Care for All

A POPULATION HEALTH ASSESSMENT FOR RESIDENTS IN GEORGINA

GEORGINA

SouthlakeHealth

Northern York South Simcoe
ONTARIO HEALTH TEAM

ACKNOWLEDGEMENTS

Land Acknowledgement

The partners to the Georgina Health and Wellness Memorandum of Understanding (MOU), including Southlake Health, the Town of Georgina, and the Northern York South Simcoe Ontario Health Team, recognize and acknowledge that this work takes place on lands traditionally used and occupied by the First Peoples of the Williams Treaties First Nations and other Indigenous Peoples. On behalf of the MOU Governance Committee and Co-Chairs, we express our gratitude for the opportunity to live, work, and collaborate on this land.

We also acknowledge the Chippewas of Georgina Island First Nation as a close neighbour and valued partner, with whom we strive to build and sustain a cooperative and respectful relationship. We recognize the Nation's unique and enduring relationship with the lands and waters of this territory, and their important role as water protectors and environmental stewards. We are committed to advancing this work in a spirit of respect, partnership, and shared responsibility.

Additional Acknowledgements

Over the past two years, many individuals and organizations contributed their time, expertise, leadership, and community knowledge to support the development of this Population Health and Wellness Assessment for residents of the Town of Georgina. We gratefully acknowledge all contributions, large and small, that helped inform this report.

Project Sponsors

- Town of Georgina
- Southlake Health
- Northern York South Simcoe Ontario Health Team (NYSS OHT)

Governance Committee and Co-Chairs

- Mayor Margaret Quirk – Town of Georgina
- Paul Woods, MD – President and CEO, Southlake Health
- Christina Bisanz – Co-Chair, NYSS OHT

Project Steering Committee

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- Local service providers and community organizations
- Local primary care providers
- Chippewas of Georgina Island First Nation
- NYSS OHT Network and Advisory Tables: Mental Health and Addictions Network Table; Long-Term Care Network Table; Community Support Sector and Home Care Network Table; Patient, Client and Caregiver Partner Council; Primary Care Provider Network; and Primary Care Council Operational Leadership Table

This assessment reflects a shared commitment to collaboration and to building a healthier, more connected, and more equitable future for residents of the Town of Georgina. We sincerely thank everyone who contributed to this work.

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A Message from the Co-Chairs

On behalf of the governance committee for the triparty Memorandum of Understanding between the Town of Georgina, Southlake Health, and the Northern York South Simcoe Ontario Health Team, we are pleased to present *Care for All: A Population Health Assessment For Residents in Georgina.* This report reflects a shared commitment to improving the health and wellness of Georgina residents through collaboration, evidence-informed planning, and coordinated action.

Mayor Margaret Quirk, Town of Georgina

Paul Woods, MD, President & CEO, Southlake Health

Christina Bisanz, Co-Chair, Nothern York South Simcoe Ontario Health Team

Over the past year, this partnership has translated that commitment into meaningful action. Together, we have helped expand access to care, delivering more than 6,600 primary care visits through Ontario Health Team clinics and establishing the Keswick Interprofessional Care Team Clinic, which has connected over 1,000 residents to ongoing care and provided more than 4,300 visits, including after-hours access.

We have also advanced prevention and community wellness, reaching hundreds of residents through health promotion events and deepening engagement with Indigenous communities, including members of the Chippewas of Georgina Island First Nation. In addition, expanding access to cardiac rehabilitation services locally has enabled residents to receive care closer to home, supporting recovery and long-term health.

As Georgina continues to grow, so too do the health and wellness needs of its residents. This report provides an assessment of the current landscape, drawing on population trends, service utilization data, and community input to identify both pressures and opportunities.

The findings confirm that Georgina benefits from strong local assets, including dedicated healthcare professionals, community organizations, and engaged municipal leadership. At the same time, population growth, an aging demographic, transportation barriers, and increasing demand for care require thoughtful planning and continued partnership.

This report serves as a roadmap for future decision-making, identifying opportunities to improve access to services closer to home, strengthen prevention and wellness supports, address inequities, and better coordinate care across organizations. It also helps inform future capacity planning, including the advancement of an Advanced Care Centre in Georgina.

The progress already made through this partnership demonstrates what is possible when organizations align around a common purpose. By sharing data, listening to residents, and working together, we are building a stronger foundation for integrated and responsive care.

We thank all residents, healthcare providers, community organizations, municipal staff, and Indigenous partners who contributed their time and expertise to this work.

Together, we have an opportunity to advance a healthier, more connected, and more resilient future for Georgina. We look forward to continuing this work in partnership.

Mayor Margaret Quirk
Town of Georgina

Paul Woods, MD
President & CEO,
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Christina Bisanz
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EXECUTIVE SUMMARY

Overview

Planning for Georgina's future requires a clear understanding of the health and wellness needs of residents, how those needs are changing, and where future pressures are emerging across the local system.

This report presents a population health and wellness assessment for the Town of Georgina, developed in collaboration with the Town of Georgina, Southlake Health, and the Northern York South Simcoe Ontario Health Team. It combines population trends, health service utilization patterns, service inventory information, and community input to provide a shared evidence base for planning, coordination, and decision-making.

The purpose of this report is to:

- Understand the current and projected health and wellness needs of Georgina residents
- Examine how residents access and use health and community services
- Identify system pressures, service gaps, and opportunities for improvement
- Inform future planning, partnerships, and coordinated action across organizations

The recommendations in this report are intended to guide coordinated future planning and collaboration, while decisions regarding implementation, sequencing, and resourcing will be determined by participating organizations and partners based on their respective mandates, priorities, and available capacity.

Community Context

Georgina is a geographically large municipality located on the southern shores of Lake Simcoe, with a mix of urban, rural, shoreline, and dispersed communities. The 2025 population is estimated at approximately 52,000[1] residents and is projected to reach approximately 70,500 by 2051[2], representing growth of approximately 36%. The current population today is estimated at 54,000 based on York Region data.

Growth has been concentrated primarily in Keswick, while eastern Georgina, including Sutton, Jackson's Point, Pefferlaw, and rural hamlets remain more dispersed1. This geography influences how residents access care, travel to appointments, and experience service availability.

Georgina's population is also aging. Approximately 16% of residents are aged 65 and older[3], and demand for chronic disease management, home care, long-term care, and community supports is expected to increase over time.

The broader Georgina community includes the Chippewas of Georgina Island First Nation, who lead and deliver culturally grounded health and wellness services that reflect the needs, values, and traditions of the community, while also accessing services across the broader region[4].

Key Findings

Strong Primary Care Foundation with Opportunities to Improve Access

Georgina benefits from a strong local primary care foundation that includes family physicians, nurse practitioners, walk-in clinics, and interprofessional team-based care models. Nurse practitioners play a significant role locally through both independent and team-based practice settings, contributing to access, continuity, and chronic disease management.

Based on recent 2025 Ontario Health data[5], approximately 47,700 residents are attached to a regular primary care provider, while approximately 4,107 residents (7.6%) remain unattached.

Overall capacity is a community strength; however, access remains uneven. Most providers are concentrated in Keswick, with fewer local options in Sutton, Jackson's Point, Pefferlaw and rural areas. Continued population growth, provider retirements, and workforce recruitment pressures may further affect timely access if not addressed.

Growing Demand from an Aging Population

Georgina's demographic profile is expected to increase demand across the health and wellness system over time. Available data indicates that ongoing care demand is significantly influenced by chronic conditions such as mental health conditions, hypertension, diabetes, and osteoarthritis[6], creating sustained need for both medical care and community-based supports.

As the population ages, demand is also expected to rise for home care, caregiver supports, mobility supports, seniors' programming, and long-term care alternatives that help residents remain safely at home.

Significant Reliance on Hospital-Based Care

Many Georgina residents continue to rely on hospital-based services, particularly Southlake Health, for emergency, inpatient, outpatient, specialist, and procedural care.

Annual 2024/25 utilization included approximately 21,609 emergency department visits[7] and 4,907 inpatient discharges[8] by Georgina residents, with approximately 76% of emergency department visits and 72% of inpatient discharges occurring at Southlake Health. Georgina residents also recorded approximately 25,440 outpatient clinic visits[9] and 4,230 day surgeries[10] at Southlake Health.

A limited but important range of locally available Southlake-affiliated clinic services is also delivered within Georgina, including approximately 2,055 X-ray visits, 1,295 ultrasound visits, and 338 ACT mental health clinic visits in 2024/25[9].

These patterns reflect the important role of Southlake Health and other regional hospital partners, while also highlighting opportunities to expand community-based care, improve navigation, and strengthen access to more services closer to home where appropriate.

Mental Health Needs and Continuity of Care Gaps

Mental health needs are a significant driver of demand across the local system. Utilization patterns indicate demand related to anxiety, depression, stress-related conditions, serious mental illness, and cognitive or age-related behavioural health presentations[8], reflecting the need for a broad range of community and clinical supports.

Residents access mental health services through a mix of hospital, community, primary care, and regional providers. However, pathways can be complex to navigate, and transitions between services may not always be seamless. Strengthening coordinated intake, clearer local first points of contact, and continued development of post-crisis and post-discharge pathways would help optimize warm handoffs and support continuity of care in the community.

Geographic and Equity Considerations

Service availability is not experienced equally across the municipality. Many health and community services are concentrated in Keswick, while residents in Sutton, Jackson's Point, Pefferlaw, rural communities and those living on Georgina Island often travel farther to access care.

Transportation barriers, wait times, income-related challenges, digital access limitations, and the need for culturally appropriate care can all influence how residents access services. These factors may be more pronounced in rural areas and for residents of Georgina Island, where travel, coordination of care, and service availability can create additional challenges. Continued partnership with Indigenous communities and targeted responses for underserved neighbourhoods will be important to improve equitable access across the municipality.

Long-Term Care, Home Care, and Aging-in-Place Pressures

Demand for seniors' services and supports is increasing. Georgina currently has 179 long-term care beds, with approximately 445 people on waitlists linked to those homes[11]. Additional long-term care capacity is planned in Keswick, which is expected to help meet future demand.

At the same time, home care demand is rising across Georgina. Utilization is higher in eastern Georgina for the neighbourhoods of Sutton, Jackson's Point and Rural areas (2,509 clients per 100,000 residents; 569 clients) compared to Keswick (2,042 per 100,000; 656 clients), with longer wait times reported for some community-referred services[12]. This suggests increasing complexity among residents who wish to remain at home and growing pressure on community supports.

These trends reinforce the importance of aging-in-place strategies, including home care, caregiver supports, supportive housing models, and coordinated community services.

Community Strengths

Despite these pressures, Georgina benefits from several important strengths that provide a strong foundation for future action:

- Strong collaboration among municipal, health system, and community partners
- A broad mix of local health, wellness, and community providers
- Significant contributions from Nurse Practitioners and interprofessional primary care teams
- Established community hubs such as The Link and the Georgina Health Centre
- Active community organizations and resident engagement
- Momentum generated through the Georgina health partnership and Memorandum of Understanding

Progress Already Underway

In alignment with the 2024 Memorandum of Understanding between the Town of Georgina, Southlake Health, and the Northern York South Simcoe Ontario Health Team, partners have already advanced several initiatives to improve access to care closer to home, strengthen integrated service delivery, and support future system capacity.

Examples of early progress in 2025 include:

- 9,085 primary care visits delivered through NYSS OHT clinics
- 1,260 residents attached to care and 5,747 visits delivered through the Keswick Interprofessional Care Team Clinic, providing coordinated team-based services such as nursing, pharmacy, social work, and chronic disease management supports
- 3,338 visits delivered through the Children's Care Clinic
- Launch of a Mobile Health Bus supporting outreach in shelters, group homes, and priority community settings
- 451 residents engaged through community health fairs and education sessions
- 12 Health & Wellness Education Sessions reaching approximately 200 residents
- 32 cancer screening outreach and education events engaging 780 participants, with approximately 10% booking screening appointments
- Launch of a local cardiac prevention and rehabilitation program at the Multi-Use Recreation Complex (MURC), with 37 participants enrolled including active participants and graduates
- 14 primary care providers enabled with Online Appointment Booking, supporting 24,142 digitally booked appointments
- Development of The Sanctuary, a new peer-led mental health and addictions drop-in initiative launching May 1, 2026. The program will offer low-barrier access to peer support, group programming, recovery education, and system navigation services at community locations including Sutton Arena Hall and Georgina Ice Palace

These early achievements demonstrate meaningful progress in expanding access, strengthening partnerships, and establishing a strong foundation for future action in Georgina.

Strategic Priorities and Recommendations

Based on the population trends, utilization patterns, service gaps, and community feedback identified through this assessment, four strategic priorities have been identified to help guide future planning and

collaboration. Together, these priorities aim to improve access, strengthen prevention, reduce inequities, and support a more coordinated local system of care.

1. Increase Access to Services for Today and Tomorrow

This priority responds to ongoing challenges with timely access to primary care and selected local services. Key areas of action include attachment strategies, workforce planning, navigation supports, and the planned expansion of local service capacity over time. Intended outcomes include improved access, reduction in avoidable hospital use, and stronger continuity of care.

2. Target Health Promotion and Education Based on Resident Needs

This priority reflects opportunities to strengthen targeted prevention efforts, reduce chronic disease risk, and improve awareness of available programs and services. Key areas of action include targeted community education, wellness initiatives, and prevention programs aligned to identified resident needs. Intended outcomes include healthier residents, earlier intervention, and lower long-term demand on acute care services.

3. Take Steps to Improve Health Equity

This priority recognizes geographic and population-based differences in how residents access care. Key areas of action include targeted responses for underserved neighbourhoods, rural communities, and continued partnership with the Chippewas of Georgina Island First Nation. Intended outcomes include more equitable access, improved service experience, and stronger outcomes across communities.

4. Optimize Mental Health Services

This priority responds to growing demand for mental health and addictions supports across Georgina. Key areas of action include improving access to counselling and psychotherapy, strengthening coordinated intake and navigation, enhancing crisis response and post-crisis follow-up, expanding youth and seniors' mental health supports, and improving continuity between hospital, primary care, and community providers. Intended outcomes include earlier intervention, improved continuity of care, reduced emergency department reliance, and better mental health outcomes for residents.

These priorities are supported by a phased roadmap in *Section 6*, which outlines how actions may advance over time based on partner priorities, resources, and opportunities.

Moving Forward

This report provides a shared understanding of Georgina's evolving health and wellness landscape and identifies practical opportunities for continued collaboration.

Some actions can build on work already underway, while others will require further planning, investment, and partnership. By aligning around shared priorities and building on existing strengths, including strong physician, nurse practitioner, and team-based care capacity, partners are well positioned to collectively advance a more connected, equitable, and responsive health and wellness system for Georgina residents now and in the future.

Introduction

1.0 INTRODUCTION

1.1 Background

Understanding the health and wellness profile of residents is an important part of planning for the Town of Georgina's future. As the community continues to grow and evolve, there is an increasing need to understand the health challenges residents face, how they access care, and how local services can better align to meet changing community needs.

Health care services for Georgina residents are delivered through a combination of community providers, primary care clinics, regional hospital services, and community-based supports. Many residents access care within the municipality, while others rely on services provided in neighbouring communities.

This report was developed through a collaborative partnership between the Town of Georgina, Southlake Health, and the Northern York South Simcoe Ontario Health Team (NYSS OHT), through a Memorandum of Understanding established in 2024. Through this partnership, organizations have advanced coordinated planning, shared data, community engagement, and early service initiatives to strengthen access to care and improve outcomes for Georgina residents.

This population health report supports a data-informed, evidence-based, and place-based approach to health planning that reflects Georgina's unique geography, population characteristics, and service landscape.

The assessment also recognizes the Chippewas of Georgina Island First Nation, an Anishinaabe community located on Georgina Island in Lake Simcoe, as an integral part of the broader community. Community-specific data and insights were shared with permission and in alignment with OCAP® principles (Ownership, Control, Access, and Possession) and are reflected in relevant sections of this report.

1.2 Purpose of this Report

This report presents a current state assessment of residents' health and wellness in the Town of Georgina. The goal is to provide a shared evidence base of the community's health needs, service utilization patterns, and opportunities for improvement, to support informed decision-making and collaboration among partners.

Specifically, the report aims to:

- Understand current and projected population health needs and the factors that influence health and wellness in Georgina
- Assess healthcare service utilization and access patterns, including how residents access, navigate, and experience available services, and how well those services are positioned to meet community needs
- Identify gaps, pressures, and opportunities within the local health and wellness system
- Provide evidence-based recommendations and an implementation roadmap to support coordinated planning, partnerships, and service improvements

The findings are intended to support coordinated, cross-sector decision-making among municipal leaders,

health system partners, community organizations, and Indigenous partners. While some health system challenges are influenced by broader provincial and regional factors beyond local control, this report focuses on identifying local priorities and areas of action where partners can work together to improve access, coordination, and service delivery for Georgina residents.

1.3 Assessment Approach

This assessment was developed using a mixed-methods approach that combines quantitative data analysis with qualitative insights from community engagement, service provider input, and partner collaboration.

The work was conducted in three phases.

Phase 1: Community and Partner Engagement, *Summer 2024 – Spring 2025*

Engagement with residents, service providers, community organizations, Indigenous partners, and health system stakeholders helped identify lived experience priorities, access barriers, service gaps, and local strengths. Surveys, consultations, meetings, and engagement sessions were used to inform early priorities and shape the focus of subsequent data analysis.

Early collaborative initiatives and service improvements undertaken through the partnership also provided practical insight into local opportunities and implementation needs.

Phase 2: Data Collection and Environmental Scan, *Spring 2025 – Winter 2026*

Population-level data was assessed to establish a baseline understanding of Georgina's population, health status, service utilization patterns, and changing demand pressures.

Data sources included provincial, regional, municipal, provider, and community-supplied information, including Indigenous community-specific data where available.

Data categories included:

- Census and demographic data
- Population health indicators
- Health system utilization and administrative data
- Service inventory and access information

These sources were used to validate themes identified through engagement and identify current and emerging system pressures.

Phase 3: Synthesis and Recommendations, *Winter 2026 – Spring 2026*

Findings from engagement and data analysis were brought together to identify key gaps, opportunities, and strategic priorities within the local health and wellness system. These insights informed the recommendations, implementation roadmap, and proposed measures presented later in the report.

Indigenous Engagement

This assessment recognizes the Chippewas of Georgina Island First Nation, an Anishinaabe community located on Georgina Island in Lake Simcoe. The community contributed community-specific data and perspectives to inform this assessment.

Engagement with Indigenous partners was approached with respect for Indigenous governance, autonomy, and data stewardship. Consistent with OCAP®, this report does not seek to define Indigenous health needs on behalf of the community. Rather, it reflects data and insights shared for the purposes of this assessment and is intended to support collective community-informed understanding.

Indigenous-specific findings are presented in relevant sections of the report and should be interpreted alongside community knowledge and leadership.

Together, these components provide a comprehensive population health profile based on the local health and wellness system, ensuring that both data-driven evidence and community perspectives inform the assessment.

1.4 How to Read this Report

This report is organized to move from community context and population trends to service access, system pressures, recommendations, and implementation considerations.

The report begins with an overview of Georgina's geography and population, including where residents live and how the community is changing over time. For analytical purposes, some sections use postal code geography, including forward sortation areas (FSA) L4P (west Georgina, primarily Keswick) and L0E (east Georgina, including Sutton, Jackson's Point, Pefferlaw, and surrounding rural communities). In selected analyses, Aggregate Dissemination Areas (ADAs) are also used to provide neighbourhood-level insight. See *Appendix A* for further details on geographic definitions and mapping.

Subsequent sections examine current health and wellness services, access patterns, and utilization trends. Based on these findings, the report identifies key gaps and opportunities, then outlines recommendations and a phased roadmap for coordinated action.

Disclaimer:
While the report provides a comprehensive overview of current conditions, it is not intended to be a statistically representative survey. Rather, it serves as a shared evidence base to support dialogue, alignment, and collective action among municipal leaders, health system partners, Indigenous partners, and community organizations.

How this report is structured

Town of Georgina Geography

Where is it and what are the different neighbourhoods? Overview of the municipality's geography, key communities, and neighbourhood distribution.

Population Profile

Who lives in Georgina? What do we know about them? Demographic trends including population growth, age structure, and social factors influencing health.

Access and Use of Health Services

What is available and how are services being used? Analysis of local health and community services, and how residents access care.

Gaps and Opportunities

What needs are not being met? How could they be addressed? Insights from data and community engagement identifying service gaps and system pressures.

Recommendations

What are the priorities and recommended actions? Strategic actions to strengthen health and wellness supports in Georgina.

Roadmap and Next Steps

Guidance for coordinated planning, partnerships, and future work.

Population Profile

2.0 POPULATION PROFILE

2.1 Overview

The Town of Georgina is a geographically large municipality located on the southern shores of Lake Simcoe. Covering approximately 288 square kilometres, the community includes a mix of urban centres, settlement areas, rural hamlets, and shoreline communities. The largest population centre is Keswick, followed by Sutton, Jackson's Point and Pefferlaw[13]. Neighbourhood groupings used in this section align with the geographic approach described in Section 1.4 with further details and explanation in *Appendix A* which are applied consistently throughout the report.

Georgina is also home to the Chippewas of Georgina Island First Nation, an Anishinaabeg community located on the remote Georgina Island in Lake Simcoe. The Nation maintains sovereignty over its governance and health planning, while also interacting with the broader regional health and social services system.

Figure 2-1. Map of the Town of Georgina and Key Neighbourhoods

Neighbourhoods	
URBAN CENTRES & SETTLEMENT AREAS	A. Keswick B. Sutton-Jackson Point C. Pefferlaw
HAMLETS	D. Baldwin E. Brownhill F. Belhaven G. Ravenshoe H. Virginia I. Udora
INDIGENOUS	J. Chippewas of Georgina Island First Nation

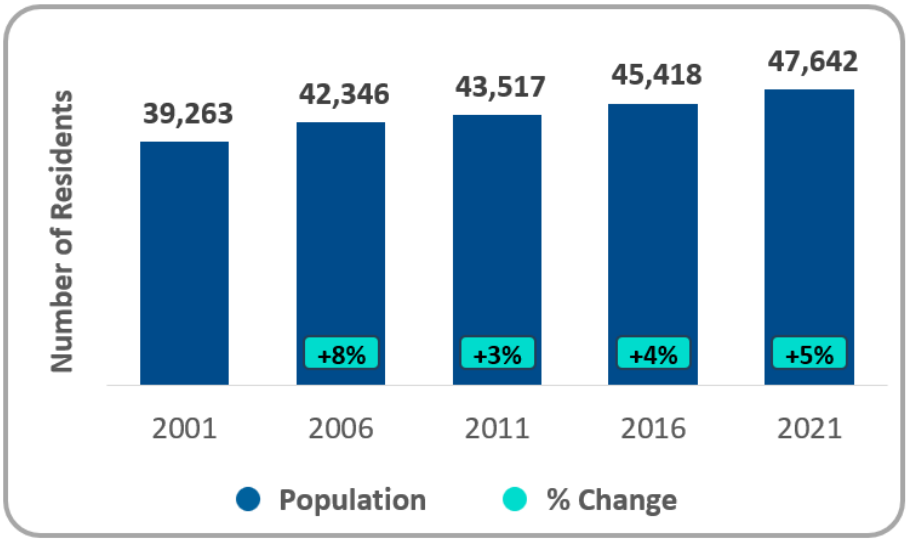
Map of the Town of Georgina showing major settlement areas, rural hamlets, and neighbourhood groupings.

Source: Town of Georgina, *Official Plan Consolidated Plan (2020).*

Georgina's large geographic footprint and dispersed settlement pattern shape how residents access health and wellness services. While many services are in the Keswick area, residents living in northern and rural communities often travel longer distances to reach health care providers and community supports.

Georgina's population is estimated at approximately 54,000 residents today based on York Region data. Population growth has been steady over the past two decades and is expected to continue[3]. Municipal projections indicate the population could reach approximately 70,500 residents by 2051[2].

Figure 2-2. Population Growth and Projection, Town of Georgina (2001–2051)



Historical population growth and projected population estimates for the Town of Georgina, indicate continued growth and increasing service demand.

Source: Statistics Canada, *Census of Population* (2001–2021).

Population growth in Georgina has been steady, and growth is projected to continue, with important implications for future service demand. Approximately 56% of residents live in Keswick (North, Central, and South), making it the municipality's primary population centre, while the remaining 44% live in Sutton, Jackson's Point, Pefferlaw, Georgina Island, Historic Waterfront, and surrounding rural communities[1]. These geographic patterns shape service planning and access to care across the community.

Understanding these population characteristics provides essential context for interpreting health trends and planning future services.

Key Insights:

- **Geography drives access.** Georgina's size and dispersed settlement pattern result in longer travel distances, particularly for residents in northern, rural and remote areas.
- **Population growth will increase demand.** The population is projected to grow from approximately 54,000 today to over 70,500 by 2051[2], increasing pressure on health and community services.
- **Growth is concentrated in Keswick.** Most residents live in the southern portion of the municipality, reinforcing Keswick as the primary service hub.
- **Rural communities require tailored approaches.** Smaller and more dispersed communities require targeted service planning and delivery models.
- **Indigenous communities are a significant population within the Town of Georgina.** The presence of the Chippewas of Georgina Island First Nation highlights the importance of coordinated and culturally appropriate care.

2.2 Demographics

Georgina's population reflects a mix of established residents, families, and an increasing number of older adults. The median age in the municipality is approximately 42.8 years, slightly higher than the provincial average[3]. The average age of residents is 41.9 years[3] reflecting a population structure that includes both working-age families and a growing proportion of older adults.

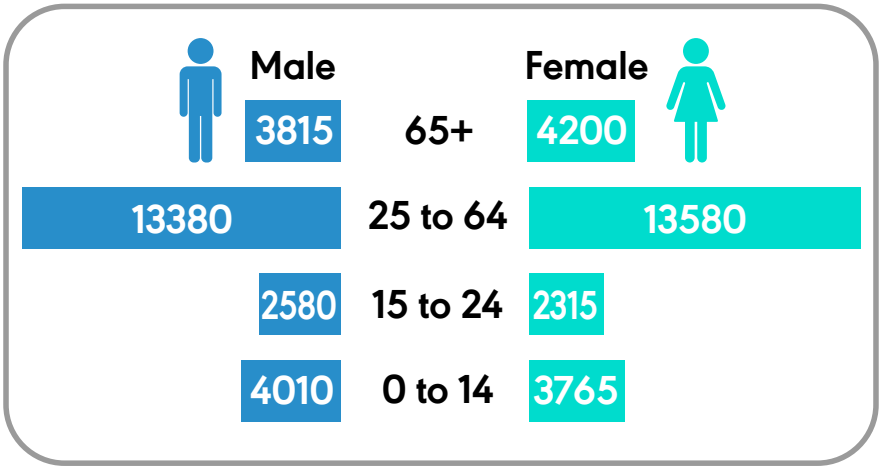
The population is relatively balanced by gender, with approximately 51% of residents identifying as female and 49% as male[3].

Population growth in the community has been influenced by regional housing development, migration from neighbouring municipalities, and Georgina's appeal as a lakeside community within commuting distance of the Greater Toronto Area[14].

One of the most notable demographic trends is the increasing proportion of residents aged 55 and older. This reflects broader patterns across Ontario and has particular relevance for Georgina given its existing age structure and settlement pattern.

The population pyramid further illustrates Georgina's age structure, showing the distribution of residents across age groups and sex.

Figure 2-3. Population Pyramid by Age Group and Sex, Town of Georgina (2021)



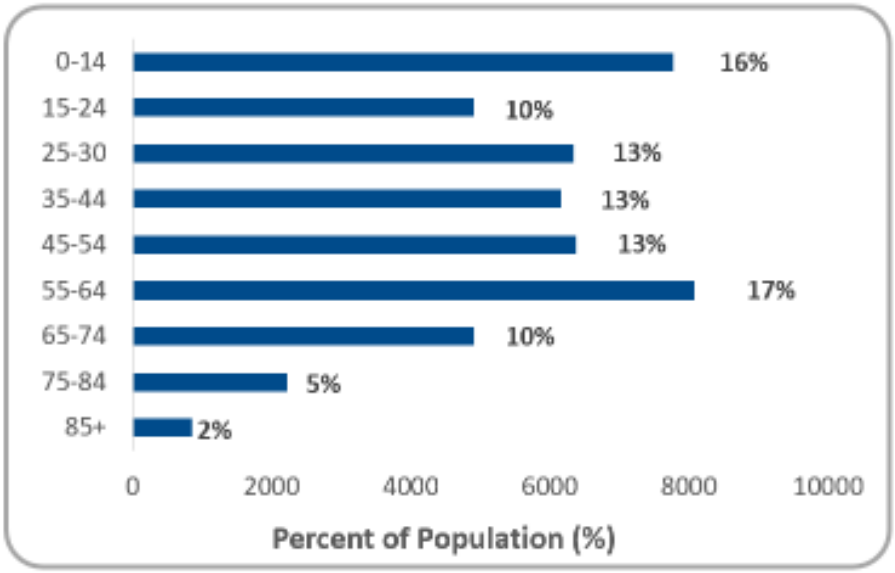
Population pyramid showing the distribution of residents by age group and sex, Town of Georgina (2021).

