

Helm: ED throughput transformation across an Ontario hospital cohort.

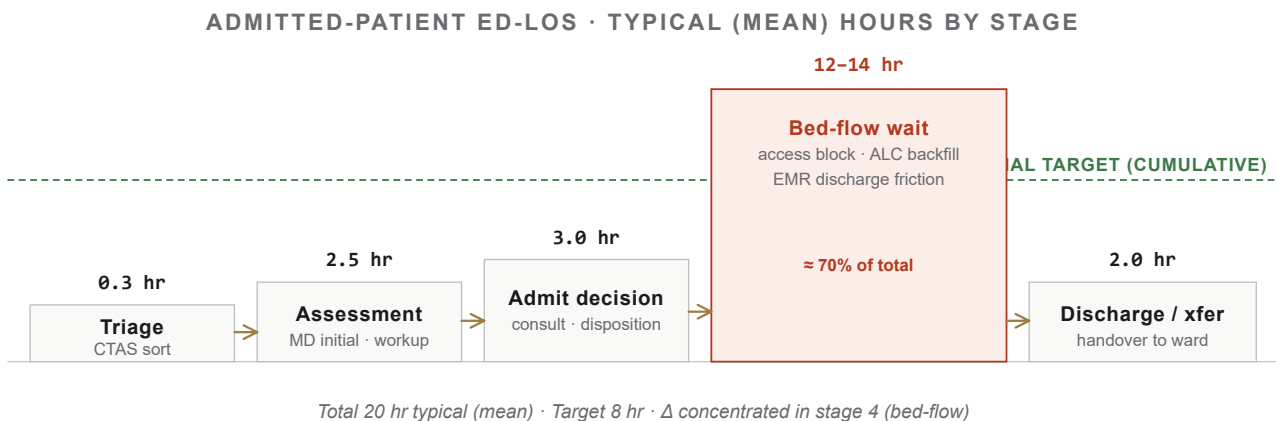
Six hospitals across two Ontario Health Teams are running 90th-percentile admitted-patient ED-LOS materially above the provincial 8-hour target: the bottleneck is downstream bed-flow, not triage.

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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; **58 OHTs** are operational (Ontario Health, 2024), 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 cohort-audited 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 blended **\$95–110 / patient-hour** capacity cost (derived from CIHI ED cost-per-visit and average length of stay), that is **C\$160–185M / yr** in capacity value released, mostly ward-displacement value, not cash savings.

For the hospital COO, released capacity defers the capital case for new inpatient beds, the most expensive way to buy throughput, which is why the board scores patient-hours recovered alongside the access-block metric rather than treating it as soft benefit.

Sources: Health Quality Ontario ED indicators (2024); CIHI Hospital Stays in Canada (2022–23); CIHI cost per ED visit (2020); Ontario Health (2024). Cohort baseline and recovery targets reflect 3 hospital-COO interviews and 2 OHT-lead conversations.

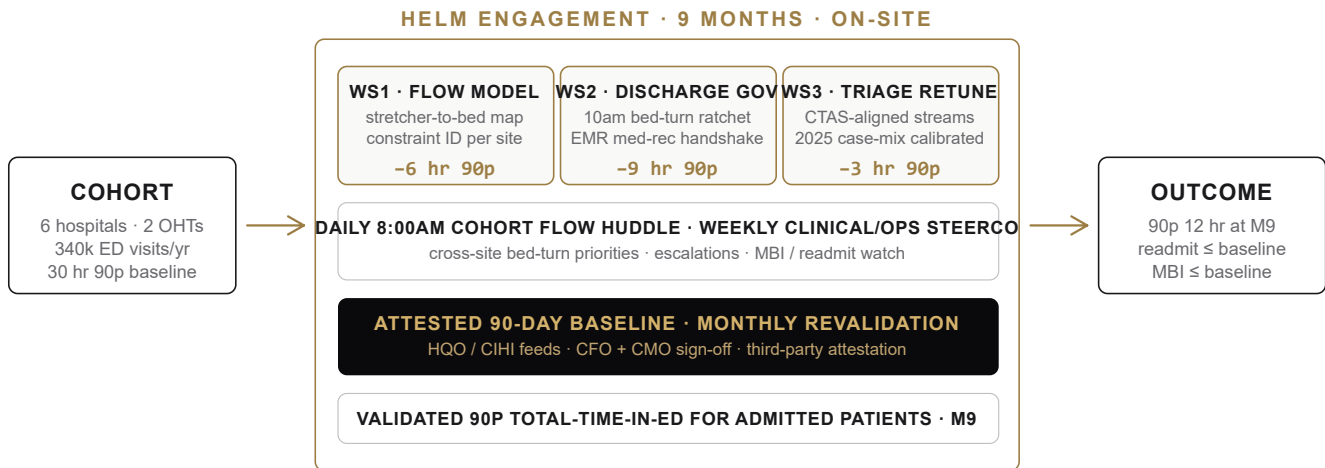
<p>PATIENT-HOURS RECOVERED 1.7M / yr <i>cohort, off ED stretchers</i></p>
<p>CAPACITY VALUE RELEASED C\$160–185M / yr <i>blended capacity-cost basis</i></p>
<p>90P ED-LOS TARGET 30 → 12 hr <i>admitted patients, by month 9</i></p>

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

Each milestone is signed by the hospital CFOs, the CMO council, and a third-party auditor against the same 90-day baseline, so the engagement is paid on verified ED-LOS reduction rather than on activity. Readmission and the case-mix-adjusted mortality-and-morbidity index are tracked in parallel as guardrails: a flow gain that pushes either past its band pauses the ratchet, which keeps the throughput target from being met by discharging too early.

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 returned 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

<p>30 DAYS</p> <p>Diagnose · attest baseline</p> <ul style="list-style-type: none"> › 6-site flow map + WS1 constraint identification › EMR discharge-friction audit across the cohort › MBI baseline pull · readmit + LWBS baseline lock 	<p>60 DAYS</p> <p>Sign · stand up rhythms</p> <ul style="list-style-type: none"> › Attested 90-day baseline + governance charter signed › Daily 8am cohort huddle live across 6 sites › Visual-management boards live in 4 of 6 EDs 	<p>90 DAYS</p> <p>First wins · measurable signal</p> <ul style="list-style-type: none"> › 10am bed-turn ratchet live on 2 anchor sites › Triage retune piloted at 2 sites › -4 to -6 hr 90p ED-LOS interim, audited
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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.