

28 August 2023

[REDACTED]

Kia ora

**Your Official Information Act request, reference: GOV-026995**

Thank you for your request of 9 August 2023, to [REDACTED] Recovery Partner, asking for information about the differences between 'Training for Independence' and 'Living My Life,' and what supports can be provided under each programme.

Due to the nature of your request, it was transferred to OIA Services for response under the Official Information Act 1982 (the Act).

**The following documents are attached as Appendix 1**

- Training For Independence Services Service Page
- Living My Life Disability Support Services Service Page

**Training for Independence (TI) is a rehabilitation service delivered by clinical professionals**

It provides education, support, training, and rehabilitation to clients to restore their independence and ability to participate in everyday life. This may be in their own home, place of work or education, or the wider community. It also aims to reduce their likely need for further rehabilitation. The core team is made up of a registered psychologist, registered nurse, occupational therapist, physiotherapist, speech language therapist, counsellor, dietitian and social worker. Each discipline is engaged according to a client's assessed rehabilitation needs.

For example, TI could be used for a client who is reliant on home help. The rehabilitation offered through TI can assist in enabling a client to undertake these duties more independently through task modification (occupational therapist), equipment provision (occupational therapist), strength and function training (physiotherapist) and education (possibly a psychologist or counsellor to help the client cope with change and their altered role within the family unit).

Section 4.0 of 'Training for Independence Services Service Page' attached, gives an overview of the services that are delivered under TI contracts.

**Living My Life (LML) is a disability support service; not a rehabilitation service**

Services like physiotherapy, psychology and clinical services are not available through LML. It is planned by an Occupational Therapist with the client but primarily delivered by support workers. The intent of the service is to help clients establish connection to their community and improve their quality of life.

LML supports people who may:

- Experience a change in relationship, role or living situation as result of their injury
- Need assistance to relocate to a new residence and/or to live independently
- Have limited social connections so need support to access recreational activities (e.g. the gym or the local bowling club) and other community-based activities (e.g. a woodworking course or other crafts).

Section 8.0 (points m & n) of 'Living My Life Disability Support Services Service Page', gives a high level overview of the differences between 'Training for Independence' and 'Living My Life'.

**As this information may be of interest to other members of the public**

ACC may decide to release a copy of this response on ACC's website. All requester data, including your name and contact details, will be removed prior to release. The released response will be made available [www.acc.co.nz/resources/#/category/12](http://www.acc.co.nz/resources/#/category/12).

**If you have any questions about this response, please get in touch**

You can email me at [GovernmentServices@acc.co.nz](mailto:GovernmentServices@acc.co.nz).

Ngā mihi



Sara Freitag

**Acting Manager Official Information Act Services**

Government Engagement



## Summary

### Objective

The Training for Independence (TI) and Training for Independence Advisory Service (TIAS) programmes provide education, support, training, and rehabilitation to clients in the most appropriate setting for the client, eg their own home, community, school, workplace, or remotely via telehealth where clinically appropriate.

The services are outcome focused and allow for providers to tailor services to a client's needs. The services aim to:

- restore the client's independence and ability to participate in their wider community as much as possible
- reduce the client's need for ongoing rehabilitation and support services.

Training and coaching can also be provided to the client's family and carers where appropriate to assist the client with their rehabilitation goals.

Owner

[Out of Scope]

Expert

## Procedure

### 1.0 Who are these services for?

- a The Training for Independence (TI) service is available to clients with a covered injury and meet the eligibility criteria for this service. These Kiritaki/Clients will require support to restore and/or maintain their independence and ability to participate in their everyday activities and within their wider community to the maximum extent practicable.

### 2.0 Eligibility criteria

- a Use the eligibility criteria below to determine the TI service to meet your client's needs.

To access TI or Advisory programmes a client must:

- Have an accepted claim for a covered injury.
- Have an assessed injury-related need for a TI service identified through:
  - an assessment and/or reassessment report,
  - social rehabilitation assessment, or
  - a recommendation from another relevant assessment/service, for example neuropsychological assessment, concussion service, psychiatric services, or a discharge report from acute or specialist rehabilitation service
- Have been assessed as requiring an interdisciplinary (IDT) rehabilitation programme tailored to their assessed, injury-related needs; and
- Are likely to have meaningful and measurable gains in independence due to the provision of the IDT programme.
- Have been assessed as being at a point in their recovery whereby they will receive the maximum benefit from the IDT programme within optimal timeframes.

**b** Te Ata Pō service specific entry criteria:

Kiritaki/client is over 16 years of age and not at school at the time of receiving service, and

Has an accepted claim for an injury/ies listed as follows:

- Spinal Cord Injury (SCI) at any spinous / vertebral level, including The American Spinal Injury Association (ASIA) Impairment Scale (AIS) Score of A-D. This includes cauda equina syndrome and central cord syndromes, when there is evidence of on-going neurological impairment that is impacting on function and participation beyond acute medical management.
- Moderate to severe traumatic brain injury (TBI) as determined by post-traumatic Glasgow Coma Scale (GCS) Score and duration of post-traumatic amnesia (PTA). Moderate TBI is defined here as GCS 9-12 and PTA 1-6 days. Severe TBI is defined here as GCS 3-8 and PTA 7 days or more. If there is discordance between severity level of the relative scores, then it is appropriate to use the more severe category. Alternatively, if a specialist / medical specialist has made a clinical diagnosis of moderate to severe TBI in the context of other factors, it is reasonable to consider inclusion under the TI Te Ata Pō service.
- Burns >15% of total burn surface area (TBSA), full thickness, causing functional impairment (particularly involving the face, hands, feet, genitalia, perineum, or major joints). These kiritaki/clients are likely to require treatment at a National Burns Centre
- Multiple Limb Amputees.
- A single limb amputee can be considered for TI – Te Ata Pō where this type of Supplier expertise is considered necessary to meet the injury-related rehabilitation needs of a client (for example in the context of polytrauma). Note: Limb is a leg or an arm. Hands and feet are not defined as limbs, they are an appendage to a limb.
- Low Vision and/or bilateral blindness caused by a covered injury, that cannot be corrected or improved by glasses, medicine or surgery and makes everyday tasks difficult.
- Where a kiritaki/client does not meet the injury inclusion criteria listed for TI Te Ata Pō, discretion can be applied by ACC if the relevant covered injury/ies, is/are expected to cause significant long-term and perhaps lifelong needs, and these needs are likely to exceed the capability and/or expertise of TI - Te Ata Tū service Suppliers.

**c** Te Ata Tū service specific entry criteria:

The kiritaki/client has:

- an accepted claim for an injury resulting in a functional impairment and does not meet the injury inclusion criteria for TI Te Ata Pō (above)
- is over 16 years of age and not at school at the time of receiving services
- is not expected to have significant lifelong needs due to their covered injury

**d** Tamariki and Rangatahi service specific entry criteria:

The kiritaki/client is:

- under 18 years of age, or
- aged between 18 and 21yrs and still at school at the time of receiving services.




The overlap in the age criteria between the services recognises that rangatahi/teenagers mature at different ages.

**e** Sensitive Claims service specific entry criteria

The kiritaki/client:

- has an accepted sensitive claim that requires input from more than a psychologist or counsellor, and the sensitive claim is the primary reason for the referral
- has the need for rehabilitation identified by psychiatric services or psychological services (independent from the counsellor or clinical psychologist providing treatment to Client)
- has evidence that counselling and psychology services are not meeting all their needs.

**f** If you are unsure your client requires a TI service, consider obtaining a Social Rehabilitation Assessment or seeking cover support guidance to confirm.**g** Referral into Training for Independence service


-  ACC2134 Training for independence referral
-  ACC705 Referral for Support Services on Discharge
-  ACC706 - Early Notification of Complex Case

### 3.0 Clients who are not eligible or suitable for TI service

- a** If the client does not meet the eligibility criteria, or a TI service is not considered the most appropriate service for the client's needs, then discuss the reasons for the decline with the client, eg the reason may be:  
there is a more suitable service for the client.  
they've already received TI or TIAS in the past and it didn't meet their needs, explain why

Discuss other suitable options available to them.

Send the client the TFI02 Training for Independence - decline letter and include the reasons why the TI service has been declined.

 TFI02 - Training for Independence - decline

### 4.0 What services are delivered under the TI contracts?

- a** Each of these services include flexible and tailored programmes to meet the individual's identified needs and achieve specific outcomes in the required timeframes.
- b** Types of services delivered under this contract:
- education of the client and their family/whānau/carers about the impact of the injury
  - training and coaching, eg: energy conservation and how to manage fatigue, behaviour, health, budgeting and hygiene.
  - developing social and communication skills, and establishing social confidence
  - identifying and managing any injury-related risks and teaching how to manage these risks safely, eg a person living alone may have rugs or electrical cords on the floor
  - engaging the client with community-based activities and teaching them skills to be able to access these activities safely, appropriately and independently
  - rebuilding a client's confidence by increasing independence with daily tasks, such as self cares, mobility, household management, childcare and transport
  - promoting healthy choices about lifestyle, which may include education around drugs and alcohol, exercise and nutrition

### 5.0 Training for Independence contracts (service schedules)

- a** The four Training for Independence services each have a separate service schedule (or contract) for each service. The Operational Guidelines covers all the TI services.


- b** TI - Te Ata Pō service schedule

 Training for Independence - Te Ata Pō service schedule

**NOTE** **Adults who are discharged from a Traumatic Brain Injury Residential Rehab (TBIRR) or Spinal Cord Injury Rehabilitation facility**

Please note: The TI Te Ata Pō contract enables these Suppliers to refer to a TI Te Ata Pō supplier without the need for obtaining ACC approval.


- c** TI - Tamariki and Rangatahi service schedule

 Training for Independence - Tamariki and Rangatahi


- d** TI - Sensitive Claims service schedule

 Training for Independence - Sensitive Claims

- e** TI - Te Ata Tū service schedule

 Training for Independence - Te Ata Tū service schedule

### 6.0 Training for Independence Operational Guidelines

 Training for Independence - Operational Guidelines

## 7.0 Key Features

- a** There are four Training for Independence contracts:
- I. TI Tamariki and Rangatahi
  - II. TI Te Ata Pō
  - III. TI Te Ata Tū
  - IV. TI Sensitive Claims

Each of the four contracts have the ability to provide interdisciplinary Training for Independence programmes (up to 6 months in length). Within Te Ata Pō, there are more provisions for rolling over services, or for services to run for longer than six months if needed.

Advisory Services has two services types and sit within the main four contracts listed above:

- **Advisory Services Short Term:** This service is for clients who have needs that can be met in 8 weeks and a maximum of 6 hours. It is to assist clients who have an injury but may require coaching and training to restore their normal pre-injury level of confidence and independence, eg an elderly client who has a fracture neck of femur and has needs that can be met in six weeks
- **Advisory Services Long Term:** These are for clients who need support over an extended period of time. This service can be used to maintain the client's function or skills and prevent secondary injury. The service allows for up to 14 hours over 12 months.

- b** Gym memberships/Pool passes

We do not usually fund gym memberships as they are considered the personal responsibility of a client. However, we may fund gym memberships alongside an approved TI or TIAS programme if the gym membership is:

- targeted to achieving a specific rehabilitation goal (eg work conditioning which will result in a return to work, or use of an injured limb which will result in a return to usual daily activities)
- limited to a specific timeframe, with clear goals which are reported on by the Provider

If approved, gym memberships/pool passes must be funded outside of the TI contracts.

- c** Clients progress should be monitored throughout the TI service to determine if the client is achieving their agreed rehabilitation goals. If there is doubt about the need for TI, consider obtaining a Social Rehabilitation Assessment or referring the client to another more appropriate service.

## 8.0 When to consider other support options

- a** When TI or TIAS has finished and the client requires further support, or there is no suitable vendor to provide a TI service, or the client is not eligible for TI or TIAS, it may be appropriate to arrange help for the client with their ongoing needs. There may also be times when it may be more appropriate to provide other option(s) in addition to, or instead of, TI or TIAS, such as:
- Integrated Home and Community Support services or Living my Life
  - Vocational Rehabilitation
  - Equipment, housing, vehicle modifications









It's important to consider the timing of any other services in relation to any TI or TIAS programme provided, so that the services provided are co-ordinated.

In these cases, review the assessments or reports and consider other options for the client's rehabilitation, including other means to increase independence, such as:

- a break from intensive rehabilitation to allow the client to independently practice and use the strategies they've learnt
- non-ACC community supports
- personal ongoing responsibility
- client self direction/management
- a support needs assessment, if the client hasn't had one already
- other ACC services

Discuss the options with the client, and if needed, refer their claim to the relevant ACC service.

## 9.0 Related pages

-  [Vocational Rehabilitation Services Overview \(VOC\) Service Page](#)
-  [Integrated Home and Community Support \(IHCS\) service](#)
-  [About the Managed Rehabilitation Equipment Services Service Page](#)
-  [Concussion Service Assessments Service Page](#)
-  [Social Rehabilitation Assessment Service Page](#)
-  [Neuropsychological Assessment Overview Service Page](#)
-  [Clinical Psychiatric Services Service Page](#)
-  [Other Social Rehabilitation](#)

## Summary

### Objective

This service page summarises the information provided in the Living my Life service schedule and operational guideline. It also provides additional background information not provided in the referral pages.

### Background

The purpose of this service is to support clients, with a significant impairment, complex needs or a disability, as a result of their injury.

The purpose of Living my Life is to support a client's understanding of their aspirations and goals, build the client's capability to create community and employment participation outcomes and to direct the services and supports they receive.

Owner







[Out of Scope]

Expert

## Procedure

### 1.0 Resources

- a Supporting documents will be updated as required.

-  LML Component Matrix.pdf
-  Living my Life Service Component Summary FINAL August 18.pdf
-  Living My Life pricing - using a composite hourly rate
-  Living my Life Service Specification
-  LML Operational Guidelines
-  LML Supplier Component Coverage

### 2.0 Philosophy

- a Living my Life uses a disability approach, in the delivery of individualised disability support, in the community. The mode of delivery is outcomes based. The expectation is that the supplier work with the client, their family/whānau to develop goals to increase participation across their life roles. This service is not an active rehabilitation service but it does sit under social rehabilitation.

The supplier will ensure that the principles of the service underpin the delivery of support:

- Client has choice and control over the support they receive, and their roles and activities. (Person-directed)
- Support is tailored to reflect changes in the client's life. (Whole of Life)
- Support provided focuses on community engagement that is meaningful to the client and their family/whānau. (Connectivity)
- Support reflects and respects the client's identity and values, and those of their family/whānau and community. (Embracing diversity)
- Service fosters the client's self-determination in a way that supports their full participation, inclusion and leadership as a citizen, or member of the community. (Citizenship)

**NOTE** Through this service ACC supports and acknowledges New Zealand's obligations to the United Nations Convention on the Rights of People with Disabilities and the New Zealand Disability Strategy, 2016 -2026. ACC provides support to build a client's capability to participate in their community, across the roles that are important to them to be able to get on with living their lives. For the majority of clients ACC provides interventions to address impairment and return the client to independence. For client's who are living with a long-term disability returning to independence may never be fully realised and the delivery of disability support ensures we address participation outcomes over the client's life span.

-  NZ Disability Strategy 2016.pdf

### 3.0 About Living my Life

- a** Living my Life is available for clients with a disability who have had an injury or who have acquired a permanent disability as a result of an injury, at any age or stage of life.

Living my Life enables and supports the client's self-determination about where they live, what they do, where they go, and who they go with.


The four components of the service are designed to be used flexibly to support the client at various stages of their journey, depending on their needs at different stages, transition and milestones. Over time all clients will have participated in the four components and some may have repeated components where needed, particularly Facilitated Pathway Mapping and Independent Facilitation.

The optimum order is


1. Facilitated Pathway Map
2. Independent Facilitation
3. Tailored Support
4. Coaching for Self-Management


Coaching for Self-Management can be offered as an exploration or investigation of the idea should the client and their family be interested.


When a client meets the criteria for Living my Life and has never received the service before it is appropriate for them to start with Facilitated Pathway Mapping and if the goals developed require supports and activities then Independent Facilitation should be used to identify where these can come from. They need not all be ACC funded.


 Living my Life Service Schedule 2018.pdf

 LML Component Matrix.pdf

 Living my Life Service Component Summary FINAL August 18.pdf

 Living my Life Service Component Summary FINAL August 18 Plain.pdf

 Living my Life Operational Guideline Final Nov 18.pdf

 Living My Life pricing - using a composite hourly rate

### 4.0 Eligibility

- a** A client can be referred to Living my Life when they have a significant impairment, complex needs or disability including mental injury. They don't have to be a serious injury client but most are likely to be.

The biggest determination of client eligibility is the client's need.

A client can be referred to the appropriate service component if the client has one or more of the following issues or if they have similar issues that hinder their active participation in their life and community.

- Difficulty identifying their aspirations and goals
- Difficulty adapting to their disability
- Limited work experience
- A lack of social connections
- A circumstance change
- Limited capability managing transition milestones
- Limited skills to live independently
- Limited knowledge of options in the community
- Lack of connection to cultural and community
- Poor decision-making skills
- Behavioural or cognitive needs
- At risk of isolation
- High and complex physical and/or social needs
- Limited knowledge about Self-Management

 ACC7436 Living My Life referral

## 5.0 Recovery Partner / Team Member

### a Relationship Based

This service is a partnership between the client, the recovery partner and the supplier.

The recovery partner has a long-term relationship with the client to help the client develop their service and supports plan across their life domains. The recovery partner will help the client identify and access the disability support options available to achieve their community, cultural and employment outcomes.

The recovery partner works with the client to identify which Living my Life component is the right component for where they are at now including

- describing their vision of their life (Facilitated Pathway Mapping)
- knowing where they can access services or find supports (Independent Facilitation)
- getting the day to day support they need to access the community (Tailored Supports)
- considering if they want to manage their supports themselves (Coaching for Self-Management).

The recovery partner will also review all of the services the client is receiving to ensure the goals of each service do not overlap, so suppliers aren't trying to achieve the same goals.

## 6.0 Facilitated Pathway Map

### a Purpose

To enable the client to explore the different parts of their life and understand what is important to them.  
To provide them with a way to share that with others.

This is a short-term support intervention for clients who would benefit from a co-design approach to create a visual plan for their aspirations and life journey.

This service can be delivered anytime during the client's journey and can be repeated at different stages or transitions during the client's life.

### b Goal:

To visually show the client's aspirations and describe what their journey might look like over a period of time.

### c Outcome

The client has a pathway map that they use easily to describe their aspirations and preferred life roles when goal setting, planning and making choices about supports.

### d Inputs

Up to 15 hours of guided exploration of the client's aspirations and co-design of a visual pathway map.

### e Activity

The provider meets with the client and their family/whanau, and significant others to develop the pathway map that describes the client's journey. They use a co-design tool that outlines the client's aspirations and journey. The map is delivered, as agreed, to the desired standard.

### f Outputs

Pathway Map (this is usually a visual map but may be delivered using technology for clients with a visual impairment).

### g Length of Service

Within 3 months. The case owner can extend the time frame if the client has challenges that make it hard for the provider to achieve the timeframe.

### h Purchasing

Set up a purchase order for LML01 Facilitated Pathway Map for 15 hours.

The provider will deliver within those hours. The case owner has the ability to add hours (within reason) where the client has challenges that make it harder for the provider to achieve the timeframe.

### i Timeliness

The supplier must:

- Accept or decline the referral within 2 business days of receiving the referral form ACC7436.
- Contact the client within 1 business day of accepting the referral.
- Notify ACC within 24 hours of the client's non-attendance.
- Provide the client and ACC with the Pathway Map within 5 days of the final session.


j A recovery partner may be asked to participate if their advice on options is required. The advice should be tentative and without any promise of any specific ACC funded supports.

## 7.0 Independent Facilitation

### a Purpose


This is a short-term support intervention for clients who would benefit from a supported decision-making process for creating a vision of what they need, how to access the information to make their vision a reality, and how to choose their supports and suppliers.

To enable the client to connect with and use the resources in the community and make choices about their local support options and suppliers.

- b** Goal  
To identify local cultural, community and employment support to choose their disability supports.
- c** Outcome  
The client has a summary of local resources and choices about their preferred support and provider(s) (includes natural, main-stream, supports and funded support)
- d** Inputs  
Up to 15 hours of independent coaching to support decision-making about what are the right supports and choose the right people.
- e** Activity  
The provider meets with the client and their family/whānau and significant others to identify what community options exist to meet the client needs (using the pathway map if available). The provider will show the client how to find the services and supports available as well as use their knowledge of the community to present options.
- f** Outputs  
  - Independent identification and choice of services and supports.
  - Completion report ACC7438
  - Summary report of options available, those that have been considered and the resulting client choice. ACC7438 LML Independent facilitation summary
- g** Length of Service  
Within 3 months. The case owner can extend the time frame if the client has challenges that make it hard for the provider to achieve the timeframe.
- h** Purchasing  
Set up a purchase order for LML02 Independent Facilitation for 15 hours.  
The provider will deliver within those hours. The case owner has the ability to add hours (within reason) where the client has challenges that make it harder for the provider to achieve the timeframe.
- i** Timeliness  
The supplier must:
  - Accept or decline the referral within 2 business days of receiving the referral form ACC7436.
  - Contact the client within 1 business day of accepting the referral.
  - Notify ACC within 24 hours of the client's non-attendance.
  - Provide the client and ACC with the summary within 5 days of the final session.
- j** A recovery partner may be asked to participate if their advice on options is required. The advice should be tentative and without any promise of any specific ACC funded supports.

---

## 8.0 Tailored Supports

- a** Purpose  
This is an episode of support (up to 12 months) for clients who would benefit from a capability (strengths-based) approach to increasing their engagement and participation across all areas of their lives, including employment, transitioning into adulthood, and other activities.  
  
To enable the client to achieve meaningful, active participation in their community via tailored individual or group support.
- b** Goal  
To build confidence, capability, relationships and networks to live an everyday life, in their local community.
- c** Outcomes  
The client has received support tailored to their needs and is working towards agreed personal, community & employment participation goals.
- d** Inputs  
A range of supports provided by a supplier who has tailored the services to the client's needs and preferences and goals for themselves. As per Tailored Support Plan.
- e** Activity  
The provider delivers disability support agreed in the client's Tailored Support plan in the community of choice, either individually or in group activities, or a combination of both.  
  
The provider and client will determine the frequency of support and where this will take place.
- f** Outputs  
The client's participation in activities that promote relationships and involvement in the community and enables self-determination about where the client lives, what they do, where they go and who with.  
  
The supplier will submit a Tailored Support plan, progress and completion report (ACC7437) as the service progressed.  
  
 ACC7437 Living my Life - Tailored support plan

**g** Purchasing

For the initial referral create a purchase order for

- LML10 Tailored Support - Introductory Meeting (2 hours)
- LML11 Tailored Support plan (5 hours)

After the plan comes in and is agreed the purchase order can be updated with

- LML12 Tailored Support – Individual activities (hours)
- LML15 Tailored Support – Group activities (4 hours per day)
- LML18 Tailored Support – Progress report (2 hours)
- LML19 Tailored Support – Service Review report (3 hours)

**h** Length of Service

Most Tailored Support Plans are for 12 months or less, but some clients needs continuing support.

Prior to the end of the plan, the provider will hold a meeting with the client, their family / whānau and you to discuss

- how the client's Tailored Support programme went
- what goals were progressed
- what the outcomes were for the client
- what, if any, next steps are needed

At the meeting, should the client's programme need to continue, the provider will ask you for a new purchase order for LML11 TS Support Plan (5 hours) to fund the service plan. Once they have the new purchase order, they will provide you with the new plan for the next period along with the ACC7437 service review report for the current period.

**i** Timeliness

The supplier must

- Accept or decline within 2 business days of receiving the referral form ACC7436.
- Hold an introductory meeting within 5 days of accepting the referral.
- Provide a copy the Tailored Support plan within 10 business days of accepting the referral.
- Provide a progress report at the midpoint or 6 months (whichever is earlier).
- Provide a completion report within 5 days of the final session or at 12 months (whichever is earlier).

**j** Recovery Partner Support

The recovery partner can expect to participate in a minimum of three meetings during the Tailored Support programme period.

Before

Before the Tailored Support programme starts (after referral but before submission of the ACC7437).

Meet to discuss the client's goals and plan for the programme. This provides an opportunity to

- get an initial idea of the client's goals, activities and what they will participate in
- explore any potential alternatives (natural supports, community programmes etc)
- discuss any potential changes to other services in the client's ACC package of services to ensure balance and cohesion.

During

At the mid-point of the Tailored Support programme (but before submission of the ACC7437)

Meet to discuss the client's participation, enjoyment and if appropriate progress/attainment within their Tailored Support programme. This provides an opportunity to ensure the programme is meeting the needs of the client and that the goals remain relevant.

Review

Near the end of the current purchase order (but before submission of the ACC7437).

Meet to discuss the client's participation, enjoyment and if appropriate progress/attainment within their Tailored Support programme. This provides an opportunity to discuss whether the programme

- has met the client's needs and can end, or
- is meeting the client's needs but must continue (See Note)

**NOTE** Review eligibility and planning

During the review meeting discuss with the client, their family and whanau the client's

- eligibility by confirm the client's needs and/or risks
- interests, participation goals and outcomes to ensure they are relevant.

When a service needs to continue the recovery partner will

- request the submission of a new plan for the next service period along with service review report.
- arrange for a new purchase order for the plan.

**k** Other services

ACC can fund other services alongside Living my Life Tailored Support but the goals of each service must be different. The recovery partner should review and consider all of the services and if needed hold a case conference with all relevant service providers. An Independent Facilitation service may help with that. Note: It is not an assessment though as it helps the client explore options.

**l** Home and community support

Look for any goals or service expectations in the IHCS plan that relate to activity and participation in the community to see if there is any conflict. Also look at any personal cares being delivered in the LmL Tailored Support programme to ensure they relate to community activities away from the home.

**m** Training for Independence

- Adults with TBI, Other Injuries, Sensitive Claims or Children and Young People

The use of TI with LmL is very limited. TI's goal is to provide rehabilitation to lift a client's function and improve their ability to do their activities of daily living. LmL's goal is to support a client's engagement and participation in the community including employment. If the client is receiving LmL their function should already be maximised. TI would be used to deliver training in specific and limited situations such as use of equipment.

Look for any goals or service expectations within the TI plan that relate to activity and participation in the community and the reason for these. It may be necessary for the recovery partner to hold a meeting with both suppliers. Discuss any situation where there is a single supplier delivery both programmes. It may be acceptable if the TI programme is short in duration and very specific.

**n** Training for Independence

- Advisory Service (Wellbeing Advisory Service)

This service for clients who have a serious injury or a comparable complex injury who require intermittent oversight or monitoring/supervision by a Rehabilitation Professional over an extended period of time, to ensure maintenance of the Client's function or skills and prevent secondary injury. The purpose is to assist the Client to maintain skills they have gained and/or prevent deterioration in health (maximum 14 hours provided over 12 months).

Look for any goals or service expectations within the TI plan that relate to activity and participation in the community and the reason for these.

**o** Residential Support Service (RSS)

A client can receive a Living my Life programme while resident in a residential facility. Review the service expectations of the residential facility.

Interim Care - A client is unlikely to be receiving both RSS interim care and LmL Tailored Support. If the client was receiving Tailored Support prior to the most their most recent injury this should be suspended as the client is unlikely to be able to participate.

Rehabilitation - If the client is participating in a rehabilitation programme the RSS provider should be managing the client's community activity and participation and it would be included in the day rate.

Home for Life – Many residential facilities do not have community activity and participation programmes. The recovery partner needs to find out what is or is not being delivered by reading the

- RSS support plan
- ACC contract
- Rest home service contract on the Ministry of Health's website

If community activity and participation is not included, it is appropriate to introduce a programme where there is a need

**9.0 Coaching to Self-Manage****a** Purpose

This is a short-term support intervention (up to 3 months) for clients who would benefit from a supported decision-making approach to learning about self-management, determining their readiness to self-manage, and choosing the type of ongoing support required to manage their budget and direct their support services.

To enable the client and their family/whānau to understand self-management and make a decision regarding their readiness to self-manage or not.

If self-managing the client will be able to decide how and what to self –manage.

**NOTE** Client self-management is currently on hold to new entries while we look at broadening the offering.

 ACC7423 Self management Checklist

**b** Goals

To determine readiness and willingness to self-manage. To be able to self-manage their ACC agreed budget.

**c** Outcomes

The client knows if they want to manage their own services, supports and funding and what support they would require to do this.

Alternatively, if now is not right time, ACC and client can revisit in the future.

**d** Inputs

Up to 15 hours of independent coaching and support to guide the clients understanding of ACC self-management and support to make decisions about their budget for services and support.


**e** Activity

A provider will educate, support and coach the client to

- understand ACC self-management and the related rights, responsibilities and expectations and
  - decide if they are ready to self manage or not
  - decide what they will self- manage and what they will need support to self-manage, and
- If ready to self manage, the provider will undertake tasks outlined in op guideline.

**f** Output

- The client has made a choice regarding their readiness to manage their own services or not.
- The client manages their own services and supports with or without support
- Summary report ACC7439 of client's choice of what and how they will use ACC self-management

 ACC7439 LML Coaching to self-manage summary

**g** Length of Service

Within 3 months. The case owner can extend the time frame if the client has challenges that make it hard for the provider to achieve the timeframe.

**h** Purchasing

Set up a purchase order for LML03 Coaching to Self-Manage for 15 hours.

The provider will deliver within those hours. The case owner has the ability to add hours (within reason) where the client has challenges that make it harder for the provider to achieve the timeframe.

**i** Timeliness

The supplier must:

- Accept or decline the referral within 2 business days of receiving the referral form ACC7436.
- Contact the client within 1 business day of accepting the referral.
- Notify ACC within 24 hours of the client's non-attendance.
- Provide the client and ACC with the summary report within 10 days of the final session