Emergency Department Overcrowding: A CAEP Position Statement

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Introduction & Background

Emergency department (ED) overcrowding has been a persistent challenge in Canada for more than three decades. Overcrowding occurs when the demand for emergency services exceeds the system's capacity to provide safe, timely, and effective care. Despite sustained advocacy from the emergency medicine community and recurrent media attention following preventable deaths related to overcrowding in EDs, the problem continues to worsen and should be considered a public health emergency (1).

Major international emergency medicine organizations (including the American College of Emergency Physicians, Australasian College for Emergency Medicine, European Society for Emergency Medicine, and International Federation for Emergency Medicine) have identified access block, the prolonged boarding of admitted patients in the ED due to insufficient downstream inpatient capacity, as the primary driver of overcrowding (2–5).

Research has shown that ED overcrowding is associated with negative patient outcomes, independent of an individual's wait time or length of stay (LOS) (5–12). Thus, ED overcrowding is a patient safety threat, not merely a problem of operational inefficiency or poor patient experience. The prolonged boarding of admitted patients further constrains an ED's capacity to safely assess and treat new arrivals, contributing to longer wait times for all patients. This is particularly concerning for those who require nursing care and cannot be treated in an ambulatory zone (13–18). Importantly, overcrowding is not solely an operational issue within EDs, but rather a manifestation of broader systemic failures in healthcare policy and capacity.

In 2013, the Canadian Association of Emergency Physicians (CAEP) published a position statement on ED overcrowding and access block (19). The statement included proposed benchmarks for time to physician initial assessment, time to being transferred to an inpatient bed,

and ED LOS (Table 1). Although these metrics were subsequently incorporated into the Canadian Institute for Health Information (CIHI)'s National Ambulatory Care Reporting System (NACRS), not all provinces and territories have mandated the submission of comprehensive ED visit data (20). The established benchmarks remain essential to evaluating ED performance and tracking progress in addressing ED overcrowding across Canada. Unfortunately, despite the urgency highlighted in the 2013 position statement, little progress has been made in addressing the underlying causes of ED overcrowding identified more than a decade ago.

This updated CAEP position statement reaffirms the core principles of the 2013 statement while incorporating new evidence from national and international organizations. Using Asplin's input-throughput-output conceptual model, we reiterate that hospital access block is the primary driver of ED overcrowding, summarize associated patient safety harms, and present evidence-based recommendations informed by interventions that have been implemented and evaluated over the past decade (21). Together, these findings support an urgent call for coordinated national, provincial, and territorial action to address a persistent and escalating crisis in Canadian healthcare.

Why Overcrowding Matters

The harms of ED overcrowding and hospital access block are frequently underestimated. It is often assumed that patients in ED waiting rooms are not seriously ill and that long waits are inconvenient rather than dangerous, or that boarded patients receive care equivalent to that received on inpatient wards. These assumptions are incorrect.

Triage assessments are brief and imperfect, and as overcrowding worsens, the risk of clinical deterioration while waiting increases. Diagnostic testing initiated at triage cannot reliably identify all life-threatening conditions, as highlighted repeatedly in media reports of patients

deteriorating or dying before receiving definitive care (22–25). For patients requiring admission, prolonged boarding in the ED is associated with worse outcomes, including increased mortality (11–13,15–18,26). Among adults older than 75 years, an overnight stay in the ED is associated with higher in-hospital mortality (27). Reviews have consistently demonstrated that ED overcrowding is associated with increases in medical errors, delays in time-sensitive treatments, longer inpatient LOS, and increased mortality (7,28–30). A large UK analysis found that for every 72 patients waiting more than 8 to 12 hours for an inpatient bed, one additional death occurred (6). Similarly, a systematic review found that mortality rates nearly doubled for patients waiting longer than 12 hours for an inpatient bed (31). Longer ED wait times are also associated with increased short-term mortality among patients discharged from the ED, suggesting that overcrowding may compromise clinical decision-making and risk assessment (26,32,33). Alarmingly, patients arriving at a crowded ED (higher occupancy) tend to experience more adverse outcomes and higher mortality, regardless of individual wait times or LOS (33–35).

Despite this robust evidence base, the excess morbidity and mortality attributable to ED overcrowding often remains invisible to clinicians, patients' families, and policymakers. Deaths are under-reported and typically attributed to underlying illness, obscuring the contribution of delayed or compromised care resulting from system-level capacity failures.

