



Keeping Emergency Departments Open

Cross-Provincial Solutions for Canada



Executive Summary

Emergency department (ED) closures have become a structural feature of the Canadian health system rather than a series of isolated local disruptions. Since 2019, roughly 34% of Canadian emergency departments have experienced at least one temporary or prolonged closure, amounting to more than 1.14 million lost operating hours.¹

The pressure is felt most acutely in rural and remote communities, where the majority of shutdowns occur. According to 2026 reports from the Canadian Institute for Health Information (CIHI), out of a record 16.1 million ED visits across Canada in 2024–2025, 1.2 million visits (7.7%) ended with the patient leaving before ever being seen and assessed by a physician.² This paper maps the crisis by following the patient journey through the ED and organizing the underlying pressures into three broad areas. These are the upstream gaps in primary care and community services that push patients toward the ED, the throughput bottlenecks that slow care once patients are inside, and the downstream blockages in acute and continuing care that trap admitted patients on the way out.

Across the country, governments, health authorities, and service provider organizations are making real progress on difficult problems. What Canada lacks is the infrastructure to evaluate these local solutions, spread them between jurisdictions, and scale what works. This sets the country on a trajectory of repeating pilots in isolation instead of adopting proven models more broadly. This is a long-standing problem. More than a decade ago, Dr. David Naylor chaired a review of Canadian research and innovation that found Canada generates considerable ingenuity in health care but struggles to share and scale it.

Why Now?

Santis Health works across the health system every day, engaging the full continuum of care to understand complex problems and co-develop strategies to tackle them. That vantage point gives us a unique view of the landscape, and this paper draws on it to bring proven ideas together in one place. Our aim is to surface the innovations that are working, connect the people solving the same problems, and help spread promising ideas.

Structural repairs to the system, including closing the health human resource gap, adding acute and long-term care beds, strengthening community care, and rebuilding primary care, are well understood and already underway. This paper does not revisit that work but instead spotlights six case studies highlighting innovative tools and care models being piloted and adopted across Canada. Each case study maps a proven solution to the specific pressure point it addresses along the patient journey.

¹ Grant, K., Ha, T. T., & Sun, Y. (2025, July 4). Canadian ERs closed their doors for at least 1.14 million hours since 2019, records show. The Globe and Mail. <https://www.theglobeandmail.com/canada/article-secret-canada-emergency-rooms-closures-hospitals/>

² Canadian Institute for Health Information. (2026, June 25). Emergency department waits reflect access to care across the system. <https://www.cihi.ca/en/emergency-department-wait-times-in-canada-insights-from-a-health-system-perspective/emergency-department-waits-reflect-access-to-care-across-the-system>

Problem Factor – Upstream (before ED entry)

Pressure Points	Innovation	Jurisdiction
Unattached patients and primary care access gaps	Community Pharmacy Primary Care Clinics	Nova Scotia

Problem Factor – Throughput (inside the ED)

Pressure Points	Innovation	Jurisdiction
Low-acuity backlog and delays in triage and assessment	Physician Assistant integration	New Brunswick
Physician shortages in rural and remote sites	Virtual Emergency Rooms	Newfoundland and Labrador
Wait times and patient flow coordination	AI-enabled online queuing system	Ontario

Problem Factor – Downstream (leaving the ED)

Pressure Points	Innovation	Jurisdiction
Acute bed shortages and inpatient gridlock	Hospital at Home	British Columbia
Alternate Level of Care gridlock	Community Paramedicine for Long-Term Care	Ontario

Framing the Problem: The Patient Journey

A scan of the factors which push patients into the ED, the bottlenecks which slow timely care inside it, and the gridlock which traps patients on the way out can help identify the cracks in the health care system.

Before ED Entry

Upstream factors are the gaps in access to primary care, community, and diagnostic services which push patients towards the ED as the default entry point for care. These pressures overburden ED waiting rooms and drive up the number of patients who leave untreated.

