Transforming Senior Healthcare in Canada:

Embracing Connected Care, AI, and Digital Innovation

IVEY | Lawrence National Centre for Policy and Management

Policy Brief
August 2026

Transforming Senior Healthcare in Canada:

Embracing Connected Care, AI, and Digital Innovation

Mariya Tsybulnyk (MBA '24) and Renee Hueston (MBA '24) wrote this policy brief under the guidance of Professor Romel Mostafa, Director of the Lawrence National Centre for Policy and Management, and Zsofia Agoston Villalba, Policy and Communications Specialist at the Lawrence National Centre.

For constructive feedback, we thank Muhammad Mamdani, Clinical Lead (Artificial Intelligence), Ontario Health; Nancy Winslade, Winslade Consultants Inc.; and Anna Garnett, Associate Professor, Faculty of Nursing, Western University.

For sharing their time and expertise, we thank Jake Tran, President & CEO, Toronto Grace Health Centre (TGHC), and Danielle Kilby-Lechman, Director of Integrated Care, TGHC; Dr. Matthew Chow, Chief Mental Health Officer, TELUS Health; Chris Engst, VP of Consumer Health, TELUS Health; Michael Page, Senior Director, Data Science & Advanced Analytics, Unity Health Toronto; Henrik Bjartun, Chief Medical Officer & Co-Founder, Medoma; Kirk Fergusson, Commercialization & Enterprise Business Development Lead, VITALL Intelligence; Noor El-Dassouki, Project Manager & Medly Coordinator, University Health Network.

We gratefully acknowledge the generous support of the Lawrence Family, the Baran Family Foundation, the Canada Life Research Fund, the Power Corporation of Canada, and the Scotiabank Digital Banking Lab at Ivey Business School.

To cite this work: Tsybulnyk, M., & Hueston, R. (2026). Transforming Senior Healthcare in Canada: Embracing Connected Care, AI, and Digital Innovation. (R. Mostafa & Z. Agoston Villalba, Eds.). Policy Brief: 26088. Lawrence National Centre for Policy and Management, Ivey Business School, Canada.

Key Highlights

Population aging and the growing prevalence of chronic disease are exposing the limits of a healthcare system built primarily for short-term, episodic care. Demand for continuous care is increasing across hospitals, long-term care, and home- and community-based settings.

Connected-care models, supported by innovations such as remote patient monitoring, virtual care, digital therapeutics, AI-enabled decision support, and hybrid care teams, can improve chronic disease management, support aging in place, and better coordinate care for older adults.

Evidence from pilot programs suggests that the central challenge lies in implementation and scale rather than technological feasibility. Meeting the needs of an aging population requires stronger evidence generation, robust governance, and clear pathways from successful pilot to sustained practice.

This brief proposes a 360-degree framework built on four interdependent pillars — digital infrastructure and interoperability, funding model reform, hybrid workforce deployment, and equity-focused design — supported by a Connected Care Policy Sandbox that provides a phased pilot-to-scale pathway using iterative evaluation to support responsible expansion.

The policy sandbox enables provinces and territories to test and refine promising connected-care models while generating comparable clinical, economic, and operational evidence — helping overcome the persistent "chicken-and-egg" cycle between investment and evidence.

Digital infrastructure should be treated as essential public infrastructure, supported by coordinated governance, common standards, stronger interoperability, and regulatory mechanisms that enable the testing and integration of connected-care innovations.

Funding models should align incentives with prevention, coordinated care, and aging in place by supporting patient-centred care across settings and sustained investment in connected-care models.

Workforce strategies should expand hybrid-care models, strengthen digital-health competencies, and develop emerging care roles that enable health professionals to work effectively in connected-care environments.

Equity must be embedded as a core design principle, requiring deliberate attention to structural, digital, and cultural barriers to ensure connected-care innovations improve access and outcomes for older adults and underserved communities.

Introduction

Canada's healthcare system is at an inflection point. Decades of demographic aging, rising chronic disease prevalence, and persistent structural fragility have converged to expose the limits of a system built around episodic, facility-based care. The COVID-19 pandemic laid these vulnerabilities bare — hospital overcapacity, fragmented digital systems, and inequitable access across communities — while accelerating the adoption of digital tools that had been underutilized for decades. Yet the innovations catalyzed during the pandemic remain unevenly distributed across jurisdictions and providers, and are often difficult to sustain beyond initial pilot funding.

Aging is one of the most significant demographic shifts facing Canada today. In 2025, approximately 8.1 million Canadians are over 65 — a 42 per cent increase over the past decade — and by 2030 seniors are projected to account for more than one-fifth of the population. More than five million seniors are estimated to live with two or more chronic conditions, increasing demand for continuous care across hospitals, primary care, home care, and community services. The result is a widening gap between the healthcare system Canada has today and the one it will need in the decades ahead.

This demographic transition coincides with a technological one. Advances in remote patient monitoring, virtual care, digital therapeutics, and artificial intelligence are reshaping how care can be delivered, coordinated, and monitored. Together, they enable a shift toward **connected care:**[1] an integrated approach that combines digital tools, hybrid care teams, engaged patients and caregivers, and interoperable data systems to deliver continuous, coordinated care across settings. Rather than relying on acute interventions after conditions worsen, connected-care models identify risks earlier, improve continuity of care, and reduce avoidable pressures on hospitals and long-term care.

Despite advances in digital health, structural barriers continue to limit the delivery of coordinated care at scale. Limited access to primary and specialty care has contributed to specialist waits of up to 77 weeks in some jurisdictions, while nearly one in seven emergency department visits in Canada could be managed in primary care. At the same time, workforce shortages are projected to leave Canada short 78,000 physicians by 2031. These structural gaps limit the adoption of connected-care models and shift the central policy challenge from technological innovation to implementation and scale.

To examine these challenges in practice, this brief draws on four case studies of connected care from Canadian and international settings: Toronto Grace Health Centre's Remote Care Monitoring program, Medly at University Health Network, TELUS Health's Home Health Monitoring program, and Medoma's hospital-at-home platform in Sweden. Together with the broader literature on remote monitoring and hybrid care, these cases illustrate both the opportunities and the structural barriers that continue to shape adoption.

This brief advances a 360-degree framework organized around four interdependent pillars: digital infrastructure and interoperability, funding model reform, hybrid workforce deployment, and equity-focused design. Progress in any one dimension depends on progress across the others. To support implementation, the framework is paired with a phased pilot-to-scale approach in which innovations move through assessment, piloting, evaluation, and expansion — with clinical, economic, and operational outcomes embedded as core evaluation metrics. Evidence generated at each stage would inform policy design, investment decisions, and scale-up pathways, reducing the risks of large-scale deployment while building the comparable evidence base needed for broader adoption.

Realizing this vision will require stronger digital foundations. Canada has made substantial investments in electronic medical records and digital-health technologies, but fragmentation remains a persistent barrier: information does not move seamlessly between providers, organizations, or jurisdictions, limiting care coordination for patients with complex needs. Interoperability and data governance must be treated as essential public infrastructure, supported by coordinated governance, common standards, sustained investment, and more adaptive regulatory approaches — including regulatory sandboxes that facilitate the testing of promising innovations.

Funding arrangements will also determine whether connected-care innovations move beyond pilots into routine practice. Across many jurisdictions, promising programs have improved care coordination, chronic disease management, and aging in place, yet long-term adoption remains constrained by fragmented, short-term investment horizons and limited mechanisms for capturing system-wide benefits. As innovation increasingly spans organizational and care-setting boundaries, funding models will need to support coordinated patient journeys, align resources with where care is delivered, and create clearer pathways for scaling proven models.

The success of connected care will also depend on workforce deployment. Digital tools create opportunities to redesign how care is delivered and coordinated, and hybrid-care models with emerging roles — such as digital navigators, remote coordinators, and virtual clinicians — can expand capacity while supporting more proactive delivery. As healthcare organizations confront growing shortages and rising demand, preparing clinicians, caregivers, and allied health professionals to operate within digitally enabled models of care will become increasingly important.

Participation in digital-health programs is shaped by factors such as digital access, affordability, accessibility, and culturally appropriate care. These factors influence who can access connected-care technologies, how they are used, and who ultimately benefits from them. Without deliberate design and targeted investment, digital transformation risks reinforcing rather than reducing existing health inequities. Embedding equity throughout the innovation lifecycle will support broader adoption and help ensure connected-care models serve diverse populations and communities across Canada.

Canada's aging population and rising chronic disease burden call for more than incremental improvements; they require a fundamental rethinking of how care is delivered. The framework presented in this brief offers a practical pathway for advancing connected care through iterative implementation, continuous learning, and evidence-informed scale. These elements provide structured guidance for strengthening Canada's capacity to support an aging population while improving the sustainability and resilience of the healthcare system.

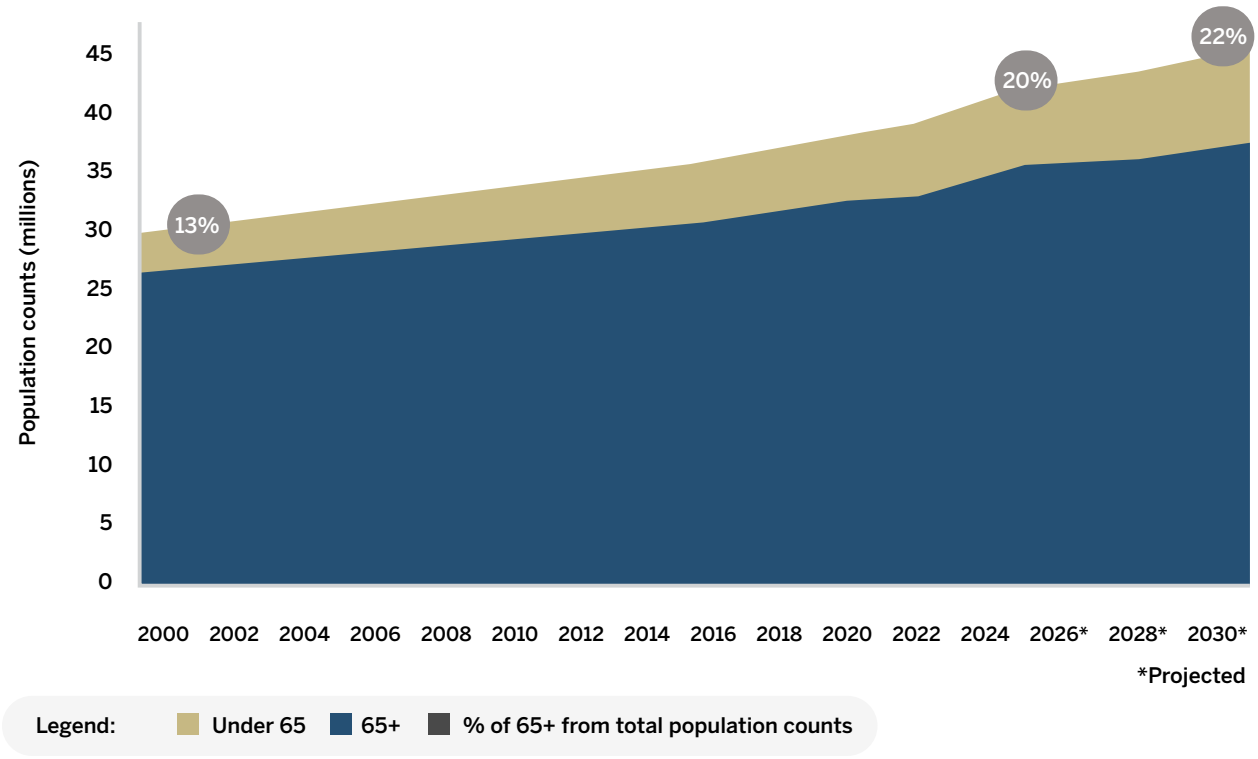
Connected care: An integrated model of care delivery that combines digital technologies, hybrid care teams, engaged patients and caregivers, interoperable data systems, and aligned funding models to deliver continuous, coordinated care across care settings.

[1] The term is used in Canadian policy contexts in narrow and broad senses; this brief adopts a broad definition that encompasses the full set of technologies, people, and processes required to deliver continuous, coordinated care across different settings.

The Aging Imperative

Population aging has become a growing concern worldwide because of its implications for economic growth, productivity, social inequality, and the increasing demands it places on healthcare systems. Canada is undergoing a major demographic shift: currently home to approximately 8.1 million seniors (individuals aged 65 and over, as defined in this brief) — a 42 per cent increase over the past decade, compared with overall population growth of 17 per cent during the same period.[2] The proportion of seniors is projected to reach 22 per cent of the total population, or 9.3 million people, by 2030, up from 13 per cent in 2000 (see Figure 1).[1]

Figure 1. Canada's Population Growth with % of seniors over 65 relative to the whole population

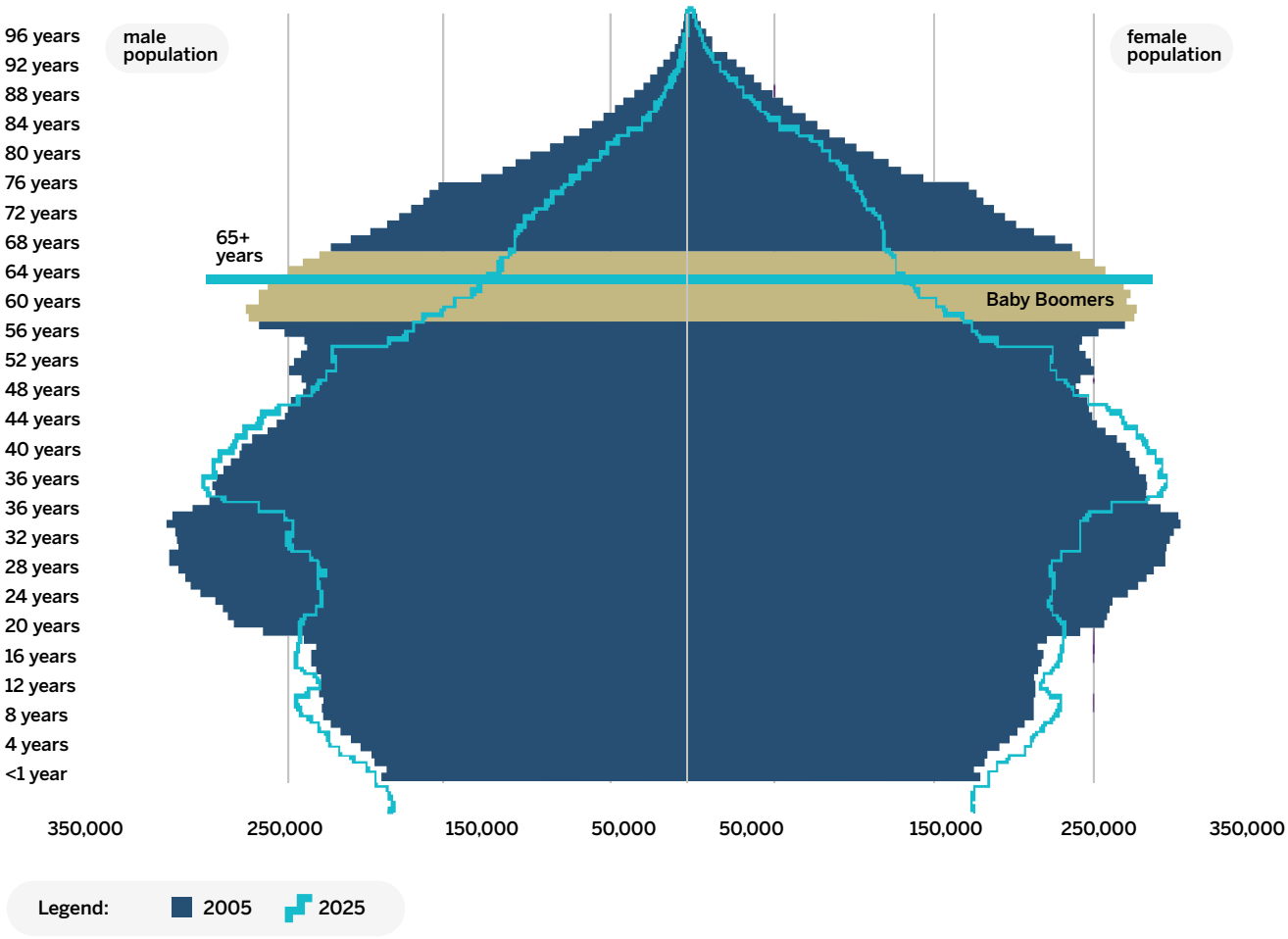


Sources: 2000-2024: Statistics Canada. Table 17-10-0005-01 Population estimates on July 1, by age and gender. Statistics Canada. Table 17-10-0057-01 Projected population, by projection scenario, age and gender, as of July 1 (x 1,000) Projection Scenario M1 (Medium growth) was used for the calculations.