Beyond its direct effects on patient safety, ED overcrowding has profound and increasingly unsustainable consequences for the ED workforce. The persistent inability to provide timely, high-quality care due to systemic access block creates moral distress among emergency physicians, nurses, and allied health professionals (36). Clinicians are routinely placed in situations in which they must deliver care in hallways, waiting rooms, or other non-

clinical spaces without adequate staffing or resources. This environment erodes professional satisfaction and undermines the fundamental commitment to safe, patient-centred care.

Overcrowding transforms emergency practice from proactive clinical assessment and decision-making into crisis management and risk mitigation. Physicians and nurses are required to simultaneously manage critically ill patients, supervise boarded inpatients, and monitor large volumes of waiting patients, often with incomplete information, limited physical space, and insufficient resources. The cognitive load associated with these competing demands increases the risk of error and contributes to emotional exhaustion (37).

Burnout among emergency physicians and nurses has been well documented, and worsening ED conditions have accelerated workforce attrition in many jurisdictions following the COVID-19 pandemic (38,39). High levels of burnout are associated with increased rates of depression, reduced work hours, early retirement, and transitions away from clinical practice or to other clinical settings (e.g., virtual care, hospitalist care, urgent care clinics). In turn, staffing shortages further exacerbate overcrowding, creating a self-perpetuating cycle of diminished capacity and escalating system strain.

ED overcrowding is therefore not solely a patient flow and safety issue; it is also a critical workforce sustainability concern. Failure to address access block risks the long-term destabilization of emergency care delivery across Canada. Protecting the well-being of emergency health professionals is inseparable from protecting patient safety and maintaining system capacity.

Current State of ED Care in Canada: Pressures and Strain

Healthcare policies in Canada are failing patients. The 2023 CAEP EM:POWER Task Force report on the future of emergency care described EDs as functioning “on the verge of

collapse," citing access block, workforce burnout, ambulance offload delays, and rising rates of patients leaving without completing care as systemic problems undermining emergency care (40).

Assessments by Canada's Drug Agency (formerly the Canadian Agency for Drugs and Technologies in Health) demonstrate that ED overcrowding is associated with delayed diagnosis and treatment, higher rates of patients leaving without being seen (LWBS), and increased mortality (1). These harms persist after adjusting for patient acuity and case mix, demonstrating that overcrowding itself, rather than simply individual patient LOS, contributes to unsafe care environments.

ED utilization continues to rise. In 2022–2023, Canadian EDs recorded 15.1 million visits, returning to pre-pandemic volumes and sustaining pressure on EDs (41). More recent CIHI NACRS data for 2024–2025 reported over 16.1 million ED visits, up from 15.5 million in 2023–2024 (20). Performance indicators have deteriorated in parallel. ED LOS for admitted patients reached 48.5 hours at the 90th percentile, up markedly from 33.5 hours in 2021, while discharged patients experienced a median LOS of 8 to 10 hours (42). Extended inpatient boarding in ED stretchers remains the primary driver of these prolonged stays and represents a key indicator of worsening ED overcrowding (20).

Wait times for physician initial assessment have increased substantially; In Ontario, for example, the 90th percentile time to physician initial assessment was 4.5 hours, failing to meet targets by 32% (43,44). Rates of LWBS have doubled in several jurisdictions, with evidence linking LWBS to higher risk of hospitalization or death in the subsequent seven to 30 days (32,45). CIHI data show that 90th percentile waits for inpatient beds frequently exceed one to two days in urban centres, further exacerbating crowding and delaying patient care (20).

In jurisdictions that do not participate in CIHI NACRS reporting, the absence of comprehensive data prevents the implementation and validation of iterative system changes to improve performance and patient care. For example, the 2025 *Report of the Auditor General of New Brunswick* concluded that the "Department of Health does not have effective oversight mechanisms in place to ensure timely access to, and adequate reporting on, emergency health services" (46). The established benchmark (proposed by CAEP in 2013) for wait time from triage to physician assessment was met only 34% of the time, including only 44% of CTAS I (requiring immediate resuscitation) patients. Severe ED overcrowding led to one hospital in New Brunswick boarding patients in the ambulance bay that lacked plumbing (47). The Auditor General's report further emphasized that the systematic measurement of key performance indicators and the establishment of accountability frameworks are essential to achieving meaningful system improvements (46).

