THE REGIONAL MUNICIPALITY OF PEEL
HEALTH SYSTEM INTEGRATION COMMITTEE
AGENDA

Meeting #:	**HSIC-2/2025**
Date:	**Thursday, June 5, 2025**
Time:	**9:30 AM - 11:00 AM**
Location:	**Council Chamber, 5th Floor** **Regional Administrative Headquarters** **10 Peel Centre Drive, Suite A** **Brampton, Ontario**
Members:	**N.K. Brar (Vice-Chair), S. deRyk, C. Early , K. Farrow, C. Fonseca (Chair), N. Hart, N. Iannicca, S. Kaur, A. Jones, M. Palleschi, M. Reid, D. Smith, A. Tedjo, P. Vicente**

The meeting will be live streamed on http://www.peelregion.ca/.

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1. CALL TO ORDER/ROLL CALL

2. DECLARATIONS OF CONFLICTS OF INTEREST

3. APPROVAL OF AGENDA

4. DELEGATIONS

   4.1 Rishika Thakur Malhi, Executive Lead, Central West Ontario Health Team; Dave Pearson, Executive Director, Hills of Headwaters Collaborative Ontario Health Team; and Lindsay Wingham-Smith, Executive Director, Mississauga Ontario Health Team
   Regarding Primary Care Access and the Primary Care Related Ontario Health Team Priorities

   4.2 Kimberley Floyd, Chief Executive Officer, WellFort Community Health Services
   Regarding Collaborative Care Models and Partnerships Focused on Improving Primary Care Access for Vulnerable and Unattached Populations

5. REPORTS

   5.1 Supporting Vulnerable Residents – An Update on Community Paramedicine in Peel
   (For information)

   Presentation by Brian Gibson, Director and Chief of Paramedic Services and Dr. Sudip Saha, Medical Director, William Osler Health System

5.2 Advancing Integrated Team Based Primary Care in Peel
(For information)

6. COMMUNICATIONS

7. OTHER BUSINESS

8. CLOSED SESSION

9. NEXT MEETING

Thursday, October 2, 2025
9:30 am to 11:00 am
Council Chamber, 5th Floor
Regional Administrative Headquarters
10 Peel Centre Drive, Suite A
Brampton, Ontario

10. ADJOURNMENT

Region of Peel
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Request for Delegation

FOR OFFICE USE ONLY

MEETING DATE YYYY/MM/DD	MEETING NAME
2025/06/05	Health System Integration Committee

DATE SUBMITTED YYYY/MM/DD
2025/05/20

Attention: Regional Clerk
Regional Municipality of Peel
10 Peel Centre Drive, Suite A
Brampton, ON L6T 4B9
Phone: 905-791-7800 ext. 4582
E-mail: council@peelregion.ca

NAME OF INDIVIDUAL(S)
(1) Rishika Thakur Malhi, (2) Dave Pearson & (3) Lindsay Wingham-Smith

POSITION(S)/TITLE(S)
(1) Executive Lead, (2) Executive Director & (3) Executive Director

NAME OF ORGANIZATION(S)
(1) Central West OHT (2) Hills of Headwaters Collaborative OHT & (3) Mississauga Health OHT

E-MAIL	TELEPHONE NUMBER	EXTENSION
(1) rishika.thakurmalhi@williamoslerhs.ca (2) dpearson@head	905-494-2120	58116

INDIVIDUAL(S) OR ORGANIZATION(S) ADDRESS

REASON(S) FOR DELEGATION REQUEST (SUBJECT MATTER TO BE DISCUSSED)
Provide an update on improving primary care access and the primary care related OHT priorities (primary care networks, attachment strategies, team based care) in Peel.

