My Plan

My Plan Manual

This manual is for planning facilitators and anyone else interested in knowing more about My Plan and the My Plan toolkit

4th edition 2022 update.

icare NSW acknowledges the Traditional Custodians, Stewards and languages groups of Australia and we recognise their connection throughout time to lands and water. We admire the collective knowledge, wisdom, strength and resilience of First Nations communities and peoples.

We acknowledge and pay respect to Elders, past, present and those of the future, for they will hold the memories, traditions and hopes of First Nations peoples and culture. We pay respect to our First Nations customers, colleagues, stakeholders, and partners in Reconciliation.

Our offices are located on the lands of the Eora (Sydney), Darkinjung (Gosford), Awabakal (Newcastle) Dharug (Parramatta) and Tharawal (Wollongong) nations.

My Plan Manual

Lifetime Care & Workers Care 4th Edition 2022

The My Plan approach

icare believes that adopting a person-centred approach in all that we and our service providers do will achieve better outcomes for participants and ensure that our service provision aligns with international best practice standards.

My Plan is the person-centred approach to planning for community participation used by icare. My Plan is the toolkit used to assist the person in planning for the things that are important to them – the things that they want to do and achieve and the supports they need to help them reach their goals

My Plan aims to promote a working partnership between participants and their families, icare and service providers. Significant national and international developments and frameworks have informed the development of My Plan.

My Plan was developed for case managers and planning facilitators working with Lifetime Care and Workers Care participants. This manual is to support case managers, icare staff, other service providers and participants and their families to understand the approach of My Plan and the contents and application of the My Plan Toolkit.

Glossary

Term	Definition
Planning Facilitator	The person who assists a participant in developing their plan is referred to as a "planning facilitator" and is usually the person's case manager. Occasionally a service provider or member of the icare staff will act as the planning facilitator – usually when there is no case manager working with the participant.
Case manager	A rehabilitation case manager or a community living facilitator – either employed by icare, by NSW Health or privately; who delivers holistic case management services aligned to the Case Management Taxonomy. Case Managers are usually (but not always) the person who does planning with the participant.
icare contact	The person at icare who has primary responsibility for the participant's file – may be called a Rehabilitation Care Manager, Community Living Facilitator or Coordinator.
Participant	The term "participant" is used throughout this manual to refer to participants of the Lifetime Care Scheme and injured workers in the Workers Care Program. Where the participant is a child, this can be read as "the participant and their parent/s or legal guardian".Where the participant requires support from one or more family members who are involved in their planning, then the term participant is inclusive of these family supports.
My Plan	My Plan is the planning template used for all plan development with participants who require a case management service.
My Plan Toolkit	The My Plan Toolkit includes all forms, templates, Information Sheets and guidance that support person-centred planning in the context of Lifetime Care & Workers Care and also best practice case management for people with lifelong disability and support needs.

Planning facilitator knowledge and skills

Every planning facilitator developing a My Plan with a participant is expected to have knowledge, experience and skills in person-centred, strengths-based planning with people with disability.

For participants with new injuries, planning facilitators are also expected to have relevant injury, and injury-management knowledge; and extensive skills in planning and coordinating complex multi-disciplinary rehabilitation programs using a person-centred approach.

Required training and skill development for the use of the My Plan Toolkit for planning facilitators involves:

- completion of eLearning
- a sound understanding of the key concepts and frameworks outlined in the manual and on the icare website:
    - Person-centred approach and key themes underpinning the approach
    - Writing goals – and the differences between client-generated, client-centred and clinician-generated goals
    - Health Literacy – icare's framework and the case managers role
    - Promoting independence
    - icare Case Manager Expectations
- Understanding of Motor Accidents (Lifetime Care & Support) Act 2006 and/or NSW Workers Compensation legislation and how this relates to the relevant scheme
- Knowledge of Lifetime Care & Support Guidelines

Tip: All of the required training and skill development listed above can be found at icare.nsw.gov.au

Fundamental to person-centred planning for a person with a disability is community participation. Community participation can mean different things to different people, and goals for community participation may change over time. People need to be supported to determine what community participation means for them. Increased community participation in any area of life for a person with a disability could lead to[1]:

- ✓ improved wellbeing outcomes for the person with a disability and their carers (concerning health, employment, education, income and life satisfaction outcomes)
- ✓ reduced longer-term costs of care and support
- ✓ economic benefits for the person with a disability and their family (e.g. work)
- ✓ enhanced social capital for the person and the wider community through inclusion, diversity and breaking down stereotypes
- ✓ creation of better networks among people

It's assumed planning facilitators know of the:

- World Health Organization International Classification of Function & Health (2001) and the biopsychosocial model of health (https://www.who.int/teams/integrated-health-services/clinical-services-and-systems/service-organizations-and-integration)
- World Health Organization Framework on integrated people-centred health care
- (http://www.who.int/servicedeliverysafety/ areas/people-centred-care/en/)
- United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), ratified by Australia 2008 (https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html)
- Australian National Standards for Disability Services 2013 (https://www.dss.gov.au/our-responsibilities/disability-and-carers/standards-and-quality-assurance/national-standards-for-disability-services)

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[1] Productivity Commission Disability Care and Support Report 2011
https://www.pc.gov.au/inquiries/completed/disability-support/report

Contents

PART 1. Principles and approach underpinning My Plan

1.1. Person-centred practice

A person-centred approach in planning for community participation ensures planning facilitators adopt practices that pro-actively consider the person's context, situation, and preferences in all decision-making.

Person-centred practitioners holistically look towards the person's aspirations and goals for participation in life, their preferences for strategies to meet these goals, and how to actively support them to be involved in planning and identifying supports.

icare has adopted five key messages which articulate the person-centred approach taken in My Plan (see Figure 1 – Five key messages of the person-centred approach).

