August 2026 **Executive Summary**

Transforming Senior Healthcare in Canada:

Embracing Connected Care, AI, and Digital Innovation

This executive summary provides a visual overview of the **LNC policy brief**, covering healthcare system pressures amid population aging and chronic disease, the potential of connected-care models, and a proposed framework for broader adoption.

1. The challenge

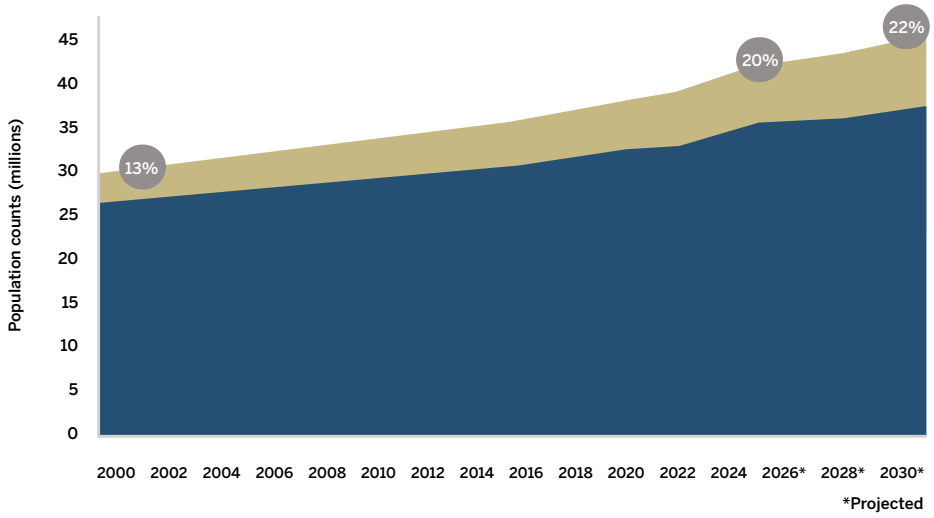
Canada's healthcare system is at an inflection point. Population aging and the growing prevalence of chronic disease are exposing the limits of a system historically organized around episodic, facility-based care. Gaps in continuous monitoring, coordinated care transitions, and long-term community-based management are adding pressure on hospital capacity, the health workforce, and system costs.

9.3M
Canadians aged 65+ by 2030[1]

~5M
Older Canadians living with multimorbidity (2+ chronic conditions)[2]

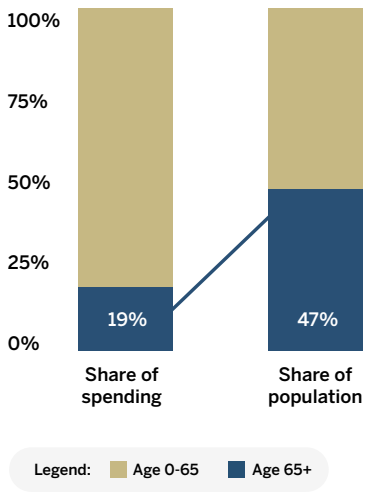
$1.5–3B
Annual excess cost of alternative level of care (ALC) patients[3]

Figure 1. Canada's Population Growth with % of Seniors Over 65 Relative to the Whole Population



Source: Statistics Canada, Tables 17-10-0005-01 & 17-10-0057-01 (Medium-growth projection)

Figure 2. Healthcare Spending on Seniors in 2023



Source: CIHI, NHEX trends, 2025 · Per-capita spend ~3× higher for 65+ vs. 15–64

Table 1. Leading Chronic Conditions in Canadian Seniors

Condition	Prevalence	System Impacts
Cancer[4]	~22% of Canadians expected to die from cancer; 96% of cases at age 50+; peak incidence 65–74	Leading cause of mortality in seniors; long wait times, high expenditures
Heart Disease[5, 6]	~1M seniors ≥65; 2nd leading cause of death overall; leading cause for ≥85; 55,000+ deaths/yr	Major driver of acute hospitalizations and readmissions
Diabetes (Type 2, prediabetes)[7]	~12M Canadians affected; risk rises with age	Significant costs in hospital care, drugs, and devices; drives multimorbidity

See policy brief for additional examples: Chronic obstructive pulmonary disease (COPD), hypertension, and dementia.[8, 9, 10, 11, 12, 13]

Scan for **references**:

2. Structural gaps in the current system

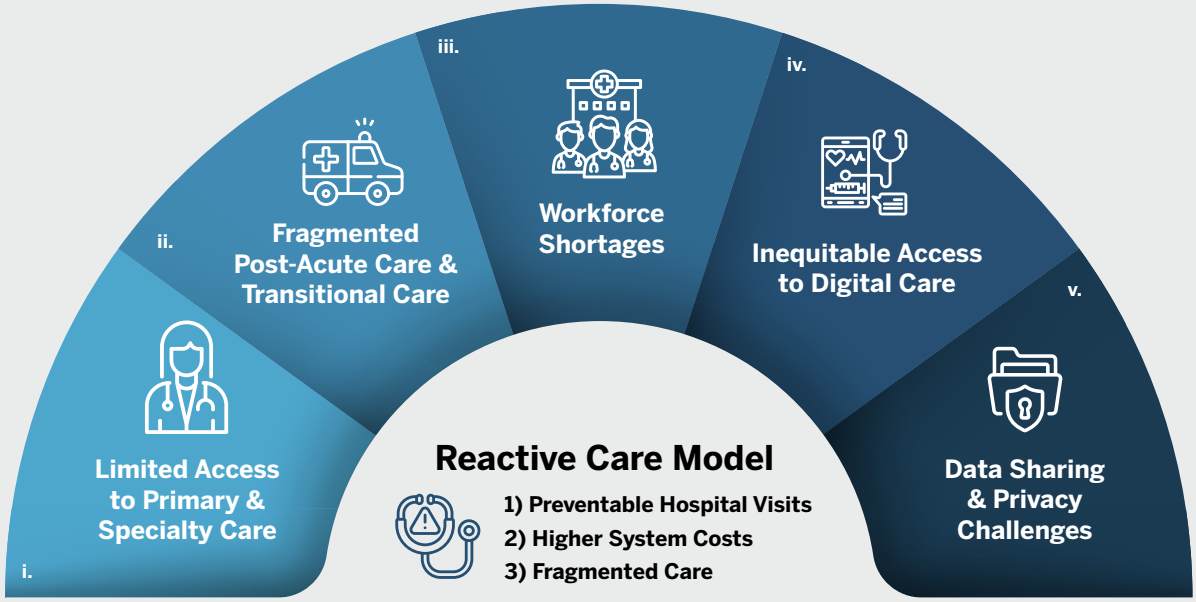
Five interconnected barriers help explain why the existing system and emerging innovations alone cannot meet the growing and increasingly complex care needs associated with population aging and chronic disease.

Figure 3. Structural Barriers to Connected Care

i. Limited access to primary and specialty care. Declining family-physician access and long specialist waits push seniors into emergency departments (ED) — one in seven ED visits in 2024 could have been managed in primary care.[14]

ii. Fragmented post-acute and transitional care. Inconsistent data sharing drives readmissions and preventable alternative level of care (ALC) stays — one in three hospitalized seniors is at risk of frailty and twice as likely to be readmitted within 30 days.[15]

iii. Workforce shortages. Rising demand, complexity, and burnout are outpacing supply — Canada is projected to be short 78,000 physicians by 2031 and 117,600 nurses by 2030.[16]



iv. Inequitable access to digital care. A 2025 survey of 2,000 older Canadians found only 9.4% used telemonitoring and 4.2% used fall-detection tools — with those in greatest need least likely to engage.[17]

v. Data sharing and privacy challenges. Only 29% of physicians routinely share patient information outside their practice; more than 35% spend 2+ hours daily searching for records.[18]

These barriers compound one another. Delayed access drives complications; fragmented transitions drive readmissions; workforce and digital gaps constrain proactive, coordinated care.

Long-term care (LTC) infrastructure alone cannot absorb this demand: Canada averages just 29 LTC beds per 1,000 population aged 65+ compared to an OECD average of 41 — yet 90 per cent of Canadians aged 45+ would rather receive care at home, and CIHI reports one in ten new LTC admissions could have been supported at home.[19]

Scan for **references**:

3. From episodic to connected care

Connected care extends care beyond episodic interactions by integrating remote patient monitoring, virtual care, digital therapeutics, AI-enabled tools, and hybrid care teams into a continuous model of prevention, monitoring, and early intervention. Table 2 summarizes their principal benefits, the adaptations they require, and the enabling conditions needed to support implementation.

Table 2. 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.				

While evidence supporting clinical outcomes continues to grow, comparable large-scale economic evaluations remain limited across technology categories.

4. Evidence from connected-care case studies

Four Canadian and international case studies illustrate how connected-care models are being applied in practice.

Case Study	Focus	Reported Outcome
Toronto Grace Health Centre - Remote Care Monitoring	Hospital-to-home transitions	Has supported 20,000+ patients at a reported ~$10–15/day; enables safer hospital-to-home transitions for seniors who might otherwise remain as ALC patients
University Health Network - Medly Digital Therapeutics	Heart failure (HF) management	Reported reductions in HF-related readmissions; one nurse coordinator can support up to 250 patients — roughly five times the traditional caseload
TELUS Health - Home Health Monitoring	Remote monitoring for chronic disease management	Program-reported reductions in hospital use of up to 59% (HF) and 88% (COPD) across BC deployments
Medoma (Sweden) - Hospital-at-Home	Acute care delivered in the home	St. Göran pilot reported a 25% reduction in readmissions and ~20% more patients per nurse

Detailed case studies are provided in the Appendix of the full policy brief. Reported outcomes are drawn from program-level evaluations and organizational reporting.

