Community-Based COPD Wellness Program

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Community-based COPD Wellness Program

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Chapter I: Introduction

Chronic obstructive pulmonary disease (COPD) is a leading cause of death, illness, and disability in the United States. Estimates of prevalence for this condition vary from 14 to 21 million individuals who are affected (American Heart and Lung Association, 2003; Kim et al. 2000; Schulman, Ronca & Bucuvalas, Inc. [SRBI], 2000; Sin, Stafinski, Chung, Bell, & Jacobs, 2002). It is currently the fourth leading cause of death nationwide and is expected to be the third by the year 2020.

Chronic obstructive pulmonary disease (COPD) is an umbrella term commonly used to refer to chronic bronchitis and emphysema. As implied by its name, COPD is characterized by progressive airflow limitation that is not fully reversible. This airflow obstruction is generally accompanied by an abnormal inflammatory response in the lungs to noxious stimuli such as dust and fumes. The feeling of breathlessness referred to as dyspnea, is a key feature of this disorder which often leads to global functional impairment in patients. (Trombly & Radomski, 2000)

Risk factors for the development of this disorder include but are not limited to: history of cigarette smoking, heredity, history of frequent childhood respiratory infections, exposure to occupational dusts and pollutants, and air pollution (Copstead and Banasik, 2000).

As with any chronic condition, COPD affects patients globally from physical and sexual performance to psychosocial and cognitive functioning. Understandably, this has a profound impact on an individual’s quality of life. Despite this knowledge, many of these aspects are not formally assessed and or addressed during the course of treatment, leaving the patient to struggle to fulfill their personal roles while...
combating the pervasive effects of this disorder. In response to this, many medical institutions are now looking towards community-based care for provision of ongoing support to this population.

Several programs have been developed across the nation in an effort to meet these needs (Barnett, 1999; Dow & Mest, 1997; Gordias & Gibbons, 1999; Monahan, 1999.) While these programs have varied in approach and duration, each suggests that community based care does have something unique to offer to this population in maintaining productivity, engagement in occupations and influencing quality of life.

The following scholarly projects describes the process of developing a community based wellness program for COPD patients. The program is based on information gained from an extensive literature review that focuses on identification of unmet needs within this patient population. This program is designed to provide ongoing support to clients within a community setting in order to positively impact their perceived quality of life while reducing the need for and duration of preventable hospitalizations.
Chapter II: Literature Review

Introduction

Chronic obstructive pulmonary disease (COPD) is a leading cause of death, illness, and disability in the United States. According to the U.S. Center for Disease Control (CDC), COPD was responsible for “119,000 deaths, 726,000 hospitalizations, and 1.5 million hospital emergency departments visits in 2000” (CDC, 2003). In addition to this, approximately 8 million cases of hospital outpatient treatment or treatment by personal physicians were directly linked to this condition (2003, ¶ 4).

This review will examine how COPD patients are affected by this dehabilitating condition. Current treatment and intervention methods will also be examined in an effort to identify areas that are not being adequately addressed.

Definition

Chronic obstructive pulmonary disease (COPD) is an umbrella term commonly used to refer to chronic bronchitis and emphysema. As implied by its name, COPD is characterized by progressive airflow limitation that is not fully reversible. This airflow obstruction is generally accompanied by an abnormal inflammatory response in the lungs to noxious stimuli such as dust and fumes. The feeling of breathlessness referred to as dyspnea, is a key feature of this disorder which often leads to global functional impairment in afflicted patients (Trombly & Radomski, 2000).

Prevalence

Estimates of prevalence for this condition vary from 14 to 21 million individuals (American Heart and Lung Association, 2003; Kim et al. 2000; Schulman,
It is currently the fourth leading cause of death nationwide and is expected to be the third by the year 2020. Officials also estimate that as many as two-thirds of those currently affected are unaware they have the disease as it is not generally diagnosed until late in its course.

Approximately 11 million people are diagnosed with chronic bronchitis annually. The prevalence rate has been consistently higher in females than in males and is most commonly found in individuals over the age of 45. Emphysema accounts for the remaining 3 million cases of COPD. While the prevalence rate for this condition is higher in males, studies indicate that the condition is increasing in females as more women are smoking (American Heart and Lung Association, 2003).

Pathophysiology

Chronic bronchitis is an inflammation process leading to the eventual scarring of bronchial tissues. Chronic bronchitis is defined by the presence of a “mucus-producing cough most days of the month, three months of a year for two successive years without other underlying disease to explain the cough” (Copstead & Banasik, 2000, p. 548). Symptoms of chronic bronchitis include shortness of breath on exertion, excessive sputum production and a chronic cough that is more severe in the morning. Risk factors for development of this disorder include but are not limited to: history of cigarette smoking, heredity, history of frequent childhood respiratory infections, exposure to occupational dusts and pollutants, and air pollution. The airways of people with this condition may also have been initially irritated by
bacterial or viral infections. It may precede or accompany pulmonary emphysema (Copstead & Banasik; Trombly & Radomski, 2000).

Emphysema causes irreversible lung damage. The walls between the air sacs within the lungs lose their ability to stretch and recoil causing them to weaken and break. Elasticity of the lung tissue is lost, causing air to be trapped in the air sacs and impairing the exchange of oxygen and carbon dioxide. Also, the support of the airways is lost, allowing for obstruction of airflow. While the causes of emphysema are not fully understood it is believed to be closely associated with cigarette smoking, air pollution and occupational dusts. This disorder tends to develop over a long period of time and is most commonly seen in the elderly (Copstead & Banasik, 2000).

**Physical Impact**

As with any chronic condition, COPD affects patients globally from physical and sexual performance to psychosocial and cognitive functioning. Understandably, this has a profound impact on an individual’s quality of life. Despite this knowledge, many of these aspects are not formally assessed and or addressed during the course of treatment leaving the patient to struggle to fulfill their personal roles while combating the pervasive effects of this disorder.

The mere effort necessary to breathe requires the expenditure of energy which then may limit the patient’s ability to participate in activities of daily living (dressing, bathing, grooming, etc.) and instrumental activities of daily living (driving, home management, money management etc.) as well as social, vocational, and leisure pursuits. Due to the unpleasant sensation associated with shortness of breath, COPD patients typically limit or reduce the amount of physical activity in which they
engage. This leads to a weakening of muscles and a decrease in overall strength and endurance levels, which in turn increases dyspnea during activity. In response, COPD patients further limit activity, ultimately leading to an overall deconditioning of the body (Huntley, 2000).

Nutrition is a prominent concern for many COPD patients. Shortness of breath makes eating uncomfortable and many patients report decreased or diminished appetites. It is estimated that 40 to 60% of COPD patients have inadequate caloric intake (American Heart and Lung Association, 2003). This impairs their body’s ability to fight off infection and may increase the likelihood of hospitalization. According to the American Association for Respiratory care (2002), ventilatory muscles in COPD patients can require “up to ten times the calories required by a healthy person’s muscles.” Inadequate nutrition leads to a wasting of the diaphragm and other pulmonary muscles and is a significant predictor of mortality in these patients (American Association for Respiratory Care).