Five key messages				
Hear, understand and respect the person and their context	Assist the person to utilise their strengths and to build capacity with their supports and the community	Assist the person to identify and aim for supports that are tailored to their individual needs	Assist the person to facilitate and promote their opportunities, rights and responsibilities	Assist the person to review progress so that supports can be refined

Figure 1: Five Key Messages of the person-centred approach

Best practice tells us that reflective listening and motivational interviewing techniques are helpful tools to engage participants in meaningful conversations. These techniques can create conditions that lead participants to identify their personal strengths and set their own goals in a respectful and safe environment.

Sometimes the participant is unable or unwilling to engage in meaningful conversations for planning. Engaging the person closest to the participant in conversations about what is meaningful to them in this situation is appropriate.

Applying these principles in practice means that:

- Case managers and planning facilitators listen and do not make assumptions about what might be best for a person. Person-centred practise includes understanding the person by listening to their words, developing shared meaning, and respecting that all people experience similar circumstances differently.
- People are supported to identify their strengths and natural supports within their family, social groups, and their local community. While assisting people via paid supports is often necessary to enable a person to be independent, we should always look for ways to enable a person to manage without paid supports and increase self-efficacy.
- People are supported to build Health Literacy by increasing their understanding of their injury, strengths, and context to achieve self-efficacy. They utilise their strengths to:
    - achieve goals,
    - identify and engage with supports they need, and
    - appraise supports they are involved with against their progress.

- For most people, developing an understanding of what services and supports are available takes time. Service providers and case managers can assist people in identifying their needs and providing relevant information regarding individual strategies, supports, programs, and services available to support the person in identifying the best way to meet their individualised needs.
- Reviewing progress allows a person to more objectively see how their progress or situation has changed over time. It can allow people to understand that progress has been made when they may feel that nothing has changed. Reviewing progress assists the person in reconsidering the support they may currently have in place.
- Active involvement of participants in planning means they and their families have opportunities to think about their aspirations and goals, make decisions, take on responsibilities and contribute to planning and solutions that support them to reach their goals. Ideas that use their knowledge of, and supports within their local community can often be the most useful.

Participation and engagement in planning (to the extent possible) is beneficial as it:

- enhances the participant's self-awareness and self-identity
- supports them and their family to adjust to changed life circumstances following a significant injury.

1.2. Choice and control

For any person, active involvement in life means having the opportunity to exercise choice, make decisions, and accept the associated responsibilities. Choices might be everyday choices (like what to have for breakfast), lifestyle choices (like how to spend your spare time) or pervasive choices (like where to live).

We have adopted the seven guiding principles around choice, control, and responsibility (see Figure 2).

People, including people with disabilities, are the experts about themselves and their situation, and should be viewed as such

Services available are flexible, and tailored to meet individual needs

People should have the opportunity to direct their assessment, plan, service provision and review, with as much support as required

People have the right to take risks and make what others may consider to be an unwise decision

People are at the centre of their decision-making, with as much support as required

People are part of an inclusive society and should be able to access their local community on an equal basis with other citizens

People receive sufficient accessible information and support to make informed choices

Figure 2: Seven Guiding Principles of Choice and Control

Planning facilitators require skills to enable participants to exercise choice, to ensure choices are well informed and to assist participants to be actively involved in identifying steps to achieve their chosen goals. Facilitators might also need to help manage expectations, discuss potential risks, or adverse outcomes, and help participants find ways to mitigate or manage risk within their choices.

Tip: More information about balancing Risk Enablement with Duty of Care in supported decision-making is available in the My Plan Toolkit Information Sheet MPI006 – Balancing dignity of risk and duty of care – providers.

How does the choice and control theme affect what icare will fund?

It's important to distinguish between enabling participants to exercise choice and control and raising unreasonable expectations about which of these choices icare will be able to provide funding for. All requests for funding are assessed against the relevant legislation and guidelines.

Planning facilitators assist participants in understanding the practical application of the Guidelines to their own goals and circumstances.

1.3. The Rehabilitation Continuum

My Plan should meet the participant's individual needs at any given point in time post-injury and in their personal circumstances. This means that the way a My Plan looks and the goals and steps included will differ between participants and over time for one person.

Following a severe injury, goals for community participation usually (but not always) move through a continuum which may start with a focus on injury recovery and resumption of pre-injury activities and roles. Over time, and with support and guidance to increase understanding of the injury and any resultant disability, the person will gradually but ultimately move to expressing goals that reflect adjusted life roles and maintaining a possible new, chosen way of life. (see Figure 4 – Rehabilitation Continuum).

My Plan is designed to be useful across this continuum and encourage participants and their families to determine what they consider community participation means for them at any point in time.

Continuing my recovery

adjusting to and settling into living at home and doing activities following severe injury

My Participation

participating in my chosen activities and major life areas - education, work, community, social life

Maintaining my way of life

living life, maintaining my health and well being

Figure 3: Rehabilitation Continuum

During the **“continuing my recovery”** phase (or Phase 1), plans may have a heavier emphasis on rehabilitation. Participants and their families may naturally seek the expert advice of their treating team regarding their goal choices and support needs. In some cases, participants may not feel ready or able to contribute towards determining their own goals and may prefer that clinician-generated goals are used.

Many participants, however, can and do wish to be actively involved in identifying goals and strategies quite soon after severe injury.

Case managers will generally be the planning facilitator during the early phases and should incorporate feedback from the rehabilitation team into their planning conversations.

Effective engagement of the participant in My Plan throughout their continuing recovery period will enable them to be more directive as they move into the **“my participation”** phase (or Phase 2).

As participants learn more about their injury and any related disability, their focus can move to resuming previous life roles and interest in new or altered roles and activities. While therapy tends to continue as a priority, people are often more able to articulate their goals, determine their priorities, and choose which supports are most suited to their needs.

Improved insight, adjustment to disability, self-efficacy, and confidence mean people can develop a stronger desire to direct their planning.

Case managers can begin the process of disengagement with many (but not all) participants as they take on the primary role in managing their supports.

By the time **“maintaining my way of life”** (or Phase 3) is reached, participants may have little, or no therapy supports in their plan. The style and content of the plan may be very different to that developed in earlier stages. There may or may not be a need for a case management service to support plan implementation. Plans are likely to go for much longer at this stage.

