Tū Ora
COMPASS HEALTH

Hauora Wellness Plan Goal Prompts

Health Care Home Resource

Better Health Outcomes
through Great Primary Care

Table of Contents

General Goal Prompts 3
Patients with Anxiety 4
Patients with Depression 5
Relapse Prevention Plan: 6
Patients with Respiratory Conditions (COPD/Asthma) 7
Patients with Diabetes and Pre-diabetes 8
Patients with Cardiovascular Disease 9
Patients who may be at risk of falling 10
Patients with sleep disorder 11

Document Name: Hauora Wellness Plan - Kick starters

Date: September 2023

Version: 2.0

Author: Tū Ora Health Care Home team

Contact info: hch@tuora.org.nz

About this Resource:

The purpose of this resource is to provide ideas and guidance to patients when they are setting goals for their health and wellbeing in primary care. The goals have been formatted to sit alongside the Hauora Wellness Plan, but it can be used for any proactive care planning consultation. Included are general health goals, and goals that relate to specific patient groups.

General Goal Prompts

Whare – Housing

- Find a warm, dry rental property
- Get insulation or heating installed
- Improve dampness in the house
- Be able to stay in my own home, with support if needed

Wairua – Spiritual

- To be able to engage in a full, active and meaningful life
- Apply relaxation techniques and breathing approaches
- I will be as compassionate to myself as I am to others
- Connect with nature
- Practice mediation or mindfulness for a few minutes each day

Mahi – Employment/Education

- Stay well enough to continue working
- Continue to do volunteer work
- Stay well so I don't miss school/lectures

Whānau – Family

- Involve my family/support person in my self-management
- Accept support from people I trust
- Ask for support when I need it
- Help my whānau/family understand my health condition

Putea – Money

- Check my eligibility for a community services card
- Ensure I am receiving financial support
- Get financial planning advice
- Save money for something special/important

Tinana – Physical Health

- Learn how my medications keep me well and check I am using them correctly
- Keep as active as I can
- Be able to walk to …
- Refer me for a Green Prescription

Pūroi/Waiwaihā/Puhipuhi – Drugs/Alcohol/Smoking

- Stop or decrease smoking/vaping
- Get addiction support
- Drink less alcohol

Hinengaro – Mental Health

- Get enough sleep
- Manage stress positively using breathing techniques or mindfulness
- Talk to my GP/nurse if I feel I am not coping well with my health conditions

Patients with Anxiety

Goals:

- To learn to manage my anxiety and panic
- Learn about anxiety and the management of my symptoms
- Stop fears and panic preventing me from everyday life activities
- Recognise and know what to do during fear/anxiety and panic attacks
- Be aware of my triggers (fears and stressors)
- Stop smoking/vaping
- Decrease caffeine intake
- Learn about the role of medications and take my medications as prescribed
- Be referred to someone that can help me understand and manage my mental health – counselling or psychology either in practice or at an external provider

Things I will do:

- Attend my medical / counselling / psychology appointments – advise my Dr/Nurse when I can't attend and why – they may be able to help or offer alternatives
- Practise relaxation skills through the exercises and therapy outlined by my health team, which I will do for at least 10 minutes daily
- Take my medications as prescribed
- Complete 30 minutes of exercise daily
- Do an activity that helps me feel calm and mindful for 10 minutes each day
- Talk to my care team if I am not coping with my anxiety

Things my care team will do:

- Help me understand my anxiety in a way that I understand
- Screening for depression and functional impairment
- Investigate for physical causes of anxiety (CBC, TSH, electrolytes, creatinine, HbA1c, LFTs, ferritin)
- Refer me for a Green Prescription
- Refer me for talking therapy or CBT
- Provide support resources – online support groups and websites

Patients with Depression

Goals:

- Live an active and productive life with better management of my depression
- Stop depression preventing me from reaching my goals, dreams, and aspirations
- Learn to recognise and manage stress
- Learn to accept and understand my depression
- Be aware of stressors and ways to manage them
- Be aware of my sleeping patterns and set good sleep habits
- Be aware of my negative thinking and worries
- Learn to manage my use of alcohol, caffeine, and other drugs
- Incorporate exercise into my daily routine
- Learn about the role of medications

Things I will do:

- Practise relaxation skills through the exercises and therapy outlined by my health team, which I will do for at least 10 minutes daily
- Attend my medical /counselling / psychology appointments – advise my Dr/Nurse when I can't attend and why – they may be able to help or offer alternatives
- I will use relaxation skills to help manage my thoughts
- Ensure I don't run out of medication
- Take my medications as prescribed
- Write about how I'm feeling in a journal
- Talk to my health provider if I am not coping
- See the Health Improvement Practitioner
- Develop a relapse prevention plan with my care team (example page 5)

