My Plan

Guide to My Plan template

icare Insurance and Care NSW | My Plan | 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:

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.

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.

Consider: your injury recovery, work, leisure, family, education, volunteering, interactions with friends, travelling, sport, driving, looking after yourself, looking after your home, involvement with your community.

Notes on aspirations:

Notes on reflections:

The aspirations are intended to be big picture, longer term hopes and dreams for the future – no matter how large or unreachable they may seem at the time of review.

Articulating aspirations will help the participant identify more specific goals for the next plan period. They offer an opportunity for the person's true hopes to be documented, and for case managers to be able to then review, and when required, address those expectations that appear unreachable throughout the plan period – either themselves or by engaging specialist supports.

Vocalising aspirations also promotes broader thinking by the participant, such that they are not just limited to injury recovery and rehabilitation. It can elicit more holistic goal identification.

Would you like support to help you find suitable work or to start getting ready for work or volunteering? If yes, what support do you think you need? If not at the moment, why?

Participants have provided feedback that the opportunity to talk about work or steps towards work is appreciated – no matter how many years have passed since their injury.

Participants who are receiving weekly benefits will have obligations under the respective legislations to receive these benefits. These need to be considered and explored as part of planning.

For participants for whom this question may be inappropriate or triggering, the case manager can simply record "not currently appropriate" in this box with a very brief reason.

Are there any important changes coming up in the future that you need to think about as part of your plan?

If the case manager is aware of upcoming changes that the participant doesn't raise, this is an opportunity to start the discussion about what these changes are and how they might impact goal development and service provision.

Information here can also help icare staff understand the context for some of the goals to follow.

Planning facilitator: is there any other relevant information which may have impacted the person's over-all progress or current situation or that may influence directions in the next plan period, that have not already been noted? (e.g. housing, family relationships, pre-existing conditions)

If This box is an opportunity for the case manager/planning facilitator to note anything else they feel needs to be stated to provide context for the plan – either to assist the participant, to assist the reviewing officer, or to simply ensure the plan is a comprehensive capture of the current situation.

Try to avoid repeating anything here that is later mentioned in the goals – either in feedback on previous goals or in justification for future goals.

3. Review of your previous plan

(This section is not relevant if this is the first plan. Go to section 4)

Note any medical, therapy or progress reports which inform this plan:

Report | Date

Identifying key reports that were used in Plan Preparation or which help to provide more detail for the next plan cycle is helpful for the participant

It is also helpful for icare staff reviewing requests. Therapy Progress reports have been identified as a key means of documenting progress and outcome measures which icare staff use in decision-making.

Goal Ratings:

W: Withdrawn 1. Not Achieved 2. Partially Achieved 3. Achieved

Strategy Ratings:

W: Withdrawn 1. Not Effective 2. Somewhat Effective 3. Effective

*include any strategies, supports or new goals that were added since the previous plan

**before starting, copy and paste the following table to match the number of goals you will be reporting on

Goal	Goal rating

Copy and paste a previous plan goal here.

Provide an over-all goal outcome rating – agreed between CM and participant.

Your Strategy Outcomes – How did you go doing the things you hoped you would do to achieve your goal?	**Agreed strategy rating**

Ask the participant to reflect on what they said they would do to work towards their goal in the previous plan, and how they feel they went with this commitment. The case manager may have thoughts to contribute to this discussion also.

CRepeat for multiple strategies.

Provide a strategy effectiveness rating – agreed between CM and participant.

Other Strategy Outcomes – How did the other strategies and supports go in helping you achieve your goal?	**Agreed strategy rating**

Have a discussion with the participant about how any support services funded for this goal have gone – did they adequately support progress toward the goal? Or were there barriers that mean this strategy might need to be amended? Is there feedback from a progress report that needs to be discussed?

CRepeat for multiple strategies.

Provide a strategy effectiveness rating – agreed between CM and participant.