The My Plan template is designed to be flexible and accommodate the range of styles and inclusions across the rehabilitation continuum.

Many participants may not require a plan when in phase 3 (and sometimes earlier). Where a community case manager is engaged to support the participant, then My Plan must be used to communicate the role that the case manager is fulfilling.

1.4. People involved

A range of people may be involved in the planning process – including but not limited to the participant themselves, their family, the case manager, therapists, icare staff and/or care staff.

The planning process must involve and engage the participant to the extent possible.

The participant has ownership of the plan and all sections of the plan. Optional tools in the Toolkit are phrased in such a way as to seek and facilitate the participant’s words and input.

A participant may need or choose to have a family member or other nominated person's assistance for planning. My Plan for children should represent both the child’s and the parents’ perspectives.

Where therapists provide rehabilitation services, they are expected to report on progress towards goals and this feedback should be shared and discussed with participants to assist in future planning. Therapists should also receive a copy of the My Plan to understand how their service provision fits within the context of the person’s aspirations and goals.

1.5. Plan duration

The duration of plans will vary from person to person and over time; and is dependent on what seems a reasonable period to see progress and predict service needs.

Typically, change and achievement occur more quickly in the “continuing my recovery” period. The person’s response to therapy slows, or the nature of their goals changes to longer-term participation-based outcomes (rather than short term improvements in function).

The shortest period for a plan is 4 months. This gives participants and their service providers time to employ strategies, review progress and develop new goals. After the first 2 years following injury, most plans are for 12 months but could be for up to 2 years.

Case managers and participants need to consider an appropriate time frame for review of progress towards goals and review of the plan as goals are met or change.

1.6. Goal setting

A goal is the object of one’s ambition or effort, the desired end, or an intended outcome.

Supported and assisted by the planning facilitator, the participant identifies their aspirations and describes their goals. It’s important that participants and their family know that if some goals are identified early, they might change over time.

Planning facilitators should support participants to consider first what they will do to help achieve their goal. Participants can also identify other strategies and supports needed to help progress toward their goals through discussion.

In the case of a young child, the goals and strategies may ultimately be the parent’s decision, but the child should contribute their view to how they believe they can move towards their goal achievement.

There are many ways goals may be presented. Primarily, they should be meaningful to the participant and preferably generated by them and presented in their voice. Case Managers may also contribute to goals.

Tip: More information on what to consider in writing goals with a participant is available in Information Sheet MPI010 – Writing Goals in My Plan.

Example – Ryan

Ryan is a 16-year-old participant and continues to experience problem-solving and memory difficulties that affect his school work. He has been back at school for 1 month and is 4 months post-TBI. He is preparing his first My Plan.

Mathematics makes Ryan anxious, and he is aware of his errors. Before his injury, he did well in the subject and has resumed his place in the top maths class.

Ryan has stated that he does not want to continue with maths and wants to change subjects. Ryan's parents want him to continue studying the same maths level as he did pre-injury.

The case manager needs to help the family manage these emerging differences in choices and aspirations while still respecting the parent's role in guiding their children's decisions, such as subject selections at school.

At 16 years, Ryan is capable and should be involved in setting his goals. However, several factors might mean that the case manager needs to negotiate the nature of the goal with Ryan and his parents.

Some of these factors may be:

- Ryan is in the early stages of recovery following his injury, and there is significant potential for improvement.
- Ryan has missed several months of school and may need some assistance to catch up on work that he has missed.
- Ryan may be expressing a very real choice – his interests and academic goal may have changed since his injury. His parents may not be aware of these changes yet.
- Ryan's parents need to be heard and be involved in decision-making. Ultimately, they are still the legal guardian for Ryan and have a role and responsibility in all school and rehabilitation decisions.
- It's possible that Ryan didn't want to study maths before his injury, but his parents influenced the decision, and he may see his new circumstances as an opportunity to re-visit this decision.
- While Ryan is expressing anxiety, it is unknown whether this is related to real or perceived reduced capacity. No assessments have been completed since his return to maths class.

The issue may be anxiety, as opposed to capability.

A skilled case manager will capture Ryan's and his parent's views regarding goals for schooling. They will negotiate a goal with steps that may not be specifically about which subjects he will drop and take up – but around catching up, re-assessing capacity, providing learning support, and maximising recovery. There may be consideration of using the school counsellor or a vocational counsellor to assist with this process.

Once Ryan, his parents, his school teachers and his therapy team have a better understanding of Ryan's potential for mathematics, a consensus between Ryan and his parents regarding subject selection may be more readily achieved in a future plan.

Example – Cyril

Cyril is a 23-year-old participant who had a severe TBI 2 years ago, resulting in significant physical, cognitive and behavioural impairments. Cyril uses a wheelchair for mobility but needs assistance with his transfers.

Cyril lives with his mother and has support for all his activities of daily living from support workers.

The case manager finds it challenging to engage Cyril in planning and goal setting due to his short attention span, agitation and fixation on his goal to 'get a girlfriend'.

The case manager has talked to Cyril about what is important to him and included his aspirational goal of getting a girlfriend in his My Plan.

The case manager has identified from the therapy reports that Cyril needs to improve his physical fitness and mobility for transfers. While Cyril does not have any insight into this, he does participate in therapy.

The case manager discusses this with Cyril and his mother and includes a therapist-generated goal in the My Plan, along with Cyril's continued participation in therapy and the detail of what therapy will be requested to support the goal.

1.7. Utilising "supports"

Case managers and planning facilitators must understand the participant in the context of their family, friends and community and the range of supports they have in their life.

"Supports" refers to those informal (unpaid) and formal (paid) supports which facilitate and enable a person to perform activities and participate in various life roles within their family and their community.

1.7.1. Informal supports

Informal supports are arrangements that form part of family or community life. They are resources such as someone who performs a task or service that enhances the person's quality of life and security but is not paid.