This shift is driven by the convergence of aging baby boomers, rising life expectancy, and declining fertility. The baby boomer generation — those born in the post-war period between 1946 and 1964 (aged 62 to 80 in 2026) — has long been the largest generational cohort in Canada. The 2021 Census counted 9.2 million baby boomers, representing 25 per cent of the Canadian population, down from almost 42 per cent in 1966.[3] The proportional share of seniors is expected to peak in 2029, when the last cohort of baby boomers turns 65, and to begin declining after 2031 (see Figure 2).[4]

The aging trend was partially offset by a recent surge in immigration: between July 1, 2021, and June 30, 2024, Canada welcomed over 1.4 million immigrants, with about 43 per cent settling in Ontario – a significant increase compared with the previous two decades.[5,6] Over a third of these newcomers were between 25 and 34 years old, resulting in the millennial generation outnumbering baby boomers for the first time in Canadian history.[7,8] Recent changes in immigration policy, including reduced intake targets, may reverse some of these demographic gains.[9] What ultimately matters for the healthcare system is the absolute number of seniors, which continues to rise.

Figure 2. Canada's Population Pyramid in 2025 (projected) vs 2005



Source: 2000-2024: Statistics Canada. Table 17-10-0005-01 Population estimates on July 1, by age and gender

The next five years will bring a surge in demand for senior care at the very moment Canada's health system is already straining to keep pace with overall population growth. Meeting this dual challenge requires more than incremental service expansion — it demands a rethinking of health infrastructure to support longer-term, more complex care needs. Aging must be treated like other critical infrastructure priorities — on par with housing, transportation, and energy — requiring foresight, sustained investment, and new models of delivery.

Chronic Disease & Multimorbidity

Chronic diseases remain the leading health concern among seniors. These long-term conditions typically cannot be cured and require ongoing management to prevent acute episodes and exacerbations. In 2021, nearly half of Canadians reported living with a major chronic disease.[10] The prevalence of most chronic diseases rises with age, and when poorly managed, they can lead to complications requiring hospitalization, and, in some cases, long-term care (LTC) (see Table 1).

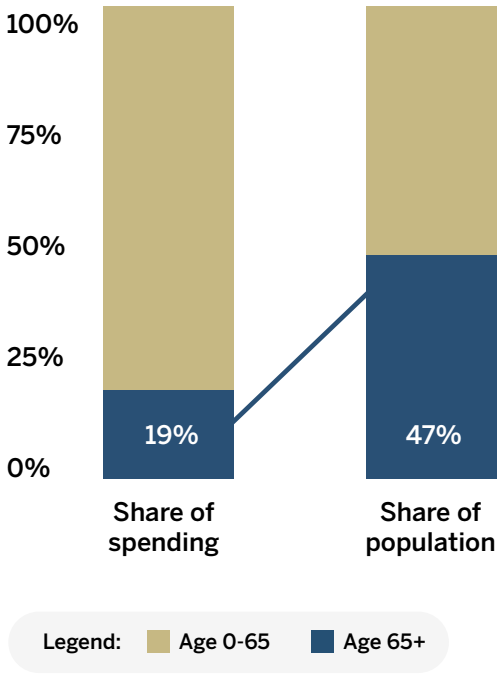
Table 1. Leading Chronic Conditions in Canadian Seniors

Condition	Prevalence	Key Risks	System Impacts
Cancer [11]	~22% of Canadians expected to die from cancer; 96% of cases occur at age 50+; peak incidence at ages 65–74	Lung, colorectal, pancreatic, prostate, and breast cancers drive 53% of cancer deaths	Leading cause of mortality in seniors; treatment drives long wait times and high health expenditures
Heart Disease [12,13]	~1M seniors ≥65; 2nd leading cause of death overall; leading cause for ≥85; 55,000+ deaths annually	Myocardial infarction, heart failure, stroke, sudden death	Major driver of acute hospitalizations and readmissions; high intervention costs
Diabetes (Type 2, prediabetes) [14]	~12M Canadians with diabetes or prediabetes; risk rises with age	Contributes to 30% of strokes, 40% of heart attacks, 50% kidney failure, 70% amputations	Significant costs in hospital care, drugs, and devices; increases multimorbidity (heart disease, COPD)
Chronic Obstructive Pulmonary Disease (COPD) [15,16]	>2M Canadians affected; 17% of seniors 65–79 and 25% of 80+; ~1M undiagnosed	Progressive lung damage, respiratory failure, frequent exacerbations	2nd leading cause of hospitalizations; high costs from emergency department visits and readmissions
Hypertension [17,18]	~1 in 5 Canadians diagnosed; ~8M affected, 60% are ≥65	Major risk factor for stroke, heart disease, kidney disease	Leading driver of hospital admissions and prescription drug use
Dementia [19,20]	~772,000 Canadians with dementia, majority ≥65; risk doubles every 5 years after 65; ~25% affected after 85	Cognitive decline, loss of independence, higher risk of institutionalization	Heavy demand for LTC and home care, high caregiver burden, hospitalizations for complications

Some chronic diseases are interrelated, which contributes to the development of multiple conditions – a state called multimorbidity. Multimorbidity adds another layer of complexity to disease prevention and management and puts seniors at a greater risk of adverse health outcomes.

About five million Canadians over 65 reported having two or more health conditions, with over half of those having three or more.[21]

Figure 3. Healthcare Spending on Seniors in 2023



Source: Canadian Institute for Health Information. NHEX trends — Infographics | CIHI, 2025

Moreover, chronic disease management has significant financial implications for both individuals and the healthcare system. Healthcare spending is highest among adults aged 65 and older, accounting for nearly half of Canada's total health expenditures (see Figure 3).[22] Per-capita spending for this population is more than three times higher than for those aged 15–64.[23]

While the costs of hospitalization are well recognized, managing chronic disease in community settings also carries substantial expenses, including prescription medications and medical devices such as blood pressure monitors and glucometers. In 2021, Canadians aged 65 and older accounted for more than 62 per cent of total prescription drug expenditures, representing approximately $10 billion in spending.[24]

Poorly managed chronic diseases also create substantial indirect costs through reduced workforce participation among older adults who remain employed, increased caregiving demands, and lost productivity among family caregivers. At the same time, multimorbidity, cognitive impairment, and functional decline often require ongoing monitoring, caregiving, and social support, creating both direct and indirect costs. These factors pose economic, social, and clinical challenges for older adults, their families, and the healthcare system.

Although many chronic diseases can be prevented or delayed through healthy behaviours — including regular physical activity, balanced nutrition, and reducing tobacco and excessive alcohol use — health outcomes are also shaped by broader social, economic, and environmental determinants, as well as non-modifiable factors such as age and genetics. Preventive interventions therefore remain important across the life course. However, many older adults are already living with one or more chronic conditions that increase their risk of multimorbidity and related complications. As a result, care for older adults should prioritize timely diagnosis, continuous monitoring, and early intervention to better manage existing conditions, reduce avoidable exacerbations, and improve long-term health outcomes.

Box 1: Quick Overview of Canada's Healthcare System

Canada has a publicly funded healthcare system known as Medicare. Rather than a single national insurance plan, it consists of 13 provincial and territorial health insurance plans that provide coverage for medically necessary hospital and physician services in accordance with the principles set out in the Canada Health Act. Provincial and territorial governments determine which additional services receive public coverage or subsidies, including prescription drugs, dental care, long-term care (LTC), and home care.

Healthcare is financed through a combination of provincial and territorial taxation and federal transfers, primarily through the Canada Health Transfer. This decentralized model allows provinces and territories to respond to local healthcare needs but also contributes to differences in service coverage, care coordination, and access across jurisdictions.

Canada's healthcare system can be understood through three interrelated dimensions: funding, delivery, and services (see Figure 5). Public funding accounts for approximately 71 per cent of total healthcare expenditures, while the remaining 29 per cent comes from private sources, including out-of-pocket payments (15 per cent), private insurance (12 per cent), and other sources (3 per cent).[25,26] Hospital and physician services are predominantly publicly funded, whereas prescription drugs, dental care, long-term care, and many home care services rely on a mix of public and private funding.

Funding

Public
- Tax revenues (provincial/territorial)
- Canada Health Transfer (federal)

Private
- Private insurance
- Out of pocket payments

Delivery

Public
- Some home and community care organizations
- Public hospital organizations

Private
- Physician corporations, private clinics, prive non-for-profit hospitals, most diagnostic imaging & labs

Services

Insured by Medicare
- Primary, specialty & hospital care, including medically necessary diagnostic and treatment proceedures

Uninsured by Medicare*
- Prescription drugs, dental services, long-term care, home care

*These services might be covered through provincial or territorial health insurance plans or federal government programs.

Source: Compiled by authors based on Public and private healthcare in Canada: What does the evidence say? - CMA Digital Library - Canadian Medical Association.

Canada's healthcare system is publicly financed but largely privately delivered. Many healthcare providers — including physicians, community laboratories, and diagnostic imaging clinics — operate as private businesses or independent practitioners and bill provincial or territorial governments for insured services. Unlike nurses, most physicians are self-employed or operate through professional corporations, while many hospital-based physicians practise as independent contractors.

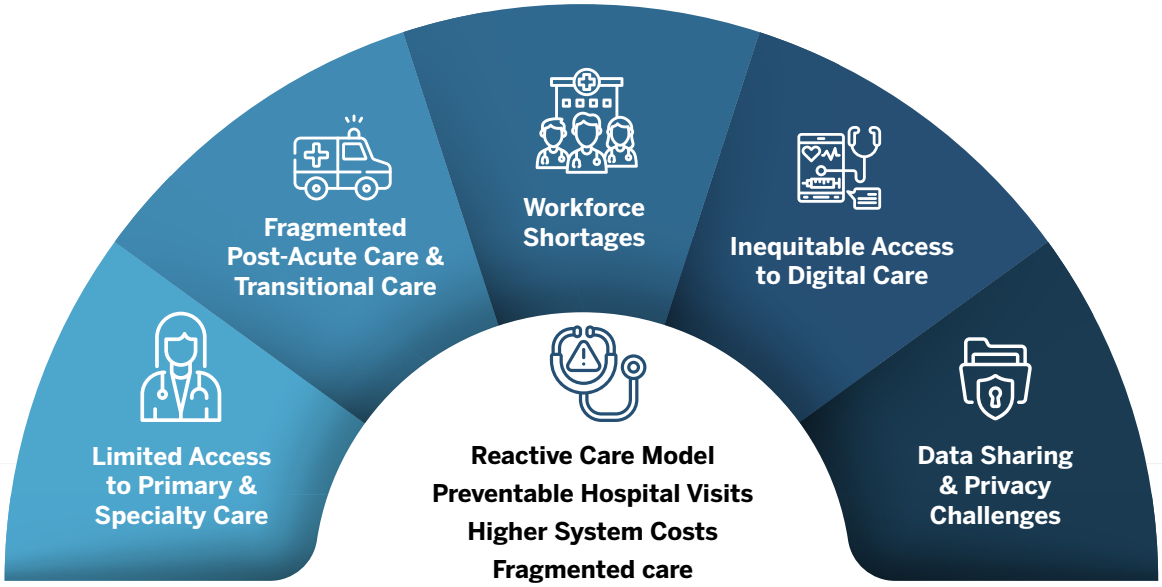
Long-Term Care and Home Care

Since neither home care nor LTC are insured under the Canada Health Act, provincial and territorial governments determine how these services are subsidized. Healthcare services provided in long-term care facilities are generally publicly funded, while residents typically pay for accommodation and meal costs. Home care services may be fully or partially subsidized, although eligibility and the scope of publicly funded services vary across jurisdictions. As a result, many individuals and families purchase additional private home care to meet unmet needs. Both long-term care and home care are delivered through a mix of public, private, and not-for-profit organizations, contributing to variation in service delivery and ongoing challenges in care coordination.

Structural Gaps in the Current Healthcare System

Canada's healthcare system is designed to deliver high-quality acute, episodic care, but it remains poorly equipped to meet the ongoing and increasingly complex needs of an aging population. Structural gaps in access to primary and specialty care, care coordination, workforce capacity, digital equity, and data sharing contribute to preventable hospitalizations, fragmented care, and rising system costs (see Figure 4). Addressing these barriers will be essential to scaling the connected-care models discussed later in this brief.

Figure 4. Structural Barriers to Connected Care



Limited Access to Primary and Specialty Care

Seniors living with chronic conditions such as heart disease, COPD, and diabetes require ongoing management through lifestyle interventions, medication adherence, and regular clinical follow-up. These conditions are considered ambulatory care sensitive, meaning they can often be effectively managed through timely access to primary care. However, barriers to accessing that care increase the risk of preventable complications and hospitalizations.

Although hospitalization is sometimes necessary, it carries significant risks for older adults. Approximately one-third of hospitalized seniors are at risk of frailty.[27] They are three times more likely to remain in hospital for more than 30 days and twice as likely to be readmitted within 30 days of discharge.[28] Reduced mobility and prolonged bed rest can lead to infections, muscle loss, and functional decline, leaving many seniors unable to regain their pre-hospital level of independence.

Despite widespread challenges accessing primary care, seniors are more likely than any other age group to have a regular family physician: 92 per cent report having one, although this ranges from 84 per cent in Newfoundland and Labrador to 95 per cent in Ontario.[29] Even so, access has declined in every province except Manitoba over the past decade. Access to specialist care remains an even greater challenge.

Once referred, patients wait an average of 24 weeks in Ontario and up to 77 weeks in Prince Edward Island before treatment begins.[30]

While these wait times may be acceptable for some non-urgent conditions, prolonged delays contribute to poorer outcomes and disrupt continuity of care by limiting timely clinical guidance as symptoms evolve.[31] As a result, many patients seek care in emergency departments because they are the only timely point of access, increasing both healthcare costs and pressure on hospital resources.

In 2024, one in seven emergency department visits in Canada could have been managed in primary care.[32]

For many seniors, access is further constrained by transportation barriers, limited health system navigation, or reluctance to seek care until symptoms become severe. These barriers make the system reactive rather than preventive. As one analogy suggests, it is like repairing a car every time it breaks down but never performing routine maintenance.

Fragmented Post-Acute Care and Transitional Care

When hospitalized, seniors generally receive high-quality acute care, including prescriptions and continuous monitoring of their condition. The challenge often begins after discharge, when responsibility for recovery shifts largely to patients and families, often with limited support from primary care physicians, specialists, or community providers. Data sharing between providers is also inconsistent, making coordinated follow-up care difficult. While hospital and physician services are insured under the Canada Health Act, home care, community care, and long-term care are not, resulting in inequities in access that vary significantly by geography. These fragmented transitions and gaps in ongoing monitoring contribute to higher readmission rates and poorer health outcomes, as demonstrated in studies from Denmark and the United States.[33, 34]

These challenges are compounded by gaps in community-based care. Family health teams, Ontario Health at Home and equivalent provincial programs, allied health providers, and personal support workers (PSWs) form an essential layer of support for older adults between physician visits and after hospital discharge. Yet this layer of care remains chronically underfunded relative to the burden it carries. Because home care, community care, and the services of non-physician providers fall outside the Canada Health Act, coverage and capacity vary substantially across provinces. As a result, seniors who would be best supported through coordinated community-based care often default to emergency departments or LTC because few alternatives are reliably available.

