBride-Henry, 2012).

Frustration is another psychological factor that may impede an individual’s occupational engagement, as well as impact how effectively the individual communicates with healthcare professionals. At times, clients feel they are not being understood by their healthcare provider and feel they could have received better treatment (Fisher et al., 2007). Therefore, it is important for healthcare professionals to be aware of the client’s needs and frustration level.

Though an individual with chronic disease may be experiencing physical and psychological distress, it is important for them to accept the illness and not let the illness run their life (White et al., 2013). For instance, continuing to engage meaningful activities daily can help decrease the amount of physical and psychological distress one may be experiencing (White et al., 2013). Thus, healthcare professionals should encourage their clients to incorporate occupational engagement into their everyday life.

An individual’s occupational performance can be greatly impacted due to the effects of chronic disease. In a research study conducted by Zayas et al. (2013), authors found the areas of occupation commonly impacted by the presence of chronic disease included traveling to locations further than walking distance, daily household chores, financial management, shopping for basic needs, laundry, meal preparation, medication management, and using the telephone. Fisher et al. (2007) found social participation was
also impacted for individuals with chronic disease. Some social relationships remained the same, but other relationships suffered due to individuals not being able to handle the effects of a chronic disease or ineffectively communicating with the people in their life. Traveling may be negatively impacted due to factors such as the demands of medication management or spending an extended amount of time on a plane (Gurgle, Roesel, Erickson, & Devine, 2013). Gurgle et al. (2013) found it would be beneficial for an individual to set up a pre-travel appointment with a healthcare professional to answer questions and to consider precautions and health risks related to traveling with chronic disease. Therefore, research indicates engagement in occupations is impacted by chronic disease; fortunately, there are numerous ways to modify or adapt the occupation or the environment to allow each individual to continue engaging in occupations he or she find meaningful.

Adaptive responses and strategies are useful for an individual with chronic disease to encourage self-management. In a research study by Zayas et al. (2013), half the participants needing assistance with Instrumental Activities of Daily Living (IADLs) also used an assistive technology device. Finding ways to modify a daily occupation through the use of adaptive equipment allowed individuals to stay independent in desired occupations (Lowe & McBride-Henry, 2012). Families can also create solutions and suggest adaptive strategies to enhance their loved one’s participation in occupations. Some examples included encouraging completing activities at a slower pace and decreasing the amount of activities to complete in a day or week (Arestedt et al., 2014). An example of an adaptive strategy is provided by Poole and Cordova (2004). They found individuals with chronic disease utilized adaptive strategies such as sitting down
while performing their dressing routine and adapting their clothing choices by choosing items that were easier to don and doff.

Individuals with chronic disease also identified their caregivers as a helpful resource while performing their dressing routine if they did not have an assistive device (Poole & Cordova, 2004). Individuals with chronic disease learned how to adapt their routine to better meet their needs including strategies such as taking breaks more often or doing activities in the morning instead of the evening (Fisher et al., 2007). Saving energy and participating in a limited amount of occupations was found to be beneficial for individuals with chronic disease (Lowe & McBride-Henry, 2012). Another way to adapt an activity was to change the way individuals think. Examples included remaining positive throughout the time spent engaging in the activity and being grateful their condition was not worse (Fisher et al., 2007). Finding adaptive techniques to facilitate engagement in meaningful occupations can be beneficial to each individual to remain active in his or her life.

Once an individual is diagnosed with a chronic disease, maintaining engagement in their occupations is beneficial to their overall health and quality of life. In a study conducted by White et al. (2013), the authors found individuals were able to use their occupations to describe their condition, overcome barriers associated with their condition, and manage their condition more effectively. Research has also indicated individuals will learn what occupations to participate in to reduce their symptoms and also avoid occupations that caused them discomfort (Fisher et al., 2007; White et al., 2013).

The more meaningful the occupation was to an individual with chronic disease, the less he or she noticed their pain or symptoms (Fisher et al., 2007). In the research
study conducted by Lowe and McBride-Henry (2012), it was found that when individuals with chronic disease engage in occupations that are meaningful to them, their quality of life is enhanced. Also, when new occupations were introduced into individuals lives that were not there prior to their chronic disease, these new occupations helped them to move forward with their life (White et al., 2013). Familiar occupations allowed individuals with chronic disease to maintain their sense of self, while new occupations encouraged the individual to grow personally (White et al., 2013). Overall, individuals with chronic disease are able to effectively manage their condition if they find effective ways to cope with their symptoms and continue to engage in meaningful occupations.

The Role of Occupational Therapy

Although multiple healthcare professionals are involved in chronic disease management, currently there is limited evidence describing occupational therapy’s role in the chronic disease treatment process (Fisher et al., 2007). Articles have been published addressing the impact of chronic disease on participation in different areas of occupation (Hand, Law, & McColl, 2011; Toole, Connolly, & Smith, 2013). These occupations included activities of daily living, instrumental activities of daily living, social participation, work, and leisure occupations and how they are affected by the presence of chronic disease. Chronic disease can affect every facet of an individual’s life so including an occupational therapist in a patient’s care plan is essential (Toole et al., 2013). In one research study, the authors discussed how an occupational therapist could play a role in modifying lifestyles, adapting activities or occupations, and educating clients on the importance of engaging in meaningful occupations (Fisher et al., 2007). Since an occupational therapist considers multiple aspects of an individual, the therapist must be
educated on community resources available for patients such as support groups and other organizations for chronic disease management (Fisher et al., 2007). Since client-centered care is a cornerstone of the occupational therapy profession, an occupational therapist would also evaluate and provide strategies for the physical and psychological aspects of a client with chronic disease to promote the highest level of occupational performance feasible for each specific client (Fisher et al., 2007).

In addition to including healthcare professionals from multiple backgrounds, the type of relationship between the professional and the client is important to consider (Lawn, Delany, Sweet, Battersby, & Skinner, 2014). When healthcare professionals have good rapport with their clients, there is an increase in client understanding of his or her chronic disease, as well as better outcomes in treatment for the individual (Lake & Staiger, 2010). Another important factor in the client and healthcare professional relationship is maintaining a partnership, which aims to promote equal investment in the creation of treatment plans and goals. In a research study by Lawn et al. (2014), authors explored the relationship between the client and the professional to determine which techniques would empower or not empower the client. The researchers observed interactions between clients and professionals and determined when clients believed they were in control, they felt they had a voice in the relationship and were more trusting of the professional. Conversely, if a client felt they were being belittled or were a nuisance to the professional, the client was more likely to shut down and a positive relationship was difficult to establish (Lawn et al., 2014). Client-therapist relationships are important to develop and maintain throughout the course of a chronic disease and there are many facets to consider to ensure this relationship is a positive one.
Chronic disease is extremely prevalent throughout the United States. Specific programs have been developed to aide individuals in self-managing their chronic disease, however, indication of OT involvement in these programs is lacking. Important factors to consider when working with this population include caregiver education and involvement, building awareness in health professionals, and facilitating clients’ occupational engagement. Occupational therapists are in a position to make a positive contribution in these individual’s treatment due to the profession’s focus on function and considering multiple facets of individuals.

Next in this scholarly project is Chapter 3, which discusses methodology. This chapter outlines the tasks required for the completion of the literature review and the production of the clinical manual. Following the methodology chapter is Chapter 4, which contains the product including information and resources to facilitate chronic disease self-management.
CHAPTER III

METHODOLOGY

The author’s aim was to develop an evidence-based manual for occupational therapists to utilize to enhance an individual’s ability to self-manage his or her chronic disease(s). In order to determine the overall need for addressing self-management of a chronic disease an extensive literature review was completed. In the literature, it was evident there was a lack of evidence-based practice in relation to an occupational therapists role in guiding an individual to enhance his or her ability to self-manage the chronic disease. Due to the gap between the literature and practice, the authors determined a product to enhance an individual’s self-management skills would be beneficial in order for occupational therapists to provide evidence-based practice.

The literature review consisted of a search for scholarly articles and evidence focusing on chronic disease self-management. These articles became the primary foundation of research supporting this product. Scholarly articles were retrieved through the Harley E. French Library located at the University of North Dakota School of Medicine and Health Sciences. Databases utilized to gather information included CINAHL, PubMed, SCOPUS, and Google Scholar. Journal articles were primary obtained through the American Journal of Occupational Therapy, Australian Occupational Therapy Journal, and various nursing journals. The handouts and intervention strategies implemented throughout the manual were obtained utilizing a
Google search and supporting research journals, but were modified to fit the needs of the product. The client educational handouts located were free to download for scholarly and therapy purposes. The educational handouts for the clients were developed using an 8th grade readability level to allow for each client to understand the materials. Other information guiding the production of this manual was obtained through credible websites. Textbook references were utilized for addressing the Occupational Adaptation model related to guiding the manual development.

The product, Infusing an Occupational Perspective into Chronic Disease Management: A Manual for Occupational Therapists, was created upon completion of a thorough literature review and knowledge gained within the previous three years in the University of North Dakota Occupational Therapy (OT) Program. To ensure accuracy and organization of the information the authors compiled the literature, and determined themes among similar articles. The themes included: existing chronic disease programs, caregiver responsibility, the importance of educating healthcare professionals, therapeutic approaches to chronic disease self-management, the impact of chronic disease on occupations, and the role of occupational therapy with chronic disease management. The result of the themed pattern of the literature review provided the authors with a foundational base from which to structure a manual to enhance an individual’s ability to self-manage chronic disease.

The authors chose to utilize the Occupational Adaptation (OA) model as a theoretical base to guide the structuring and concepts of the manual (Schkade & Schultz, 1992). The OA model emphasizes the importance of the individual evaluating their own relative mastery, which is determined by efficiency, effectiveness, satisfaction to self, and
satisfaction to society. This model also allows the individual to adapt and learn from his or her experiences, therefore, responding effectively to future occupational challenges. The OA model fit with this product; it corresponded to an individual’s need to develop mastery in order to increase independence with self-managing a chronic disease.

The authors began creating the product with an outline addressing key points to be included in the manual. Some of the key components included facts about chronic disease, chronic disease self-management techniques, OT assessments, OT intervention planning, OA terminology, and outcome measures. The product was further divided into parts following the guidelines for occupational therapy implementation. Part I consists of motivational interviewing, assessing an individual’s readiness to change, a needs assessment, an occupational profile interview, and possible assessments for a therapist to utilize to evaluate a client. The needs assessment and occupational profile interview were created by the authors of this manual and are based off the Occupational Therapy Practice Framework (American Occupational Therapy Association, 2014).

Part II was divided into three sections based on the person definition in the OA model including cognitive, psychosocial, and sensorimotor. Each of these sections was further broken down into more detail. The evidence informed the content of each section and the authors categorized self-management topics by OA’s cognitive, psychosocial, and sensorimotor constructs. The cognitive section focused on problem solving, decision-making, setting goals, and developing an action plan. The psychosocial section consisted of coping with stress, self-efficacy, self-esteem, community resources, and communication. The final section of sensorimotor focused on energy conservation, lifestyle modifications, and pain management. Each of these three sections included an
overview of each topic, how the topic was relevant to chronic disease, how an OT could implement the topic into therapy sessions, possible OT intervention strategies, and handouts or worksheets to provide clients with during therapy. The handouts and intervention strategies are the original scholarly work of the authors or have been modified from credible therapy websites.