These patterns reflect a deteriorating national standard of emergency care and signal ongoing risk for avoidable morbidity and mortality. High inpatient bed occupancy, longer hospital LOS, persistent staffing shortages, temporary ED closures, and limited discharge capacity for alternate level of care patients, have produced a system-wide inability to move admitted patients out of the ED. Existing literature consistently identifies these downstream constraints and not inappropriate ED use by lower acuity patients or those lacking access to a primary care provider, as the dominant cause of severe overcrowding (1,6,40).

Beyond the ED

ED overcrowding is complex. Its causes and solutions lie largely outside EDs. Delays in accessing primary care, specialty care, hospital care, and community care lead to rising ED demand; consequently, ED overcrowding is best understood as a manifestation of failures in

hospital and system-wide access. An environmental scan by Canada's Drug Agency found that few of the factors contributing to overcrowding originate within the ED, and emphasized the need for coordinated, multi-level interventions spanning hospitals, health system planning, and community and social care sectors (1). Although all hospital flow initiatives differ in efficacy based on unique centre factors, a recent review showed that all high-performing departments, regardless of heterogeneity in type of intervention, shared the following four attributes in implementation: direct executive leadership involvement, hospital-wide coordinated strategies, data-driven management, and performance accountability (48). Thus, it is not so much the specific interventions a hospital selects, but rather how the strategies are implemented and supported that are key to addressing ED overcrowding.

The input-throughput-output model provides a useful framework for organizing contributors across phases of care occurring before, within, and after an ED visit. Evidence consistently demonstrates that severe overcrowding is mainly caused by system-level capacity constraints, not inappropriate ED utilization or ED inefficiencies (1,40,49–51). Despite this, over the past two decades, media and government attention has largely focused on input and throughout interventions, which have consistently failed to reduce overcrowding or its sequelae. In contrast, output failure, commonly referred to as hospital access block, remains the most important driver of ED overcrowding, and effective interventions must align with this operational reality (1,19,40).

Input Factors

Governments across Canada have invested substantial resources on initiatives intended to reduce ED demand, including urgent care centres for low acuity patients, primary care and ambulance diversion strategies, virtual care options, public campaigns to deter non-urgent ED

visits, and the publication of real-time ED wait times. However, systematic reviews and evaluations consistently demonstrate these input-focused interventions have had minimal or no sustained impact on ED overcrowding or access block, and may be dangerous (51–56). Discouraging ED use could lead to delayed presentations for patients with serious conditions, and deferred care may result in lack of care altogether. Canada's Drug Agency has identified several strategies that show promise in improving ED overcrowding in selected contexts; however, evidence suggests they are insufficient to meaningfully address the issue in the absence of parallel investments in downstream capacity (1,57).

Poor access to primary care is an important system challenge, but it is not the primary driver of ED overcrowding. While evidence suggests that patients who have a primary care provider make fewer ED visits, the gap between demand and supply in Canada means that it will take many years to achieve the goal of everyone in Canada having access to a regular primary care provider (58). Even for those who have a primary care provider, Canada ranked last among 10 countries in a Commonwealth Fund survey assessing the proportion of older adults who could access same- or next-day appointments, meaning patients often have no other choice than to seek ED care (59). Evidence suggests that patients with minor concerns who require fewer investigations or less nursing care have a minimal impact on the wait times or provision of care for patients with more complex problems (50,51,60). ED waiting rooms are increasingly filled by patients with episodic complications of complex chronic disease, functional complications associated with frailty and aging, substance use, inadequate access to preventive care, and need of advanced diagnostic testing or specialty care (19,40,61–63). When community-based services are inaccessible or insufficient, EDs increasingly serve as a default access point for patients experiencing mental health problems, unstable housing, and unmet social needs (61,64). Unlike

patients with minor episodic illness, those with more complex, non-emergent needs occupy substantial ED stretcher and provider time, contributing to ED demand and prolonged care delays.

Throughput Factors

ED throughput is constrained by growing human health resource deficits and a lack of surge capacity. Hospitals operating at or above full occupancy cannot accommodate surges, predictable seasonal peaks (e.g., influenza cases), disasters, or unexpected public health emergencies such as COVID-19 (65,66). The aging population in Canada, combined with these patients having increasingly complex medical and psychosocial needs, further contributes to ED LOS and throughput challenges (39,67). Delays in consultation, diagnostic testing, and disposition decision delays also extend ED LOS, reducing the capacity to assess new arrivals and worsen ED overcrowding (68–70). Operational constraints, including physical infrastructure limitations and the requirement for ED nursing staff to care for patients who are boarded while simultaneously managing newly arriving patients, further exacerbate throughput delays.