The consequences of these gaps extend across the healthcare continuum. LTC homes provide essential support for seniors living with chronic diseases, disabilities, or age-related conditions. However, many seniors are unable to access LTC facilities due to insufficient capacity and lengthy wait times, while others cannot be discharged home safely.[35]

These patients often remain in hospital as Alternate Level of Care (ALC) cases, reducing patient flow, constraining hospital capacity, and contributing an estimated $1.5-3.0 billion in excess system costs.[36]

Demand for LTC and home care is expected to grow substantially over the coming decade. Approximately one in five adults over the age of 80 requires LTC for complex medical needs, and by 2031 more than 600,000 Canadians are projected to require LTC services, while an additional 1.8 million will need home care.[37, 38] Current LTC infrastructure is insufficient to meet this growing demand, with Canada averaging 29 LTC beds per 1,000 population compared to an OECD average of 41, creating downstream pressures across the system.[39, 40] Considering that the cost of providing care in LTC is approximately three to five times lower than in acute care settings, expanding LTC capacity remains an important priority.[41]

However, LTC represents only one component of the continuum of care. Most older adults prefer to age at home and within their communities, and LTC expansion alone will not be sufficient to meet projected demand. Meeting future needs will require both physical infrastructure expansion and the deployment of new care delivery models that better support older adults across settings.

Workforce Shortages

One of the most pressing challenges facing Canada's health system is the growing shortage of qualified providers. By 2031, the country is projected to be short 78,000 physicians, and by 2030, 117,600 nurses will be needed to meet demand.[42] This shortage is exacerbated by the aging of the workforce itself, with many physicians expected to retire in the coming years.

At the same time, fewer medical graduates are choosing primary care careers. Payment models, administrative burdens, and high levels of burnout have made family medicine less attractive. The traditional fee-for-service model undervalues activities such as documentation, care coordination, and patient follow-up, creating disincentives to remain in community-based practice. As a result, more physicians are moving into private practice or non-insured services.

The challenge extends beyond physicians. Nurses, PSWs, and family caregivers face similar pressures, including low wages, heavy workloads, and high rates of exhaustion. These conditions contribute to workforce attrition and make it increasingly difficult to recruit and retain staff. Without systemic reform, workforce shortages will continue to constrain the capacity of hospitals, long-term care (LTC), home care, and community-based services to meet the needs of an aging population.

Informal caregivers, most often family members supporting older relatives, also play a critical but often overlooked role in the healthcare workforce. They shoulder significant time, financial, and emotional responsibilities, yet their ability to continue providing care depends on access to respite services, training, and digital tools that connect them with the formal care team. However, LTC represents only one component of the continuum of care. Most older adults prefer to age at home and within their communities, and LTC expansion alone will not be sufficient to meet projected demand. Meeting future needs will require both physical infrastructure expansion and the deployment of new care delivery models that better support older adults across settings.

Inequitable Access to Digital Care

The COVID-19 pandemic accelerated an unprecedented shift toward digital care in Canada. At the height of public health restrictions in 2020, more than half of physician visits were conducted virtually, compared to fewer than 5 per cent before the pandemic.[43] In Ontario, for example, virtual primary care visits increased from 1.2 per cent in 2019 to over 70 per cent in April 2020.[44] For seniors, this rapid pivot demonstrated the potential of digital health: remote monitoring, virtual consultations, and electronic records enabled continued access to providers without leaving home. Although virtual care use declined as restrictions eased, and some provinces, including Ontario, later reduced publicly funded virtual care services, the pandemic demonstrated that digital tools can meaningfully improve access to care when widely available.

Despite this progress, access to digital health technologies remains uneven. Many older adults face barriers such as limited internet access, affordability, and low digital confidence. These challenges are especially pronounced in rural and remote communities. In 2024, 96.4 per cent of Canadian households had access to high-speed internet meeting the federal 50/10 Mbps target. However, access fell to 69.6 per cent in the three territories and 65.7 per cent on First Nations reserves.[45] Affordability is also a barrier, with lower-income households spending a larger share of their income on internet services.[46]

These inequities translate directly into health outcomes. A 2025 national survey of 2,000 older Canadians found that adoption of digital health tools remains low, with only 9.4 per cent using telemonitoring and 4.2 per cent using fall detection technologies, and that those with the greatest health needs were the least likely to engage with these tools: older adults who had not had a recent emergency department visit were more than twice as likely to use mobile health apps than those who had, and home care recipients were similarly less likely to use digital health technologies.[47]

In effect, the seniors who stand to benefit the most from connected care are the least likely to access it.

Without addressing these disparities, digital health risks reinforcing existing inequities. Seniors who can access connected care benefit from earlier intervention and continuous monitoring, while those who cannot face a greater risk of hospitalization. Closing this digital divide requires investments in broadband infrastructure, affordable internet access, and technologies designed to meet the needs of people with limited digital literacy.

Data Sharing and Privacy Challenges

Seniors often find that their health data cannot be easily transferred between providers, and physicians themselves report struggling with fragmented systems. A Canadian Medical Association (CMA) survey found that only 29 per cent of Canadian physicians routinely share patient information outside their practice, and more than 35 per cent spend over two hours daily searching for records.[48] Electronic health records have been in use in Canadian hospitals and primary care for over a decade, with nursing-led adoption of electronic charting preceding broader physician uptake. The pandemic accelerated the use of additional digital platforms, but adoption has occurred without coherent national standards. This inefficiency burdens providers and undermines continuity of care for older patients who see multiple specialists.

Privacy concerns compound the problem. Older adults are particularly sensitive to risks of data breaches and misuse, which can discourage them from adopting new technologies.[49] Fragmented and duplicative record systems heighten these vulnerabilities by creating more points of failure. In 2024, the Digital Health Interoperability Task Force underscored the urgency of national governance, recommending the creation of a Health Data Council, mandatory interoperability standards, clinician supports, and innovation incentives.[50, 51]

These inequities and fragmentation challenges do not exist in isolation. They are magnified by the structure of Canada's healthcare system itself. With 13 provincial and territorial insurance plans, varying coverage for home, community, and LTC, and a mix of public and private delivery, the system is complex and often inconsistent. To understand why digital health adoption has been so uneven, it is important to consider how the system is organized and financed (see Box 1).

Connected Care and Digital Innovation

Chronic diseases require a fundamentally different approach to care than the episodic model on which Canada's healthcare system was built. Rather than relying on isolated visits and acute interventions, connected care emphasizes continuity, coordination, and proactive monitoring across the patient's care journey. Connected care provides this shift by integrating digital technologies, home-based services, hybrid care teams, and patient engagement into a continuous cycle of prevention, treatment, recovery, and long-term disease management. Chronic disease management is cyclical: each acute episode restarts a loop of prevention, monitoring, and intervention. Connected care aims to close this loop by extending care beyond hospital discharge and supporting continuous management in the community.

From Episodic to Connected Care

Connected care combines digital technologies, home-based services, and coordinated care teams to support continuous care beyond traditional healthcare settings. As in many other sectors, digital technologies are shifting healthcare away from a predominantly facility-based model toward one centred on prevention, daily disease management, and improved transitions across care settings. Seniors and caregivers take a more active role by self-tracking vital signs and reporting changes in their condition, while clinicians receive alerts only when intervention is required. Connected care models shift the emphasis from reactive crisis management to proactive, continuous support. Table 2 compares the traditional episodic model with the connected-care approach across key dimensions of chronic disease management.

Table 2. Episodic vs. Continuous Care in Chronic Disease Management

Dimension	Episodic Care (Current Model)	Continuous Care (Connected Model)
Care Trigger	Patients seek care only when symptoms appear or worsen	Ongoing monitoring identifies risks early, even before symptoms escalate
Patient Role	Passive recipient; limited self-monitoring; relies on scheduled visits	Active participant: self-tracks vitals, engages in self-management with real-time feedback
Data Use	Fragmented records: data generated only at point of care	Integrated, interoperable data follows patient across providers and settings
Access	Limited by geography, wait times, and office hours	Virtual consultations, remote monitoring, and home-based care expand access
Care Transitions	Fragmented handoffs; poor discharge follow-up; high readmissions	Seamless transitions with shared data and continuous oversight
Workforce Burden	High demand on physicians/nurses for acute episodes	Shared with hybrid teams, digital navigators, and automated alerts
System Costs	High costs from avoidable Emergency Department visits, readmissions, and ALC	Strategic upfront investments to scale effective solutions that lower long-term healthcare costs by preventing avoidable illness, reducing hospitalizations, optimizing resources, and improving system productivity.
Equity	Seniors with limited mobility or rural residence often excluded	Virtual/hybrid models expand reach but require equity-focused design (connectivity, literacy support)

These differences make connected care particularly well suited to supporting older adults at home, where most seniors prefer to receive care.

In a 2022–23 survey, 90 per cent of Canadians aged 45 and older said they would rather receive home care than move into a long-term care (LTC) facility.[52] The Canadian Institute for Health Information (CIHI) also reports that one in ten new LTC admissions could potentially have been cared for at home.[53]

Combining home-based care with digital technologies allows existing health system resources to be used more efficiently while reducing pressure on hospitals and long-term care. It also strengthens care coordination and supports smoother transitions from hospital to home, helping older adults remain safely in their communities.

Illustrative Connected Care Models

Several Canadian and international initiatives demonstrate how digital technologies, remote monitoring, and hybrid care teams are extending care beyond hospitals and improving support for seniors with chronic and complex needs. These initiatives span different parts of the connected-care continuum, from acute care at home to long-term chronic disease management. The following examples provide a brief overview of four connected-care models; detailed case studies are included in the appendix.

Toronto Grace Health Centre's Remote Care Monitoring program supports seniors transitioning from hospital to home through connected devices, home sensors, automated medication dispensers, and a 24/7 command centre. The program has served more than 20,000 patients and reduced readmissions, while enabling safe discharge for seniors who might otherwise remain as ALC patients. According to Toronto Grace, monitoring costs a small fraction of hospital-based care, and the model shows how coordinated remote supports can improve safety and continuity. This case illustrates structured monitoring and escalation pathways in supporting aging in place (See Appendix Case Study 1).

University Health Network's Medly is a clinician-designed Health Canada regulated digital therapeutic application that supports heart failure management through daily biometric and symptom reporting, a clinician dashboard, and a rules-based algorithm that provides personalized guidance. The program is reported to have reduced heart failure-related hospital readmissions and shortened medication titration timelines, while allowing one nurse coordinator to manage five times more patients than in traditional hospital settings. Medly is in use across several Toronto hospitals and shows how digital therapeutics can improve disease management and reduce avoidable acute care. This case highlights the role of guideline-based digital tools in chronic care delivery (See Appendix Case Study 2).

Sweden's Medoma platform demonstrates how hospital-at-home models can deliver measurable system impact. During its pilot at St. Göran Hospital, Medoma treated more than 600 patients and achieved a 25 per cent reduction in readmissions, while nurses were able to manage 20 per cent more patients compared to conventional wards. This program used a hybrid approach with approximately 40 per cent digital monitoring and 60 per cent in-person care, showing that acute treatment can be delivered safely, and at lower cost outside hospital walls. This case demonstrates how hybrid, digitally supported teams can extend hospital capacity into the community (See Appendix Case Study 3).

TELUS Health's Home Health Monitoring program equips patients with Bluetooth-enabled devices and daily symptom questionnaires linked to a secure clinical dashboard. Implemented across British Columbia and expanded to other provinces, the program has been reported by TELUS to be associated with up to a 90 per cent reduction in hospital admissions for heart failure patients and a 67 per cent reduction for patients with COPD, based on program-reported data. By enabling continuous oversight in the home, the model improves self-management and reduces pressure on emergency and inpatient services. This case illustrates how virtual monitoring programs can strengthen chronic disease management, potentially at scale (See Appendix Case Study 4).

Together, these cases show how digitally enabled models can enhance continuity, reduce preventable hospital use and support safe care delivery outside traditional facilities. They reflect the increasing use of virtual care, remote monitoring, digital therapeutics and hybrid care teams in improving outcomes for seniors.

Technologies Powering the Shift

The case studies above demonstrate how connected care is already being implemented through remote monitoring, virtual care, and digital therapeutics. This section examines the core technologies that support these models, their relevance for seniors, and the opportunities and challenges associated with broader implementation.

Virtual Care

Virtual care refers to any healthcare delivered remotely through technology, typically by video, phone, or secure messaging. It is estimated that about 9 per cent of emergency department visits could be managed virtually.[54] Although virtual care existed in Canada before COVID-19, adoption accelerated rapidly during the pandemic. At its peak, monthly virtual visits increased from 52 per 1,000 population to more than 240 per 1,000 in central and western Canada (excluding Quebec), with seniors accounting for nearly 29 per cent of all virtual visits.[55] To support this transition, provinces introduced new physician billing codes for virtual care.[56]

Since the pandemic, provincial policies have diverged. Ontario's 2022 billing reforms cut fees for virtual-only care by up to 75 per cent, weakening incentives for virtual-first models.[57, 58] By contrast, British Columbia continued to support virutal care integration, enabling more than one million virtual visits.[59] Nova Scotia adopted a different approach through VirtualCareNS, which launched in 2021 to connect unattached patients with healthcare providers. Within three years, the service facilitated more than 150,000 visits and expanded to over 250 consultations per day.[60, 61]

Virtual care has also expanded through private-sector innovation. For example, TELUS Health's MyCare platform allows patients to connect with healthcare providers through secure virtual appointments for services including primary care, mental health, women's health, and weight management (See Appendix Case Study 4).

Remote Patient Monitoring

Remote Patient Monitoring (RPM) is a virtual care technology that enables patients to receive clinical care remotely, reducing the need for in-person visits. RPM combines connected medical devices with clinical oversight through a centralized care team that reviews patient data, provides real-time support, and triages alerts as needed. The technology typically includes medical devices, a patient-facing application, and a secure platform for clinicians. Depending on the patient's condition, devices may include blood pressure monitors, glucometers, pulse oximeters, thermometers, spirometers, wearables, smart scales, and home sensors.

Patients typically submit health data daily, either manually or through automatic device transmission. RPM enables continuous monitoring of vital signs, symptoms, medication adherence, physical activity, and other health indicators. Based on this information, the care team provides timely feedback and escalates concerns when necessary, including to family caregivers, primary care providers, specialists, paramedics, or hospital teams. RPM is particularly well suited to chronic disease management, post-surgical recovery, senior care, and patients in rural or remote communities.

Although RPM requires upfront investment in technology and clinical infrastructure, it has the potential to reduce healthcare costs by preventing complications and avoiding hospital admissions, readmissions, emergency department visits, and unnecessary outpatient care. A 2024 systematic review of 29 studies across 19 countries found consistent reductions in hospital readmissions, length of stay, outpatient visits, and overall healthcare costs associated with RPM.[62, 63]

Toronto Grace Health Centre's Remote Care Monitoring program demonstrates how RPM can support transitional care by enabling patients to return home rather than remain in hospital while awaiting long-term care placement. The program combines remote monitoring with a centralized command centre, home sensors, GEO-pendants, and automated medication dispensers to support safe discharge and ongoing care in the community (See Appendix Case Study 1).

Digital Therapeutics

Digital therapeutics are evidence-based software applications that help prevent, manage, or treat health conditions, including chronic diseases. They support patient self-management by providing personalized guidance, reminders, progress tracking, and alerts, while complementing — and in some cases reducing reliance on — traditional treatments.

For example, digital therapeutics can help people with diabetes manage diet, physical activity, blood glucose monitoring, and medication use. They are also used in areas such as mental health, where they can deliver cognitive behavioural therapy and other evidence-based interventions. Because these technologies directly influence patient care, they must meet Health Canada regulatory requirements, including licensing as a Class II medical device where applicable.[64]

University Health Network's Medly is one example of a digital therapeutic designed for heart failure management. The application enables patients to report symptoms daily and receive personalized guidance, including medication recommendations based on clinician-defined protocols. Secure messaging with the care team further supports timely intervention and ongoing disease management.

Artificial Intelligence and AI-enabled Tools

Artificial intelligence (AI) is increasingly being integrated into connected-care technologies such as RPM and digital therapeutics. By analyzing continuous streams of patient data, AI can identify patterns that support earlier intervention, clinical decision-making, and more personalized care. For example, AI can detect early signs of deterioration by identifying changes in vital signs, symptoms, or behavioural patterns and alert healthcare providers before an emergency occurs. AI can also support patient triage by assessing symptoms and directing patients to the most appropriate level of care.