Source: Statistics Canada, *Census of Population (2021).*

This age structure suggests growing demand for health and wellness services related to chronic disease management, home care, and long-term care. At the same time, the age distribution reflects a continued presence of working-age families and children, supporting a balanced population profile.

Age distribution across major groups is shown below.

Figure 2-4. Population Distribution by Age Group, Town of Georgina (2021)



Proportion of the population across major age groups, highlighting Georgina's relatively older age structure.

Source: Statistics Canada, *Census of Population* (2021).

Household structure in Georgina is typical of many mid-sized Ontario communities. The average household size is 2.6 people, and the median household income is $98,000[3]. Two-person households represent the majority (65%)[3], consistent with an aging population and smaller household sizes.

Table 2-1. Key Demographic Indicators, Town of Georgina (2021)

Indicator	Value
Median age	42.8 years
Average age	41.9 years
Median household income	$98,000
Average household size	2.6 people
Visible minority population	12.6% (5,955 residents)

Summary of key demographic indicators for Georgina.

Source: Statistics Canada, *Census of Population* (2021).

The community is also becoming gradually more diverse. Approximately 12.6% of residents identify as part of a visible minority population[3], which is lower than the average across York Region[15]. Immigration

[15] York Region Public Health. (2025). Understanding the Health of People in York Region: Key Trends Report

continues to contribute to population change, although the proportion of recent immigrants is relatively small at approximately 4% of the population[3].

Neighbourhood Distribution

Population distribution across Georgina is uneven, with more than half of the residents[1] concentrated in the southern portion of the municipality. Based on neighbourhood-level estimates, Keswick (North, South, and Central) accounts for a large share of the municipality's population[1]. Smaller population centres include Sutton, Jackson's Point and Pefferlaw, alongside several rural and shoreline communities with more dispersed populations[1]. The Chippewas of Georgina Island First Nation, located on Georgina Island in Lake Simcoe, is also a significant part of the broader community[4].

This distribution reflects Georgina's development pattern, where residential growth has been concentrated in Keswick while other communities maintain smaller populations across a larger geographic area. As a result, many health and community services are located in the southwest corner of the municipality. Residents in northern or rural areas may travel longer distances to access services, particularly specialized healthcare.

Table 2-2. Population Distribution by Neighbourhood, Town of Georgina (2025 Estimate)

Neighbourhood	Population Estimate (2025)
Keswick North	10,131
Keswick South	9.415
Sutton and Jackson's Point	8,190
Keswick Central	7,514
Pefferlaw and Rural Hamlets	6,490
Historic Waterfront	6,439
Georgina Island	283

Note: This is based on Aggregate Dissemination Area according to Statistics Canada, please see Appendix A for further details.

Estimated population by neighbourhood based on aggregated dissemination areas.

Source: Ontario Health, *eReport Portal OHT – Population Overview;* Statistics Canada, *Aggregate Dissemination Area (ADA) Reference Maps (2016);* Chippewas of Georgina Island First Nation (2026), *Community Population Data* (March 2026).

Together, these patterns highlight the municipality's geographic diversity and the importance of considering travel distances and service distribution in planning health and wellness supports.

Indigenous Population

The Town of Georgina includes the Chippewas of Georgina Island First Nation, an Anishinaabeg community located on Georgina Island in Lake Simcoe. The Nation maintains its own governance structures and approaches to health planning and service delivery, while also accessing a range of public health and healthcare services across the broader region.

Based on community-provided data[4], the total registered population is approximately 963 members, with 212 registered members living on-reserve and 744 living off-reserve. The on-reserve population also includes unregistered children, spouses, and other residents, contributing to an estimated on-reserve population of approximately 283 individuals. During the spring and summer months, the population increases significantly, with more than 1,100 individuals present on the island, reflecting seasonal residents and visitors.

The age distribution within the community reflects a strong working-age population alongside a growing number of older adults. This pattern is consistent with broader demographic trends observed across the municipality, while also reflecting community-specific dynamics.

Household composition on-reserve is characterized by a mix of one- and two-person households, along with a smaller number of larger households. The community experiences a modest level of overcrowding, with some households consisting of multi-generational arrangements.

Population estimates for the Chippewas of Georgina Island First Nation vary depending on data source and definition. Where available, community-provided data has been prioritized in this report to reflect local context and understanding.

Key Insights:

- **Georgina's population is aging.** The median age of residents is 42.8 years, and the proportion of adults aged 55 and older continues to increase[4]. This demographic trend is expected to contribute to growing demand for chronic disease management, home care, and long-term care services.
- **Population growth and settlement patterns shape access to services.** Most residents live in Keswick, while Sutton/Jackson's Point is the second largest population centre followed by Pefferlaw. Outside these communities, much of Georgina is rural or more dispersed, which influences travel distances and access to health care and community services.
- **Household composition reflects an aging community.** Two-person households represent the majority of households, consistent with a growing number of older adults and smaller household sizes.
- **The community is becoming more diverse.** Approximately 12.6% of residents identify as part of a visible minority population, up from 8.0% in the 2016 census, indicating continued demographic change. Immigration and broader population growth are contributing to a more diverse community over time, although at a smaller scale than in many neighbouring municipalities[3].

- **Indigenous residents live across York Region, with the Chippewas of Georgina Island First Nation as the only First Nation community located on an island within the region.** Indigenous populations across York Region are diverse and interconnected, highlighting the importance of culturally responsive, coordinated health and service delivery systems that support access, equity, and community-driven care.

2.3 Social Determinants of Health

Health is shaped by a range of social, economic, and environmental conditions. These social determinants influence both health outcomes and residents' ability to access services. Factors such as income, employment, housing, food security, transportation, and community supports affect the conditions in which people live, work, and age, and can contribute to differences in health outcomes across communities.

Several social determinants of health are particularly relevant within the Georgina context.

Income, Employment and Economic Stability

Economic stability plays an important role in supporting health and well-being. Income levels influence access to housing, nutritious food, transportation, and healthcare services.

In Georgina, the median household income is approximately $98,000[3], reflecting a generally stable economic base. However, some residents experience financial pressures related to rising housing costs and the broader cost of living.

Employment patterns in the community are closely connected to the broader regional economy. Approximately 65.7% of residents aged 15 and older participate in the labour force, with an employment rate of about 58.4%[3]. Major employment sectors include construction, retail trade, health care and social assistance, and manufacturing[3].

Education is closely linked to employment opportunities and long-term health outcomes. In Georgina, 42.8% of adults aged 25 to 64 years do not have a post-secondary credential[3]. This may influence access to higher-skilled employment opportunities and contribute to differences in income and economic stability across the community.

A notable feature of the local economy is commuting, with many residents travelling outside the municipality for work, reflecting Georgina's integration within the Greater Toronto Area. Approximately 93.8% of commuters travel by private vehicle, with an average commute time of 33 minutes[3]. These patterns highlight reliance on external employment centres and have implications for time use, transportation needs, and access to services (see *Mobility, Transportation and Access to Services* section below).

While median household income is relatively high, approximately 7.9% of residents live in low-income households (Low Income Measure – After Tax, LIM-AT)[3], highlighting persistent income disparities within the community. These disparities may limit access to essential resources, including housing, food, transportation, and health services.

Financial pressures may be further amplified in smaller or more remote communities, including the Chippewas of Georgina Island First Nation. Income, employment, and economic stability are critical social determinants of health, with financial pressures often creating barriers to sustaining consistent employment. The Chippewas of Georgina Island First Nation has developed local economic and employment opportunities that support both community members and the broader population. However, due to its island location, the community faces ongoing weather-related barriers that can affect access to employment and workforce participation. Despite these challenges, the community continues to strengthen pathways that support income stability, local employment, and long-term economic resilience, including access to education, training, and skills development.

Table 2-3. Employment and Commuting Patterns, Town of Georgina (2021)

Labour Indicators	Estimate (2021)
Labour force participation rate	65.7% (25,850 residents in labour force)
Employment rate	58.4% (22,970 employed residents)
Commuters using a private vehicle	93.8% (16,735 residents)
Estimated average commute time	33 minutes

Key labour force participation, employment, and commuting indicators for the Town of Georgina.

Source: Statistics Canada, *Census of Population* (2021).

Housing and Physical Environment

Housing conditions and the built environment play an important role in health. Safe, stable, and affordable housing supports both physical and mental well-being.

While many households in Georgina experience housing stability, affordability pressures remain a concern. Approximately 24% of households spend more than 30% of their income on housing[3], a commonly used indicator of housing affordability stress. Access to subsidized and supportive housing is limited. Only about 2% of housing units are designated as subsidized rental housing[14]. This may create challenges for lower-income households, seniors, and individuals requiring accessible housing.

Georgina's natural environment is an important community asset. The municipality benefits from waterfront access, green spaces, and low-density neighbourhoods that support outdoor recreation. However, dispersed settlement patterns can also limit walkability and access to services in some areas. These dynamics may be further shaped in island and remote settings, where geography and transportation influence how housing and services are experienced.

Table 2-4. Housing Affordability Indicators, Town of Georgina (2021)

Housing Indicators	Estimate (2021)
Households spending >30% income on housing	23.5% (4,185 households)
Subsidized housing units	2%

Key indicators related to housing affordability and availability of subsidized housing in Georgina.

Source: Statistics Canada, *Census of Population* (2021); Town of Georgina, *Georgina Housing Needs Assessment* (2025).

Food Security and Social Supports

Access to affordable and nutritious food is an important contributor to overall health. Rising living costs have increased demand for food support programs in many communities, including Georgina[16].

While local-level data is limited, regional trends provide important context. In York Region, approximately 22.1% of households report experiencing some level of food insecurity in 2024, and local service providers report increasing reliance on food banks and community food programs[17].

For residents of the Chippewas of Georgina Island First Nation, access to food may also be influenced by transportation requirements and reliance on off-island services, contributing to additional cost and access considerations[4].

Community organizations play an important role in addressing these challenges. Service hubs such as The Link in Sutton provide access to food programs, youth services, and community supports for residents experiencing financial or social challenges. Strong social networks and community support also contribute to improved health outcomes, with local organizations supporting seniors, families, and individuals with diverse needs and/or disabilities[18].

Table 2-5. Food Insecurity Indicator, York Region (2021)

Food Insecurity Indicator	Estimate (2024)
Households experiencing food insecurity (York Region)	22.1%

Prevalence of household food insecurity in York Region, providing regional context for conditions affecting Georgina.

Source: York Region, *Understanding the Health of People in York Region: A Population Health Assessment Dashboard* (2025).

Mobility, Transportation and Access to Services

Transportation plays a central role in shaping access to health care, employment, and community services across Georgina. The municipality's large geographic area, rural settlement pattern, and limited public transit contribute to a strong reliance on personal vehicles for daily travel.

High levels of commuting and limited transit availability create barriers for residents without access to a vehicle, including seniors, youth, and lower-income households. These barriers can affect access to health care appointments, employment opportunities, and community programs. At the same time, York Region

Transit (YRT) has taken important steps to expand and improve transit service across Georgina, which may help strengthen access to health care, employment, and community services over time.

For members of the Chippewas of Georgina Island First Nation, transportation challenges are more pronounced due to the community's location on Georgina Island[4]. Access to off-island services depends on ferry transportation, which operates on a fixed schedule and may limit flexibility in attending appointments. In some cases, residents reported missing appointments or being unable to return to the island following evening or late-day services, requiring overnight stays on the mainland.

Table 2-6. Transportation and Mobility Patterns and Implications, Town of Georgina

Transportation and Mobility Indicators	Insight
Primary travel mode	Personal vehicle
Transit availability	Limited
Commute patterns	Many residents travel outside Georgina
Access barriers	Seniors and non-drivers affected

Summary of transportation patterns and their implications for access to services in Georgina.

Source: Statistics Canada, *Census of Population* (2021); *York Region, Understanding the Health of People in York Region: A Population Health Assessment Dashboard* (2025).

Transportation therefore influences not only physical access to services, but also continuity of care, timeliness of treatment, and overall system navigation. In both Georgina and Georgina Island, mobility is a key determinant of equitable access to health and social services.

Key Insights:

- **Economic and employment patterns shape daily life and access to services.** While incomes are relatively strong overall, commuting patterns and reliance on external employment centres influence time, transportation needs, and access to care.
- **Housing affordability pressures are emerging for some households.** A portion of residents spend more than 30% of their income on housing, with limited availability of subsidized housing affecting lower-income residents and seniors[14].
- **Food security remains a concern for some residents.** Rising costs and regional trends indicate increasing reliance on food programs and community supports.
- **Rural communities require tailored approaches.** Smaller and more dispersed communities require targeted service planning and delivery models.
- **Transportation plays an important role in access to services.** Georgina's rural geography and reliance on private vehicles create barriers for some residents, while island geography introduces additional complexity for the Chippewas of Georgina Island First Nation, particularly in relation to timing, coordination, and emergency access.

2.4 Ontario Marginalization Index

The Ontario Marginalization Index (ON-Marg)[19] is a census-based tool used to assess levels of marginalization across communities in Ontario. It captures social and economic conditions that influence health outcomes, access to services, and overall well-being. By examining multiple dimensions of marginalization, the index helps identify where residents may face greater structural barriers and where targeted supports may be needed. Higher levels of marginalization are associated with increased barriers to accessing services and poorer health outcomes.

Scores are expressed in quintiles from 1 (least marginalized) to 5 (most marginalized), relative to other communities across Ontario. Higher scores indicate greater barriers to access and increased risk of poorer health outcomes. The index includes four dimensions: age and labour force, household dwellings, material and resources, and racialized newcomers (Table 2-7).

Table 2-7. Ontario Marginalization Index Dimensions

Dimension	Description
Age and Labour Force	Age distribution and labour force participation
Household Dwellings	Housing turnover and family structure
Material and Resources	Income, education, and housing conditions
Racialized Newcomers	Immigration status and racialized populations

Overview of Ontario Marginalization Index (ON-Marg) dimensions and what they measure.

Source: Public Health Ontario, *Ontario Marginalization Index (ON-Marg)* (2021).

Overall Marginalization in Georgina

Overall, Georgina demonstrates low to moderate marginalization across most dimensions with variation indicating local pressures.

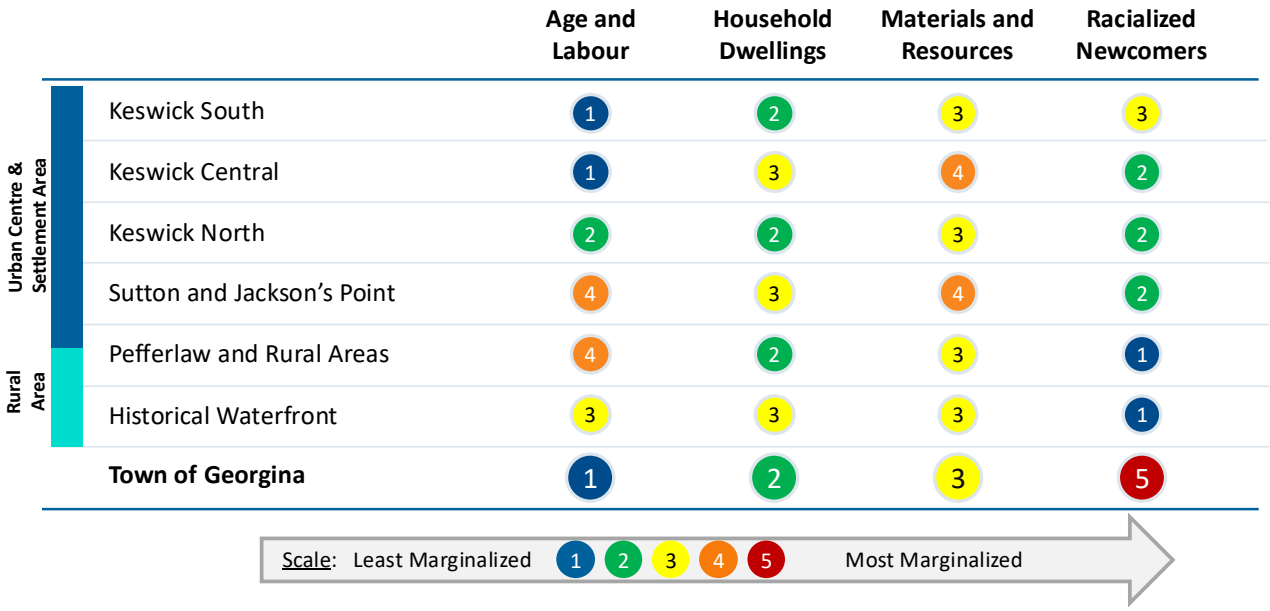
- **Age and Labour (Quintile 1):** Reflects a relatively strong working-age population and lower dependency levels.
- **Household Dwellings (Quintile 2):** Indicates generally stable housing conditions, including high rates of homeownership.
- **Material and Resources (Quintile 3):** Points to moderate economic vulnerability, including pressures related to income and housing affordability.
- **Racialized Newcomers (Quintile 5):** Indicates a higher relative concentration of newcomers and racialized populations compared to many other Ontario communities.

These results are relative to other jurisdictions and do not necessarily indicate high absolute marginalization. However, they highlight emerging economic pressures and demographic changes that may influence future service demand.

Neighbourhood-Level Variation

Marginalization patterns vary across Georgina's neighbourhoods (Figure 2-5), reflecting differences in age structure, housing conditions, and economic characteristics.

Figure 2-5. Ontario Marginalization Index (ON-Marg) by Neighbourhood, Town of Georgina (2021)



Distribution of marginalization across Georgina neighbourhoods by ON-Marg dimension (quintiles, where 1 = least marginalized and 5 = most marginalized).

Source: Public Health Ontario, *Ontario Marginalization Index (ON-Marg)* (2021).

Overall, marginalization levels in Georgina are generally low to moderate, with variation across neighbourhoods and dimensions.

- **Keswick (South, Central, North):** Lower dependency overall, but Keswick Central shows higher material deprivation, suggesting localized economic pressures despite its role as a service hub.
- **Sutton and Jackson's Point:** Higher scores in both dependency and material deprivation, indicating a combination of aging population dynamics and economic vulnerability.
- **Pefferlaw and Rural Areas:** Elevated dependency levels alongside moderate material deprivation, consistent with aging populations and rural access challenges.
- **Historical Waterfront:** Moderate scores across dimensions, reflecting a balanced but still vulnerable profile.

Data was not available for Georgina Island within the ON-Marg dataset.

These patterns highlight several important considerations for service planning. Economic vulnerability is concentrated, particularly in Keswick Central and Sutton and Jackson's Point, indicating a need for targeted supports in these areas. Higher dependency levels in rural and lakeshore communities are likely to increase

demand for chronic disease management, home care, and transportation services. At the same time, growth in racialized and newcomer populations, especially in urban areas, underscores the need for culturally appropriate and accessible services. Overall, the geographic variation in marginalization aligns with known service access challenges and reinforces the importance of place-based planning approaches.

Key Insights:

- **Marginalization levels in Georgina are generally low to moderate;** however, variation across neighbourhoods highlights localized needs.
- **Material deprivation is higher in some areas,** pointing to localized economic pressures related to income and housing.
- **Higher dependency levels in rural and lakeshore communities reflect aging population patterns** and may increase demand for health and social services.
- **Population diversity is growing,** particularly in the Keswick area, reflecting changing community demographics.
- **Rural settlement patterns and distance from service centres may create barriers to accessing services,** particularly for residents living outside the main settlement areas.

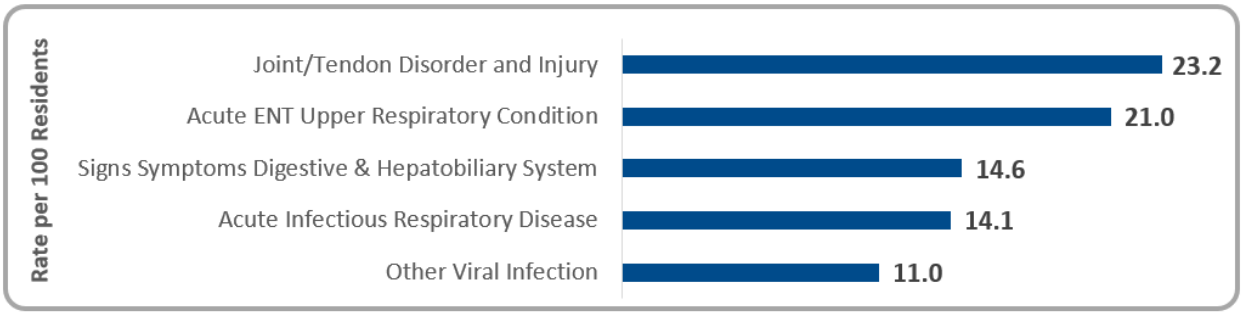
2.5 Top Health Conditions

Patterns of health service utilization provide insight into the most common health conditions affecting residents in the Town of Georgina. Examining both acute and chronic conditions helps identify the types of care most frequently required, while supporting planning for appropriate health and wellness services and interventions.

Among acute health concerns, respiratory infections, musculoskeletal injuries, and viral illnesses are among the most common drivers of health care visits[6].

Common acute conditions driving health care encounters are shown below.

Figure 2-6. Common Acute Health Conditions, Town of Georgina



Common acute conditions driving health care encounters, including emergency department visits and episodic care.

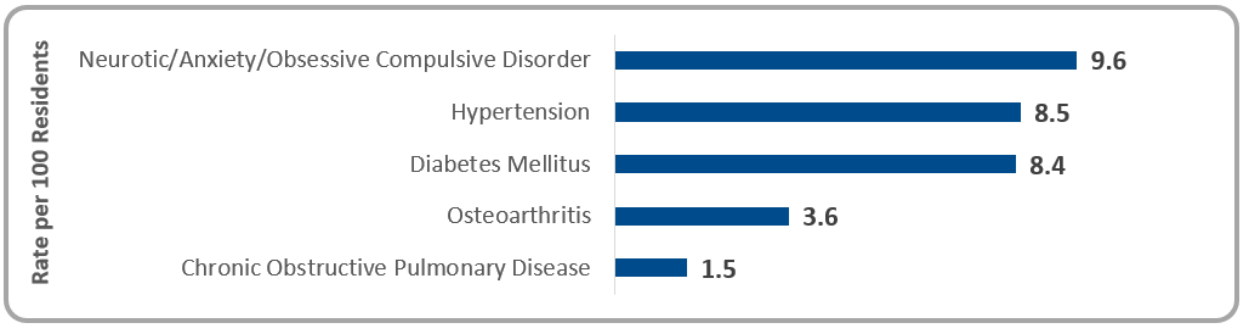
Source: Ontario Health, *eReport Portal OHT – Health Conditions by CIHI Grouper* (2021–2024).

These conditions typically require same-day or urgent care services and contribute to a substantial number of emergency department visits and episodic clinic encounters.

Chronic conditions also represent a significant share of health care demand within the community. Hypertension, diabetes, and mental health conditions such as anxiety disorder and depression are among the most reported chronic health issues[6].

Common chronic conditions driving health care encounters are shown below.

Figure 2-7. Common Chronic Health Conditions, Town of Georgina



Common chronic conditions contributing to overall health burden among residents.

Source: Ontario Health, *eReport Portal OHT - Health Conditions by CIHI Grouper* (2021-2024).

Together, these patterns indicate that Georgina's health system must respond to both episodic acute care needs and ongoing chronic disease management across the community.

Additional insight into health conditions for the Chippewas of Georgina Island First Nation is available through community-specific data sources. These data indicate a significant burden of chronic disease within the community, particularly diabetes, along with patterns of service use consistent with cardiovascular conditions and mental health and substance use-related care needs[4].

Key Insights:

- **Available data suggests acute care needs represent a significant portion of health care use in Georgina.** Respiratory infections, musculoskeletal injuries, and viral illnesses are among the most common reasons residents seek care. Many of these conditions often require same-day or urgent care, contributing to emergency department and episodic clinic visits.
- **Chronic conditions remain a significant part of health care demand,** particularly hypertension and diabetes, which require ongoing management through primary care.
- **Mental health conditions are among the most common chronic issues,** contributing to both primary care visits and hospital utilization.
- **Population aging is likely to increase demand for chronic disease management and supportive care services,** including conditions such as osteoarthritis and dementia.
- **Improving access** to primary care, mental health services, and community-based supports may help reduce avoidable acute care use and support better continuity of care through earlier upstream interventions.

2.6 Priority Populations

Certain groups within the community may experience greater health needs or face barriers to access services. Identifying these populations supports targeted planning and helps ensure services are designed to meet the needs of residents who may require additional support.

In the Town of Georgina, several populations emerge as priorities for health planning and service delivery. These groups include:

- Older adults[3]
- Residents living in rural or geographically dispersed communities[1]
- Low-income households[3]
- Indigenous communities, including Chippewas of Georgina Island First Nation[4]
- Individuals living with chronic health conditions, including mental health conditions[6]

These populations may face a range of challenges, including higher health needs, transportation barriers, financial constraints, and limited access to nearby services, which can contribute to inequities in access and health outcomes. Recognizing these factors helps inform planning efforts aimed at improving access to care and supporting health equity across the community.

The following section examines how residents' access and use health and wellness services across Georgina and the surrounding region.

Access and Use of Health Services

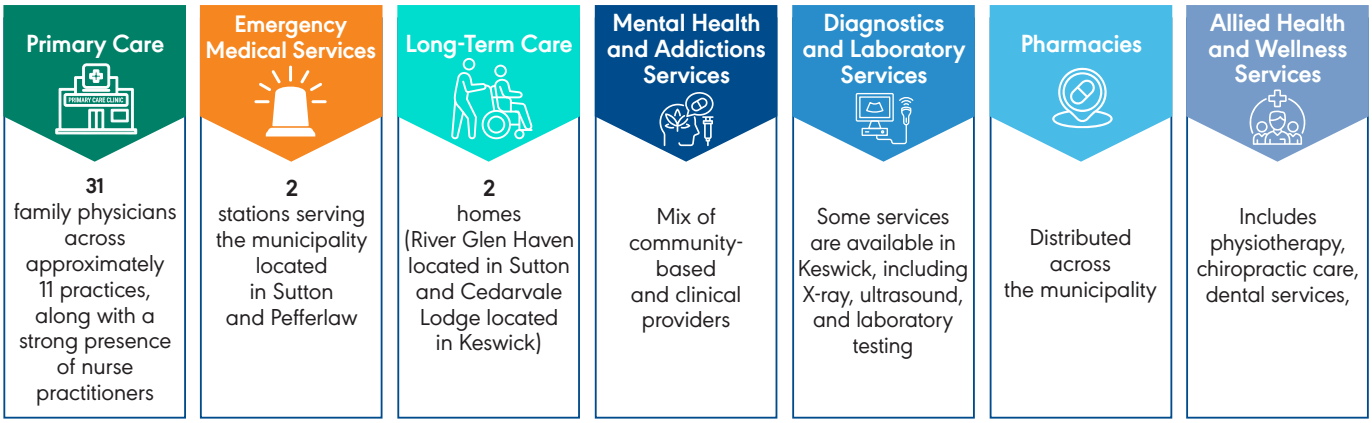
3.0 ACCESS AND USE OF HEALTH SERVICES

3.1 Overview of Local Health Services

Georgina is served by a range of health and wellness providers across the public, private, and community sectors. These services include primary care clinics, pharmacies, dental practices, diagnostic and laboratory services, mental health and addictions providers, emergency medical services, home care providers, and long-term care homes. In addition to clinical care, community-based organizations and social service providers play an important role in supporting the health and well-being of residents.

