Ontario

BACKGROUNDER

Ministry of Health and Long-Term Care

Integrated Comprehensive Care Project

September 27, 2013

The Integrated Comprehensive Care Project at St. Joseph's Healthcare Hamilton is an innovative model of care that emphasizes faster and easier movement of patients from the hospital bed to community care.

Key to the success of the program is the role of the Integrated Care Co-ordinators who follow patients through various care settings to ensure continuity of care, working collaboratively with all existing providers in the hospital and community. Through this approach, the co-ordinators are able to prevent complications for patients and readmissions to hospital. They also help to remove any duplications in care and ensuring timely care for the patients.

Other important features of the program include:

One contact number for the patient allows the patient concerns to be directed to the most appropriate member of the health care team on a 24/7 basis.

A shared electronic health record for the patient used by the co-ordinators and the home care team allows team members to quickly and securely access patient information.

Community partner support enables the team to act decisively and implement necessary changes effectively across the continuum of care.

Flexibility in communications strengthens patient care by allowing service providers to connect using the latest technology including cell phones, tablets and Skype.

Samantha Grant, Minister's Office, 416-326-4905
David Jensen, Ministry of Health and Long-Term Care, 416-314-6197

ontario.ca/health-news
Disponible en français