Part III is to be utilized as a re-evaluation tool for the therapist as well as the client. In this section there are evaluations or surveys for the client to complete to evaluate their satisfaction with the treatment and to assess their level of mastery with certain occupations. There are also self-evaluations for the OT to complete, assessing to what degree how effective and client-centered the treatment was provided to the client. These evaluations and surveys can be accessed through the references provided in the manual. This manual was developed to serve as a reference for occupational therapists to utilize with clients who have a chronic disease in order to provide them with the best evidence-based and client-centered treatment.
Infusing an Occupational Perspective into Chronic Disease Management: A Manual for Occupational Therapists
Katelyn Mari, MOTS
Abby Wicklund, MOTS
Jan Stube, PhD, OTR/L
Introduction

This clinical guide is meant to provide occupational therapy (OT) practitioners with an outline to provide treatment to clients with one or more chronic diseases. Due to the prevalence of chronic disease and its global impact on individuals, occupational therapy has a role in the treatment of these illnesses. The occupational therapy profession has a unique view of clients; we consider occupational performance and how clients function across environments to be of utmost importance. Historically, occupational therapists have not had much of a voice in the effective management of chronic disease. This manual is meant to provide OT practitioners with information regarding interventions to implement for this population.

This guide explains how to assess a client’s readiness for change, techniques to motivate a client, specific intervention strategies addressing cognitive, psychosocial, and sensorimotor client factors, and how to follow-up with the client to assess the efficacy of your interventions. Chronic disease may impact many facets of an individual’s life, so addressing the whole person using principles from the Occupational Adaptation model (Schkade & Schultz, 1992) is the cornerstone of this manual. Client handouts are included to provide the therapist with resources for client education or intervention. OT practitioners have permission to reproduce or modify these handouts as needed.

The first two sections of this manual, Readiness for Change and the Needs Assessment and Evaluation, are important to use with each client as they provide the foundations for intervention. The subsequent intervention sections can be utilized on an individual basis to meet the needs of each unique client; these sections may not be useable until the client has demonstrated readiness for change and is prepared to apply strategies learned in therapy to self-manage their disease. Each client’s limitations and strengths are different, thus utilization of this manual will be different for each individual client. Sections intended for OT practitioners are labeled for clarity. In addition, client handouts will be labeled throughout the manual to reduce confusion about the intended audience for each resource. This manual is only a guide for intervention; it is important to utilize clinical reasoning skills to determine what is best for each individual. The authors hope this manual provides a framework to implement efficacious OT interventions for individuals with chronic disease to promote self-management and improve quality of life.
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ASSESSING THE CLIENT’S READINESS FOR CHANGE

Resources for the occupational therapy practitioner

Stages of Change
Readiness Ruler
Motivational Interviewing
Tool for OT Practitioners: Assessing Readiness for Change

As humans, we are often resistant to change. Laziness, lack of knowledge, lack of motivation, or many other reasons may be behind this resistance. According to the American Occupational Therapy Association (AOTA) (2014), OT practitioners use their knowledge about the person, the context, and meaningful occupations to “design occupation-based intervention plans that facilitate change or growth in client factors” (p. S1). As an occupational therapist, our role is to facilitate clients to more effectively manage their chronic disease through modification and development of client factors. The first step is to assess the client’s readiness for change and meet them at their current functional level. Whether clients are ready for action or not considering change at all, our professional role is to move them to the next stage in the change process.

There are several models explaining the components of change and how to facilitate an individual’s readiness for change (Coleman & Pasternak, 2012). The Transtheoretical Model (Prochaska & DiClemente, 1983) will be utilized in this manual to address change because of its congruency with the Occupational Adaptation model (Schkade & Schultz, 1992), which provides the framework for this manual.

Prochaska and DiClemente developed the Transtheoretical Model, with its stages of change, in 1983. This model breaks down readiness for change into five stages: pre-contemplation, contemplation, preparation, action, and maintenance. As a clinician, it is imperative to identify where the client is in this change process and tailor intervention toward their unique needs. Table I illustrates the six stages, how to determine what stage the client is in, what to do for clients at each specific stage, and suggested foci for OT intervention.
<table>
<thead>
<tr>
<th>Stages of Change</th>
<th>Characteristics of Individuals in this Stage</th>
<th>Questions to Ask to Facilitate Movement to the Next Stage</th>
<th>Foci for Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-contemplation</td>
<td>Unaware of problems</td>
<td>Would you like more information about…?</td>
<td>- Assist the individual to recognize they have a problem and there is a need for change.</td>
</tr>
<tr>
<td></td>
<td>No thoughts about the need for change</td>
<td>What has happened as a result of your smoking, unhealthy eating, etc.?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Does not see behavior as a risk to self</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contemplation</td>
<td>Considering benefits and risks of behavior</td>
<td>What are reasons you are considering change?</td>
<td>- Facilitate client to weight the pros and cons of the behavior change.</td>
</tr>
<tr>
<td></td>
<td>Awareness of the problem but still no plan of action</td>
<td>What are some benefits of changing? Risks?</td>
<td>- Continue to foster the client’s awareness of the behavior they are considering changing and its possible benefits.</td>
</tr>
<tr>
<td></td>
<td>Intention to change in the next 6 months</td>
<td>What is keeping you from developing a plan of action?</td>
<td></td>
</tr>
<tr>
<td>Preparation</td>
<td>Intending to take action within the next month</td>
<td>What behaviors are you planning to modify?</td>
<td>- Make a specific plan for change.</td>
</tr>
<tr>
<td></td>
<td>Plan of action in place</td>
<td>What have you started doing specifically to work toward changing those behaviors?</td>
<td>- To start, suggest changes that are smaller in focus and achievable.</td>
</tr>
<tr>
<td></td>
<td>Small changes may already be present</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Action</td>
<td>Action toward change is observable</td>
<td>What is your first step?</td>
<td>- Support the individual’s autonomy.</td>
</tr>
<tr>
<td></td>
<td>Specific modifications in person’s lifestyle can be identified</td>
<td>Who is supportive of these changes and can help you in this process?</td>
<td>- Identify specific steps toward achieving client’s goals.</td>
</tr>
<tr>
<td>Maintenance</td>
<td>Client working to prevent relapse</td>
<td>How will you continue to maintain the gains you have made?</td>
<td>- Create a plan for relapse prevention and a plan for what to do if the client relapses.</td>
</tr>
<tr>
<td></td>
<td>Focusing on gains</td>
<td>How will you respond to barriers that may challenge the progress you have made?</td>
<td>- Support continued change and identify ways the client can continue to improve.</td>
</tr>
<tr>
<td></td>
<td>Confidence toward lasting change increasing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relapse</td>
<td>Return to old habits and behavior</td>
<td>What behaviors indicate you have relapsed?</td>
<td>- Recognize that relapse is a normal part of the change process.</td>
</tr>
<tr>
<td></td>
<td>Individuals can revert back to any stage of change</td>
<td>What is your plan to get back on track?</td>
<td>- Facilitate the client to get back on track by meeting them where they are in the change process.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Sources:**
The Readiness Ruler, found on the following page, is a tool to assess your client’s readiness for change. Once you have assessed the stage of change the client is currently in, it is important to tailor your treatment to that specific stage. For example, if the client is in the pre-contemplation or contemplation stage, it may be necessary to address their motivation and find out what is holding them back from making change. If a client is not ready for change, they may not be ready for this manual. Making an action plan for someone who is in the pre-contemplation stage is inappropriate and will likely be an ineffective intervention. Helping the client recognize what the problem is and what specific areas of their life they are unsatisfied with is important to help individuals prepare for the preparation and action stages of change. Motivational interviewing techniques, found on pages 9, 10, and 11 of this manual, provide useful methods of communicating with your client to promote change. Here are a few helpful guidelines for implementing the stages of change into your practice as discussed by Prochaska, Norcross, and DiClemente (2013).

1. Start by assessing the client’s stage of change.
2. Beware of treating all clients as if they are in the action stage.
3. Assist and encourage clients to move one stage at a time.
4. Clients in the action stage are likely to be more successful in implementing treatment recommendations.
5. Anticipate relapse and moving through the stages more than once.
6. Change is a process and takes time.
7. Provide interventions that match the stage your client is in.
8. Involve the client in the change preparation process, as he or she is the expert on their condition.
Readiness Ruler

The readiness ruler is utilized to assess a client’s commitment to change and how motivated they are to make changes in their life. It is measured on a scale from 0 to 10, with 0 being “not at all ready” and 10 being “very ready”. This scale is one way to assess a client’s readiness for change.

<table>
<thead>
<tr>
<th>Score</th>
<th>Readiness</th>
<th>Stage of Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – 3</td>
<td>Not ready</td>
<td>Pre-contemplation; early contemplation</td>
</tr>
<tr>
<td>4 – 7</td>
<td>Unsure</td>
<td>Contemplation</td>
</tr>
<tr>
<td>8 – 10</td>
<td>Ready</td>
<td>Preparation; action</td>
</tr>
</tbody>
</table>

Source:
Motivational Interviewing

One technique utilized to prepare individuals for change or allow them to move through the change phases is motivational interviewing (MI) (Miller, 1983). Evidence has shown clients who are in a passive state and lectured to by health care professionals become demotivated to fully participate in the therapeutic process (DeRosa, 2013). Self-managing a chronic disease requires client motivation and investment in the therapeutic process. Many facets of these individual’s care will depend on their ability to advocate for themselves and utilize skills and knowledge gained in therapy. As a result, it is important for occupational therapists to assist building internal motivation within their clients and resolve ambivalence about change. One technique utilized to do this is MI.

MI is focused around principles of collaboration with the client, internal motivation, and autonomy (Bray, Kowalchuk, & Waters, 2014). The essence of MI is that the client is the expert on their condition and the motivation to change is within them. The relationship between the client and the therapist is meant to elicit from the client the tools that will allow them to make desired behavioral changes (DeRosa, 2013). MI is an invaluable skill to learn and incorporate into everyday practice. Here are some resources to help you get started.

Table 2, Principles of Motivational Interviewing, is a brief overview of MI and strategies to communicate with your client effectively. Table 3, OARS, offers specific questioning strategies and a sequence to move through the MI process. Page 11 of the manual outlines a pneumonic device for integrating MI into the therapeutic process.

<table>
<thead>
<tr>
<th>Principle</th>
<th>Goal/Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Express empathy</td>
<td>Build rapport with client; enable the client’s own verbalization of the need for change. Reflective listening is imperative.</td>
</tr>
<tr>
<td>Develop discrepancy</td>
<td>Elicit pros and cons of behavior; help the client identify any discrepancies between their wellness goals and their behavior.</td>
</tr>
<tr>
<td>Roll with resistance</td>
<td>Do not challenge the client or become confrontational; avoid the urge to offer solutions to the client in an attempt to fix their problem.</td>
</tr>
<tr>
<td>Support self-efficacy</td>
<td>Communicate to the client they are capable of change; support their hope that change is possible and can have positive effects on their quality of life.</td>
</tr>
</tbody>
</table>

Sources:
Table 3: OARS - Strategies to Implement Motivational Interviewing Principles

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>O</td>
<td>Ask open-ended questions to encourage dialogue between you and your client. “Can you tell me more about…?”</td>
</tr>
<tr>
<td>A</td>
<td>Affirmation and empathy; listen for client’s strengths and reflect back to client. Validate client’s concerns. “You were able to overcome challenges before. You will be able to again.”</td>
</tr>
<tr>
<td>R</td>
<td>Reflective listening and developing discrepancy; rephrase what the client says to affirm your understanding. Help the client see their current situation in relation to where they want to be. “What have you tried in the past to address this problem?” “It sounds to me like… Does that sound accurate?”</td>
</tr>
<tr>
<td>S</td>
<td>Summary – Discuss what you and the client have talked about to show you were listening and to help build trust with the client. Reinforce the client’s motivation to change and highlight key points addressed in the dialogue. “So what I am hearing you say is…” “Have I got it correct?”</td>
</tr>
</tbody>
</table>

Source:
FRAMES - Conversation Techniques to Facilitate Motivational Interviewing

- **F** • Provide client **feedback** on personal impairment and risks involved.

- **R** • **Responsibility** resides within the client; they have the power over their own behavioral change.

- **A** • Provide clients with **advice** that is clearly stated and succinct.

- **M** • Offering the client a **menu** of items to make change possible is best practice.

- **E** • **Empathetic** style is utilized to build rapport and trust with the client.

