Transforming Patient Flow Through Southlake's Integrated Care Centre (ICC)

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Overview

Southlake Health implemented a major quality improvement initiative titled **"Transforming Patient Flow Through Southlake's Integrated Care Centre (ICC)"** to improve access and flow across the hospital system. The initiative responded to increasing Emergency Department (ED) demand, prolonged waits for inpatient beds, and system-wide capacity constraints driven by rising volumes, ALC pressures, and limited community resources. The core aim was to reduce **Time to Inpatient Bed (TIP)** by shifting from a fragmented, department-based model of patient flow to a coordinated, hospital-wide system supported by real-time data and centralized decision-making. The ICC, supported by a Distributed Health Network (DHN) model, was established to bring together clinical, operational, and community partners to improve visibility of demand and capacity, enabling faster escalation and resolution of flow barriers. The initiative aligns with Southlake's broader goal of becoming a high-reliability organization and evolving toward a more integrated, distributed model of care.

Key Elements of Initiative

Change Ideas Tested or Implemented

- Established an **Integrated Care Centre (ICC)** as a real-time coordination hub for patient flow, supported by a Distributed Health Network model.

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- Implemented **extended flow leadership coverage (12 hours/day, 7 days/week)** and expanded evening/weekend bed meetings.
- Introduced **standardized bed prioritization and surge planning tools**, including updated unconventional bed-space criteria.
- Expanded **Admission/Discharge Lounge usage** and implemented **Electronic Transfer of Accountability (ETOA)** to support faster patient movement.
- Strengthened **discharge processes**, including Expected Date of Discharge (EDD), ALC/Home First processes, and weekend discharge planning.

Objective of Change Ideas

- educe Time to Inpatient Bed (TIP).
- Improve coordination of patient flow across hospital and community settings.
- Improve use of acute and sub-acute capacity.
- Shift toward proactive and system-wide flow management aligned with high reliability principles.

Team Members Involved

- Access & Flow, Bed Allocation, Support Services, Clinical Programs, Infection Prevention and Control, Transitions, Ontario Health atHome, Southlake@home, OHT partners, IT/Digital Health, Analytics/Decision Support, and frontline clinical and operational teams.

Target Population

- Patients admitted through the Emergency Department awaiting inpatient beds, along with broader inpatient, sub-acute, and transitional care populations.

Measurement Progress

- Primary measure: **Time to Inpatient Bed (90th percentile).**
- Supporting metrics: ED admission volumes, ETOA performance, discharge lounge utilization, ALC days, length of stay, bed turnover, and flow barrier tracking through dashboards.

Implementation Experience: Successes & Challenges

Results/Early Wins

- TIP reduced from approximately 43–44 hours to ~37 hours, achieving sustained improvement and falling below target in later measurement periods.
- Improved visibility of system-wide capacity and demand through dashboards.
- Faster identification and escalation of flow barriers.
- Increased ED-to-inpatient transfers and better coordination of bed turnover and discharge processes.
- Improved weekend and evening discharge activity and strengthened cross-team accountability.

Enablers of Success

- Strong executive sponsorship and leadership alignment.
- Use of real-time dashboards and digital tools.
- Shared accountability across clinical, operational, and community partners.
- Strong frontline engagement and continuous feedback loops.
- High reliability culture and structured PDSA cycles.

Challenges and Solutions

- Implementing transformation during peak seasonal pressure (respiratory virus season).
- Simultaneously building new governance, workflows, and technology while maintaining operations.
- Resistance to shifting from siloed ownership to shared accountability.
- Addressed through continuous engagement, frontline feedback, iterative refinement, and standardized escalation processes.

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- **Advice for other teams:**
    - Co-design solutions with frontline staff from the start.
    - Build strong partnerships with IT and analytics early.
    - Learn from other organizations and adapt best practices.
    - Use iterative PDSA cycles and remain flexible to changing conditions.

Future Steps & Sustainability

Next Steps and Embedding into Practice

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    - Transition from reactive to **predictive flow management**.
    - Implement a **flow blocker tracking application**.
    - Integrate systems (dispatch, transport, bed turnover, MEDITECH).
    - Strengthen discharge planning processes (EDD, ALC reduction, Home First).
    - Enhance physician integration across the Distributed Health Network.
    - Improve patient/family communication about discharge expectations.
    - Refine metrics and strengthen forecasting capabilities.

Embedding into practice:

- ICC processes embedded into formal policies and standard workflows.
- Integration into daily rounds, bed meetings, discharge planning, and orientation.
- Ongoing use of dashboards and steering committee reviews.
- Continuous frontline feedback used to refine workflows and sustain improvements.
- Shift from project-based work to an organizational operating model for patient flow.

The Data

[Optional section: add any relevant figures or graphs here]

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