Due to its progressive nature, COPD often interferes with an individual’s ability to work, leading to increased absenteeism, decreased work production and lost wages for workers and employers. In 1994, an estimated 9.9 billion dollars in work participation and revenue were lost secondary to COPD. “COPD is associated with a 3.9% reduction in the work force participation rate in the community” (Sin et al. 2002, p. 708). Sin et al. found that moderate to severe COPD leads to significant unemployment in the U.S. A survey of COPD patients and providers was conducted in an effort to better understand this pervasive disorder (SRBI, 2000). These authors found nearly 50% of all COPD patients were under the age of 65. Of these, 34%
reported that COPD keeps them from working and 17% say that their condition limits them in the kind or amount of work they can do. The inability of patients with COPD to maintain gainful employment secondary to progression of their illness, results in an ever increasing societal burden. It is estimated that the annual economic costs of this disease are approximately 40 billion dollars with 18 billion in direct costs (Kim, et al., 2000; Sin, et al., 2002).

**Psychosocial Impact**

As their condition progresses, COPD patients are faced with numerous emotional stressors. Many individuals are pushed into early retirement by their condition, forcing a re-evaluation, re-invention and in most cases a loss of productive roles. The resulting economic strain in terms of personal lifestyle and management of healthcare costs are often compounded by increasing difficulties in completing basic self-care tasks, reduced mobility and problems with dyspnea.

The development of depression in this population is common. Researchers indicate that patients with severe COPD may be 2.5 times more likely to develop depression than the general population. In many cases, depression goes undiagnosed due to failure to recognize the symptoms. Kim et al. (2000) states that there is a “great disparity between the prevalence of anxiety and depression symptoms and the recognition and treatment of these symptoms by primary care providers” (p.471). Depression exacerbates the symptoms associated with COPD, by increasing social isolation and decreasing engagement in functional activity, “leading to increasing levels of dyspnea, loss of energy, diminished appetite, and disrupted sleep (Dow & Mest, 1997, p. 416).
Anxiety associated with shortness of breath is common amongst these patients. Many begin to limit the duration and nature of community involvement to prevent or reduce the humiliation associated with extreme shortness of breath. This gradually leads to progressive social isolation which impacts not only the afflicted but their caregivers as well. The following excerpt illustrates this point and is taken from a qualitative study conducted to explore the experience of individuals living with severe COPD.

“I don’t go out hardly at all now… I’ve had a few bad experiences—it really frightens you. You try to slow your breathing down, and then I feel dizzy… you feel such a fool, people stare at you. It’s a horrible feeling—I don’t go out unless I have to, just really to doctor’s or chemist; and that’s often not as much as once a week” (Guthrie, Hill, & Muers, 2001, p.198).

Changing roles within spousal relationships also impacts psychosocial functioning. Feelings of worthlessness, guilt, shame, helplessness, resentment and fear can all be readily associated with these changes and are commonly felt by both the patient and the caregiver. The patient may experience a sense of guilt that lifestyle choices contributed to the disease and constantly worry about symptoms. Reliance upon someone else to complete basic tasks previously taken for granted can lead to feelings of shame, helplessness and in some cases resentment. The inability to significantly contribute financially and physically to the relationship might also translate into feelings of worthlessness. Emotional dependence in these relationships generally increases as the disease progresses as evidenced by the following excerpt:

“I’m not lonely... that must be terrible; but I am afraid... really and truly, I just don’t know what I’d do without George and the girls to see to me... they do all that [household tasks] because I can’t do anything...” (Guthrie et al., p. 200).
Not all patients have someone on which to rely for social, emotional and physical support for various reasons. Community resources such as support groups and church groups can provide some relief for these individuals. The following excerpt demonstrates the impact such groups can have on the psychosocial well-being of an individual.

“At St. Augustine’s, there is a good community… this Saturday for example, they’ve a meeting of all parishioners… it’s the only way I’ll ever get to know anyone… I do get lonely at times… if you settle down reminiscing different times and people, it makes an impression… if you let someone else [priest] know, it brings a bit of relief” (Guthrie et al., p. 199).

This quote gives a voice to the inherent need in every individual to feel accepted and understood by their peers, to seek and receive comfort and some form of intimacy from another person.

**Interpersonal relationships and Sexuality**

In advanced stages of the disease, COPD can affect an individual’s ability to perform sexually. This can be due to a combination of factors. A patient’s age and the presence of co-morbid disease may require the use of drugs that can affect sexual functioning. Discomfort caused by dyspnea with even mild activity and the anxiety associated with it may dissuade patients from engaging in sexual activities. Additionally, psychosocial issues such as decreased self-esteem, altered body image, fear of sexual failure and depression can limit their desire and ability to sexually perform (Ibanez, et al. 2001; Nelson, 2000).

The ability to engage in sexual and intimate activity can have a profound impact on marital relationships. The following quote demonstrates the sensitivity of
this issue and the impact it has not only on the patient but also on marital satisfaction
and reciprocity in the relationship.

“I am really in need of some form of intimate contact with him, but I
do not want to press him... and this is something one cannot talk so
easily about... I am afraid he could sense it as an accusation.” (Bergs,
200 p.617).

Ibanez et al, (2001) conducted a study to evaluate client’s perceptions of
sexual difficulties and changes in communication with their partners. The researchers
found that out of 49 participants, 33 or 67.3% expressed some sexual dysfunction
whether from lack of desire or impotence. In addition to this the authors found that
46 spouses (94%) felt that some sexual changes had taken place. Of these, 55% felt
that it was due to their own lack of desire due to personal anxiety associated with
dyspnea in their partner.

Communication was found to be impacted by the client’s illness in 33% of the
couples. Overall, researchers found that spouses were significantly less satisfied with
their relationship than were patients. It is interesting to note that this dissatisfaction
was found to correlate not with the presence or absence of sexual dysfunction but
with changes in communication between the couple (Ibanez, et al. 2001). This would
indicate that intimacy does not end at sexual interaction. Rather it encompasses all
aspects of our lives and is heavily connected to the communication between two
individuals. When one or both individuals pull back in this arena, intimacy is lost
resulting in personal and social isolation. Spousal dissatisfaction associated with
changes in communication was also identified by Bergs (2001):

“Gradually we have had less and less to talk about... gives the
impression that he has no interest anymore, neither in myself nor in his
surroundings. I think this is some kind of envy of me, in my heart I can feel it... After he started to go in and out of the hospitals we stopped being good friends like we used to be... The disease has isolated him from the family and myself, and now we have restricted issues to talk about... it makes me sad when I think about it.” (p. 617)
Despite awareness of this problem within the medical community, this remains an issue that is commonly under-addressed during treatment. A survey conducted to assess sexual concerns in older patients supports this fact in that many patients and spouses want their physicians to spend more time in this area. Healthcare professionals should keep in mind that this is a sensitive issue and should treat their clients with respect and foster an open relationship that encourages clients to discuss their concerns (Nelson, 2000).

Environmental Obstacles to Function

The environment plays a vital role in the day-to-day functioning of an individual with COPD. It is important to note that the environment is not limited to physical surroundings but also encompasses social and cultural settings in which an individual engages.

Physical Environment

Many patients with COPD are further limited in their physical functioning by their physical environment. Whether it be steps to enter their home or the heat and humidity of summer months, it all impacts their endurance levels and ability to manage shortness of breath. Perhaps one of the biggest challenges facing these patients is the ongoing struggle with both indoor and outdoor air quality.