Services are delivered through a mix of independent practices, private providers, and public and not-for-profit organizations. Community-based programs support mental health, seniors' care, community support services, and system navigation. Key access points such as The Link in Sutton and the Georgina Health Centre serve as important hubs for coordination, connection, and access to both health and social services within the municipality.

Figure 3-1. Distribution of Health and Wellness Services in Georgina



Distribution of health and wellness services across the Town of Georgina, with services concentrated in the Keswick area and more limited availability in rural and northern communities.

Source: York Region. (2024). *Business Survey Data.*

Georgina has a broad local care network that includes 30+ family physicians, 10+ primary care sites, two long-term care homes, two EMS stations, and numerous pharmacy, diagnostic, community, and allied health providers[20]. However, services are geographically concentrated, particularly in the Keswick area. While this concentration improves access for residents living nearby, it can create challenges for those in Sutton, Pefferlaw, and surrounding rural communities, who may face longer travel distances and fewer local service options.

Taken together, Georgina's health system offers a broad range of services, but access is not experienced evenly across the municipality. The geographic distribution of services influences where and how residents obtain care, and contributes to differences in transportation needs, travel burden, and reliance on services outside the community. These structural patterns have important implications for health equity, service coordination, and future planning.

Services and access considerations specific to the Chippewas of Georgina Island First Nation are discussed in *Section 3.3.2*.

3.2 HEALTH SERVICE UTILIZATION BY SECTOR

3.2.1 Primary Care

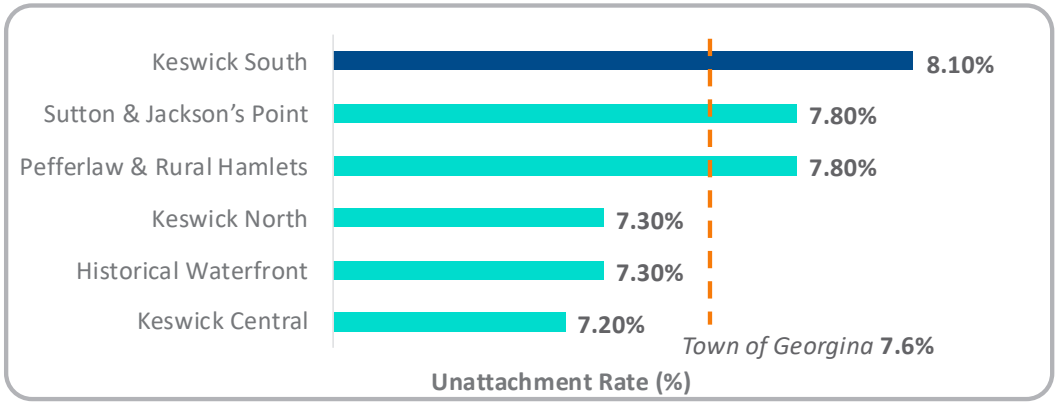
Primary care is the foundation of the local health system and plays a central role in prevention, early intervention, chronic disease management, and coordination across the continuum of care. In Georgina, primary care is delivered through a mix of rostered family practices, walk-in clinics, hybrid models, and nurse practitioner-led services.

Access to Primary Care

Georgina benefits from a relatively strong local primary care base. Based on recent 2025 Ontario Health data, approximately 47,700 residents are attached to a regular primary care provider, representing 92.4% of the population[5]. Approximately 4,107 residents (7.6%) remain unattached.

While overall attachment levels are a community strength, access is not evenly distributed across neighbourhoods. Unattachment rates are highest in Keswick South (8.1%) and remain elevated in Sutton and Jackson's Point (7.8%), and Pefferlaw and Rural Hamlets (7.8%)[5], suggesting localized access pressures. Lower attachment rates in some areas may reflect a combination of provider distribution, transportation barriers, housing growth, and workforce capacity constraints.

Figure 3-2. Primary Care Unattachment Rate (%) by Neighbourhood, Town of Georgina (2025)



Primary care unattachment varies across neighbourhoods, with higher rates in Keswick South and similar levels across rural and lakeshore communities.

Source: Ontario Health. *eReport Portal – OHT Primary Care Action Table (PCAT)* (2025).

Primary Care Supply and Capacity

Based on available data, Georgina has approximately 31 primary care providers, equivalent to 0.66 providers per 1,000 residents[5]. This is below commonly cited national reference ranges of 1.0 to 1.2 primary care providers per 1,000 residents in Canada[21].

Despite this lower provider-to-population ratio, current attachment rates suggest that existing providers, nurse practitioners, and team-based models are supporting a substantial portion of community need. However, this capacity may be increasingly strained by population growth, provider retirements, and recruitment challenges.

Figure 3-3 provides additional context on the distribution of providers, care delivery models, and geographic access patterns within the municipality.

Figure 3-3. Primary Care Supply and Model Mix, Town of Georgina

Primary care supply includes a mix of rostered, walk-in, and team-based models, with services concentrated in Keswick and more limited access in rural areas.

Source: Ontario Health. *eReport Portal – OHT Primary Care Action Table (PCAT)* (2025).

Implications for Access and System Use

Attachment to a regular primary care provider is associated with better continuity of care, stronger preventive care uptake, and lower avoidable hospital use[22,23]. Georgina's relatively high attachment rate is therefore an important system asset.

However, attachment alone does not guarantee timely access. Residents may still experience delays for urgent or same-day appointments, leading some attached and unattached patients to rely on walk-in clinics or emergency departments for conditions that could otherwise be managed in primary care settings.

Key Insight: Georgina's primary care system demonstrates a strong attachment foundation, with most residents connected to regular care. The principal challenge is less about overall attachment and more about equitable, timely, and geographically distributed access. Continued growth, workforce pressures, and uneven provider distribution may increase future strain if not proactively addressed.

3.2.2 Home Care

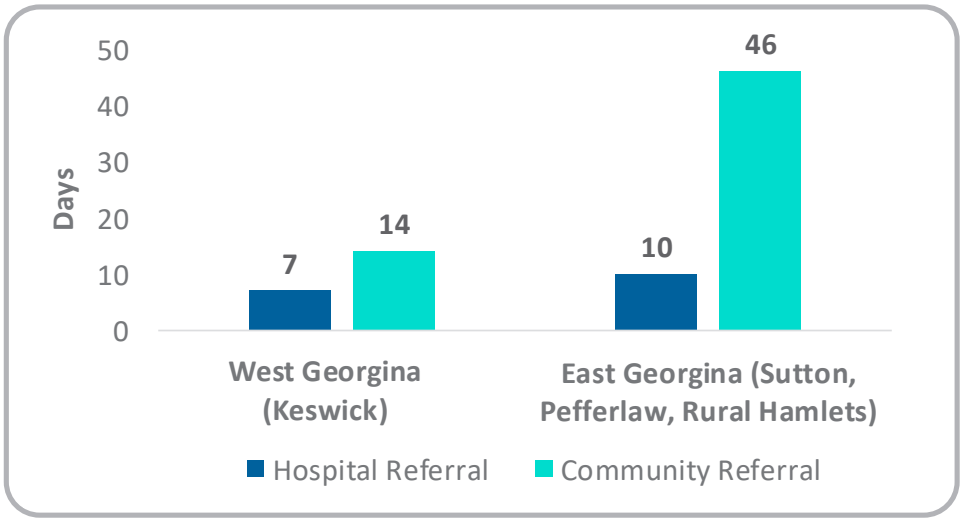
Home care services provide essential supports for residents who require care in their homes, including personal support, nursing care, rehabilitation services, and post-acute care following hospital discharge. These services play an important role in supporting aging in place and reducing reliance on hospital and long-term care services.

Home care demand is increasing across Georgina, with approximately 2,042 clients per 100,000 residents in Keswick (656 clients) and 2,509 per 100,000 residents in East Georgina (569 clients) in 2023/24[12]. Higher utilization in East Georgina reflects an older population and greater reliance on community-based supports in rural and lakeshore communities.

Referral patterns indicate that hospitals are the primary entry point for home care services, with 383 hospital-initiated referrals in Keswick and 311 in East Georgina, compared to 146 and 137 community referrals, respectively in 2023/24[12]. This suggests that access to home care is more consistently achieved through hospital discharge pathways than through direct community access.

Wait times also differ by referral pathway. Hospital-initiated referrals are completed relatively quickly (approximately 7 days in West Georgina and 10 days in East Georgina), while community-based referrals experience significantly longer delays (approximately 14 days in West Georgina and 46 days in East Georgina)[12]. This gap is most pronounced in East Georgina, where community referral wait times are more than three times longer than hospital-based pathways.

Figure 3-4. Home Care Referral Pathways and Wait Times (Days), Town of Georgina



Hospital referrals experience shorter wait times, while community referrals, particularly in East Georgina, experience longer delays.

Source: Ontario Health. *eReport Portal OHT – Community-Based Care – Home Care* (FY2018/19–FY2023/24).

These patterns indicate that while hospital-linked pathways provide timely access to home care, community-based access is more limited, particularly in rural areas. This creates inequities in access and may delay care for individuals seeking support outside of hospital settings.

Key Insight: Home care access varies by referral pathway, with longer wait times for community-based referrals, particularly in East Georgina, indicating capacity constraints in community-based service delivery.

Service intensity is also increasing, reflecting growing complexity of care needs. Personal support worker (PSW) and homemaking hours reached 17,622 hours in Keswick and 11,390 hours in East Georgina, while nursing visits totaled 3,658 and 3,028 visits, respectively in 2023/24[12]. These levels suggest demand for complex, ongoing care in the home.

Longer wait times for community-based referrals may also contribute to broader system pressures, including delayed hospital discharges and ongoing reliance on acute care for individuals who could otherwise be supported in the community.

Rural geography further compounds service delivery challenges, including longer travel distances, workforce constraints, and limited-service availability. Together, these factors highlight the need to strengthen home care capacity, improve coordination across referral pathways, and enhance service delivery models in rural and underserved areas.

3.2.3 Long-Term Care

Long-term care provides residential care and support for individuals with complex health needs and assistance with daily living.

Facilities located in Georgina include:

- River Glen Haven (Sutton)
- Cedarvale Lodge (Keswick)

Table 3-1. Long-Term Care Capacity and Waitlists in Georgina

Facility	Location	Number of Beds	Waitlist
River Glen Haven	Sutton	119	101
Cedarvale Lodge	Keswick	60	344

Long-term care demand exceeds available capacity, with substantial waitlists across both facilities.

Source: Government of Ontario. (2026). *Long-Term Care in Ontario Database* (January 31, 2026).

Long-term care demand in Georgina exceeds available capacity with a total of 179 beds and 445 individuals on waitlists[11], indicating unmet need. This represents more than two individuals waiting for every available bed, highlighting sustained pressure on the long-term care system.

Demand is not evenly distributed across the municipality. Utilization rates are higher in East Georgina, with approximately 476 long-term care residents per 100,000 population, compared to 152 long-term care residents per 100,000 in Keswick[24]. This may reflect an older population and greater care needs in rural and lakeshore communities.

Waitlists are high in both regions, at approximately 321 per 100,000 residents in East Georgina and 280 per 100,000 residents in Keswick[24], indicating that demand continues to outpace capacity across the municipality.

Care needs among long-term care residents are also increasingly complex. A large proportion of residents have extended lengths of stay, with many exceeding 180 days[24], reflecting sustained high-acuity needs and limited turnover within existing beds. These factors constrain system flow and limit the availability of spaces for new admissions.

Limited long-term care capacity contributes to broader system pressures, including delayed hospital discharges and continued reliance on acute care for individuals awaiting placement. These pressures are further compounded by geographic factors, as access to facilities and services varies across communities.

Additional long-term care capacity is planned within Georgina, including two proposed developments in the Keswick area totaling approximately 384 beds (an expansion of Cedarvale Lodge and a new facility).

While these developments are expected to increase local capacity, timelines for construction and occupancy remain uncertain.

Key Insight: Long-term care demand in Georgina exceeds current capacity, with high waitlists, increasing care complexity, and limited turnover contributing to sustained system pressure despite planned expansions.

3.2.4 HOSPITAL SERVICES

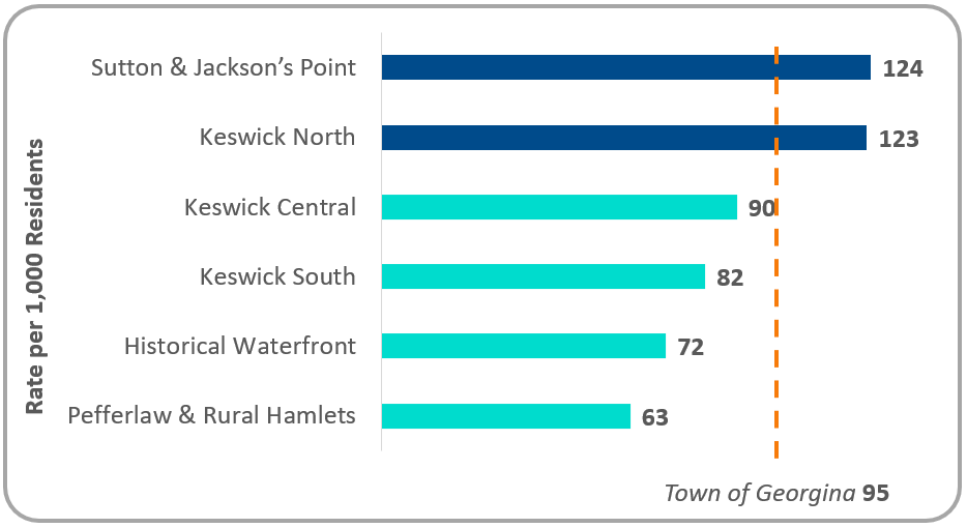
3.2.4.1 Inpatient Care

Hospital inpatient services provide acute care for residents requiring medical or surgical treatment, including care related to chronic disease, maternal health, and other complex conditions. Georgina residents primarily access inpatient services at hospitals located outside the municipality, with a strong reliance on regional providers, particularly Southlake Health[8]. This reliance reflects both regional service planning and limited availability of specialized services locally.

In 2024/25, Georgina residents accounted for approximately 4,907 inpatient discharges across all hospital facilities, representing a rate of 95 discharges per 1,000 residents[8]. Overall inpatient use remains substantial and reflects ongoing demand for acute care services. Separately, Alternate Level of Care (ALC) patient volumes declined from a peak of 342 in 2019/20 to 295 in 2024/25, but remain elevated, indicating continued pressure on discharge flow and community-based capacity[8].

Inpatient utilization varies across neighbourhoods (Figure 3-5). Rates are highest in Sutton and Jackson's Point (124 per 1,000) and Keswick North (123 per 1,000), both above the municipal average[8]. Lower rates are observed in rural and lakeshore communities, including Pefferlaw, and Rural Hamlets (63 per 1,000) and the Historical Waterfront (72 per 1,000)[8]. These differences likely reflect a combination of population health needs, age distribution, and access to community-based supports, with lower utilization in some rural areas potentially indicating access barriers rather than lower need.

Figure 3-5. Inpatient Utilization Rate (per 1,000 residents) by Neighbourhood, Town of Georgina (FY2024/25)

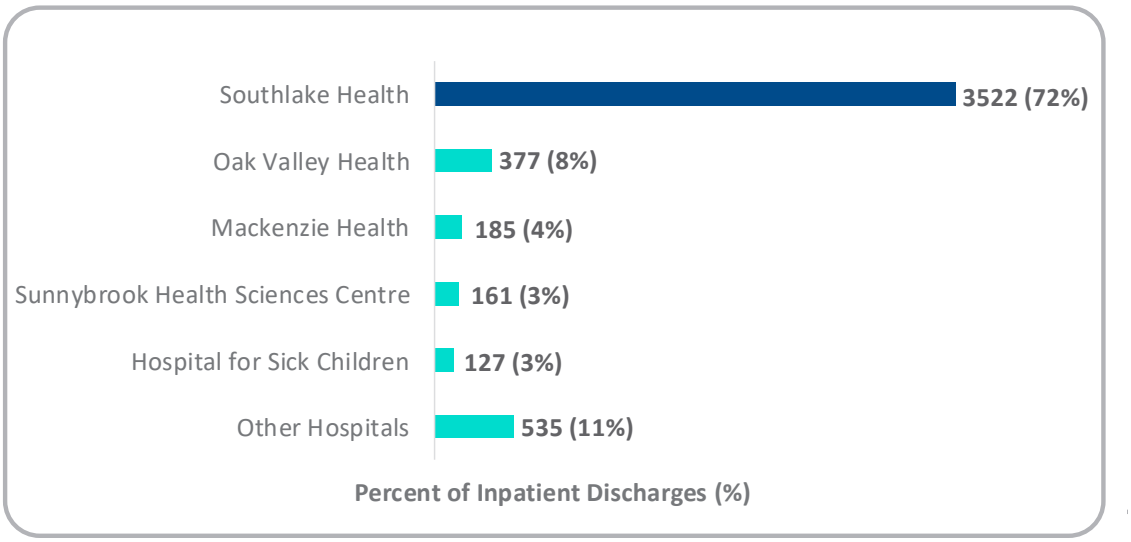


Inpatient utilization varies across neighbourhoods, with higher rates in Sutton and Jackson's Point and Keswick North, and lower rates in rural and lakeshore areas.

Source: IntelliHealth Ontario. *Discharge Abstract Database (DAD)* (FY2024/25).

Georgina residents rely heavily on a small number of hospital providers for inpatient care (Figure 3-6). Southlake Health accounts for approximately 72% of all inpatient discharges, with significantly smaller proportions distributed across other regional and academic/speciality hospitals[8]. This concentration indicates a high level of dependency on a single provider for acute care services.

Figure 3-6. Average Annual Distribution of Inpatient Discharges by Facility, Georgina Residents (FY2024/25)

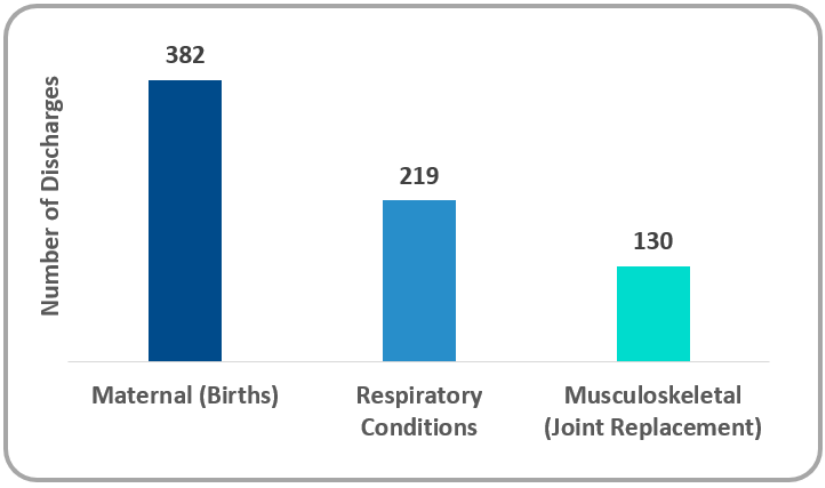


Most inpatient care is delivered at Southlake Health, accounting for almost three-quarters of discharges and indicating strong reliance on a single regional provider in FY2024/25. Historical data show similar trends over the past 7 years.

Source: IntelliHealth Ontario. *Discharge Abstract Database* (DAD) (FY2024/25).

The primary drivers of inpatient admissions reflect both predictable and ongoing health needs (Figure 3-7). Birth-related admissions represent the largest share of inpatient activity, followed by respiratory conditions (e.g., pneumonia, COPD) and musculoskeletal procedures such as joint replacement[8]. These patterns are consistent across neighbourhoods and reflect the combined effects of population growth, aging, and the ongoing burden of chronic disease.

Figure 3-7. Top Presenting Conditions on Admission Based on the Number of Discharges, Town of Georgina (FY2024/25)

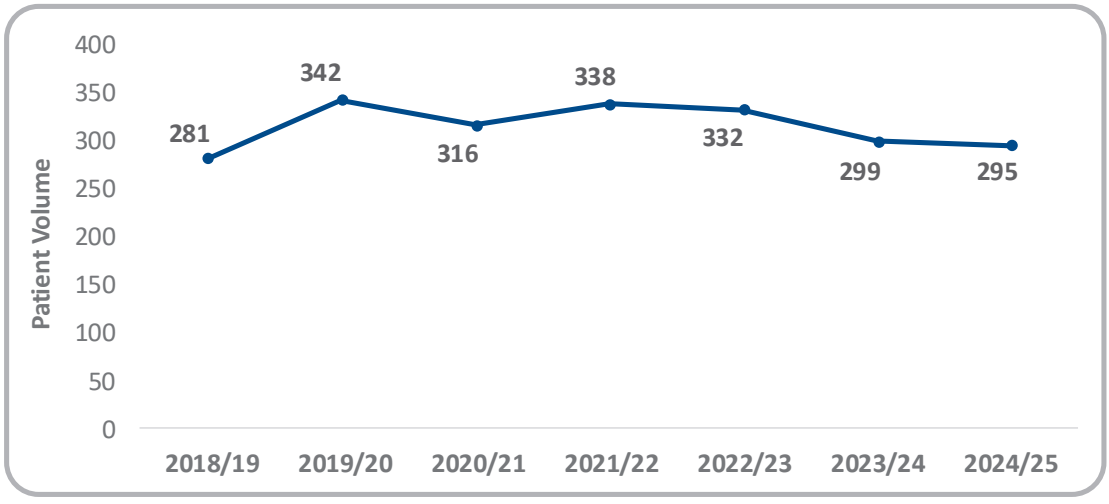


Inpatient admissions are primarily driven by maternal, respiratory, and musculoskeletal conditions, reflecting both acute and chronic care needs.

Source: IntelliHealth Ontario. *Discharge Abstract Database (DAD)* (FY2024/25).

In addition to admission patterns, inpatient utilization is significantly influenced by system-level pressures related to patient flow and discharge. Alternate Level of Care (ALC) patients, individuals who no longer require acute hospital care but remain in hospital due to limited availability of appropriate community-based supports, continue to occupy a substantial portion of inpatient capacity as shown below in Figure 3-8 for residents of Georgina.

Figure 3-8. Alternate Level of Care (ALC) Patient Annual Volume, Town of Georgina (FY2018/19–FY2024/25)



ALC annual volumes based on patient count remain elevated despite recent declines, suggesting ongoing pressures related to discharge delays and limited community-based capacity.

Source: IntelliHealth Ontario. *Discharge Abstract Database (DAD)* (FY2018/19–FY2024/25).

Although ALC patient counts have declined from peak levels, they remain elevated relative to earlier years, with approximately 295 patients in 2024/25[8], suggesting ongoing challenges in transitioning patients to appropriate settings such as home care, long-term care, and community supports.

Taken together, these patterns indicate that inpatient utilization in Georgina is shaped by a combination of population health needs and system capacity constraints. High reliance on a single hospital provider, combined with ongoing discharge challenges, underscores the importance of strengthening community-based care, improving care transitions, and expanding capacity outside of hospital settings.

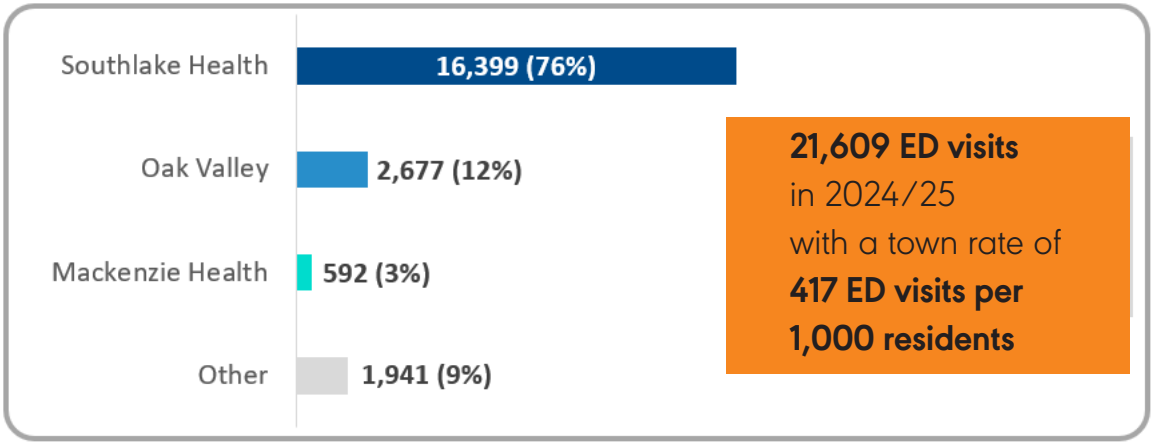
Key Insight: Inpatient demand is driven by maternal, chronic, and respiratory conditions, while ongoing ALC pressures highlight constraints in community-based capacity and care transitions.

3.2.4.2 Emergency Department

Emergency departments provide care for urgent and life-threatening conditions but are also frequently used when alternative care options are unavailable or not easily accessible. Utilization patterns among Georgina residents reflect both population health needs and broader system access challenges.

Emergency department use in Georgina is high relative to population size, with approximately 21,609 visits in 2024/25, representing a rate of 417 visits per 1,000 residents[7]. Volumes have continued to increase over time, rising by approximately 7.9% since 2019/20[7], indicating sustained growth in demand for emergency care.

Figure 3-9. Emergency Department Visits by Facility, Georgina Residents (FY2024/25)



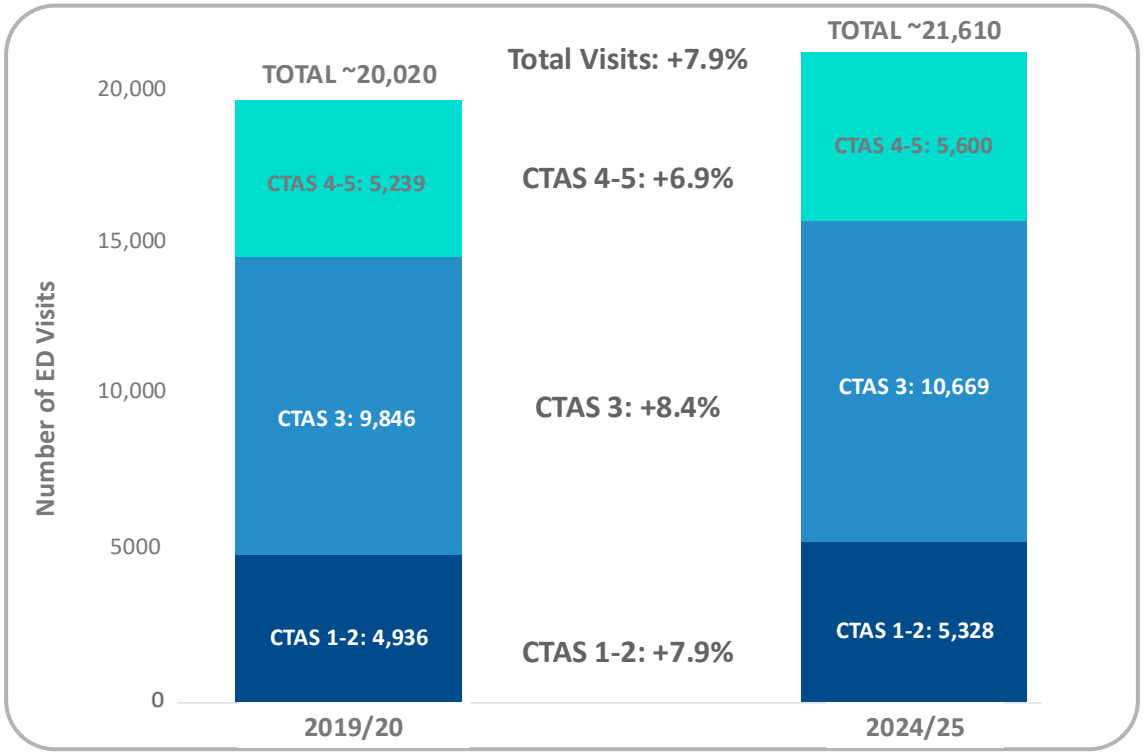
Most emergency department visits occur at Southlake Health, accounting for approximately three-quarters of use and indicating strong reliance on a single provider.

Source: IntelliHealth Ontario. *National Ambulatory Care Reporting System (NACRS): Emergency Department Visits* (FY2024/25).

Emergency department use is highly concentrated among a small number of providers, with Southlake Health accounting for approximately 76% of visits, followed by Oak Valley Health (12%) and Mackenzie Health (3%)[7]. This pattern reflects strong regional referral relationships but also indicates limited diversification in access to emergency care.