Things my care team will do:

- Help me understand my health condition in a way that I understand
- Screening for medical conditions that cause or aggravate depression – Hypothyroidism, Parkinson disease, sleep disturbance, cardiovascular disease, diabetes, dementia, chronic pain and disability
- Investigate physical causes for depression – CBC, TSH, ferritin, LFTs, creatinine, sodium, potassium, B12 and folate.
- Monitor my mental state
- Refer me for a Green Prescription
- Provide support resources – online support groups or websites
- Refer me for CBT or talking therapy

Relapse Prevention Plan:

List of my triggers/Stressors for example:

- Interpersonal: sleep difficulties, anxiety/worrying, unpaid bills
- Familial: Partner criticizing me
- Work/social: Not coping with work.

1.
2.
3.

Things I will do to manage my triggers/stressors for example:

- sleep habits
- actively plan how to pay my bill rather than to worry about them or use a budgeting agency.
- communicate with my family/friends about how they might be able to contribute to managing triggers/stressors or family meeting.
- have a work stress management plan, preferably in discussion with my manger.

1.
2.
3.

Things I will like my family/friends to do for me for example:

- encourage me to walk regularly.
- take me to my appointments.
- take to me out for a coffee or church or support group.
- remind me to use my coping strategies.

1.
2.
3.

Things I will like my care team to do for me:

- Help me book appointment with my doctor/psychologist/psychiatrist.
- Involve ……, phone …… in my care when I am really down.

1.
2.
3.

Patients with Respiratory Conditions (COPD/Asthma)

Goals:

- To walk to the RSA at least three times a week to see all my friends by the end of summer
- Reduce or stop smoking/vaping by the end of the year
- To keep active by walking every day
- Stay well enough to keep working
- Be able to walk to…
- Continue playing bowls without needing to sit down

Things I will do:

- Know personal signs of COPD getting worse (i.e., exacerbation) e.g., increased phlegm/yellow/green coloured phlegm/increased shortness of breath/loss of appetite/ a strange taste in mouth/fatigue.
- Act appropriately with early signs – e.g., start course of antibiotics and call practice nurse to notify of this. May increase Ventolin/Atrovent – take regularly for a few days – again personalise this according to patients' disease severity.
- Weight/ ankle check for fluid – if right side heart failure
- Learn how to take my medication
- Take my medications as prescribed
- Seek help early and follow the instructions on my COPD/Asthma Action Plan
- Attend my doctor's appointments or reschedule these as necessary
- Eat a balanced diet and eat small meals frequently
- Attend Pulmonary rehab self-management programme
- If prescribed, I will use my home oxygen as instructed by my Nurse and follow the safety instructions
- Keep a bag packed if hospital stay required
- Get the flu vaccine each year
- Let my GP/Nurse know if I have used my back pocket script

Things my care team will do:

- Check I'm using my inhalers correctly with a spacer if appropriate
- Give me a COPD/Asthma Action Plan
- Refer me to a stop smoking programme – Quit line
- Refer me for a Green Prescription
- Refer to Pulmonary Rehabilitation/Better Breathing – Health pathways.
- Refer me to a self-management programme – Group Self-management e.g., Stanford programme
- Do a lung spirometry testing if appropriate.
- Prescribe treatment according to GOLD criteria – Health pathways.

Patients with Diabetes and Pre-diabetes

Goals:

- Live a long and active life (through better diabetes management)
- Learn more about diabetes
- Stop smoking/vaping
- Exercise daily
- Stop having hypos so I feel safe leaving the house
- Recognise and know what to do when hypos occur
- Lose x kilos
- Plan my meals so I eat healthier food
- Drink water instead of soft drinks
- Improve my cholesterol/blood pressure through diet and exercise

Things I will do:

- Complete my blood tests in a timely manner
- Check my feet each day after my shower
- Have my flu vaccine each year
- Test my blood sugars when necessary and understand what the results mean
- Tell my care team about any problems I am having
- Take my medications as prescribed
- Get my retinal screening done when required
- Come in for my diabetes annual review
- Monitor my weight and blood pressure regularly

Things my care team will do:

- Teach me about my diabetes in a way I can understand
- Provide me with in practice nutrition advice or a refer to a community dietitian
- Start me on insulin – Insulin initiation by PN or DNPP nurse
- Send me for a podiatry referral – If my feet are at high risk
- Send me for retinal screening - Diabetes Retinal Screening Service
- Teach me about diabetes complications in a way I can understand
- Refer me to a stop smoking programme
- Refer me to help to get more active – Green Prescription
- Regularly check my CVD risk, lipids, BP and renal function
- Refer me to a self-management programme – Group Self-management e.g., Stanford course/ Your Life Your Journey
- Teach me about what to do on sick days
- Refer me to someone that can help me cope with my mental health – Health Improvement Practitioner

Patients with Cardiovascular Disease

Goals:

- Learn more about my health condition
- Stop smoking/vaping
- Exercise daily
- Lose x kilos
- Plan my meals so I eat healthier food
- Improve my cholesterol/blood pressure through diet and exercise
- Be able to walk to…

Things I will do:

- Complete my blood tests in a timely manner
- Tell my care team about any problems I am having
- Take my medications as prescribed
- Monitor my weight and blood pressure regularly
- Reduce sodium in my diet
- Reduce processed food in my diet
- Know the signs of my health deteriorating – shortness of breath, fluid retention, chest pain, fatigue and act on symptoms early

Things my care team will do:

- Teach me about my health condition in a way I can understand
- Provide me with in practice nutrition advice or a refer to a community dietitian
- Refer me to a stop smoking programme
- Refer me to help to get more active – Green Prescription
- Regularly check my CVD risk - lipids and BP
- Treat me for high blood pressure / high cholesterol
- Refer me to a self-management programme – Group Self-management e.g., Stanford course/ Your Life Your Journey

Patients who may be at risk of falling

Goals:

- To be able to walk around my home without the fear of falling over
- Continue with my everyday jobs (like hanging out my washing) without the fear of falling and injuring myself
- Walk to the shops each day to collect my paper
- Stay in my own home with support

Things I will do:

- Discuss any fears I have of falling with my Dr or Nurse
- Make my home safer by removing clutter
- Remove non-secured mats or rugs that I might trip over
- Make sure my home is well lit, with good lighting especially on steps/stairs
- Ask my family to help install handrails on stairs and grab bars in bathroom as required
- Make sure I have an annual eye check and get glasses updated as necessary
- Attend doctor or any specialist appointments or reschedule these as necessary
- Attend a falls prevention exercise class at……
- Exercise regularly – needs to be tailored to patient
- Attend a local Tai Chi or yoga class
- Inform my Dr or Nurse if I have a "near fall" or trip
- Take medications and discuss any problems I'm having with my Dr
- Get enough sleep
- Drink adequate fluids each day

Things my care team will do:

- Check my bone health – DEXA scans are not funded
- Refer me to a Physiotherapist for a walking, balance and strength assessment
- Refer me to an Occupational therapist –who will assess my safety needs in my home – Care Coordination Centre
- Review my medicines especially if any of them make me lightheaded or drowsy
- Review my blood pressure when I get up from sitting
- Refer me to a podiatrist to review my feet – if at risk of complication
- Refer me for help to try and get more active – Green Prescription
- Check my weight and refer for dietary advice/supplements as needed
- Reassess my falls risk regularly

Resources for falls prevention for clinicians:

Falls | Health Quality & Safety Commission (hqsc.govt.nz)

Patients with sleep disorder

Patient Goals:

- I would like to get 7 hours sleep at least 5 times a week so that I wake up feeling refreshed and ready for the working day
- I would like to feel refreshed each morning and energised so I can go and do a 30-minute walk or run around the block
- I would like to stop snoring, so I do not keep my partner awake each night
- I would like to stop snoring so that I can sleep in the same room as my partner

Things I will do:

- Reduce my alcohol intake by limiting myself to one beer or wine on Saturday and Sunday
- Reduce caffeine intake
- Get addiction support for drug use
- Establish a regular sleep routine by aiming to go to bed at 10 pm and setting the alarm for 7am
- Create a pleasurable, relaxing nightly routine (e.g., warm milk drink, bath, reading)
- Attend my medical appointments regularly
- Involve my family/support person in my care
- Tell my care team about any problems I am having
- Exercise regularly to stay fit, reduce stress and induce deeper sleep
- Take my medications as prescribed

Things my care team will do:

- Give me some advice on how to get a better night's sleep
- Refer me to a self-management programme – Group Self-management Stanford Programme
- Refer me to someone that can help me cope with my mental health
- Complete an Epworth Sleepiness Score – Health Pathways
- Refer me to a sleep clinic
- Refer me to respiratory clinic if I have sleep apnoea