- **Deficits in primary care attachment:** According to 2025 estimates from CIHI, 5.7 million adults and 765,000 children and youth do not have a primary health care provider.³ Without a family doctor, the ED becomes the key entry point to health care services for unattached patients.
- **Barriers to accessing timely care:** Even patients attached to family physicians struggle to get access to care at the right time. Seventy-four percent of Canadian adults report not being able to get a same-day or next-day appointment, and 77% report finding it difficult to access medical care in the evening or on weekends or holidays.⁴
- **Delays in community diagnostic services:** Long waits for specialist appointments and diagnostic tests drive patients to the ED in search of faster access to care. One in 10 Canadians who required scans waited more than 200 days for an MRI⁵ and over 140 days for a CT scan.⁶
- **Unmanaged chronic illness:** An aging population with growing health needs means that patients are increasingly presenting to the ED with complex chronic conditions. When access barriers delay disease management these conditions are left to worsen until they culminate in exacerbations that ultimately require intensive emergency intervention and acute hospital admission.

Across Canada, ED wait times have increased, and several EDs are facing challenges with overcrowding, staffing shortages, and limited bed capacity that have not kept pace with growing demand.



³ Canadian Institute for Health Information. (2025). Most Canadians have a regular health care provider. <https://www.cihi.ca/en/taking-the-pulse-measuring-shared-priorities-for-canadian-health-care-2025/primary-health-care-2025/most-canadians-have-a-regular-health-care-provider>

⁴ Canadian Institute for Health Information. (2024). Access to primary care: Many Canadians face challenges. <https://www.cihi.ca/en/primary-and-virtual-care-access-emergency-department-visits-for-primary-care-conditions/access-to-primary-care-many-canadians-face-challenges>

⁵ Canadian Institute for Health Information. (2026). Wait times for MRI scan. <https://www.cihi.ca/en/indicators/wait-times-for-mri-scan>

⁶ Canadian Institute for Health Information. (2026). Wait times for CT scan. <https://www.cihi.ca/en/indicators/wait-times-for-ct-scan>

Inside the ED

Throughput factors are the internal bottlenecks that slow patients down once they are through triage. This is about how quickly the ED can assess, test, and treat the people already in front of it.

- **Triage to assessment delays:** When patients arrive in the ED, they are assessed by a nurse and triaged based on the urgency and severity of their condition. Patients present with multiple conditions at once. These cases take longer to assess, which widens the gap between triage and seeing a physician.
- **Diagnostic and workup inefficiencies:** Following triage, patients are assessed by a physician or another ED care provider and may undergo diagnostic procedures. Delays and inefficiencies in these procedures and specialist consults keep patients inside the department longer than they need to be.
- **Ambulance offload delays:** As ward beds fill, admitted patients are held on ED stretchers in hallways and resuscitation bays. According to June 2026 statistics from Ontario Health, patients waited over 16 hours in the ED before receiving a ward.⁷ With admitted patients occupying these stretchers, arriving ambulances are left with little space to offload incoming patients. This also leads to paramedics getting stalled in hospital hallways impacting emergency response capacity for neighbouring communities.

Leaving the ED

Downstream factors are the acute and continuing care challenges that hinder admitted patients from moving out of the ED.

- **Inpatient bed capacity shortages:** According to a 2025 report by the Organisation for Economic Co-operation and Development (OECD), Canada has just 2.5 acute care hospital beds per 1,000 residents, ranking well below the OECD average of 4.2.⁸
- **Alternate Level of Care bottlenecks:** CIHI data from 2021 states that there are only 29 long-term care beds per 1,000 people aged 65 and older in Canada.⁹ Downstream shortages in long-term and community support contribute to hospital beds being occupied by patients who cannot leave due to a lack of outpatient resources.



⁷ Ontario Health. (2026). Time spent in emergency departments. <https://ontariohealth.ca/system/reporting/performance/time-spent-in-emergency-departments>

⁸ OECD. (2025). Health at a glance 2025: Canada. OECD Publishing. https://www.oecd.org/en/publications/2025/11/health-at-a-glance-2025-country-notes_2f94481e/canada_06cf2e54.html

⁹ Canadian Institute for Health Information. (2021). How many long-term care beds are there in Canada? <https://www.cihi.ca/en/how-many-long-term-care-beds-are-there-in-canada>

The Catalyst: A Persistent Health Human Resource Crisis

While upstream demand, throughput congestion, and downstream gridlock contribute to chronic strain inside EDs, it is ultimately the lack of health care staff that tips a struggling department into a total closure. Emergency nurses and physicians have to balance continuously managing complex, admitted inpatients while triaging, assessing, and treating incoming emergencies.