- **S** • Support **self-efficacy** by helping the client feel empowered to make changes in his or her life.

**Source:**
References


THE EVALUATION PROCESS

Resources for the occupational therapy practitioner

OT Needs Assessment
Occupational Profile Interview
Recommended Assessments
**Tool for OT Practitioners: Needs Assessment**

A needs assessment can be defined as the “process by which problems, needs, gaps, and issues are identified for the purpose of developing strategies or programs to address the concerns of a community of population” (Scaffa, Doll, Estes, & Holmes, 2011, pp. 311). The following needs assessment can be utilized in an initial encounter with a client who has a chronic disease to gain a better understanding of the areas that need to be addressed during the treatment process.
**Occupational Therapy Needs Assessment**

1. Who is taking this survey?
   - ☐ Individual with a chronic disease
   - ☐ Caregiver
   - ☐ Other: ____________________

2. What type of chronic disease do you (or the person for whom you are caring for) have? (*Circle all that apply.*)
   - Arthritis
   - Asthma
   - Cancer
   - Chronic Obstructive Pulmonary Disease (COPD)
   - Diabetes
   - Heart Disease
   - Obesity
   - Osteoporosis
   - Reflex Sympathetic Dystrophy (RSD) Syndrome
   - Other: ____________________

3. How long have you or the person you are caring for been living with chronic disease? (*Check the one that applies.*)
   - ☐ less than 1 year
   - ☐ 1-5 years
   - ☐ 5-10 years
   - ☐ 10-15 years
   - ☐ 15 years+ If this is checked, please list amount of years: _______

4. Has the person with chronic disease experienced any of the following? (*Check all that apply.*)
   - ☐ Pain
   - ☐ Difficulty with memory
   - ☐ Fatigue
   - ☐ Weight Changes
   - ☐ Depression or mood changes
   - ☐ Muscle weakness
   - ☐ Headache
   - ☐ Dizziness or balance problems
   - ☐ Difficulty sleeping
   - ☐ Appetite changes
   - ☐ Other

5. What type of residence does the individual with chronic disease live in?
   - ☐ Apartment Complex
   - ☐ Single Level Home
   - ☐ Multiple Level Home
   - ☐ Other: ____________________

6. Who is currently providing care for the individual with chronic disease at their place of residence? (*Check all that apply.*)
   - ☐ Spouse/Partner
   - ☐ Sibling
   - ☐ Children
   - ☐ Friend/Neighbor
   - ☐ Home Health
   - ☐ Distant relative
☐ None  ☐ Other

7. How many hours a day do you (or the individual with chronic disease) require a caregiver? *(Check all that apply.)*
☐ No time at all, completely independent
☐ 1-6 hours per day
☐ 6-12 hours per day
☐ 12-18 hours per day
☐ 18-24 hours per day
☐ All the time, dependent on caretaker

8. What activities are you, or the individual you are caring for, experiencing difficulties with due to chronic disease? *(Check all that apply.)*
☐ Bathing  ☐ Grocery Shopping
☐ Dressing  ☐ Moving in the home/community
☐ Social Participation  ☐ Exercise
☐ Hobbies  ☐ Work Activities
☐ Cooking  ☐ Sleeping
☐ Care of home  ☐ Transportation
☐ Other: ________________

9. On a scale of 1-5, how knowledgeable do you feel about self-managing your chronic disease?

<table>
<thead>
<tr>
<th>Not Knowledgeable</th>
<th>Very Knowledgeable</th>
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<td>1</td>
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</table>

10. Do you know of ways to learn more about self-managing your chronic disease? *(If yes, please explain.)*

☐ No  ☐ Yes ___________________________________________________________________

11. On a scale of 1-5, how beneficial would receiving help for self-managing your chronic disease be?

<table>
<thead>
<tr>
<th>Not Beneficial</th>
<th>Very Beneficial</th>
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</table>

12. What information would you like to learn more about related to chronic disease? *(Check all that apply.)* *(Cognitive)*

☐ Problem solving
☐ Decision-making
☐ Creating goals and action plans to achieve those goals
☐ Planning for the future

(Psychosocial)
☐ Coping with stress or relaxation strategies
☐ Feeling confident in yourself
☐ Staying positive throughout your day
☐ Community Resources
☐ Communicating with healthcare professionals and caregivers

(Sensorimotor)
☐ Energy conservation/fatigue management
☐ Making your home more accessible
☐ Moving about in your home or community
☐ Pain management
☐ Other: ____________________________

13. On a scale of 1-5, how would you rate your readiness to change to better self-managing your chronic disease?

<table>
<thead>
<tr>
<th>Not Ready to Change</th>
<th>Ready to change</th>
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<tbody>
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<td></td>
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<td>3</td>
<td>4</td>
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<tr>
<td>5</td>
<td></td>
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</tbody>
</table>

14. Do you have any additional concerns related to self-managing your chronic disease?
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Source:
Tool for OT Practitioners: Evaluation of Chronic Disease

Performing a comprehensive evaluation is an important aspect of the occupational therapy process (American Occupational Therapy Association, 2014) and will help determine the approach for treatment. During the evaluation portion of the occupational therapy process, developing a holistic occupational profile and utilizing assessments and measurement scales will allow the therapist to gather adequate information about the client. The information gathered during the evaluation portion of the therapy process will provide the therapist the opportunity to implement client-centered treatment through what the individual finds meaningful (American Occupational Therapy Association, 2014).

The authors of this manual developed the following occupational profile questionnaire. This questionnaire is to be utilized by an occupational therapist to gather a comprehensive overview of the client, which will assist in the OT evaluation process and enhance the effectiveness of treatment. These are possible questions for a therapist to potentially utilize during an interview. An OT can decide which questions he or she would like to utilize and also develop additional questions not provided in this questionnaire as necessary.
Occupational Profile Interview

• Your reason for seeking services:
  __________________________________________________
  __________________________________________________
  __________________________________________________

• What is your past medical history?
  __________________________________________________
  __________________________________________________
  __________________________________________________

Cognitive

• What has changed the most since being diagnosed with a chronic disease?
  __________________________________________________
  __________________________________________________
  __________________________________________________

• What are your current concerns related to daily activities while managing a chronic disease?
  __________________________________________________
  __________________________________________________
  __________________________________________________

• What are your priorities for therapy?
  __________________________________________________
  __________________________________________________
  __________________________________________________

• What are the goals to achieve in therapy?
  __________________________________________________
  __________________________________________________
  __________________________________________________

Psychosocial

• Can you describe yourself to me?
  __________________________________________________
  __________________________________________________
  __________________________________________________
• What type of social supports do you have (i.e. family, friends, significant other, etc.)?

________________________________________________________________________

________________________________________________________________________

• How would you rate your motivation level for self-managing your chronic disease? (Check the box that applies to the client’s response.)

☐ Highly motivated ☐ Somewhat motivated ☐ Not motivated

• What are your interests?

________________________________________________________________________

________________________________________________________________________

• Describe the strengths you possess:

________________________________________________________________________

________________________________________________________________________

• Describe any weaknesses you have:

________________________________________________________________________

________________________________________________________________________

Sensorimotor

• What activities are you currently completing successfully?

________________________________________________________________________

________________________________________________________________________

• What activities are challenging for you at this time?

________________________________________________________________________

________________________________________________________________________

• What types of environments support your participation in activities?

________________________________________________________________________

________________________________________________________________________
• What types of environments reduce your participation in activities?

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

• What are some common roles you occupy in your daily life? (Parent, sibling, caregiver, worker, etc.)

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

• Please describe your daily routine to me:

____________________________________________________________________
____________________________________________________________________

Source:
Recommended Occupational Therapy Assessments

The following assessments provided in this section are possible options for a therapist to choose from when completing the evaluation and treatment plan. Although many other assessments are available, these are most applicable for this population. The Occupational Adaptation model has one specific assessment to utilize when evaluating clients, the Relative Mastery Scale, and it is included in this section. Additional assessments included in this section are from a variety of models. The occupational therapist should determine the most appropriate assessment to utilize to evaluate multiple facets of the person (cognitive, psychosocial, sensory, etc.), occupational performance, and the satisfaction level for completing their chosen occupations. Multiple assessments are presented in this section; though it is not required to use these specific assessments, it is recommended a therapist use 1-4 assessments to gather adequate information about the person, their occupational performance, and desired outcomes for treatment.
**Relative Mastery Measurement Scale (RMMS)**

**Authors:** Lorrie George, Janette Schkade, & Jimmy Ishee

**Purpose of Assessment:** Therapists can utilize the RMMS to help guide clients through the self-evaluation process. The RMMS is used to measure an individual’s relative mastery, which is a component of the Occupational Adaptation (OA) model. The statements used during this assessment highlight the three domains represented in OA including efficacy, effectiveness, and satisfaction toward self/society.

**Model Used:** Occupational Adaptation

**Relevancy:** This measurement scale directly correlates with the model used to develop this manual. The occupational therapist will gain a better understanding of the client’s perceived level of relative mastery. The results obtained from this scale could be used as a pre-test and post-test to determine a client’s progress toward relative mastery.

**Cost:** Free

**Additional Resource:** Scale can be found in the article provided here.

**Source:**
Occupational Self-Assessment (OSA)

Authors: Kathi Baron, Gary Kielhofner, DrPh, Anita Lyenger, Victoria Goldhammer, and Julie Wolenski

Purpose of Assessment: The OSA is a self-report evaluation tool and outcome measure designed to capture client perceptions of their occupational competence and the impact their environment has on their occupational adaptation. The OSA can be utilized to help the client establish priorities for change and identify goals he or she wants to achieve in treatment.

Model Used: Model of Human Occupation

Administration: The OSA typically takes clients 10-20 minutes to complete. Discussion after completion of assessment takes about 15 minutes.

Relevancy: This assessment tool directly correlates with the objectives of this manual as it addresses the individual’s self-perception of their occupational performance, as well as environmental adaptation. Results from this assessment can be used during treatment planning by using the individual’s priorities for change and utilizing the goals the client wants to achieve. This assessment can also be used as a pre-test/post-test to evaluate the client’s progress.

Cost: $40.00

Source: www.moho.uic.edu
The Occupational Circumstances Assessment Interview and Rating Scale (OCAIRS) 4.0

Authors: Kirsty Forsyth, Shilpa Deshpande, Gary Kielhofner, Chris Henriksson, Lena Haglund, Linda Olson, Sarah Skinner, and Supriya Kulkarni

Purpose of Assessment: The OCAIRS is a semi-structured interview that provides qualitative (interview responses) and quantitative (ratings on response) information. The OCAIRS provides information about a client’s life and occupational participation using a 4 point rating scale. The assessment includes 14 areas: roles, habits, personal causation, values, interests, skills, short-term goals, long-term goals, interpretation of past experiences, physical environment, social environment, and readiness for change.

Model Used: Model of Human Occupation

Administration: The OCAIRS can be completed within 20-30 minutes. Interpretation of the data is estimated to take 5-20 minutes.

Relevancy: This assessment tool is recommended for therapists to utilize while developing the occupational profile and treatment plan, as it provides details about the client’s life and identifies occupations an individual is engaging in.

Cost: $40.00

Source: www.moho.uic.edu
**Canadian Occupational Performance Measure (COPM) - 3rd Edition**

**Authors:** Mary Law, Sue Baptiste, Anne Carswell, Mary Anne McColl, Helene Polatajko, and Nancy Pollock

**Purpose of Assessment:** The COPM is a semi-structured interview to measure change in clients’ self-perception of occupational performance and satisfaction in identified activities through utilization of a client-centered approach.

**Model Used:** Canadian Model of Occupational Performance

**Administration:** The COPM takes 20-30 minutes to complete.

**Relevancy:** This assessment is recommended to be utilized for clients with chronic disease to enhance client-centered intervention and evaluate where the client is experiencing occupational performance deficits. This assessment also focuses on environments in which the occupations are performed. In addition, the COPM is related to this manual as it assesses the client’s awareness and perception of occupational performance, which is a component of a chronic disease self-management. This can be used throughout the treatment process to track performance and satisfaction levels of the client.

