icare™ Insurance and Care NSW

My Plan

Information Sheet MPI001

Information for service providers working with the Lifetime Care and Workers Care

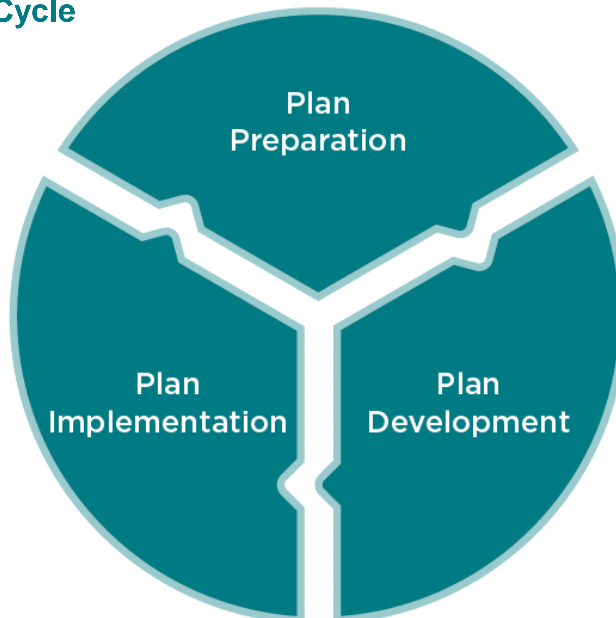
My Plan Framework

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

Its simple structure is designed to emphasise three key principles:

1. Active involvement in **planning preparation** by all parties is key to maximising engagement – and there-by maximising input by and outcomes for participants and injured workers across plan development and plan implementation
2. **Plan development** is a collaboration between informed and engaged parties and includes identification of personal strategies to facilitate goal achievement
3. **Plan implementation** requires 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.

My Plan Framework Cycle



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

While the framework segments are the same size, this does not represent 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 the cycle may change as the person's planning needs change. Experience with My Plan shows that the vast majority of plans after Lifetime Participation has been achieved, are for 12 months. Case managers are therefore welcome to work with the person to an annual My Plan cycle.

Plan Preparation

We know that My Plan's success is closely linked to the **level of engagement** people have with their plan.

To build on this knowledge Plan Preparation is identified as a distinct phase in the My Plan Framework – with the focus being on strategies and tools to support developing and maximising the level of engagement a person has with their My Plan.

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 effort 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 next plan development	• 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 previous plan / DSN – and from any services added via Service Request during the My Plan period • consider own 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 previous plan period includes 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 which might influence their next plan development

Tools to support Plan Preparation*	
• Plan Preparation Tool – standard template • Plan Preparation Tool – bespoke template • Primary Care-giver questionnaire • Therapy Progress report template • Conversation tools: o Activities and Participation o Personal considerations o Current living arrangements o 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 Assessment such as CHAT • Outcome rating scales such as Goal Attainment Scale / MPAI - 4

Plan Development

Drafting the My Plan most 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 with each other what they learned / concluded from their Plan Preparation
- going through the previous plan and agreeing outcome ratings for goals (including any goals added via Service Requests during the plan period)
- discussing the strategies used to achieve goals and considering the feedback from providers and agreeing outcome ratings for the strategies (including any services / strategies added via Service Requests during the plan period)
- identifying goals which were not achieved and having candid conversations about whether the goal was realistic, should be modified, or is no longer a goal
- identifying goals which 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 own plan and it is refined in Plan Development discussions with the case manager ahead of submission to Lifetime Care/Workers Care
- participant/injured worker and case manager draft the plan during Plan Development, with case manager further refining prior to submission to Lifetime Care/Workers Care
- case manager writes the My Plan and sends to participant/injured worker for endorsement before submission to Lifetime Care/Workers Care.
- case manager writes the My Plan and submits it to Lifetime Care/Workers Care (the person and family have no interest / desire to be involved, or it is not possible 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 information sheet • Promoting independence information sheet

Plan Implementation

Once the plan is written and associated services have been approved by Lifetime Care/Workers Care, 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:

- 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 • Working with children and families Positive Behaviour Support Framework

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