Beyond patient care, AI is increasingly being used to support clinicians. One of the fastest-growing applications is the use of AI scribes, which automatically generate clinical documentation during patient encounters.[65] By reducing administrative workloads, these tools allow clinicians to spend more time with patients while helping address documentation burden and burnout. Looking ahead, more advanced forms of AI, sometimes referred to as agentic AI, are being explored to support routine, lower-risk tasks such as answering patient questions, providing self-management guidance, surfacing recommendations for clinician review, and connecting patients with appropriate members of the care team. In Canada, however, prescribing and other restricted clinical acts remain the responsibility of licensed healthcare professionals, with AI intended to support — not replace — clinical judgment.

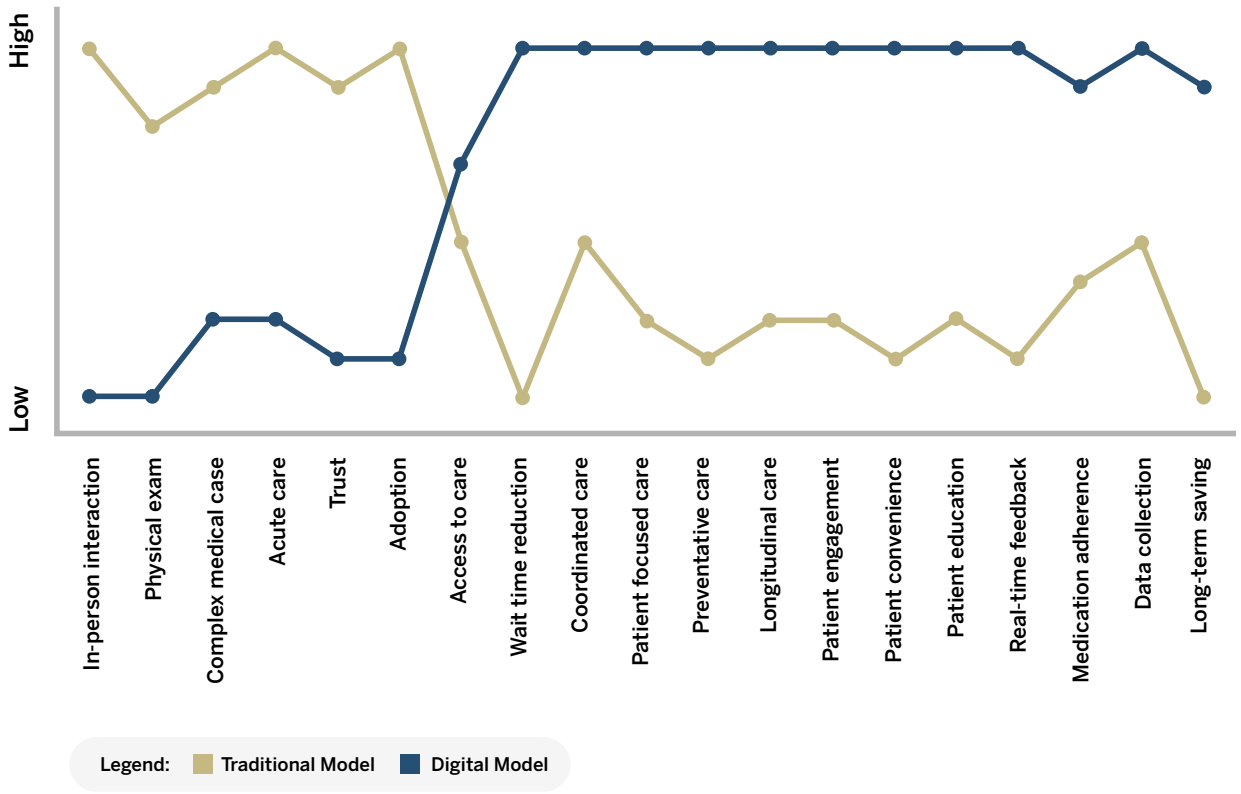
Several connected-care programs are already incorporating AI into clinical workflows. Toronto Grace Health Centre is testing AI within its Remote Care Monitoring program to identify patterns that may predict patient deterioration. Medoma uses AI-powered planning and capacity forecasting tools to support hospital-at-home operations and care coordination (see Appendix Case Study 3), while Medly has integrated AI to reduce false alerts, support medication titration within clinician-defined parameters, provide after-hours patient guidance, and automate elements of clinical documentation (see Appendix Case Study 2). [66, 67]

Despite its potential, the adoption of AI in healthcare requires careful implementation. Clinical oversight remains essential to address risks associated with algorithmic bias and errors in patient care. Organizations must also address challenges related to data governance, privacy and cybersecurity, infrastructure, and implementation costs. As AI technologies continue to evolve, ensuring they are deployed safely, transparently, and equitably will be critical to realizing their full potential within connected-care models.

The Value Curve for Connected vs. Traditional Care Models

The contrast between episodic and connected care can be illustrated through the value curve (see Figure 6). The figure is conceptual in nature and does not represent empirical estimates. Traditional models often deliver the greatest value during acute episodes and complex in-person care but provide fewer opportunities for continuous monitoring, prevention, and long-term disease management. Connected-care models may initially generate lower perceived value as organizations invest in new technologies, redesign clinical workflows, and build patient and provider trust. As these models mature and become integrated into routine care, however, they have the potential to improve patient outcomes, strengthen care coordination, support preventive interventions, and reduce pressure on the healthcare system. The inflection point shown in the figure represents this expected transition as connected care becomes more widely adopted and embedded

Figure 6. Value Curve for Traditional vs Connected Chronic Disease Management

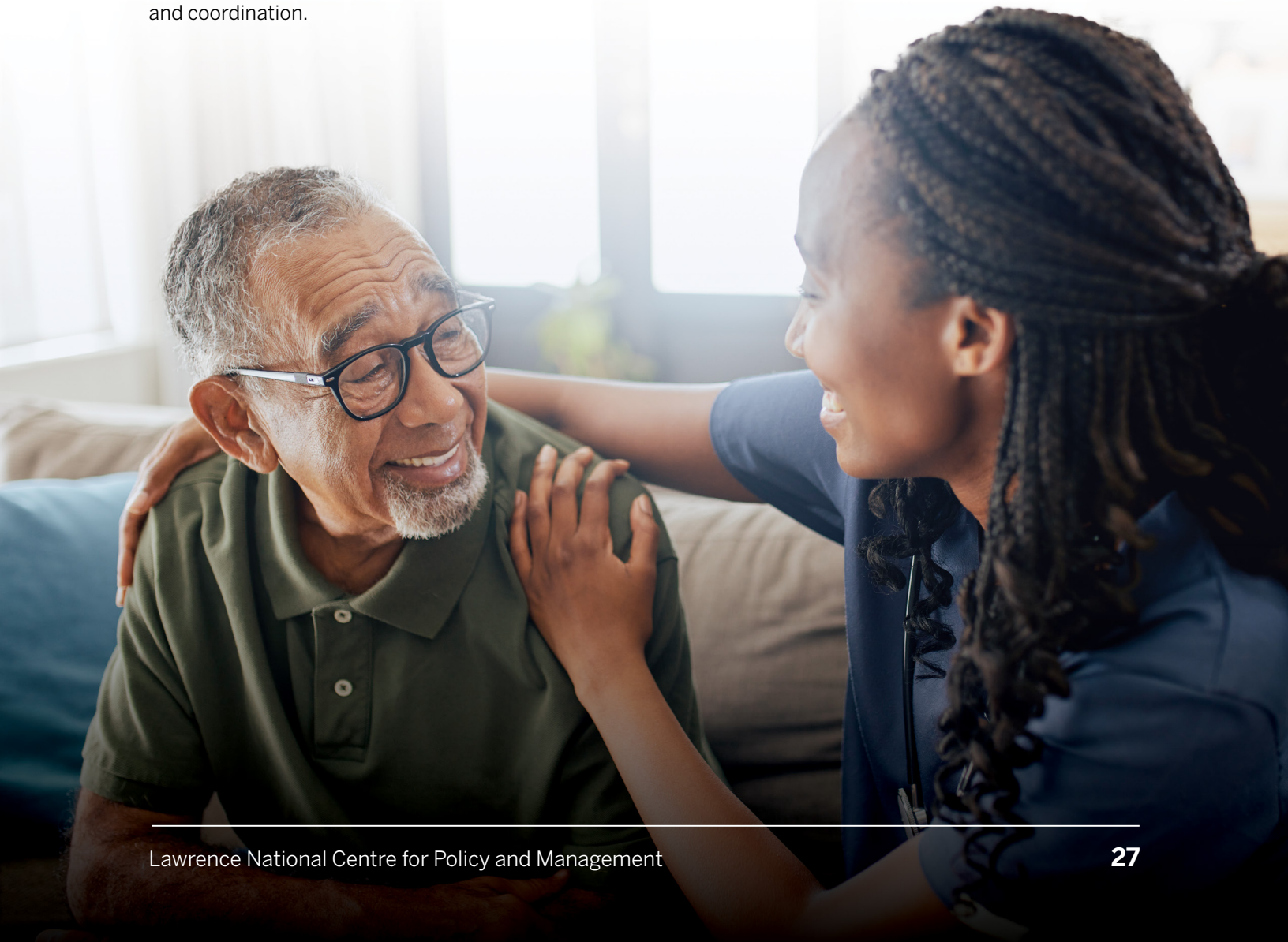


Source: Figure created by the author for illustrative purposes using publicly available evidence on connected-care models and healthcare outcome dimensions. It is intended as a conceptual framework and should not be interpreted as an empirical estimate or used for formal decision-making.

The value illustrated in Figure 6 reflects the cumulative benefits of connected care discussed throughout this brief. Instead of concentrating care around isolated clinical encounters, connected-care models extend care into patients' daily lives through continuous monitoring, proactive disease management, and ongoing engagement. Digital technologies allow patients to track symptoms, medications, and other health indicators while enabling clinicians to detect changes earlier and intervene before complications arise.

Connected care can also improve access for individuals with mobility challenges and those living in rural or underserved communities by reducing unnecessary travel and enabling more care to be delivered in the home. Community organizations and local care providers can further strengthen these models by supporting home-based approaches, improving continuity and coordination.

Continuous data collection also supports more personalized care by providing clinicians with richer information to guide treatment decisions. Because up to 80 per cent of the most common chronic diseases can be prevented through healthy behaviours, patient education and self-management are essential components of connected care.[68] Combined with interactive videos, digital learning tools, and ongoing clinical support, connected-care models can empower patients to play a more active role in managing their health while helping reduce avoidable emergency department visits and hospitalizations. Shifting appropriate care from hospitals to the home can also lower healthcare costs by reducing reliance on resource-intensive settings and optimizing the use of hospital and long-term care services.



Barriers to Scaling Connected Care Innovations

Canada's challenge in scaling connected care for seniors reflects a broader pattern that extends beyond healthcare. While Canada performs strongly in research and early-stage innovation, it has historically struggled to translate promising discoveries into widespread adoption and productivity gains.[69, 70] This pattern is evident in healthcare, where connected-care pilots often demonstrate positive results but face persistent barriers to broader implementation. As a result, many innovations remain confined to individual organizations, regions, or short-term funding arrangements rather than becoming embedded within routine care delivery. The challenge is therefore less about generating new innovations and more about creating the conditions needed to scale and sustain proven models.

The Remote Care Monitoring program at Toronto Grace Health Centre (see Appendix Case Study 1) illustrates how funding misalignment can undermine adoption. The program supports seniors at home for approximately $10–$15 per patient per day and reports improvements in continuity of care, reduced readmissions, and greater patient independence. Yet, as CEO Jake Tran argued, the program relies on fragmented, short-term funding that covers only a quarter of its operating costs. He noted that "the government should shift its focus from 'just building new beds (transitional and LTC),' because just doing that alone won't allow us to provide proper care to elderly people… Funding needs to follow the patient." For older adults with chronic conditions, outcomes and system efficiency can improve when funding shifts from expanding hospital capacity toward community- and home-based care. Without sustainable, patient-centred financing models, however, even successful programs remain vulnerable.

Funding is only one part of the challenge. The Medly digital therapeutics program (see Appendix Case Study 2) illustrates the difficulty of moving successful innovations beyond individual organizations and into routine healthcare delivery. Despite strong clinical outcomes, Medly's expansion has relied on bespoke hospital-by-hospital agreements rather than coordinated system-wide adoption. Originally developed through research funding as a minimum viable product, Medly successfully demonstrated clinical value but lacked a clear pathway for broader implementation once the model proved effective. This reflects Canada's broader innovation challenge: strong research and pilot activity, but limited mechanisms to embed proven innovations into mainstream healthcare delivery.

The case studies also highlight how fragmented procurement and implementation processes slow adoption. Both Medly and Toronto Grace identified inconsistent escalation pathways and coordination processes across Ontario's regional health system, requiring substantial customization for each implementation. By contrast, provinces such as British Columbia and Prince Edward Island operate under unified health authority structures with standardized processes and single points of contact, simplifying the deployment of connected-care models.

Technology alone is insufficient to scale connected care. Both Toronto Grace Health Centre and University Health Network's Medly demonstrate that digital care depends on complementary human infrastructure. At Medly, nurse coordinators review alerts, provide patient guidance, and train patients to use the technology. At Toronto Grace, call centre coordinators monitor daily alerts and respond to patient needs in real time. As Danielle Kilby-Lechman, Director of Integrated Care at Toronto Grace Health Centre, observed, "anyone can buy a pendant; it is what we do with this information that is meaningful." These examples highlight that scaling connected care requires investment not only in technology but also in new workforce models, including digital health navigators, hybrid care teams, and mobile clinicians.

Scaling connected care also requires changes to the institutional and professional structures that govern clinical practice. Reimbursement models, scope-of-practice regulations, and professional expectations have evolved around physician-led, facility-based care. Modernizing these arrangements to support team-based, technology-enabled models requires coordinated action among governments, regulators, professional associations, and labour organizations. These are structural policy challenges rather than technological ones and cannot be addressed by individual programs acting alone.

Taken together, these barriers hinder the scaling of connected care despite promising pilot programs. Misaligned and short-term funding keeps programs financially precarious; fragmented procurement and the lack of common standards force organizations to rebuild solutions from scratch; pilot fatigue and adoption inertia slow the diffusion of successful innovations; and workforce planning continues to lag behind the hybrid models of care enabled by technology. Table 3 maps the structural gaps identified throughout this brief to connected-care solutions, highlighting both their potential benefits and the conditions required for successful adoption.

Table 3. Connected-Care Solutions: Benefits, Adaptations, and Enabling Conditions

Structural Gaps	Remote Patient Monitoring	Virtual Care	Digital Therapeutics	AI-Enabled Tools	Hybrid Care Teams & Navigators
Limited access to primary & specialty care	Reduces routine follow-up visits	Removes geographic & mobility barriers	Supports guided self-management	Prioritizes specialist referrals	Allied health & PSWs deliver care between physician visits
Fragmented post-acute care & transitional care	Continuous patient monitoring across discharge transitions	Maintains post-discharge communication	Standardized care pathways shared across team	Alert-based escalation to appropriate provider	Navigators coordinate handoffs across settings
Workforce shortages	Expands clinician capacity	Reduces in-person visit load on providers	Automates routine medication adjustments and check-ins	Automates documentation & routine triage	Task-shifting to allied health, PSWs, & caregivers
Inequitable access to digital care	Requires broadband & device access; risks widening gap	Expands reach to rural/remote when access exists	Age-friendly design supports older-adult uptake	Risks bias against under-represented populations	In-home setup & navigators' close usability gap
Data sharing & privacy challenges	Requires interoperable data feeds to clinician dashboards	Depends on integrated EMRs across jurisdictions	Patient-generated data must flow securely	Model performance depends on cross-system data access	Team-based care requires shared records & consent
Cross-cutting evidence gap	Robust, scaled health-economic evidence remains limited across all five categories.				