Air pollution is a growing concern in many cities and certainly for the COPD patient. Air pollution arises from a wide variety of sources including vehicle emissions, combustion of fuels (wood, coal, etc.) dust and chemicals such as
pesticides. Other components such as pollen, mold and even perfume further contribute to poor air quality and make breathing very difficult for patients suffering from COPD (Environmental Protection Agency [EPA], 1995). This often serves as an additional deterrent for individuals already anxious about their ability to control dyspnea in public settings, thereby contributing to social isolation (Abelsohn, Steib, Sanborn & Weir, 2002).

According to the EPA (1995), the air within an individual’s home can actually contain more pollutants than the outdoor air of even the largest, most industrialized cities. The average person spends 90% of their time indoors and for vulnerable populations such as the young, elderly and chronically ill, this rate is even higher. This translates into a serious threat to lung functioning in individuals suffering from COPD (EPA).

Indoor pollution can arise from a variety of sources ranging from combustion sources such as kerosene, wood and tobacco products to building materials and furnishings such as damp carpeting, household cleaners, air fresheners and central heating and cooling systems. When insufficient ventilation is present, outdoor air is unable to enter the home causing indoor air quality to reach unhealthy levels. Physiological reactions to this stimulus can vary in severity and duration. Individuals with pre-existing respiratory conditions may experience an exacerbation of their symptoms and an increase of dyspnea (EPA, 1995). Awareness of the impact indoor air quality has on a patient’s condition is commonly understood but often overlooked and under appreciated during the treatment process.
The social and cultural environment in which an individual participates also impacts their condition. The fear of humiliation brought on by the inability to control dyspnea leads many patients to restrict social outings and engagement in meaningful relationships outside of their immediate family (Guthrie et al., 2001). Cultural expectations of the individual and family members may contribute to either the individual underplaying the severity of their condition by pushing themselves too hard or taking on the role of an invalid, facilitated by overprotection of family members.

**Treatment/ Intervention**

Pulmonary rehabilitation is the main form of intervention available for COPD patients today. Programs typically vary in services provided, duration and location (inpatient vs. outpatient). It combines exercise training with educational and behavioral programs to help patients with COPD control symptoms and improve performance in day-to-day activities. The typical pulmonary rehabilitation team is composed of physicians, nurses, respiratory, physical and occupational therapists, psychologists, exercise specialists and dietitians (Celli, 1998; Lenert, 2002).

Pulmonary rehabilitation provides exercise training for the upper body, lower body, and ventilatory muscles with programs designed to meet the specific needs of a client. Lower body exercises such as walking or riding a stationary bike help to increase muscle tone and flexibility making it easier to locomote, climb steps and perform tasks. Upper body strengthening helps to ease breathing and makes tasks such as vacuuming, dressing, and showering less taxing. Ventilatory muscle training
in some cases helps to reduce the severity of breathlessness, improves the ability to exercise and may improve respiratory muscle function (Celli, 1998; Lenert, 2002).

Pulmonary rehabilitation programs also commonly offer educational programs that focus on a wide variety of topics designed to aid patients in understanding their illness and medications. Courses are often provided to aid patients in smoking cessation as this is recognized as a primary risk factor for the development and progression of COPD. Other examples of educational themes include: diet, nutrition, weight management, understanding and using oxygen therapy, and symptom management (Celli, 1998; Lenert, 2002).

As previously mentioned, many patients with COPD develop emotional distress such as depression, anxiety and other emotional problems as a result of their disease. With this in mind, many pulmonary rehabilitation programs offer some form of psychosocial support and education. Patients are counseled about depression and anxiety, taught relaxation and stress management skills and can participate in support groups. There they are encouraged to talk about their feelings and learn the importance of giving and receiving emotional support from others (Celli, 1998; Lenert, 2002).

Participation and adherence to pulmonary rehabilitation programs can significantly improve a patient’s quality of life and their ability to function independently. Indeed, they have been repeatedly proven to be one of the most effective interventions for patients with COPD. Unfortunately, many COPD patients have limited access to health care services such as these secondary to a wide array of
obstacles including: lack of adequate transportation, lack of availability of services, and poor financial resources.

With this in mind, sources indicate that the medical community as a whole is primarily concerned with controlling the physical symptoms of this illness (Dow & Mest, 1997; Kim, et al. 2000). Regrettably, psychosocial impairments are often overlooked in both the patient and caregiver, greatly impacting their quality of life and possibly increasing the likelihood of hospitalization and mortality. Dahlen and Janson (2002) found that patients identified as having anxiety or depressive symptomology were more likely to require hospitalization and to relapse following emergency care. This would further indicate that comprehensive evaluation and treatment of psychosocial impairment in COPD patients is a necessity.

**Areas of continuing need**

Research indicates that despite the best efforts of the medical community, the vast ongoing needs of COPD patients continue to go unmet. The question that now faces many medical institutions is what can be done to meet these ongoing needs in an effective and yet fiscally responsible manner. In response to this, the medical community has begun to look to community based care for provision of ongoing support to this population.

Several programs have been developed across the nation in an effort to meet these needs (Barnett, 1999; Dow & Mest, 1997; Gordias & Gibbons, 1999; Monahan, 1999). While these programs have varied in approach and duration, each suggests that community based care does have something unique to offer to this population in maintaining productivity, engagement in occupations, and quality of life. Program
results have also varied but the general consensus is that they provide a cost-effective way to reduce unneeded hospitalizations and increase patient independence. To date, most of these programs have been led by nursing with support from an interdisciplinary team.

The goal of this project will be to outline the role of occupational therapy within this arena. The purpose of this project is to create a community based wellness program for patients with COPD in order to improve their overall perception of health related quality of life while reducing or preventing the need for hospitalization.
Chapter III: Methods

A comprehensive literature review was completed based on information obtained from current text-books, peer-reviewed journals and electronic resources. The focus of this literature review was to first develop a thorough understanding of the disease, its etiology and the short and long term impact it has on an individual’s life. Next, current treatment strategies were reviewed and continuing areas of need were identified. Once these needs were identified, it was possible to identify potential treatment strategies to meet them.

A protocol for a community-based COPD wellness program was developed in an effort to address the unmet needs of clients. The structure of this program was influenced by existing community-based programs within both the United States and Great Britain. Unlike the existing programs which primarily utilize nursing professionals for the provision of care, this program was developed with an interdisciplinary team consisting of social-work, occupational therapy and nursing. Program goals and objectives were developed based upon previously identified areas of need within this population.

A 10-week revolving schedule of educational classes was developed that outlined the topics to be covered and the professions responsible for providing it. Occupational therapy was responsible for the development and provision of five of these presentations which are included in Appendix B. All educational materials were developed with information obtained from current text-books and internet sources. Information within these handouts is presented at a sixth grade reading level.
Chapter IV: Program Overview

It is the mission of this program to positively impact patients’ quality of life through a holistic approach to COPD management within a community-based setting. The underlying goals on which this program is based are to: complete comprehensive assessments of a client’s physical and psychosocial wellbeing, provide suitable client-centered interventions to affect lifestyle changes and improve quality of life, and to reduce the need for and expense of hospitalization in this population.

This program takes an interdisciplinary approach to the provision of treatment and interventions for patients with COPD within a community setting. Three primary professions (social work, nursing and occupational therapy) are represented within the program with the skills and the knowledge to appropriately refer patients to other professionals as needed. In this approach, each team member completes independent evaluations of client needs and shares the information with the team in order to develop an integrated and coordinated plan of care. Team members also share responsibility for the provision of care and may at times, share roles.