Informal support is typically "ordinary" and less structured than formal support and may be ad hoc. The maintenance and development of a person's informal support network is an integral part of community participation and integration following a severe injury.

Examples of informal supports include:

- A next-door neighbour offering to put a person's rubbish bins out each week when they are putting their own bins out.
- Another parent offers to collect a person's child and drive them home after their children have been to sports training.
- A neighbour who collects the mail from the post office and drops it into the person on their way home.
- A brother who has always mown the lawns for the person and is happy to continue doing so.
- A grandparent who looks after a grandchild 2 days/week while the person works.
- Friends who offer to take the person with them when they go out dancing on a Saturday night so the person can socialise safely.

Frequently, people receiving informal support from family, friends or others in the community will seek to reciprocate support, giving the person a sense of value, equal contribution and recognition. For example:

- A friend giving the person a lift to their weekly bridge club. To reciprocate the favour, the person might buy their friend a cup of coffee once they are at the club.

Participation in, and membership of, clubs, interest groups, organisations, classes/ education, volunteer work programs and other civic activities often result in a network of informal supports. This network can be referred to as a "circle of support".

While the participant's network may provide the opportunity for support, it does not necessarily result in actual or consistent support and so cannot be presumed. Some informal supports will remain available to the individual following severe injury. Others may need to be re-established or re-negotiated, as circumstances and opportunities for reciprocation may have changed.

Sometimes, strategies may be adopted to enhance the range or type of informal support for participants and their families. Examples may be:

- intentional approaches to community groups (e.g. Scouts)
- formally establishing a circle of support (for the participant and/or informal support person/ family)
- involvement in structured peer support groups or networks.

Strengthening a participant's informal support network can be a vital part of their journey back to living an adjusted life and gaining independence. While icare values informal support's role in a person's life and community, it does not expect informal support to replace formal supports where funded support meets treatment, rehabilitation, and care guidelines.

1.7.2. Formal supports

Formal support is a job, duty or task completed by someone for another, for which they receive payment. The support may be paid by the participant, their family, or icare (where the support relates to providing treatment, rehabilitation, or care related to their injury). The support is usually organised or structured.

Some examples of formal supports include:

- agency care support – assistance with self-care, household duties, mobility and moving around the community, leisure, and community participation
- health & allied health services – such as physiotherapy, counselling services, podiatry, or medical reviews
- services to support wellbeing and health - such as gym memberships or Pilates classes
- support in education or employment – such as a classroom assistant or personal support in the workplace
- communication support – such as written information, education and explanation of documents, sign language or other language interpreters
- information and advice services – including advocacy and supported decision-making

Just because a support is formal (i.e. paid for) does not mean that icare is responsible for funding it. Some formal supports were used pre-injury or are considered everyday supports. Some formal supports may also be injury-related but outside the scope of icare funding guidelines (e.g. solicitor's fees to help manage a CTP claim). Others will be funded through alternative government or non-government agencies.

Examples of formal supports that the participant or their family may pay for or are funded by the Government, the commercial sector, or NGOs include:

- after school care
- public transport to get to work and leisure activities
- public or private school education
- music or sports coaching

Recent research documents the views of users of support services and suggests that:

- Participants can view formal supports in three ways – as a right, complement to other arrangements, or intrusion into their personal life.
- Formal support can enhance the quality of relationships with informal support people, as the informal support people are then not obliged to provide all the primary care.

Example – Margaret

Margaret is 53 years old. She worked full time as a Vet Practice receptionist pre-injury and is currently on a graded return to work program (3 days/week). She has paid for a domestic cleaning service for 2 hours/week for 20 years.

Since her injury, Margaret has found that there are additional household domestic chores that she cannot manage. These include changing bed sheets and hanging linen on the clothesline, spring cleaning tasks and some of the gardening and lawn mowing that she enjoyed doing herself pre-injury.

Margaret also has a large pet dog which she currently does not feel she can manage for regular walking.

Margaret identifies her responsibility in continuing to fund her regular cleaning service. She is reluctant to cease this arrangement as she anticipates being able to resume many of her domestic duties in the future but would like to retain her cleaner in the long term, particularly as she returns to work.

She recognises her need for additional formal support with some domestic tasks and will include this in her care needs request to icare.

Margaret stated that next door is a 17-year-old boy who lives with his family and who she is friendly with. He is often out walking his dog at the same time as herself. She has looked after her neighbour's dog when they have gone on holiday. Margaret feels confident that her neighbour would walk her dog for her until she is stronger.

Exploration of these formal and informal supports helps Margaret articulate some of her goals: resuming full-time work, managing her domestic responsibilities, and being strong enough to walk her dog. Therefore, other formal supports identified in the planning process include physiotherapy and a gym membership to work on range of motion, strength, and endurance.

1.8. Ending planning

Participants who do not wish/need to request any services through icare may choose not to participate in My Plan. Approximately 50% of people over 8 years post-injury in Phase 3 on the rehabilitation continuum and who no longer require a case manager do not have a My Plan.

All participants have the right to choose to participate in planning. My Plan is, however, the primary means by which participants lodge a request for icare funding of formal supports, so usually a participant with a need for treatment or rehabilitation funding will have a plan.

PART 2. The My Plan Framework and Toolkit

The My Plan toolkit includes:

- the My Plan Framework
- the My Plan template and Request for Funding
- a series of optional Forms to support best practice across the phases of the My Plan cycle
- Information Sheets to support the application of the Forms and best practice planning and case management

My Plan can be used with both adults and children.

The My Plan Framework is designed to support the person-centred approach to planning.

The framework is designed to define objectives and assigned roles and responsibilities of three in-distinct stages in planning. Its cyclical structure demonstrates that planning is an ongoing process, with the completion of one plan seamlessly informing the commencement of the next:

1. Active involvement in **planning preparation** by all parties is key to maximising engagement – and thereby maximising input by, and outcomes for, participants across plan development and plan implementation
2. **Plan development** is a collaboration between informed and engaged parties and includes the identification of personal strategies to facilitate goal achievement
3. **Plan implementation** requires a clear allocation of responsibilities and conscious, proactive investment by all parties to ensure strategies are completed, and goals are achieved. Regular monitoring across the plan period is essential to ensure momentum and progress.