**Cost:** $210.00

**Source:** http://www.thecopm.ca/
Occupational Role Checklist

Authors: Frances Oakley

Purpose of Assessment: The goal of the Role Checklist is to assess an individual’s self-perception of his or her occupational roles and determine which roles are most important to the individual. The Occupational Role Checklist covers: continuous roles, disrupted roles, role changes, past roles, present roles, and future roles. Goals will focus on roles the individual may be having difficulties with, but still find important.

Model Used: Model of Human Occupation

Administration: The Occupational Role Checklist takes 15 minutes to administer.

Relevancy: The Occupational Role Checklist is congruent with the objectives of the manual as it assesses the client’s roles in his or her life. This assessment can assist the client in determining what roles are most important and how the client can use self-managing techniques to continue engagement in these roles.

Cost: No Cost - Log into source provided to access free assessment forms.

Source: www.moho.uic.edu
CLIENT FACTORS IMPACTED BY CHRONIC DISEASE

Cognitive Factors
Psychosocial Factors
Sensorimotor Factors
Cognitive Client Factors

Problem Solving
Decision-Making
Setting Goals and Developing an Action Plan

Source:
OT Information: Problem Solving

What is problem solving?
According to dictionary.com, problem solving is defined as using cognitive processing to find solutions to complex issues one might encounter throughout their life.

Relevance to chronic disease:
The ability to problem solve is a key skill needed by individuals learning to self-manage a chronic disease (Coleman & Newton, 2005). Problem solving is an integral component in navigating barriers individuals with chronic disease may encounter throughout their lives. Fortunately, problem-solving skills can be learned and occupational therapists are in an ideal position to educate their clients on this topic area.

How to implement problem solving into the intervention plan:
Problem solving can be implemented into a client’s treatment plan in a number of ways. When talking with the client, ask them questions about barriers to their occupational participation or areas of their lives they wish they could change for the better. Ask questions related to strategies they have tried before and the results of those strategies. Problem solving is ongoing throughout the therapeutic process and the goal of the occupational therapist is to facilitate the client in learning these skills and generalizing them across contexts.
Suggested Intervention Strategy for the OT Practitioner

Problem solving can be broken down into a 7-step process (Chronic Disease Self-Management Support Toolkit, 2008; Lorig et al., 2012). Educating your client on this process may facilitate their learning, as it simplifies the components of problem solving and emphasizes it as a dynamic process.

Step 1: Identify the Problem
- Be specific
- May be the most difficult step in the process

Step 2: Brainstorm Ideas to Solve the Problem
- List all possible solutions
- Utilize friends, family, and caregivers for ideas

Step 3: Pick One Idea to Try
- It may be a combination of two ideas
- Give your solution at least two weeks to determine if it is useful or not

Step 4: Check the Results
- Assess the problem and whether or not it is diminishing
- Specify changes that have occurred, if any

Step 5: Pick Another Idea if Necessary
- If the first solution did not work, select another idea from the list and start the process again

Step 6: Use Other Resources
- Seek professional help or consult with people close to you

Step 7: Accept the Problem May Not be Solvable at this Point
- Not all problems can be solved when we expect
- Choose another problem and focus your energy there
Handout: Steps of Problem Solving

Identify a specific problem or challenging issue in your life right now. Reflect on the problem or issue. Fill in this table as if you were trying to solve the problem; be as specific and complete as you can.

<table>
<thead>
<tr>
<th>Step</th>
<th>Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Identify the Problem</td>
</tr>
<tr>
<td>2</td>
<td>Brainstorm Ideas to Solve the Problem</td>
</tr>
<tr>
<td>3</td>
<td>Pick One Idea to Try</td>
</tr>
<tr>
<td>4</td>
<td>Check the Results</td>
</tr>
<tr>
<td>5</td>
<td>Pick Another Idea if Necessary</td>
</tr>
<tr>
<td>6</td>
<td>Use Other Resources</td>
</tr>
<tr>
<td>7</td>
<td>Accept the Problem May Not be Solvable at this Point</td>
</tr>
</tbody>
</table>
Handout: A Problem-Solving Worksheet

Often a problem seems difficult to solve because you limit your options for solutions. This exercise will allow you to come up with more solutions than you may have thought possible.

**First, identify the problem; be specific.**

Now for the solution. Write any solution you can think of, even if it’s not practical. Remember, an unusual or unexpected idea can spark the most innovative solutions.

<p>| | |</p>
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<td>4</td>
<td>9</td>
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<td>5</td>
<td>10</td>
</tr>
</tbody>
</table>

Take a break. Set this aside for a day or two. Let these solutions roll around in your mind. When you pick up this list again, choose what seems like the three best solutions. Write down your choices.

**Solution:**

<table>
<thead>
<tr>
<th></th>
<th>Why?</th>
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<td>3</td>
<td></td>
</tr>
</tbody>
</table>

Look over your solution lists again. Take another break if needed and then pick your favorite solution and write about it in more detail below.

**Solution:**

Source:

References


OT Information: Decision-Making

What is decision-making?

According to businessdictionary.com, decision-making is defined as the thought processes involved in selecting a logical choice from a set of options.

Relevance to chronic disease:

The ability to make decisions effectively and efficiently is an essential part of chronic disease self-management (Bodenheimer, MacGregor, Sharifi, 2005; Lorig et al., 1999; Lorig et al., 2012). Individuals with chronic disease will likely have to change the way they make decisions as a result of symptomology related to his or her chronic illness. Decision-making is a multiple-step process that is important to address for these individuals.

How to implement decision-making into the intervention plan:

To implement decision-making into the intervention plan, an OT must develop a full occupational profile and establish the stage of change a client is in currently. Without this background information, it will be difficult to determine which decisions need to be made for the specific client. Once it is determined which stage of change the client is at, it is your job as a therapist to help them make a decision related to change and weigh the pros and cons of each decision. The type of decision clients need to make will vary significantly with each unique individual.
Suggested Intervention Strategy for the OT Practitioner

Decision-making can be broken down into logical steps (Lorig et al., 2012). Educating your client on these steps and how to navigate through the process will simplify decision making for him or her in relation to their chronic disease and in other facets of their life.

Step 1: Identify the Options
✓ What are you deciding between?
✓ Sometimes, the decision is between doing something or nothing at all

Step 2: Identify What You Want
✓ Consider your values and priorities
✓ What is motivating to you?

Step 3: Write Down Pros and Cons for Each Option
✓ List as many items as you can on each side
✓ Don't forget about social, emotional, and psychological factors

Step 4: Rate Each Item on a Scale
✓ 0 indicates “not at all important” and 5 indicates “extremely important”
✓ Be honest and truthful with yourself

Step 5: Add Up the Ratings for Each Column
✓ Compare the rating for the pros to the cons
✓ Which is higher?

Step 6: Utilize the “Gut Test”
✓ Does the decision feel right to you?
✓ Consider all factors and reflect on past experiences
Handout: Weighing the Pros and Cons of a Decision

Decision to be made and what you want:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

One way to simplify decision-making is to consider the pros and cons of your decision and rate each statement based on its importance to you. On a scale of 0 – 5, 0 being “not important at all” and 5 being “extremely important”, rate each item listed under your pros and cons. Total up each column in the space provided and utilize these totals to consider your decision.

<table>
<thead>
<tr>
<th>Pros</th>
<th>Rating</th>
<th>Cons</th>
<th>Rating</th>
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<tbody>
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</table>

Once you are finished, add up the totals and take the “gut test” to reach your final decision.

Source:
Handout: Steps of Decision-Making

Step 1: Identify the Options
Step 2: Identify What You Want
Step 3: Write Down the Pros and Cons for Each Option

Step 4: Rate Each Item on a Scale
Step 5: Add Up the Ratings for Each Column
Step 6: Utilize the "Gut Test"
References


OT Information: Setting Goals and Developing an Action Plan

**What does it mean to set goals and develop an action plan?**

Setting goals is a means of objectifying what an individual wants to accomplish in a specific amount of time; action planning is identified as what the individual specifically plans to do to achieve their goal. Both goals and action plans should be specific, objective, and measurable so both clients and therapists know whether or not they are achieved.

**Relevance to chronic disease:**

Setting goals and developing an action plan to achieve those goals is an integral part of chronic disease self-management (Bodenheimer, MacGregor, Sharifi, 2005; Chronic Disease Self-Management Support Toolkit, 2008; Coleman & Newton, 2005; Handley et al., 2006). Setting goals gives clients a direction for where they are going and identifies how they know when they get there. Action plans lay out a specific strategy to achieve goals. This framework provides guidance to clients and holds them accountable for following through with their plan. It is important both goal setting and action planning occur in a collaborative manner where the client is actively involved in the therapeutic process.

**How to implement goal setting and action plans into the intervention plan:**

To implement goal setting and action plans into the intervention plan, it is important to ask the client what they expect from therapy. As an occupational therapist, it is imperative to ask about the client’s daily routine and areas of their life in which they may be struggling. It is also important to ask the client what they would like to change about their life so you can get an idea of where to focus your intervention.
Suggested Goal-Setting and Action Planning Strategies for the OT Practitioner

➢ Educate the client on the importance of setting SMART goals:
   • Specific
   • Measurable
   • Achievable
   • Relates
   • Time bound

➢ Set goals collaboratively
   1. **Explore problems together** – Client and therapist priorities are likely different. Establishing what is important to your client is imperative; what a client views as important to him or her likely has personal meaning.
   2. **Assess** – Consider the impact of the client’s illness: What is most difficult? What is the main problem? What concerns do you have? Could you tell me more about that? Can you paint a picture of your daily routine for me?
   3. **With the client, determine the physical, psychological, and emotional symptoms of the chronic illness** – Utilize objective measurements when possible; consider lifestyle factors when assessing symptomology.
   4. **Identify feelings** – Discussing feelings with clients may energize them and motivate them to continue toward their goals. You may find motivational interviewing techniques helpful here (pp. 9). When clients identify why there is a need for change they will be more likely to take action.
   5. **Assist the client in establishing goals** – Help the client see the changes that would need to happen to improve their situation and identify how he or she would feel. Ask questions such as: What do you want? What needs to happen? How will you feel if you don’t meet your goals? How will you feel if things do not change?
   6. **Determine motivation** – Clients need to determine their own level of readiness for change. Clients who make changes because of what someone else wants rarely last. Ask questions such as: Are you willing to take action to change your situation? How important is it to you to change this situation?

***It is important the client feels they are in control throughout this process and their thoughts are being heard. The therapist must help the client formulate goals based on their own unique needs and commitment to change.

➢ **Create an action plan to work toward the established goals**
   1. Must be created by the client
   2. Small and realistic plan
   3. Choose one step at a time
   4. Assess client’s confidence in carrying out the action plan
   5. Address barriers that may come up
   6. Give the client a copy of the action plan
   7. Follow-up with the client at subsequent therapy sessions and make adjustments as needed
   8. Track client’s progress throughout the treatment period
Handout: SMART Goals

- **S**pecific - Goals are simplistically written and state exactly what you want to accomplish; the what, why, and how of the goal.

- **M**easurable - Goals are measurable so you can identify when the goal has been met.

- **A**chievable - Goals must be plausible; they are challenging enough so you have something to strive for, while still being within your range of skills.

- **R**elates - Goals should be directly related to your priorities.

- **T**ime-bound - Goals are written to be achieved within a specified time frame.

My SMART Goals:

1. ________________________________________________________________________
   ________________________________________________________________________

2. ________________________________________________________________________

3. ________________________________________________________________________
Handout: SMART Goal Setting and Action Planning

Goal Statement:

*Refer to the SMART goal format.

Why is this goal important?

What is needed to accomplish this goal?