Services provided through this program include:
- Ongoing access to healthcare professionals
- Physical and Mental Health Screenings
- Assistance in applying for disability status and public programs
- Support groups
- Social opportunities and activities
- Education (diagnosis, exercise training, energy conservation etc.)

A full description of these services is available in Appendix A. An initial intake form was created based upon assessment data from each of the professions. A copy of this form is included in Appendix C. In addition, all educational pieces that will be provided by an occupational therapist can be found in Appendix B. This
educational series has been developed at a sixth grade level to help ensure that clients are able to read and understand the information contained within. Educational topics were selected for this program based upon needs identified within the literature review. It is important to note that client needs vary widely and it may be necessary at times to expand or otherwise alter the services and education provided in order to meet those needs. This program serves as a template for a community-based program for clients with COPD and can be adapted to meet the specific needs of this or other patient populations.

In order to determine program efficacy, it is necessary to establish a system of outcome measures. During the first year of operations, it will be important to review the program quarterly to help identify potential problems and make necessary changes. Program efficacy will be established in regards to the primary goals of improving perceived quality of life while reducing the need for and expense of hospitalization in this population. Specific measures that will be used for this purpose include the Canadian Occupational Performance Measure (Law et. al., 1991), Quality of Life Index (Ferrans & Powers, 1998), Beck’s depression Inventory (Aspen Press, 1974) as well as information gained from regular physical assessments. It will also be necessary to track the number and duration of hospitalizations. This information will help to establish the cost-effectiveness of the program.

This program is meant to be used as an adjunctive treatment and should not replace any type of existing treatment. Rather, it should be utilized to provide ongoing support and follow-up services within a community-based setting to COPD patients and their families.
Chapter V: Summary

This scholarly project has focused on the development of a community-based COPD wellness program. The ultimate goal of this program is to increase the perceived quality of life while reducing the need for and duration of preventable hospitalizations in this population. With this in mind, the program was designed to provide ongoing support and follow-up services to COPD patients and their families.

This program was developed based upon information gained from an extensive literature review. Current research indicates that this population has far-reaching needs that are not being met and or addressed through traditional treatment approaches (Kim, et al., 2000; Sin, et al., 2002; Dow & Mest, 1997).

Several community-based programs have been developed across the nation in an effort to meet these needs (Barnett, 1999; Dow & Mest, 1997; Gordias & Gibbons, 1999 Monahan, 1999). While these programs have varied in approach and duration, each suggests that community based care does have something unique to offer to this population in maintaining productivity, engagement in occupations, and quality of life. Program results have also varied but the general consensus is that they provide a cost-effective way to reduce unneeded hospitalizations and increase patient independence.

To date, most of these programs have been led by nursing with referrals given to other health care professionals as needed. This program is unique in that it uses an interdisciplinary team consisting of nursing, social work and occupational therapy professionals to provide client-centered assessments and interventions to this patient population.
This program offers a wide array of services to its clients and places a heavy emphasis on education and opportunities for socialization. Educational programming is provided on a 10-week rotational basis and can be modified as necessary to meet client needs and interests. Socialization is encouraged in every aspect of this program and is facilitated through support groups and a variety of program events and activities. In this way clients and their families can give and receive much needed support, gaining a sense of altruism and self-efficacy while reducing social isolation.

Other key components of this program are the ongoing physical and mental health screenings which are conducted every eight weeks. These screenings will help to identify changes in functional status, allowing for quick intervention and potentially reducing the need for hospitalization. These screening will also serve as an outcome measure of program effectiveness.

Potential barriers for the implementation of this program include: finding adequate funding sources; transportation issues and access to program; working with diverse cultural backgrounds and rural environments. Previous programs have worked closely with community hospitals, sharing staff and receiving support and financing. Other options include identifying and procuring grant monies from federal, state and private organizations or marketing the program to insurance companies as a cost-effective means of preventing unnecessary hospitalizations within this population.

One of the limitations of this program is that it does not directly address the issue of operating expenses and funding. These factors will vary based upon the size of the community, number of participants and the level of services provided.
This program has been designed to provide ongoing support and services to COPD patients and their families. It is meant to be used in conjunction with existing methods of COPD management and should not replace any other forms of treatment.
APPENDIX A:

COMMUNITY BASED COPD WELLNESS PROGRAM
Community-Based COPD Wellness Program

I. Mission Statement
Chronic obstructive pulmonary disease (COPD) is a leading cause of death, illness, and disability in the United States. While aspects of physical dysfunction, such as shortness of breath or decreased strength and endurance, are commonly addressed, other pertinent factors such as psychosocial functioning are often overlooked and under-treated. It is the mission of this program to positively impact patients’ quality of life through a holistic approach to COPD management within a community-based setting. Program goals include:

• providing comprehensive assessment of a client’s physical and psychosocial wellbeing
• providing suitable client-centered interventions to affect lifestyle changes and improve quality of life
• reducing the need for and expense of hospitalization in this population.

II. Personnel
This program utilizes an interdisciplinary team approach for treatment intervention. This means that team members share responsibility for providing services and may share roles. Team members conduct separate evaluations but share the results with the team in order to develop an integrated and coordinated care plan.

Upon referral to this program, each client is assigned to a case manager. The case manager is the designated person that clients and family members can consistently rely on to explain, clarify, or acquire necessary information. The case load is divided equally amongst the various disciplines.

The primary roles of each discipline are outlined below. Additional services within each professions realm of practice will be provided as necessary to meet each client’s individual needs.
Social Work
- Assists client, family, or other important people in the clients life to achieve a maximal level of social and emotional functioning
- Provides client and family counseling
- Provides education on entitlements and other available resources
- Assists in identifying transportation and attendant care resources
- Serves as a referral source for external services as needed
- Provides chemical addiction counseling as needed

Nursing
- Provides assistance with medication management
- Provides nutritional consultation
- Conducts regular health status checks
- Administers Beck’s Depression Inventory and Quality of Life Questionnaire
- Provides education on diagnosis
- Serves as a referral source for external services as needed
- Provides chemical addiction counseling
- Crisis intervention

Occupational Therapy
- Administers Canadian Occupational Performance Measure and reviews results with team members to facilitate individualized treatment planning
- Administers ADL assessment within client’s home in order to facilitate problem-solving and ensure confidentiality
- Completes a home assessment to determine what if any changes need to be made to the environment to increase safety, efficiency, and independence
- Provides adaptive equipment and training to assist in the performance of activities of daily living when necessary
- Provides education on energy conservation and work simplification
- Creates an upper extremity exercise routine to specifically meet each clients needs
- Develop and run weekly exercise group
- Provides education on breathing and relaxation techniques
- Suggests modifications in work settings when appropriate

Shared Responsibilities
- Provide case-management services for assigned clients
- Responsible for documentation of client progress
- Crisis intervention
- Act as a patient advocate
- Serve as a support group facilitator
Program Director

- Responsible for the day-to-day operations of the program
- Plans and organizes weekly social events and activities
- Responsible for scheduling education classes and support groups

III. Services

  g. Ongoing access to healthcare professionals
  h. Physical and Mental Health Screenings
  i. Assistance in applying for disability status and public programs
  j. Support groups
  k. Social opportunities and activities
  l. Education (diagnosis, exercise training, energy conservation etc.)