Reports from Canada's Drug Agency highlight several promising throughput interventions, many aligned with Lean Six Sigma principles that improve flow (41,71–73). Lean Six Sigma is a combined, data-driven methodology that improves operational efficiency, reduces waste, and minimizes process defects or variation. This process allows for individualized solutions adapted to each unique centre. Recommended strategies include dedicated ambulance offload spaces and staff, surge management and prediction tools, staffing alignment with patient arrival patterns, standardized triaging and medical directive protocols, rapid assessment and fast-track zones, dedicating staff accountable for patient flow (e.g., flow navigators), rapid point-of-care testing, short-stay mental health crisis units, and time-based policy reforms such as

Ontario's Pay-for-Results (P4R) program (1,74–82). Throughput interventions with limited supporting evidence include updated electronic medical records, artificial intelligence–assisted documentation, and expanded care teams that incorporate nurse practitioners, physician assistants, and physician navigators to expedite patient flow. While these interventions can improve ED flow, they are often temporizing measures. Sustainable reductions in ED overcrowding require alignment with system-level efforts to increase patient outflow to inpatient beds or community services in a timely manner. Although regular review and optimization of ED throughput processes are essential, even highly efficient EDs can be overwhelmed during periods of prolonged admission delays and resultant crowding.

Output Factors

Hospital access block remains the greatest threat to emergency care in Canada (6). Canada ranks poorly in comparisons of Organisation for Economic Co-operation and Development (OECD) in hospital LOS, acute-care bed capacity, bed occupancy rates, long-term care bed availability, and access to community-based supports for older adults with frailty (83,84). These structural deficiencies are well-established drivers of access block and contribute directly to sustained ED overcrowding.

In 2021, Canada's acute care bed occupancy rate was 86.7%, ranked second-highest among 31 OECD countries, with the 4th longest average inpatient LOS (7.8 days), reflecting both increasing patient complexity and limited capacity in community or transitional care facilities (83,84). Importantly, reported acute inpatient LOS does not include days designated as ALC, as acute LOS is calculated only until a patient's status changes to ALC. Consequently, official LOS metrics likely underestimate the true duration of hospital occupancy and downstream system strain.

National acute care bed occupancy averages also obscure important regional and temporal variation. Large urban and tertiary referral centres, and consequently smaller regional and rural centres, frequently operate at sustained occupancy levels of 95% or higher, and at times exceed 100% capacity when surge spaces are used. Annualized occupancy data further mask predictable seasonal surges, particularly during respiratory virus season, when hospital capacity is routinely exceeded.

Evidence suggests that hospital efficiency and patient flow deteriorate when acute care bed occupancy rates exceed approximately 85% (40). Above this threshold, small increases in demand can produce disproportionate delays in admissions and discharges, amplifying access block and contributing directly to ED overcrowding. Canada's persistently high occupancy rates for acute care beds therefore represent not merely a marker of system strain, but a structural condition that predictably generates ED gridlock.

A key challenge in optimizing care and disposition for ED patients stems from a fundamental dichotomy between emergency medicine and the broader healthcare system: EDs operate 24/7, whereas most medical services function on traditional "bankers' hours." While ED staff can rapidly identify the need for specialty consultations, advanced imaging, or diagnostic and therapeutic interventions beyond the ED's scope, patients often face delays of hours (evenings and nights) or days (weekends and holidays) before these resources become available. During this time, patients remain in medical limbo, contributing to access block. This phenomenon, described as "artificial variability," is one of four key components of flow management identified by the Institute for Healthcare Optimization (85). A 2006 Institute of Medicine report on emergency care further emphasizes that "by applying variability

methodology, queuing theory, and the I/T/O model, hospitals can identify and eliminate many of the patient flow impediments caused by operational inefficiencies" (86).

