ENGAGEMENT PLAN · HOSPITAL ED THROUGHPUT

Helm: *ED throughput transformation* across an Ontario hospital cohort.

Six hospitals across two Ontario Health Teams are running 90th-percentile admitted-patient ED-LOS materially above the provincial 8-hour target: the bottleneck is downstream bed-flow, not triage.

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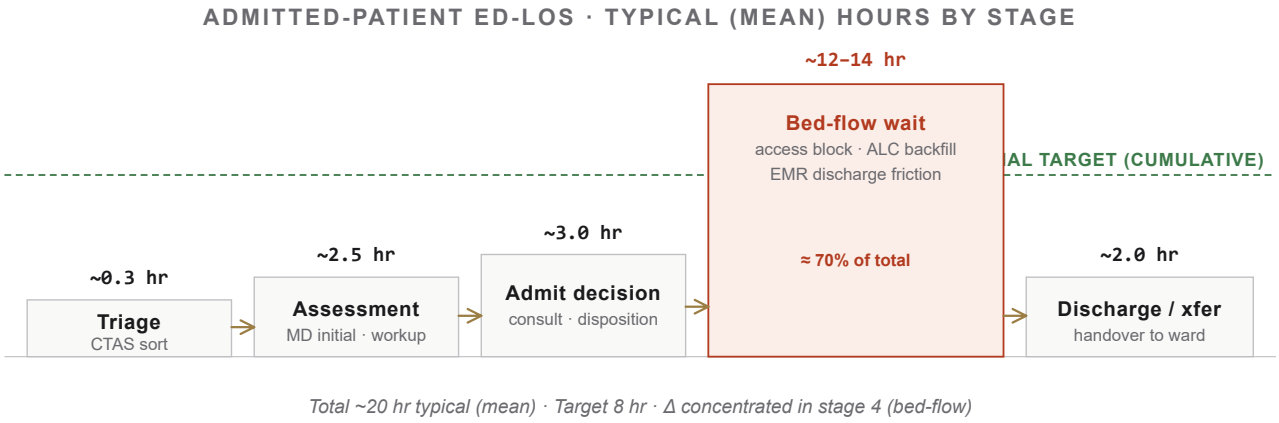
Targets McKinsey Public Sector · Deloitte Public Sector · BCG Public Sector · Bain PI Healthcare

The Problem

Ontario's ED problem is a flow problem, not an intake problem. The provincial target for total time-in-ED for admitted patients is **8 hours**; reported 90p ED-LOS has run materially above that into 2024 (CIHI / HQO). The bottleneck is access block: admitted patients holding stretchers because inpatient beds are occupied, with **~17% of acute-care bed-days** nationally consumed by ALC patients (CIHI, 2022–23). MoH regulates; **Ontario Health** implements; **~50 OHTs** are operational, with a tightened total-time-in-ED expectation feeding the next budget cycle. The structural opportunity is inside the hospital (discharge-readiness governance and bed-turn lookahead), not at the front door.

FIGURE 1 · WHERE THE HOURS ARE LOST (TYPICAL/MEAN)



Stage decomposition shown as typical (mean) hours; the 90p baseline used in sizing below runs ~30 hr, with bed-flow carrying the tail. Triage + assessment are <15% of total; the ~70% loss is the bed-flow wait.

Sizing the prize

Six-hospital cohort across two OHTs, ~340,000 ED visits / yr, ~28% admit rate (~95,000 admissions). At a 90th-percentile admitted ED-LOS baseline of ~30 hours and a target of ~12 hours by month 9, recoverable hours are **~1.7M patient-hours / yr** off ED stretchers. At a directional **$95–110 / patient-hour** blended cost (CIHI ED-cost methodology), that is **~C$160–185M / yr** in capacity value released, mostly ward-displacement value, not cash savings.

Directional sizing: HQO indicator library + CIHI NACRS aggregates + 3 hospital-COO interviews + 2 OHT-lead conversations. Engagement-plan ballpark; not committed.