Emergency department volumes have increased across all acuity levels (Figure 3-10). Visits classified as CTAS 1-3 (higher acuity) and CTAS 4-5 (lower acuity) have both grown, with lower-acuity visits (CTAS 4-5) increasing by approximately 6.9% and higher-acuity visits increasing by 7.9-8.4% over time[7]. This indicates that growth is broad-based and not limited to non-urgent use alone.

Figure 3-10. Emergency Department Visits by Acuity (CTAS), Georgina Residents (FY2019/20 vs FY2024/25)



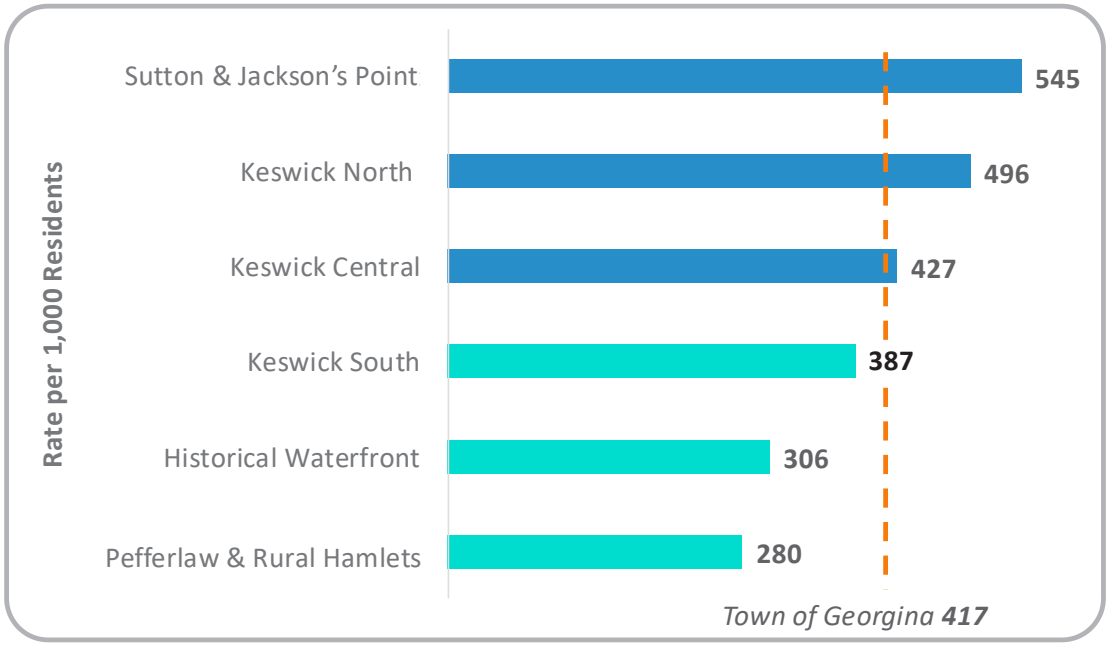
Emergency department visits have increased across all acuity levels, indicating broad-based growth in demand rather than a shift toward lower-acuity use alone.

Source: IntelliHealth Ontario. *National Ambulatory Care Reporting System (NACRS): Emergency Department Visits* (FY2019/20; FY2024/25).

Despite this, lower-acuity visits represent a substantial share of overall volume and are a key contributor to rising demand. Common presenting conditions, including chest pain, abdominal pain, respiratory infections, and urinary tract infections suggest that a portion of emergency department use may be associated with conditions that could be managed in primary care or community-based settings if timely access were available.

Emergency department utilization varies across neighbourhoods (Figure 3-11). Rates are highest in Sutton and Jackson's Point (545 visits per 1,000 residents) and Keswick North (496 per 1,000), both above the municipal average[7]. Lower rates are observed in rural and lakeshore communities, including Pefferlaw, and Rural Hamlets (280 per 1,000) and the Historical Waterfront (306 per 1,000)[7]. These differences likely reflect variation in access to primary care, transportation, and alternative care pathways, with lower utilization in some rural areas potentially indicating access barriers rather than lower need.

Figure 3-11. Emergency Department Visit Rate Per 1,000 by Neighbourhood, FY2024/25

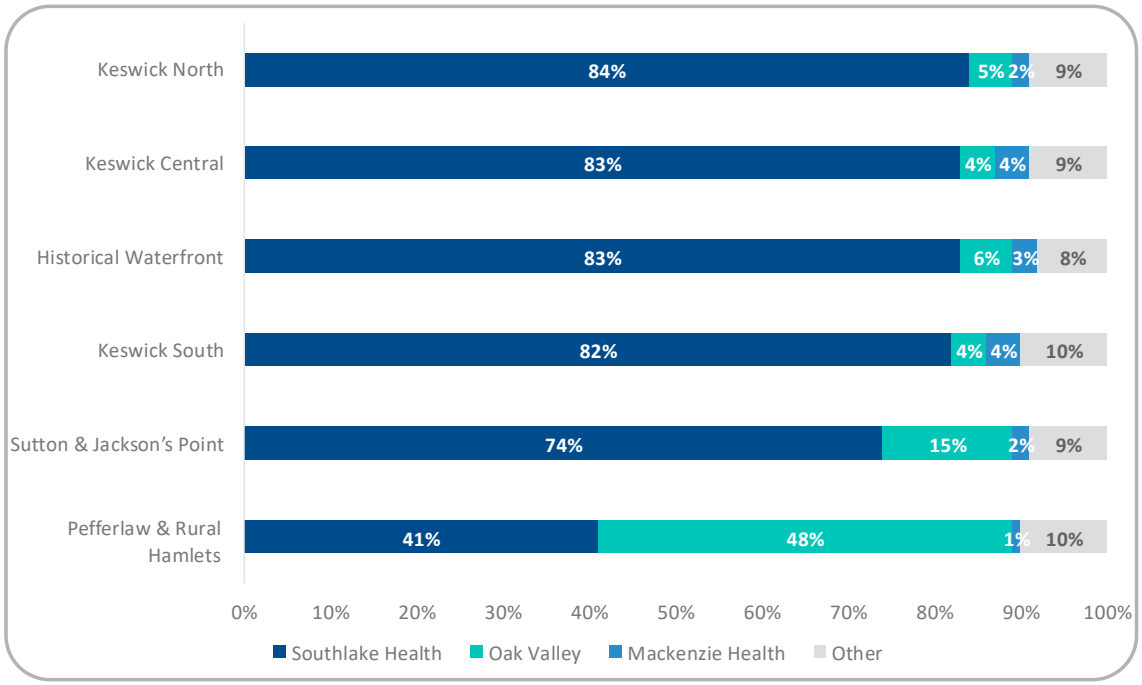


Emergency department visit rates vary across neighbourhoods, with higher rates in Sutton and Jackson's Point and Keswick North, and lower rates in rural and lakeshore communities.

Source: IntelliHealth Ontario. *National Ambulatory Care Reporting System (NACRS): Emergency Department Visits* (FY2024/25).

Patterns of facility use also vary by geography (Figure 3-12). While most neighbourhoods rely heavily on Southlake Health, rural areas, particularly Pefferlaw, and Rural Hamlets, show more distributed use across multiple providers, including greater reliance on Oak Valley Health[7]. These patterns reflect differences in geographic proximity, access, and care-seeking behaviour.

Figure 3-12. Emergency Department Visits by Facility and Neighbourhood, FY2024/25



Emergency department visits are highly concentrated at Southlake Health across most neighbourhoods, while rural areas show more distributed use across multiple providers.

Source: IntelliHealth Ontario. *National Ambulatory Care Reporting System (NACRS): Emergency Department Visits* (FY2024/25).

Overall, increasing emergency department use across all acuity levels, combined with geographic variation and reliance on a single provider, indicates system pressures related to access, coordination, and availability of primary and community-based care.

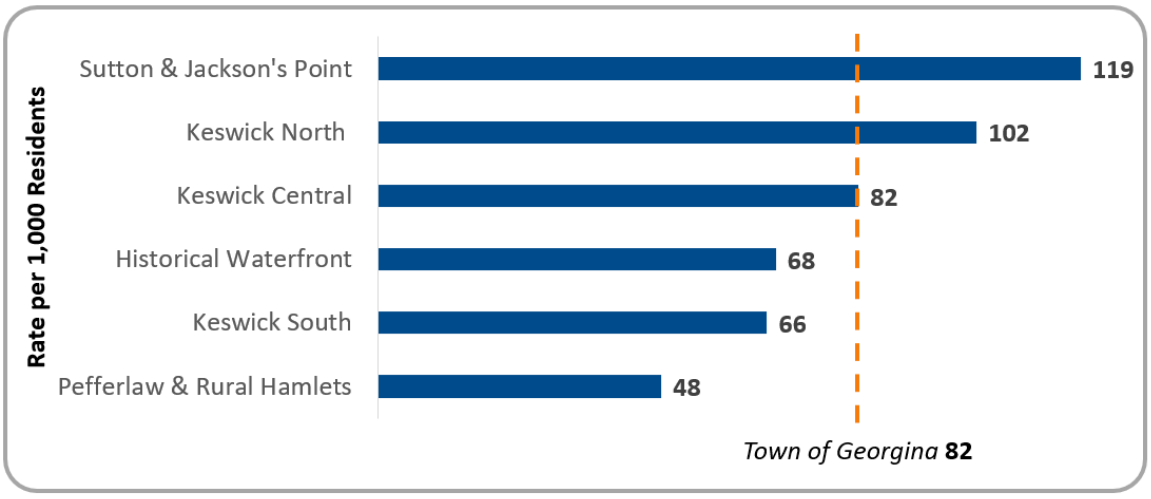
Key Insight: Emergency department use is increasing across all acuity levels, reflecting broad system demand; however, sustained growth in lower-acuity visits suggests gaps in timely access to primary and community-based care.

3.2.4.3 Day Surgery

Day surgery services provide non-emergency procedures that do not require overnight hospital stays and are delivered through planned outpatient care.

Georgina residents undergo approximately 4,230-day surgery procedures annually, at Southlake Health representing a rate of 82 surgeries per 1,000 residents[10] (Figure 3-13). Volumes declined during the COVID-19 period (FY2020/21–FY2021/22)[10] but have since recovered and stabilized, indicating sustained demand for procedural care.

Figure 3-13. Day Surgery Utilization by Neighbourhood, Town of Georgina (FY2024/25)



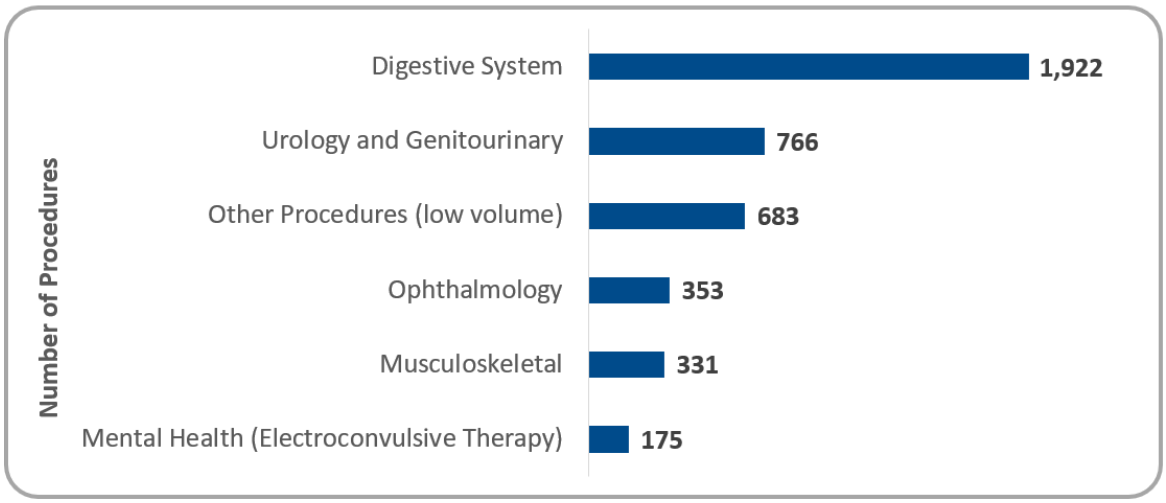
Day surgery utilization varies across neighbourhoods, with higher rates in Sutton and Jackson's Point and Keswick North, and lower rates in rural areas.

Source: IntelliHealth Ontario. *National Ambulatory Care Reporting System (NACRS): Day Surgery* (FY2024/25).

Utilization varies across Georgina neighbourhoods[10]. Rates are higher in Sutton and Jackson's Point and in Keswick North, which may reflect population age, proximity to Southlake Health, and established referral patterns. In contrast, lower utilization in Pefferlaw and Rural Hamlets likely reflects residents accessing care outside the area, particularly at hospitals further east. The continued high utilization in Sutton and Jackson's Point suggests that proximity alone does not fully explain these patterns.

In addition to geographic variation, the types of procedures performed provide insight into the nature of day surgery demand in Georgina.

Figure 3-14. Day Surgery Procedures by Clinical Category, Town of Georgina (FY2024/25)



Day surgery activity is concentrated in digestive system procedures, followed by urology and a range of lower-volume procedure types.

Source: IntelliHealth Ontario. *National Ambulatory Care Reporting System (NACRS): Day Surgery* (FY2024/25).

Day surgery activity is concentrated in a small number of high-volume clinical areas[10]. Most procedures relate to the digestive system, including endoscopy and colorectal care. Urology and genitourinary procedures, such as cystoscopy, also make up a significant share of activity. Ophthalmology procedures, primarily cataract surgery, are another major contributor and reflect demand associated with an aging population. Mental health procedures, including electroconvulsive therapy (ECT), represent a smaller but consistent portion of overall volume.

Other activity includes musculoskeletal procedures and a range of lower-volume services such as skin, ENT (e.g., ear, nose, and throat), and minor surgical interventions.

Overall, day surgery utilization reflects steady demand for planned, non-emergency procedures linked to chronic conditions, aging, and ongoing diagnostic care. A large share of activity is concentrated in a small number of common procedures, indicating consistent and ongoing service needs.

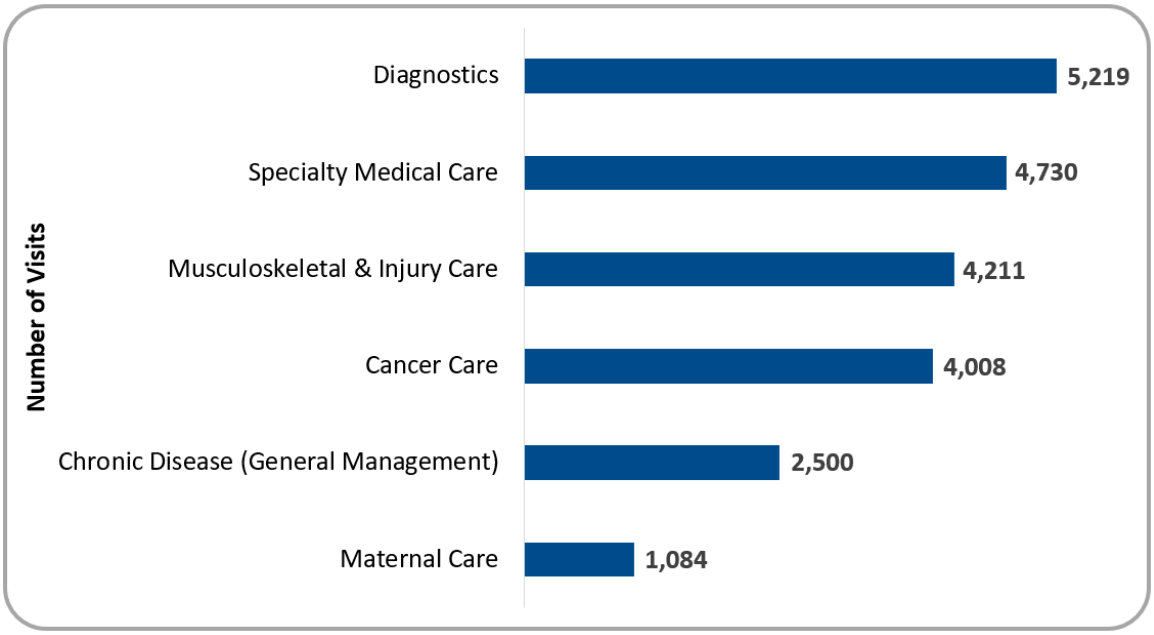
Key Insight: Day surgery demand in Georgina is stable and largely planned, with activity concentrated in a small number of common procedures. Differences across neighbourhoods suggest that access, referral patterns, and regional care relationships influence where residents receive care.

3.2.4.4 Hospital Clinics

Hospital-based outpatient clinics provide access to a wide range of specialized services, including diagnostic imaging, oncology care, musculoskeletal and fracture services, chronic disease management, and pre- and post-procedural care. These clinics are a central component of the care continuum, supporting diagnosis, treatment, and ongoing management of complex and chronic conditions.

Outpatient clinic utilization among Georgina residents is high, with approximately 25,440 visits in 2024/25, reflecting a 9.9% increase from the previous year and a return to pre-pandemic levels following earlier declines[9]. This corresponds to approximately 490 visits per 1,000 residents, indicating substantial reliance on hospital-based outpatient care.

Figure 3-15. Hospital Outpatient Clinic Utilization by Service Type, Town of Georgina Residents (FY2024/25)



Outpatient clinic use is concentrated in diagnostic imaging and musculoskeletal services, followed by specialty medical and cancer-related care.

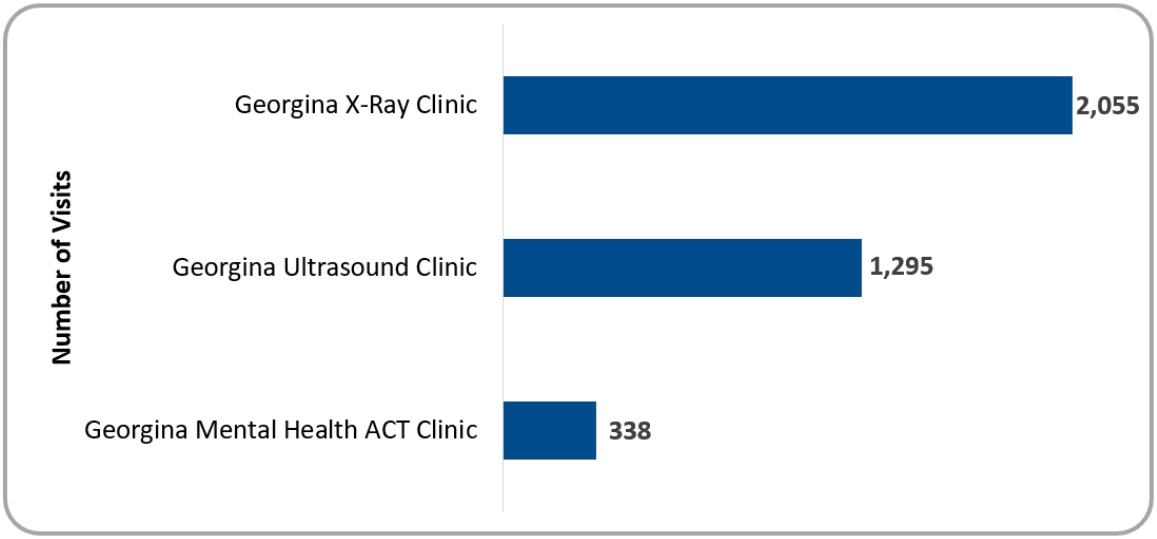
Source: Southlake Health, *Ambulatory Clinic Visits via Meditech-Hospital Information System via LEAP-Analytics Tool* (FY2024/25).

Outpatient activity is concentrated in a small number of high-volume service areas[9]. Diagnostic imaging represents the largest category of use, followed by specialty medical care, musculoskeletal and injury services, and cancer care. High-volume clinics include fracture care, MRI, CT, and oncology-related treatment and follow-up.

These patterns reflect ongoing demand for services related to chronic disease management, injury care, and cancer treatment. Many of these pathways involve repeat visits for diagnostics, treatment, and follow-up, reinforcing the role of hospital-based outpatient clinics in managing complex and continuing care needs.

While most outpatient services are accessed through regional hospital sites, a subset of services is available locally within Georgina. Overall demand is substantial, suggesting that additional services could be localized over time to improve access and patient experience.

Figure 3-16. Utilization of Locally Available Hospital Clinics by Neighbourhood, Town of Georgina (FY2024/25)



Locally available hospital-affiliated services in Georgina are concentrated in diagnostic imaging, with x-ray and ultrasound accounting for the majority of visits. A smaller volume of activity is observed in specialty services, including mental health care through the ACT program. These patterns reflect a limited but important local service base, with most specialized care accessed at regional hospital sites.

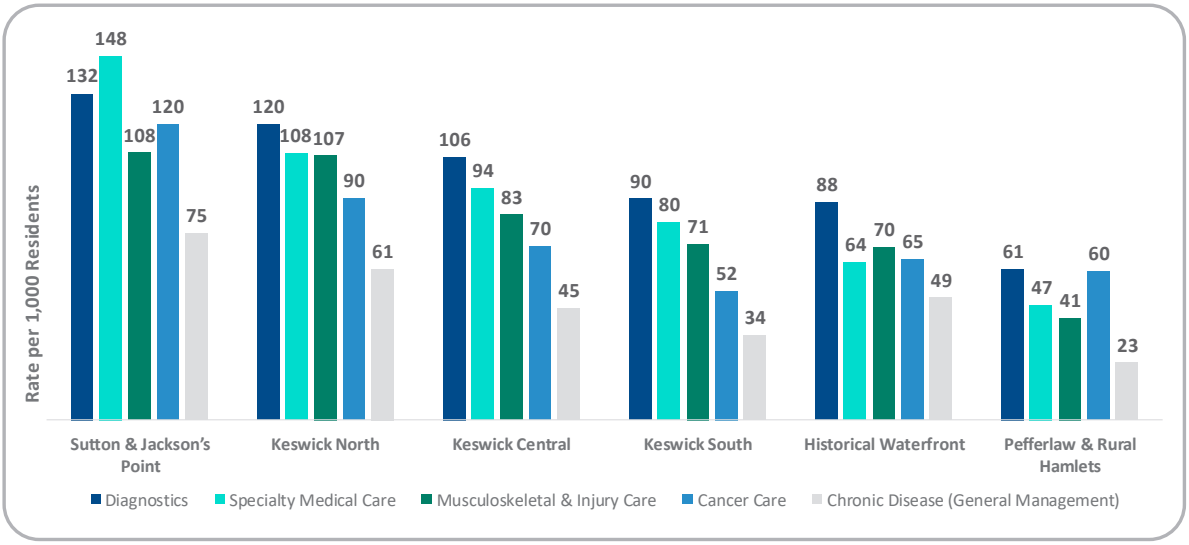
Source: Southlake Health, *Ambulatory Clinic Visits via Meditech-Hospital Information System via LEAP-Analytics Tool* (FY2024/25).

Locally available services are concentrated in diagnostic imaging, with x-ray and ultrasound accounting for the majority of visits[9]. Smaller volumes are observed in specialty services, including mental health care through the Assertive Community Treatment (ACT) program. This reflects a limited but important local service base, with most specialized care continuing to be accessed outside the municipality.

Outpatient clinic utilization varies across neighbourhoods[9] (Figure 3-17). Rates are highest in Sutton and Jackson's Point and in Keswick North, particularly for diagnostics, specialty medical care, and cancer services. Keswick Central also shows elevated utilization across multiple service areas.

Lower rates are observed in Pefferlaw, and rural hamlets. This likely reflects differences in referral patterns, transportation access, and use of providers outside the Southlake Health catchment area, rather than lower demand.

Figure 3-17. Hospital Clinic Utilization Rate (per 1,000 residents) by Neighbourhood and Service Type, Town of Georgina (FY2024/25)



Hospital outpatient clinic utilization varies across neighbourhoods, with the highest rates in Sutton and Jackson's Point and consistently elevated use in Keswick North and Central.

Source: Southlake Health, *Ambulatory Clinic Visits via Meditech-Hospital Information System via LEAP-Analytics Tool* (FY2024/25).

Overall, outpatient clinic utilization in Georgina reflects strong and growing demand for diagnostics, specialist-led care, and ongoing management of chronic and complex conditions. Limited local service availability reinforces reliance on regional hospital-based care, while geographic variation highlights differences in access, referral patterns, and service use across the municipality.

Key Insight: Outpatient clinic use in Georgina is driven by high-volume services such as diagnostics, cancer care, and musculoskeletal care. Limited local availability of specialized services contributes to reliance on regional hospital sites and variation in access across neighbourhoods.

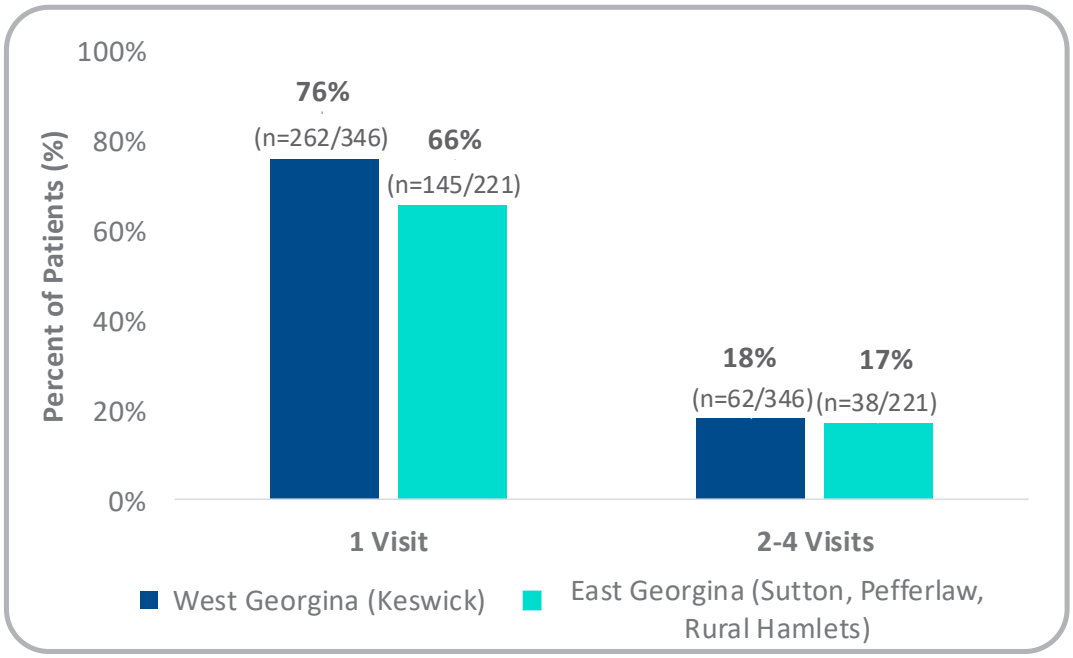
3.2.5 Mental Health and Addictions

Mental health and addictions (MHA) services support residents experiencing mental health challenges, substance use concerns, and crisis situations across a range of care settings, including emergency departments, inpatient services, community-based care, primary care, and regional specialist services.

Demand for MHA services in Georgina remains significant and has increased over time. Utilization patterns suggest need related to anxiety, depression, stress-related conditions, serious mental illness, substance use, and cognitive or age-related behavioural health presentations[8]. Service use includes both episodic crisis care and ongoing support needs.

Emergency departments continue to play an important role in the local response to urgent mental health needs, particularly during acute episodes or when other access pathways are less immediate. Most MHA-related emergency department visits are episodic, with approximately 66% to 76% of patients having one visit per year, while a smaller proportion return multiple times[25].