Canada's long-term care bed capacity per 1,000 population aged 65 years or older has decreased annually since 2016, contributing to access block for patients requiring transitional and long-term care after an acute hospital stay (87). Canada also has a low number of hospital beds, at per 2.5 per 1,000 population, compared with other OECD countries, which have an average of 4.2 hospital beds per 1,000 population (88). EDs are designed for short encounters (1 to 6 hours) and are staffed for acute problems. They are not equipped for inpatient care, intensive care, complex mental health interventions, chronic disease management, rehabilitation, or primary or preventive care. Nonetheless, these roles increasingly consume substantial ED resources. Even when emergency care is complete, admitted patients often remain boarded in ED stretchers or hallways for hours to days without privacy, sleep, bathroom access, or specialized nursing care. This limits nurse-staffed stretcher capacity for newly arriving patients. Within hospitals, patients who no longer require acute care, but who cannot be discharged block a substantial percentage of beds. These ALC patients reduce the outflow of admitted patients from the ED, which in turn blocks ED beds, causes ambulance offload delays, and compromises prehospital community care response. This domino effect of providing care in inappropriate settings increases inefficiency, healthcare costs, and adverse patient outcomes (11,12,16,28,89).

Long-term care and community care services are often at capacity and unable to accept patients with complex needs. Approximately 15% of acute care beds, and much higher in some jurisdictions, are occupied by ALC patients who no longer require hospitalization but lack safe discharge destinations (1). This reduces hospital capacity, limits movement of admitted patients out of the ED, and is a major cause of hospital access block. It should also be noted, separate

from the impact on EDs, that any prolonged ED or ward stays also increase morbidity and mortality in older patients, who may experience cognitive decline, deconditioning, and increased risk of institutionalization (27,90–92).

An important limitation of occupancy data is their tendency to oversimplify system dynamics, which can obscure key leverage points for change. Typically measured at a single time point (often midnight) and reported as averages, these data mask predictable surges such as seasonality and day-of-week variation. These metrics also underestimate the magnitude of access block by including wards that rarely receive ED admissions.

Reports from Canada's Drug Agency highlight promising output interventions, including aligning hospital bed capacity using simulation to optimize inpatient occupancy (target 70% to 85%), active bed management with dedicated staff to monitor discharges and bed availability, over-capacity protocols, rapid transfer of admitted patients from the ED to inpatient wards, hospital-led transitional care programs, care coordination between health system partners, and dedicated discharge planning staff and resources (1,93,94). Evidence demonstrates that optimizing inpatient flow can substantially reduce ED boarding and overcrowding, which improves patient outcomes and system efficiency (95–99).

Recommendations Prioritizing the Impact of the Input-Throughput-Output Framework on ED Overcrowding

ED overcrowding is a system-level failure driven primarily by output constraints. While EDs must optimize internal processes, sustainable improvement requires multi-level hospital accountability and vertical reporting structures with minimal rungs between the ED and the CEO, expanded system capacity, and coordinated system action beyond the ED.

OUTPUT DOMAIN (Primary Driver): Hospital Access Block and Downstream Capacity

System/Government-Level Recommendations

Recommendation 1: Governments must establish standards and local/regional/provincial/territorial/national accountability for ED access and hospital flow metrics and time-based targets for access to inpatient beds and ED LOS for admitted patients.

Rationale: ED boarding is a direct manifestation of output failure and is independently associated with increased morbidity and mortality. National standards shift accountability from ED operations to hospital and system capacity.

Actionable steps:

- Mandate reporting of ED flow performance metrics (time to physician initial assessment, ambulance offload time, time to inpatient bed, LOS for admitted, and LOS for discharged CTAS 1-3 and CTAS 4-5 cohorts) to CIHI NACRS across all jurisdictions.
- Implement CAEP benchmarks as national patient safety standards (Table 1).
- Publicly report 90th percentiles for all ED performance benchmarks.

Recommendation 2: Governments must model and define acute care, transitional care, long-term care, and home care capacity population needs.

Rationale: Canada's high inpatient occupancy rates and limited post-acute capacity directly drive access block and ED overcrowding. Failure to plan for and respond to population growth and aging has contributed to this crisis. Accountability frameworks will ensure new investments made where needed have the expected impact.

Actionable steps:

- Increase acute care bed supply to OECD-aligned benchmarks.

Hospital-Level Recommendations

Recommendation 3: Hospitals must actively reduce access block by optimizing inpatient flow and maintaining sustainable occupancy levels.

Rationale: Hospitals operating at or near full occupancy cannot absorb demand variability, resulting in prolonged ED boarding.