My Action Plan:

<table>
<thead>
<tr>
<th>Specific Action:</th>
<th>Due Date:</th>
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</table>
Handout: Personal Action Plan

Name: ___________________________  Date: ______________

The change I want to make happen is:
________________________________________________________________________
________________________________________________________________________

My goal for the next month is:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Action Plan: What specific steps will I take to reach my goal?
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Things that may make it difficult to achieve my goal include:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

My plan for overcoming these challenges includes:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Support and resources that will help me reach my goal include:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

My confidence level that I can achieve my goal is: (scale of zero to 10, with zero indicating not confident at all and 10 being extremely confident) _______

Source:
References


Psychosocial Client Factors

Coping with Stress
Self-Efficacy
Self-Esteem
Community Resources
Communication

Sources:
OT Information: Coping with Stress

What is coping with stress?

Stress can be defined as a reaction to a situation which causes an individual a great deal of pressure. Stress can impact an individual mentally, physically, and emotionally (Molander, 2009). An individual will have to manage his or her stress by utilizing healthy coping strategies, which can include relaxation techniques, stress relieving activities, and other techniques beneficial for the patient (Molander, 2009).

Relevance to chronic disease:

Stress can become a limiting factor when an individual has a chronic disease. Not only can constant stress be a contributing factor leading to chronic disease, but constant stress can also worsen the symptomology of chronic disease. When an individual with chronic disease is experiencing excessive stress, he or she may engage in unhealthy coping strategies if they are not educated properly (Novant Health, 2014).

How to implement coping with stress into intervention plan:

Research has shown incorporating stress management into a client’s intervention plan may improve the overall health of the client (Branstrom, Kvillemo, & Moskowitz, 2012). When implementing strategies for coping with stress into an intervention plan, the therapist must also focus on important factors involving the client (Lorig et al., 2012). An occupational therapist must be aware there are many ways to manage stress and not all techniques work for every client. In addition, coping with stress takes time to learn and master, therefore, encourage the client to persist and try many techniques until they find what works for them. Finally, techniques should not have negative effects on the client; if negative effects occur, suggest alternative techniques (Lorig et al., 2012).
Suggested Intervention Strategies for Coping with Stress for the OT Practitioner

- Educate the client on healthy ways to cope with stress
  - A list of examples is provided on the handout for the client
- Educate the client about unhealthy ways to cope with stress
  - A list of examples is provided on the following handout for the client
- Guidelines to utilize to help the client practice relaxation strategies
  - Remind the client to choose a quiet place and time
  - Encourage the client to practice relaxation strategies twice a day
  - Practice the techniques - it may take time before the client notices a change
  - Relaxation strategies should be helpful, and if not encourage client to use another strategy to cope with stress
- Educate client on relaxation strategies to utilize. The following strategies are suggested relaxation techniques to utilize, and a therapist can use other relaxation strategies if they prefer. *(Refer to handouts for instructions on the relaxation strategy.)*
  - **Body Scan**
    - This technique focuses on relaxing all the muscles in the body to encourage the client to be aware of where they are tense. This helps to release tension anywhere in the body and is usually most successful when client is lying down.
  - **Distraction**
    - During this technique the client will focus his or her attention on a positive situation. This is helpful when a client is feeling stressed or overwhelmed with his or her life.
  - **Positive Thinking and Self-Talk**
    - Remind the client about the importance of using positive thoughts to successfully manage his or her chronic disease.
  - **Visualization**
    - This strategy is when the client develops his or her own positive image in their mind. Visualization encourages the client to imagine being successful and reaching the goals they have set for themselves.
  - **Deep Breathing**
    - Provide the client options for different deep breathing techniques and allow them to choose which one works best. This technique can easily be done throughout the day when completing different occupations. Deep breathing can ease muscle tension and bring clarity to the mind.
# Handout: Coping with Stress

## Healthy Ways to Cope with Stress

- Take a nap or bath
- Read a book
- Watch a funny movie
- Get a massage
- Engage in a leisure activity
- Go for a walk
- Listen to your favorite music
- Put your head down and rest your eyes for 5 minutes
- Play with an animal
- Call a family member or friend to talk
- Go on a vacation

## Unhealthy Ways to Cope with Stress

- Smoking
- Drinking
- Watching TV or sitting on computer for extended amount of time
- Not staying in contact with family or friends
- Ending all participation in activities
- Overeating or undereating
- Using medications to relax
- Over sleeping
- Procrastinating
- Avoiding all problems
- Taking out problems on others
Handout: Relaxation Strategies

Possible relaxation strategies to use when feeling stressed.

- **Body scan**
  - Find a position you are comfortable and relaxed in
  - Close your eyes
  - Relax all the muscles in your body, starting at your feet and moving up to your face. Keep them relaxed.
  - Breathe in through your nose. (Be aware of your breathing throughout this activity.) Breathe out through your mouth. Focus on your breathing and getting rid of any negative thoughts in your head.
  - Complete activity for 10-20 minutes, or until you feel relaxed. Sit quietly for a few minutes, and do not stand up right away.
  - Keep a positive mindset after completing the body scan activity.

- **Distraction**
  - Challenge yourself to count backwards from 100 by fours
  - Think about a reward to give yourself after completing an unpleasant activity
  - Think back to a favorite memory or story of your childhood
  - Say “stop” if you start worrying about a situation

- **Positive Thinking and Self-Talk**
  - Use the Internet to find positive sayings or quotes and print them off
  - Use the positive sayings when feeling sad or in a bad mood (For example, if you encounter a challenging task, tell yourself “This may be challenging but it is also an opportunity to better myself and learn something”.
  - Write down positive and negative characteristics about yourself
    - Change all the negative ones into positive
  - Think about yourself achieving success

- **Visualization**
  - Play relaxing music or sit in a quiet place
    - Think back to a pleasant and relaxing experience you once had
    - Try to picture a favorite memory
    - Try to visualize yourself on a beach
    - Think about a romantic date

- **Deep Breathing**
  - Find a relaxing and quiet place where you are comfortable
    - Breathe in through your nose and count to 4
    - Hold your breath for 2 seconds
    - Breathe out through your mouth and count to 4
    - Hold your breath for 2 seconds
    - Repeat these steps until you feel relaxed
Handout: Stress Management Strategies

#1: Avoid unnecessary stress
- Remember to say “no”
- Do not involve yourself with people who add stress to your life
- Control the environment you are in
- Avoid topics that cause you stress
- Prioritize your to-do list

#2: Adjust the situation
- Share your feelings with others, even if it is something that is bothering you
- Have a give-and-take relationship with others
- Be confident
- Use good time-management skills

#3: Modify yourself to the stress
- Look for the positives in each situation
- Focus on the future
- Set reasonable limits for yourself, and remember you do not have to be perfect
- Appreciate what you have in life

#4: Some things cannot be changed
- Focus on the situations in life where you can or do have control
- Look at every challenge or situation as an opportunity to learn
- Communicate with others
- Mistakes happen, learn to forgive

#5: Make time for leisure activities
- Put aside time to relax
- Keep people who are positive in your life
- Engage in an activity you enjoy every day
- Remember to laugh

#6: Lifestyle modification
- Engage in daily exercise
- Try to use healthy eating habits
- Cut out pop and candy from your diet
- Stop using alcohol, cigarettes, or drugs
- Try to get adequate sleep each night

Source:
References


OT Information: Self-Efficacy

What is self-efficacy?
Self-efficacy can be defined as believing in one’s own ability to successfully reach a goal. Self-efficacy can continue to grow as individual’s gain new skills, experiences, and understandings (Cherry, 2015).

Relevance to chronic disease:
Improving one’s self-efficacy is essential to self-managing a chronic disease and has been shown to have long-term health benefits. In a research study conducted by Farrell, Wicks, and Martin (2004) the authors found when an individual increases his or her self-efficacy they have an improved ability to self-manage their chronic disease. Improved self-efficacy provides the client with more confidence to identify the areas they need to improve in order to better manage their chronic disease when collaborating with healthcare professionals (Farrel et. al., 2004). In a research study conducted by Curtin et al. (2008), the authors found that individuals with a chronic disease who had good self-efficacy were able to communicate better with caregivers, have better communication behaviors, have increased ability to complete self-cares, and had improved medication adherence.

How to implement self-efficacy into the intervention plan:
An occupational therapist can implement self-efficacy into the intervention plan by educating the client, providing encouragement, being supportive, providing training, and by having the client reflect on positive experiences he or she may have had in the past (Curtin et al., 2008). Utilizing handouts and worksheets to improve a client's self-efficacy would also be beneficial in the treatment process.
Suggested Intervention Strategies for Self-Efficacy for the OT Practitioner

➢ Educating client on the benefits of improving self-efficacy
  o Long-term health benefits
  o Increased ability to self-manage his or her chronic disease
  o Increased confidence when collaborating with healthcare professionals

➢ Incorporate activities that involve reflection on positive experiences in his or her life
  o Utilize handouts or worksheets
  o Ask questions to clients about positive experiences
    ▪ Could you name any positive experiences in your life?
    ▪ How could you change a negative experience into a positive experience?

➢ Have client complete the self-efficacy for managing chronic disease 6 item scale (p. 56)
  o Review the client’s responses at the end of the session
  o If client is not confident in a certain area, ask the client why they do not feel confident in this area?
  o Discuss strategies with the client to increase his or her confidence level in areas they did not feel confident
  o At the end of the intervention session, ask the client to complete the questionnaire again and evaluate results to check for improvement

➢ Discuss with the client the positive self-efficacy cycle
  o Increasing confidence in self-managing their chronic disease
  o Demonstrating effective behaviors
  o Having an increased self-esteem
  o Improving their motivation to make a change in their life
  o Taking steps towards reaching their end goal
    ▪ Utilize discussion questions, worksheets, or handouts to improve these areas on the self-efficacy cycle (p. 57)

➢ Educate client on how to enhance his or her self-efficacy (p. 58)
  o Utilize client handouts provided in the manual
  o Ask the client if they have any questions while discussing the worksheet
  o Collaborate with the client to determine strategies or activities they can complete for each of the steps provided on the worksheet
  o Make sure the client understands the information on the worksheet
    ▪ Ask them to rephrase the information on the worksheet
Handout: 6-item Scale to Measure Self-Efficacy for Managing Chronic Disease

The following questions will determine how confident you are in completing certain activities. For each of the questions, please choose the number that best represents your confidence level for completing these tasks at the present time.

1. How confident are you that you can keep the fatigue caused by your disease from interfering with the things you want to do?
   1 2 3 4 5 6 7 8 9 10
   Not at all confident  Totally Confident

2. How confident are you that you can keep the physical discomfort or pain of your disease from interfering with the things you want to do?
   1 2 3 4 5 6 7 8 9 10
   Not at all confident  Totally Confident

3. How confident are you that you can keep the emotional distress caused by your disease from interfering with the things you want to do?
   1 2 3 4 5 6 7 8 9 10
   Not at all confident  Totally Confident

4. How confident are you that you can keep any other symptoms or health problems you have from interfering with the things you want to do?
   1 2 3 4 5 6 7 8 9 10
   Not at all confident  Totally Confident

5. How confident are you that you can do the different tasks and activities needed to manage your health condition to reduce your need to see a doctor?
   1 2 3 4 5 6 7 8 9 10
   Not at all confident  Totally Confident

6. How confident are you that you can do things other than just taking medication to reduce how much your illness affects your everyday life?
   1 2 3 4 5 6 7 8 9 10
   Not at all confident  Totally Confident

Source:
Handout: Self-Efficacy

Positive Self-efficacy Cycle

Taking steps towards reaching a goal → Increased confidence

Increased Motivation → Effective Behavior

Increased Self-esteem → Taking steps towards reaching a goal

Source:
Handout: Enhancing Self-Efficacy

- Challenge Negative Thoughts
  - Identify negative thoughts
  - Replace negative thoughts with positive thoughts

- Goal Setting
  - Set realistic goals for yourself
  - Identify strategies to reach these goals

- Celebrate Success
  - Help to enhance self-perception
  - Create positive emotions

- Utilize Opportunities for Mastery
  - Focus on your strengths to help you increase your self-efficacy
  - Improve on your weaknesses

Source:
http://www2.hvrsd.org/Offices/SpecialEducation/Articles/Self%20efficacy%20handout.pdf
References


OT Information: Self-Esteem

What is self-esteem?