These observations are consistent with a growing body of literature on connected-care implementation. Recent systematic reviews of remote patient monitoring have found consistent improvements in clinical adherence and patient-reported outcomes, alongside promising — but uneven — evidence of health-economic benefits across conditions such as hypertension, chronic obstructive pulmonary disease, and heart failure.[71] A 2026 study reached a similar conclusion, finding that positive clinical outcomes continue to coexist with structural barriers to scaling, including fragmented funding, workflow integration costs, and regulatory uncertainty.[72] The Canadian case studies examined in this brief reflect these broader implementation challenges.

One consequence of this uneven evidence base is that it complicates adoption decisions. This creates a chicken-and-egg problem: health systems are often reluctant to make the upfront investments needed to scale connected-care models without robust evidence of system-wide value, yet generating that evidence typically requires implementation at scale. As a result, decision-makers and procurement bodies must often make investment decisions without comparable, large-scale health-economic evaluations across pilot programs. Where cost savings have been reported, they are generally based on program-level evaluations rather than rigorous, externally validated studies conducted across multiple settings. Breaking this cycle will likely require policy interventions that support implementation alongside rigorous evaluation, as discussed below.

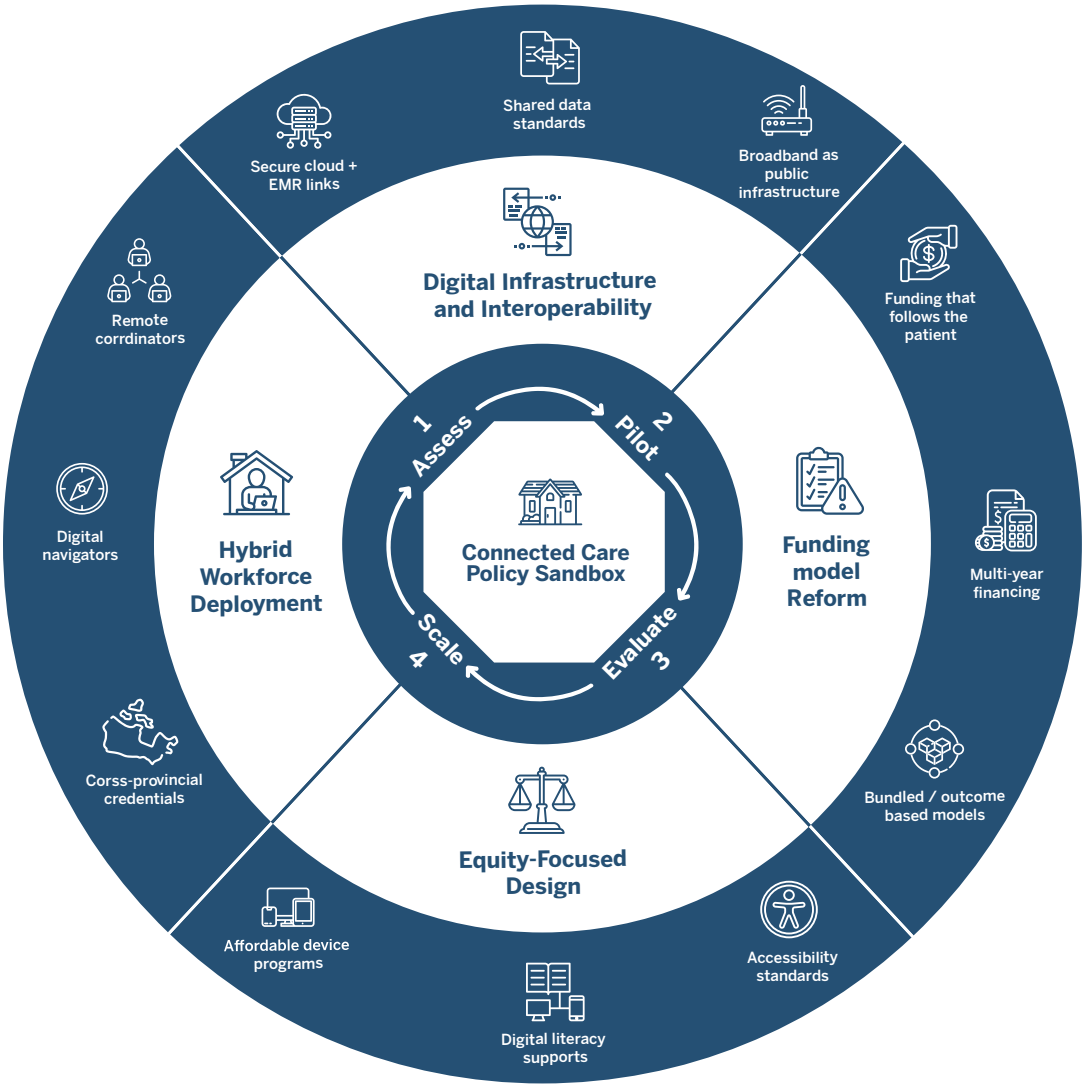
Policy Recommendations – Enabling Connected Care Models

Canada's ability to meet the needs of an aging population depends on translating promising connected-care pilots into sustained, system-wide practice. The evidence reviewed in this brief demonstrates that connected-care models can extend care beyond hospital walls, improve chronic disease management, and support aging in place. Yet many encouraging innovations remain confined to pilot projects because structural barriers continue to limit their adoption and long-term sustainability (see Table 3).

Addressing these barriers requires system-level action rather than incremental program changes. This brief proposes a 360-degree framework built around four interdependent pillars: digital infrastructure and interoperability, funding model reform, hybrid workforce deployment, and equity-focused design (see Figure 7). Together, these pillars establish the enabling conditions needed to support the responsible scaling of connected-care models.

Beyond these enabling conditions, the framework incorporates a phased pilot-to-scale pathway that positions implementation and evaluation as integral components of system-wide adoption rather than downstream considerations. Central to this pathway is a connected-care policy sandbox, which provides a structured environment for testing, refining, and evaluating promising models at meaningful scale before broader implementation across provinces and territories. The policy sandbox is discussed following the four pillars.

Figure 7. Connected Care for Aging in Place: A 360-Degree Systems Approach to Policy Design



The four outer pillars represent the enabling conditions required to support connected care for aging in place. The inner cycle illustrates the proposed pilot-to-scale pathway within a connected-care policy sandbox. Innovations are first assessed for readiness and feasibility, then piloted, evaluated using standardized clinical, economic, and operational measures, and scaled once sufficient evidence has been generated.

Digital Infrastructure and Interoperability

A connected healthcare system depends on the ability to share information securely and seamlessly across jurisdictions, providers, and technologies. Yet Canada's digital health infrastructure remains fragmented. Electronic medical record (EMR) systems are often siloed, data-sharing requirements differ across provinces, and broadband and cloud capacity remain uneven, particularly in rural, remote, and Indigenous communities.

Stakeholders across healthcare, industry, and academia consistently identify governance as the primary constraint to scaling connected care. Michael Page of Unity Health notes that current privacy frameworks and risk-averse institutional practices routinely prevent the exchange of health information between providers, even when doing so would improve patient safety and continuity of care. Recent federal initiatives — including Canada's AI for All strategy (2026), Working Together to Improve Health Care for Canadians Plan (2023), Joint FPT Action Plan on Health Data and Digital Health (2023), and the proposed Connected Care for Canadians Act (Bill C-72) — reflect growing recognition that interoperable digital infrastructure is foundational to modern healthcare delivery.[73, 74, 75, 76]

Canada's AI for All strategy, launched in June 2026, identifies health and life sciences as one of five national priority sectors and includes a flagship Health AI Mission designed to accelerate the adoption of AI in diagnostics, patient care, and health-system efficiency.[77] The strategy emphasizes digital infrastructure, workforce readiness, public trust, and adoption as foundational conditions for realizing the benefits of emerging technologies: an important policy signal that digital health infrastructure is now being treated as essential public infrastructure.

To translate these national commitments into practice, governments should establish a coordinated federal-provincial governance framework that sets and enforces minimum standards for interoperability, device integration, data exchange, and patient consent. Privacy and cybersecurity frameworks should be modernized to enable appropriate data sharing while maintaining public trust. Public-private partnerships can also accelerate the development of secure cloud infrastructure and domestic digital health technologies, provided they operate within transparent national standards.

Procurement and regulatory frameworks must also evolve to keep pace with innovation. Fragmented purchasing processes and risk-averse approval systems continue to delay the adoption of effective technologies. As digital health investor and former health-data entrepreneur Adam Lorant observes, Canada's innovation challenge is less about technological capability than institutional fragmentation and decision-making incentives, which often make it easier to defer adoption than to implement promising solutions.

The case studies presented in this brief demonstrate the value of coordinated digital infrastructure. Medly at the University Health Network (UHN) has reduced heart failure readmissions by combining remote patient monitoring with clinician dashboards, while Medoma's hospital-at-home model in Sweden uses centralized command centres and digital logistics platforms to coordinate mobile care teams across large geographic areas. Both illustrate how interoperable digital infrastructure can support more coordinated, continuous, and scalable models of care.

Scaling these models in Canada requires moving beyond short-term pilot funding toward sustained investment in digital infrastructure as a core component of healthcare delivery. Governments should establish transparent evaluation frameworks, streamline procurement pathways, and equip clinicians, administrators, and health system leaders with the tools needed to assess and adopt proven digital innovations. A coordinated national digital health investment strategy would help transform Canada's patchwork of pilot projects into an integrated, interoperable digital health ecosystem that supports better patient outcomes, greater system efficiency, and long-term productivity.

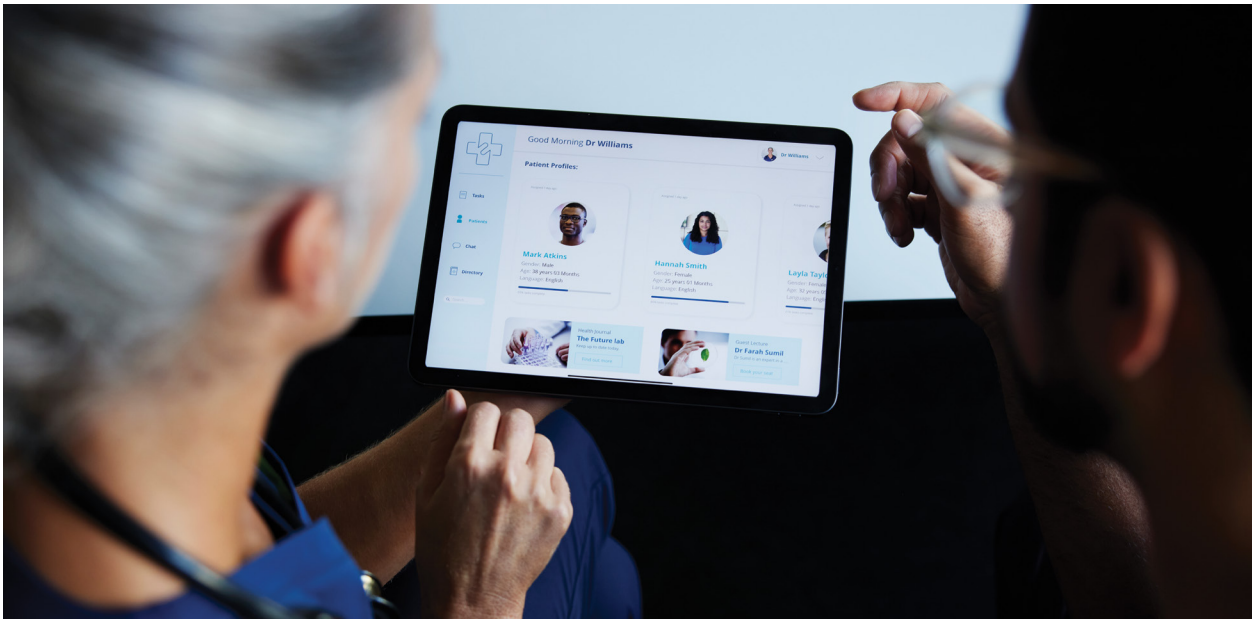
Hybrid Workforce Deployment

Delivering connected care requires a workforce equipped to provide digitally enabled, community-based care across home, virtual, and clinical settings. This requires healthcare professionals who are proficient with data-driven tools, able to work across professional boundaries, and prepared to deliver care within hybrid (in-person and virtual) models. Yet workforce planning, education, and credentialing frameworks remain anchored in traditional, facility-based models, limiting the system's capacity to deploy staff effectively within emerging models of care. Modernizing workforce systems is therefore a structural prerequisite for scaling connected care and supporting high-quality care for an aging population.

The COVID-19 pandemic offered a clear demonstration of how workforce adaptability determines the uptake of digital innovation. Virtual-care use in Canada increased more than tenfold in early 2020, but only after governments temporarily modified reimbursement rules and authorized providers to deliver care through new modalities. This rapid shift reflected the system's ability to adapt scopes of practice, workflows, and staffing models when supported by enabling policy frameworks. It also highlighted the rigidity of traditional workforce structures that continue to constrain the long-term adoption of connected-care models.

The case studies presented in this brief illustrate the value of workforce redesign. For instance, TGHC's Remote Care Monitoring program employs a tiered staffing model in which PSWs triage non-clinical alerts while nurses oversee medical escalation. Its 24/7 command centre routinely manages high alert volumes, with coordinators handling up to 80 calls per day, demonstrating how hybrid staffing models can absorb significant operational demand without compromising patient safety.

Similarly, the Medly program at UHN demonstrates how digitally enabled workflows can expand clinical capacity. Whereas a cardiac nurse traditionally manages approximately 50 heart failure patients, Medly's algorithmic triage and standardized workflows enable a single nurse coordinator to safely monitor up to 250 patients — a fivefold increase in capacity — while achieving a 50 per cent reduction in heart-failure-related hospital readmissions.



International evidence reinforces these findings. Evaluations of virtual ward and hospital-at-home models in the United Kingdom and Sweden demonstrate that hybrid staffing models — supported by mobile care teams, digital coordinators, and centralized command centres — can increase care capacity by 20–30 per cent without increasing clinical risk.[79,80] Organization for Economic Co-operation and Development (OECD) analyses similarly conclude that digital transformation increases demand for interdisciplinary teams, digitally literate clinicians, and more flexible role design rather than reducing overall workforce requirements.[81]

AI is expected to accelerate this shift. An OECD study (2024) estimates that up to 36 per cent of activities in health and social care could be automated through AI-enabled tools, primarily administrative, documentation, and routine diagnostic tasks.[82] Activities requiring clinical judgment, patient communication, empathy, and complex decision-making, however, have low automation potential, indicating that AI is more likely to augment than replace the health workforce.[83] Studies of AI-enabled nursing and clinical decision-support tools similarly suggest that workforce transformation will involve task reallocation and skill evolution, with clinicians increasingly responsible for interpreting data outputs, supervising automated systems, and integrating digital tools into care pathways.[84]

Realizing these workforce gains at scale will require deliberate policy action across jurisdictions. While provinces and territories remain responsible for healthcare delivery and workforce planning, federal leadership can help establish common priorities, support knowledge sharing, and enable coordinated approaches to workforce transformation. This includes supporting the development of new care roles designed for connected systems, such as remote care coordinators, digital health navigators, mobile acute-care teams, and data-informed nursing positions. Provinces and territories can advance this shift through training hubs that integrate clinical knowledge with digital literacy, communication skills, workflow redesign, and AI-assisted decision support. Greater alignment on cross-provincial credential recognition and flexible task-sharing frameworks would allow clinicians and allied health providers to practice to their full scope, improve workforce mobility, and strengthen capacity across regions. Preparing for this transition will require sustained investment in continuous professional development, curriculum reform across medical and allied health programs, and system-wide digital readiness.

Equity-Focused Design

Equity is a foundational principle of connected care and a guiding objective of national and international digital health strategies. Yet access to digital health services in Canada remains uneven. Persistent gaps in broadband connectivity, device affordability, digital literacy, accessibility, and culturally responsive design disproportionately affect older adults and populations facing barriers to accessing healthcare, including people living in rural and remote communities.

The case studies presented in this brief demonstrate that equitable access depends on more than the availability of technology. TGHC's Remote Care Monitoring program shows that successful implementation requires ongoing technical support, digital literacy, and community-based delivery. Technicians install monitoring devices in patients' homes, provide individualized training, and offer continuous assistance through a 24/7 call centre, helping older adults build the confidence needed to engage with remote monitoring. The program's expansion into remote communities through locally hired Personal Support Workers also illustrates how workforce design can strengthen access while creating community-based employment.