Actionable steps:

- Maintain inpatient occupancy targets of 70% to 85%.
- Implement daily discharge targets and mandate weekend services on inpatient units to enable consistent, seven-day-a-week patient discharges.
- Use real-time bed management and dedicated flow teams.

Recommendation 4: Hospitals must implement formal accountability frameworks that assign executive responsibility for access block and patient flow, ensuring 24/7 oversight across the hospital and in the ED.

Rationale: Access block is a hospital-wide patient safety failure, not an ED performance issue. Without executive accountability, overcrowding persists despite local optimization efforts.

Actionable steps:

- Embed access block and ED boarding as key hospital quality and safety indicators.
- Hospitals should report and review access block metrics regularly at the executive and board levels and be accountable for their performance with regional and provincial/territorial health authorities.
- Establish hospital-wide flow governance 24/7/365 and establish flow committee(s) with the authority to coordinate across all services.

- Develop clear surge plans (e.g., demand-driven overcapacity protocols) that specify triggers to initiate a response, authority to act, and stepwise actions to take to manage demand.

THROUGHOUT DOMAIN: Workforce, Operations, and Internal Flow

ED-Level Recommendations

Recommendation 5: EDs should implement continuous Lean Six Sigma or similar quality improvement methodologies to optimize patient flow in the ED and reduce waste.

Rationale: Structured quality improvement approaches enhance throughput and the reliability of care processes but cannot fully address system capacity.

Actionable steps:

- Establish 24/7 accountability for ED access and flow.
- Conduct regular flow mapping and bottleneck analyses, including matching of staffing to patient arrival patterns.
- Use real-time dashboards to monitor key throughput metrics.
- Implement rapid-cycle testing of flow interventions.

Recommendation 6: EDs must implement dedicated strategies to eliminate ambulance offload delays.

Rationale: Ambulance offload delays compromise prehospital care, worsen ED crowding, and delay emergency response in the community.

Actionable steps:

- Create dedicated ambulance offload zones with appropriate staffing.
- Implement rapid handover protocols.

- Escalate prolonged offload delays as hospital safety events and trigger ED and hospital-wide surge protocols.

Recommendation 7: EDs should implement evidence-based triage and early care initiation models to inform streaming of patients to flow zones.

Rationale: Early triaging of patients to appropriate zones improves ED flow, reduces LOS, and mitigates crowding-related delays.

Actionable steps:

- Implement ambulatory, fast-track, and rapid assessment zones, intermediate care areas where stretchers/care spaces can be shared by stable patients.
- Standardize, implement, and optimize evidence-based nurse-initiated medical directives for early diagnostic and treatment initiation where resources and support exist to implement and monitor such directives.

Recommendation 8: EDs should review and optimize care pathways for patients experiencing emergencies related to mental health and/or substance use issues. This includes time to psychiatric consultation, access to inpatient beds, substance use/withdrawal management resources, and where appropriate, the use of crisis workers and short-stay stabilization units.

Rationale: Patients with mental health issues experience disproportionately high levels of ED boarding due to limited inpatient and community care capacity. Marginalized groups including those experiencing unstable housing and those with chronic mental illness and/or substance use make frequent ED visits due to inadequate community supports. Without targeted resources and strategies, the ED care these patients receive is suboptimal and staff can become frustrated or experience moral distress.

Actionable steps:

- Assess and monitor time to psychiatric consultation and time to inpatient bed for patients with mental health and/or substance use presentations.
- Implement context-appropriate interventions, such as ED-adjacent short-stay units or the deployment of crisis workers, to expedite care and disposition.
- Set operational targets for maximum ED boarding times for patients with mental health presentations and include defined escalation processes when thresholds are exceeded.
- Implement evidence-based harm reduction strategies and order sets or protocols for patients with common substance-use related presentations.

Recommendation 9: EDs should integrate discharge planning into routine emergency care for patients with frailty and for those who require social supports for safe discharge rather than acute medical interventions.

Rationale: ED-based discharge planning reduces return visits and improves care transitions for vulnerable patients.

Actionable steps:

- Embed social workers and discharge planners in the ED.
- Implement standardized discharge pathways for patients requiring social services and support.
- Ensure rapid outpatient follow-up and connection to community resources occur.
- Adopt a structured approach for older patients with frailty and consider adding geriatric emergency management (GEM) nurses to ED clinical teams, as well as access to physiotherapy, occupational therapy, and other supportive services as appropriate.