- **Workforce exhaustion and moral injury:** When staff are simultaneously handling constant overcrowding, and providing care in hallways, the strain adds up over time. In the Canadian Medical Association's 2025 National Physician Health Survey, 46% of physicians report high levels of burnout.¹⁰
- **Nursing and physician vacancies:** An estimated 49% increase in family physicians is required to fulfill the current demand for health services.¹¹ Across provinces, nursing shortages are also driving ED closures, rooted in remuneration, stressful work environments, and poor work-life balance. In rural regions the gaps are even more alarming, with only 7% of Canada's physicians based in these areas.¹²
- **Reliance on agency nursing:** To fill vacant nursing shifts, hospitals frequently turn to private staffing agencies that place temporary nurses at premium rates. Provinces spent over \$1.5 billion on agency nurses in the 2023–2024 fiscal year, diverting budgets from permanent positions and deepening frustration among team members.
- **Operational threshold failure:** Rural and small hospitals operate with lean teams, hence losing even a single nurse or physician can disrupt the hospital call schedule. When there is no one available to cover the gap, administrators have no safe or legal option left but to issue a closure notice.



¹⁰ Canadian Medical Association. (2025, October 14). Five years since onset of COVID-19, Canada's physicians still suffer high rate of burnout. <https://www.cma.ca/about-us/what-we-do/press-room/five-years-onset-covid-19-canadas-physicians-still-suffer-high-rate-burnout>

¹¹ Government of Canada. (2025). Caring for Canadians: Canada's Future Health Workforce — The Canadian Health Workforce Education, Training and Distribution Study. <https://www.canada.ca/en/health-canada/services/health-care-system/health-human-resources/workforce-education-training>

¹² Canadian Institute for Health Information. (2024). A profile of physicians in Canada. <https://www.cihi.ca/en/a-profile-of-physicians-in-canada>

Mapping the Response: Cross-Provincial Solutions

While the crisis may be severe, it is solvable and solutions are taking shape across Canada. Provincial governments, regional health authorities, and clinical leaders are moving beyond reactive crisis management toward structural solutions to ease ED pressures. The reforms required are well understood, from closing the health human resource gap to adding acute and long-term care beds, strengthening community care, and rebuilding primary care. These approaches are underway and the paper does not revisit it. Our focus is on spotlighting the innovative tools and technologies being piloted and adopted across the country to facilitate better sharing of lessons learned.

Jurisdictions are treating the emergency crisis as a catalyst for overdue health system modernization, proving that targeted policy interventions can successfully rebuild capacity and stabilize emergency care. The following case studies map pressure points in the patient journey to tried and tested innovations in Canada.

Our focus is on spotlighting the innovative tools and technologies being piloted and adopted across the country to facilitate better sharing of lessons learned.



Primary Care Gaps and Community Pharmacy Clinics

Community pharmacies are being converted into primary care access hubs and independent prescribing authorities for minor ailments which are active in almost every province. When unattached patients get immediate, low-barrier access to a pharmacist for infections or chronic disease management, health symptoms are managed before they escalate into an ED visit.

Case Study, Nova Scotia: Community Pharmacy Primary Care Clinics

What They Did

In February 2023, Nova Scotia Health and the Pharmacy Association of Nova Scotia (PANS) launched the Community Pharmacy Primary Care Clinic (CPPCC) project. The intention was to enable pharmacists to work to their full scope and convert community pharmacies into a real front door for primary care. CPPCC sites offer publicly-funded, dedicated clinical appointments for services such as minor ailment assessment and prescribing, prescription renewals, strep throat diagnosis and treatment, chronic disease management, and publicly-funded vaccines. In July 2024, PANS added a virtual consultation pathway to these appointments to enable consultations with nurse practitioners on more complex cases like chronic kidney disease and diabetes.