Figure 3-18. Mental Health and Addictions Emergency Department Visit Frequency, by Geography, Town of Georgina (FY2023/24)

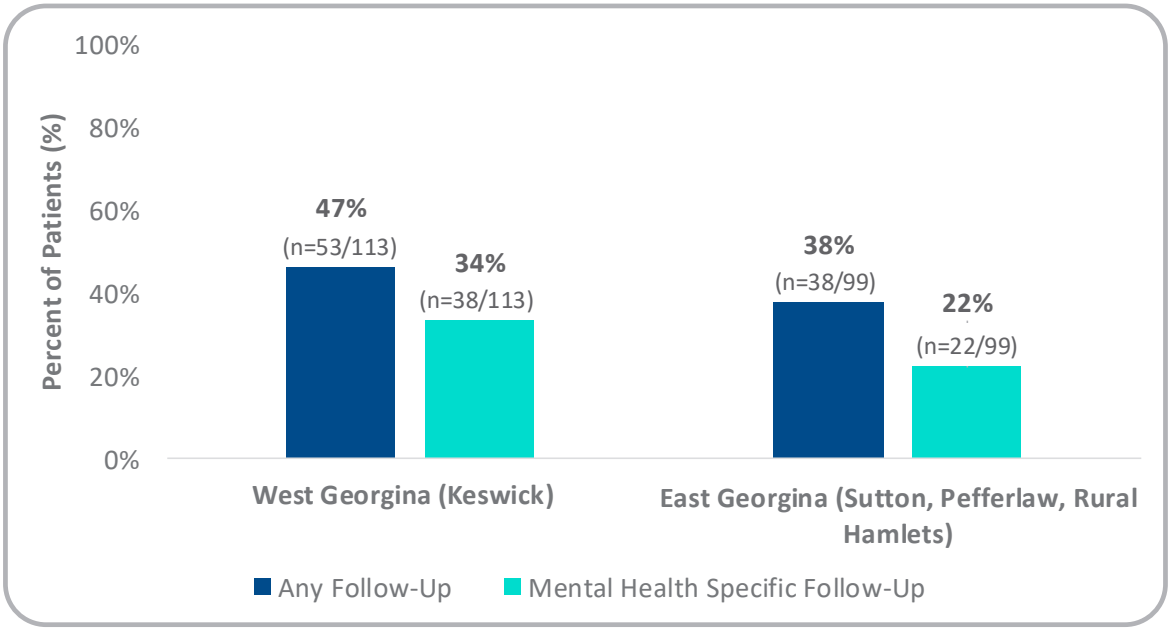


Most mental health and addictions-related emergency department visits are single visits per year, indicating largely episodic use across geographies.

Source: Ontario Health, *eReport Portal – Community-Based Care – MHA Geography* (FY2023/24).

Follow-up after hospital encounters is an important indicator of continuity of care. Available data suggest that 38% to 47% of residents receive any follow-up within 7 days, while 22% to 34% receive mental health-specific follow-up based on billing claims data[25]. Rates vary across the municipality, including lower levels in East Georgina.

Figure 3-19. Follow-Up Within 7 Days After Mental Health-Related Hospital Encounters, by Geography, Town of Georgina (FY2023/24)



Follow-up within 7 days is limited, with lower rates for mental health-specific care and consistently lower access in East Georgina.

Source: Ontario Health, *eReport Portal – Community-Based Care – MHA Geography* (FY2023/24).

These patterns suggest opportunities to strengthen transitions between emergency, hospital, community, and primary care settings. Many residents appear to rely on emergency departments during periods of crisis without always having seamless connection to ongoing care afterward based on available system level data.

Inpatient utilization reflects similar pressures. Adult inpatient volumes increased from 187 cases in 2018/19 to a peak of 329 in 2022/23, before stabilizing at 249 cases in 2024/25[8]. Utilization is highest in Sutton and Jackson's Point, with additional concentration in Keswick North and Keswick Central.

Child and youth inpatient activity remains lower in absolute terms but follows similar geographic patterns, with higher utilization in Keswick and Sutton and Jackson's Point neighbourhoods[8]. Common reasons for admission include mood disorders, anxiety, stress-related conditions, developmental conditions, and substance-related harms.

Community-based indicators provide additional context. Opioid agonist therapy (OAT) is delivered across a range of settings, including primary care, specialized addiction services, and community-based programs, with geographic variation in access and uptake across the municipality.

Overall, residents access mental health and addictions services through a mix of hospital, community, primary care, and regional providers. However, pathways can be difficult to navigate, and transitions between services may not always be seamless. Community-based service use is also not fully captured in this assessment, suggesting that total support activity may be broader than reflected here.

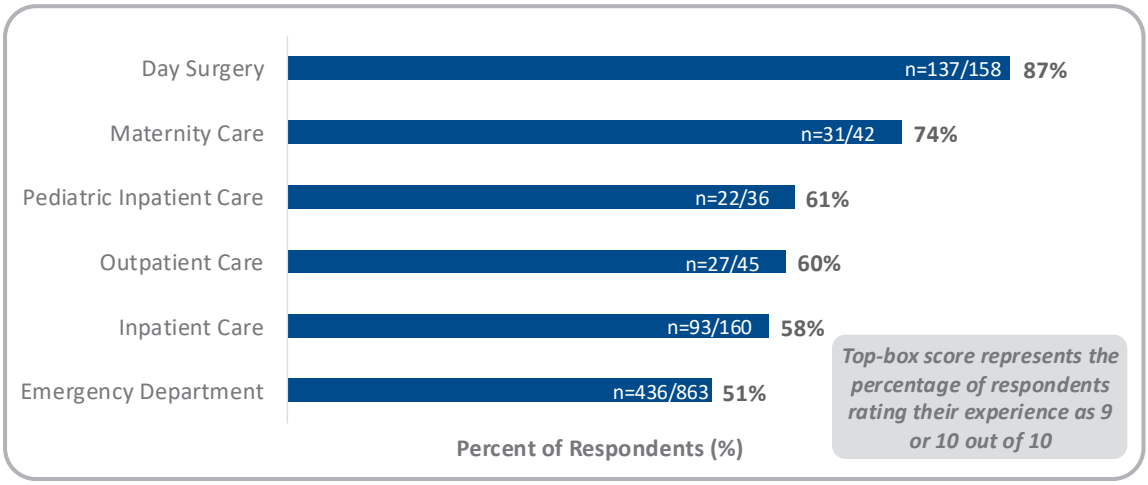
Key Insight: Mental health needs are a significant driver of demand across the local system. Georgina residents access care through multiple pathways, but opportunities remain to strengthen coordinated intake, local first points of contact, timely follow-up after crisis or hospital encounters, and smoother transitions into ongoing community-based support.

3.3 EXPERIENCE OF CARE

3.3.1 Resident Experience

Understanding how residents experience health and wellness services provides important insight into system performance, access, and the ability of services to meet community needs.

Figure 3-20. Patient Experience Ratings (Top-Box Score 9–10) by Hospital Care Setting, Town of Georgina (FY2024/25)



Patient experience ratings are highest for day surgery and maternity care, with strong results across inpatient, outpatient, and pediatric services. Lower ratings in emergency department settings reflect ongoing challenges related to wait times and communication.

Source: Southlake Health, *Patient Experience Survey Data* (2024-2025).

Survey results show generally strong experiences with hospital-based care[26]. Top-box ratings remain high across most settings, with modest improvements from 2023/24 to 2024/25. Inpatient experience ratings increased from 54% to 58%, while day surgery ratings remained consistently high at approximately 87 to 88%. Emergency department experience also improved, increasing from 43% to 51%, though it continues to be lower than other care settings.

Residents report more variation in experience related to access and communication, including care navigation. Wait times and communication during care, especially for lower-acuity patients, remain key areas of concern.

Beyond hospital care, residents identify ongoing challenges accessing services locally, including primary care, mental health and addictions supports, and diagnostic services[27]. While access to care is often described as fair, many residents report relying on services outside the municipality or experiencing delays in obtaining care.

Residents also report difficulty navigating the health system[27,28], particularly among seniors and caregivers. These challenges are more pronounced in rural and remote areas, where transportation and geographic distance affect timely access to services.

Across engagement activities, residents identified priority areas for improvement[27]. These include expanded local access to care, enhanced mental health supports, strengthened services for seniors, and improved supports for system navigation and transportation.

Key Insight: Residents report strong experiences with hospital-based care, while access, navigation, and availability of community-based services remain ongoing challenges, particularly in rural areas.

3.3.2 Indigenous Experience - Chippewas of Georgina Island First Nation

Health care access for members of the Chippewas of Georgina Island First Nation is shaped by its location on Georgina Island in Lake Simcoe. The following data and information were shared by the Chippewas of Georgina Island First Nation for the purpose of this report[4].

Transportation to and from the island is dependent on seasonal conditions, including ferry service during open-water months and an ice road during the winter. During periods when the ferry is not operating, access is limited to the ice road, which is weather-dependent and may not always be reliable or safe. As a result, mainland service providers may be unable to travel to the island, creating disruptions in service delivery and limiting timely access to essential care.

As a remote island community, access to services depends on transportation to the mainland. Most primary, diagnostic, and specialist services are accessed off-island, requiring travel by ferry or ice road followed by additional transportation. These factors increase travel time, coordination, and reliance on weather-dependent connections.

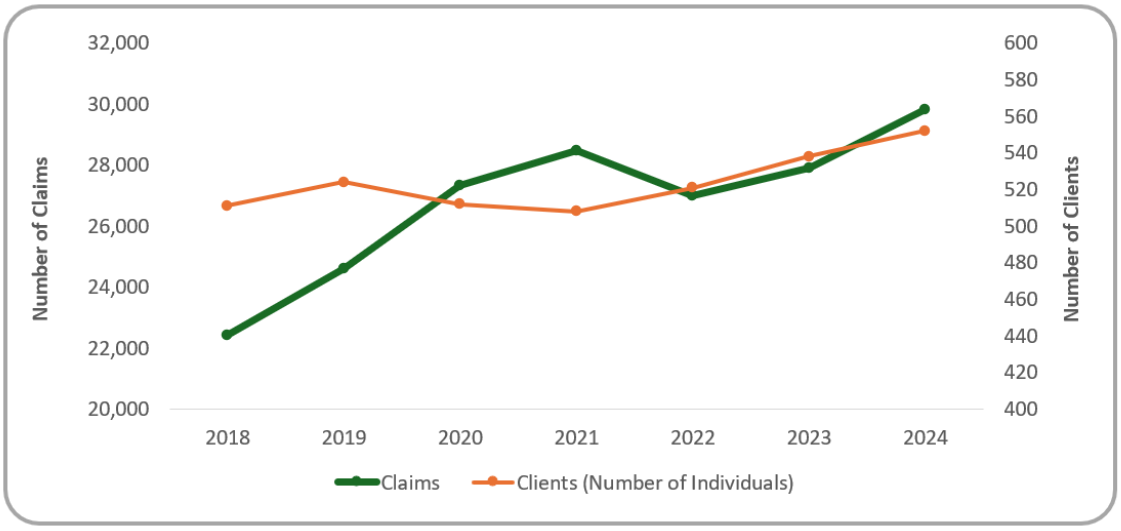
Community members described how ferry schedules, seasonal access, and transportation availability influence their ability to access care. Fixed travel times and limited flexibility can make it difficult to schedule and attend appointments, particularly for services offered later in the day. In some cases, individuals may miss appointments or be unable to return to the island following care, requiring overnight stays on the mainland. These challenges can contribute to delays in accessing care and add additional logistical and financial burden for residents.

Access challenges are more pronounced in urgent and emergency situations, where transportation off the island may depend on water taxi services or seasonal conditions. The absence of a helipad limits direct access to air ambulance (Ornge) services, requiring additional coordination and transfers that may affect response times.

The community has strengthened local service delivery through community-based programs, interdisciplinary care approaches, and culturally grounded wellness services delivered through the Health Centre. These services provide important supports for chronic disease management, family and community services, mental health and counselling, and prevention-focused programming. Ongoing efforts to build internal capacity and support workforce development continue to enhance access to care on the island. While these services provide an important foundation, many specialized and diagnostic services continue to be accessed off island.

Non-Insured Health Benefits (NIHB) pharmacy data provide additional insight into service use within the community[29].

Figure 3-21. NIHB Pharmacy Utilization Trends (Claims and Clients), Chippewas of Georgina Island First Nation (2018–2024)



Trends in NIHB pharmacy utilization show increases in both the number of clients accessing services and the total number of claims over time, with a more pronounced rise in claims, indicating increasing intensity of service use per individual.

Source: Non-Insured Health Benefits (NIHB) Reports, 2018–2024.

NIHB pharmacy utilization has increased over time, with both the number of clients and total claims rising. Claims have grown more rapidly, indicating increased intensity of service use per individual.

Medication use patterns are consistent with ongoing management of chronic conditions, including diabetes, as well as mental health and substance use. As there is no on-island pharmacy, prescriptions are filled off island, requiring coordination with mainland providers and consideration of ferry schedules and weather conditions.

Community-level data indicate that approximately 1 in 7 on-reserve residents are living with or at risk of diabetes as of October 2025[29]. For a population of approximately 270 residents, this represents a significant burden of chronic disease and ongoing demand for monitoring, medication management, and follow-up care. Health centre data indicate that at least 36 individuals require active chronic disease management[29].

This demand is managed within a limited local care model, including part-time nurse practitioner and physician availability and no on-island pharmacy, in coordination with off-island providers.

Housing conditions also influence health and well-being within the community. Overcrowding and multi-generational living arrangements can create challenges related to privacy, infection prevention, and the management of chronic conditions. These factors may also place additional pressure on caregivers and families, particularly when supporting individuals with complex health needs. Addressing housing-related pressures is an important component of supporting overall health, well-being, and access to care within the community.

Accessing care across multiple settings, including on-island services, mainland providers, and federally supported programs, can create challenges in care coordination and continuity. Differences in service models, communication pathways, and system navigation may result in fragmented care experiences. Strengthening coordination across providers and improving continuity of care remain important opportunities to better support community members.

Key Insight: Access to culturally appropriate services that reflect the lens and lived experiences of Indigenous populations is essential to effective care. When mainland services within York Region provide support to Indigenous individuals, it is important to acknowledge the impacts of intergenerational trauma and ensure that care is delivered through trauma-informed, culturally safe, and responsive approaches.

3.4 Summary of Access, Utilization, and System Pressures

Across the continuum of care, health service use in Georgina points to a system under sustained and growing pressure. Demand is increasing across sectors, with continued reliance on hospital-based care, uneven access across the municipality, and gaps in continuity between care settings.

Demand is rising across emergency, inpatient, outpatient, and community-based services, driven by population growth, aging, and increasing rates of chronic disease and mental health needs. These pressures are not isolated to a single part of the system but are seen across the full continuum of care.

Hospital-based care plays a central role. Residents rely heavily on a small number of regional providers, particularly Southlake Health, for emergency, inpatient, and outpatient services. Emergency department use is high across all acuity levels, reflecting both urgent care needs and challenges accessing timely primary and community-based care. Inpatient care shows similar pressures, with discharge delays and limited community capacity affecting system flow.

At the same time, community-based care has not kept pace with demand. Home care wait times, especially in East Georgina, point to limited access outside hospital discharge pathways. Long-term care demand continues to exceed available capacity, with long waitlists and limited turnover. In mental health and addictions, care is often accessed through hospital settings, with limited follow-up and challenges in continuity after acute episodes.

Access and Use of Health Services

Primary care remains an important local strength, with most residents attached to a regular provider. However, access to timely appointments and geographically convenient care remains uneven, particularly in rural and northern communities. These pressures can increase reliance on walk-in clinics, urgent care, and emergency departments for needs that could otherwise be managed in primary care settings.

Access to care varies across the municipality. Higher utilization in Keswick and Sutton contrasts with lower use in rural and eastern communities. In these areas, barriers such as transportation, fewer local services, and reliance on providers outside the immediate area affect access. Lower utilization does not necessarily indicate lower need.

Across service areas, care is increasingly organized around specialist and repeat-use pathways. High volumes in diagnostics, musculoskeletal care, oncology, and chronic disease management reflect ongoing care needs. Many of these services are not available locally, contributing to continued reliance on regional hospitals and more fragmented care experiences.

Taken together, Georgina's health system is characterized by:

- High and increasing demand across all sectors
- Heavy reliance on hospital-based services
- Limited capacity in community and long-term care
- Gaps in transitions and continuity of care
- Uneven timely access despite strong primary care attachment
- Geographic differences in access

These pressures are interconnected. Limited access to primary care, mental health services, and community supports contributes to higher use of emergency departments and hospitals. At the same time, constraints in home care and long-term care slow patient flow and add pressure to acute care.

Overall, Georgina has a broad range of services, but the system is under strain. Addressing these challenges will require strengthening community-based care, improving access across the municipality, and reducing reliance on hospitals as a primary entry point into care.

Gaps and Opportunities

4.0 Gaps and Opportunities

4.1 Overview

The findings from this assessment highlight a range of gaps and system pressures affecting how residents' access and experience health and wellness services in the Town of Georgina. These reflect a combination of population growth, an aging population, increasing chronic disease complexity, health workforce constraints, and geographic and access-related barriers.

Many of these challenges are not unique to Georgina. Increasing demand, workforce shortages, and limited capacity in areas such as primary care, mental health, home care, and long-term care are being experienced across the province. However, in Georgina, these pressures are shaped by local factors, including geography and service distribution, which create distinct challenges related to access, equity, and how people move through the system.

At the same time, Georgina benefits from a strong foundation of providers, partnerships, and community assets. A diverse network of health and social service providers, established community organizations, and ongoing collaboration through the NYSS OHT support access to care across a range of settings. Many residents are able to access services locally or within the broader region, and ongoing efforts to expand community-based care provide a solid base to build on.

Within this context, the analysis identifies key gaps and opportunities where local action can have the greatest impact. These include improving access to primary and community-based care, strengthening care coordination and transitions, addressing geographic and rural access barriers, and expanding local service options where feasible.

While not all system challenges can be addressed at the local level, targeted improvements can make it easier for residents to access care, reduce reliance on hospital-based services, and strengthen continuity of care. The following section outlines these priority gaps and opportunities, with a focus on areas where local action can make a meaningful difference.

4.2 Integrated Primary and Community-Based Care

Primary care and community-based services play a central role in how residents access and experience care.

Gap:

While many residents are connected to a primary care provider, this does not always mean they can get care when they need it. Approximately 7.6% of residents (4,107 individuals) remain unattached, and attachment rates vary across neighbourhoods[5].

For those who are attached, limited same-day availability, appointment delays, and differences across care models and locations can make timely care difficult. As a result, some residents turn to walk-in clinics

or emergency departments for issues that could be managed in primary care. This points to broader challenges in how care is organized and delivered across the community.

Implication:

Gaps in both attachment and timely access can lead to fragmented care and increased reliance on emergency departments. Over time, this makes it harder to provide consistent, coordinated care, particularly for residents with ongoing or more complex needs.

Opportunity:

- ✔ Improve both primary care attachment and timely access, particularly in high-needs areas
- ✔ Strengthen team-based and integrated care models
- ✔ Better connect primary care with community services to support more coordinated care

4.3 Hospital and Community Care Utilization Patterns

Gap:

Residents rely heavily on hospital services, particularly emergency departments and regional providers, for care that could be managed in community settings in a more cost-efficient manner. Emergency department use remains high, at approximately 417 visits per 1,000 (21,609 annually) residents in 2024/25[7]. About 76% of visits occur at a single regional provider (Southlake Health), and volumes have increased by approximately 7.9% since 2019/20[7].

Implication:

Hospitals are playing a significant role in meeting a broad range of care needs. This pattern suggests challenges in accessing timely, community-based care and contributes to ongoing pressure on hospital services.

Opportunity:

- ✔ Improve access to same-day care in the community
- ✔ Expand local access to diagnostics and specialist services
- ✔ Strengthen care transitions and discharge planning

Together, these patterns highlight the opportunity to shift more care into community settings where appropriate.

4.4 Aging Population and Increasing Complexity of Care Needs

Gap:

A growing number of residents are living with chronic conditions such as diabetes, respiratory illness, and mental health concerns, often requiring ongoing support from multiple providers. This is reflected in increased demand for home care and community-based services, with utilization reaching approximately

2,042 clients per 100,000 residents[12], representing a significant number of individuals across the community.

At the same time, capacity in home care and long-term care remains limited. There are 179 long-term care beds and approximately 445 individuals on waitlists[11], and access to home care varies depending on referral source, with longer wait times for community-based referrals.

Implication:

Limited capacity in community and post-acute care makes it harder to support residents at home and to move people out of hospital when they no longer need acute care. This contributes to delays, increased pressure on hospitals, and challenges in providing care in the most appropriate setting.

Opportunity:

- ✔ Expand home care and caregiver supports
- ✔ Support more options for aging in place
- ✔ Strengthen connections between hospital, home care, and long-term care services

Improving capacity in these areas will help support residents closer to home and improve overall system flow.

4.5 Mental Health and Addictions Care Coordination and Continuity

Mental health and addictions needs continue to be a significant and growing area of demand across the local system.

Gap:

Residents access mental health and addictions care through a range of pathways, including emergency departments, hospitals, community agencies, primary care, and regional providers. Emergency departments continue to play an important role during periods of acute need, with most visits being one-time or episodic (approximately 66-76% single visits annually)[25].

Follow-up after emergency or hospital visits varies based on billing data, with approximately 38-47% of patients receiving any follow-up within 7 days, and fewer receiving mental health-specific follow-up. In addition[25], there is limited visibility into the full range of community-based mental health services and outcomes, as data from some community providers is not consistently captured across the system.

Implication:

While urgent needs are often addressed, variation in follow-up and limited system-wide visibility can make it harder to ensure smooth transitions into ongoing care. This may contribute to repeat emergency department use, fragmented service experiences, and challenges connecting residents to the most appropriate supports over time.

Opportunity:

- ✔ Strengthen coordination across mental health and addictions services, providers, and referral pathways
- ✔ Improve timely follow-up and continuity of care after emergency or hospital visits
- ✔ Enhance coordinated intake, navigation supports, and local first points of contact
- ✔ Improve data sharing and system visibility to better understand needs, pathways, and outcomes
- ✔ Expand connections between primary care, community mental health, crisis response, and hospital services

Better coordination and visibility will support more effective planning and improved continuity of care.

4.6 Geographic and Neighbourhood Differences in Access

Gap:

Service use varies across neighbourhoods, including differences in emergency department visits, primary care attachment, hospital use, mental health service access, and home care availability.

Emergency department use varies across neighbourhoods[7]. Visit rates range from approximately 545 visits per 1,000 residents in Sutton and Jackson's Point to 280 per 1,000 in Pefferlaw and Rural Hamlets in FY2024/25, indicating differences in how residents access care across the community. Population size also influences how service use should be interpreted. Rates show the level of use relative to population size and help identify communities with proportionally higher need, while volumes show the total number of visits and help identify where the greatest absolute demand exists. For example, Sutton and Jackson's Point has the highest visit rate at 545 per 1,000 residents (4,570 visits), while Keswick North records the highest total volume at 5,379 visits with a rate of 496 per 1,000 residents. In contrast, Pefferlaw and Rural Hamlets has the lowest rate at 280 per 1,000 residents, with 2,655 visits. Together, these measures show that both relative need and total demand vary across neighbourhoods and should inform planning decisions.

Primary care attachment also varies across the community[5], with 7.6% (4,107 residents) unattached overall[5]. Unattachment rates are above the town average in Keswick South (8.1%), Sutton and Jackson's Point (7.8%), and Pefferlaw and Rural Hamlets (7.8%), indicating localized access pressures. In total numbers, the largest unattached populations are in Keswick North (979 residents), Sutton and Jackson's Point (912), and Keswick South (813), reflecting areas where the greatest absolute demand for attachment solutions may exist.

Home and community care access also varies across Georgina[12]. Utilization rates are higher in East Georgina (2,509 clients per 100,000 residents) than West Georgina (2,042 per 100,000), reflecting greater reliance on community-based supports in eastern and more rural areas. At the same time, community referral wait times are significantly longer in East Georgina (46 days) compared with West Georgina (14 days), indicating potential capacity, travel, or workforce constraints.

Services are largely concentrated in the Keswick area, while residents in more rural and northeastern communities face longer travel distances and fewer local options.

Implication:

Differences in service use reflect a combination of access barriers, population distribution, and service availability. Residents in some areas may experience greater challenges accessing care locally, while larger population centres may generate higher overall demand due to population size. Longer wait times for community-based services in rural and northeastern areas may further widen access gaps over time.

Opportunity:

- ✔ Use both service rates and total volumes to better understand neighbourhood need and plan resource allocation
- ✔ Focus efforts on high-need and high-growth areas
- ✔ Expand mobile, virtual, and outreach services
- ✔ Improve transportation and service distribution
- ✔ Strengthen home and community care capacity in underserved areas

Addressing these differences will help ensure more consistent and equitable access across the community.

4.7 System Navigation and Coordination

Across the system, residents often need to navigate multiple services and providers.

Gap:

Care is delivered across many entry points, with limited coordination and inconsistent transitions between services. This can make it difficult for residents to know where to go and how to access care, particularly for those with more complex needs.

Implication:

Challenges with navigation can delay care, contribute to repeated use of emergency departments, and make it harder to maintain continuity across providers.

Opportunity:

- ✔ Improve system navigation and coordination across providers
- ✔ Strengthen communication and referral pathways
- ✔ Make it easier for residents to understand and access available services

Ongoing collaboration among local providers provides a strong foundation to build on.

4.8 Summary of Gaps and Opportunities

Across the health and wellness system in Georgina, several consistent themes emerge that shape how residents access and experience care. These include growing demand linked to population growth and an aging population, increasing chronic disease complexity, continued reliance on hospital-based services, rising mental health needs, geographic differences in access, and capacity pressures in home and community care.

These challenges are closely connected. Gaps in primary care attachment and timely access can contribute to greater use of emergency departments and walk-in clinics. At the same time, limited capacity in home and community care can delay discharges from hospital and make it harder for residents to receive care closer to home. Challenges with system navigation and coordination can also make it difficult for residents to move between services and receive consistent follow-up.

Georgina also benefits from a strong foundation of providers, partnerships, and community organizations. Many residents are able to access care locally or within the broader region, and ongoing efforts to expand community-based services provide a solid base to build on.

Key gaps and opportunities include:

- ✔ **Primary care attachment and timely access:** Approximately 7.6% of residents (4,107 individuals)[5] are not attached to a primary care provider, and those who are attached may still face challenges accessing timely care. Improving both attachment and access, particularly in high-needs areas, is critical to supporting continuity of care.
- ✔ **Reliance on hospital-based care:** Emergency department use remains high, with approximately 21,609 visits annually (417 visits per 1,000 residents)[7], indicating opportunities to strengthen access to appropriate community-based services.
- ✔ **Growing demand for home and community care:** Demand for home care and long-term care is increasing, with approximately 445 individuals on long-term care waitlists[11]. Expanding supports for aging in place can help improve system flow and reduce pressure on hospitals.
- ✔ **Mental health and addictions continuity of care:** Mental health needs are increasing, with inconsistent follow-up after emergency department visits (approximately 38-47% receive any follow-up within 7 days, and 22-34% receive mental health-specific follow-up)[25]. Limited visibility into community-based services further challenges continuity. Strengthening coordination and follow-up is an important opportunity.
- ✔ **Geographic and neighbourhood differences in access:** Access varies across the community, with emergency department visit rates ranging from approximately 280 to 545 per 1,000 residents[7]. While rates may be higher in some rural areas, total volumes remain higher in more populated areas such as Keswick. Targeted, place-based approaches to service planning and delivery can help address these variations and improve equitable access across the municipality.
- ✔ **System navigation and coordination:** Care is delivered across multiple providers and settings, with limited coordination between services. This can contribute to delays, repeated visits, and challenges in maintaining continuity of care. Strengthening coordinated intake, navigation supports, and information sharing across providers presents an opportunity to improve continuity and overall system efficiency.

Together, these gaps highlight the need to strengthen primary care attachment and timely access, improve coordination across services, and address geographic differences in how care is accessed. Targeted local action can help better align services with community needs and support more consistent, connected care across the system.

Recommendations

5.0 RECOMMENDATIONS

The following recommendations build on the gaps identified in Section 4 and focus on practical actions to improve access, coordination, and continuity of care in Georgina. They are organized around four priority areas that focus on improving primary care access, strengthening prevention and system navigation, addressing equity gaps, and enhancing mental health services.

These priorities respond to key pressures identified in this assessment, including gaps in primary care attachment, challenges accessing timely care, geographic variation across neighbourhoods, and continued reliance on hospital-based services. They also reflect growing demand related to population growth, aging, and increasing chronic disease complexity.

At the same time, Georgina benefits from a strong foundation of providers, partnerships, and ongoing collaboration through the Ontario Health Team and municipal initiatives. Many of the actions outlined below build on work already underway and provide an opportunity to further strengthen coordination and expand local service capacity.

Together, these recommendations provide a practical path forward to improve access to care, strengthen continuity across the system, and better align services with community need.

5.1 Priority 1: Increase Access to Services for Today and Tomorrow

Improving access to primary and community-based care is central to addressing both primary care attachment gaps and timely access challenges. While attachment remains a key foundation for continuity of care, timely access to services is also critical to ensuring residents can receive care when needed to avoid further escalation.