INPUT DOMAIN: ED Demand, Access to Primary Care and Community Services, and Upstream Care

System/Government-Level Recommendations:

Recommendation 10: Governments must expand community-based mental health, substance use, and social services to reduce reliance on EDs as default points of access to care.

Rationale: EDs increasingly provide care for unmet social and mental health needs due to insufficient community capacity. This is also described as the wrong care in the wrong place at the wrong time. In most parts of Canada, social and health services are siloed between different provincial or territorial ministries and between federal (for Indigenous populations, military personnel, and refugees), provincial, territorial, and municipal levels of government.

Actionable steps:

- Increase the availability of and access to primary care teams.
- Expand 24/7 crisis response and mobile mental health teams.
- Increase supportive housing and medical respite capacity.
- Integrate health and social care planning at the provincial/territorial funding level.

Next Steps

We urge health ministries, regional health authorities, and hospital leaders to implement the recommendations outlined in this statement. This includes monitoring access block and patient flow metrics and activating timely interventions across hospitals and communities to address ED overcrowding. CAEP remains committed to partnering with all stakeholders to support the implementation, evaluation, and continuous refinement of these strategies to ensure safe, efficient, and equitable emergency care is available to everyone in Canada.

Conclusion

ED overcrowding is a system-wide patient safety and public health crisis. It reflects broader capacity and flow challenges, not failures of individual EDs, and requires coordinated, accountable action across hospitals, health authorities, and community services. Canada finds itself at a crossroads due to global geo-political shifts. Federal, provincial, and territorial governments have promised that they will meet this challenge through a new spirit of collaboration and a commitment to shared values. Healthcare generally—and emergency services, specifically, as a bellwether of health system status—is increasingly seen as an important industry and socioeconomic sector that is an essential driver of Canadian prosperity (66). We have the knowledge and resources we need to solve ED overcrowding and improve emergency care for everyone in Canada; we hope we now have the will.

Table 1. ED performance benchmarks from the 2013 CAEP position statement.

Benchmark	Description
Time to physician initial assessment	Median of 1 hour, 90th percentile of 3 hours
Time (to transfer) to in-patient bed	Median of 2 hours, 90th percentile of 8 hours
ED length of stay for patients discharged at CTAS levels IV or V	Median of 2 hours, 90th percentile of 4 hours
ED length of stay for patients discharged at CTAS levels I to III	Median of 4 hours, 90th percentile of 8 hours
ED length of stay for patients admitted to hospital (all CTAS levels)	Median of 8 hours, 90th percentile of 12 hours

CAEP = Canadian Association of Emergency Physicians; CTAS = Canadian Triage Acuity Scale; ED = emergency department.

Table 2. Summary of recommendations.

Recommendation	Domain	Level for Action
Recommendation 1: Governments must establish standards and local, regional, provincial, territorial, and national accountability for ED access and hospital flow metrics and time-based targets for access to inpatient beds and ED length of stay for admitted patients.	Output	System/government
Recommendation 2: Governments must model and define acute care, transitional care, long-term care, and home care capacity population needs.	Output	System/government
Recommendation 3: Hospitals must actively reduce access block by optimizing inpatient flow and maintaining sustainable occupancy levels.	Output	Hospital
Recommendation 4: Hospitals must implement formal accountability frameworks that assign executive responsibility for access block and patient flow, ensuring 24/7 oversight across the hospital and in the ED.	Output	Hospital
Recommendation 5: EDs should implement continuous Lean Six Sigma or similar quality improvement methodologies to optimize patient flow and reduce waste.	Throughput	ED
Recommendation 6: EDs must implement dedicated strategies to eliminate ambulance offload delays.	Throughput	ED
Recommendation 7: EDs should implement evidence-based triage and early care initiation models to inform streaming of patients to flow zones.	Throughput	ED
Recommendation 8: EDs should review and optimize care pathways for patients experiencing mental health and/or substance use–related emergencies.	Throughput	ED
Recommendation 9: EDs should integrate discharge planning into routine emergency care for patients with frailty and for those who require social supports for safe discharge rather than acute medical interventions.	Throughput	ED
Recommendation 10: Governments must expand community-based mental health, substance use, and social services to reduce reliance on EDs as default points of access to care.	Input	System/government

ED = emergency department.

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