What Happened

The project launched with 12 sites and was expanded twice due to the strength of its results. Ninety-eight percent of patients rated their satisfaction levels with services at eight or higher out of 10. A final evaluation covering 31 clinics demonstrated the success of the model at scale. Between February 2023 and October 2024, CPPCC sites provided 188,276 visits to more than 90,000 unique patients and delivered over 218,000 services.¹³ (Nearly half of all visits 45%), targeted unattached patients. Most importantly, the clinics diverted over 10% of patients from EDs and over 25% from walk-in clinics.¹⁴

What We Learned

Pharmacists working to full scope can absorb a real share of the demand that would otherwise flow to EDs and walk-in clinics, especially for unattached patients. However, the project evaluation also revealed where Nova Scotia's model fell short. The gaps were prevalent across four areas: disconnected IT systems that duplicated work and fragmented patient information, the absence of clear referral pathways to specialists, workload and time management pressures, and the lack of a sustainable long-term funding model.

¹³ Research Power Inc. (2025). Community pharmacy primary care clinics: Final learning and evaluation report (Condensed version). Pharmacy Association of Nova Scotia. https://pans.ns.ca/wp-content/uploads/2025/12/final_eval_report_short_-_pans_cppcc_eval_updated_final_march_13_2025_003.pdf

¹⁴ Pharmacy Association of Nova Scotia. (2025, March 17). Community pharmacy primary care clinics: Changing the face of healthcare in Nova Scotia. <https://pans.ns.ca/community-pharmacy-primary-care-clinics-changing-face-healthcare-nova/html>

Low-Acuity Backlog and Physician Assistant Integration

As emergency physicians prioritize high-acuity resuscitation, low-acuity cases build up in waiting rooms, driving triage-to-assessment delays and prompting record numbers of patients to leave without being seen. Integrating Physician Assistants (PAs) into emergency and urgent care teams to manage low-acuity streams is a growing provincial strategy. The profession is regulated in Alberta, Saskatchewan, Manitoba, Ontario, Newfoundland/Labrador, New Brunswick and Nova Scotia by the colleges of physicians and surgeons in these provinces.

Case Study, New Brunswick: Physician Assistant (PA)

What They Did

A PA is an advanced practice clinician who practices medicine with negotiated autonomy under the supervision of a licensed physician. At the discretion of the supervising physician, the scope of work can include taking complete patient histories, performing advanced physical examinations, doing workups, interpreting labs, diagnosing, and prescribing medication.

New Brunswick established PAs as a strategic health care human resources intervention designed to alleviate ED congestion. The operational foundation of the project was conceived by Dr. Graeme Young, an emergency physician at the Dr. Everett Chalmers Regional Hospital (DECRH) in Fredericton, who drew upon frameworks from military medicine to address severe localized ED overcrowding. The pilot extended across a twelve-year period from 2011 through late 2023.¹⁵

What Happened

The program managed over 7,000 patients in one year at the Chalmers hospital and reduced emergency department wait times. Recognizing the empirical success of the trial, the provincial government committed to making PAs a permanent fixture at the hospital. The province also expanded regulations to permit PAs to practice outside of acute care hospital settings, enabling their integration into community-based primary care clinics and rural health centres.¹⁶

What We Learned

Filling additional PA positions across the health system will require the expansion of training opportunities. While new programs are in development across the country, there are currently only seven programs available in Canada to educate and train PAs.¹⁷

¹⁵ Brown, L. (2023, November 27). After 12-year pilot program, physician assistants become permanent at Fredericton hospital. CTV News. <https://www.ctvnews.ca/atlantic/article/after-12-year-pilot-program-physician-assistants-become-permanent-at-fredericton-hospital>

¹⁶ Canadian Association of Physician Assistants. (2025, October 31). PAs part of New Brunswick's solution to health workforce initiatives. <https://capa-acam.ca/articles/pas-part-of-new-brunswicks-solution-to-health-workforce-initiatives-2025-10-31>

¹⁷ Canadian Association of Physician Assistants. (n.d.). PA education programs. Retrieved August 26, 2026, from <https://capa-acam.ca/pa-students/pa-education-programs>

Rural Physician Shortages and Virtual Emergency Rooms

Rural and remote communities face the sharpest imbalance in availability of health human resources. Virtual EDs are an innovative approach to cope with physician shortages and a growing number of rural and remote hospitals are using them. British Columbia's publicly-funded Virtual Emergency Room Rural assistance (VERRa) program deploys emergency physicians to work overnight virtual shifts. Alberta, Ontario, Nova Scotia, Newfoundland, and Saskatchewan are also deploying similar care models.