Self-esteem can be defined as an individual’s sense of personal value or how confident one feels in oneself. Low self-esteem can cause people to feel depressed; too much self-esteem may lead people to become arrogant. There are three important components of self-esteem, which include (a) self-esteem is an important human need, (b) self-esteem is based on an individual’s beliefs, and (c) self-esteem is correlated with an individual’s thoughts, behaviors, feelings, and actions (Cherry, 2015).

Relevance to chronic disease:

Low self-esteem can negatively impact the health of an individual; therefore, finding a balance of self-esteem is essential to self-managing chronic disease. An individual with chronic disease may experience low self-esteem from constantly battling the chronic disease. Ways to improve self-esteem include having the individual engage in more positive experiences, educating the individual on how to increase social competence, and introducing strategies to decrease the amount of stressors in one’s life (Pinquart, 2012).

How to implement self-esteem into the intervention plan:

An occupational therapist can implement improving self-esteem into the intervention plan by educating a client on how to become assertive, confident, and self-aware. Finding activities to enhance a client’s confidence will also improve the individual’s ability to manage their chronic disease. Collaborating with the client to take steps to improve his or her self-esteem will enhance an individual’s ability to manage their chronic disease (Curie & Arons, 2002; Mayo Clinic Staff, 2014).
Suggested Intervention Strategies for the OT Practitioner

- Educate the client to pay attention to their needs and wants
  - Ask client to make a list of what they want to focus on in treatment
- Remind the client to take good care of themselves
  - Exercise, eating healthy, coping strategies, etc.
  - Refer to the lifestyle modification section in the manual (pp. 79-81)
- Educate client on the importance of setting aside time to complete activities they enjoy
  - Make a self-esteem calendar with activities they enjoy doing
  - Encourage individuals to block off time each day to engage in an activity they enjoy
- Develop a reward system with the client
  - Every time clients complete something or feel they accomplished a task, they are encouraged to reward themselves in a healthy way
  - Client can make a scrapbook that displays activities or rewards they have received
- Educate client on the importance of spending time with people
  - Social supports should have a positive impact on the client
- Educate client on using positive thoughts
  - Develop a positive thought list
  - Repeat positive thoughts over and over
  - Ask client to put positive thoughts throughout their home or environment where they spend the majority of their time
  - Have the client make a list of what they are grateful for
  - Remind the client to avoid using “should” or “must” statements; rather, encourage them to use “I can” or “I will” statements
- Ask the client to identify situations that decrease their self-esteem to encourage self-awareness in the client
  - Do not allow the client to jump to negative conclusions
  - Do not allow the client to mistake feelings for facts
- Do not allow the client to dwell on mistakes; remind the client to look toward the future
- The client can make a journal of positive activities, positive affirmations, etc.
<table>
<thead>
<tr>
<th>Day</th>
<th>Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td>What is something you did well today?</td>
</tr>
<tr>
<td></td>
<td>Name an activity that is fun:</td>
</tr>
<tr>
<td></td>
<td>You felt proud when you did what?</td>
</tr>
<tr>
<td>Tuesday</td>
<td>What is one task you accomplished?</td>
</tr>
<tr>
<td></td>
<td>Name a positive experience:</td>
</tr>
<tr>
<td></td>
<td>What did you do for someone else?</td>
</tr>
<tr>
<td>Wednesday</td>
<td>I felt good about myself when:</td>
</tr>
<tr>
<td></td>
<td>I was proud of someone else because:</td>
</tr>
<tr>
<td></td>
<td>Name something interesting that happened today:</td>
</tr>
<tr>
<td>Thursday</td>
<td>I felt proud when I:</td>
</tr>
<tr>
<td></td>
<td>Name a positive experience from today:</td>
</tr>
<tr>
<td></td>
<td>Name something you accomplished today:</td>
</tr>
<tr>
<td>Friday</td>
<td>What is something you did well today?</td>
</tr>
<tr>
<td></td>
<td>What positive thought did you experience today?</td>
</tr>
<tr>
<td></td>
<td>How much time did you set aside for you?</td>
</tr>
<tr>
<td>Saturday</td>
<td>What is one topic you want to discuss with your healthcare provider?</td>
</tr>
<tr>
<td></td>
<td>Name something you are looking forward to in the future:</td>
</tr>
<tr>
<td></td>
<td>Who have you spent time with lately? Are they positive people in your life?</td>
</tr>
<tr>
<td>Sunday</td>
<td>What have you done to take care of yourself?</td>
</tr>
<tr>
<td></td>
<td>Name one way you have been assertive this week:</td>
</tr>
<tr>
<td></td>
<td>How has your confidence improved?</td>
</tr>
</tbody>
</table>

**Source:**
Handout: Identifying Strengths and Personal Qualities

Identify things you are good at:
1. 
2. 
3. 
4. 

State compliments you have received in the past:
1. 
2. 
3. 
4. 

Beneficial ways I self-manage my chronic disease:
1. 
2. 
3. 
4. 

Name what you like about yourself:
1. 
2. 
3. 
4. 

List any challenges you have overcome with your chronic disease:
1. 
2. 
3. 
4. 

Source:
References


OT Information: Community Resources

What are community resources?

A community resource is something that is utilized by community members and exists to improve the quality of life of the community as a whole. Community resources are valuable as they are cost effective and readily accessible.

Relevance to chronic disease:

Due to the prevalence of chronic disease and its widespread impact, it is important to provide individuals with resources to more effectively manage their symptoms. Consequently, connecting clients with community resources is an integral part of chronic disease self-management (Coleman & Newton, 2005). Clients experiencing chronic disease and symptoms associated benefit from additional information and services tailored toward their specific needs.

How to implement community resources into the intervention plan:

Depending on your geographic location, integrating community resources into the intervention plan is as simple as identifying your client’s primary needs and directing them to the appropriate resources to meet these needs. There are many local, state, and national organizations geared toward chronic disease management. If your client expresses interest in these resources, it is your job as a therapist to connect him or her to as many resources as possible.
Suggested Community Resources

To locate community resources offered in your area, it might be helpful to consult with individuals around you and perform an Internet search of the area to find out what is available. It is recommended you keep track of resources available and have information readily available to offer clients.

Community resources may be found in:
- Churches
- Local non-profit organizations
- Hospitals
- Long-Term Care Facilities
- Bulletin boards in the community
- Newspapers and television programs
- Other public sites accessible by the public

Internet Resources:
- http://medlineplus.gov
  - Offers information on a wide range of health-related resources
  - Provides a plethora of health information for all family members
- www.health.gov/NHIC/
  - Offered free by the government and focuses on a variety of specific topics
- http://nccam.nih.gov/
  - Information on alternative medicine options
- www.211.org
  - Free and confidential phone number to call to get connected with resources in your community
- www.ncoa.org
  - National Council on Aging; offers programs on chronic disease management specifically, and a number of other resources
  - This website provides information on a specific workshop aimed toward chronic disease self-management.
- www.eldercare.gov
  - This website offers a means to search for community resources present in a community, specifically for older adults
<table>
<thead>
<tr>
<th>Community resource I plan to contact:</th>
<th>Why I chose this specific resource:</th>
<th>Date I will contact them by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
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<td>7.</td>
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</tbody>
</table>

**Source:**
OT Information: Communication Skills

What is communication?

Communication can be defined as a message between two or more individuals with the goal of being to understand each other. Communication can be completed through words (written or spoken), gestures, sign language, and various technology based-services. Having good communication can enhance an individual’s physical, emotional, and psychological health, as well as improve the relationship between a therapist and client (National Communication Association, 2015).

Relevance to chronic disease:

When living with a chronic disease, good communication skills are important to relay the client’s needs to the healthcare provider. In addition, good communication is the basis for understanding what others are saying, which is essential when working within a healthcare team. If a healthcare professional is reporting information to the client he or she does not understand, negative results for the client may result (Lorig et al., 2012).

How to implement communication skills into the intervention plan:

When including communication skills in the intervention plan, there are important factors for the healthcare professionals to consider. First, the therapist must learn to truly listen to the client. Second, the healthcare professional is encouraged to evaluate the client’s body language. In addition, the therapist must utilize different forms of communication if necessary, such as a translator, gestures, or sign language. Lastly, the therapist is encouraged not to assume anything when working with clients; always make sure the client understands the information provided to them (Lorig et al., 2012).
Suggested Communication Strategies for the OT Practitioner

- Effective communication with your client will likely allow for better therapeutic outcomes.

- Key guidelines for effective communication
  - Establish trust with your client
    - Build rapport
    - Be approachable to your client
    - Make time for your client
  - Listen to the client
    - What is the client’s tone of voice?
    - Does the client have concerns or questions?
  - Evaluate the client’s body language
    - Is the client leaning forward and listening or slouching in the chair?
    - Is the client making eye contact?
    - Is the client asking questions?
    - Does the client look dazed or confused?
  - Utilize appropriate communication methods to relay information to your client
    - Do not use medical jargon
    - Utilize a translator if needed
    - Utilize caregivers or other family members to help explain information when appropriate
    - Ask how the client learns best
      - Visual
      - Auditory
      - Kinesthetic
  - Remember to never assume the client understands what you have said
    - Always ask if they have questions
    - Provide examples when giving new information
    - Provide the client with resources they can utilize related to their personal goals in therapy
  - Communicate treatment plan with caregiver
    - Keep caregiver informed with any changes or modifications of the treatment plan
    - Make sure caregiver understands the treatment plan
    - Allow the caregiver time to ask questions
Handout: Communication Skills

➢ Communicate effectively with members of the healthcare team
   o A key component to receiving good healthcare treatment is being able to communicate with your healthcare provider
   o Do not be afraid of talking with your healthcare provider about concerns
   o Remember to take P.A.R.T in your treatment plan
     ▪ Prepare
       • Come to appointments with a written list of any questions or concerns for the healthcare provider.
     ▪ Ask
       • Always ask questions if you are uncertain about a topic or information.
     ▪ Repeat
       • Rephrase what the healthcare provider has told you to make sure you understand the information.
     ▪ Take action
       • Ask for additional resources from healthcare professionals or ask for advice about the next step.

➢ Express your feelings
   o Be sure to tell your healthcare professional what you are thinking
   o Be honest with your healthcare provider

➢ Use “I” statements
   o An “I” statement is a statement such as “I think” or “I feel”
   o These statements display confidence and ownership about your feelings

➢ Minimize conflicts
   o Understand your own viewpoints and viewpoints of the healthcare professionals
   o Compromise with healthcare professional to find the ideal intervention

➢ Ask for help
   o Caregivers and healthcare professionals are there to assist you

➢ Accept help
   o Tell others what you need help with and always be grateful

➢ Listen
   o Rephrase what the healthcare professional said
   o Ask for more information on the topic

➢ Body language and conversational styles
   o Body language accounts for half of what you communicate to others
   o Be aware of your body positioning, facial expressions, and tone of voice
   o Utilize a positive, assertive language style

99
Handout: Taking PART in Your Treatment Plan

Prepare
- Come to therapy with a plan.
- Make a list of discussion points.
- Emphasize your priority items.

Ask
- Ask questions about your chronic disease, tests you may have to complete, treatment, and follow-up appointments.

Repeat
- Rephrase key points back to your healthcare provider.
- If you do not understand something, ask the healthcare provider to repeat it.