A formal presentation will accompany my delegation ☑ Yes ☐ No

Presentation format:
☑ PowerPoint File (.ppt) ☐ Adobe File or Equivalent (.pdf)
☐ Picture File (.jpg) ☐ Video File (.avi,.mpg)
☐ Other

Additional printed information/materials will be distributed with my delegation:
☐ Yes ☑ No ☐ Attached

Please save the form to your personal device, then complete and submit via email attachment to council@peelregion.ca

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Request for Delegation

Note:
Delegates are requested to provide an electronic copy of all background material / presentations to the Clerk's Division if possible 72 hours prior to the meeting start time. **Delegation requests and/or materials received after 9:30 a.m. on the Wednesday prior to the meeting will not be provided to Members.**

Delegates should make every effort to ensure their presentation material is prepared in an accessible format. Once the above information is received in the Clerk's Division, you will be contacted by Legislative Services staff to confirm your placement on the appropriate agenda.

In accordance with the Region of Peel Procedure By-law, delegates appearing before Regional Council or Committee are requested to limit their remarks to 5 minutes and 10 minutes respectively (approximately 5/10 slides). Delegations may only appear once on the same matter within a one-year period, unless a recommendation pertaining to the same matter is included on the agenda within the one-year period and only to provide additional or new information.

Notice with Respect to the Collection of Personal Information
(Municipal Freedom of Information and Protection of Privacy Act)
Personal information contained on this form is authorized under Section 4.4 of the Region of Peel Procedure By-law 27-2022, as amended, for the purpose of contacting individuals and/or organizations requesting an opportunity to appear as a delegation before Regional Council or a Committee of Council. The completed Delegation Request Form will be redacted and published with the public agenda. The Procedure By-law is a requirement of Section 238(2) of the Municipal Act, 2001, as amended. Please note that all meetings are open to the public except where permitted to be closed to the public under legislated authority. All Regional Council and Committee meetings are live streamed via the internet and meeting videos are posted and available for viewing subsequent to those meetings. Questions about collection may be directed to the Manager of Legislative Services, 10 Peel Centre Drive, Suite A, 5th floor, Brampton, ON L6T 4B9, (905) 791-7800 ext. 4462.

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Request for Delegation

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MEETING DATE YYYY/MM/DD	MEETING NAME
2025/06/05	Health System Integration Comm

DATE SUBMITTED YYYY/MM/DD
2025/05/20

Attention: Regional Clerk
Regional Municipality of Peel
10 Peel Centre Drive, Suite A
Brampton, ON L6T 4B9
Phone: 905-791-7800 ext. 4582
E-mail: council@peelregion.ca

NAME OF INDIVIDUAL(S)
Kimberley Floyd

POSITION(S)/TITLE(S)
Chief Executive Officer

NAME OF ORGANIZATION(S)
WellFort Community Health Services

E-MAIL	TELEPHONE NUMBER	EXTENSION
Kimberley.Floyd@wellfort.ca	905-451-8090	

INDIVIDUAL(S) OR ORGANIZATION(S) ADDRESS
40 Finchgate Blvd, Suite 224, Brampton, ON L6T 3J1

REASON(S) FOR DELEGATION REQUEST (SUBJECT MATTER TO BE DISCUSSED)
Provide an update on collaborative care models and partnerships focused on improving primary care access for vulnerable and unattached populations.

A formal presentation will accompany my delegation ☑ Yes ☐ No

Presentation format:
☑ PowerPoint File (.ppt) ☐ Adobe File or Equivalent (.pdf)
☐ Picture File (.jpg) ☐ Video File (.avi,.mpg)
☐ Other

Additional printed information/materials will be distributed with my delegation:
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WellFort

Strengthening Primary Care Access and Improving Integrated Care in Peel

Presented to Health Systems Integration Committee, Region of Peel
Kimberley Floyd, CEO
June 5, 2025

WellFort Community Health Services

Getting started – CHC Model of Care

Model of Health and Wellbeing

WellFort Community Health Services is a CHC with two sites: Malton and Brampton

•CHCs are interprofessional primary care teams that serve communities and populations who may have barriers to health services. They focus on addressing the underlying conditions that affect people's health, such as social determinants of health, diet and literacy.

•The CHC employs a wide variety of interprofessional healthcare professionals such as nurse practitioners, social workers, outreach workers, midwives, health promoters, Diabetes Educators, Support and Care Navigators, Dentists and Dental Assistants

•Regular and extended hours

•Physicians who work in a CHC setting are salaried employees.