One of the primary services provided by this program will be the on-going availability of and access to health care professionals to its clients. This will provide individuals with an opportunity to ask questions regarding symptoms, medications, ADL performance and or any other areas in which they are experiencing difficulty or need assistance in. Team members will meet with both clients and family members to address client needs and will provide referrals to external sources when necessary.

The team will also be responsible for monitoring client health status. Physical and mental health screenings will be conducted by the team every eight-weeks and results will be documented in the client’s file. Crisis intervention will be provided to prevent or decrease the need for hospitalization for clients demonstrating a significant decline in any functional area that jeopardizes their ability to remain in the community.

The program will assist clients in identifying and applying for suitable community, state and federal programs to help meet their needs. Examples of these programs include: Meals on Wheels, Dial –A-Ride, Medicaid, Medicare, SSI and SSDI.
Members will also be invited to participate in support groups in order to share their personal experiences and learn from one another. Professional staff members will take turns facilitating these groups in order to help offer suggestions and support as needed. Groups will meet for two hours once a week and will be open to both clients and family members.

Many COPD patients become socially isolated due to the severity of their condition and the fear and anxiety often associated with it. This program will offer opportunities to engage in meaningful group activities within a supported environment. These activities will be arranged and facilitated by the program director based upon client interests and are subject to change.

An essential component of this program will be a series of educational presentations (Please refer to Appendix B for detailed information). Topics will include:

“Understanding COPD” (Nursing)
“Symptom Management” (Nursing)
“Nutrition and COPD” (Nursing)
“Understanding Depression” (Nursing/Occupational Therapy)
“Energy Conservation and Work Simplification” (Occupational Therapy)
“Breathing and Relaxation Techniques” (Occupational Therapy)
“Upper-body exercise” (Occupational Therapy)
“Stress Management & Coping Skills” (Occupational Therapy)
“Understanding and accessing financial assistance sources” (Social Work)
“Smoking Cessation” (Social Work/Nursing)
Additional topics will be covered based upon client needs and interests.

IV. Referral Process

Referrals will be accepted from physicians, health care professionals and social services in addition to self referrals by clients and their family members.

V. Intervention Methods

Initial Assessment

After referral to this program, each client will complete an intake interview (please refer to Appendix C for basic format) and be asked to complete the following mental health assessments:

- Quality of Life Index- Pulmonary Version/III (Ferrans & Powers, 1998)
- Sickness Impact Profile (SIP) (John Hopkins University, 1977)
- Beck’s Depression Inventory (Aspen Press, 1974)

Each client will be assigned to a primary case-manager upon completion of these screenings. This individual will be responsible for overseeing the patient’s care and ensuring that their needs are being met.

Clients will then be scheduled to meet with an RN to assess physical health status. Assessment data will include: temperature, pulse rate, respiratory rate, blood pressure, Spirometry testing, and O₂ saturation at rest and during exercise.

An occupational therapist then arranges to meet with the client in order to complete the following assessments:

- Home evaluation
• ADL assessment (completed in the client’s home in order to facilitate problem-solving and increase client independence whenever possible)

• Canadian Occupational Performance Measure (COPM) (Law et. al., 1991)

Information gathered from these assessments will be reviewed with the client and utilized in developing client-specific goals and objectives. Each client will be reassessed every eight weeks in order to monitor progress and ensure that the client’s needs are being met.

Education

Educational programming will be provided on a 10 week revolving basis. Clients will be provided with a schedule of topics and integrated into the classes upon entering the program. They will also have the option of discussing topics one-on-one with health care providers in cases of immediate need. Special topics are available based upon client needs and interests.

In addition to these classes, an ongoing exercise course will be provided three days a week for 30 minute sessions by the OTR/L. Each client will receive training in an individualized upper extremity exercise program designed to increase strength and endurance. Clients and their caregivers will also be instructed in an individualized home exercise program to help integrate exercise into their daily lives.

VI. Outcome Measures

This program will be reviewed every three months for the first year of operation and then annually in order to evaluate program efficacy. Physical and mental health assessments will be completed at intake and then in eight week intervals thereafter. This information will be utilized to document progress and
provide a measurable outcome. The program will also track the number and duration of preventable hospitalizations for each client. This will help to establish program efficacy in reducing and preventing unnecessary hospitalizations.

**VII. Potential Barriers to Implementation**

One of the biggest barriers to the implementation of this program will be identifying and procuring sufficient funding. The COPD population is already subject to high medical costs from hospitalizations, rehabilitation and medication. In addition to this, many are no longer able to maintain gainful employment, causing them to rely on public and federal support programs. With this in mind, community based care should be provided on a sliding scale basis to the consumer. This means that the majority of funding must come from external sources. In the past, similar programs have worked in conjunction with and therefore received funding and support from local hospitals. Another option is to market the program to insurance companies as a preventative program emphasizing the cost effectiveness of reducing the number and duration of preventable hospitalizations for this population. Grants are also available for this type of programming from federal, state and private sources. This can provide funding to develop and implement the program but should ultimately be replaced by more concrete funding sources.

Transportation may be an issue that could potentially prevent clients and their families from utilizing these services. Rural areas would require that an individual commute longer distances which may serve as a deterrent to participation in the program especially during temperature extremes seen in summer and winter months. These individuals are at special risk due to the remoteness of their location as social
opportunities may be limited, contributing to social isolation. In addition to this, cultural barriers may prevent potential clients from participating. In these situations, the program coordinator and health care professionals will need to work closely with individuals and the community to overcome these barriers.
APPENDIX B:

OCCUPATIONAL THERAPY EDUCATIONAL PROGRAMS:

“ENERGY CONSERVATION AND WORK SIMPLIFICATION”
“BREATHING AND RELAXATION TECHNIQUES”
“UNDERSTANDING DEPRESSION”
“STRESS MANAGEMENT AND COPING SKILLS”
Energy Conservation

A Guide to Daily Living
Hygiene: Bathing and Showering

- Sit on a chair or stool while washing, shaving, or applying makeup.

- Organize frequently-used equipment such as towels and shaving kits in accessible areas in the bathroom.

- Eliminate getting right into a tub or standing in the shower by using a bath stool and a hand shower. If you are unable to manage washing your hair in the shower, tub or at a sink, ask for help.

- Ensure safety with grab bars or rails that attach to the walls or bathtub. Non-skid mats also improve safety.

- Increase independence by using a long-handled bath brush and towel sling to wash your back and feet.

- Minimize shortness of breath by wearing a terry-cloth bathrobe or wrapping up in a large towel to dry off.

- Avoid using spray deodorants and aerosol shaving creams, which may irritate your lungs.

- Control your breathing when showering or bathing. Keep the water temperature warm (not hot) to minimize shortness of breath.
Laundry and Ironing

- Carry dirty or folded clothes in a rolling laundry cart or laundry basket. If your laundry area is downstairs, throw the clothes downstairs instead of carrying them.

- Raise front-load washers and dryers on blocks to avoid bending.

- Use the perma-press setting on your dryer to avoid ironing.

- Schedule laundry days during the week to avoid making frequent trips up and down stairs if your laundry facilities are in the basement.

- Always fold clothes while sitting, preferably directly from the dryer.