Take Action
- What are your personal goals and action plan?
- Ask healthcare providers for additional resources.
- Ask for advice.
References


Sensorimotor Client Factors

Energy Conservation
Lifestyle Modifications
Pain Management

Sources:
OT Information: Energy Conservation

What is energy conservation?

Energy conservation is defined as using certain strategies or techniques to manage symptoms of fatigue. These techniques are designed to improve functional performance in daily occupations (Dreiling, 2009).

Relevance to chronic disease:

Fatigue is a common symptom experienced by individuals with chronic disease. Educating individuals on energy conservation techniques will assist them to perform daily occupations successfully. Energy conservation techniques are recommended to maintain a client’s independence and participation in occupations (Dreiling, 2009).

How to implement energy conservation into the intervention plan:

When developing an intervention plan, the occupational therapist is encouraged to find the most effective way to implement activities each client finds meaningful. Implementing these strategies can be completed in individual client sessions, as well as group sessions. The occupational therapist and physician collaborate with the client throughout treatment to ensure energy conservation techniques are supportive of other medical intervention. Additionally, continuous communication with the client and caregiver is essential to provide support and make changes to the treatment plan. An occupational therapist can utilize energy conservation techniques such as organizing, utilizing correct positioning, modifying self-care tasks, modifying household tasks, and utilizing adaptive equipment (Dreiling, 2009).
Energy conservation techniques are incorporated into the treatment process through demonstration and educating the client on specific strategies. The following information are possible techniques to utilize.

- Encourage the client to make a journal.
  - Develop a to-do list for each day or week
    - Client writes down everything he or she needs to complete, which will allow them to feel accomplished if they can check a task off
  - Rate the level of energy needed to complete activities on a scale of 0-10

- Encourage the client to plan and prioritize.
  - Client completes easier tasks during times they are fatigued and harder tasks when they have more energy
  - Clients prioritizes tasks that need to be completed independently or ones that can be delegated to others
  - Plan enough time to complete tasks and incorporate rest breaks
    - 10 to 15 minutes of rest every hour
    - If an activity takes much effort, show the client how to break up an activity into smaller parts
  - Client organizes work spaces through planning what supplies will be needed, collecting supplies, and putting supplies in a desired location
  - Remind clients to allow rest between visitors
    - Encourage clients to ask visitors to call prior to coming

- Pace
  - Allow client to find balance between completing a task and rest periods
    - Teach clients to utilize proper breathing techniques
  - Encourage clients to utilize proper posture
    - Encourage clients to use proper body mechanics, such as changing positions often to activate different muscles
    - Remind clients to avoid excessive bending or reaching
    - When moving objects, inhale before lifting and exhale during the lift
    - Slide objects instead of lifting them
    - Carry items using larger joints; carry objects close to the body
    - Encourage use of wheeled carts to carry heavy objects

- Managing the home and work environment
  - Gather all items needed to complete a task prior to engaging in the activity
  - Evaluate client’s living space to assess organization
    - Utilize fans to circulate air; install railings on stairs for safety; eliminate throw rugs; use pump soaps versus bars of soap

- Self-Care Activities
  - Encourage clients to plan extra time and rest breaks during self-care activities
Bathing and showering: Modify the bathroom by installing grab bars or shower chairs and handheld shower heads; ensure bathrooms are properly ventilated to decrease energy expenditure for clients.

Dressing: Encourage clients to: place all clothing items in one location; sit while dressing; complete lower body dressing first; put on pants and underwear at the same time; wear slip-on shoes versus shoes with laces; utilize button hooks and reachers if needed; and wear clothes that open in the front.

Grooming: Encourage clients to sit during all tasks; utilize an electric toothbrush; utilize built up handles on grooming items if needed; utilize electric shavers; and avoid high-maintenance hair.

Cooking and Kitchen Activities
- Encourage the client to utilize lightweight pans, sit while cooking or preparing a meal, utilize recipes with shorter preparation time, and to freeze parts of the meal if preparing larger portions.

Laundry
- Remind client to avoid lifting and carrying large baskets of clothes, wash clothes in smaller loads, and wear clothing that does not require ironing.

Cleaning
- Remind client to take rest breaks periodically; do not clean the whole house in one day. Use a rolling cart to move cleaning supplies; use long-handled cleaning supplies; and utilize self-cleaning foam cleaners.

Shopping
- Provide assistance for the client to utilize online shopping; plan ahead to avoid busy shopping times; encourage shorter shopping trips that, and go shopping with friends or family members for assistance.

Source:
Handout: Energy Conservation

Everyone gets worn out at times. Fatigue resulting from chronic disease can affect your ability to complete tasks independently. Energy conservation techniques may be useful if you feel you are negatively impacted by fatigue. The techniques listed below are suggestions for you to decrease tiredness throughout your day.

Remember: Energy is like money – you only have a certain amount, so think about what you want to spend it on!

Rearranging the Environment:

- Place items used on a daily basis in easily accessible places (i.e. between shoulder and waist level). For example, keep commonly used kitchen appliances on the counter instead of in high or low cupboards.
- Add long handles to faucets, doorknobs, and cleaning equipment.
- Make all work spaces user friendly and comfortable. For example, elevating countertops, rising chairs, and placing all materials needed in one location.
- Modify shelving to slide out or install swivel holders in cupboards.
- If possible, move frequently used rooms in the home to one level to decrease stair use.

Eliminating Unnecessary Effort:

- Whenever possible, sit rather than stand during daily activities such as showering, cooking, folding clothes, etc.
- Use adaptive devices if possible including electric mixers, reachers, shower chairs, and electric can openers.
- Use a dishwasher or let dishes air-dry.
- Use a cart with wheels to transfer items around your home or slide objects across the counter when possible.
- If possible, have groceries delivered to your home. Call your local grocery store if available or AmazonPantry.com can deliver directly to your home.
- Use electric scooters at stores if available.
- Take two smaller trips to carry bags in from your car versus taking all bags at once.

Plan Ahead:

- Complete strenuous activity at the beginning of the day when you have more energy.
- Alternate between easy and hard tasks rather than doing challenging tasks for long periods of time.
- Gather all supplies needed for an activity before starting.
- When making a meal, prepare a larger portion to freeze for easy access later.
- Plan ahead for enough time to complete each activity.
Prioritize:

- Eliminate tasks that are not important to you.
- If possible, delegate tasks to other individuals such as laundry or vacuuming.
- Hire a professional cleaning service or hire someone to prepare meals for you.

Additional Information:

- Control breathing throughout activities.
  - Engage in pursed lip breathing or diaphragmatic breathing as instructed by your occupational therapist.
  - When completing activities, exhale during difficult parts of the activity using pursed lips. For example, exhale while lifting a laundry basket up off the floor.
  - If short of breath, stop and rest by sitting down before finishing activity.
- Carry objects with both hands instead of one hand.
- Do not take overly hot or cold showers.
- Maintain good posture. Do not slouch, bend, or twist for long periods of time.
- Utilize relaxation techniques as instructed by your occupational therapist.
- Rest breaks planned periodically throughout the day are a must to maintain energy.

***If you become short of breath, dizzy, or light-headed during activity, it is important to stop immediately and rest. IF THESE SYMPTOMS PERSIST, IT MAY BE NECESSARY TO CALL FOR EMERGENCY HELP.

Source:
References


OT Information: Lifestyle Modifications to Improve Health and Wellness

What is lifestyle modification?
Lifestyle modification can be defined as utilizing interventions to change a client’s life. These interventions can incorporate a wide variety of modifications including nutritional intake, incorporating exercise into daily routine, and implementing stress management techniques into everyday life (Golubic, 2013).

Relevance to chronic disease:
If individuals with chronic disease make poor lifestyle choices, consequences include worsening symptoms and increasing the progression of the chronic disease. Individuals with chronic disease who participate in lifestyle modification programs may experience rapid and significant improvements in overall health outcomes (Golubic, 2013).

How to implement lifestyle modifications into the intervention plan:
To start, the therapist should focus on what is motivating for the client to prepare the client for lifestyle change. Positive outcomes are more likely when a client is in the preparation or action stage of change, rather than pre-contemplation or contemplation. It is especially important to encourage an increase in physical activity and dietary changes to reduce or slow the progression of the disease (Teng, Yen, Fetzer, Sung, & Hung, 2013).
Suggested Lifestyle Modification Strategies for the OT Practitioner

- Be sure to consider what stage of change the client is in and modify the intervention approach to fit the needs of this particular stage of change.
- **Do not** utilize the one-size-fits-all approach due to the different stages of change a client may be in.
  - Use multiple strategies to educate the client, including motivational interviewing (pp. 9-11).
- Encourage health promotion for the client to improve his or her control over their overall health and well-being.
  - Healthy eating
    - Drink more water and less pop, coffee, and alcohol
    - Eat balanced meals including vegetables, fruits, protein, and carbohydrates
    - Prepare meals ahead of time to avoid being rushed.
    - Encourage client to stop smoking.
    - Remind the client a diet is not a temporary solution, but a lifestyle change.
    - Provide the client with resources to contact a dietician or other nutrition specialist to address more serious dietary issues.
  - Exercise
    - Provide resources for local gyms in the area.
    - Educate the client on how to include safe exercise in daily life.
    - Encourage exercising with a friend to increase the frequency of exercise.
  - Reduce the amount of stress in the client’s life
    - Incorporate stress relief activities into daily routine.
    - Encourage client to sleep 7-9 hours each night.
  - Medication management
    - Help the client identify why it is important to take medications.
    - Develop ways to help the client remember to take medications as prescribed.
  - Social groups
    - Encourage clients to utilize support groups as necessary.
    - Involve family members throughout the therapy process.
  - Resources
    - Remind client to call a healthcare professional if he or she has questions.
    - Encourage client to ask questions during therapy.
### Handout: Lifestyle Modifications

Steps toward making appropriate lifestyle modifications.

<table>
<thead>
<tr>
<th>Step 1</th>
<th>Step 2</th>
<th>Step 3</th>
<th>Step 4</th>
<th>Step 5</th>
<th>Step 6</th>
</tr>
</thead>
</table>
| • Healthy eating; be sure to follow the guidelines of your dietician  
  • Less pop, coffee, and alcohol  
  • Eat foods that are a variety of different colors  
  • Prepare balanced meals (fruits, veggies, proteins, carbs)  
  | • Exercise  
  • Exercise 3-4 times per week  
  • Find exercises classes in the community  
  • Join a gym  
  | • Reduce stress  
  • Incorporate stress relieving activities into your daily routine  
  | • Medication Management  
  • Learn the importance of taking medications  
  • Remember to take your medications as prescribed  
  | • Social Groups  
  • Engage in activities with family and friends  
  | • Use your resources  
  • Physician or therapist  
  • Resources provided in handouts  

### Additional Resource:
http://www.cdc.gov/

This website is a great resource to use when looking for information related to chronic disease. It offers information on many topics related to chronic disease, as well as additional ways to promote healthy living.
References


OT Information: Pain Management

What is pain management?

Pain management can be defined as individuals utilizing therapeutic approaches offered by a healthcare professional to prevent, reduce, or stop the symptoms of pain (Grieve & Schultewolter, 2014).

Relevance to chronic disease:

Many individuals with chronic disease experience pain; therefore, the individual may be motivated to learn pain management techniques to manage his or her pain more successfully. Chronic pain can lead to disturbances in sleep patterns, anxiety, depression, irritability, medication dependence, and may interfere with work and other valued occupations (Grieve & Schultewolter, 2014).

How to implement pain management into the intervention plan:

According to Grieve and Schultewolter (2014), pain management is approached using the biopsychosocial model, which utilizes a holistic approach to pain management. The biopsychosocial model is shown to be effective when utilized within a team of healthcare professionals (Grieve & Schultewolter, 2014). An occupational therapist can be helpful in the pain management process in several ways including: educating the client on correct body mechanics, incorporating energy conservation and work simplification strategies into daily activities, completing assessments on the work and home environment, recommending adaptive devices, and implementing relaxation and stress management strategies into the client’s routine (Huet, Innes, & Stancliffe, 2013).
Suggested Pain Management Intervention Strategies for the OT Practitioner

- **Roles**
  - Encourage the client to focus on familiar or valued roles in his or her life.