PATIENT-HOURS RECOVERED
~1.7M / yr
cohort, off ED stretchers

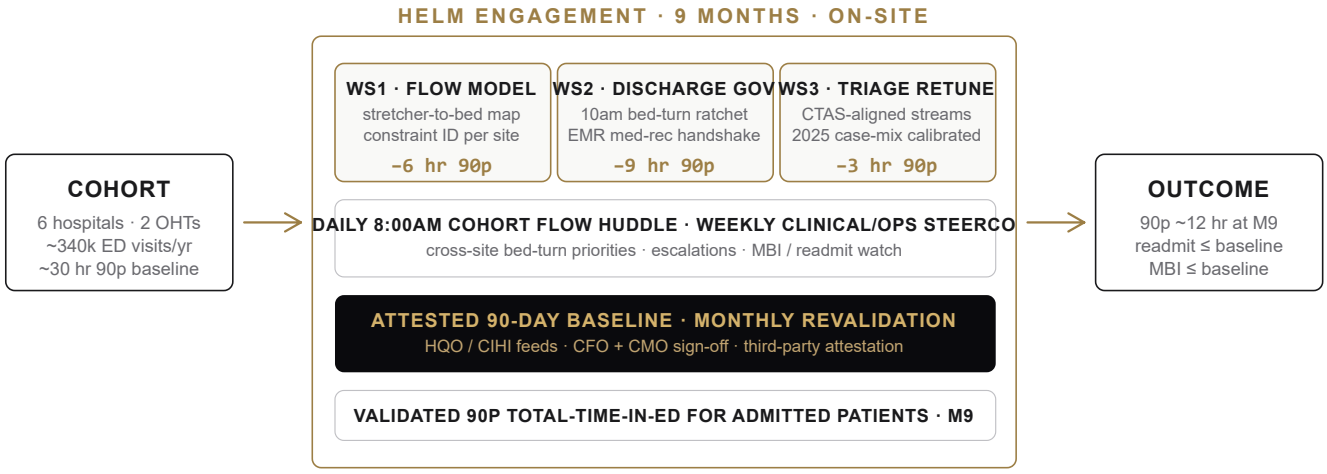
CAPACITY VALUE RELEASED
~C$160–185M / yr
directional · blended cost basis

THE UNLOCK

Run **three workstreams in parallel against a single audited 90-day baseline**, governed by a daily 8:00am cohort flow huddle and a weekly clinical/ops steerco co-chaired by the OHT lead and a hospital COO. WS1 maps stretcher-to-bed transitions and identifies the two highest-leverage constraints per site; WS2 institutes a next-day discharge lookahead, a 10:00am bed-turn ratchet, and an EMR-embedded med-rec + transport handshake; WS3 recalibrates CTAS-aligned streaming to 2025 case-mix. Operational, not advisory.

Engagement architecture

FIGURE 2 · THREE-WORKSTREAM OPERATING MODEL



Three workstreams run in parallel from week 2; daily cohort huddle + weekly clinical/ops steerco govern the work; a 90-day attested baseline (HQO / CIHI-fed, third-party attested, revalidated monthly) is the audit anchor. The north-star (90p total-time-in-ED for admitted patients) is read at M9 against the pre-engagement baseline.

WORKED EXAMPLE · HOSPITAL 3 · 10AM BED-TURN RATCHET

Hospital 3 (community teaching, ~52,000 ED visits / yr) discharges 78% of medicine-ward patients after 2:00pm; admit-to-bed wait runs ~16 hr at 90p. WS2 adds a next-day discharge lookahead at the 4:00pm prior-day huddle, an EMR med-rec + transport handshake by 9:00am, and a 10:00am ratchet for confirmed discharges. By week 14: **discharge-before-2pm rises 22% → 51%**; **admit-to-bed 90p falls ~16 hr → ~9 hr**; readmission held flat at 12.8% (CIHI 30-day all-cause).