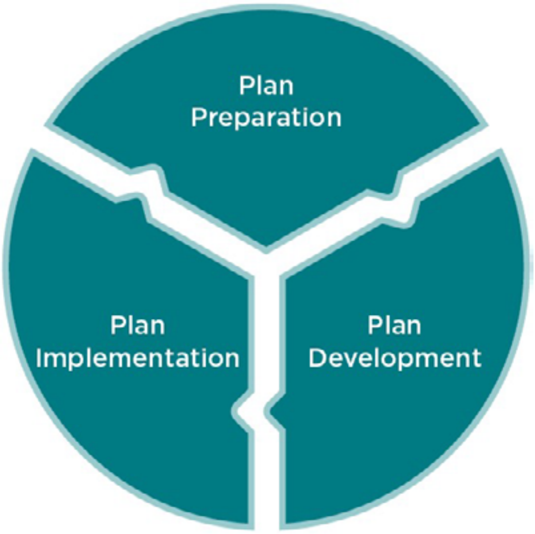


Figure 4: My Plan Framework

The 3 segments of the framework will require different types and intensity of attention for individual participants depending on their circumstances and their level of interest and involvement in their plan preparation, development, and implementation.

While the framework segments are the same size, this does not represent an equal time for each segment but rather equal importance to achieving person-centred planning.

Framework cycles have no pre-determined timeframe – it may be a 4-monthly cycle or up to a 2-yearly cycle. The length of a cycle may change as the person’s planning needs change. Experience with My Plan shows that most plans after Lifetime Participation has been achieved are for 12 months. Therefore, case managers and Planning Facilitators are welcome to work with the person on an annual My Plan cycle.

For each phase of the My Plan cycle, the participant's and case manager's roles and responsibilities are identified. A range of Forms and Information Sheets are provided on the icare website to help support the implementation of these roles and responsibilities.

2.1. Plan Preparation

Role of the person (and/or their family) during Plan Preparation	Role of case manager during Plan Preparation
• read / review previous plan / goals • consider their progress towards their goals • reflect on own efforts and strategies to facilitate personal goal achievement • reflect on the services / strategies from other service providers and how effective these were in supporting goal achievement • use the Plan Preparation Tool from the icare website OR as provided by the case manager to think holistically about their previous plan goals, strategies and outcomes, and make notes (if desired) to take with them to their Plan Development meeting • consider what level of involvement they want in their next plan development – do they wish to try writing it themselves? Do they want any involvement at all? • consider what type of goals they might like to include in their next plan – just rehabilitation or perhaps some quality of life goals as well • consider who to involve in the next plan development	• ensure the person and their family understand the My Plan purpose and approach and can access Information Sheets to help their understanding • provide the person with a copy of the previous plan / goals if they don't have this available for review • provide the person with a Plan Preparation Tool – either the standard template or create a bespoke sheet with targeted questions and prompts • determine the level of involvement the person wants in their next plan development (do not assume that it is the same as for the previous plan) • ascertain if the person is happy / able to complete their Plan Preparation independently, or if they require / want support from someone to do this (and who – family, friend, case manager) • collect and review progress reports and feedback from all services involved in the previous plan / DSN – and from any services added via Service Request during the My Plan period • consider your role as a case manager across the previous plan period – are there opportunities to reduce reliance on the case manager? Has case management considered all domains of the CM taxonomy? • review other programs / supports the person may be receiving, e.g. care needs program, schools, Positive Behaviour Support program • consider any tools which might support best practice person-centred planning and maximising engagement • read / review previous plan / goals & consider progress towards goals and effectiveness of the strategies used • ensure review of the previous plan period includes a review of any additional services added throughout the plan period (and may therefore not appear in the previous My Plan) • have conversations with the person and / or their family that will promote their self-reflection and awareness of factors that might influence their next plan development

Tools to support Plan Preparation*	
• Plan Preparation Tool – standard template • Plan Preparation Tool – bespoke template • Therapy Progress report template • Conversation tools: ◦ Activities and Participation ◦ Personal considerations ◦ Current living arrangements ◦ Thinking about you *all tools are optional	• My Plan to Keep me Safe • My Plan to Manage My Affairs • Quality of Life measures such as WHOQOL and KINDL • Health Literacy Assessments such as CHAT • Outcome rating scales such as Goal Attainment Scale / MPAI - 4

2.2. Plan Development

Writing the My Plan commonly occurs in a face-to-face meeting between the person (and their family as appropriate) and the case manager.

Key elements of Plan Development include:

- sharing what they learned / concluded from their Plan Preparation
- going through the previous plan and agreeing on outcome ratings for goals (including any goals added via Service Requests during the plan period)
- discussing the strategies used to achieve goals, considering the feedback from providers and agreeing on outcome ratings for the strategies (including any services / strategies added via Service Requests during the plan period)
- identifying goals that were not achieved and having candid conversations about whether the goal was realistic should be modified or is no longer a goal
- identifying goals that need to be carried forward and why
- identifying new goals for the next plan period
- determining if a new plan is required
- drafting the next My Plan
- discussing what the case manager role may / may not need to include in the next plan period – and what the person will do / manage for themselves.

Options for drafting My Plan include:

- participant/injured worker drafts their plan, and it is refined in Plan Development discussions with the case manager ahead of submission to icare
- participant/injured worker and case manager draft the plan during Plan Development, with case manager further refining before submission to icare
- case manager writes the My Plan and sends it to participant / injured worker for endorsement before submission to icare
- case manager writes the My Plan and submits it to icare (the person and family have no interest / desire to be involved, or it is impossible to involve the person).