Medly similarly demonstrates the importance of user-centered design. Developed with UHN's Lab for Healthcare Human Factors, the platform combines an age-friendly interface with personalized onboarding to support older adults, including many over the age of 70, in managing complex cardiac conditions. As digital therapeutics continue to expand, features such as multilingual functionality and accessible interface design will become increasingly important for supporting diverse patient populations. Medly's implementation in Northern Ontario also demonstrates how connected care can improve access to specialist services for rural and remote communities that face long travel distances and limited local availability.

Structural barriers remain, however, even within successful models. Medoma's hospital-at-home program delivers strong clinical outcomes and reduces hospital readmissions, yet eligibility is restricted to patients with stable housing and residence within 40 minutes of a participating hospital. These requirements demonstrate how program design can unintentionally exclude populations experiencing housing instability or geographic isolation if equity considerations are not incorporated from the outset. Building on existing national digital health commitments, Canada should adopt a coordinated digital health equity strategy that embeds equity throughout the design, implementation, and evaluation of connected-care programs.[85]

Such a strategy should prioritize sustained investment in broadband infrastructure for underserved regions, device affordability initiatives for seniors and low-income households, and universal accessibility standards for digital health technologies. Connected-care solutions should also be designed to reflect the cognitive, linguistic, cultural, and physical needs of diverse populations through plain-language interfaces, large-print options, multilingual functionality, and voice-enabled navigation where appropriate.

Program evaluation should include measures of access and participation across diverse population groups. Monitoring these indicators enables decision-makers to identify unintended gaps in access, evaluate whether connected-care initiatives are reaching intended populations, and inform future policy and program design.

Achieving equitable connected care will require coordinated action across the health system. Federal and provincial governments should align regulatory frameworks and long-term funding to support equitable virtual care and interoperable digital infrastructure. Regional health authorities and healthcare organizations should integrate hybrid workforce models and community-based digital outreach into service delivery. Canadian health technology companies have an important role in developing inclusive digital infrastructure and accessible technologies, while academic institutions and training centres should strengthen digital literacy, implementation research, and equity-focused evaluation.

Connected-Care Policy Sandbox

While the four pillars provide the foundational conditions needed for scaling, realizing broader adoption of connected-care solutions requires overcoming a fundamental chicken-and-egg challenge: health systems are hesitant to invest in scaling without robust evidence of clinical and economic value, yet generating such evidence depends on implementation at sufficient scale. To address this challenge, this brief proposes establishing a **connected-care policy sandbox** that enables provinces and territories to test, refine, and evaluate promising models while generating comparable evidence to support broader adoption.

Given Canada's decentralized healthcare system, where provinces and territories retain primary responsibility for healthcare delivery while the federal government plays an important role in funding, coordination, and advancing national health priorities, the sandbox would provide a structured platform for interjurisdictional collaboration. Rather than imposing a uniform model across provinces, it would enable jurisdictions to test and adapt promising connected-care innovations within different operational contexts while generating comparable evidence to inform broader adoption decisions.

The sandbox would begin with an assessment phase in which candidate connected-care innovations are evaluated based on their potential system impact, scalability, implementation feasibility, and alignment with health-system priorities, including equity, continuity of care, and improved outcomes for older adults. High-potential innovations would then move into sandbox testing, where they would be evaluated as integrated models of care operating within real-world health-system environments.

Within the sandbox, provincial health systems, federal partners, technology providers, researchers, and other stakeholders would collaboratively identify and test the policy conditions required for scale. This would include examining changes to funding models, workforce configurations, interoperability standards, data governance arrangements, and accountability structures. The sandbox would enable these conditions to be developed, tested, and refined alongside the innovations being implemented.

A central feature of the policy sandbox is that it would create the conditions for rigorous evidence generation by embedding evaluation into implementation from the outset.
Rather than delaying adoption until stronger evidence becomes available, promising connected-care models could be implemented within structured evaluation frameworks that generate evidence while supporting ongoing refinement. Evaluation approaches would be selected based on the intervention being tested. For discrete interventions or clearly defined care pathways, pragmatic randomized controlled trials (RCTs) could generate high-quality evidence on clinical effectiveness, patient outcomes, healthcare utilization, and costs while maintaining real-world applicability.

Because connected-care models often involve changes to care delivery processes, workforce roles, and organizational structures, the sandbox would also support evaluation designs suited to complex health-system interventions. These may include cluster randomized trials, where healthcare teams, clinics, or regions are randomized rather than individual patients, and stepped-wedge designs, where participating sites transition from usual care to the connected-care model over time. For example, a remote monitoring program for older adults with chronic heart failure could be implemented across few primary-care networks in different provinces. Some networks could adopt the model initially, while others continue usual care before transitioning at a later stage. Outcomes — including hospital admissions, emergency department visits, quality of life, provider workload,

equity of access, and total healthcare costs — could then be compared across implementation periods. This approach would generate rigorous evidence while allowing provinces and health systems to progressively adopt, refine, and adapt the model.

Sandbox initiatives would be evaluated using standardized measures of clinical effectiveness, cost-effectiveness, workflow integration, patient and provider experience, and equity impacts. Health-economic evaluation would be a core component, requiring participating programs to assess direct costs, cost offsets, system-level savings, and return on investment over defined time horizons. This would address one of the most persistent barriers identified throughout this brief: the lack of comparable, externally validated evidence on the economic and system-level value of connected-care models.

The four pillars would evolve alongside the evidence generated through the sandbox. Implementation would identify where digital infrastructure, funding arrangements, workforce models, interoperability standards, and equity considerations require refinement, allowing these enabling conditions to develop alongside emerging solutions. This recognizes that the conditions needed for scale cannot always be fully designed in advance but must be refined through structured experimentation, evaluation, and continuous learning.

Once innovations demonstrate sufficient clinical, economic, and operational value, evidence generated through the sandbox would support coordinated investment and broader adoption within and across provinces. In this way, the sandbox moves beyond traditional pilot programs by providing a structured pathway from experimentation to system transformation. It enables governments and health-system leaders to evaluate whether connected-care models — and the policies, incentives, governance structures, and delivery models that support them — can achieve sustained impact at scale.


MEDICAL GENERAL
DOCTOR

Conclusion

Canada stands at a demographic crossroads. The growing population of older adults is reshaping the nation's health and economic landscape, revealing the limits of a system designed for episodic, institution-based care. Scaling the systems of care that can meet this transition, particularly connected-care models, has become an infrastructure challenge as much as a health policy issue. The capacity to age in place safely and with dignity depends on coordinated investment in digital systems, workforce training, and long-term funding mechanisms that treat connected care as essential public infrastructure.

The four case studies presented demonstrate both the promise and the fragility of innovation in this space. Each show how well-designed technology can expand capacity, prevent unnecessary hospitalization, and improve quality of life for seniors. Yet each also exposes structural weaknesses: fragmented data governance, short-term funding cycles, and uneven access that limits scalability. Interviews with system leaders across public, private, and academic sectors reinforce this assessment. Despite strong technological capability, Canada's barriers lie in the structure of decision-making, funding, and data governance. Bridging these divides will require coordinated reform that empowers collaboration across institutions and jurisdictions.

The opportunity is urgent but within reach. Implementing a cohesive framework that links funding reform, digital infrastructure, skilled hybrid workforces, and equitable access can create a health system capable of meeting demographic change with resilience rather than crisis. This requires deliberate action by governments, health institutions, and private partners to align incentives, share data securely, and invest in the human and technological foundations of care.

Technology will be central to this transition, but it cannot substitute for trust, empathy, and human connection, much of which is provided by the clinicians, allied health providers, personal support workers, and family caregivers who form the front line of care for older adults. The path forward lies in pairing technological capacity with policy coherence and human judgment, and in approaching the next phase deliberately: a phased pilot-to-scale strategy that learns from what works, generates the comparable evidence that current literature does not yet provide, and turns population aging from a crisis to be managed into the impetus for building the infrastructure of care Canada will need for the decades ahead.

Appendix: Connected Care Case Studies

Case Study 1: Toronto Grace Health Centre — Remote Care Monitoring

"We need to think differently. We need a paradigm shift. I believe that successful aging is aging in place,and this is such a perfect time for this change."
— Jake Tran, President & CEO, Toronto Grace Health Centre

About the Project

Toronto Grace Health Centre (TGHC) is a sub-acute care hospital specializing in complex continuing care, post-acute rehabilitation, palliative care, and transitional services. In 2019, TGHC launched its Remote Care Monitoring (RCM) program to help seniors with complex functional, psychological, and social needs transition safely from hospital to home. Initially piloted for post-surgical patients, the program has since supported more than 20,000 individuals — 95 per cent over age 65 — and expanded to British Columbia and Prince Edward Island in 2024.

The Challenge

Seniors with multidimensional needs frequently face fragmented follow-up after discharge, leading to preventable readmissions, caregiver strain, and prolonged stays as alternate level of care (ALC) patients. Limited primary–community integration and reliance on emergency departments further exacerbate risks. TGHC identified the need for an infrastructure model capable of bridging hospital and home through continuous monitoring and proactive intervention.

The Solution

RCM combines remote monitoring with coordinated team-based care. Patients receive tailored kits, including:

- **Fall Detection & Geo-fencing Pendants.** Alerts for falls or wandering trigger immediate followup from the 24/7 command centre.
- **Automated Medication Dispensers.** Deliver the correct dose at the scheduled time and send alerts to both the patient and the command center if a dose is missed.
- **Home Sensor Systems.** Detect changes in daily activity (e.g., fridge or bathroom use) for early intervention.
- **Vital Signs Monitoring.** Bluetooth-enabled devices track weight, blood pressure, oxygen, glucose, and more, integrated via a tablet into TGHC's dashboard.
- **Virtual Engagement.** Exercise classes (Active Together T.I.M.E.™ at Home), YouTube health education, and weekly chaplain calls to reduce social isolation.

A TGHC technician installs the technology and combination of devices is tailored to each patient based on their cognitive, physical, and technological needs. Alerts from the RCM devices are sent directly to the TGHC 24/7 command center, where a tiered staffing model enables efficient triage: PSWs monitor non-clinical alerts while nurses oversee vital signs monitoring and escalation. This approach preserves nursing capacity for complex decision-making and keeps operating costs low, approximately $10–$15 per patient per day, far below the cost of hospitalization.

The system's proactive design allows care teams to intervene early. For example, when a geo-fencing alert indicated that an older adult had wandered from home, command-centre staff coordinated directly with the family, avoiding an unnecessary 911 or police response and enabling a rapid, safe resolution — underscoring the importance of human judgment alongside technology.

For patients requiring more intensive transitional support, TGHC's RCM+ model deploys locally recruited PSWs to provide on-the-ground assistance for the first 2–3 months until patients stabilize and can use the technology independently. Recruiting PSWs from the communities served reduces travel barriers and ensures continuity of support, particularly in rural or remote areas where clinical teams cannot be physically present.

Outcomes & Insights

RCM/RCM+ has reduced readmissions, improved continuity of care, and increased patient satisfaction. However, scaling and sustaining the program presents several challenges:

- **Funding misalignment.** The Ontario Ministry of Health currently covers only ~25 per cent of program needs, often through one-year approvals. Tran notes: "Funding needs to follow the patient… We need the money to flow rather than finding new money. It needs to shift from acute care to community care."
- **Care integration.** Kilby-Lechman notes that coordination with independent physicians is challenging, as solo practitioners often have unique data preferences, requiring customization and complicating standardization. She highlighted that British Columbia and Prince Edward Island benefit from more standardized escalation protocols, while Ontario requires extensive customization.
- **Caregiver support.** Families managing seniors with chronic conditions face significant emotional and physical strain. TGHC's partnerships, such as caregiver relief program with KinVillage in British Columbia, demonstrate opportunities to add respite and wellness resources for caregivers.
- **Data sharing.** This presents legal and logistical hurdles. While TGHC has secured patient consent for information sharing, other providers are often unable or unwilling to share due to privacy complexities. Tran argues that if data ownership resides with the patient, consent should unlock full accessibility for all providers involved.

Across these insights, a consistent message emerges: successful connected care depends on technology plus human infrastructure. RCM demonstrates the value of early intervention, efficient resource allocation, and hybrid workforce models. By integrating digital tools with community-based support, TGHC provides a scalable, cost-effective pathway for aging in place — one that illustrates how strategic infrastructure investment can reduce system strain while improving quality of life for older adults.

Case Study 2: Centre for Digital Therapeutics at the University Health Network – Medly Therapeutics

"Traditionally, one nurse could manage 50 patients. With Medly, a single nurse can effectively support even more — redefining how we deliver care."
— Noor El-Dassouki, Medly Project Manager at University Health Network, Centre for Digital Therapeutics

About the Project

Medly Therapeutics (Medly) is a nurse-led digital therapeutic program developed at the Peter Munk Cardiac Centre in collaboration with the Centre for Digital Therapeutics at UHN. Designed to support patients with chronic conditions, particularly heart failure, Medly delivers guideline-based medical advice through a mobile app and clinician dashboard. Launched in 2016, Medly has supported over 2,500 patients, with more than 1,000 currently enrolled across four major hospitals: UHN's Peter Munk Cardiac Centre, Mount Sinai Hospital, Women's College Hospital, and Sunnybrook Health Sciences Centre. In January 2026, UHN finalized an exclusive, global licensing agreement with VITALL Intelligence to commercialize Medly.

The Challenge

Heart disease affects over 2.4 million Canadians and remains the second leading cause of death nationwide — first among seniors over 85.[86,87] Among its most serious consequences is heart failure, a condition that often follows a heart attack and leads to impaired heart function, frequent exacerbations, and hospitalizations. Without daily monitoring, early warning signs are missed, resulting in preventable hospital admissions. Medly addresses this gap by enabling guidelinebased, remote medication titration and real-time symptom tracking, transforming care delivery to help patients recover faster and stay out of hospital.

The Solution

Medly enables patients to submit daily biometric and symptom data, which is analyzed through a rules-based algorithm to generate personalized feedback and alerts for clinical teams. The solution is composed of two core components: the Medly Service, which provides operational support and clinical resources, and the Medly System, a Health Canada–certified Class II Medical Device that enables continuous monitoring and intervention. Key features include:

- **Patient App.** A mobile application helps patients actively manage their condition by recording daily biometric data, such as blood pressure, heart rate, weight, and symptoms, and receive personalized feedback.
- **Proprietary Algorithm.** Medly's algorithm analyzes patient data in real time to give personalized guidance, including pre-approved medication instructions. For example, it may recommend a water pill if signs of fluid overload appear. The algorithm is designed to detect early indicators of deterioration, often before patients notice symptoms, and automatically alerts both the patient and clinician.
- **Clinician Dashboard.** A web-based interface consolidates patient data, trends, and alerts, allowing nurse coordinators to efficiently manage large patient panels.

- **Device Integration.** Medly supports both Bluetooth-enabled and manually entered data from commonly used devices. Patients can use their own equipment or receive devices through the program to ensure equitable access.

- **Medly-AI.** A next-generation enhancement to the existing algorithm, Medly-AI will incorporate broader clinical data, including lab results, to improve predictive accuracy and reduce false positives. The pilot, supported by the Vector Institute, is expected to launch later this year.[88]

Outcomes & Insights

Medly has demonstrated significant clinical impact, including a 50 per cent reduction in heart failure-related hospital admissions and shorter lengths of stay.[89] By enabling medication titration based on clinical guidelines, Medly reduced the typical 6–8 month process to just 3 months, enabling faster stabilization and improved outcomes.

The program's nurse-led model has proven highly efficient, allowing a single coordinator to manage up to 250 patients. A centralized view of patient data, enables faster responses and better clinical oversight, with patients reporting high satisfaction due to daily monitoring and direct access to their care team.

Medly's digital infrastructure also supports remote care delivery in underserved regions. In Northern Ontario, the program has expanded access to cardiology expertise for First Nations, Métis, and Inuit communities.[90] Early results show improved access and patient engagement in disease self-management.

