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The Hidden Drivers of Emergency Department Overcrowding: Long-Term Care Delays, Community Care Gaps, and Patient Safety in Canada

A Statement from the Geriatric Emergency Medicine Committee of
the Canadian Association of Emergency Physicians

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Canada's emergency departments (EDs) are under severe strain because of system-wide failures – particularly for older adults (≥ 65 years). A widening gap between those in need of enhanced daily support as they age – including long-term care and community-based supports – and timely access to them has made the ED the **only accessible option** for many older Canadians, who currently make up 20 to 40% of ED visits in Canada (1, 2).

Insufficiencies in long-term care and community capacity **directly drive hospital and ED overcrowding** (3). When older adults cannot access these services, they remain in hospital beds after their acute medical issues are resolved. These patients are designated as Alternate Level of Care (ALC). In Canada, 10 to 20% of inpatient hospital bed days are occupied by ALC designated patients, of which 84% are older adults (4, 5).

ALC bed days impacts all Canadians: ALC patients cause backflow of other admitted patients into emergency stretchers, ambulances crews wait hours to offload patients, treatment spaces in the ED are lost, and waiting rooms fill up. EDs remains open, creatively using what little space remains to care for everyone else. However, emergency care teams hold their breaths, knowing the sickest patient could be stuck in the waiting room, with a disastrous outcome only seconds away. **Boarding admitted patients in the ED is not merely inconvenient or inefficient, it is dangerous**.

Prolonged ED boarding is a patient safety emergency.

Older adults are disproportionately impacted by hospital and ED overcrowding. Prolonged time in the emergency department from boarding increases the risk of preventable harms and death, including delayed diagnosis, longer hospital stays, and increased mortality (6-9).

- Every additional 4 hours of ED boarding is associated with an 8.4% increase in death within 30-days (10).
- Overnight boarding of older adults in the ED increases in-hospital mortality by 39% (11).

These grim figures reinforce a growing body of evidence demonstrating how overcrowding and access block are not simply operational challenges, they are **measurable patient-safety risks**.

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Long-term care delays are worsening across Canada.

Canada has only 47 long-term care beds per 1000 population, which is **low**, compared to other countries (12). Canada is **currently 200,000 long-term care beds short** and will need an additional 200,000 beds by 2035 (13).

- **Ontario:** Tens of thousands await LTC placement (14).
- **British Colombia:** the number of patients awaiting long-term care has tripled over six years, while provincially subsidized long-term care beds have reduced by 16% (15).
- **Nova Scotia:** Delays in residential and geriatric care drive recurrent ED visits and caregiver burnout (16,17).
- **Saskatchewan:** Demand continues to outpace capacity, especially in rural and remote areas (18).

Community-based supports are failing older adults who want to age in place.

90% of older Canadians want to age in place (19), but publicly funded home and community care cannot keep pace with our aging population (1, 20). Older adults and their families frequently encounter insufficient home support hours, fragmented after-hours care, workforce shortages, and substantial, unsustainable out-of-pocket costs for private services (21). As a result, many remain at home in unsafe conditions until a crisis precipitates an ED visit and hospitalization (22). **Access and affordability must be addressed now.**

A CALL TO ACTION

ED overcrowding is a late symptom of cascading healthcare system failures and must be recognized as a **patient safety emergency that disproportionately harms older adults.** Consistent with CAEP's EM:POWER, we call on government, health systems, and policy makers to act on **four priorities**:

1. **Recognize long-term care and home care as essential healthcare infrastructure.**
   Investments in community care and caregiver supports are investments in patient flow, capacity, and safety across the entire system.

2. **Build capacity across the entire continuum of care.**
   Expanded, timely access to long-term care placement, transitional care, rehabilitation, primary care, and community-based supports - in urban, rural and remote settings alike. Preventing avoidable ED visits and facilitating timely discharge requires sufficient downstream resources.

3. **Improve transparency and accountability.**
   Mandate public reporting of ALC occupancy, ED boarding times, delayed discharges, and overcrowding-related outcomes.

4. **Adopt a whole-system approach.**
   Sustainable solutions require coordinated strategies spanning acute care, continuing care, primary care, mental health, community care, and social supports. ED only fixes will not work.

Strategic investments guided by these recommendations and the CAEP EM:POWER framework can reverse system capacity failures — creating health systems right-sized for the needs of **all Canadians** today and tomorrow and allowing older adults to age in place with dignity.

About CAEP

As the national voice of emergency medicine (EM), CAEP provides continuing medical education, advocates on behalf of emergency physicians and their patients, supports research and strengthens the EM community. In co-operation with other specialties and committees, CAEP also plays a vital role in the development of national standards and clinical guidelines. CAEP keeps Canadian emergency physicians informed of developments in the clinical practice of EM and addresses political and societal changes, that affect the delivery of emergency health care.

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