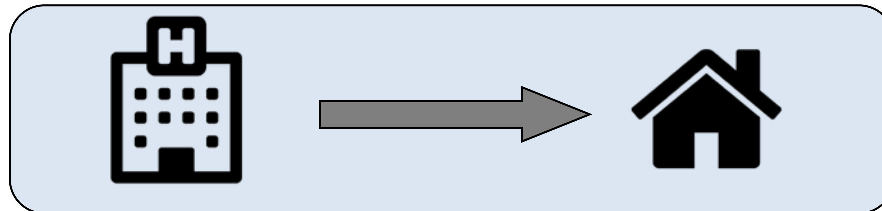
Hamilton Health Sciences
PATIENT EDUCATION

INTEGRATED COMPREHENSIVE CARE PROGRAM

Integrated Comprehensive Care (ICC) Program

What is the ICC Program?

This program is for patients who have chronic obstructive pulmonary disease and/or heart failure. The ICC Program offers support from a coordinator while you are in the hospital. The ICC Program will continue to support you for 60 days after you go home from the hospital.



What support will I receive while I am in the hospital?

While you are in the hospital, you will meet an ICC coordinator. The coordinator will work with you, your family, and the health care team to organize home care services that you will need after you go home.

This includes:

- Making sure you have a smooth transition from hospital to home.
- Coordinating home care that may include care from a nurse, occupational therapist, physiotherapist, respiratory therapist, dietitian and personal support worker.
- Communicating your discharge plan with your family doctor and specialist.
- Connecting you with community resources to support independent living.
- Using technology to communicate between team members (such as video conferencing, an electronic medical record, tablets/computers and other mobile devices).

please turn over ➔

What support will I receive when I return home?

At home	Support you will receive
Within 24 hours	• A team member will visit you to assess how you are doing and make sure your follow-up appointments have been made.
During the first week	• The home care team (may include a nurse, occupational therapist, physiotherapist, respiratory therapist, dietitian and/or personal support worker) will visit you to assess how you are doing and teach you how to manage your chronic obstructive pulmonary disease and/or heart failure.

During weeks 2 through 7	• The coordinator will:
	  • call you to assess how you are doing and review the support you have received to date.
	  • make referrals to additional community resources if needed to support you at home.
	• The home care team will continue to support and teach you how to manage your chronic obstructive pulmonary disease and/or heart failure.

At 8 weeks	• The coordinator will:
	  • follow-up with you to see if you need any additional help to manage your condition.
	  • communicate the discharge or transition plan to members of your health care team including your family doctor.

An ICC Program team member can be reached 24 hours a day, 7 days a week during your 60 day program at: 1-877-611-0669 or 905-522-2324

© Hamilton Health Sciences, 2016
PD 9169 – 08/2016
dpc/pted/ICCProgram-trh.docx
dt/August 2, 2016