- Sort clothes on a table (never on the floor) and use a rolling laundry cart.

- If you hang clothes to dry, use a wheeled utility cart. Raise it to your height to eliminate frequent bending.

- Sit to iron, adjusting the height of the board to a comfortable level. Keep a rack next to the ironing board for hanging freshly ironed clothes.

- Slide the iron; do not lift it or set it on end. Place it on an asbestos pad while adjusting clothes on the ironing board.

- Don’t iron what doesn’t need to be ironed! Instead of ironing, fold sheets, towels and underwear.
Cooking

Eliminate unnecessary motion when cooking to help prevent fatigue and shortness of breath.

Preparation:

✓ Plan menus in advance.

✓ Use menus that require short preparation time and little effort (for example, frozen foods, convenience foods, ready mixes).

✓ Gather together and move all necessary items to the work area on a wheeled utility cart.

✓ Sit at a table or counter of correct height to mix ingredients, chop and slice vegetables, etc.

✓ Slide or use a wheeled utility cart to move items (slide pots, don’t lift them).
Setting the Table and Serving

- Collect all dishes and silverware needed for the meal and move them on a wheeled utility cart.

- Consider eating meals in the kitchen or breakfast room.

- Avoid using serving dishes. Serve directly from the baking dish.

- Transport prepared food to the table by wheeled utility cart.

- Use a cutting board that fits over the sink.

- Use a hose to add water to pots and pans.

- Avoid items that require constant stirring or attention.

- Use lightweight dishes. Consider lightweight and double-handled pots and pans.

- To eliminate scrubbing pots and pans, use vegetable spray.
After-Meal Clean-Up

- Rest for a while before starting clean up.

- Have each family member carry his or her own dishes and rinse and pile them by the sink.

- Collect all remaining items on a wheeled utility cart and move them to the sink area.

Washing dishes by hand
- Sit on a high stool at the sink when washing dishes.

- Air-dry dishes.

- When putting away dishes, remove them from drainer to a wheeled utility cart, then take one trip around the kitchen to put them away.

Washing dishes using a dishwasher
- Rinse dishes at the sink close to dishwasher and organize them into groups (plates, glasses, silverware, bowls, etc.).

- Load the dishwasher by filling the bottom rack first.

- Unload dishes onto a wheeled utility cart, then take one trip around the kitchen to put them away.
Shopping

- Plan menus to avoid unnecessary trips to the market.
- Jot down items as you need them or as supplies get low.
- Plan your market list in keeping with the layout of the store.
- Plan to do your shopping when the store is not busy.
- Have someone assist you to reach high and low items and to lift heavy items.
- Use a shopping cart and place heavy items near the handle for better leverage.
- Transport groceries in the trunk of the car, not in the back seat.
- Use a wagon to bring food home from the store.
- If carrying groceries, load the bags half full.
- Use phone order service where available and/or store delivery to avoid carrying parcels.
- Use a small, wheeled cart to carry groceries inside.
Storage of Groceries

- If possible, have a family member do this for you.
- Make several trips with rest periods between to carry groceries into the house. If necessary, carry one bag at a time.
- Sit on a stool and sort according to storage locations.
- Transport items on a wheeled utility cart to their storage place.
- Sort groceries at work height, not on the floor.

Helpful Hints
- Shop at markets where they unload your carts and deliver groceries to your car.
- Take advantage of advertised specials so you can buy as much as you can store.
- Keep a detailed list so someone else could shop for you.
- Ask the grocery clerk to pack bags lightly so they are easier to carry.
- Consider taking handled grocery bags to the store for easy carrying.
Bed Making

It's important to break this activity into small manageable steps. Focus on one step at a time. Breath in, start blowing out air with pursed lips and at the same time move your arms to straighten out the bed-clothes. Inhale again and start breathing out as you bend to tuck ends and corners etc.

Do not rush. Rushing will only cause shortness of breath.

- When straightening or changing bed sheets, make one side of the bed at a time.

- Sit down to change pillow cases and take a rest.

- Unfold linen, and line up center fold of the sheet with the center of the bed.

- When changing bed linen, put bottom sheet, top sheet, blanket and spread on first, and then tuck in the bottom sheet at both ends. Continue making the bed on that side as usual.

- When shaking out bed linen, inhale as you raise your arms, and exhale as you bring the linen onto the bed. When smoothing bed clothes, inhale as you extend and exhale as you pull towards your body.

- Avoid bending. Instead, stoop, squat, or sit on a chair.

- A comforter can allow you to eliminate numerous top sheets and blankets.

- Casters on the bed allow it to be moved more easily.
Cleaning the floors

- When using a broom or mop, stand tall to avoid bending at the waist.
- Use a long-handled dust pan to pick up sweepings.
- Use floor covering that require little upkeep (not wax).

Scrubbing the floor
Use a long-handled sponge mop. Inhale as you push the mop away from you. Exhale as you pull it towards you.

Kneeling and scrubbing is hard work; if you have to do it, use breathing control. In the kneeling position breathe in, start breathing out with pursed lips, and at the same time bend down and scrub the floor. Always make a point to raise yourself to kneeling position and breathe in. Pursed lip breathing should always be done with heavier tasks such as bending and scrubbing. Select the best part of the day for a heavy task such as this, as it takes most of your energy.

Wiping Spills and Picking Up
- Use a small mop for wiping up spills to save bending.
- Use pick-up tongs to pick up articles from the floor.
- Use paper towel to eliminate extra laundry
Vacuuming

• Take a deep breath before you start the machine; start breathing out with pursed lips and at the same time start the machine and push forward.

Correlate pushing and pulling movements with your breathing pattern

When Vacuuming:
• Move slowly and rhythmically with the vacuum. Inhale as you push the vacuum away from you, exhale as you pull it towards you.

• Maintain good posture.

• Take frequent breaks.

To minimize dust particles in the air, use a damp newspaper to empty the vacuum cleaner bag or carpet sweeper.
Ways to Conserve Energy

- **Control Your Breathing:** Use breathing control during activities to help reduce shortness of breath and fatigue. Exhale during the strenuous part of an activity and use pursed-lip and diaphragmatic breathing.

- **Eliminate Unnecessary Activities:** For instance, use a terry robe after showering to avoid the work of drying yourself, and allow dishes to air dry after washing.

- **Sit for as many activities as possible:** Sitting uses 25% less energy than standing.

- **Get Assistance:** Don’t be afraid to ask for assistance when necessary. Some jobs may be too difficult to do alone. Or, there may be a task that you dislike doing, and which someone else may enjoy doing for you. Asking for help does not mean you are dependent; it means you are using your energy to its best advantage.

- **Organize Your Time:** Plan daily and weekly schedules so you are doing the most energy-consuming activities at the time of day or time of week when you have the most energy. Alternate difficult and easy tasks. Take planned rest periods. Keep your schedule flexible to allow for the unexpected.

- **Organize Your Space:** Organize your most used items in drawers or shelves that are between waist and shoulder level, so you won’t have to stoop or stretch to reach them. Keep items in the area in which they are used, in order to avoid unnecessary walking and carrying.
Ways To Conserve Energy

• **Pace Yourself:** A slow, steady pace consumes less energy. Do one activity at a time and use slow, smooth movements. Rushing only increases discomfort. Be certain to alternate periods of work and rest. Try to plan out your activities in steps, so if you start to get short of breath you can stop and rest when necessary, instead of working faster and harder in order to finish.