Case Study, Newfoundland and Labrador: Virtual Emergency Rooms

What They Did

In 2023, Newfoundland and Labrador worked with Teladoc Health Canada to staff 11 rural and remote emergency rooms when there were no available doctors on site.¹⁸ A virtual emergency room works much like a traditional ED, except that the physician joins remotely. The model brings together three elements: an on-site team of nurses and clinicians, a remote emergency physician, and a centralized flow team that coordinates care. It can supplement in-person physician coverage to reduce wait times, or provide full physician coverage at sites that would otherwise have to close. A patient arriving at the health centre is assessed in person by a nurse or other clinician, who then connects them with a virtual emergency physician. Together, the team determines a diagnosis and treatment plan, including bloodwork, prescriptions, and follow-up with local providers as needed.

What Happened

Virtual coverage has allowed the province to maintain emergency services at rural sites that would otherwise have faced temporary closures. It is estimated to have prevented approximately 40,000 hours of emergency department closures in 2025. Keeping these doors open means a wide range of presentations can be assessed and treated locally. These range from semi-urgent and urgent conditions such as sprains, infections, and acute asthma to serious emergencies including cardiac events and trauma. When patients need specialist consultation or transfer to a higher level of care, the virtual team supports their stabilization before they leave.

What We Learned

Tens of thousands of avoided closure hours show that virtual coverage can keep rural emergency care available when local physicians cannot be. Unlike temporary staffing arrangements that fill a vacant shift with an individual clinician, virtual coverage is built into the site's care model. It pairs a remote physician with the local nursing team and a centralized flow team. But its value depends on the people in the room. Virtual models change how physician expertise reaches a community. They do not replace the on-site nursing team that assesses patients, administers treatment, and responds to emergencies. A stable on-site nursing workforce remains a fundamental requirement of any functioning emergency department, whether the physician is present in person or joining virtually.

¹⁸ Tollinsky, N. (2025, October 1). Virtual medical services are keeping many rural and remote EDs open. Canadian Healthcare Technology. <https://www.canhealth.com/2025/10/01/virtual-medical-services-are-keeping-many-rural-and-remote-eds-open/>

ED Wait Times and AI-Enabled Patient Flow

According to CIHI data, in 2024–2025, half of ED patients spent four hours or less in care, and over a third spent five to 14 hours in the ED. Hospitals across provinces are embedding advanced technologies into their systems to transform patient care in emergency services.

Case Study, Ontario: AI-Enabled Online Queuing System

What They Did

Hennick Humber Health (Humber) manages one of the busiest EDs in Ontario, serving almost 130,000 patients annually and around 360 patients daily.¹⁹ To better ensure effective and positive patient flow and safety, Humber implemented an AI-enabled online queuing system into their Apotex Emergency Department, supported by a centralized command centre. Senior nurses, known as clinical expeditors, are positioned in the command centre and monitor how long emergency patients have been waiting. Other screens track patients who came from nursing homes or continuing care facilities and flash a warning in orange when a patient has stayed long enough to risk losing their long-term care bed under Ontario's rules. In recent upgrades, the queuing system has been leveraging AI and machine learning to predict patient queues and forecast advanced timeslots, based on urgency and resource availability. Patients with less emergent cases are able to schedule a future timeslot to self-manage their wait, improving their overall experience inside the ED.

What Happened

Despite operating one of the busiest EDs in Ontario, Humber noted a wait time of just more than 12 hours for emergency patients requiring admission.²⁰ This is notably shorter than the provincial average, which Ontario Health reports at 16.8 hours for admitted patients.²¹ The project revealed that data on ED wait times is often incomplete or inaccessible, making it difficult for average Canadians to judge the performance of their local hospital.