Medly is now being evaluated for broader use through a nearly completed two-year randomized controlled trial covering conditions such as COPD, hypertension, diabetes, mental health, liver failure, and cardiometabolic syndrome. Key considerations for scaling the program include:

- **Funding and commercialization.** With initial Ontario Health funding now expired, UHN has engaged an experienced Ontario-based technology partner, VITALL Intelligence, to lead commercialization activities globally. Uncertainty around billing structures and limited hospital incentives remain barriers to broader adoption.

- **Plartform enhanecement.** Initially developed as a minimum viable product through government grants, Medly now requires further enhancement. With additional investment, the platform can expand its cloud infrastructure and integrate with EMR systems, allowing for system-wide deployment.

- **Accessibility.** A large proportion of Medly's users are seniors, who have demonstrated strong engagement with the platform in practice. This success is supported by Medly's inclusive design and personalized support. Its age-friendly interface, developed by UHN's Lab for Healthcare Human Factors, combined with in-person and virtual training, has enabled high engagement among older adults. However, broader equity challenges such as access to such technology and language accessibility remain in place.

Case Study 3: Medoma – Hospital-At-Home

"Hospital-at-Home isn't just digital. Once you have multiple patients, it's not only about monitoring—it's about managing planning, logistics, and communication."
—Henrik Bjartun, Chief Medical Officer & Co-Founder, Medoma

About the Project

Medoma, a healthcare technology company aimed at transforming acute care delivery, was founded by a group of Swedish physicians. Their vision was to shift acute care services from hospitals to patients' homes, thereby reducing strain on hospital infrastructure while maintaining high-quality care. Backed by venture capital funding, Medoma launched a pilot project in 2021 in partnership with St. Göran Hospital, one of the largest in Stockholm. This initiative tested the feasibility and effectiveness of home-based acute care, leveraging both technology and in-person care. The two-year program allowed for virtual ward treatment of 640 patients usually cared for in hospital.

The pilot with St. Göran Hospital served as a showcase where Medoma provided management, performed risk analysis and brought its own clinical team of nurses and doctors. The next step for the Medoma team is to scale its partnerships with the hospitals and provide consulting work on program implementation.

The Challenge

Healthcare systems around the world are facing growing pressures, driven by an aging population, such as increased demand for acute care services, hospital overcrowding that leads to longer wait times, insufficient capacity, and the high operational costs associated with inpatient care. Many

patients occupy hospital beds despite being clinically stable enough to receive treatment at home, which further strains limited resources. Hospital-at-home programs offer a solution by freeing up hospital beds for patients with more complex needs, improving patient comfort and outcomes through care in familiar environments, reducing costs by shifting care delivery to lower-cost settings, and enhancing system flexibility during surges or emergencies. However, delivering highacuity care in a decentralized setting demands purpose-built technology for care coordination.

The Solution

Medoma combines advanced medical technology, a centralized monitoring center, and a mobile care team to treat patients in their own homes. Its proprietary technology connects care planning, logistics, and communication in a Remote Patient Operations Platform which is integrated with Remote Patient Monitoring (RPM) technology provided by partner companies. Key components of the platform include:

- **Medoma Center.** An integrated platform enables care planning, chat and video communication with patients, and team coordination using live schedules and route optimization. It also provides real-time visibility into the entire care flow, helping clinicians understand what care has been delivered, and where each team member is located.

- **Medoma Go.** The mobile app designed for mobile care teams, enables them to view daily visits, access patient information and checklists, and navigate routes directly from their phones.

- **Medoma Care.** The patient-facing app provides personalized care plan with live updates. Patients can complete self-care tasks, receive reminders, and track vital signs.

The Command Center serves as the operational hub for care delivery. Staffed by nurses and physicians, it is responsible for planning all medical activities for each patient, coordinating mobile visits, and reallocating resources in real time. Medoma's Mobile Team comprised of nurses, clinicians, and paramedical staff delivers hands-on care directly in patients' homes. They onboard patients, administer medications, collect blood samples, conduct vital assessments, and manage discharge procedures.

The program is designed for short-term acute care, with an average patient stay of four days, focusing on close monitoring during the acute phase rather than long-term treatment. Eligibility for the program is based on the patient's condition at the time of the acute episode and on logistical component: patients must have a home and live within a 40-minute drive from the hospital.

Medoma is not limited to specific diagnoses; a wide range of conditions have been treated through the program, including pneumonia, pyelonephritis, heart failure, and diabetes. Patients have ranged in age from 18 to 95 years old, with an average age of 72. Medoma also plans to begin serving pediatric patients in the near future.

Outcomes & Insights

Medoma's hospital-at-home model has demonstrated improvements in patient outcomes, including fewer complications such as infections and falls. The program also achieved a 25 per cent reduction in readmission rates and enabled care teams to treat 20 per cent more patients per nurse compared to traditional hospital wards. Patients reported higher satisfaction, citing greater comfort, faster response times, and feeling more informed and involved in their care. Here are some key takeaways for hospital-at-home implementation and scalability:

- **Hybrid care delivery.** Hospital-at-home is never just digital. Data from Medoma reveals that 40 per cent of care activities are delivered remotely, while 60 per cent require in-person visits. This balance highlights the need for hybrid care delivery, to ensure patients receive the right care, at the right time, in the right setting.

- **Logistics.** While Medoma's model has proven to be 40 per cent more cost-effective than traditional hospital care, implementing hospital-at-home program requires thoughtful planning. As acute care shifts into the home and more hospitals become interested in running their own command centers and mobile teams, logistics becomes central to safe, timely and coordinated care.

- **Patient communication.** In hospital-at-home care, keeping patients informed and engaged is essential for safety, adherence, and trust. Medoma addresses this with AI-powered communication tools that translate complex EMR notes into patient-friendly language. This improves patient satisfaction and reduces the burden on clinicians.

Case Study 4: TELUS Health – Home Health Monitoring

"In order to solve healthcare crisis – we need to fundamentally rethink where and how care should be delivered. Care at home creates better quality of life, lowers costs, and reduces strain on the acute care system."
—Dr. Matthew Chow, Chief Mental Health Officer, TELUS Health

About the Project

TELUS Health Home Health Monitoring (HHM) is a digital health initiative that reimagines chronic disease management by enabling patients to receive clinical oversight and education about managing their condition in their own homes. Launched in 2013 through a collaboration between TELUS Health, the British Columbia Ministry of Health, and multiple health authorities — including Interior Health, Island Health, Fraser Health, and Vancouver Coastal Health — the program has since expanded to five provinces. By enabling early intervention and proactive chronic disease management, HHM reports improvements in patient outcomes and reduced healthcare costs. The program offers 35 monitoring plans covering chronic conditions, infectious diseases, surgical recovery, senior and specialty care (cancer, palliative, transplant care, etc.).[91,92]

In addition to its HHM program, TELUS Health offers a range of digital health tools that support remote care delivery. Its Medical Alert system includes a GPS-enabled pendant and a caregiver app, and is designed for individuals at risk of falls or wandering.[93] TELUS Health also operates MyCare, one of the most widely used virtual care apps in Canada, which connects patients with clinicians, nurses, dietitians, and mental health professionals, and is publicly available. In British Columbia, more than 1 million virtual consults have been provided to 530,000 patients, 88 per cent of whom did not have a family doctor.

The Challenge

Health systems across Canada are experiencing growing pressures due to an aging population and the increasing prevalence of chronic diseases, which drive up demand for acute care services and contribute to hospital overcrowding, longer wait times, and high operational costs. Traditional models of care often lack the tools to support patients in managing their health, highlighting the need for virtual solutions that extend clinical oversight into the home and empower patients to take a more active role in their care, therefore, relieving pressure on hospitals and shifting to lower-cost, patient-centered care models.

The Solution

The vision behind HHM is to provide monitoring and self-management support at home, using connected devices and a secure digital platform. Patients are equipped with Bluetooth-enabled devices (such as blood pressure cuffs, weight scales, and pulse oximeters) and a tablet or smartphone app. Training is provided to ensure patients and caregivers are comfortable with the technology and understand their care plan.

Each day, patients record vital signs and answer subjective symptom questions. This information is transmitted securely to a digital platform monitored by a clinical team — typically nurses and allied health professionals — who review trends, respond to alerts, and provide coaching. The clinical team escalates care as needed, coordinates with medical providers who adjust treatment and care plans in real time. Patients receive tailored education and action plans for their health condition to help them recognize and respond to early warning signs. Secure messaging and video conferencing features support clinicians in delivering patient-centered care and facilitate effective communication with patients.

Outcomes & Insights

The HHM program has demonstrated improvements in patient outcomes, including fewer complications and greater patient satisfaction. Evaluation across British Columbia Island Health Authority has shown that the HHM program is associated with a 59 per cent reduction is hospital readmission for heart failure patients and 88 per cent for COPD patients.[94,95]

Despite these results, provincial disparities in digital health adoption, driven by variable funding models, and scopes of practice, continue to limit scalability of HHM program. While the technology is proven, realizing its full potential requires addressing the following structural and policy barriers:

- **Funding.** Provincial differences in budget allocation, program approaches and reimbursement models create significant variability in the scalability of Remote Patient Monitoring (RPM) programs across Canada. While some provinces have established comprehensive and standardized funding frameworks that enable widespread RPM deployment across multiple conditions, others have adopted more limited and localized approaches, resulting in varying virtual care accessibility that reflects each province's unique healthcare funding priorities.
- **Public-private collaboration.** Private sector organizations play a growing role in delivering public health services than before, requiring more of a strategic partnership than traditional vendor-client transactions. Clear frameworks are needed to guide collaboration, ensure accountability, and align incentives between public health systems and private technology partners.
- **Workforce capacity.** Traditional community-based patient care is often siloed, with fragmented communication systems that limit coordination of care among clinicians. RPM creates a centralized, real-time view of patient status, that can support more integrated care models, but realizing these benefits requires enabling clinicians — including nurses, nurse practitioners, pharmacists, and allied health professionals — to work to their full scope.
- **Technology potential.** The technology to support RPM is already available and proven. There is potential to significantly scale the patients served by RPM solutions as AI and predictive analytics capabilities advance and are integrated into clinical workflows in the future. The opportunity now is to further align policy, funding, and clinical workflows to ensure patients receive timely, appropriate, and cost-effective care, particularly those who might otherwise rely on emergency services.

References

[1] Statistics Canada. (2025, September 24). Table 17-10-0005-01 Population estimates on July 1, by age and gender. https://www150.statcan.gc.ca/t1/tbl1/en/cv.action?pid=1710000501

[2] Statistics Canada. (2026, January 1). Table 17-10-0057-01 Projected population, by projection scenario, age and gender, as of July 1 (x 1,000). Projection Scenario M1 (Medium growth) was used for the calculations. https://www150.statcan.gc.ca/t1/tbl1/en/cv.action?pid=1710005701

[3] Statistics Canada. (2021, April 27). A Generational Portrait of Canada's Aging Population from the 2021 Census. https://www12.statcan.gc.ca/census-recensement/2021/as-sa/98-200-X/2021003/98-200-x2021003-eng.cfm

[4] Government of Ontario. Ontario Population Projections: 2023-2051. https://www12.statcan.gc.ca/censusrecensement/2021/as-sa/98-200-X/2021003/98-200-x2021003-eng.cfm

[5] Statista. Number of immigrants in Canada from 2000 to 2024.https://www.statista.com/statistics/443063/number-of-immigrants-in-canada/

[6] Statista. Number of immigrants arriving in Canada in 2024, by province or territory of residence. https://www.statista.com/statistics/444906/number-of-immigrants-in-canada/

[7] Statista. Number of people immigrating to Canada in 2023, by age. https://www.statista.com/statistics/443305/international-migrants-in-canada-2014/

[8] Statistics Canada. Millennials now outnumber baby boomers in Canada. https://www150.statcan.gc.ca/n1/daily-quotidien/240221/dq240221a-eng.htm

[9] Government of Canada: Immigration, Refugee, and Citizenship Canada. Canada's immigration levels. https://www.canada.ca/en/immigration-refugees-citizenship/corporate/mandate/corporateinitiatives/levels.html

[10] Statistics Canada. (2023, September 13). Health of Canadians. https://www150.statcan.gc.ca/n1/pub/82-570-x/82-570-x2023001-eng.htm

[11] Canadian Cancer Statistics Advisory Committee in collaboration with the Canadian Cancer Society, Statistics Canada and the Public Health Agency of Canada. (2023). Canadian Cancer Statistics. https://cdn.cancer.ca/-/media/files/research/cancer-statistics/2023-statistics/2023_PDF_EN.pdf

[12] Statistics Canada. (2026, January 13). Table 13-10-0394-01 Leading causes of death, total population, by age group. https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1310039401

[13] Statistics Canada. (2021, October 1). Table 13-10-0788-01 Chronic conditions among seniors aged 65 and older, Canadian Health Survey on Seniors. https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1310078801

[14] Diabetes in Canada. (2024, October). Backgrounder. Toronto: Diabetes Canada. https://www.diabetes.ca/getmedia/9c717b08-e53e-47c4-a522-c0937ce0861b/2024-Backgrounder-Canada-EN_FINAL_1.pdf

[15] Canadian Lung Association. Chronic Obstructive Pulmonary Disease (COPD): Causes and Symptoms of COPD. https://www.lung.ca/lung-diseases/copd/causes-and-symptoms-copd/

[16] Government of Canada. (2024). Canadian Chronic Disease Surveillance System (CCDSS): Chronic Obstructive Pulmonary Disease, Crude Prevalence. https://health-infobase.canada.ca/ccdss/data-tool/

[17] Statista. Percentage of Canadian adults who reported being diagnosed with high blood pressure from 2015 to 2023. https://www.statista.com/statistics/434103/share-of-canadians-reporting-being-diagnosed-withhigh-blood-pressure/

[18] Government of Canada. (2024). Canadian Chronic Disease Surveillance System (CCDSS): Hypertension, Crude Prevalence. https://health-infobase.canada.ca/ccdss/data-tool/

[19] Alzheimer Society of Canada. Dementia numbers in Canada. https://alzheimer.ca/en/aboutdementia/what-dementia/dementia-numbers-canada

[20] Alzheimer Society of Canada. (2024). The many faces of dementia in Canada. https://alzheimer.ca/sites/default/files/documents/ASC_The Many Faces of Dementia In Canada_LandmarkStudy_Vol2.pdf

[21] Government of Canada. (2024). Canadian Chronic Disease Surveillance System (CCDSS): Multimorbidity, Crude Prevalence. https://health-infobase.canada.ca/ccdss/data-tool/

[22] Canadian Institute for Health Information. (2025, November 27). NHEX trends — Infographics. https://www.cihi.ca/en/national-health-expenditure-trends/nhex-trends-infographics

[23] Canadian Institute for Health Information. (2024, November). Health Expenditure Data in Brief. Ottawa, ON. https://www.cihi.ca/sites/default/files/document/health-expenditure-data-in-brief-2024-en.pdf

[24] Canadian Institute for Health Information. Trends in public drug program spending in Canada

[25] Canadian Institute for Health Information. (2025, November 27). NHEX trends — Infographics. https://www.cihi.ca/en/national-health-expenditure-trends/nhex-trends-infographics

[26] Canadian Institute for Health Information. (2025, November 27). NHEX trends — Infographics. https://www.cihi.ca/en/national-health-expenditure-trends/nhex-trends-infographics

[27] Canadian Institute for Health Information. (2026, February). A profile of hospitalized seniors at risk of frailty in Canada — Infographic. https://www.cihi.ca/en/indicators/hospitalized-seniors-at-risk-of-frailty

[28] Canadian Institute for Health Information. (2026, February). A profile of hospitalized seniors at risk of frailty in Canada — Infographic. https://www.cihi.ca/en/indicators/hospitalized-seniors-at-risk-of-frailty

[29] Statistics Canada. (2025, August 6). Table 13-10-0905-01 Health indicator statistics, annual estimates. https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1310090501

[30] Statista. Median waiting times for medical care, from general practitioner to treatment, in Canada as of 2024, by province. https://www.statista.com/statistics/649600/medical-treatment-wait-times-canadaprovince/