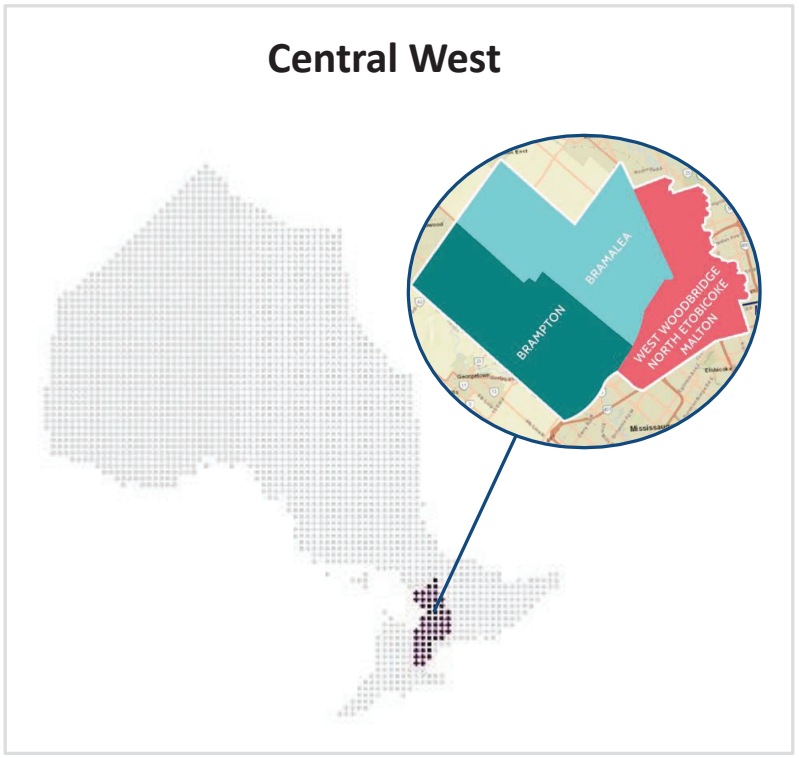
•WellFort has a strong reliable history in these communities as a full service primary care and social support agency and is a leader in actionable transformative care with the Central West OHT at a population health level

WellFort

Introduction to the PCNN

Who We Serve

- **Our network is in the Central Region of Ontario Health. The populations we serve in this model span 3 municipalities: Toronto, Mississauga and Brampton.**



Breakdown of Our Population

500,000 Residents	**80%** Visible Minorities	**20%** Medium to High Comorbidity
18% Mental Health Diagnosis in Past 2 Years	**11-21%** Unattached to Primary Care	**<80** Family Physicians per 100k Residents

WellFort

Discussion

Personas

	Darshan	Hassan	Ayesha	Esther	John	Errol
						
DEMOGRAPHIC	• Elderly Female • South Asian • 65 – 80+	• Young adult male • African • 18 - 35	• Young female • Childbearing • South Asian • 18 – 40	• Middle aged female • Caribbean • 40 - 70	• Middle-aged white male • 40 - 50	• Middle-aged black male • 50 - 60
BACKGROUND	• Newcomer from India • Does not speak English (Punjabi) • Low-income multi-generational household	• Canadian, immigrated as child from Somalia • Supports siblings and mother • Precarious employment	• Canadian, immigrated from India • Young professional • Minimal family support (family in India)	• Canadian, immigrated from Jamaica • Settled and working	• Canadian, married with teenage kids • English speaking • Blue collar job • High debt – working poor	• Jamaican-Canadian • English speaking • Married, family in Jamaica • Incomplete high-school education, unemployed and on social assistance
HEALTH CONCERNS	• Uncontrolled diabetes • Arthritis • Frailty	• Mental health stress • Diagnosed PTSD, childhood trauma • Occasional substance use	• Healthy pregnancy • Ensuring baby is healthy	• Does not participate in cancer screening programs	• Life-long smoker • Shortness of breath • Arthritis	• Uncontrolled diabetes • Hypertension • Poor kidney function, • Retinopathy • Depression & anxiety
HEALTHCARE UTILIZATION	• Unattached • Frequent walk-in clinic and ED utilization	• Unattached • Attends walk-in clinics when necessary	• Unattached • Attends appointments related to pregnancy • Uses technology to navigate health concerns	• Unattached • Uses homeopathic/ traditional medicine as first choice • Uses online sources to find traditional remedies	• Attached to FHO • Visits hospital, if necessary • Does not complete follow-ups, routine tests & screenings	• Unattached • Experiences healthcare discrimination