If needed: person and planning facilitator further comments on over-all progress towards the goal, including barriers/facilitators and implications for the next plan

There is space for additional comments if necessary. Please avoid repeating anything that has already been included in the report.

Do provide enough information in the Goal review section to justify if you will be carrying the goal/strategies forward into the next plan.

Specific feedback (brief/ summary) from service providers contributing to this goal might also be relevant to include.

Examples of questions to facilitate thorough reflection on each goal:

- Did you achieve what you wanted to achieve in the time you were expecting?
- What helped you most in achieving these outcomes?
- What were the difficulties or barriers?
- When you think of what you have experienced and learnt, is there anything you would do differently now?
- Do you think this goal is achieved and therefore finished? Or are there changes you want to make to the goal?
- Do you think you have developed new strengths?
- Do you have any ideas on what might work better for you?
- Is there something you would like to continue working on related to this goal?

Note: The blank template provides for 1 goal. Additional tables can be copied and pasted to match the actual number of goals the participant had in their previous plan.

4. Priorities for the next plan period

Think about what the main things are you'd like to work on in the next [12] months that will help you achieve your aspirations.

Is there anything that you are not doing that you would like to do? Consider what is stopping you doing these things and how we can plan to over-come these barriers.

4.1 Goals & actions

Goal no 1	Goal:
What you'll do to work towards this goal	

Ask first "what will you do to work towards this goal?"

The participant may nominate some personal strategies they will implement to help achieve their goal or express a commitment to comply with services or home programs.

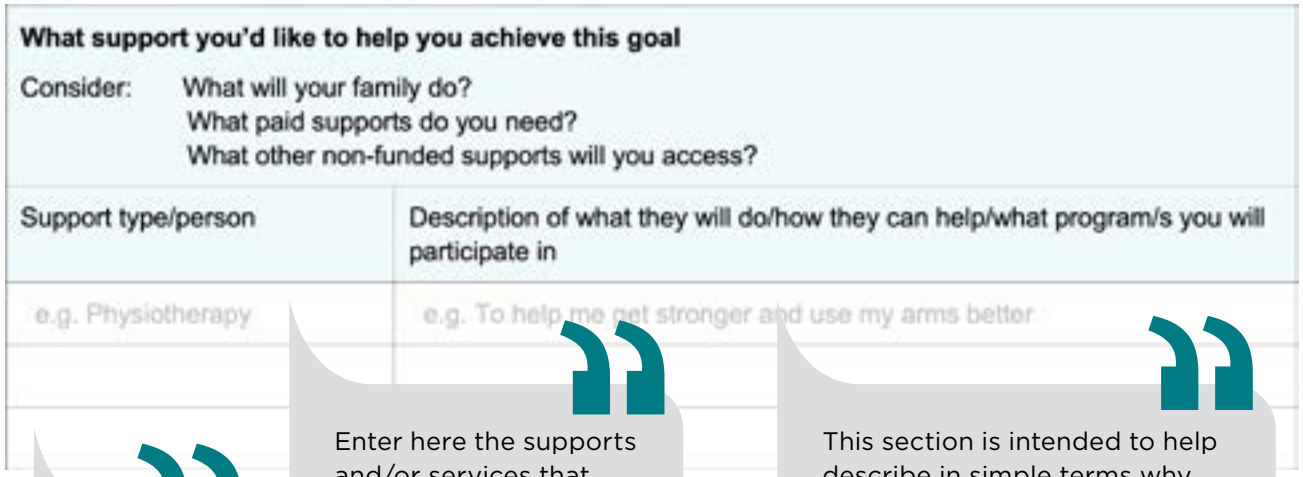
There may be multiple strategies identified.

Goal: write the goal here.

It may be in the person's own words, re-written into a SMART (or other) format; or a case-manager-generated goal.

The goal needs to be meaningful to the participant and enable the icare reviews officer to understand what the person is wanting to work towards related to the services requested below.