Tools to support Plan Development

- My Plan template
- My Planned Supports (internal use only)
- Request for Funding – Lifetime Care
- Request for Funding – Workers Care
- Goal Summary Sheet
- My Plan to Keep me Safe
- My Plan to Manage My Affairs
- Selecting service providers information sheet
- Writing goals for My Plan information sheet
- Promoting independence information sheet

2.3. Plan Implementation

Once the plan is written and associated services have been approved by icare, plan implementation commences. The implementation roles and responsibilities of those involved should be clear from the plan.

Periodic monitoring and review are essential to ensure the plan remains on track and is amended as needed. A range of actions and processes may be used to ensure effective plan implementation, such as:

- periodic case conferencing
- periodic progress reports from service providers as agreed in the My Plan
- regular consultation between the case manager and participant/injured worker as agreed
- submission of Service Requests if additional services are required throughout the plan period
- ensure all service providers involved understand the plan goals and their role in working towards the goals
- ensure all service providers involved understand how to work effectively with Lifetime Care/Workers Care, our systems and our processes

Tools to support plan implementation

- Working with Lifetime Care & Working with Workers Care booklets
- Information Sheets to support best practice case management:
    - Working with Aboriginal and Torres Strait Islander People
    - Mandatory reporting
    - Dignity of risk v duty of care
    - icare Health Literacy Framework
    - Case manager role in health literacy
    - Telehealth practice guide
    - Promoting independence
    - Positive behaviour support Framework and guidance

PART 3.Completing the My Plan Forms

Part 3 includes information and advice about completing the My Plan forms.

Information on the following forms is included:

- My Plan
- Request for Funding – Lifetime Care
- Request for Funding – Workers Care
- Goals Summary Sheet
- Plan Preparation – Template, First & Next
- Meaningful Conversations
    - Activities and Participation
    - Personal considerations
    - Current living arrangements
    - Thinking about you
- Assessment Tools – WHOQoL and CHAT
- My Plan for Keeping me Safe
- My Plan for Managing my Affairs

3.1. My Plan form and My Plan guidance

My Plan Form is available on the icare website https://www.icare.nsw.gov.au/practitioners-and-providers/forms-and-resources/

Form MPF001
Form for Lifetime Care and Workers Care

My Plan

Person's name
icare reference number
Date of birth or age
Plan number
Plan Period
From: Enter a date. To: Enter a date.
Plan length (weeks)
Person's address
Date of injury
Interim (with end date) or Lifetime
Injury type and CANS level or ASIA score (if applicable)
Name of family member or nominated person & contact details
Relationship to person
Name of icare contact & contact details
Name of case manager / planning facilitator & contact details

1. Reflection summary

Capture below, a summary of reflections from your review of the previous plan period. (Summarise the insights gained from your Plan Preparation).

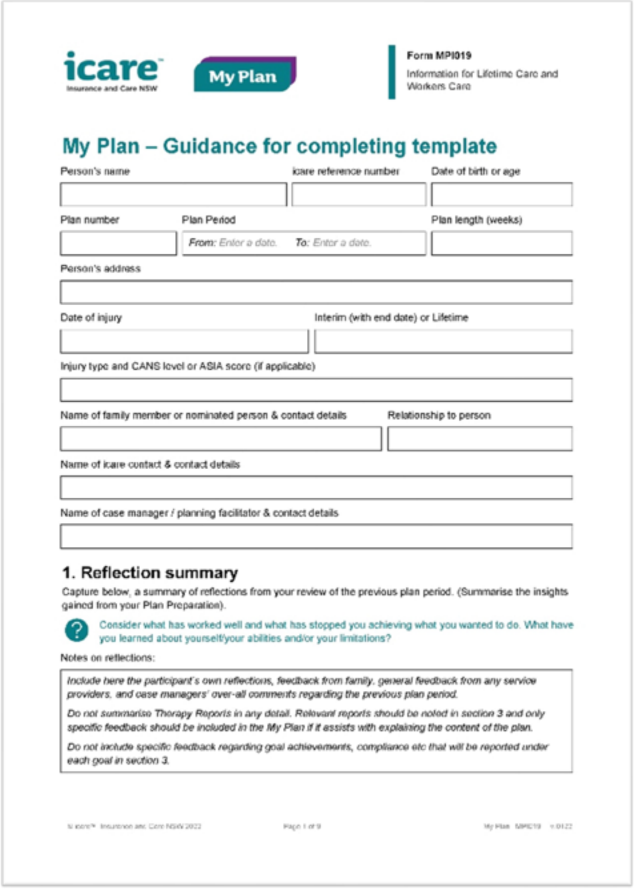
Consider what has worked well and what has stopped you achieving what you wanted to do. What have you learned about yourself/your abilities and/or your limitations?

Notes on reflections:

2. Aspirations

Think about your hopes for the future and the things you are looking forward to doing or achieving in the future. Thinking about these aspirations can help you decide what you'd like to focus on in your next plan.

My Plan template guidance instruction is available on the icare website https://www.icare.nsw.gov.au/practitioners-and-providers/forms-and-resources/



Form MPI019
Information for Lifetime Care and Workers Care

My Plan – Guidance for completing template

Person's name
icare reference number
Date of birth or age
Plan number
Plan Period
From: Enter a date. *To: Enter a date.*
Plan length (weeks)
Person's address
Date of injury
Interim (with end date) or Lifetime
Injury type and CANS level or ASIA score (if applicable)
Name of family member or nominated person & contact details
Relationship to person
Name of icare contact & contact details
Name of case manager / planning facilitator & contact details

1. Reflection summary

Capture below, a summary of reflections from your review of the previous plan period. (Summarise the insights gained from your Plan Preparation).

? Consider what has worked well and what has stopped you achieving what you wanted to do. What have you learned about yourself/your abilities and/or your limitations?

Notes on reflections:

Include here the participant's own reflections, feedback from family, general feedback from any service providers, and case managers' over-all comments regarding the previous plan period.

Do not summarise Therapy Reports in any detail. Relevant reports should be noted in section 3 and only specific feedback should be included in the My Plan if it assists with explaining the content of the plan.

Do not include specific feedback regarding goal achievements, compliance etc that will be reported under each goal in section 3.