WellFort

Primary Care Neighbourhood Network Model Overview

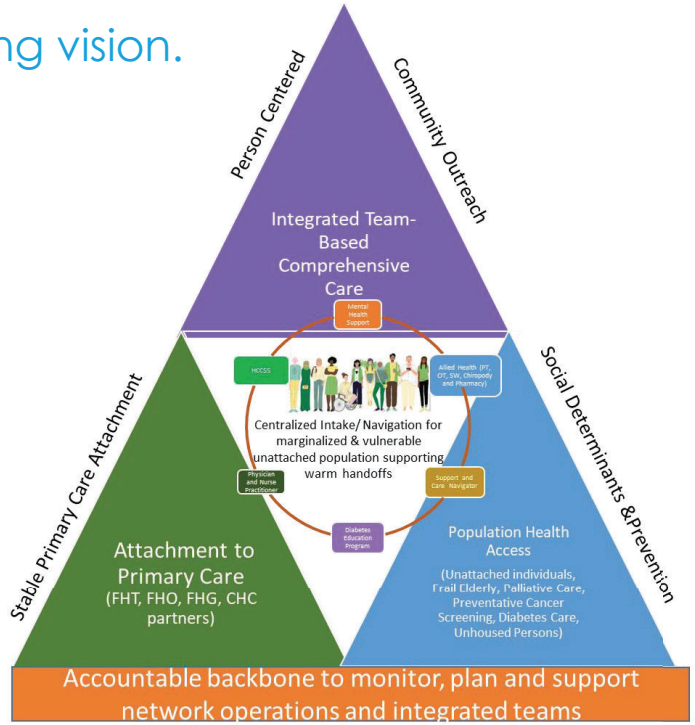
WellFort
Community Health Services

Primary Care Neighbourhood Network (Medical Home)

Over the past year, we have been building an exciting vision.

Together, we are achieving:

- Increased **primary care capacity** and increase **access** to interprofessional team-based primary care.
- Deliver person-centred care through a **population health approach** that ensures all individuals receive the care they need, when they need it.
- Leverage our **shared expertise and resources** to optimize patient experiences and outcomes.



This is funded through OH, as part of integrated interprofessional primary care network initiative

Our Partners:

WellFort CHS (Backbone Hub) | Rexdale Medical FHO | Malton United FHO | Central Brampton FHT | North Peel FHT | Main Street Medical FHO | Shopper's World Medical FHO | CMHA Peel Dufferin

Overview of Model

We have built a scalable model that helps local people who are unattached to primary care.

1. Increased interprofessional shared system resources

- Increase capacity of system to attach patients to primary care through partnerships and access to interprofessional care
- Resources and program expertise shared across practices

2. New Population Health Clinic for our unattached population

- Clinic embedded in the community focusing on population health programming and access to interprofessional resources
- Place for initial attachment and understanding needs to inform longitudinal primary care attachment

3. Set-up centralized intake and navigation function

- System-wide resource to create ease of access to primary care resources for unattached, marginalized and complex patients
- Includes single point of contact, initial assessment, personalized care planning and navigation to primary care
- Population health based assessment and data collection to identify care needs for unattached population in the neighbourhood network

4. Increased backbone support to enable the model and serve most complex patients

- Infrastructure investment to build WellFort as a central coordinating entity (administration, HR, finance, PM, IT, data, and QI)
- Digital enablement support locally among providers