Strengthening access will support increased primary care attachment, particularly in high-needs areas, while also reducing reliance on emergency departments for non-urgent care. With approximately 21,609 emergency department visits annually[7], improving access to appropriate community-based services represents a key opportunity to better align care with need and reduce system pressure.

Expanding local service capacity and strengthening coordination across providers will support more consistent access and long-term system sustainability.

Key outcomes include:

- Increased primary care attachment across the population
- Improved access to timely, community-based care
- Reduced reliance on emergency departments for non-urgent needs
- Strengthened local service capacity and system sustainability

1.1 Increase Primary Care Attachment in High-Needs Areas

Recommendation:

Increase primary care attachment through targeted strategies focused on high-needs populations and geographic areas.

Rationale:

Approximately 7.6% (4,107 residents) of residents are not attached to a primary care provider[5], with higher concentrations in specific neighbourhoods. Population growth, aging, and chronic disease are expected to increase demand for longitudinal primary care.

Anticipated Outcome:

✔ Improved attachment rates in high-needs areas and more consistent access to ongoing primary care.

1.2 Advance Advanced Care Centre Planning

Recommendation:

Continue to progress the development of an Advanced Care Centre that collocates primary care, diagnostics, specialist and other community-based services to help increase access to care.

Rationale:

Residents rely on services outside the community for diagnostics and specialty care, contributing to travel burden and avoidable hospital use. Ongoing management of chronic conditions can be supported through primary care, further reducing needs to acute care intervention.

Anticipated Outcome:

✔ Increased availability of local services and improved access to timely diagnostics, primary care, and specialist supports.

1.3 Develop a Primary Care Workforce Recruitment and Retention Strategy

Recommendation:

Develop a coordinated strategy to recruit, retain, and support primary care providers.

Rationale:

An aging workforce and uneven provider distribution create risks for future access and continuity of care.

Anticipated Outcome:

✔ A more stable and sustainable primary care workforce, with improved provider distribution and long-term system capacity to meet patient needs on an extended horizon.

5.2 Priority 2: Target Health Promotion and Education Based on Resident Needs

Strengthening prevention, early intervention, and system navigation can help residents manage their health earlier and reduce avoidable use of acute care services. Improving awareness of available services and supporting residents to access care appropriately can help reduce reliance on emergency departments and improve overall system flow.

Key outcomes include:

- Improved population health and self-management of chronic conditions
- Increased awareness and use of appropriate services
- Reduced avoidable emergency department visits and hospitalizations
- Enhanced community engagement and health literacy

2.1 Provide Community-Based Education on Priority Health Conditions

Recommendation:

Expand community-based education and wellness programming focused on priority health conditions.

Rationale:

Chronic disease and modifiable risk factors contribute to avoidable health system use and poorer long-term outcomes.

Anticipated Outcome:

✔ Improved knowledge and self-management capacity, supporting earlier intervention and reduced reliance on acute care.

2.2 Improve Public Information and System Navigation

Recommendation:

Enhance access to clear, accessible information and system navigation supports.

Rationale:

Residents report challenges navigating available services, particularly in rural and underserved areas.

Anticipated Outcome:

✔ Improved awareness of services and more appropriate use of care pathways.

5.3 Priority 3: Take Steps to Improve Health Equity

Addressing geographic and population-level differences in access is important to ensuring more consistent health outcomes across the community. Variations in service availability, travel distance, and referral patterns contribute to differences in how residents access care.

Key outcomes include:

- More equitable access to home and community care services
- Reduced geographic variation in service availability and utilization
- Improved access for underserved and priority populations
- Strengthened culturally appropriate care and community partnerships

3.1 Review Home Care Referral Patterns and Address Inequities

Recommendation:

Assess and address geographic variation in home care referral patterns and access.

Rationale:

Differences in referral wait times and service access across east and west Georgina suggest potential inequities in service delivery.

Anticipated Outcome:

✔ More consistent access to home care services and reduced variation across the community.

3.2 Strengthen Indigenous Partnerships and Culturally Appropriate Care

Recommendation:

Provide allyship to the Chippewas of Georgina Island First Nation to support culturally appropriate and community-informed care.

Rationale:

Indigenous communities face unique access challenges and require approaches that reflect community priorities, lived experience, and self-determination.

Anticipated Outcome:

✔ Improved access to culturally appropriate care and strengthened relationships with Indigenous partners.

5.4 Priority 4: Optimize Mental Health Services

Improving access, coordination, and continuity of mental health and addictions services is important to addressing growing demand and reducing fragmentation across the system.

Strengthening care pathways and post-discharge follow-up can support earlier intervention, improve continuity, and reduce avoidable emergency department use.

Key outcomes include:

- Improved access to timely mental health and addictions services
- Reduced reliance on emergency departments as a point of access

- Improved continuity of care and patient outcomes
- Stronger integration across hospital, primary care, and community services

4.1 Establish a Local First Point-of-Contact Pathway for Mental Health Services

Recommendation:

Develop a coordinated entry pathway to improve access to mental health and addictions services.

Rationale:

Fragmented pathways contribute to delays in care and reliance on emergency departments.

Anticipated Outcome:

✔ Improved access to appropriate services and reduced reliance on emergency departments.

4.2 Improve Post-Discharge Follow-Up and Continuity of Care

Recommendation:

Strengthen post-discharge follow-up and care coordination for individuals with mental health needs.

Rationale:

Gaps in follow-up care contribute to readmissions and poorer outcomes.

Anticipated Outcome:

✔ Improved continuity of care, reduced readmissions, and better patient outcomes.

While the recommendations outlined above identify key areas for further action, partners have already made meaningful progress in advancing access to care and strengthening services across the community.

5.5 Progress to Date and Early Achievements

Since signing the Memorandum of Understanding in June 2024, Southlake Health, NYSS OHT, and the Town of Georgina, have been working collaboratively to improve access to integrated, community-based care for residents of Georgina. Initiatives have focused on expanding primary care access, strengthening team-based care, improving digital access, supporting prevention and screening, and reducing barriers for residents facing complex needs.

Early progress has been made across several areas, demonstrating a shared commitment to strengthening care closer to home.

Key highlights from June 2024 to March 2026 include:

- 9,085 primary care visits delivered through NYSS OHT clinics in Georgina
- 1,260 residents rostered and 5,747 visits delivered through the Keswick Interprofessional Care Team (IPCT) Clinic

Recommendations

- 3,338 visits delivered through the Children's Care Clinic
- Launch of a Mobile Health Bus (July 2025), supporting 85 individuals through outreach in shelters and group homes
- 451 residents engaged through community health fairs and education sessions
- 12 Health & Wellness Education Sessions reaching approximately 200 residents
- 32 cancer screening outreach and education events engaging 780 participants, with approximately 10% booking screening appointments
- 37 participants enrolled in the Southlake Health Cardiac Prevention and Rehabilitation Program at the Multi-Use Recreation Complex (MURC), including active participants and program graduates

The Keswick Interprofessional Care Team (IPCT) Clinic and the Children's Care Clinic have helped residents access timely primary care closer to home. These initiatives have expanded access to team-based and community-based care, with the IPCT Clinic improving access to timely and after-hours care, while the Children's Care Clinic has enhanced access for families through extended service hours.

Digital access to care has also improved through implementation of Online Appointment Booking across 14 primary care providers, enabling 24,142 appointments to be booked electronically. This has improved convenience for patients, reduced administrative burden on clinic staff, and increased system efficiency.

To better support residents facing barriers to care, the Mobile Health Bus was launched in July 2025 and has provided outreach services in shelters and group homes across Georgina, helping bring care directly to vulnerable populations.

Health promotion and prevention have also remained a priority. Community members have participated in health fairs, wellness workshops, and cancer screening outreach initiatives focused on improving awareness, early detection, and access to preventive care.

Through the MOU, partners have also introduced a local cardiac rehabilitation program at the Multi-Use Recreation Complex, enabling residents to access recovery and prevention services closer to home.

Partnerships with Indigenous communities have also been strengthened through targeted engagement, including the Fall Harvest Celebration Indigenous Engagement Event, which brought together 67 participants, including 14 members of the Chippewas of Georgina Island First Nation. The event supported relationship-building and increased awareness of culturally safe services, including psychotherapy supports, cancer care navigation, and primary care information.

In response to a locally identified gap in mental health and addictions services, partners supported the development of The Sanctuary, a new peer-led drop-in initiative launching May 1, 2026. The program will provide low-barrier access to peer support, group programming, recovery education, and system navigation services across multiple community locations.

Together, these achievements demonstrate how integrated planning and local partnerships can strengthen access to care, reduce barriers, and improve health outcomes in Georgina.

Roadmap and Next Steps

6.0 ROADMAP AND NEXT STEPS

This roadmap outlines a phased approach to advancing the recommendations presented in Section 5. It is intended to support coordinated action over time, with an emphasis on improving access to primary and community-based care, strengthening prevention and health promotion, addressing geographic and equity-related gaps, and improving mental health service continuity.

Actions are organized across short-, medium-, and long-term time horizons to reflect different levels of readiness, investment, partnership, and implementation complexity. Some actions can build on existing initiatives already underway, while others will require further planning, resourcing, and collaboration across organizations.

The roadmap builds on existing partnerships and initiatives across the Ontario Health Team, municipalities, and community providers, and is intended to support ongoing alignment as priorities evolve.

Together, these actions are intended to:

- Improve access to primary and community-based care
- Strengthen continuity and coordination across the system
- Address geographic and equity-related differences in access and outcomes
- Support long-term system sustainability and population health improvement
- Reduce avoidable reliance on hospital-based care where appropriate

Advancing this work will depend on available resources, organizational priorities, and opportunities for collaboration. Next steps, including funding, roles, and timelines, will be determined through ongoing planning.

6.1 Phased Roadmap

The phased roadmap identifies priority areas for action over time. These priorities reflect the key themes identified through data analysis, service mapping, community engagement, and partner consultation.

Figure 6-1. Phased Roadmap to Advance Priority Areas

PRIORITY AREA	SHORT TERM Establish Foundations and Early Action 0-12 Months	MEDIUM TERM Expand Services and Build Capacity 1-3 Years	LONG TERM Strengthen Integration and System Sustainability 3-5+ Years
1 Increase Access to Services for Today and Tommorrow	• Advance primary care attachment strategies • Initiate primary care workforce recruitment and retention planning • Advance planning for Advanced Care Centre in Georgina	• Expand team-based primary care • Implement primary care workforce strategy • Develop phased implementation plan for Advance Care Centre in Georgina • Strengthen coordinated intake and navigation	• Expand diagnostics and urgent care • Improve attachment across the population • Stabilize workforce capacity • Strengthen system integration
2 Target Health Promotion and Education based on Resident Needs	• Deliver community-based health education and wellness sessions • Develop and share public resources for service navigation	• Expand prevention programs targeting high-burden conditions • Support delivery through community partners	• Sustain and scale prevention and health promotion programs • Integrate education into system-wide care models
3 Take Steps to improve Health Equity	• Confirm priority populations and high-needs areas • Identify geographic inequities and service gaps	• Address geographic gaps (East Georgina focus) • Review inequities in home care referral pathways	• Strengthen partnerships with Indigenous communities • Improve equity in access, utilization, and outcomes across populations
4 Optimize Mental Health Services	• Define and plan local first point of contact for mental health services	• Implement community-based mental health pathways • Improve post-discharge follow-up and continuity of care	• Expand community mental health capacity and service integration • Reduce reliance on emergency and acute care for mental health

Short-Term (0–12 Months): Establish Foundations and Early Action

In the near term, efforts focus on advancing early improvements, confirming priority populations and service gaps, and initiating foundational planning for future system changes.

Priority 1 – Increase Access to Services for Today and Tomorrow

- Advance primary care attachment strategies in priority neighbourhoods and for residents currently unattached to care
- Initiate primary care workforce recruitment and retention planning
- Advance planning for Advanced Care Centre in Georgina

Priority 2 – Target Health Promotion and Education Based on Resident Needs

- Deliver community-based health education and wellness sessions aligned to resident needs
- Develop and share public information resources for service navigation

Priority 3 – Take Steps to Improve Health Equity

- Confirm priority populations and high-needs areas using available data
- Identify geographic inequities in service access and utilization

Priority 4 – Optimize Mental Health Services

- Define and plan a local first point of contact pathway for mental health services

Medium-Term (1–3 Years): Expand Services and Build Capacity

Over the medium term, efforts focus on expanding service capacity, strengthening coordination, and improving continuity across care pathways.

Priority 1 – Increase Access to Services for Today and Tomorrow

- Expand team-based and interprofessional primary care models
- Implement primary care workforce recruitment and retention initiatives
- Develop a phased implementation plan for an Advanced Care Centre in Georgina
- Strengthen coordinated intake and navigation across services

Priority 2 – Target Health Promotion and Education Based on Resident Needs

- Expand prevention programs targeting high-burden health conditions

Priority 3 – Take Steps to Improve Health Equity

- Address geographic service gaps, including opportunities in East Georgina (Sutton, Jackson's Point, Pefferlaw, Rural Hamlets)
- Review referral pathway inequities, including home care wait-time variation where applicable

Priority 4 – Optimize Mental Health Services

- Implement community-based mental health pathways
- Improve post-discharge follow-up and continuity of care for mental health clients

Long-Term (3–5+ Years): Strengthen Integration and System Sustainability

Over the longer term, efforts focus on sustainable system improvements, expanded local access, and measurable improvements in outcomes.

Priority 1 – Increase Access to Services for Today and Tomorrow

- Expand diagnostics and urgent care access, including future local service opportunities
- Improve primary care attachment across the population
- Stabilize workforce capacity and provider distribution
- Strengthen integration across primary care, hospital, community, and municipal partners

Priority 2 – Target Health Promotion and Education Based on Resident Needs

- Sustain and scale prevention and health promotion programs
- Integrate education and prevention supports into broader care pathways

Priority 3 – Take Steps to Improve Health Equity

- Strengthen partnerships with Indigenous communities and continue collaborative allyship approaches
- Improve equity in access, utilization, and outcomes across populations

Priority 4 – Optimize Mental Health Services

- Expand community mental health capacity and service integration
- Reduce avoidable reliance on emergency and acute care for mental health needs

6.2 Moving Forward and Next Steps

Advancing these recommendations will require continued collaboration across system partners, with a shared focus on improving access, coordination, and health outcomes for residents.

Through this work, the NYSS OHT, municipalities, hospitals, primary care providers, and community organizations have strengthened relationships and identified common priorities. These partnerships provide a strong foundation to continue aligning efforts and improving coordination across the system.

As next steps, partners may consider the following approaches:

- Continue building on established partnerships and areas of shared interest
- Prioritize actions that can deliver near-term community benefit while planning for longer-term change
- Focus efforts on high-needs populations and neighbourhoods experiencing access barriers
- Strengthen coordination across primary care, hospital, home care, community services, and municipal supports
- Use local data and community insight to guide implementation and monitor progress over time
- Align future investments and service planning with identified population needs and system pressures

The priority areas, recommendations, and implementation considerations presented in this report reflect a shared understanding of Georgina's current strengths, pressures, and opportunities. Together, they provide a practical framework to guide continued collaboration and locally informed decision-making.

Implementation will vary across organizations and over time. Some actions may advance quickly through existing initiatives, while others will require further planning, new resources, or broader system coordination.

Roadmap and Next Steps

Progress will depend on sustained partnership, responsiveness to changing community needs, and ongoing use of data to inform decisions.

By building on existing strengths and aligning efforts around shared priorities, partners are well positioned to collectively advance a more connected, equitable, and responsive health and wellness system for Georgina residents.

Table 6-1. Summary of Priority Areas, Recommendations, and Measures

Priority Area	Recommendation	Insight	Lead Partner	Measure of Success
1 - Increase access to services for today and tomorrow	1.1 - Increase Primary Care Attachment in High-Needs Areas	~4,107 residents (7.6%) are unattached; attachment varies by neighbourhood and does not always ensure timely access	NYSS OHT	• ↑Attachment rate (%) • ↓unattached residents (#)
	1.2 - Advance Advanced Care Centre Planning	Residents rely on out-of-region services for diagnostics and specialty care	Southlake Health	• ↑Local service utilization • ↓out-of-region care • ↓avoidable ED visits
	1.3 - Develop a Primary Care Workforce Recruitment and Retention Strategy	Aging workforce and uneven distribution create risks to access and continuity of care	NYSS OHT with support from the Town of Georgina	• ↑providers per capita • Improved retention • ↓attachment gaps
2- Target health promotion and education based on resident needs	2.1 - Provide Community-Based Education on Priority Health Conditions	Chronic disease and modifiable risk factors contribute to avoidable system use	NYSS OHT	• ↑participation in programs • Improved self-management indicators
	2.2 - Improve Public Information and System Navigation	Residents experience challenges navigating services and accessing appropriate care pathways	NYSS OHT; Town of Georgina	• ↑awareness of services • ↓non-urgent ED use
3 - Take steps to improve health equity	3.1 - Review Home Care Referral Patterns and Address Inequities	Variation in home care access and wait times across geography	NYSS OHT	• ↓variation in wait times
	3.2 - Strengthen Indigenous Partnerships and Culturally Appropriate Care	Need for culturally appropriate care and improved access for Indigenous communities	NYSS OHT; Town of Georgina; Southlake Health	• ↑culturally appropriate service access
4 - Optimize mental health services	4.1 - Establish a Local First Point-of-Contact Pathway for Mental Health Services	Fragmented access pathways contribute to delays and reliance on ED	NYSS OHT	• ↑culturally appropriate service access • ↓ED use for mental health
	4.2 - Improve Post-Discharge Follow-Up and Continuity of Care	Low follow-up rates contribute to repeat ED visits and poor continuity	NYSS OHT	• ↑follow-up within 7 days • ↓repeat ED visits

Appendices

A. Neighbourhood Mapping
B. Inventory of Local Health and Community Services
C. Health System Data Snapshots
D. Stakeholder Engagement, Validation and Community Input
E. References

A. Neighbourhood Mapping

A1. Purpose

This appendix describes the geographic units used throughout the assessment and outlines the rationale for applying different levels of geography across datasets. A consistent geographic framework supports clear interpretation of findings and comparability across analyses.

The geographic boundaries used in this appendix were developed for planning and analytical purposes based on available data sources. They do not represent official municipal, political, or service boundaries and may not align exactly with formal jurisdictional boundaries.

A2. Neighbourhood Definitions

The Town of Georgina is divided into six planning geographies to reflect differences in population distribution, service access, and community context.

Neighbourhood	Included Areas	Key Characteristics
Keswick North	West Georgina/Northern Keswick	Higher-density residential area with strong access to primary care and hospital-connected services
Keswick Central	West Georgina/Central Keswick	Core service area with the highest concentration of local health and community services
Keswick South	West Georgina/Southern Keswick	Moderate-density residential area with access to services, though less concentrated than central Keswick
Sutton and Jackson's Point	East Georgina/Sutton, Jackson's Point	Mixed urban and lakeshore communities with moderate local access to services
Historical Waterfront	East Georgina/Lakeshore communities	Older population profile with varying levels of access to care and community services
Pefferlaw and Rural Hamlets	East Georgina/Pefferlaw and surrounding rural hamlets	Low-density area with longer travel distances and more limited local service availability
Georgina Island	East Georgina/Georgina Island	Includes Chippewas of Georgina Island First Nation lands. Data availability and reporting approaches may vary depending on source and permissions

Notes:

- Neighbourhoods are based on aggregated local planning areas and postal code groupings
- Boundaries are designed to support analysis of access and service use rather than reflect formal administrative divisions
- These geographies are used consistently across figures and tables where data availability permits

A3. Geographic Levels Used in the Analysis

Health system data are available at multiple geographic levels. This assessment applies a structured approach to ensure clarity and consistency in how these geographies are used.

1. Town-Level (Georgina Total)

Used to present overall system utilization, population-level indicators, and comparisons to regional, provincial, or national benchmarks.

Examples:

- Overall population profile
- Service volumes
- Comparisons with York Region or Ontario

2. Neighbourhood-Level (Six Local Areas)

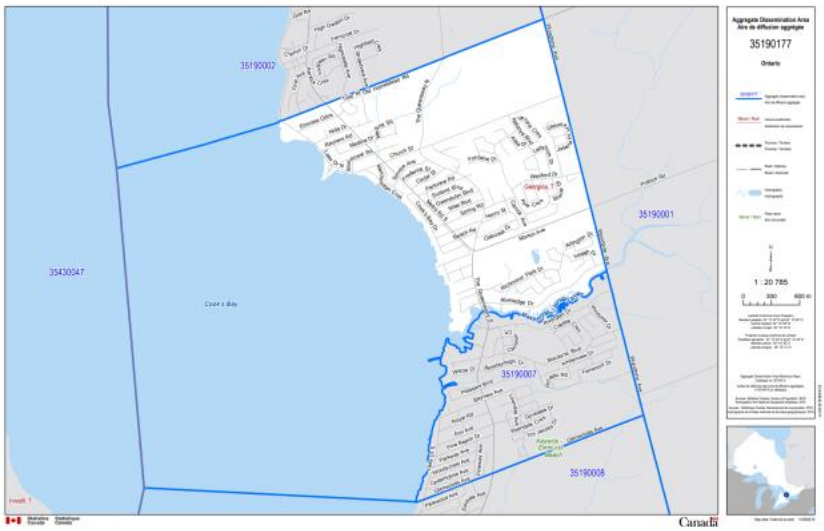
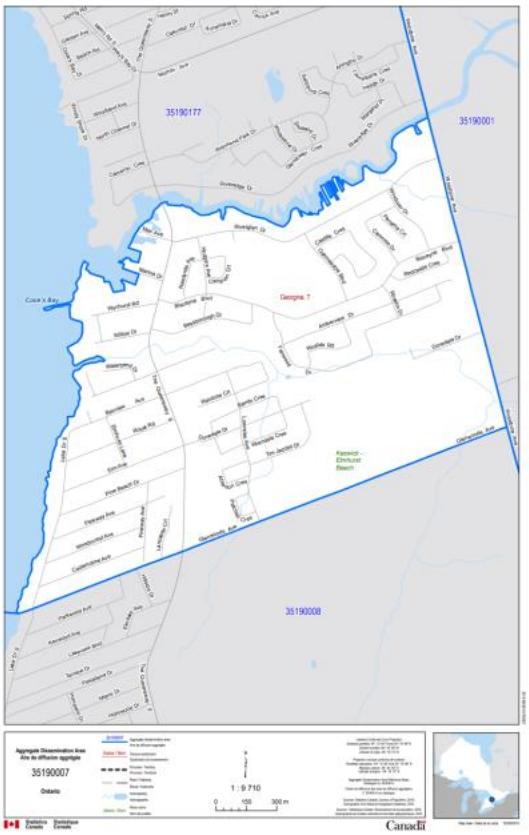
Used to examine variation within the municipality and identify geographic differences in access, utilization, and outcomes. These are based on Statistics Canada Aggregate Dissemination Areas (ADA)[30].

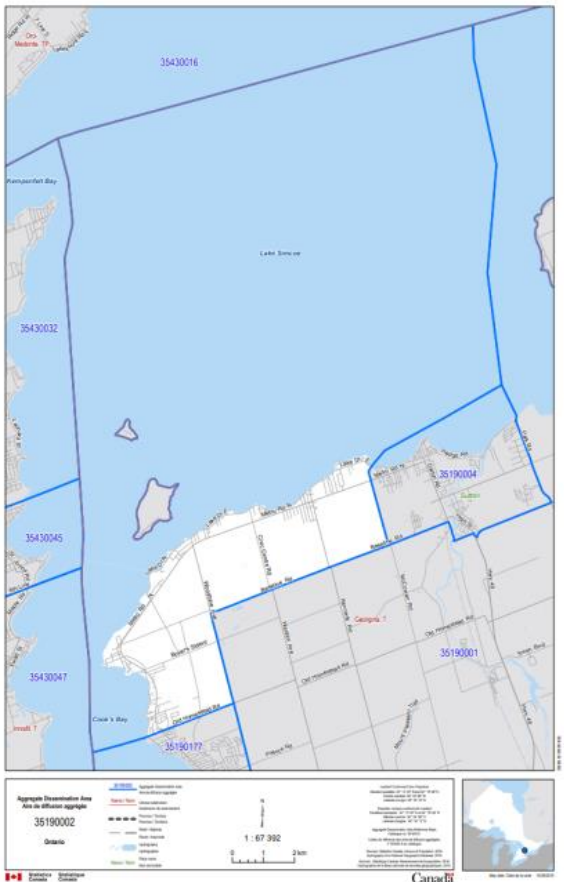
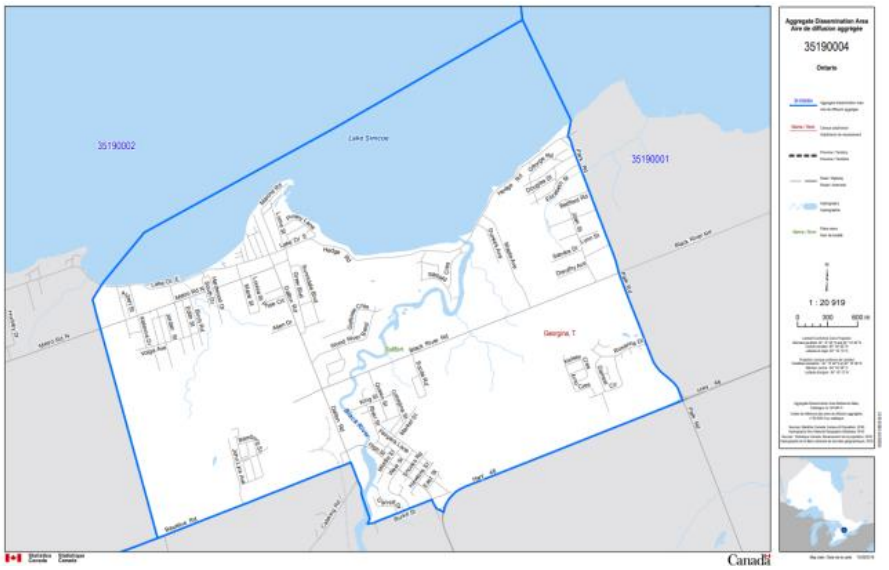
Examples:

- Emergency department visit rates by neighbourhood
- Differences in service use between Keswick and rural areas
- Variation in attachment and access indicators

Geography Boundary Images	Description
	Keswick South *ADA 35190008*

Appendices

Geography Boundary Images	Description
	Keswick North *ADA 35190177*
	Keswick Central *ADA 35190007*

Geography Boundary Images	Description
	Historical Waterfront *ADA 35190002*
	Sutton and Jackson's Point *ADA 35190004*

Geography Boundary Images	Description
	Pefferlaw and Rural Areas *ADA 35190001*
	Chippewas of Georgina Island *ADA 35190003*

Source: Statistics Canada. (2016). *Aggregate dissemination area (ADA) reference maps* (Catalogue no. 92-640-X). Retrieved January 15, 2026.

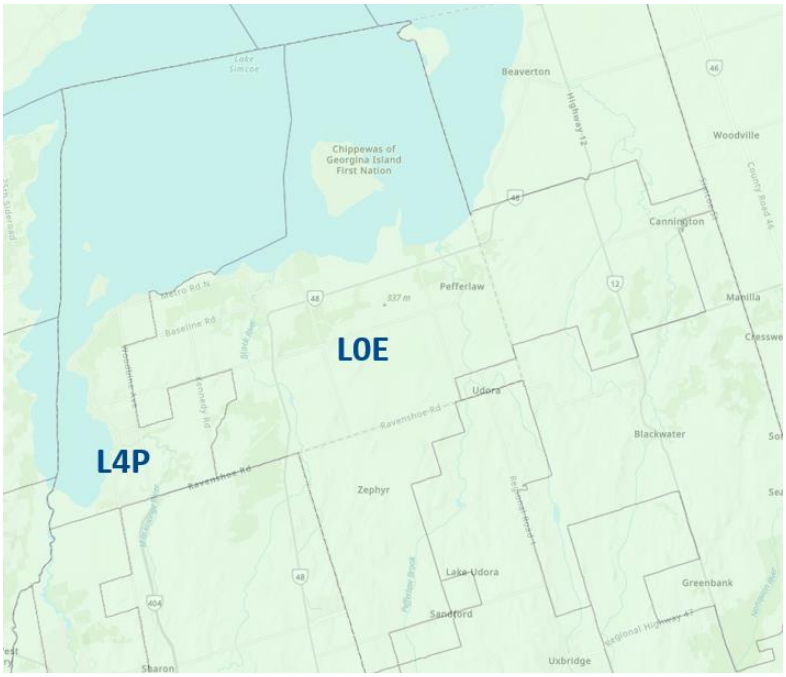
3. Sub-Municipal Geography (e.g., Keswick vs. East Georgina)

Used where data are not available at the neighbourhood level and are instead reported using broader postal-code groupings or Forward Sortation Areas (FSAs)[31].