3.2. Request for Funding – Lifetime Care / Workers Care

Any supports that require a request for funding by icare must be included in the relevant request for funding form and submitted along with the plan.

Attendant care supports are NOT included as part of My Plan, as these will continue to be assessed and requested using the Care Needs Assessment and Attendant Care Service Request. The cost of care needs assessments should not be entered into the funding request, as these assessments are initiated and managed by icare.

The Request for Funding form is an Excel spreadsheet with calculations embedded.

It allows you to enter either a flat rate fee or hourly rate along with the hours requested.

When selecting service providers during Plan Development, the case manager is responsible for ensuring that:

- the participant and their family have been engaged in the selection of service providers to the extent possible
- all services identified as part of the plan have been included in the Request for Funding
- service providers listed are qualified to provide the services requested
- the location of the provider is appropriate for the participant to access the service
- the correct service codes have been used, and the information provided is complete
- service providers requested do not represent a conflict of interest.

Case managers need to think about how they can engage and support the participant in selecting service providers as part of the plan.

Tip: Information Sheets MPI017 and MPI018 are available on the icare website to assist participants and workers (respectively) in selecting their service providers.

Completing the Request for Funding - Lifetime Care

- select the correct code and service type from the drop-down menu
- add complete information about the service provider. This is essential as we will use this information to generate a purchase order to send to the provider. Complete details including:
    - name including title, surname (correctly spelled) and either first name or initials
    - practice/ business name as will be invoiced to icare
    - business address
- include the number of hours being requested under each code
- provide details of the service provider’s hourly rate, GST inclusive.

Completing the Request for Funding - Workers Care

- begin entering either the code (if known) or the service type, and then select the correct code and service type from the drop-down menu
- add complete information about the service provider. This is essential as we will use this information to generate a purchase order to send to the provider. Complete details including:
    - name including title, surname (correctly spelled) and either first name or initials
    - practice/business name as will appear on the invoice to icare
    - business address
    - SIRA/Medicare registration number
    - the number of hours being requested
    - the service provider’s hourly rate, GST inclusive.

Tip: Go to icare.nsw.gov.au > Invoicing & Payment page for more information about submitting invoices and to access the current payment codes

3.3. Goals Summary Sheet

The Goals Summary Sheet is a one-page document that can be used for participants who do not wish to have a copy of their complete My Plan.

It includes space to record what the participant identified as their actions and responsibilities for working towards their goals.

It is a useful quick reference for monitoring plan progress and to assist with reflection as part of the next Plan Preparation.

3.4. Plan Preparation Forms (self-reflection sheets)

Three versions of an optional Plan Preparation “reflection tool” are provided.

All the forms are used to achieve the same purpose, and case managers are encouraged to select the version that best suits the participant's circumstances and needs.

The Plan Preparation reflection tools are designed to engage participants and their families as much as possible in their planning.

TIP: **Plan Preparation TEMPLATE** is a generic form of common questions/topics to guide participant reflection. Participants can access this form on the icare website, or case managers can provide them with a copy – digital or printed.

My FIRST Plan Preparation Tool and My NEXT Plan Preparation Tool

These two Plan Preparation forms are the same, but the language varies such that the FIRST tool is for use before the first plan development, and the NEXT tool is for use with all subsequent planning.

The forms should be used flexibly depending on the participant's relevant information. They include a wide range of optional prompt questions and topics (and different versions of similar questions), which case managers may wish to include in an individual’s reflection tool. Case Managers are encouraged to **select, delete, amend, and add** questions and prompts before giving one of these forms to the participant.

Case managers should ensure any potentially triggering questions / prompts are removed.

All Plan Preparation reflection sheets are designed for use before and during Plan Development meetings. Participants can peruse/complete them digitally or using a printed copy. It is helpful for them to bring their notes to the Plan Development meeting.

The participant may need support to complete this reflection activity in some cases. Case managers may use the sheets to guide a conversation about each of the topics, preferably in a separate meeting before Plan Development, so that the participant has time for thorough reflection before Plan Development.

icare does not need to receive a copy of this completed reflection sheet.

3.5. Conversation and assessment tools

A range of prompt sheets are included to support case managers in having meaningful conversations with participants on a range of self-awareness topics. These conversations may occur throughout Plan Preparation or Plan Development; however, they can be used at any time in the My Plan cycle.

While not compulsory and not used by everyone, these tools have been found to assist in initiating difficult conversations and guide new case managers in the types of questions to ask when assisting participants in building self-awareness.

The conversation tools now available in the toolkit are:

- Activities and Participation
- Personal considerations
- Current living arrangements
- Thinking about you

icare does not need to receive a copy of any of these conversation tools when used; they are provided to support case managers having difficult conversations.

Links to a range of assessment tools are also provided on the icare website. This includes:

- WHOQoL and KINDL
- Health Literacy – CHAT tool

Tools to promote meaningful conversations

Activities and participation

The activities and participation tool helps the participant and their family explore and articulate their own assessment of the frequency and range of support needed to complete activities and participate. It considers the following areas:

- communication
- moving around
- self-care activities
- learning and daily routines
- responsibilities at home
- major areas of life.

This tool may be helpful during Plan Preparation to guide candid conversations about functional abilities and limitations, help to share progress, and begin framing new goals for the next plan period.

It can help identify any issues around insight, risk aversion, confidence, and self-awareness and provide a visual representation of strengths and capabilities within the context of independent living.

Personal considerations

The personal considerations tool focuses on the participant's responses to what is happening around them. It considers how they adjust to or accept any short and/or longer-term changes they have experienced.

Getting input from family is an integral part of this conversation, especially when the participant is a child.

Detailed responses may be difficult for people with a new, serious injury. A skilled case manager will re-phrase the scripted questions to be most meaningful to the participant and will, over time, assist the participant in fully exploring their responses.

Current living arrangements

It is widely recognised that family circumstances can impact progress and planning following a severe injury. The current living arrangements tool allows the participant, their family, and the case manager to explore current family and household supports and identify any potential barriers that may impact the recovery and planning process.