Sequenced delivery (parallel-track from week 2)

PHASE	WORKSTREAM CADENCE	FORCING-FUNCTION DELIVERABLE	AUDITED PROOF POINT
M0–3 Diagnose · attest	WS1: 6-site flow map · WS2: discharge-friction taxonomy + EMR audit · WS3: case-mix decomposition	Attested 90-day baseline · governance charter · risk register · MBI baseline	Baseline signed by hospital CFOs, CMO council, third-party auditor
M3–6 Implement · operate	WS1: visual-mgmt boards live · WS2: 10am ratchet on 4 of 6 sites · WS3: triage retune piloted on 2 sites	Daily cohort huddle in continuous operation · weekly steerco · monthly indicator pack	−6 hr 90p ED-LOS by M6 · readmit + MBI within ±5% of baseline
M6–9 Sustain · transfer	Capability transfer to OHT operations leads · governance institutionalization · MoH pack	Final validated 90p ED-LOS · handover signed by hospital COOs + OHT leads	~12 hr 90p at M9 · cohort owns 100% of the daily cadence

Metrics that matter

LAYER	METRIC	M9 TARGET	WHY IT MATTERS
North-star	90p total-time-in-ED for admitted patients (audited vs. 90-day baseline)	~30 hr → ~12 hr	The metric MoH and OHTs both score; HQO-publishable
Throughput	Discharge-by-noon rate (medicine wards)	≥ 50% by M6	Lead indicator that bed-turn is shifting earlier
Quality (counter)	30-day all-cause readmission (CIHI)	≤ baseline	If readmits rise, "throughput" came from premature discharge; voids the engagement
Quality (counter)	Left-without-being-seen (LWBS) rate	≤ baseline	Counter-check retuned triage hasn't pushed risk to the waiting room
People (counter)	MBI score, ED + medicine	≤ baseline · two-wave	Gold-standard burnout instrument; rising MBI invalidates capability transfer
Capability	Daily cohort huddle continuity post-engagement	> 80% cohort-days at M12	The work doesn't sustain without the daily rhythm

Risks & mitigations

HIGH **Clinical pushback: ED physicians and ward charge nurses disengage from the daily huddle, framing the work as "consultants cosplaying patient flow."**

Mitigation: the 8am huddle is co-chaired by an ED physician lead and a medicine-ward charge nurse, not a consultant. Every operational decision is co-signed by clinical leadership. Sponsorship is hired for at hospital level, not negotiated after.

HIGH **ALC backfill from long-term-care wait-lists makes the bed-flow gain structurally impossible at one or more sites.**

Mitigation: WS1 site-screen flags ALC-saturation early (≥ ~25% of medicine bed-days); over-threshold sites trigger steerco escalation to Ontario Health for placement-pathway intervention. Cohort target holds; site target is hedged.

MED **EMR-driven discharge friction varies by site (Epic, Oracle Health / Cerner, Meditech); no single technical fix scales.**

Mitigation: WS2 builds a vendor-agnostic discharge-readiness checklist enforced via visual-management board, not the EMR; EMR-embedded changes pursued only where ROI clears a 90-day horizon. Governance does the work; the EMR catches up later.

30 / 60 / 90, first-quarter sprint plan

30 DAYS

Diagnose · attest baseline

- 6-site flow map + WS1 constraint identification
- EMR discharge-friction audit across the cohort
- MBI baseline pull · readmit + LWBS baseline lock

60 DAYS

Sign · stand up rhythms

- Attested 90-day baseline + governance charter signed
- Daily 8am cohort huddle live across 6 sites
- Visual-management boards live in 4 of 6 EDs

90 DAYS

First wins · measurable signal

- 10am bed-turn ratchet live on 2 anchor sites
- Triage retune piloted at 2 sites
- −4 to −6 hr 90p ED-LOS interim, audited

DECISION ASKED

Authorize a **9-month engagement** with a seven-person on-site team (partner + three senior associates + three clinical-ops embeds), **fixed-fee with a measurable-outcome at-risk component** tied to attested 90p ED-LOS reduction at M9. Success: ~30 hr → ~12 hr cohort 90p, no degradation on readmit / LWBS / MBI, daily huddle still cohort-owned at M12. Public-sector commercial conventions respected: no gainshare on patient outcomes; baselines and proof points HQO-publishable.