• **Maintain Good Posture:** One of the easiest ways to save energy is to use your body properly. When the body is in proper alignment, less effort is required to maintain that posture.
  - Avoid Bending
  - Avoid lifting. Push, pull or slide instead. If you must lift and carry, lift with your legs, use both hands and carry close to your body.

Be certain to choose a work height that allows you to maintain good posture and eliminate strain. Try adjusting either the height of the chair or the work surface in order to find which height is most comfortable.

• **Relax:** Relaxation can help restore energy. Sit in a comfortable chair with your back supported, shoulders relaxed, arms resting in your lap with elbows slightly bent and palms up and feet flat on the floor. Concentrate on relaxing your muscles and slowing down you breathing. **REMEMBER:** Tension only uses energy!!!

• **Use Proper Equipment:** Use the right tool to do the job. For example, use long-handled equipment to avoid reaching or bending, use equipment to stabilize items in order to avoid holding, and use carts or wagons to do your carrying.
Breathing & Relaxation Techniques
Anxiety and Shortness of Breath

For many COPD patients, anxiety and fear associated with shortness of breath can prevent them from engaging in and enjoying certain activities.

Reduced physical activity leads to a weakening of muscles, ultimately increasing shortness of breath and the fear and anxiety associated with it.

Fortunately, it's possible to break this cycle! By using proper breathing and relaxation techniques, you can continue to engage in some of your favorite activities.
Pursed Lip Breathing

What does it do?
- Improves Ventilation
- Decreases Air trapping in the lungs
- Decreases the work of breathing
- Improves breathing patterns
- Causes general relaxation

How?
- Prolongs exhalation—slows down the breathing rate
- Causes a slight back pressure in the lungs that keeps the airways open longer
- Improves the movement of old air out of the lungs and allows for more new air to get into the lungs

Procedure:
REMEMBER: Exhalation must be 3-4 times longer than inhalation, so do not force the air out!

- Sit down but sit up straight, relaxed.
- Breath in through your nose.
- Purse lips slightly (as if to whistle).
- Breath out slowly through pursed lips.
- Do not force the air out.

Practice this procedure 4-5 times a day initially to get the correct breathing pattern. You should utilize pursed lip breathing when you are experiencing shortness of breath either at rest or with exertion, or if you feel nervous or apprehensive.

IMPORTANT: You may experience a light-headed feeling while doing pursed lip breathing. This indicates that you are overventilating yourself and you should breathe more slowly.
Diaphragm Breathing

What does it do?

- Strengthens the diaphragm
- Coordinates diaphragm movement when breathing
- Less effort required to breathe
- Less energy utilized for breathing

How?

- by correctly using the most effective breathing muscle

Procedure:

- Lie on your back in a bed with your knees bent.
- Place one of your hands on your abdomen.
- Place your other hand on your upper chest.
- As you inhale through your nose, make your stomach move out and keep your upper chest as still as possible.
- As you exhale through pursed lips, let your stomach fall inward. Your hand on the upper chest must remain as still as possible during the entire procedure.

In the beginning, practice this procedure for 5-10 minutes, 3-4 times a day. You can gradually increase the length of your exercise period and perhaps the effort required by placing a book on the abdomen. After you feel comfortable with this procedure, practice while sitting in a chair or standing.
Rib-Cage Breathing

Procedure:

• Lie on your back in a bed with your knees bent.
• Place one of your hands on your ribs (do not pull in your abdominal muscles).
• Place your other hand on your upper chest.
• As you inhale through your nose, make your stomach move out and keep your upper chest as still as possible.
• As you exhale through pursed lips, let your stomach fall inward. Your hand on the upper chest must remain as still as possible during the entire procedure.

These methods will make breathing less work, control your breathing when it's hard to breathe, and help more air get to your lungs and the air sacs where oxygen reaches your bloodstream.
Relaxation Technique

The following relaxation techniques can help relieve the tension and anxiety that often accompanies your respiratory difficulties. By learning to relax your mind and body, you may feel better, and you will be decreasing the amount of oxygen that your body needs.

Procedure:

Lie down on a comfortable surface and place pillows under your head and knees. *If you are more comfortable on your side, use pillows under your head and between your knees.*

• Lie quietly in a comfortable position.
• Take a slow deep breath through your nose. Hold the breath for several seconds; purse your lips, and slowly exhale. Relax.
• Take another deep, slow breath through your nose. Hold your breath and pull your toes towards your head and tighten your leg muscles (No longer than a count of 3). Feel the tension. Purse your lips, exhale slowly and relax your legs. Relax.
• Take another deep slow breath through your nose. Hold your breath and tighten your arm muscles. Feel the tension. Purse your lips, exhale slowly and relax your arms and hands. Relax.
• Take another slow, deep breath through your nose. Hold your breath and bite down as hard as you can and tighten your jaw muscles. Feel the tension. Purse your lips, exhale slowly and relax your jaws.
• Take another slow deep breath through your nose. Hold your breath and lift up your head and tighten your neck muscles. Feel the tension. Purse your lips, exhale slowly, let your head rest back on the pillow, and relax your neck muscles.

Lie still and enjoy the relaxed feeling you’re experiencing. You should do this relaxation technique several times a day, even if you do it while sitting in a chair.
Walking Exercise

- Start with short walks. Your breathing muscles and your walking muscles need to get into shape.
- Use “rhythmic breathing”. Count the number of steps your take while inhaling and double the number of steps for exhalation. Example: 2 steps—inhale, 4 steps—exhale. Do not change the rhythm from inhalation to exhalation.
- With practice you may find that a 3 to 1 rhythm is more comfortable than 2 to 1. Use the rhythm that is most comfortable for you.
- Gradually increase your walking distance as you get stronger. Try to add a little more distance every week. Don’t overextend yourself.
- Set reasonable goals. Plan rest stops. Don’t allow yourself to get overtired.
- During poor weather, or times of the year when you’re most uncomfortable, you can get your exercise in climate controlled areas like shopping malls or in a more formal environment like a hospital’s rehabilitation area.
- Remember, go slow, don’t rush, get stronger and most of all, enjoy yourself.

These slides were adapted from information provided by the following reference. For this, or additional information on related topics, please visit their website.
Understanding Depression
Understanding Depression

Depression is a disorder in mood characterized by varying degrees of sadness, disappointment, loneliness, hopelessness, self doubt, and guilt.

Most people tend to feel depressed at one time or another, but some People may experience these feelings more frequently or with deeper, more lasting, effects. In some cases, depression can last for months or even years.

The most common type of depression is what is referred to as “feeling blue” or “being in a bad mood.” These feelings are usually brief in duration and have minimal or slight effects on normal everyday activities.

In the next level of depression, symptoms become more intense and last for a longer period of time. Daily activities may become more difficult...but the individual is still able to cope with them. It is at this level, however, that feelings of hopelessness can become so intense that suicide may seem the only solution.

A person experiencing severe depression may experience extreme fluctuations in moods or even a desire for complete withdrawal from daily routine and/or the outside world.
Symptoms of Depression

Depression may affect one’s life in the following ways:

— Changes in Feelings and or Perceptions
  • Crying spells or, at the other extreme, lack of emotional responsiveness.
  • Inability to find pleasure in anything.
  • Feelings of hopelessness and/or worthlessness.
  • Extreme sense of guilt or self-blame.
  • Loss of sexual desire.
  • Loss of warm feelings toward family or friends.

