

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

<hr/>	<hr/>	<hr/> /
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
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Print Consulting Service Coordinator Name	Signature and Title	/ / Date
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A3. COPY OF PLAN GIVEN TO

Primary Care Provider (PCG)

Support Provider(s) :

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			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
—	— / — / —	— / — / —					— / — / —	— / — / —
<u>Priority</u>	<u>My Actions</u>			<u>Barriers</u>	<u>Who Will Help Me</u>	<u>Action Progress</u>	<u>Progress Note</u>	
						<input type="checkbox"/> <u>Not Started</u> <input type="checkbox"/> <u>In Progress</u> <input type="checkbox"/> <u>Completed</u>		
						<input type="checkbox"/> <u>Not Started</u> <input type="checkbox"/> <u>In Progress</u> <input type="checkbox"/> <u>Completed</u>		
						<input type="checkbox"/> <u>Not Started</u> <input type="checkbox"/> <u>In Progress</u> <input type="checkbox"/> <u>Completed</u>		
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					<input type="checkbox"/> <u>Not Started</u> <input type="checkbox"/> <u>In Progress</u> <input type="checkbox"/> <u>Completed</u>			
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						<input type="checkbox"/> <u>Not Started</u> <input type="checkbox"/> <u>In Progress</u> <input type="checkbox"/> <u>Completed</u>		
						<input type="checkbox"/> <u>Not Started</u> <input type="checkbox"/> <u>In Progress</u> <input type="checkbox"/> <u>Completed</u>		
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<u>Priority</u>	<u>My Actions</u>			<u>Barriers</u>	<u>Who Will Help Me</u>	<u>Action Progress</u>	<u>Progress Note</u>	
						<input type="checkbox"/> <u>Not Started</u> <input type="checkbox"/> <u>In Progress</u> <input type="checkbox"/> <u>Completed</u>		
						<input type="checkbox"/> <u>Not Started</u> <input type="checkbox"/> <u>In Progress</u> <input type="checkbox"/> <u>Completed</u>		
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					<input type="checkbox"/> <u>Not Started</u> <input type="checkbox"/> <u>In Progress</u> <input type="checkbox"/> <u>Completed</u>			
					<input type="checkbox"/> <u>Not Started</u> <input type="checkbox"/> <u>In Progress</u> <input type="checkbox"/> <u>Completed</u>			
					<input type="checkbox"/> <u>Not Started</u> <input type="checkbox"/> <u>In Progress</u> <input type="checkbox"/> <u>Completed</u>			
					<input type="checkbox"/> <u>Not Started</u> <input type="checkbox"/> <u>In Progress</u> <input type="checkbox"/> <u>Completed</u>			

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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
<input type="checkbox"/>	/ /			
<input type="checkbox"/>	/ /			

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
<input type="checkbox"/> Adult Day Care (ADC)	/ /			
<input type="checkbox"/> Adult Day Health (ADH)	/ /			
<input type="checkbox"/> Home Delivered Meals	/ /			
<input type="checkbox"/> Personal Emergency Response Systems (PERS)	/ /			
Personal Assistance Level I (PA I Chore)* <input type="checkbox"/> PA I Agency <input type="checkbox"/> PA I	/ /			
Personal Assistance Level II (PA II Personal Care)* <input type="checkbox"/> PA II Agency <input type="checkbox"/> PA II CDPA	/ /			
Personal Assistance Level II Delegated (PA II Delegated)* <input type="checkbox"/> PAII Agency <input type="checkbox"/> PAII CDPA	/ /			
<input type="checkbox"/> Skilled (or private duty) Nursing*	/ /			

C3. Home and Community Based Services (HCBS)

☐ N/A

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

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<input type="checkbox"/> Environmental Accessibility Adaptations (EAA)	/ /			
<input type="checkbox"/> Home Delivered Meals	/ /			
<input type="checkbox"/> Home Maintenance	/ /			
<input type="checkbox"/> Moving Assistance	/ /			
<input type="checkbox"/> Non-Medical Transportation	/ /	CCFFH Providers	PRN	
Personal Assistance Level I (PA I Chore)* <input type="checkbox"/> PA I Agency <input type="checkbox"/> PA I CDPA	/ /			
Personal Assistance Level II (PA II Personal Care)* <input type="checkbox"/> PA II Agency <input type="checkbox"/> PA II CDPA	/ /			
Personal Assistance Level II Delegated (PA II Delegated)* <input type="checkbox"/> PAII Agency <input type="checkbox"/> PAII CDPA	/ /			
<input type="checkbox"/> Skilled (or private duty) Nursing*	/ /			
<input type="checkbox"/> Personal Emergency Response Systems (PERS) <input type="checkbox"/> Basic Reassurance <input type="checkbox"/> Enhanced Reassurance/Calls	/ /			
<input checked="" type="checkbox"/> Residential Care <input type="checkbox"/> Expanded Adult Residential Care Home (E-ARCH) <input checked="" type="checkbox"/> Community Care Foster Family Home (CCFFH)	/ /		Daily & PRN	
<input type="checkbox"/> Respite <input type="checkbox"/> In-home <input type="checkbox"/> Community based <input type="checkbox"/> Institutional	/ /		<input type="checkbox"/> Hourly <input type="checkbox"/> Overnight	
<input type="checkbox"/> Specialized Medical Equipment/Supplies (SMES)	/ /			
<input type="checkbox"/> Other:	/ /			
C4. INSTITUTIONAL SERVICES <input type="checkbox"/> N/A				
TYPE OF FACILITY				START DATE
<input type="checkbox"/> ICF/ID <input type="checkbox"/> Nursing Facility <input type="checkbox"/> Hospital				/ /
Facility Name:		Name of Contact:		Phone:
<input type="checkbox"/> Discharge Planning <i>(Must complete if pending discharge)</i> Pre-Discharge Assessment Date: <u> / / </u> Anticipated Discharge Date: <u> / / </u> Discharge Location: Anticipated Discharge Planning Meeting Date: <u> / / </u> Discharge Date: <u> / / </u>				
<input type="checkbox"/> Other:				
C5. ADDITIONAL SUPPORT SERVICES				

