

## FREQUENTLY ASKED QUESTIONS

**Q: How long does a patient receive these services?**

**A:** The Complex Care Management Services are intended to last until your goals are met. You are usually enrolled for 3-12 months.

**Q: Can my caregiver or family be involved?**

**A:** Yes, we encourage caregivers and families be involved with your medical care to work with you to achieve the best outcomes.

**Q: How much does it cost?**

**A:** These services are free. We support our PCPs and specialists to ensure complete patient care.

**Q: If I decide to leave or decline services, can I return?**

**A:** Yes, you can always contact us, and we will work with you to explore your options.

**Q: If I am discharged from the Complex Care Management Services for meeting all my medical goals and something else happens to me, can I come back?**

**A:** Yes, you can always return without a referral from your PCP. We urge you to keep in contact with us should you develop a new medical issue.

## FOR MORE INFORMATION, CONTACT:

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Work with your PCP to decide whether the Complex Care Management Services are right for you and determine next steps. In addition to your regular appointments, you may have the ability to communicate with your PCP through MyChart.



MyChart is an online patient portal that gives you access to your health care information and allows you to connect with your doctor in a way that's convenient for you.

Visit us online at:

[MyChart.HawaiiPacificHealth.org](http://MyChart.HawaiiPacificHealth.org)

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## COMPLEX CARE MANAGEMENT SERVICES



*For those who need it most*

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## COMPLEX CARE MANAGEMENT SERVICES



Our goal is to give the best care possible to patients and their families. The care team will work with you to ensure you receive the right care at the right time, at the right place.

The Complex Care Management Services are designed for patients with two or more major medical conditions. Our goal is to give the best care possible to you and your family, in a holistic approach, to achieve the best outcomes.

The services allow the Care Team to work closely with you and your family. We assist with scheduling medical appointments, understanding and following instructions for taking necessary medications, receiving health education and identifying and accessing community resources. This ensures you receive the right care at the right time at the right place.

The Care Team is comprised of a case manager (RN) and care coordinators (MAs) who assist you and your family through all aspects of your care. We focus on a patient-centered care model and work closely with primary care providers (PCPs) and specialists to provide continuous high-quality care and services.

### WHAT HAPPENS AFTER THE REFERRAL?

Your PCP will refer you to our services, and, depending on the reason for the referral, one of the following will occur:



**Step 1:** A member of the team will meet with you and your PCP – this allows your PCP to introduce our team to you and explain how we work together OR your PCP will discuss the Complex Care Management Services with you, and we will contact you to set up an appointment to meet with you and/or your family.



**Step 2:** The Care Team will contact the PCP or referring provider to discuss the care plan you and the team have developed.



**Step 3:** The care plan is entered into your electronic medical record to allow the PCP and any specialists to follow your progress.

### WHAT DOES THE CARE TEAM DO?

- Create a care plan and goals based on the patient's needs
- Assist patients and their families in working through barriers in the health care system
- Provide a primary contact for addressing all health care needs
- Communicate with patients, caregivers and family members on a regular basis to share status of goals and address concerns
- Communicate with PCPs and/or specialists
- Arrange access to needed services in the clinics
- Assist with access to needed services in the community – for example, housing, finance and transportation
- Offer wellness classes through our Health Education Department