What We Learned

AI could make a genuine difference in reducing wait times and improving overall patient flow and experience. However, innovations of this nature and scale are difficult to accommodate inside smaller EDs. Better prediction of patient traffic does little to help when the underlying constraint is a shortage of staff and inpatient beds. The Humber case study is best understood as evidence that smart patient-flow coordination can meaningfully reduce boarding delays where the surrounding capacity exists to support it.

¹⁹ Humber River Health. (2024, August 21). An inside look at Ontario's busiest emergency department. <https://www.hrh.ca/2024/08/21/an-inside-look-at-ontarios-busiest-emergency-department/>

²⁰ Grant, K. (2024, October 11). One of the busiest emergency departments in Ontario also has some of the shortest wait times. The Globe and Mail. <https://www.theglobeandmail.com/canada/article-one-of-the-busiest-emergency-departments-in-ontario-also-has-some-of/>

²¹ Ontario Health. (2026). Time spent in emergency departments. <https://ontariohealth.ca/system/reporting/performance/time-spent-in-emergency-departments>

Acute Bed Shortages and Hospital at Home

Canada's acute bed deficit creates inpatient gridlock as admitted patients board on stretchers in ED hallways, stalling ambulance offloading and backing up triage. To relieve that pressure, several networks have operationalized Hospital at Home programs that move acute-level care out of the building entirely.

Case Study, British Columbia: Island Health, Hospital at Home

What They Did

In November 2020, Island Health, with support from the BC Ministry of Health, introduced the Hospital at Home (HaH) at Victoria General Hospital and expanded to Royal Jubilee Hospital and Cowichan District Hospital.²² The program provides comprehensive hospital-level care directly to the homes of low-risk adult patients, offering the comfort and convenience of receiving medical services in a familiar environment. The care team is multidisciplinary, including physicians, registered nurses, nursing unit assistants, allied health, and pharmacists. HaH patients have a virtual call bell and 24/7 phone access to their care team. Care teams provide services, including medication management, blood draws, IV therapy and supplemental oxygen. If a patient's condition changes or they choose to leave the program, the health authority coordinates their transfer back to hospital.

What Happened

Data demonstrated that with 18 beds, the HaH initiative has been able to provide more than 17,500 added days of treatment since its launch. A first-year evaluation also revealed overwhelming support for the model; with 99% of patients citing they would recommend the program to family and friends.²³ Documented outcomes include improved patient comfort, privacy, and independence; higher caregiver satisfaction and involvement; and lower risk of hospital-acquired delirium, infection, and mortality.

What We Learned

Island Health, in collaboration with health care providers and the Ministry of Health, has successfully expanded the physician-led initiative across the province. Eligible patients at Vancouver General, UBC Hospital, St. Paul's, and Mount Saint Joseph can now choose to receive acute care at home when it is safe and appropriate. The expansion reflects a growing recognition that the HaH model relieves hospital capacity pressure and improves patient outcomes at the same time.

²² Island Health. (2024, April 11). About Hospital at Home. <https://www.islandhealth.ca/our-services/hospital-home-services/hospital-home>

²³ Ministry of Health. (2024, April 12). Hospital-level care at home launches in Lower Mainland. BC Gov News. <https://news.gov.bc.ca/releases/2024HLTH0045-000554>

Alternate Level of Care Gridlock and Community Paramedicine

Unmanaged chronic illness among frail seniors, combined with diagnostic delays and inadequate home support, leads to acute exacerbations. Seniors awaiting long-term care placement often end up in the ED, driving Alternate Level of Care (ALC) gridlock. Community paramedicine models are expanding nationwide to treat high-risk seniors in their residences before a hospital visit becomes necessary.

Case Study, Ontario: Community Paramedicine for Long-Term Care

What They Did

The Community Paramedicine for Long-Term Care (CP-LTC) program provides 24/7 proactive home visits, continuous remote patient monitoring, and non-emergency clinical management to seniors who are eligible for, or waiting on, long-term care placement.