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SERVICES	START DATE	PROVIDER(S)	FREQUENCY/AMOUNT	DURATION
<input type="checkbox"/> Dental	/ /			
<input type="checkbox"/> Home Health Agency <input type="checkbox"/> HHA* <input type="checkbox"/> LPN* <input type="checkbox"/> RN* <input type="checkbox"/> OT <input type="checkbox"/> PT <input type="checkbox"/> Speech	/ /			
<input type="checkbox"/> Hospice	/ /			
<input checked="" type="checkbox"/> Transportation, Medical	/ /	CCFFH Providers	SCHEDULED APPOINTMENTS & PRN	
Department of Education (DOE) School Based Services <input type="checkbox"/> Home Schooling <input type="checkbox"/> Skilled Nursing <input type="checkbox"/> Behavioral Health <input type="checkbox"/> Speech <input type="checkbox"/> OT <input type="checkbox"/> PT <input type="checkbox"/> Special Education	/ /			
Department of Health (DOH) <input type="checkbox"/> Early intervention (0-3) <input type="checkbox"/> OT <input type="checkbox"/> PT <input type="checkbox"/> Speech <input type="checkbox"/> Skilled Nursing <input type="checkbox"/> PHN <input type="checkbox"/> Audiology <input type="checkbox"/> Healthy Start <input type="checkbox"/> DD/ID Waiver <input type="checkbox"/> WIC <input type="checkbox"/> CAMHD <input type="checkbox"/> AMHD (Legally Encumbered) <input type="checkbox"/> ADAD <input type="checkbox"/> Other	/ /			
Department of Human Services (DHS) <input type="checkbox"/> CWS <input type="checkbox"/> APS <input type="checkbox"/> Foster care <input type="checkbox"/> LIHEAP <input type="checkbox"/> SNAP <input type="checkbox"/> VOC Rehab <input type="checkbox"/> Financial Assistance <input type="checkbox"/> Other	/ /			
<input type="checkbox"/> Community Care Services (CCS)	/ /			
<input type="checkbox"/> HIV/AIDS Services	/ /			
<input type="checkbox"/> Congregate Meals	/ /			
<input type="checkbox"/> Housing Assistance	/ /			
<input type="checkbox"/> Disabled Parking Permit	/ /			
<input type="checkbox"/> Homeless Shelter	/ /			
<input type="checkbox"/> Legal Assistance <input type="checkbox"/> Guardianship <input type="checkbox"/> POA for Healthcare <input type="checkbox"/> Advance Directives	/ /			
<input type="checkbox"/> Volunteer <input type="checkbox"/> Companion	/ /			
<input type="checkbox"/> Other State Agencies	/ /			
<input type="checkbox"/> Other:	/ /			
SECTION D. MY SUPPORT PLAN DETAILS <i>(Select all that apply) *Skilled Nursing RN/LPN only</i>				
D1. VITAL SIGNS	Frequency/Amount	Special Instructions		

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

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

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<input type="checkbox"/> Enema	<input type="checkbox"/> Fleet Enema*		
Other:			
D10. MOBILITY			
<input type="checkbox"/> Turning and Repositioning			
<input type="checkbox"/> Transfers			
<input type="checkbox"/> Chair			
<input type="checkbox"/> Manual Wheelchair			
<input type="checkbox"/> Front Wheeled Walker (FWW)			
<input type="checkbox"/> Patient Lift			
<input type="checkbox"/> Walk			
<input type="checkbox"/> Exercise			
<input type="checkbox"/> Safety Belt			
<input type="checkbox"/> 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:
<input type="checkbox"/> Review Service Plan annually and as needed	<input type="checkbox"/> Coordinate overall medical care of member		
<input type="checkbox"/> Perform Health and Physical Exam as needed	<input type="checkbox"/> Provide requested medical information, complete and return forms		
<input type="checkbox"/> Complete DHS 1147/1147e annually and as needed	<input type="checkbox"/> 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			
<input checked="" type="checkbox"/> <input checked="" type="checkbox"/> Implement the Service Plan and coordinate services of the member with physician(s) and other providers			

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- ☒ ☒ 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:

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SECTION H. ADDITIONAL COMMENTS

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