While goals do not have to be achievable in the plan period per se, it is helpful to assist the participant to identify goals that may be more achievable in a shorter period of time while they work towards the aspirations they identified in section 2. This may assist people whose goals are still likely unreachable, to focus on goals, supports and services that may be more realistic as they develop insight and adjustment.



New line for each support identified.

Enter here the supports and/or services that the person may need engaged to help them achieve their goal.

Use a new line for each support/service type.

e.g. Physiotherapy

(NB delete the examples in grey in the template)

This section is intended to help describe in simple terms why that support/service is being engaged – how that service can help move towards the goal.

This section is not intended to describe hours, frequency, or cost of services – that will come in section 5.

e.g. To help me get stronger and use my arms better.

Only add more information here if it has not already been stated and if it helps to explain or justify the supports/services listed.

Additional reasoning may include information such as:

- anything not already provided to justify the funding requests
- why formal (paid) supports are reasonable and necessary, and brief reference to alternatives that were considered but not included and why
- potential barriers to achieving the goal

5. Services summary

5.1 Services to achieve goals

NB for each service type, consider related enablers such as report writing and travel

Service type	Goals this service relates to	Description of hours, frequency and duration, OR flat rate/quote (do not include codes & costs – these are recorded in the Request Sheet)	Total hours for this plan, or quoted flat fee
delete this example before completing: physiotherapy	2,3 & 5	1 x 2hour assessment fortnightly sessions in clinic for 4months, then monthly 6months (1hr/session) HEP review – 2 x HV @ 90mins/visit 1 x 1hr case conference travel – 2 x HV @ 1hr/visit 2 x progress reports	2hrs assess 18hrs physio 2hrs travel 2hrs reports

The following table aims to consolidate all formal supports identified in section 4 into a meaningful service delivery program. For example, suppose a psychologist is going to assist with insight, adjustment to disability, behaviour management and anxiety across 3 goals. In that case, the psychology program may look like fortnightly sessions of an hour duration for 3 months, followed by monthly. Because the sessions will be held in the psychologist's rooms, no provider travel will be requested, but there may be 2 progress reports, each of 1 hour. The psychologist may be required to join 2 case conferences in the 6 month period – an additional 3 hours of clinical time.

Thinking through and presenting the treatment program here then informs what is entered in the Request for Funding sheet, along with provider details and codes.

Do not include case management in this table – case management hours will be consolidated and explained in section 6.

6. Plan implementation

(To be completed by the planning facilitator/case manager)

Is case management required to help implement this plan?

☐ Yes ☐ No

If yes, outline case management role and reasons (please focus on role not already included in the Goals tables)

Case managers should consider all domains of the Case Management Taxonomy in articulating their role throughout the plan period. Aspects of case complexity which impact case management hours should be clear in this section.

This information will help to justify the case management hours requested in the table below.

How is the person's independence, health literacy and self-efficacy being developed, such that they may be able to move towards disengagement from case management?

For all participants, case managers should be working to build their skills so they can achieve self-management in the future rather than remaining dependent on a case manager for longer than is necessary.

Section 6 provides opportunity for a case manager to discuss their role and to explore opportunities for reduced case management in plan implementation over time. Where the participant requires support to implement some or all of the activities in their plan, the case manager should discuss the type and frequency of support that the participant will need and explore who is most appropriate to provide support.

Summary of case manager hours

	Hours attached to the goals	Hours attached to plan implementation	Total CM hours for plan
Case Management	Enter here hours that were identified for the case manager attached to specific goals in section 4. e.g. 5hrs	Enter here additional case manager hours required to deliver the holistic case management service described under Plan Implementation. e.g. 30hrs	Provide a total of case management hours for the plan period e.g. 35hrs
Travel		e.g. 6 x 2hr return home visits	e.g. 12hrs
Report writing		list the type of report: e.g. My Plan: 5hrs	e.g. 5hrs
Other			

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