

Group Proposal Protocol: Chronic Obstructive Pulmonary Disease (COPD) and Anxiety

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Chronic Obstructive Pulmonary Disease, better known as COPD, is the third leading cause of death in the United States, “accounting for more than 120,000 deaths per year” (Hunter et al., 2016). According to GOLD (2020), “both anxiety and depression are associated with poorer COPD prognosis.” The prevalence of patients with COPD and comorbid anxiety is between 16% and 31%, according to Baker et al., (2018). Caryn Blanton of Rush University Medical Center reports that anxiety is associated with many factors that associate with COPD related to emotional, cognitive, and environmental factors (Blanton, 2018). According to Schwab et al. 2017, “COPD-related medical costs were estimated to be \$32.1 billion in 2010, including \$29.5 billion in direct health care costs.” Formulating a group to meet the needs of a population with cooccurring COPD and Anxiety is imperative to not only save healthcare billions of dollars per year but also to meet the needs and improve the health of the population suffering from comorbidity.

Section I

The chosen population for the proposed group is adults aged 50-65 years old. Patients must meet the criteria of a diagnosis of COPD along with Anxiety. This group will be open to ten to twelve participants who meet the requirements based on assessments conducted during the previous weeks. Possible participants must also be part of a lower socioeconomic population and have a high need for physiological assistance. The population-based group will be a 6-8 week program with a week in the beginning for assessments, introductions, and questions and a week, in the end, to wrap up the group, answer any questions that need solving and developing treatment goals.

Section II

An extended consultation must take place to determine appropriate participants for the group. Considering appropriate assessment measures is imperative when preparing a group based on population. The proper assessment makes the difference between identifying a patient's correct stage of change and what materials will speak their language. Assessments will be conducted during the consultation session to assist in the identification of participants. One assessment tool used will be the COPD Assessment Test (CAT), which will give insight into what symptoms each participant is currently experiencing. Another assessment tool to be used will be the Generalized Anxiety Disorder 7-item scale (GAD-7). Other assessments to be conducted may include but are not limited to self-assessment measures identifying patient needs from their perspective.

As stated previously, this group will be for 6-8 weeks, depending on the results of the initial extended consultation session. The group schedule is as follows:

- Week 1: Initial assessments, identification of needs, and goals per participant.
 - group rules; protocol; the structure of sessions
- Week 2: Values and Lifestyle
 - housing needs, current and past value systems
 - Have you outgrown your beliefs?
- Week 3: Nutrition and Exercise
 - SNAP benefits, food pantry options, fresh produce options
- Week 4: Sleep and Breathing
 - sleep patterns; sleep apnea
 - Does patient use/need a CPAP?

- Week 5: Quitting Smoking
 - Biodyne Tobacco Cessation Program
- Week 6: Plans for follow-up, lifestyle changes, resources provided
 - What are the treatment goals per patient?
 - How can the BHC facilitate positive changes in participants?

During week three, a dietician will be invited to the group to speak about healthy eating habits to assist in dietary changes. During week four, a registered respiratory therapist will talk about sleep apnea, CPAPs, and any other breathing related information to improve the patient's knowledge of their condition.

The Biodyne Model will be used in the tobacco cessation process, as well as identification of where the patients are, to assess their stage of change further, whether they are onion or garlic, and best practices for their individualized and group treatment. As stated previously in other research, the way to meet the needs of the population will be to “do something novel in the first session,” according to Cummings & Cummings, 2012. Doing something novel will facilitate patient engagement, which will allow the group to hear what they need to know to make behavioral changes. Each topic will have psychoeducation to assist in the knowledge acquired. Each session will be part of a drop-in group medical appointment (DIGMA). While there will be portions of the PCP being present, this group will be on a modified DIGMA where the BHC will be the primary person providing resources, information and facilitating the group. Ideally, this group would happen in a fully integrated primary care behavioral health (PCBH) clinic where the PCP could step in as the need arose.

Section III.

COPD and anxiety have hidden costs in each diagnosis individually. There are many more costs associated with the comorbid group. According to Baker et al., 2018, the financial burden caused by the treatment of COPD estimates to be close to \$70 billion annually. The misdiagnosis and mismanagement of COPD impact costs related to hospitalizations and higher rates of worsening of symptoms. According to Hunter et al. (2016), “individuals of low socioeconomic status are at a heightened risk of developed COPD.” May & Li, 2016, report “COPD patients commonly experience psychological comorbidities, such as anxiety, with 10%–55% of patients having clinical anxiety disorders. Anxiety is known to affect the functional status, health-related quality of life, and health care use.” Healthcare costs are affected by treatment exacerbations and medication costs, including hospitalization and outpatient therapy” (May & Li, 2016). Multiple resources speak to the increased costs with comorbid anxiety and COPD concerning higher utilization, increased hospitalizations, higher pharmaceutical costs due to comorbidity, and higher behavioral health costs in outpatient therapy. Hunter et al. (2016) claim a prevalence of “36% of anxiety symptoms” in patients diagnosed with COPD. By decreasing this percentage, healthcare costs improve as well as population health. Reducing costs, increasing patient’s health and behavioral changes, and positively affecting population health are all advantages and benefits of a group for this population. “Among patients with COPD, anxiety was related to poorer health outcomes, including worse submaximal exercise performance and a higher risk of self-reported functional limitations (Eisner et al., 2010).

Final Considerations.

Chronic Obstructive Pulmonary Disease and anxiety are two of the most often comorbid conditions discussed. By forming a group with a population in the age range of 50-65, living in a

low socioeconomic community, suffering from cooccurring COPD and anxiety will reduce costs on the healthcare system by decreasing high utilization rates. Patients and their families will experience increased quality of life and interpersonal connectedness by relieving the anxiety symptoms this population experiences concerning biological and environmental factors related to COPD.

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