[31] Hajizadeh, M., & Jalili, F. (2025, September 22). Addressing Healthcare Waiting Time Challenges in Canada: Insights from Emerging Initiatives. International Journal of Health Policy and Management: 14, 8986. https://doi.org/10.34172/ijhpm.8986

[32] Canadian Institute for Health Information. (2024, December 5). 1 in 7 visits to the emergency department are for conditions that could potentially have been managed in primary care. https://www.cihi.ca/en/news/1-in-7-visits-to-the-emergency-department-are-for-conditions-that-could-potentially-have-been

[33] Prior, A., Vestergaard, C. H., Vedsted, P., Smith, S. M., Virgilsen, L. F., Rasmussen, L. A., & Fenger-Grøn, M. (2023, August 15). Healthcare Fragmentation, Multimorbidity, Potentially Inappropriate Medication, And Mortality: A Danish Nationwide Cohort Study. BMC Medicine: 21(1), 305. https://doi.org/10.1186/s12916-023-03021-3

[34] Joo J. Y. (2023, January 9). Fragmented care and chronic illness patient outcomes: A systematic review. Nursing open, 10(6), 3460–3473. https://doi.org/10.1002/nop2.1607

[35] Health Quality Ontario. Wait Times for Long-Term Care Homes. https://ontariohealth.ca/system/reporting/performance

[36] Wyonch, R. (2024, May 10). Fixing the ALC Patient Problem is a Triple Win for Canadians. C.D. Howe Institute: Health Policy. https://cdhowe.org/publication/rosalie-wyonch-fixing-alc-patient-problem-triplewin-canadians

[37] Ontario Long Term Care Home Association. The Data: Long-Term Care in Ontario. https://cdhowe.org/publication/rosalie-wyonch-fixing-alc-patient-problem-triple-win-canadians/

[38] Statista. Demand for LTC and home care in Canada in 2019 and 2031. https://www.statista.com/statistics/1445708/ltc-and-home-care-demand-current-and-forecast-canada/

[39] Canadian Institute for Health Information. (2021, June 10). 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

[40] Organization for Economic Cooperation and Development (OECD). (2025, November 13). Health at a Glance 2025: OECD Indicators. https://www.oecd.org/en/publications/health-at-a-glance-2025_8f9e3f98- en/full-report/long-term-care-settings_9f4aa221.html#

[41] Wyonch, R. (2024, May 10). Fixing the ALC Patient Problem is a Triple Win for Canadians. C.D. Howe Institute: Health Policy. https://cdhowe.org/publication/rosalie-wyonch-fixing-alc-patient-problem-triplewin-canadians/

[42] Government of Canada (2024, July 11). Supporting Canada's health workers by improving health workforce research, planning and data. Health Canada News Release. https://www.canada.ca/en/healthcanada/news/2024/07/supporting-canadas-health-workers-by-improving-health-workforce-researchplanning-and-data1.html

[43] Canadian Medical Association. (2022, February). Virtual Care in Canada: Progress and Potential – Report of the Virtual Care Task Force. https://www.cma.ca/sites/default/files/2022-02/Virtual-Care-in-Canada-Progress-and-Potential-EN.pdf

[44] Canadian Medical Association. (2022, February). Virtual Care in Canada: Progress and Potential – Report of the Virtual Care Task Force. https://www.cma.ca/sites/default/files/2022-02/Virtual-Care-in-Canada-Progress-and-Potential-EN.pdf

[45] Government of Canada: Canadian Radio-television and Telecommunications Commission. (2026, March 18). CRTC making it easier to connect Indigenous communities to high-speed Internet and cellphone services. https://www.canada.ca/en/radio-television-telecommunications/news/2026/03/crtc-making-iteasier-to-connect-indigenous-communities-to-high-speed-internet-and-cellphone-services.html

[46] Scott, I. (2024, June 10). Conquering the next frontier in bridging the digital divide. Institute for Research on Public Policy. https://irpp.org/research-studies/conquering-the-next-frontier-in-bridging-the-digital-divide/

[47] Jaana, M., Tamim, H., & Paré, G. (2025, November 25). eHealth and the Digital Divide Among Older Canadians: Insights from a National Cross-Sectional Study. Journal of medical Internet research, 27, e72274. https://doi.org/10.2196/72274

[48] Canadian Medical Association. (2022, February). Virtual Care in Canada: Progress and Potential – Report of the Virtual Care Task Force. https://www.cma.ca/sites/default/files/2022-02/Virtual-Care-in-Canada-Progress-and-Potential-EN.pdf

[49] Public Health Ontario. (2023, October). Evidence Brief: Barriers and Strategies to Equity in Digital Health Programs and Services. https://www.publichealthontario.ca/-/media/Documents/E/2023/eb-barriersstrategies-equity-digital-health-programs-services.pdf

[50] Royal College of Physicians and Surgeons of Canada. (2025, February 25). Breaking down digital barriers: New task force sets path to connected Canadian health care. https://www.royalcollege.ca/en/newsroom/posts/breaking-down-digital-barriers--new-task-force-sets-pathto-conn.html

[51] Government of Canada: Health Canada. (2022). Virtual Care – Policy Framework: A product of the Federal, Provincial and Territorial Virtual Care / Digital Table. https://www.canada.ca/en/healthcanada/corporate/transparency/health-agreements/bilateral-agreement-pan-canadian-virtual-carepriorities-covid-19/policy-framework.html

[52] Statista. Percentage of older adults in Canada who would prefer in-home care to moving to a long-term care facility in 2022 and 2023. https://www.statista.com/statistics/1381857/preference-for-home-care-over-ltcin-canada/

[53] Canadian Institute for Health Information. (2025 October). New Long-Term Care Residents Who Potentially Could Have Been Cared for at Home. https://www.cihi.ca/en/indicators/new-long-term-care-residents-whopotentially-could-have-been-cared-for-at-home

[54] Canadian Institute for Health Information. (2024, December 5). Virtual primary care: Impacts and opportunities. https://www.cihi.ca/en/primary-and-virtual-care-access-emergency-department-visits-forprimary-care-conditions/virtual-primary-care-impacts-and-opportunities#ref3

[55] Canadian Institute for Health Information. (2022, March 24). Virtual care: A major shift for Canadians receiving physician services. https://www.cihi.ca/en/primary-and-virtual-care-access-emergencydepartment-visits-for-primary-care-conditions/virtual-primary-care-impacts-and-opportunities#ref3

[56] Canadian Institute for Health Information. (2022, April 19). Physician billing codes in response to COVID-19. https://www.cihi.ca/en/physician-billing-codes-in-response-to-covid-19

[57] Government of Ontario. (2022, December 1). New insured Virtual Care Services are epective December 1, 2022. https://www.ontario.ca/document/education-and-prevention-committee-billing-briefs/virtual-care-1-comprehensive-and-limited#section-2

[58] Jones, A.M. (2023, March 16). Patients who rely on virtual care now facing fees in Ontario: health-care platform founder. CTV News. https://www.ctvnews.ca/health/article/patients-who-rely-on-virtual-care-nowfacing-fees-in-ontario-health-care-platform-founder/

[59] CTV News Vancouver Island. (2021, July 12). British Columbians log more than a million virtual health visits, says provincial health authority. https://www.ctvnews.ca/vancouver/vancouver-island/article/britishcolumbians-log-more-than-a-million-virtual-health-visits-says-provincial-health-authority/

[60] Government of Nova Scotia. VirtualCareNS Action for Health. https://www.cihi.ca/en/physician-billingcodes-in-response-to-covid-19

[61] Healey, P. (2023, March 10). VirtualCareNS sees significant increase in those receiving care. The Laker News. https://thelaker.ca/virtualcarens-sees-significant-increase-in-those-receiving-care/

[62] De Guzman, K. R., Snoswell, C. L., Taylor, M. L., Gray, L. C., & Capery, L. J. (2022). Economic evaluations of remote patient monitoring for chronic disease: A systematic review. Value in Health, 25(6), 897–913. https://doi.org/10.1016/j.jval.2021.12.001

[63] Zhang, Y., Peña, M. T., Fletcher, L. M., Lal, L., Swint, J. M., & Reneker, J. C. (2023). Economic Evaluation and Costs of Remote Patient Monitoring for Cardiovascular Disease in the United States: A Systematic Review. International Journal of Technology Assessment in Health Care: 39(1). https://doi.org/10.1017/S0266462323000156

[64] Government of Canada. Guidance Document: Software as a Medical Device (SaMD): Definition and Classification. Table 2. https://www.canada.ca/en/health-canada/services/drugs-health-products/medicaldevices/application-information/guidance-documents/software-medical-device-guidance-document.html

[65] Agarwal, P., Lall, R., & Girdhari, R. (2024). Artificial Intelligence Scribes in Primary Care. CMAJ: Canadian Medical Association: 196(30). https://doi.org/10.1503/cmaj.240363

[66] Medoma. Product. https://www.medoma.com/product

[67] Ontario Hospital Association. Health System News Scaling from Within: Medly's Digital Health Journey. https://www.oha.com/news/scaling-from-within-medly%E2%80%99s-digital-health-journey

[68] World Health Organization. Noncommunicable Diseases. https://www.who.int/data/gho/data/themes/noncommunicable-diseases

[69] York University: Courtesy of the Conversation Canada. (2025, April 15). Canada is lagging in innovation, and that's a problem for funding the programs we care about. https://www.yorku.ca/news/2025/04/15/canada-islagging-in-innovation-and-thats-a-problem-for-funding-the-programs-we-care-about/

[70] Organization for Economic Co-operation and Development (OECD). The Innovation Imperative Contributing to Productivity, Growth and Well-Being. https://www.oecd.org/en/publications/the-innovationimperative_9789264239814-en.html

[71] Tan, S. Y., Sumner, J., Wang, Y., & Wenjun Yip, A. (2024). A systematic review of the impacts of remote patient monitoring (RPM) interventions on safety, adherence, quality-of-life and cost-related outcomes. NPJ digital medicine, 7(1), 192. https://doi.org/10.1038/s41746-024-01182-w

[72] Meda, G.V, & Brennan-Davies, A.H. (2026, February 1). Remote Patient Monitoring and the Need for a New Care Model: A Narrative Review of Implementation Challenges. Cureus. https://doi.org/10.7759/cureus.102803.

[73] Government of Canada: Prime Minister's Opice. (2026, June). AI for All: Canada's New National Artificial Intelligence Strategy. Ottawa. https://www.pm.gc.ca/en/news/news-releases/2026/06/04/prime-ministercarney-launches-ai-all-canadas-new-national-artificial

[74] Government of Canada. Working with partners to modernize public health data. https://www.canada.ca/en/public-health/programs/working-with-partners-modernize-public-healthdata.html

[75] Government of Canada, Ministry of Health. (2023, February 7). Working together to improve health care for Canadians. https://www.canada.ca/en/health-canada/news/2023/02/working-together-to-improve-healthcare-for-canadians.html

[76] Government of Canada, Ministry of Health. (2024, June 6). The Government of Canada introduces the Connected Care for Canadians Act. https://www.canada.ca/en/health-canada/news/2024/06/thegovernment-of-canada-introduces-the-connected-care-for-canadians-act-improving-patients-safety-andaccess-to-their-health-information.html

[77] Government of Canada. (2026, June). Canada's National Artificial Intelligence Strategy: AI for All. https://ised-isde.canada.ca/site/ised/en/canadas-national-artificial-intelligence-strategy-ai-all

[78] Kfrerer, M. L., Zheng, K. Z., & Austin, L. C. (2024). From 0–50 in pandemic, and then back? A case study of virtual care in Ontario pre–COVID-19, during, and post–COVID-19. Mayo Clinic Proceedings: Digital Health.https://doi.org/10.1016/j.mcpdig.2023.07.004

[79] Kastengren, M., Frisk, L., Winterfeldt, L., Wahlström, G., & Dalén, M. (2025). Implementation of Sweden's first digi-physical hospital-at-home care model for high-acuity patients. Journal of telemedicine and telecare, 31(6), 891–897. https://doi.org/10.1177/1357633X241232176

[80] Evaluation of virtual ward models in Southwest London. (2022). Health Innovation Network South London: London (UK): https://healthinnovationnetwork.com/wp-content/uploads/2022/11/SWL-VW-evaluationreport_final-version-21.11.22.pdf

[81] Organization for Economic Co-operation and Development (OECD). Digital Transformation. https://www.oecd.org/en/topics/policy-issues/digital-transformation.html

[82] Organization for Economic Co-operation and Development (OECD). (2024, November 20). Artificial Intelligence and the Health Workforce: Perspectives from medical associations on AI in health. https://www.oecd.org/en/publications/artificial-intelligence-and-the-health-workforce_9a31d8af-en.html

[83] Houser, S. H., Crew, D., Flite, C. A., & Goethals, C. (2025). Shaping the Future of the Health Information Profession: The Impact of Emerging Technologies on the Workforce. Advances In Health Information Science and Practice:1(2), RBQG5825. https://doi.org/10.63116/RBQG5825

[84] Wei Q, Pan S, Liu X, Hong M, Nong C and Zhang W (2025) The integration of AI in nursing: addressing current applications, challenges, and future directions. Front. Med. 12:1545420. https://www.frontiersin.org/journals/medicine/articles/10.3389/fmed.2025.1545420/full

[85] Government of Canada. About the Vision 2030 initiative. https://www.canada.ca/en/publichealth/services/public-health-practice/surveillance/vision-2030-future-public-health-surveillancecanada.html

[86] Canadian Institute for Health Information. Cardiac care. https://www.cihi.ca/en/cardiac-care

[87] Statistics Canada. Leading causes of death, total population, by age group. https://www150.statcan.gc.ca/t1/tbl1/en/cv.action?pid=1310039401

[88] Vector Institute. (2022, November 22). Mind the Gap: Enabling AI Deployment in Health. https://vectorinstitute.ai/wp-content/uploads/2023/05/Health-Summit-Article-Final-1.pdf

[89] Vector Institute. (2022, November 22). Mind the Gap: Enabling AI Deployment in Health. https://vectorinstitute.ai/wp-content/uploads/2023/05/Health-Summit-Article-Final-1.pdf

[90] Petrie, Samuel at al. (2024, December). Bringing Care Close to Home: Remote Management of Heart Failure in Partnership with Indigenous Communities in Northern Ontario, Canada, The Canadian Journal of Cardiology. CJC Open, Volume 6, Issue 12, P. 1423-1433. https://pmc.ncbi.nlm.nih.gov/articles/PMC11681357/

[91] TELUS Health. (2024, March 5). TELUS Health selected to provide Remote Care Management program in Ontario. https://www.telus.com/en/about/news-and-events/media-releases/telus-health-selected-toprovide-remote-care-management-program-in-ontario

[92] TELUS Health. (2020, June 11). Home Health Monitoring supports patients in Saskatchewan. https://www.telus.com/en/health/press-releases/telus-healths-home-health-monitoring-technologysupports-lung-transplant-patients-saskatchewan

[93] TELUS Health. TELUS Health Medical Alert. https://www.telus.com/en/personal-health/medical-alertsystems/seniors

[94] Ho, K., Novak Lauscher, H., Cordeiro, J., Hawkins, N., Scheuermeyer, F., Mitton, C., Wong, H., McGavin, C., Ross, D., Apantaku, G., Karim, M. E., Bhullar, A., Abu-Laban, R., Nixon, S., & Smith, T. (2021). Testing the Feasibility of Sensor-Based Home Health Monitoring (TEC4Home) to Support the Convalescence of Patients with Heart Failure: Pre-Post Study. JMIR formative research, 5(6), e24509. https://doi.org/10.2196/24509

[95] UBC Digital Emergency Medicine & Vancouver Coastal Health. TEC4Home COPD Infoway Benefits Evaluation Report. https://www.infoway-inforoute.ca/en/component/edocman/3576-evaluation-oftelehealth- for-emergency-community-continuity-of-care-connectivity-via-home-telemonitoring/viewdocument?Itemid=0

Ivey | Lawrence National Centre for Policy and Management

Ivey Business School at Western University
1255 Western Road, London, Ontario N6G 0N1

Telephone: 519-661-2111 ext. 88487
Email: LNC@ivey.ca
www.ivey.uwo.ca/lawrencecentre