Ontario has invested \$426 million over six years to fund 56 municipal, District Social Services Administration Board, and Indigenous-governed paramedic services. In August 2025, the government made the program permanent, backed by an \$89 million annualized investment.

What Happened

Since launching in 2020 and expanding across the province in late 2022, the program has served more than 81,000 people and provided more than 310,000 hours of direct care to Ontario seniors.²⁴ In 2024, the province expanded the framework through CP-LTC+, which lets community paramedics deliver diagnostic services such as bloodwork, ultrasound, and urinalysis for long-term care residents. The government is also providing funding to long-term care homes to receive equipment and training for diagnostic services within existing long-term care homes. CP-LTC+ is being rolled out by paramedic services in Cochrane District, Hastings-Quinte, Middlesex-London, Ottawa, and the Region of Durham.²⁵

What We Learned

Community paramedics can ease demand and reduce waitlists for hospitals and the long-term care system, by catering to seniors and preventing escalation in medical conditions. By managing complex, medically frail seniors in their homes, the program delays or prevents avoidable long-term care admissions.

²⁴ Ministry of Long-Term Care. (2025, August 5). Ontario investing \$89 million to help people age safely at home. Ontario Newsroom. <https://news.ontario.ca/en/release/1006273/ontario-investing-89-million-to-help-people-age-safely-at-home>

²⁵ Ministry of Long-Term Care. (2024, August 29). Ontario expanding diagnostic services at long-term care homes in York Region. Ontario Newsroom. <https://news.ontario.ca/en/release/1004990/ontario-expanding-diagnostic-services-at-long-term-care-homes-in-york-region>

What This Adds Up To

Taken together, these case studies demonstrate that provinces are developing thoughtful, evidence-informed responses to the pressures that push EDs toward closure. These solutions map onto the patient journey that frames this paper. Primary care models like Nova Scotia's community pharmacy clinics ease the upstream pressure that burdens waiting rooms. Innovations like New Brunswick's physician assistants, Ontario's AI-enabled queuing system, and Newfoundland and Labrador's virtual emergency rooms keep patient flow moving inside the ED.

Further downstream, programs like British Columbia's Hospital at Home and Ontario's community paramedicine create the care capacity patients need to transition out of hospitals. Each solution targets a specific point of failure in the ED patient pathway and is producing measurable results. Despite their strengths, none of these innovations resolve the structural deficits in staffing, beds, and primary care attachment which are the root causes of ED closures.

They are best understood as ways to stabilize emergency care and relieve pressure while systemic health system repairs are underway. The harder problem is the lack of diffusion of good ideas between provinces. What Canada lacks is not ingenuity but the infrastructure to move a proven solution from one jurisdiction to the next, which leaves the country repeating pilots in isolation instead of building on foundations that have already demonstrated value.

This is the same gap Dr. David Naylor identified roughly a decade ago, when his review found that Canada generates considerable ingenuity in health care but struggles to share and scale it. Closing it will depend on exchanging lessons across provincial borders and supporting governments in adapting proven approaches to their own systems.



How Santis Can Help

Santis Health provides first-class counsel exclusively in the health care and life sciences sectors. For organizations working to stabilize emergency care, scale a proven model across jurisdictions, or shape the policy environment that governs these programs, we support the full path from insight to impact.

Shape the policy environment: We help clients develop and communicate their perspective to the government, from formal consultation submissions to direct engagement with decision-makers.

Understand the landscape: We provide the market and policy intelligence organizations need: what is happening across provinces, what peers are doing, and where the system is heading.

Build readiness and strategy: For organizations preparing to adopt, deploy, or scale new models of care, we help develop the strategies, governance approaches, and partnerships needed to lead.

Access funding and scale programs: We support clients through the full lifecycle of public funding by identifying opportunities, shaping competitive proposals, and turning successful pilots into sustainable, cross jurisdictional programs.



Santis Health provides first-class counsel exclusively in the health care and life sciences sectors.

Head Office:

439 University Avenue, Suite 780

Toronto, ON M5G 1Y8

Phone: 1+ (647) 776-8010

For all inquiries, please contact

Email: info@santishealth.ca

Website: SantisHealth.ca