Ontario's Primary Care Action Plan Pillars
Alignment of Primary Care Neighbourhood Network

Connecting You to a Primary Care Team

- Equity focused approach to understand needs and match attachment to team best suited to meet needs within the neighbourhood
- Centralized intake with knowledge of primary care access within neighbourhood network
- Expanded attachment capability due to increased interprofessional team resources
- Creation of standardized pathways based on segmenting the population to meet the holistic and longitudinal needs

Making Primary Care More Connected and Convenient

- Digitally connected through Primary Care Digital Front door aligned with provincial digital assets for community
- Population health planning through coordinated data collection and digital systems
- Network operates as shared care model where resources are less duplicated based on expertise
- Improved referral methods to support primary care clinicians in shared care and adjustment of services due to patient care complexity

Supporting Primary Care Providers

- Back office supports
- Provider experience evaluation
- Interprofessional care education and supports to maximize scopes of practice
- Common vision with primary care driving planning and implementation (building coalition) and system transformation
- Mutual agreement of attachment volume targets and support of interprofessional resource support with clinical governance oversight
- Local leadership and expertise of community and connection to community supports is offered

WellFort Community Health Services

Interprofessional Primary Care for People Experiencing Homelessness

Leveraging Region of Peel's Leadership in Planning

HEALTH IMPACTS

Compared to the general population, homeless individuals are:

- **4×** more likely to have cancer
- **28×** more likely to have hepatitis C
- **5×** more likely to have heart disease

ADDITIONAL HEALTH BURDENS

- Higher burden of acute health issues
- Higher burden of chronic health issues
- Mental health challenges
- Substance use challenges

BARRIERS TO HEALTHCARE

- Lack of family doctor
- No proof of health insurance
- Extended homelessness duration
- Discrimination in healthcare

KEY FINDING: Less than half of homeless individuals report having a family doctor

THE HOSPITAL CYCLE

Sicker at hospital admission due to being unhoused

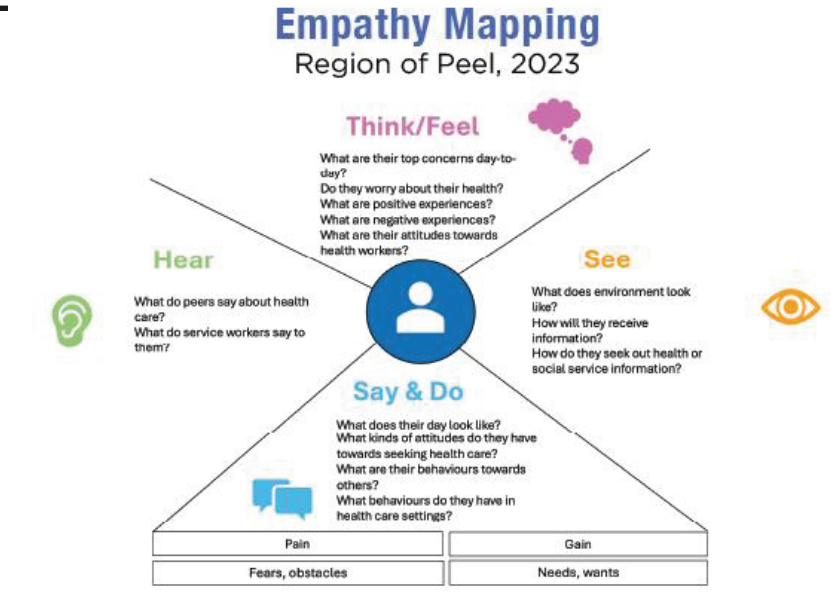
Unable to access primary care and home care after discharge

Some hospitals are building housing - is this the most appropriate response given limited resources?