These proxy geographies help preserve local relevance where direct neighbourhood-level reporting is not available.

Examples:

- Home care referral patterns and wait times
- Mental health and addictions follow-up indicators
- Service access patterns by broader local geography

Geography Boundary Images	Description
	**L4P:** Includes the eastern part of Georgina, primarily Keswick and the upper historical waterfront area. **L0E:** Includes Sutton, Jackson's Point and Pefferlaw, in additional to rural hamlets located within Georgina. Note that some of the borders for this FSA extend beyond the municipal borders.

Source: Statistics Canada. (2023). *Forward sortation area (FSA) boundary files and reference maps.* Retrieved January 15, 2026.

4. Regional / System-Level Geography (e.g., Hospital Catchment or OHT)

Used to describe broader system patterns, particularly for hospital-based care and regional service utilization.

Examples:

- Inpatient discharges
- Emergency department visits by facility
- Hospital utilization trends
- Reliance on regional providers

These data provide context on broader system pressures but are not used to assess within-municipality variation.

A4. Application of Geographic Framework

Across the report, geographic levels are applied using a consistent hierarchy:

- Town-level data are used to establish overall scale and system context
- Neighbourhood-level data are used to identify variation and differences within the municipality
- Sub-municipal proxy geographies are used where required by data availability
- Regional data are used to provide system context, particularly for hospital-based services.

This approach ensures that findings are both locally relevant and grounded in the broader health system context.

A5. Limitations

Interpretation of neighbourhood-level findings should consider several limitations:

- Not all datasets are available at the neighbourhood level; proxy geographies were required in some cases
- Geographic aggregation may mask variation within neighbourhoods, particularly in rural areas.
- Reporting boundaries differ across municipal, census, postal, and health system datasets, which may affect comparability
- Indigenous-specific data are subject to data governance, availability, privacy, and community-sharing considerations. Publicly reported information may therefore be limited or presented differently depending on source permissions

B. Inventory of Local Health and Community Services

B1. Purpose

This appendix provides a structured overview of health and community services available to residents of the Town of Georgina. Information is presented at an aggregated level to describe service categories, local availability, geographic distribution, and common delivery models.

The appendix includes both services physically located within Georgina and regional services commonly accessed by residents where local availability is limited.

Service inventories reflect publicly available information and targeted environmental scanning completed during the assessment period. Listings should be interpreted as indicative rather than exhaustive.

B2. Service Categories and Distribution

B2.1 Overview of Services by Category

The Town of Georgina has a foundational range of locally available health and community services, including primary care, pharmacy, laboratory services, home and community care, mental health supports, and long-term care.

Some diagnostic, specialist, and hospital-based services are available locally; however, many higher-acuity, specialized, or referral-based services are accessed through providers outside the municipality.

Service Category	Availability in Georgina	Primary Locations	Delivery Model
Primary Care	Available	Primarily Keswick	Rostered, walk-in, team-based
Walk-in Clinics	Available	Primarily Keswick with some services in Sutton	Walk-in (FFS-based)
Diagnostics (X-ray, Ultrasound)	Limited local	Keswick	Hospital + community clinic
Laboratory Services	Available	Keswick	Community lab
Specialist Care	Mostly regional	Outside Georgina	Referral-based
Mental Health & Addictions	Specialist Care	Mixed (community + hospital)	Community + hospital
Allied Health	Available	Distributed across municipality	Independent providers that includes physiotherapy, occupational therapy, dental services, pharmacy, chiropractic, and other non-physician health services
Home and Community Care	Available	Across municipality	Regionally coordinated
Long-Term Care	Available	River Glen Haven (Sutton) and Cedarvale Lodge (Keswick)	Facility-based

Source: York Region. (2024). *Business Survey Data – Town of Georgina.* Survey results were confirmed by a public practice presence as of January 2026.

Notes:

- Availability reflects general local service presence and may vary by provider capacity, referral requirements, hours of operation, and wait times
- "Mostly regional" refers to services commonly accessed outside Georgina
- Counts and inventories reflect information available at the time of review period

B3. Primary Care Services

B3.1 Primary Care Supply

Primary care services in Georgina are delivered through a mix of family physicians, nurse practitioners, enrolled patient practices, walk-in clinics, and team-based care models. Service capacity is concentrated in larger settlement areas, particularly Keswick.

Metric	Approx. # of Providers
Family Physicians	31
Nurse Practitioners	9
Primary Care Clinics	11
Delivery Models	Enrolled primary care, team-based care, walk-in clinics, nurse practitioner-led clinics
Walk-in Clinics	Physician-led and Nurse Practitioner-led

Source: York Region. (2024). *eReport Portal OHT – Primary Care Action Table (PCAT) Data Package.* (as of March 31, 2025).

Notes:

- Counts are approximate and reflect identifiable active providers with a public practice presence as of the review period
- Physician counts were validated using publicly available CPSO practice listings
- Nurse practitioner inventories may not be fully captured through physician-focused administrative sources
- Clinic counts and models may change over time

B3.2 Primary Care Delivery and Access Models

Primary care in Georgina is delivered through several service models that influence continuity of care and access pathways. These include enrolled or rostered care, team-based care, walk-in clinics, and mixed-access models.

Model Type	Description	Practice Groups
Enrolled / Rostered Care	Patients are formally attached to a provider (physician or nurse practitioner) responsible for ongoing primary care	Georgina Nurse Practitioner-Led Clinic; Children's Care Clinic; NYSS OHT Primary Care Clinic; Georgina Family Health; Georgina Family Medical Centre; Georgina Grace Medical Centre
Team-Based Care	Interdisciplinary care teams that may include physicians, nurse practitioners, nurses, and allied health professionals	Georgina Nurse Practitioner-Led Clinic; Children's Care Clinic; NYSS OHT Primary Care Clinic; Georgina Family Health
Walk-in Clinics	Episodic care provided without formal patient attachment, typically for urgent but non-emergency needs	Keswick Medical and Wellness Clinic; WELL Health; Georgina Family Medical Centre; Georgina Grace Medical Centre; Orange Health Medical Centre; Woodbine Medical Centre
Mixed Access Clinics	Clinics offering both ongoing primary care and walk-in/episodic services	Georgina Family Medical Centre; Georgina Grace Medical Centre; Woodbine Medical Centre; Orange Health Medical Centre

Source: Ontario Health. (2025). *eReport Portal OHT – Primary Care Action Table (PCAT) Data Package* (as of March 31, 2025).

Notes:

- Some clinics operate multiple access pathways
- Internal compensation or enrollment arrangements may vary and are not always publicly identifiable
- Listings reflect publicly observable service models

B3.3 Geographic Distribution

Primary care services are distributed across the municipality, with the highest concentration in Keswick. Sutton and surrounding communities have a smaller number of providers. Pefferlaw and rural communities have more limited local availability.

Area	Distribution Pattern	Identified Clinic Locations
Keswick	Highest concentration of primary care clinics, including rostered, walk-in, and mixed-access models	Georgina Family Health; NYSS OHT Primary Care Clinic; Children's Care Clinic; Keswick Medical and Wellness Clinic; WELL Health; Georgina Family Medical Centre; Woodbine Medical Centre; Intrepid Medical Centre & Walk-In Clinic
Sutton / Jackson's Point	Smaller cluster of clinics and nurse practitioner-led care	Georgina Nurse Practitioner-Led Clinic; Orange Health Medical Centre; Georgina Grace Medical Centre
Pefferlaw	Limited local primary care availability	The Family Health Center of Pefferlaw
Rural Hamlets / Surrounding Areas	Limited fixed-site local availability; residents commonly access nearby settlement areas	No identified dedicated primary care clinic locations
Georgina Island	Community-based health services may be available through the Georgina Island Health Centre and visiting provider arrangements, subject to local availability	Georgina Island Health Centre; mainland and regional referral locations commonly used by residents

Source: Ontario Health. (2025). *eReport Portal OHT – Primary Care Action Table (PCAT) Data Package* (as of March 31, 2025) supplemented by desktop research and confirmation of public practice location.

Notes:

- Table reflects identifiable fixed-site clinic locations included in the inventory
- Some providers may offer both enrolled and episodic access models
- Virtual care, outreach services, or visiting programs may supplement fixed-site availability
- For Georgina Island, service access may be affected by ferry schedules, seasonal conditions, and transportation logistics

B4. Community-Based Services

B4.1 Mental Health, Addictions and Wellness Supports

Mental health and addictions services are available through multiple service settings, including primary care, community agencies, hospital-based services, outreach models, and regional providers. Services may include counselling, crisis response, treatment, care coordination, and follow-up supports.

Service Type	Approx. # of Providers	Primary Locations	Provider(s)
Child and Youth Mental Health Services	1	Keswick	Kinark Child & Family Services (Keswick)
Counselling / Psychotherapy	3	Keswick, Sutton	York Region Psychotherapy and Counselling Services (Keswick); Family Services York Region (Sutton); Evolove Healing (Keswick)
Community Mental Health Treatment	1	Keswick	Southlake Health – Assertive Community Treatment Team (Keswick)
Crisis / Emergency Mental Health	Regional	Regional / Hospital-Based	Regional hospital emergency departments and crisis response services
Addictions Treatment Services	2	Keswick	Ontario Addiction Treatment Centre (Keswick); Addiction Services for York Region (Keswick)
Follow-up Care / Community Supports	Variable	Community / Regional	Community agencies, primary care providers, hospital discharge supports, and regional programs
Mental Health and Wellness Supports*	Included above	Keswick, Sutton	Selected private and community-based counselling and wellness providers

Source: York Region. (2024). *Business Survey Data – Town of Georgina.* Survey results were confirmed by a public practice presence as of January 2026.

Notes:

- A comprehensive centralized inventory of all mental health and addictions providers serving Georgina is not publicly available
- Counts reflect identified local physical sites or publicly visible programs only and should not be interpreted as a complete system count
- Additional community, virtual, outreach, mobile, or regional providers may also serve Georgina residents
- Some providers may serve Georgina without maintaining a permanent office within the municipality.
- Services are delivered through multiple settings, including primary care, community agencies, private practice, hospital-affiliated community programs, and regional systems
- Some providers support both mental health and broader wellness needs; services are categorized by primary publicly identified focus

- Crisis psychiatry, inpatient mental health, and specialized hospital-based services are primarily accessed through regional providers outside Georgina
- Availability, referral requirements, eligibility criteria, and wait times may vary by provider
- *Included within counselling / psychotherapy or broader support categories where applicable

B4.2 Allied Health Services

Allied health services are available locally through private and community-based providers. Services include physiotherapy, chiropractic care, hearing care, vision care, foot care, and related wellness support.

Service Type	Approx. # of Providers	Primary Locations	Provider(s)
Physiotherapy	6	Keswick, Sutton	Glenwoods Rehab and Physiotherapy (Keswick); Georgina Physiotherapy & Sports Injury Clinic (Keswick); Sutton Physiotherapy & Rehabilitation Clinic (Sutton); Dynamic Health Therapy Inc. (Keswick); Keswick Physiotherapy & Sports Injuries Clinic (Keswick); Keswick Active Health Group (Keswick)
Chiropractic	7	Keswick, Sutton, Pefferlaw	Georgina Chiropractic (Keswick); Clark Chiropractic (Keswick); Sutton West Chiropractic (Sutton); Queensway North Chiropractic (Keswick); Pefferlaw Chiropractic (Pefferlaw); Pike Chiropractic (Keswick); Chiropractic Health Centre (Sutton)
Hearing Care	3	Keswick	Amplifon Hearing Experts (Keswick); Hearing Life (Keswick); Keswick Hearing Centre (Keswick)
Vision Care	4	Keswick, Sutton	The Spectacle Shoppe (Sutton); iFashion Optical (Keswick); Keswick Family Eyecare (Keswick); Eyes On Georgina (Keswick)
Foot Care / Orthotics	1	Keswick	Georgina Foot & Orthotic Centre (Keswick)

Source: York Region. (2024). *Business Survey Data – Town of Georgina.* Survey results supplemented by public provider listings and environmental scan (reviewed January 2026).

Notes:

- Counts are approximate
- Some providers may offer multiple disciplines from one location
- Categories reflect the primary publicly marketed service of each provider

B4.3 Pharmacy Services

Retail and community pharmacy services are available across Georgina, with locations concentrated in Keswick and additional access in Sutton, Jackson's Point, and Pefferlaw.

Service Type	Approx. # of Providers	Primary Locations	Provider(s)
Pharmacy Services	14	Keswick, Sutton, Jackson's Point, Pefferlaw	Ben's Pharmacy (Keswick); Shoppers Drug Mart (Keswick); Healthcare Rx Pharmacy (Keswick); Glenwoods IDA Pharmacy (Keswick); Georgina Medical Pharmacy (Keswick); Rexall (Keswick); Procare Pharmacy (Keswick); Keswick Medical Pharmacy & Clinic (Keswick); Orange Health Pharmacy / Sutton Apothecary (Sutton); Shoppers Drug Mart (Sutton); Ben's Pharmacy (Sutton); Better Care Pharmacy Sutton (Sutton); Eustace Jackson's Point Pharmasave (Jackson's Point); Ben's Pharmacy (Pefferlaw)

Source: York Region. (2024). *Business Survey Data – Town of Georgina.* Survey results supplemented by public provider listings and environmental scan (reviewed January 2026).

B4.4 Dental Services

Dental services are available through multiple private clinics across Georgina, with the largest concentration in Keswick and additional services in Sutton and Pefferlaw.

Service Type	Approx. # of Providers	Primary Locations	Provider(s)
General / Family Dentistry	11	Keswick, Sutton / Jackson's Point, Pefferlaw	Cook's Bay Dental (Keswick); Pefferlaw Dental Centre (Pefferlaw); Glenwoods Dental Office (Keswick); Jacksons Point Dentistry (Jackson's Point); Keswick Dental Centre (Keswick); Riveredge Dental – Keswick (Keswick); Yorkwood Village Dental (Keswick); Cedarwood Dental (Keswick); The Manor Dental Centre (Sutton); Sutton West Dental (Sutton); Dawson Dental Centre – Keswick (Keswick)
Orthodontics	3	Keswick	Orthowear Inc. (Keswick); Docbraces – Keswick (Keswick); Keswick Braces (Keswick)
Denture Services	2	Sutton, Keswick	Denture Clinic & Lab (Sutton); Queensway Denture Clinic (Keswick)
Pediatric / Family-Focused	4	Keswick, Sutton	Keswick Kids and Family Dental (Keswick)

Source: York Region. (2024). *Business Survey Data – Town of Georgina.* Survey results supplemented by public provider listings and environmental scan (reviewed January 2026).

Notes:

- Count reflects distinct physical dental service locations identified in Georgina
- Categories reflect the primary publicly marketed service of each provider
- Some clinics may offer multiple services beyond the category listed above

B4.5 Community / Social Supports

Community and social support services play an important role in resident well-being by addressing practical, social, developmental, housing, food security, and supportive care needs. In Georgina, these services are delivered through municipal, not-for-profit, and community-based organizations. Locally identified supports include community hubs, food security programs, youth services, developmental supports, family counselling, adult day programming, hospice and palliative supports, and selected supportive housing or assisted living settings.

Service Type	Approx. # of Providers	Primary Locations	Provider(s)
Community Hub / Multi-Service Access	1	Sutton	The Link (Sutton)
Food Security Supports	1	Sutton	Georgina Community Food Pantry (Sutton)
Youth Shelter / Youth Supports	1	Sutton	The Sutton Youth Shelter (Sutton)
Developmental Supports	1	Sutton	Community Living Georgina (Sutton)
Family Counselling / Social Supports	1	Sutton	Family Services York Region (Sutton)
Adult Day Program	1	Keswick	Adult Day Care Keswick (Keswick)
Hospice / Palliative Support	1	Sutton	Hospice Georgina (Sutton)
Supportive Housing / Residential Care / Assisted Living	6	Keswick, Sutton and Jackson's Point	Halsey Lodge (Jackson's Point); Fairpark Manor (Sutton); Hilltop Manor Retirement Residence (Keswick); Pipe and Slipper Home (Keswick); Sunnybrook Residential Care Home (Jackson's Point); Victoria House (Keswick)

Source: York Region. (2024). *Business Survey Data – Town of Georgina.* Survey results supplemented by public provider listings and environmental scan (reviewed January 2026).

Notes:

- Several organizations are co-located at The Link, a multi-service community hub in Sutton
- Provider counts reflect organizations/sites, not unique buildings

B5. Diagnostic and Specialty Services

Basic diagnostic services are available locally, including laboratory testing, X-ray, ultrasound, and selected cardiology diagnostics. Many specialist consultations and advanced diagnostics are accessed through regional providers outside Georgina.

Service Type	Approx. # of Providers	Primary Locations	Provider(s)
X-ray	2	Keswick	Southlake X-Ray and Ultrasound (Keswick); Keswick Advanced Imaging (Keswick)
Ultrasound	2	Keswick	Southlake X-Ray and Ultrasound (Keswick); Keswick Advanced Imaging (Keswick)
Laboratory Services	1	Keswick	Dynacare Healthcare Solutions (Keswick)
Cardiology Diagnostics	1	Keswick	AV Diagnostics – Georgina Cardiology (Keswick)
Advanced Diagnostic Imaging	1	Keswick	Keswick Advanced Imaging (Keswick)
Specialist Care	Mostly regional	Outside Georgina	Regional hospital and specialist providers Outside Georgina)

Source: York Region. (2024). *Business Survey Data – Town of Georgina*. Survey results supplemented by public provider listings and environmental scan (reviewed January 2026).

Notes:

- Local availability may require referral
- Local availability may require referral or requisition
- Diagnostic service scope may vary by provider site
- Regional specialist access varies by specialty, referral pathway, and wait time

B6. Hospital Services (Utilization by Georgina Residents)

Georgina residents rely significantly on regional hospital providers for inpatient (IP) and emergency department (ED) services. Southlake Health is the primary hospital provider for many residents, reflecting established referral patterns and geographic proximity.

B6.1 Inpatient Hospital Use

Hospital	Hospital Type	IP Discharges (% and #) 2024/25
Southlake Health	Community/Regional Hospitals	72% (3,522)
Oak Valley Health	Community/Regional Hospitals	8% (377)
Mackenzie Health	Community/Regional Hospitals	4% (185)
Sunnybrook Health Sciences Centre	Academic/Teaching Hospital	3% (161)
Hospital for Sick Children	Speciality Pediatric Hospital	3% (127)
Other	Mixed	~11%

Source: IntelliHealth Ontario. (2025). *Discharge Abstract Database* (DAD) (FY2018/19-FY2024/25).

Metric	Value 2024/25
Total IP Discharges	4,907
ED Visit Rate	95 per 1,000 residents

Source: IntelliHealth Ontario. (2025). *Discharge Abstract Database* (DAD) (FY2018/19-FY2024/25).

Notes:

- Multi-year trends (FY2018/19 to FY2024/25) were reviewed
- Percentages may not sum exactly due to rounding
- Rates are based on estimated population

B6.2 Emergency Department (ED) Use

Emergency department services are accessed primarily through Southlake Health, with additional use of nearby regional hospitals.

Provider	ED Visits (% and #) 2024/25
Southlake Health	76% (16,399)
Oak Valley Health	12% (2,677)
Mackenzie Health	3% (592)
Other	~9%

Source: IntelliHealth Ontario. (2025). *National Ambulatory Care Reporting System (NACRS): Emergency Department Visits* (FY2018/19-FY2024/25).

Metric	Value 2024/25
Total ED Visits	21,609
ED Visit Rate	417 per 1,000 residents

Source: IntelliHealth Ontario. (2025). *National Ambulatory Care Reporting System (NACRS): Emergency Department Visits* (FY2018/19-FY2024/25).

Notes:

- Multi-year trends (FY2018/19 to FY2024/25) were reviewed
- Percentages may not sum exactly due to rounding
- Rates are based on estimated population

B7. Home and Community Care

Home and community care services support residents in maintaining independence, recovering after hospitalization, and receiving care outside institutional settings.

Services may include nursing, personal support, rehabilitation, homemaking, and care coordination delivered through hospital and community referral pathways.

Service	Delivery Model
Home Care	Coordinated by Ontario Health atHome/ regional care coordinators
Referral Pathways	Hospital and community-based

Source: Ontario Health. (2024). *eReport Portal OHT - Community-Based Care (Home Care)* (FY2018/19-FY2023/24).

Notes:

- Access pathways may differ between hospital discharge and community referral streams
- Service levels vary based on assessed need

B8. Long-Term Care Capacity

Long-term care services provide residential care for individuals requiring ongoing nursing and personal support.

Current local capacity includes two licensed long-term care homes located in Keswick and Sutton.

Facility	Primary Location(s)	Beds	Waitlist
River Glen Haven	Sutton	119	101
Cedarvale Lodge	Keswick	60	344

Source: Government of Ontario. (2026). *Long-Term Care in Ontario Database* (January 31, 2026).

Notes:

- Waitlists fluctuate over time
- Waitlist totals do not necessarily represent unique individuals

B9. Definitions

Allied Health: Non-physician health services such as physiotherapy, chiropractic, hearing care, vision care, foot care, counselling, and related wellness supports.

Assertive Community Treatment (ACT): A multidisciplinary, community-based service providing intensive outreach support for individuals with complex mental health needs.

Emergency Department (ED): Hospital-based urgent and emergency care services for acute conditions.

Fee-for-Service (FFS): A payment model where providers are reimbursed per visit or service delivered.

Home and Community Care: Health and personal support services delivered in the home or community setting, coordinated through Ontario Health atHome.

Inpatient Care: Hospital care requiring admission and overnight stay.

Primary Care (Rostered): Patients formally enrolled with a provider responsible for ongoing care.

Regional Services: Services commonly accessed outside the municipality through referral pathways.

Team-Based Care: Care delivered by interdisciplinary teams such as physicians, nurse practitioners, nurses, and allied health providers.

Walk-in Care: Episodic care provided without prior patient enrolment.

C. Health System Data Snapshots

C1. Purpose

This appendix compiles the most current publicly available and partner-supplied quantitative indicators relevant to Georgina residents. Measures are drawn from multiple administrative and survey sources and may use differing methodologies, geographies, and reporting periods. Tables are intended to support planning discussions rather than provide audited counts.

C2. Data Notes and Geography

This appendix provides supplementary quantitative tables referenced throughout the report. Data are presented to summarize population trends, social determinants of health, health conditions, service utilization, and selected health system indicators relevant to residents of Georgina.

Unless otherwise noted, data reflect the most recent year publicly available at the time of report preparation (2024/25). Sources vary by table and are listed directly below each table.

For comparative reporting purposes, Georgina is grouped into the following planning geographies as described in Appendix A:

- **West Georgina:** Keswick
- **East Georgina:** Sutton, Jackson's Point, Pefferlaw, and surrounding rural communities

Neighbourhood-level analysis is presented using available Aggregate Dissemination Areas (ADA) or equivalent reporting geographies where available.

Level	Definition	Included Areas
Town	Town of Georgina	All communities
Sub-Regional	West Georgina East Georgina	West Georgina: Keswick East Georgina: Sutton, Jackson's Point, Pefferlaw,and Rural Areas
Neighbourhood (ADA)	Administrative small-area reporting geographies	Keswick North, Keswick Central, Keswick South, Sutton and Jackson's Point, Historic Waterfront, Pefferlaw and Rural Hamlets, Georgina Island*

* Georgina Island is an identified reporting geography within some administrative datasets; however, separate data are not consistently available and may be suppressed, aggregated, or excluded depending on source and reporting rules. Indigenous community information is included primarily in the main body of the report using data provided with permission from the Chippewas of Georgina Island.

Data Notes:

- Rates are presented per 1,000 residents, per 100 residents, or as percentages, as noted in each table
- Some values may be rounded
- Small-area data may be aggregated to improve reliability and privacy protection
- Administrative geographies used by source organizations may differ from municipal boundaries
- East / West Georgina groupings are planning geographies created for this report and may not reflect official service catchments

C3. Population and Demographics

Georgina has experienced sustained population growth over the past two decades and is projected to continue growing over the medium term. Growth has occurred across established settlement areas.

C3.1 Population Growth and Projection

Year	Population
2001	39,263
2006	42,346
2011	43,517
2016	45,418
2021	47,642
2025 (estimated)	51,821
2026 (estimated)	54,000
2051 (projected)	~70,500

Source: Statistics Canada, *Census Profiles* (2001-2021); Ontario Health. (2024). *eReport Portal OHT – Population Overview,* York Region Official Plan (2024).

Notes:

- Census years reflect official enumeration counts
- 2025 value is an estimate used for current planning purposes
- 2051 value reflects longer-range population projection assumptions

C3.2 Age Distribution

The population includes a broad mix of age groups, with a comparatively large share of mid-life and older adult residents.

Age Group	% of Population
0-14	16%
15-24	10%
25-44	26%
45-64	30%
65+	17%

Source: Statistics Canada, *Census Profiles* (2021).

C3.3 Median Age

Indicator	Value
Median Age	42.8 years

Source: Statistics Canada, *Census Profiles* (2021).

C3.4 Population by Neighbourhood

Neighbourhood-level population estimates help illustrate where population growth and service demand may be concentrated across Georgina. Estimates reflect the most recent available Ontario Health neighbourhood population data and are aligned to the reporting geographies described in Appendix A.

Neighbourhood	Census 2021	Ontario Health Estimate (2025)
Keswick South	8,349	9,415
Keswick Central	6,896	7,254
Keswick North	10,155	10,843
Sutton and Jackson's Point	7,728	8,390
Pefferlaw and Rural Hamlets	8,600	9,480
Historical Waterfront	5,912	6,439
Chippewas of Georgina Island	231	269
Town of Georgina	**47,642**	**51,821**

Source: Ontario Health. (2024). *eReport Portal OHT – Population Overview.*

Notes:

- 2025 values reflect the most recent Ontario Health neighbourhood population estimates available at the time of report preparation
- Totals may differ slightly from York Region published municipal projections due to differing methodologies, update cycles, and geography definitions
- Estimates are used throughout this appendix where neighbourhood-level current population denominators are required for population rate calculations

C4. Social Determinants of Health

C4.1 Income

Indicator	Value
Median household income	$98,000

Source: Statistics Canada, *Census Profiles (2021).*

C4.2 Housing

Housing affordability pressures affect a portion of local households.

Indicator	Value
Households spending >30% income on housing	23.5% (4,185 households)
Subsidized housing units	2%

Source: Statistics Canada, *Census Profiles* (2021); Town of Georgina, *Georgina Housing Needs Assessment* (2025).

C4.3 Education

Indicator	Value
Adults aged 25 to 64 who do not hold a post-secondary credential	42.8%

Source: Statistics Canada, *Census Profiles* (2021).

C4.4 Labour and Transportation

Labour and transportation patterns indicate strong reliance on private vehicles and commuting beyond the municipality for work.

Indicator	Value
Labour force participation rate	65.7% (25,850 residents in labour force)
Employment rate	58.4% (22,970 employed residents)
Commuters using a private vehicle	93.8% (16,735 residents)
Estimated average commute time	33 minutes

Source: Statistics Canada, *Census Profiles* (2021).

C4.5 Food Insecurity

Indicator	Value
Households experiencing food insecurity (York Region) in 2024	22.1%

Source: York Region, *Understanding the Health of People in York Region: A Population Health Assessment Dashboard* (2025).

C5. Ontario Marginalization Index

The Ontario Marginalization Index (ON-Marg) is a census-based composite measure that summarizes dimensions of marginalization across communities in Ontario. Scores are used to compare relative social and economic conditions across geographies.

C5.1 Ontario Marginalization Index

Dimension	Description	Score/Quintile
Age & Labour	Concentration of seniors, children, and residents outside the labour force	1
Household Stability	Residential instability, living alone, rental mobility, family structure	2
Material Resources	Income, education, employment, and housing adequacy	3
Racialized & Newcomer	Concentration of recent immigrants and racialized populations	5

Source: Public Health Ontario. (2023). *Ontario Marginalization Index (ON-Marg), 2021 Census-based data.*

Notes:

- Quintiles range from 1 (least marginalized) to 5 (most marginalized) relative to Ontario communities
- Results should be interpreted comparatively rather than as absolute measures
- Different ON-Marg releases may use updated census inputs and geographies

C6. Health Conditions

This section summarizes selected health condition categories identified through Ontario Health administrative data using the CIHI Population Group methodology. Indicators are derived from diagnoses and service records across multiple care settings, including hospital care, emergency departments, clinics, physician billings, home care, long-term care, and mental health services.

Residents may be associated with more than one condition category; therefore counts are not mutually exclusive and should not be summed.

C6.1 Common Acute Conditions

Condition	Count	Rate per 100 Residents
Joint/Tendon Injury	10,849	23.2
Acute Upper Respiratory Infection	9,820	21.0
Gastrointestinal Symptoms	6,825	14.6
Acute Infectious Respiratory Disease	6,600	14.1
Other Viral Infection	5,161	11.0

Period: April 1, 2021 to March 31, 2024

Source: Ontario Health, eReport Portal OHT - *Health Conditions by CIHI Grouper*

Notes:

- Acute condition categories are based on CIHI grouper health condition codes
- Individuals may appear in multiple condition categories
- Rates are presented per 100 residents

C6.2 Common Chronic Conditions

Condition	Count	Rate per 100 Residents
Mental Health	4,510	9.6
Hypertension	3,958	8.5
Diabetes	3,912	8.4
Osteoarthritis	1,697	3.6
COPD	704	1.5

Period: April 1, 2021 to March 31, 2024

Source: Ontario Health, eReport Portal OHT - *Health Conditions by CIHI Grouper*

Notes:

- Chronic condition categories are based on CIHI grouper health condition codes
- Individuals may appear in multiple categories
- Rates are presented per 100 residents

C7. Primary Care

Primary care services in Georgina are delivered through a mix of family physicians, nurse practitioners, enrolled or rostered practices, walk-in clinics, and team-based care models. As outlined in Appendix B, clinic locations are concentrated primarily in Keswick, with additional supply in Sutton, Jackson's Point, Pefferlaw, and Georgina Island.

C7.1 Primary Care Supply

Indicator	Value
Family Physicians	31
Nurse Practitioners	9
Identified Practice/Clinic Organization	11
Walk-in Clinics	3

Source: Ontario Health. (2025). *eReport Portal OHT – Primary Care Action Table (PCAT) Data Package* (as of March 31, 2025).

C7.3 Primary Care by Geography

Area	Number of Sites	Notes
Estimated attached residents	8	Highest concentration of family practice, walk-in, and mixed-access clinics
Unattached residents	3	Smaller cluster including NP-led and physician clinics
Unattachment rate	1	Limited local fixed-site access
Georgina Island	1	Community-based access through Georgina Island Health Centre; visiting providers may supplement services
Rural Hamlets / Surrounding Areas		Residents typically access nearby settlement areas

Source: Ontario Health. (2025). *eReport Portal OHT – Primary Care Action Table* (PCAT) *Data Package* (as of March 31, 2025); Chippewas of Georgina Island First Nation. (2026). *Community experience shared with permission for report use.*

C7.2 Attachment and Unattachment

Indicator	Value
Estimated attached residents	47,700
Unattached residents	4,107
Unattached residents	7.6%

Source: Ontario Health. (2025). *eReport Portal OHT – Primary Care Action Table (PCAT) Data Package* (as of March 31, 2025).

C7.2 Unattachment by Neighbourhood

Neighbourhood (ADA)	Unattached Rate (%)	Unattached Residents (#)
Keswick South	8.1%	813
Keswick Central	7.2%	551
Keswick North	7.2%	979
Historical Waterfront	7.3%	351
Sutton and Jackson's Point	7.8%	912
Pefferlaw and Rural Hamlets	7.8%	497
Town of Georgina	**7.6%**	**4,107**

Source: Ontario Health. (2025). *eReport Portal OHT – Primary Care Action Table (PCAT) Data Package* (as of March 31, 2025).

Notes:

- "Unattached" refers to residents not formally enrolled or rostered to a primary care provider within the source methodology
- Unattachment rates are calculated relative to the estimated 2025 population for each respective ADA / neighbourhood geography
- Rates may not sum exactly due to rounding and source suppression practices
- Neighbourhoods are based on report planning geographies aligned to available ADA reporting areas

C8. Home and Community Care

Home and community care supports help residents remain safely at home and may include nursing, rehabilitation, personal support, homemaking, and care coordination services. Utilization patterns indicate meaningful demand across Georgina, with higher per-capita use observed in East Georgina.

C8.1 Utilization

Indicator	West Georgina	East Georgina
Clients per 100,000	2,042	2,509
Total clients	656	569
Hospital referrals Q4	383	311
Community referrals Q4	146	137

Period: FY2023/24 (Q4 where noted)

Source: Ontario Health, *eReport Portal OHT – Community-Based Care – Home Care* (FY2018/19–FY2023/24).

C8.2 Wait Times

Referral Type	West Georgina	East Georgina
Hospital Referral	7 days	10 days
Community Referral	14 days	46 days

Period: FY2023/24 (Q4 where noted)

Source: Ontario Health, *eReport Portal OHT – Community-Based Care – Home Care* (FY2018/19–FY2023/24).

Notes:

- Client rates are standardized per 100,000 residents to allow comparison across populations of different sizes
- Wait times represent approximate days from referral to first service visit
- East Georgina shows higher utilization rates despite a smaller population base
- Community referral wait times are substantially longer in East Georgina than West Georgina
- Geographic dispersion, travel time, and workforce availability may contribute to longer waits in rural and outlying communities

C9. Long-Term Care

Long-term care provides residential nursing and personal support for individuals who require ongoing support and can no longer be safely cared for at home. Georgina residents access both locally based homes and the broader regional placement system.

C9.1 Resident Need by Geography

Indicator	West Georgina	East Georgina
LTC Residents (FY2023/24 year-end)	49	105
LTC Residents per 100,000	152.5	476.2
Waitlist (FY2023/24 year-end)	90	73
Waitlist per 100,000	280.2	321.9

Source: Ontario Health, *eReport Portal OHT – Community-Based Care – Long-Term Care* (FY2023/24).

C9.2 Local Licensed Long-Term Care Homes

Facility	Location	Beds	Waitlist
River Glen Haven	Sutton	119	101
Cedervale Lodge	Keswick	60	344

Source: Government of Ontario, Long-Term Care in Ontario Database (as of January 31, 2026).

Notes:

- East Georgina has substantially more current LTC residents and a higher resident rate than West Georgina
- Waitlist rates are high in both geographies and slightly higher in East Georgina
- Waitlist totals represent approved applicants waiting for placement and may not represent unique individuals, as applicants can select multiple homes

C10. Mental Health and Addictions

Mental health and addictions services are accessed through local primary care, community agencies, hospital-based services, and regional programs. Local service inventory details are summarized in Appendix B.

C10.1 Emergency Department Visit Frequency

Indicator	West Georgina	East Georgina
1 ED visit	76%	66%
2–4 visits	18%	17%
5+ ED visits	6%	17%

Source: Ontario Health, *eReport Portal OHT – Community-Based Care – Mental Health and Addictions* (FY2023/24).

C10.2 Seven-Day Follow-Up After Mental Health Hospital Discharge

Indicator	West Georgina	East Georgina
Any follow-up (7 days)	47%	38%
MH-specific follow-up	34%	22%

Source: Ontario Health, *eReport Portal OHT – Community-Based Care – Mental Health and Addictions* (FY2023/24).

Notes:

- A centralized inventory of all providers serving Georgina is not publicly available
- Some residents may access care outside the municipality or through virtual services
- Utilization indicators do not measure total community need or unmet need
- Follow-up indicators are derived from physician billing and hospital administrative data. They may not capture follow-up provided by community mental health agencies, counsellors, social workers, nurse practitioners, Indigenous providers, or other service models not captured in physician billing data

C11. Hospital Utilization – Inpatient

This section summarizes selected inpatient hospital utilization indicators for Georgina residents, including where residents receive inpatient care, neighbourhood-level discharge patterns, and Alternate Level of Care (ALC) activity. Indicators are derived from hospital administrative data and reflect completed inpatient stays.

C11.1 Inpatient Hospital Use by Receiving Hospital

Georgina residents rely primarily on Southlake Health for inpatient care, with additional use of nearby regional hospitals and specialized centres.

Hospital	% of Discharges	# of Inpatient Discharges
Southlake Health	72%	3,522
Oak Valley Health	8%	377
Mackenzie Health	4%	185
Sunnybrook Health Sciences Centre	3%	161
Hospital for Sick Children	3%	127
Other Hospitals	~10%	535
Total	**100%**	**4,907**

Source: IntelliHealth Ontario. (2025). *Discharge Abstract Database (DAD)* (FY2024/25).

C11.2 Inpatient Discharges by Neighbourhood

Neighbourhood-level discharge rates illustrate variation in inpatient utilization relative to population size.

Neighbourhood (ADA)	# of Inpatient Discharges	Rate per 1,000 Residents
Keswick South	772	82
Keswick Central	650	90
Keswick North	1,331	123
Historical Waterfront	461	72
Sutton and Jackson's Point	1,040	124
Pefferlaw and Rural Hamlets	593	63
Town of Georgina	**4,907**	**95**

Source: IntelliHealth Ontario. (2025). *Discharge Abstract Database (DAD)* (FY2024/25).

C11.3 Alternate Level of Care (ALC) Patient Count

ALC reflects patients occupying hospital beds who no longer require acute hospital care and are awaiting transition to another care setting.

Neighbourhood (ADA)	FY2024/25 ALC Count
Keswick South	27
Keswick Central	46
Keswick North	109
Historical Waterfront	23
Sutton and Jackson's Point	58
Pefferlaw and Rural Hamlets	30
Town of Georgina	**295**

Peak Town Total: 342 (FY2019/20)

Current vs Peak: -14%

Source: IntelliHealth Ontario. (2025). *Discharge Abstract Database (DAD)* (FY2018/19-FY2024/25).

Notes:

- Inpatient discharges refer to completed hospital stays
- Rates are presented per 1,000 residents using 2025 population estimates
- Percentages may not sum exactly due to rounding
- Neighbourhood variation may reflect differences in age structure, health needs, and utilization patterns
- ALC activity may be influenced by availability of long-term care, rehabilitation, home care, supportive housing, and discharge planning capacity

C12. Hospital Utilization – Emergency Department

This section summarizes emergency department (ED) utilization by Georgina residents, including where residents seek emergency care, neighbourhood-level visit rates, and selected service pattern indicators. Data reflect unscheduled ED visits recorded through hospital administrative systems.

C12.1 Emergency Department Use by Receiving Hospital

Georgina residents rely primarily on Southlake Health for emergency care, with secondary use of Oak Valley Health and smaller volumes at other regional hospitals.

Hospital	% of Visits	Number
Southlake Health	76%	16,399
Oak Valley Health	12%	2,677
Mackenzie Health	3%	592
Other Hospitals	9%	1,941
Total	**100%**	**21,609**

Source: IntelliHealth Ontario. (2025). *National Ambulatory Care Reporting System (NACRS): Emergency Department Visits* (FY2024/25).

C12.2 Emergency Department Visits by Triage Acuity (CTAS)

Emergency department visits occurred across all CTAS acuity levels.

CTAS Level	Description	Visits
Level 1	Resuscitation	243
Level 2	Emergent	5,085
Level 3	Urgent	10,669
Level 4	Less Urgent	4,510
Level 5	Non-Urgent	1,090
Unknown	Not assigned/missing	12
Total		**21,609**

Source: IntelliHealth Ontario. (2025). *National Ambulatory Care Reporting System (NACRS): Emergency Department Visits* (FY2024/25).

C12.3 Neighbourhood Emergency Department Rates

Neighbourhood-level rates show meaningful variation in ED utilization intensity across Georgina.

Neighbourhood	ED Visits	Rate per 1,000 Residents
Keswick South	3,646	387
Keswick Central	3,096	427
Keswick North	5,379	496
Historical Waterfront	1,968	306
Sutton and Jackson's Point	4,570	545
Pefferlaw and Rural Hamlets	2,655	280
Town of Georgina	**21,609**	**417**

Source: IntelliHealth Ontario. (2025). *National Ambulatory Care Reporting System (NACRS): Emergency Department Visits* (FY2024/25).

Notes:

- ED visits represent encounters, not unique individuals; some residents may have multiple visits in a year
- Rates are presented per 1,000 residents using 2025 population estimates
- CTAS refers to the Canadian Triage and Acuity Scale used in Ontario emergency departments
- Higher ED use may reflect age structure, chronic disease burden, access to primary care, transportation patterns, or repeat utilization

C13. Ambulatory and Outpatient Services at Southlake Health

This section summarizes selected ambulatory and outpatient hospital clinic utilization by Georgina residents, including diagnostic imaging, fracture and specialty clinics, oncology-related pathways, rehabilitation, and other scheduled outpatient services. Data reflect hospital administrative clinic encounters and do not represent emergency department visits.

C13.1 Total Hospital Clinic Visits

Outpatient utilization includes a broad range of scheduled hospital-based services, grouped below into major care pathways with example clinics shown for reference.

Indicator	Visits
Total Visits	25,440
Georgina-Based Clinic Visits	3,688
Hospital-Based Clinic Visits	21,752

Source: Southlake Health, *Ambulatory Clinic Visit Data (Meditech via LEAP)* (FY2024/25).

C13.2 Highest Volume Clinic Types

Category	Example Included Clinics/Services	Visits
Diagnostics	CT, MRI, X-ray, Ultrasound, Breast Screening	5,219
Specialty Medical Care	Cardiology, Respiratory Therapy, Neurology, Rheumatology, Psychiatry	4,730
Musculoskeletal & Injury Care	Fracture Clinic, Hand Clinic, Physiotherapy, Orthopaedics	4,211
Cancer Care	Systemic Therapy, Radiation Treatment, Oncology Pre/Post Care	4,008
Chronic Disease Management	Diabetes Clinic, Aging Well Clinic, ACT Clinic	2,500
Maternal & Perinatal Care	Birthing Triage, Prenatal Clinic	1,084

Source: Southlake Health, *Ambulatory Clinic Visit Data (Meditech via LEAP)* (FY2024/25).

C13.3 Clinic Types by Neighbourhood

Neighbourhood	Diagnostics Visits (Rate)	Speciality Medical Care Visits (Rate)	MSK & Injury Visits (Rate)	Cancer Care Visits (Rate)	Med Chronic Disease Visits (Rate)	Maternal Care Visits (Rate)
Keswick South	843 (89.5)	754 (80.1)	668 (71.0)	491 (52.2)	322 (34.2)	258 (27.4)
Keswick Central	771 (106.3)	679 (93.6)	601 (82.9)	513 (70.7)	327 (45.1)	125 (17.2)
Keswick North	1,296 (119.5)	1,169 (107.8)	1,162 (107.2)	974 (89.8)	661 (61.0)	323 (29.8)
Historical Waterfront	567 (88.1)	410 (63.7)	451 (70.0)	420 (65.2)	318 (49.4)	74 (11.5)
Sutton and Jackson's Point	1,109 (132.2)	1,238 (147.6)	907 (108.1)	1,004 (119.7)	633 (75.4)	196 (23.4)
Pefferlaw and Rural Hamlets	580 (61.2)	441 (46.5)	391 (41.2)	570 (60.1)	219 (23.1)	82 (8.6)
Town of Georgina	5,219 (100.7)	4,730 (91.3)	4,211 (81.3)	4,008 (77.3)	2,500 (48.2)	1,084 (20.9)

Source: Southlake Health, *Ambulatory Clinic Visit Data (Meditech via LEAP)* (FY2024/25).

Rate is per 1,000 Residents in the table above.

C13.4 Georgina-Based Clinics

Clinic	Type of Service	Visits (Rate Per 1,000 Residents)
Georgina X-Ray Clinic	Diagnostic Imaging	2,055 (39.7)
Georgina Ultrasound Clinic	Diagnostic Imaging	1,295 (25.0)
Georgina Mental Health ACT Clinic	Diagnostic Imaging	338 (6.5)

Source: Southlake Health, *Ambulatory Clinic Visit Data (Meditech via LEAP)* (FY2024/25).

Notes:

- Clinic visits represent encounters, not unique individuals
- Categories are grouped pathways and are not additive to unique patients
- Rates are per 1,000 residents using 2025 population estimates

C13.1 Total Hospital Clinic Visits

C13.5.1 Total Day Surgery Cases

This section summarizes selected same-day surgical procedures received by Georgina residents, including neighbourhood variation in utilization. Data reflect completed day surgery procedures and do not include inpatient admissions.

Indicator	Value
Total Day Surgery Procedures	4,230
Rate per 1,000 Residents	82

Source: Southlake Health. (2025). *Discharge Abstract Database (DAD) data (via WinRECS)* (FY2024/25).

C13.5.2 Day Surgery by Neighbourhood

Neighbourhood	Procedures	Rate per 1,000 Residents
Keswick South	622	66
Keswick Central	592	82
Keswick North	1,102	102
Historical Waterfront	435	68
Sutton and Jackson's Point	1,001	119
Pefferlaw and Rural Hamlets	456	48
Town of Georgina	**4,230**	**82**

Source: Southlake Health. (2025). *Discharge Abstract Database (DAD) data (via WinRECS)* (FY2024/25).

C13.5.3 Highest Volume Procedure Groups

Procedure Group	Cases
Digestive System	1,922
Urology & Genitourinary	766
Other Lower-Volume Procedures	683
Ophthalmology	353
Musculoskeletal	331
Mental Health (ECT)	175

Source: Southlake Health, *Ambulatory Clinic Visit Data (Meditech via LEAP)* (FY2024/25).

Notes:

- Day surgery cases represent completed same-day procedures
- Rates are per 1,000 residents using 2025 population estimates
- Procedure groups are aggregated categories for reporting purposes
- Multiple cases may relate to the same individual during the year
- Neighbourhood totals may not sum to the Town of Georgina total due to a small number of cases with unassigned or incomplete postal code information

C14. Resident Experience at Southlake Health (Selected Survey Indicators)

This section summarizes selected patient experience survey results for Georgina residents receiving care at Southlake Health. Percentages shown represent the share of respondents providing a top-box rating (9 or 10 out of 10) for their overall care experience. Results should be interpreted alongside service complexity, patient acuity, and operating pressures, which can influence experience ratings across care settings.

Care Area	Visits (Rate Per 1,000 Residents)
Day Surgery	87% (n=158)
Maternity	74% (n=42)
Inpatient	58% (n=160)
Emergency Department	51% (n=863)

Source: Southlake Health. (2025). *Patient Experience Survey Data* (2024-2025).

Interpretation Note: Reported satisfaction was highest in scheduled care settings such as Day Surgery and Maternity, while lower scores in Inpatient and Emergency Department settings may reflect the complexity of care needs, wait times, length of stay, and broader system capacity pressures.

C15. Definitions

Attached: Residents formally enrolled or rostered with a regular primary care provider.

Unattached: Residents not formally enrolled or rostered to a regular primary care provider within the source methodology.

Day Surgery: Procedures where patients are discharged the same day.

Emergency Department Visit: Hospital-based urgent or emergency visit not resulting in direct admission unless otherwise noted.

ALC (Alternate Level of Care): Hospital patients who no longer require acute care but remain in hospital awaiting transfer or discharge supports.

CTAS: Canadian Triage and Acuity Scale used to classify emergency department urgency levels.

Home Care: Health and personal support services delivered in the home or community.

Top-Box Score: Highest satisfaction category on a standardized survey scale.

Encounter / Visit: A service event or clinic interaction; not necessarily a unique individual.

Rate: Number of cases relative to population size (for example per 1,000 residents), allowing comparison across areas.

West / East Georgina: Planning geographies used for comparative reporting in this appendix.

D. Stakeholder Engagement, Validation and Community Input

D.1 Purpose

Input to this report was gathered throughout the course of the project through prior community feedback, stakeholder meetings, surveys, working group discussions, service planning conversations, community events, education sessions, and targeted validation meetings. These activities helped inform local priorities, identify barriers to access, provide operational context, validate emerging findings, and refine recommendations.

Engagement was iterative and completed throughout the development of the report. Activities occurred at different stages of the project and reflected available opportunities to gather input from residents, providers, community organizations, Indigenous partners, and health system stakeholders.

D.2 Engagement Across Project Phases

Phase 1: Prior Input and Early Engagement

Existing feedback and early engagement activities were reviewed to help identify local priorities and areas requiring further analysis. These included:

- March 2024 – NYSS OHT Town Hall held on March 6, 2024, with responses and feedback from approximately 40 attendees
- May 2024 – Southlake Health Strategy Development Georgina consultation held May 22, 2024, with participation from approximately 24 attendees
- June 2024 – Engagement discussions with the Chippewas of Georgina Island First Nation, including a visit to Georgina Island
- August 2024 – Southlake Strategy Development Survey with over 350 responses including residents from Georgina
- 2024 – Health Georgina Resident Survey with 83 responses

These sources provided early insight into resident priorities, access challenges, demand for local services, and considerations related to health equity, navigation, and care closer to home.

Phase 2: Consultations During Assessment

During the assessment process, additional consultations and stakeholder discussions were undertaken to gather current perspectives, validate recurring issues, and understand service delivery realities.

Activities included:

- July 2004 - Discussions with Hospice Georgina and Better Living Health on July 24, 2024
- August 2024 – Discussions with Health Georgina on August 16, 2024
- September 2024 – Discussions with Cedarvale Lodge and Hospice Georgina on September 16, 2024

- October 2024 – Discussions with the Chippewas of Georgina Island First Nation on October 8, 2024
- October 2024 – Discussions with Health Georgina on October 23, 2024
- April 2025 – Discussions with Health Georgina on April 17, 2025
- April 2025 – Discussions with the Chippewas of Georgina Island First Nation on April 22, 2025
- January 2026 – Discussions with the Chippewas of Georgina Island First Nation on January 20, 2026, and January 27, 2026
- March 2026 – Discussions with the Chippewas of Georgina Island First Nation on March 10, 2026

These discussions supported understanding of community needs, aging population pressures, navigation barriers, caregiver needs, and opportunities for improved service coordination.

Phase 3: Validation and Refinement

In the later stages of report development, targeted validation sessions and partner discussions were completed to review findings, confirm priorities, and refine recommendations. Validation was undertaken through existing regional and local tables, councils, and provider meetings.

Validation sessions included:

- March 4, 2026 – NYSS OHT Mental Health and Addictions Network Table (10 attendees)
- March 9, 2026 – NYSS OHT Patient, Client and Caregiver Partner Council (9 attendees)
- March 10, 2026 – NYSS OHT Long-Term Care Network Table (19 attendees)
- March 13, 2026 – NYSS OHT Primary Care Council (10 attendees)
- March 13, 2026 – NYSS OHT Community Support Sector and Home Care Network Table (15 attendees)
- March 26, 2026 – NYSS OHT Operational Leadership Table (10 attendees)
- April 9, 2026 – Primary Care Provider Engagement Session for OHT and non-OHT providers serving Georgina (10 attendees)

These sessions helped validate findings, identify gaps in interpretation, and refine recommendations based on operational, provider, and community perspectives.

D.3 Key Community Engagement Activities

Georgina Health Fairs and Community Events

Two community health fairs were held during the project period, along with additional public-facing outreach events.

- November 9, 2024 – Community Health Fair: *Info & Resources for Newcomers* (26 attendees)
- October 2, 2025 – MURC Open House (119 attendees)
- October 4, 2025 – Community Health Fair: *Caregiver Support* (205 attendees)
- October 15, 2025 – Indigenous Engagement Event: *Fall Harvest Celebration* (67 attendees)

These events provided opportunities for residents to connect directly with service providers, learn about available programs, and identify ongoing needs related to newcomer supports, caregiving, Indigenous community connection, and access to community-based care.

Health and Wellness Education Sessions

A series of health and wellness education sessions were delivered on a range of topics intended to support prevention, self-management, and awareness of available services.

Sessions included:

- June 18, 2025 – Caring for Caregivers (1 attendee – note 7 registered)
- July 16, 2025 – Stroke Prevention (11 attendees)
- August 20, 2025 – CBT for Insomnia (25 attendees)
- September 17, 2025 – Clearing the Air: Understanding Vaping and Supporting Youth to Quit (17 attendees)
- November 4, 2025 – Supports for Mental Health Crisis (13 attendees)
- November 19, 2025 – York Region Plan to Support Seniors (9 attendees)
- December 10, 2025 – Advance Planning (5 attendees)
- January 14, 2026 – Building Healthy Kids for Parents and Caregivers (7 attendees)
- February 3, 2026 – Living Well with Lung Disease (8 attendees)
- February 18, 2026 – Menopause (25 attendees)
- March 11, 2026 – Over-the-Counter Medication and Senior Wellness (17 attendees)
- April 15, 2026 – From Home Care to Long-Term Care (24 attendees)

Across the reporting period, community events and education sessions reached over 500 residents and reflected sustained efforts to improve awareness, prevention, and navigation supports.

Indigenous Community Engagement

Engagement with Indigenous communities included multiple meetings and discussions with the Chippewas of Georgina Island First Nation throughout the project period, as well as the Fall Harvest Celebration held on October 15, 2025. These conversations and events supported relationship-building, identification of community priorities, and consideration of culturally appropriate approaches to service access and care delivery.

The Chippewas of Georgina Island First Nation also provided community data and information for inclusion in this report with their permission and approval. This contribution helped ensure Indigenous perspectives and community context were appropriately reflected in the assessment.

Primary Care Provider Engagement

Primary care perspectives were incorporated through multiple engagement channels during the development of this report.

A virtual Primary Care Provider Engagement Session was held on April 9, 2026 with approximately 10 participants, including both OHT-affiliated and non-OHT primary care providers serving Georgina. This session created an opportunity to gather direct feedback from local clinicians providing care within the community.

Primary care input was also obtained through the NYSS OHT Primary Care Council, which participated in the project validation phase on March 13, 2026. The Council provided an additional forum for discussion of emerging findings, local service pressures, and practical implementation considerations.

D.4 Findings from Engagement Activities

Several recurring themes emerged across engagement activities, consultations, and validation sessions.

Residents and stakeholders consistently emphasized the importance of timely access to primary care and the need for more services available closer to home. Transportation and travel distance were identified as ongoing barriers, particularly for seniors, individuals with mobility limitations, and residents living farther from service hubs.

Participants also highlighted the need for stronger navigation supports and improved awareness of existing programs and services. Many residents indicated that services may exist but can be difficult to locate, understand, or access in a coordinated way.

Demand for seniors' supports, caregiver resources, and aging-in-place services was raised repeatedly. This included interest in home and community care, respite supports, wellness programming, and planning for transitions in care.

Mental health and addictions supports remained a consistent area of concern. Stakeholders identified the importance of timely access, clearer pathways to care, crisis response options, and prevention-focused supports.

Engagement activities also reinforced the importance of health promotion, screening, and education. Strong participation in community events and educational sessions suggested ongoing interest in practical, prevention-oriented programming delivered locally.

Finally, discussions with Indigenous partners and community organizations highlighted the importance of equity-focused approaches that recognize differing experiences, cultural contexts, and barriers to access across populations.

D.5 How Input Informed This Report

Stakeholder and community input was used throughout the development of this report to strengthen analysis and inform recommendations.

Engagement findings helped identify priority issues for further review, including primary care access, aging population pressures, caregiver supports, transportation barriers, and mental health service needs.

Community and provider perspectives also provided important context for interpreting quantitative data. In several cases, engagement findings helped explain patterns observed in utilization, service demand, and geographic access.

Validation sessions with sector leaders, providers, patient representatives, and primary care clinicians were used to confirm emerging findings and test the practicality of proposed recommendations.

Input gathered through the project also highlighted initiatives already underway within the community and identified opportunities to build on existing partnerships, outreach efforts, and integrated models of care.

The inclusion of information shared with permission by the Chippewas of Georgina Island First Nation also helped strengthen the report's consideration of Indigenous community experience and priorities.

D.6 Limitations

This appendix summarizes engagement activities and themes that informed the development of the report based on project documentation, meeting materials, and participant feedback.

The engagement activities described in this appendix were intended to support planning, validate findings, and inform recommendations. They should be understood as one component of the broader evidence base for this report, alongside demographic analysis, service utilization data, system planning information, and stakeholder expertise.

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