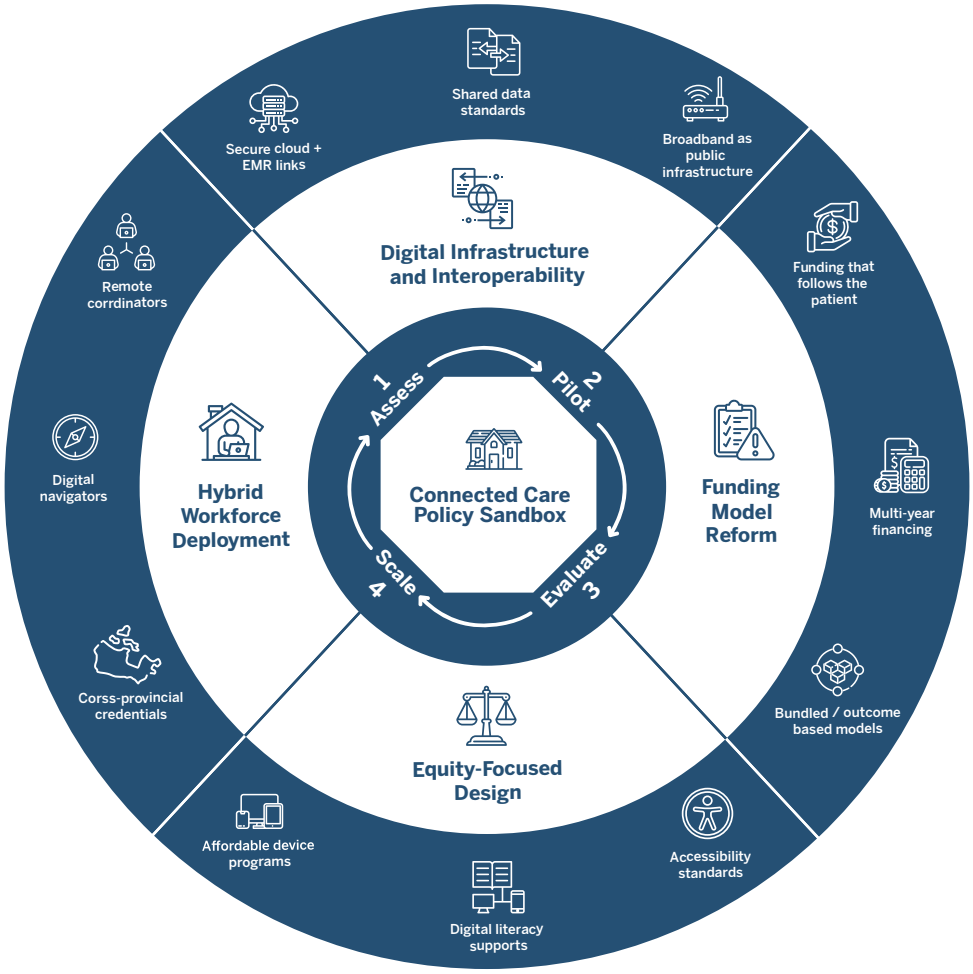
Together, these case studies illustrate the potential of connected-care models to support continuity of care, reduce preventable hospital use, and extend care beyond traditional healthcare settings — across hospital-to-home transitions, chronic disease management, and acute care at home.

4. A framework for scaling connected care

Supporting the broader adoption of connected care requires attention to the system-level conditions that shape implementation and scale. The policy brief proposes a 360-degree systems framework built around four interdependent pillars, anchored by a Connected Care Policy Sandbox that provides a pathway for translating these enabling conditions into practice. A key challenge is the evidence needed to support broader adoption: health systems often seek stronger evidence before investing, but generating that evidence depends on testing innovations at meaningful scale, creating a "chicken-and-egg" problem.

The Connected Care Policy Sandbox provides a structured way to address this challenge through a pilot-to-scale pathway for connected-care innovations. By embedding evaluation throughout the process, comparable clinical, operational, and economic evidence can be generated in real-world health-system settings — within the limited context of the sandbox, but at sufficient scale to assess suitability for wider adoption.

Figure 4. Connected Care for Aging in Place: A 360-Degree Systems Approach to Policy Design



The four outer pillars enable connected care; the inner cycle provides an iterative pilot-to-scale pathway.

- **Digital Infrastructure and Interoperability:** Treat digital infrastructure as essential public infrastructure: shared data standards, secure cloud + EMR links, and broadband access.
- **Funding Model Reform:** Align incentives with prevention, coordination, and aging in place through multi-year financing, bundled and outcome-based models, and funding that follows the patient.
- **Workforce Deployment:** Expand hybrid-care models, build digital-health competencies, and enable emerging roles (remote coordinators, digital navigators, cross-provincial credentialing).
- **Equity-Focused Design:** Embed equity as a core design principle through affordable device programs, accessibility standards, and digital literacy supports.

Read the full policy brief for detailed case studies, technology deep-dives, and complete policy recommendations at **lawrencecentre.ca**.

This Executive Summary accompanies: Tsybulnyk, M., & Hueston, R. (2026). Transforming Senior Healthcare in Canada: Embracing Connected Care, AI, and Digital Innovation. (R. Mostafa & Z. Agoston Villalba, Eds). Lawrence National Centre for Policy and Management, Ivey Business School.