— Changes in Behavior and Attitudes
  • Lack of interest in prior activities and withdrawal from others.
  • Neglect of responsibilities and appearance.
  • Irritability, complaints about matters previously taken in stride.
  • Dissatisfaction about life in general.
  • Impaired memory, inability to concentrate, indecisiveness, and confusion.
  • Reduced ability to cope on a daily basis.

— Physical Complaints
  • Chronic weakness and lack of energy.
  • Complete loss of appetite, or at the other extreme, compulsive eating.
  • Trouble sleeping, early morning wakefulness, or excessive sleeping.
  • Unexplained headaches, backaches, and similar complaints.
  • Digestive problems including stomach pain, nausea, indigestion, and or change in bowel habits.
Causes of Depression

Depression is often the result of an unhappy event such as the death of a loved one. When the source of depression is readily apparent and the person is fully aware of it, the individual can expect the reaction to moderate and then fade away within a reasonable amount of time. In cases where feelings of depression exist with no apparent source or the source is unclear, the depression may get worse because the person is unable to understand it. This sense of loss of control may add to the actual feelings of depression.

Any number of stressors may be involved in depression. These can include personality, environmental, or biomedical factors. The brain has certain chemicals that help manage moods. If there isn’t enough of these chemicals or not they aren’t balance, depression may occur. Such imbalances may be created by illness, infections, certain drugs (including alcohol and even prescribed medications) and improper diet and nutrition. In general depression may be viewed as a withdrawal from physical or psychological stress. Identifying and understanding the underlying causes of such stress in a necessary step in learning to cope with depression.
Helping Yourself

Being honest with yourself about changes in mood or the intensity of negative feelings as they occur will help you identify possible sources of depression or stress. You should examine your feelings and try to determine what is troubling you—relationships with family or friends, financial responsibilities, and so forth. Discussing problems with the people involved or with an understanding friend can sometimes bring about a resolution before a critical stage of stress is reached. Even mild depression should be dealt with if it interferes with your effectiveness.

You might also try:

- Change your normal routine by taking a break for a favorite activity or something new—even if you don’t feel like it.
- Exercise to work off tension, improve digestion, help you relax, and perhaps improve your ability to sleep.
- Avoid known stressors.
- Avoid making long-term commitments, decisions, or changes that make you feel trapped or confined—it is better to put them off until you feel you are better able to cope.
- See a doctor, especially if physical complaints continue.
Helping a Depressed Loved One

Since severely depressed individuals can be very withdrawn, tired, lost in thought and possibly suicidal, a concerned friend or family member can provide a valuable and possibly life-saving service. Talking openly with the individual regarding your concern for his or her well being will often bring the problems out into the open.

As you talk to your loved one, keep the following in mind:
- Do not try to “cheer up” the individual.
- Do not criticize or shame, as feelings of depression cannot be helped.
- Do not sympathize and claim that you feel the same way as he or she does.
- Try not to get angry with the depressed individual.

Your primary task is to let the person know you are concerned and willing to help.

If feelings of depression appear to turn to thoughts of suicide, urge the individual to seek professional help. If the person resists such a suggestion and you feel that suicide is likely—seek professional help yourself, so you will know how to best handle the situation.
When Professional Help is Necessary

Depression is treatable and needless suffering of those who experience it can be lightened. A mental health professional should be consulted when an individual experiences any of the following circumstances:

- When pain or problems outweigh pleasures much of the time.
- When symptoms interfere with day-to-day functioning.
- When stress seems so overwhelming that suicide seems to be a viable option.

Medications are also available to “prevent” recurrent episodes of depression or mania, particularly in patients who suffer from bi-polar disorder. These drugs include lithium and anticonvulsant medications such as valproic acid.

These slides have been adapted from information provided by the following resource. For this, or additional information, please visit their website.

Stress Management and Coping Skills
What is Stress?

We all experience stress in our day-to-day lives but what is it and how does it affect us? Stress is a common result of any demand placed upon the body, whether mental or physical.

**There are 2 types of stress:**

- **Distress** (bad stress): seen as a threat to health
  - Related to bad emotions such as: anger, frustration, envy, sadness, guilt, shame and disgust
- **Eustress** (good stress): seen as motivational
  - Helps you to set personal standards, helps to set goals and priorities

The body cannot tell the difference between good and bad stress.
The Stress Response

Step 1: Information is picked up by one of the body’s five senses and sent to the brain.

Step 2: The brain decides whether or not there is any threat to safety. If not, then the cycle ends here. If there is, the body responds by gearing up the body to either fight or flee.

Step 3: The body stays alert until the threat has passed.

Step 4: Once the threat is over, the body returns to normal functioning.
Steps to Successful Stress Management

Step #1

Although it seems obvious enough, sometimes the most difficult step in dealing with stress is just identifying what the root of it is. In order to identify the cause of stress, you must pay close attention to your body and what cues it may be giving off. Get in touch with your personal symptoms!

Try keeping a journal. When you have identified a symptom, jot it down along with information about what might have caused it. Possible questions that might help you get started include:

- What were you doing when you first felt the symptom?
- How did you feel?
- How did you act towards others?
- What do you think could have led to this?
- Have you experienced similar feelings before? If so, when and why?
Step 2: Identify possible solutions

The key to successful stress management lies in the individual’s ability to properly respond to stressors.

Examples of how to deal with stress include:

- Talking about a stressful event with a friend or a good listener.
- Exercising to help relieve body tension.
- Writing feelings in a journal.
- Listening to relaxing music.
- Practicing breathing techniques.
- Doing a craft or hobby.
- Break down tasks so they are easier to complete.

Try to come up with a plan that outlines how you will respond to stress in the future.
Step 3: Put your plan into action

Once you have developed a plan for coping with stress put it to use!

The next time you begin to feel stressed, try using one of your coping strategies.

Step 4: Evaluate your level of success

Afterwards, try reflecting in a journal about what worked well and what didn’t work at all. How might you change your plan to better meet your needs? What will you do next time?

Remember, this is a process and it may take several attempts before you find an activity that works for you. Try not to get discouraged!

Reference:
APPENDIX C:

INITIAL INTAKE FORM
Initial Intake Form

Name: ___________________________  Sex: _____

DOB: _________  Diagnosis: ________________________ 

Pertinent Medical History:

Date of Onset: _________________

Past and Recent Hospitalizations: _______________________

Medications: __________________

Allergies: _____________________

Social History:

Family: _______________________

Education: ____________________

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Work History: ________________________________________________
________________________________________________________
________________________________________________________
Community involvement: ______________________________________
________________________________________________________
________________________________________________________

Home Setup:
Type of Home: ___________  #Steps to enter: ___________
Are all necessary facilities on one floor? ______  # of Steps ______
Bathroom setup: Tub ___  Tub/Shower Combo ___  Shower ___
  Sliding glass doors ___  Curtain/Rod ___
Available Adaptive Equipment: ________________________________

Referral Source: __________________________________________
Insurance Information: ____________________________________

Date: ________________

Interviewer’s Name and Signature: ____________________________
APPENDIX D

REFERENCES
References:


