Submit

STATE OF HAWAII
QUEST Integration Service Plan (SP)
Initial SP Date: __/__/____

Member Name _____ **Member ID #** _____ **SP Date: __/__/____**
Lead Service Coordinator Name _____ **Phone Number** _____
☐ **Adult** ☐ **Child**
Long Term Services and Supports (LTSS) ☐
Special Health Care Needs (SHCN) ☐
At Risk ☐

SECTION A. AUTHORIZATION OF MY SUPPORT SERVICES

A1. MEMBER/AUTHORIZED REPRESENTATIVE

I have signed this document because I agree that: I/We have directed this service plan meeting as much as possible; Information about all my available choices was provided and I/We made my own choices and decisions in this meeting; and I/We reviewed and agree to the support services written in my plan.

		__/__/____
Print Member Name	Signature	Date
		__/__/____
Print Authorized Representative Name	Signature	Date

Indicate who directed the meeting. If someone other than the member directed the service plan meeting, explain why.

_____

A2. SERVICE COORDINATOR(S)

		__/__/____
Print Lead Service Coordinator Name	Signature and Title	Date
		__/__/____
Print Consulting Service Coordinator Name	Signature and Title	Date

A3. COPY OF PLAN GIVEN TO

Primary Care Provider (PCG)

Support Provider(s) :

STATE OF HAWAII
QUEST Integration Service Plan (SP)

		SECTION B. MY GOALS, AND ACTIONS						
# __	**Start Date** __/__/____	**Modified Date** __/__/____	**My Needs, Risks, Issues**	**My Goals**	**My Outcomes** (include timeframe)	**Past Efforts to Meet Goal** (include successful & unsuccessful efforts)	**Next Review Date** __/__/____	**Resolved Date** __/__/____

Priority	**My Actions**	**Barriers**	**Who Will Help Me**	**Action Progress**	**Progress Note**
				☐**Not Started** ☐**In Progress** ☐**Completed**	
				☐**Not Started** ☐**In Progress** ☐**Completed**	
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				☐**Not Started** ☐**In Progress** ☐**Completed**	

SECTION C. MY SUPPORT PLAN

*Check appropriate service and complete information. Complete the Personal Assistance/Nursing Task section as indicated**

C1. SHCN Services ☒ N/A

SERVICES	START DATE	PROVIDER(S)	FREQUENCY/AMOUNT	DURATION
☐	/ /			
☐	/ /			

DHS 1147/1147e
Approved LOC: Click here to enter text. **Functional Points***:* Click here to enter text. **Expiration Date:** Click here to enter text.

C2. At Risk Services ☐ N/A

SERVICES	START DATE	PROVIDER(S)	FREQUENCY/AMOUNT	DURATION
☐ Adult Day Care (ADC)	/ /			
☐ Adult Day Health (ADH)	/ /			
☐ Home Delivered Meals	/ /			
☐ Personal Emergency Response Systems (PERS)	/ /			
Personal Assistance Level I (PA I Chore)* ☐ PA I Agency ☐ PA I	/ /			
Personal Assistance Level II (PA II Personal Care)* ☐ PA II Agency ☐ PA II CDPA	/ /			
Personal Assistance Level II Delegated (PA II Delegated)* ☐ PAII Agency ☐ PAII CDPA	/ /			
☐ Skilled (or private duty) Nursing*	/ /			

C3. Home and Community Based Services (HCBS) ☐ N/A

SERVICES	START DATE	PROVIDER(S)	FREQUENCY/AMOUNT	DURATION
☐ Service Coordination	/ /	RN: SW:		
☐ Adult Day Care (ADC)	/ /			
☐ Adult Day Health (ADH)	/ /			
☐ Assisted Living Facility (ALF)	/ /			
☒ Community Care Management Agency (CCMA) **ALL ISLAND CASE MANAGEMENT CORPORATION**	/ /	RN: SW:	MONTHLY & PRN	
Counseling and Training ☐ Nutrition ☐ Coping/Support ☐ Crisis Intervention ☐ Family Training ☐ Caregiver Training ☐ **Other:**	/ /			

☐ Environmental Accessibility Adaptations (EAA)	/ /			
☐ Home Delivered Meals	/ /			
☐ Home Maintenance	/ /			
☐ Moving Assistance	/ /			
☐ Non-Medical Transportation	/ /	CCFFH Providers	PRN	
Personal Assistance Level I (PA I Chore)* ☐ PA I Agency ☐ PA I CDPA	/ /			
Personal Assistance Level II (PA II Personal Care)* ☐ PA II Agency ☐ PA II CDPA	/ /			
Personal Assistance Level II Delegated (PA II Delegated)* ☐ PAII Agency ☐ PAII CDPA	/ /			
☐ Skilled (or private duty) Nursing*	/ /			
☐ Personal Emergency Response Systems (PERS) ☐ Basic Reassurance ☐ Enhanced Reassurance/Calls	/ /			
☒ Residential Care ☐ Expanded Adult Residential Care Home (E-ARCH) ☒ Community Care Foster Family Home (CCFFH)	/ /		Daily & PRN	
☐ Respite ☐ In-home ☐ Community based ☐ Institutional	/ /		☐ Hourly ☐ Overnight	
☐ Specialized Medical Equipment/Supplies (SMES)	/ /			
☐ Other:	/ /			

C4. INSTITUTIONAL SERVICES ☐ N/A

TYPE OF FACILITY			**START DATE**
☐ ICF/ID ☐ Nursing Facility ☐ Hospital			/ /
Facility Name:	Name of Contact:	Phone:	

☐ Discharge Planning *(Must complete if pending discharge)*
Pre-Discharge Assessment Date: __/__/____
Anticipated Discharge Date: __/__/____
Discharge Location:
Anticipated Discharge Planning Meeting Date: __/__/____
Discharge Date: __/__/____

☐ Other:

C5. ADDITIONAL SUPPORT SERVICES

SERVICES	START DATE	PROVIDER(S)	FREQUENCY/AMOUNT	DURATION
☐ Dental	/ /			
☐ Home Health Agency ☐ HHA* ☐ LPN* ☐ RN* ☐ OT ☐ PT ☐ Speech	/ /			
☐ Hospice	/ /			
☒ Transportation, Medical	/ /	CCFFH Providers	SCHEDULED APPOINTMENTS & PRN	
Department of Education (DOE) School Based Services ☐ Home Schooling ☐ Skilled Nursing ☐ Behavioral Health ☐ Speech ☐ OT ☐ PT ☐ Special Education	/ /			
Department of Health (DOH) ☐ Early intervention (0-3) ☐ OT ☐ PT ☐ Speech ☐ Skilled Nursing ☐ PHN ☐ Audiology ☐ Healthy Start ☐ DD/ID Waiver ☐ WIC ☐ CAMHD ☐ AMHD (Legally Encumbered) ☐ ADAD ☐ Other	/ /			
Department of Human Services (DHS) ☐ CWS ☐ APS ☐ Foster care ☐ LIHEAP ☐ SNAP ☐ VOC Rehab ☐ Financial Assistance ☐ Other	/ /			
☐ Community Care Services (CCS)	/ /			
☐ HIV/AIDS Services	/ /			
☐ Congregate Meals	/ /			
☐ Housing Assistance	/ /			
☐ Disabled Parking Permit	/ /			
☐ Homeless Shelter	/ /			
☐ Legal Assistance ☐ Guardianship ☐ POA for Healthcare ☐ Advance Directives	/ /			
☐ Volunteer ☐ Companion	/ /			
☐ Other State Agencies	/ /			
☐ Other:	/ /			

SECTION D. MY SUPPORT PLAN DETAILS *(Select all that apply) *Skilled Nursing RN/LPN only*		
D1. VITAL SIGNS	**Frequency/Amount**	**Special Instructions**

☐ Temperature ☐ Pulse ☐ Respiration ☐ Blood Pressure ☐ Oxygen Saturation ☐ Height and Weight Other:		
D2. PERSONAL ASSISTANCE LEVEL I (PA I Chore)		
Routine House Cleaning ☒ Bathroom ☒ Kitchen ☒ Bedroom ☒ Changing linen ☒ Make bed ☒ Empty Trash	Daily &/or PRN	As determined by CCFFH Operator
Laundry ☒ Washing ☒ Drying ☐ Ironing ☐ Mending	Daily &/or PRN	As determined by CCFFH Operator
☐ Shopping/Errands		
☒ Transportation/Escort	PRN	
☒ Meal preparation	3x/Daily	Provide snacks in between meals
Other:		
D3. PERSONAL ASSISTANCE LEVEL II (PA II Personal Care)		
☒ Eating/Feeding DIET: _____ LIQUID: _____	3x/Daily	☐ Prepare/Serve ☐ Assist/Feed ☐ Record Intake
☒ Bathing ☐ Bed ☐ Shower ☒ Shampoo		Shampoo EOD (Every other day)
☒ Dressing ☒ Upper Body ☒ Lower Body	Daily & PRN	
☒ Grooming ☒ Oral care ☐ Shave	Daily & PRN	SHAVE As needed
☒ Hair and Skin care ☒ Brush ☒ Comb ☒ Nail Care ☒ Foot Care		
☐ Toileting (do not include transfer and ambulation)		
☐ Bed Mobility/Transfers		
☐ Manual Wheelchair mobility		
Medication Assistance Remind Assist ☒ ADMINISTER		
Other:		
D4. PERSONAL ASSISTANCE LEVEL II DELEGATED (PA II Delegated)		
☐ Task:		
☐ Task:		
D5. MEALS/FEEDING		
☐ Record Feeding Intake		
☐ Tube Feeding*		Feeding Orders:
☐ G-Tube care		

☒ Monitor skin condition for adequate hydration		
Other:		
D6. CARDIAC/RESPIRATORY CARE		
☐ Oxygen* Oxygen Orders:		
☐ Oral Suctioning		
☐ Suctioning*		Every hour(s) or as needed to maintain clear airway
☐ Nebulizer/Aerosol Treatments*		
☐ Humidifier		
☐ Apnea Monitor		
☐ Pulse Oximeter		
☐ Tracheostomy Care*		
☐ Ventilator Type:		FIO2 _____ %, VT _____, Peep _____, Rate _____, PS _____ ☐ Check ventilator settings every shift
☐ O2 concentrator		_____ L/min
☐ Resuscitator/Ambu bag on hand		
☐ Chest physiotherapy		
☐ Cough stimulator		
☐ See manuals/information provided by equipment vendors for specific instructions about respiratory equipment		
Other:		
D7. WOUND CARE		
☐ Decubitus Care ☐ Dressing ☐ Clean ☐ Sterile*		
Other:		
D8. MEDICATIONS		
☒ See Medication Sheet and administer as ordered by physician*		
☒ Update medication list		MAR Reconciled every 6 months or as changes occurs
☒ All caregivers to know medication, purpose, effects and side effects		Refer to AICMC Resource Binder
☐ Blood glucose monitoring		
Other:		
D9. BOWEL AND BLADDER ELIMINATION		
☐ Brief/Diaper change and check site and skin daily -		
☐ Bedpan ☐ Urinal ☐ Commode		
☐ Toilet		
☐ Catheter* ☐ Catheter Care ☐ Catheter Irrigation* ☐ Condom care		☐ Empty Drainage Bag ☐ Record Output ☐ Drain bag: Empty ½ full or more often
☒ Check for bowel movement (BM)		
☐ Digital Stimulation ☐ Suppository		

☐ Enema ☐ Fleet Enema*		
Other:		
D10. MOBILITY		
☐ Turning and Repositioning		
☐ Transfers		
☐ Chair		
☐ Manual Wheelchair		
☐ Front Wheeled Walker (FWW)		
☐ Patient Lift		
☐ Walk		
☐ Exercise		
☐ Safety Belt		
☐ Side Rails		
Other:		

SECTION E. DISEASE MANAGEMENT/EDUCATION

Learning Needs	Provider Name and Contact Information	Frequency/Amount and Duration	Comments
Asthma			
Diabetes			
Other:			

SECTION F. REFERRALS

Referral Service/Specialty	Provider Name and Contact Information	Frequency/Amount and Duration	Comments

SECTION G. SUPPORT PROVIDER RESPONSIBILITIES

G1. PRIMARY CARE PROVIDER (PCP)

Name: Phone: Fax:

☐ Review Service Plan annually and as needed
☐ Perform Health and Physical Exam as needed
☐ Complete DHS 1147/1147e annually and as needed
☐ Coordinate overall medical care of member
☐ Provide requested medical information, complete and return forms
☐ Other:

G2. LEAD (L) AND CONSULTING (C) SERVICE COORDINATORS

Lead Service Coordinator Name and Title: Phone: Fax:
Consulting Service Coordinator Name and Title : Phone: Fax:

L	C	
☒	☒	Implement the Service Plan and coordinate services of the member with physician(s) and other providers

☒ ☒ Review and update Service Plan every 6 month(s), if not occurred earlier due to the occurrence of a significant event ☒ ☒ Review and update current medications during each home visit and as needed
☒ ☒ Monitor the member and the primary caregiver status through
☒ Home Visits every 1 month(s) and as needed ☒ Phone Contacts every PRN and as needed
☒ ☒ Monitor the member within 48 hours after or next business day: hospitalization, acute medical or emotional crisis, adverse event report
☐ ☐ Review and update Individualized Emergency Back Up Plan annually and as needed
☐ ☐ Review and update Disaster Preparedness form annually and as needed
☐ ☐ Reviewed Infection Control Guidelines with member and caregiver
☐ ☐ Monitor operating status of smoke alarm at every home visit
☐ ☐ Identify fire hazard(s) and establish a Fire Safety Plan
☒ ☒ Provide referrals and supportive resources to the member and caregivers as needed
☒ ☒ Teach/provide health information based on members needs
☒ ☒ Assist with ordering equipment and supplies
☒ ☒ Complete DHS 1147/1147e annually and as needed
☐ ☐ Other:

G3. PRIMARY CAREGIVER (PC) AND MEMBER (M)

PC M PCG:
☒ ☐ Responsible for the members care and safety when a paid personnel are not present
☒ ☐ Maintain operating smoke alarm at all times
☒ ☐ Maintain operating telephone
☒ ☐ Maintain a clear pathway from member's bed to the closest exit
☒ ☐ Report all hospitalizations, health problems, injuries, falls, skin breakdown or other health or social problems to Lead SC within 24 hrs
☐ ☐ Report worker "no show" or problems with assigned worker to the service provider then to the Lead SC
☐ ☐ Report 2 hours in advance to service provider when canceling services
☒ ☐ Use 24 hour emergency number 911 for all emergencies
☒ ☐ Assure that all backup caregivers have been trained & are signed off on service plan by health professional i.e., PT, OT, RN, etc.
☐ Other:

G5. ALL CAREGIVERS

☒ Report any medical and/or social changes to the Lead SC and PCP.
☒ Maintain a clean environment and prevent the spread of disease with frequent hand washing. Use Infection Control barriers as needed.
☒ See home binder for detailed information and instructions on the member's care.
☒ Communication: Communicate with the member regularly with dignity and respect, listen to what's important to the member, face the member when speaking, talk clearly, and pronounce words.
☒ Verbally interact with the member during meaningful activities.
☐ Give verbal cues to the member prior to touching member due to _____ impairment.
☒ Check equipment and supplies regularly. Notify Vendor and Lead SC if equipment needs repair and if supplies are low quantity on hand.
☒ Provide a safe environment and review the Individualized Emergency Backup Plan annually and as needed.
☐ Other:

SECTION H. ADDITIONAL COMMENTS