- **Social supports**
  - Incorporating social supports throughout the treatment process has been shown to contribute to the individual successfully manage his or her pain.

- **Psychological factors**
  - Encourage the client to be involved in meaningful activities to promote mental health.

- **Acceptance and Readiness to change**
  - The individual with chronic disease must be aware of chronic pain to overcome this barrier.

- **Goal setting**
  - When setting goals with a client, incorporate activity tolerance and valued occupations into the goal.

- **Pacing**
  - Allow the client enough time to complete activities and, if possible, provide extra time so he or she does not feel rushed.
  - Encourage the client to take periodic rest breaks throughout the day.

- **Relaxation techniques**
  - Educate the client on deep breathing techniques to utilize when he or she feels stressed during the day.
    - Diaphragmatic breathing (While sitting, have the client place their hands directly on their stomach; have them breathe in deep, concentrating on making their stomach expand; finally, let the stomach return to it’s shape naturally while the air is slowly exhaled.)
    - Deep breathing (pp. 50)

- **Utilize Cognitive Behavioral Techniques**
  - Encourage positive thinking; this will promote pain avoidance and negative thinking.
  - Allow the client to talk about his or her pain.
  - Incorporate thought stopping and distraction techniques into therapy as appropriate.

- **Adaptation**
  - Advocate for client to create a work environment that is meaningful and does not elicit pain.
Managing Chronic Disease

Being
Maintain your values and utilizing your support systems.

Doing
Find ways to manage pain such as utilizing relaxation strategies, decreasing stress, and getting adequate sleep each night.

Knowing
Be aware of your readiness to change to manage your chronic pain.

Source:
Handout: Persistant Pain Cycle

Persistant pain

Not working and financial difficulties

Decreasing activity

Decrease in physical fitness

Create list of what you cannot do

Fluctuation in weight

Side effects from medications

Experience stress, fear, anxiety, anger, and frustration

Thinking negatively, fear of the future, depression

Difficulties sleeping, feeling tired, and fatigued

Additional Resource:
Paintoolkit.org
This website has additional information on tips and skills to support self-management of pain.

Source:
References


POST-INTERVENTION EVALUATION

For the client and occupational therapist

Client Questionnaire
Relative Mastery Measurement Scale
Summary Questionnaire
Clinician Questionnaire
This section of the manual is to be utilized at the end of the intervention process before the client is discharged. Included in this section is a recommended client questionnaire to allow the client to evaluate the therapeutic process and the relationship he or she had with their therapist. This questionnaire also includes a section where the client is asked to assess how the environment contributed to the intervention process. In addition, the Relative Mastery Measurement Scale, which is based off the Occupational Adaptation model, can be utilized to assess the client’s satisfaction and relative mastery with an occupation that is meaningful to them. The Summary Questionnaire, a discussion-based outline with questions, is also included in this section; it is best to be completed before a client is discharged. These questions can also be utilized throughout the intervention process to receive client feedback regarding what is going well and what needs to be modified. Lastly, an OT self-reflection questionnaire is recommended for the therapist to complete once the intervention process has been completed. This allows the OT to evaluate the services they provided, how client-centered their intervention was, and to assess their therapeutic use of self. Post-intervention reflection is important for both the clinician and client. It is a source of measurement for the effectiveness of intervention, as well as a tool to improve understanding about the OT role in chronic disease management.
Client Questionnaire

Authors: G. Restall, M. Stern, and J. Ripat

Purpose of Assessment: The Client Questionnaire is intended to capture the client’s perspective of the relationship between them and their occupational therapist. It asks questions related to the therapist’s character, as well as questions related to the environment where therapy was provided.

Administration: The Client Questionnaire takes 2-7 minutes to complete.

Source:

Relative Mastery Measurement Scale (RMMS)

1. Administer the items in the order they appear on the scale (#1-12).
2. Do not attempt to paraphrase or define the terms or words used in any items (i.e. successful, failed, desired level). The meaning of these words is likely unique to each person and therefore each client must interpret the terms or words for themselves. Allowing clients to define the terms or words will allow an assessment of whether or not the scale works.
3. If the client does not understand any items you may repeat them as many times as needed before going on to the next item.
4. If after repeating an item a number of times, and after encouraging a client to either agree or disagree with the item, you may circle the item number of any item to reflect a client’s inability to respond.

Read the following instructions exactly as they appear:
“Tell me the name of an important activity that you have recently performed in occupational therapy.”
Thinking back on your most recent performance of this activity, tell me whether you ‘agreed’ or ‘disagreed’ with the 12 statements I am about to read to you. I will be recording your responses as we go along.” If a client changes their mind before going on to the next question, please place an X over their first answer and circle their new answer. (Raters: Circle A for Agree or D for Disagree).

1. A D My performance was not adequate to complete the task.
2. A D I completed the task within about the same time frame it usually takes.
3. A D Overall, I am satisfied with myself regarding this activity.
4. A D I felt physically or mentally tired after finishing the task.
5. A D People other than my family and friends would be happy with my level of ability on this task (give an example that relates to this person and task).
6. A D I did not produce the result I expected.
7. A D I am very pleased with my performance of this task.
8. A D I failed to complete all steps of the task.
9. A D The task took a great deal more time than is typical for me.
10. A D I am aware of people, equipment, and techniques that would help make this task easier.
11. A D My family members would not be happy with my performance of this task.
12. A D I successfully completed the task.

Source:
Summary Questionnaire

These questions do not have to be completed in any order and are only suggested questions a therapist could utilize. A therapist may modify these questions or develop his or her own questions to ask a client at the end of the treatment process.

- What went well during the treatment process?

- How have your roles changed?

- How have your routines changed?

- Do you feel as if you have reached relative mastery for certain occupations? If so, please explain.

- Do you feel as if you are better able to self-manage your chronic disease after being educated on the topics covered in the manual?

- What information did you find helpful?

- Are there any additional resources you would like to receive?
Clinician Questionnaire

Authors: G. Restall, M. Stern, and J. Ripat

Purpose of Assessment: The Clinician Questionnaire is intended to capture the clinician’s perspective of how well they provided intervention to the client. It asks questions related to their relationship with their client, as well as questions about the client-centeredness of their interventions.

Administration: The Clinician Questionnaire takes 5-10 minutes to complete.

Source:

CHAPTER V
SUMMARY

There is a lack of research identifying the role of an occupational therapist when treating individuals with chronic disease. Therefore, the purpose of this manual was to provide occupational therapists with a comprehensive tool that can be utilized throughout the intervention process to enhance an individual’s ability to self-manage their chronic disease. The manual emphasizes the importance of implementing self-managing techniques into an individual’s daily routines utilizing the Occupational Adaptation model (Schkade & Schultz, 1992). The manual developed contains three parts, each of which correlates with the terminology and framework of the Occupational Adaptation model. Part one is an introduction to the manual with motivational interviewing techniques, assessing the individual’s readiness to change, an occupational profile interview, a needs assessment, and possible assessments for a therapist to utilize when evaluating the client at the beginning of the therapy process. Part two is comprised of OT interventions to be used by the therapist and handouts to provide to clients. Part two has three components, which include cognitive, psychosocial, and sensorimotor sections, all OA constructs. These sections are further broken down into more detailed topics based off the information gathered from the literature review. The cognitive section contains the topics of problem-solving, decision-making, and setting goals and developing an action plan. The psychosocial section contains the topics of coping with stress, self-efficacy,
self-esteem, community resources, and communication. The sensorimotor section contains the topics of energy conservation, lifestyle modification, and pain management. Part three is the conclusion section of the manual. This section provides outcome evaluations for the client and OT to complete to determine their level of satisfaction with the therapy process.

A clinical practice strength of this manual includes its comprehensive approach to facilitate occupational therapy services and will likely enhance the outcomes of individuals who are trying to self-manage their chronic disease. An extensive literature review was completed to develop the manual to gain further information about the topic of chronic disease, therefore is evidence-based. This manual correlates with the Occupational Adaptation model, which provides the therapist with the foundational parts for completing the therapy process. The manual is at an adequate readability level for both the therapist and the client, as well as provides the occupational therapist the ability to modify intervention strategies to fit the needs of the client. Additionally, this manual allows occupational therapists and clients to collaborate on the topics to be discussed in therapy, and the client can decide which interventions would be the most beneficial to self-managing his or her chronic disease. The intervention strategies provided in this manual are possible options for the OT to choose from and the strategies are not a comprehensive list. The occupational therapist is encouraged to utilize clinical reasoning skills to determine what topics would be the most beneficial to each client and modify the interventions, as necessary.

This manual does have some limitations. For example, this manual is not intended for individuals who do not have a cognitive level high enough to process information or
determine readiness to change. If an individual has a lower cognitive level, the interventions included in this manual may need to be modified to match the level of the client. In order to determine a client’s cognitive level, the therapist should complete cognitive screening assessments to determine the client’s readiness to utilize this manual. Since the Occupational Adaptation model does not have an adequate supply of evaluation tools developed, the authors utilized assessments from other models that matched the goals of the manual. Finally, another limitation to this manual is that it has not been clinically tested; this could begin with an OT expert review process.

This manual is meant to be utilized in settings where chronic diseases are a common diagnosis, such as a long-term physical disabilities setting or in a primary care setting. This manual should be utilized with adults versus adolescents or children, due to the higher level of cognitive processing. A substantial factor contributing to the implementation of this manual is the cost to produce and distribute the manual so it is readily available for therapists to utilize locally, state-wide, and nationally. The authors recommend this manual be included in a pilot study to determine its effectiveness, which will enhance the potential for the manual to be implemented into clinical practice. Further research is recommended based on the results from the pilot study to strengthen the content included in the manual and to enhance its relevancy to individuals with a chronic disease. The authors plan to provide this guide to occupational therapists at the facilities where they will be employed in the future, as well as their fellow students at the Occupational Therapy Program at the University of North Dakota. This will expand the number of practitioners to which the manual is introduced and distributed. If an OT utilizes this manual in the future, an outcome assessment is recommended to determine
the effectiveness of this manual. The outcome assessment can be found in the Appendix of this scholarly project. A copyright is in the process of being completed for this manual. In conclusion, it is a goal of the authors that this manual can serve as a comprehensive set of tools that will prove to be effective in the treatment of individuals who are self-managing their chronic disease to increase their independence in functional daily activities.
APPENDIX
Appendix A
Outcome Assessment

Feedback Form
Infusing Occupational Perspective into Chronic Disease Management: A Manual for Occupational Therapists

1. How would you rate the overall quality of the content? (Circle your answer.)
   Excellent    Good    Fair    Poor
   Comments:

2. What content, in particular, was new to you? (Check all that apply.)
   ___ Assessing Readiness for Change   ___ Psychosocial Client Factors
   ___ Motivational Interviewing   ___ Sensorimotor Client Factors
   ___ Needs Assessment   ___ Post-Intervention Assessment
   ___ Occupational Adaptation Model   ___ Cognitive Client Factors

3. How would you rate the overall usefulness of the content of this manual? (Circle your answer.)
   Excellent    Good    Fair    Poor
   Comments:

4. What content, in particular, will be most useful to you in your OT practice? (Check all that apply.)
   ___ Assessing Readiness for Change   ___ Psychosocial Client Factors
   ___ Motivational Interviewing   ___ Sensorimotor Client Factors
   ___ Needs Assessment   ___ Post-Intervention Assessment
   ___ Occupational Adaptation Model   ___ Cognitive Client Factors

5. Should the content of this occupational therapy manual for chronic disease be expanded?
   Yes___ No ___ If yes, what content should be added?

6. Additional comments or suggestions:
REFERENCES


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