Thinking about you

This conversation tool supports using a strengths-based approach in planning, exploring the participant's strengths (and their family) and building on these. Strengths-based approaches actively find, direct and support the participant's capabilities and potential for activities and participation.

Identifying and talking about one's strengths can be unusual, and participants and families may initially find this challenging. In early planning conversations, participants may tend to see only what they cannot do because of their injury and may be more inclined to leave goal setting up to their treating team. A skilled case manager guides the identification of strengths and builds upon the participant's ability to recognise their strengths and use these to expand their goals.

The scripted questions in this tool rely on the skilled case manager re-phrasing questions to engage the participant in the conversation. Explanation, prompting and using information gathered from others (family, friends, treating professionals) may be needed to realise the potential of this tool.

Assessment Tools

Quality of Life measures such as WHOQOL and KINDL

It is valuable to explore a participant's perceived wellbeing and quality of life as this can contribute to planning and identifying goals. While a case manager may have concerns about exploring these topics with some participants (a couple of questions are quite intimate), many more participants will value the time to consider and share their current quality of life assessment. Annual assessment of quality of life can assist both the participant and the case manager in identifying positive outcomes related to program delivery or deteriorations in scores on one or more domains that may indicate specific supports are needed.

TIP: The WHO-QoL and KINDL are offered on the icare website after an extensive literature review to determine the most appropriate tools for measuring the quality of life for Lifetime Care participants and injured workers in the Workers Care program. Calculators for the WHOQoL and the KINDL are also available on the icare website to enable the calculation of the scores.

Health Literacy Assessment

The Conversational Health Literacy Assessment Tool (CHAT) is a quick health literacy conversation tool that anyone can use to assist with:

- identifying health literacy support needs
- identifying barriers and challenges across the four categories of health literacy (access, understand, apply, and appraise) which may be preventing the person from managing and maintaining their health
- managing health literacy challenges and needs in a conversational way
- building rapport and trust
- delving beneath superficial responses to health and wellness questions to better identify possible challenges
- increasing understanding of the person's context to inform planning and case manager role

The CHAT is a series of ten open-ended questions across five domains. It's not intended to provide a score or "measure" of health literacy. Instead, it enables an open and thorough discussion that reveals health literacy information is key to promoting self-efficacy and independence.

The CHAT is an optional tool to use throughout the My Plan cycle to assess the participant and their family's health literacy and inform case managers on areas of health understanding and management they may need to address through planning and rehabilitation.

Where you identify a gap in the person's health literacy on one or more domains, you can build remediation strategies into the next My Plan.

3.6. My Plan to Help Keep me Safe

Having plans and strategies to manage different emergencies is recommended for any person.

For a person with a significant disability, it is critical that there are plans in place in case of an emergency. The family and those working with the participant are aware of the plan and its location.

Emergencies can arise from natural disasters, personal health complications, environmental safety issues, essential assistive technology failures, or even failure of a support worker to arrive for shift (due to illness or accident).

Emergencies can arise within the person's home or out in the community.

This supplementary plan assists participants in considering all potential risks in their personal and environmental context, identifying what they can do to safeguard against risks, and managing should they experience an adverse event.

While icare does not need to receive a copy of this plan if used, it may benefit the icare contact, so they are fully informed about potential risks and safeguarding plans for the participant should they experience an adverse event.

3.7. My Plan to Manage My Affairs

This supplementary plan aims to support the participant (and, where relevant, their family) to explore their preferences and support them in preparing for a deterioration in health or potentially dying.

It can be used at any time appropriate for the participant and their family. It covers conversations on the following topics:

Future living arrangements if the participant’s circumstances change (such as the death of a spouse or carer).

Advanced Care Directives – whether the participant has discussed their treatment and care options with their treating doctor if their health deteriorates and whether an Advanced Care Directive has been or needs to be put in place.

Whether the participant has a current Will, Power of Attorney and Enduring Guardianship in place.

Planning for how the participant’s partner or family will manage if they die.

icare does not need to receive a copy of this plan if completed, but it may be helpful so that the icare contact is aware of the participant's preferences.

Appendix 1. About Lifetime Care and Workers Care

Lifetime Care

The Lifetime Care and Support Scheme provides treatment, rehabilitation and care to meet the injury needs for people who are severely injured in a motor vehicle accident in NSW through their life Injuries include spinal cord injury, moderate to severe brain injury, amputations, severe burns or permanent blindness

The person can be a participant of Lifetime Care and have an accepted Compulsory Third Party (CTP) or Workers Compensation claim.

Lifetime Care will manage the treatment and care of the participant according to the Lifetime Care legislation/guidelines The participant may have additional responsibilities and entitlements under the CTP legislation if they have a CTP claim or the Workers Compensation legislation if they have a Workers Compensation claim For those participants with a CTP claim, different CTP legislation applies depending if the motor vehicle accident occurred before or after 1 December 2017

Workers Care

The Workers Care Program provides treatment, rehabilitation and care to meet the injury needs for people who are severely injured in a work place accident and have a NSW workers compensation claim Injuries include spinal cord injury, moderate to severe brain injury, amputations, severe burns or permanent blindness. The Workers Care Program manages the treatment and care as per the NSW Workers Compensation Legislation utilising the Lifetime Care model. The worker still has requirements under the Workers Compensation legislation.

Relevant Legislation

- Motor Accidents (Lifetime Care and Support) Act 2006
- Compulsory Third Party (CTP)
  - Motor Accident Compensation Act 1999 - relevant for anyone injured in a motor vehicle accident prior to 1 December 2017
  - Motor Accident Injures Act 2017 â€“relevant for anyone injured in a motor vehicle accident from the 1 December 2017
- Workers Compensation Act 1987
- Workplace Injury Management and Workers Compensation Act 1998

TIP: For further information regarding the CTP and workers compensation scheme refer to the State Insurance Regulatory Authority (SIRA) icare.nsw.gov.au