SOLUTIONS: Accessible primary care · Improved health insurance · Anti-discrimination

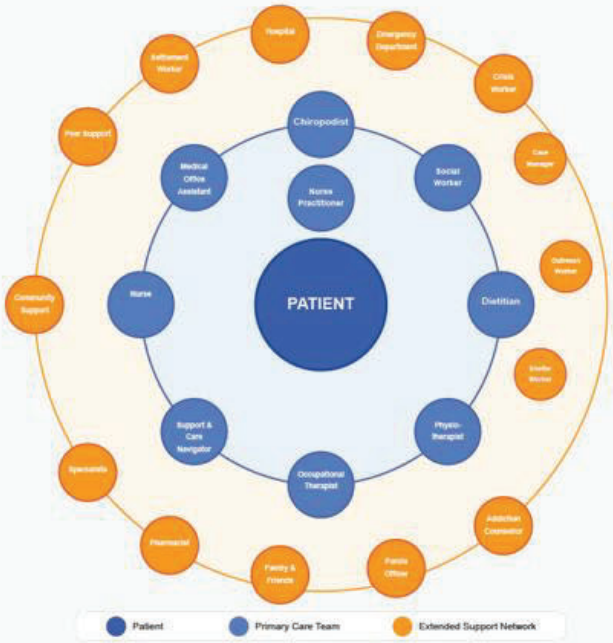
Lived Experience Co-Design and Service Model

The foundational aspects of the model and emphasis on low barrier and comprehensive access to primary care were derived from feedback and recommendations gleaned through human-centred co-design processes led by the Region of Peel's Housing Division. People with lived and living experience of homelessness and housing precarity were provided creative and flexible options to engage and inform the model. Co-design processes included peer-led interviews, empathy mapping, story-telling and story curation sessions.



WellFort's Homelss Health Program Model

Patient-Centered Care Model



In-Shelter Primary Care

- NP-led, 24/7 nursing and primary care supports
- 45 medical beds in dedicated wing of a shelter
- NPs, RNs, RPNs, PSWs
- Clients referred by shelters and hospitals
- Dundas St. Shelter location

Interprofessional Mobile Community Primary Care

- NP-led interprofessional primary care teams
- Regular clinics at shelters and drop-ins
- Ad hoc co-located pop-up clinics where needed
- NPs, RNs, RPNs, SW, RD, PT, OT, Chiropody, Navigator
- Community-based care across Peel Region

Service Needs/Offerings

- Primary care (screening, acute/chronic conditions management)
- Wound care
- Substance use supports, withdrawal management
- Harm reduction supports
- Mental health supports, pharmacotherapy
- Pharmacy supports, medication management
- Health system navigation and case management
- Post-ED and post-inpatient stabilization

Collaboration & Partnership

Interprofessional Team Approach

- Team members working to full scope of practice
- Navigating overlapping scopes of practice
- Maintaining client relationships while using resources efficiently
- Working alongside staff and partners in adjacent systems to augment impact
- Not replacing or duplicating existing supports already attached to the client

WellFort

Community Impact

11,550
Access to interprofessional primary care across both programs in 8 months

3,000
New attachments created to primary care

Ongoing advocacy and funding is required!

The Primary Care Neighbourhood Network was one of 5 recent proposals in the Central West OHT, that were submitted to the Ministry of Health to expand the model of care.

Ongoing sustainable and disproportionate funding is required in Peel to develop the right primary care system that is community driven and meets their unique needs.

WellFort


WellFort

Region of Peel
working with you

REPORT
Meeting Date: 2025-06-05
Health System Integration Committee

For Information

REPORT TITLE:	**Supporting Vulnerable Residents – An Update on Community Paramedicine in Peel**
FROM:	Nancy Polsinelli, RD HBSc MPA, Commissioner of Health Services

OBJECTIVE

To provide an update on the Community Paramedicine (CP) program in Peel highlighting it as an innovative model of care, its role in supporting vulnerable populations and addressing health system pressures. This report will also highlight opportunities for continued advancement and integration in Peel's health system.

REPORT HIGHLIGHTS

- Community Paramedicine (CP) in Peel continues to ease system pressure on emergency services and remove barriers to healthcare access by providing in-home and community care to vulnerable residents.
- In 2024, the program served 1,833 patients which has helped reduce the occurrence of hospital visits and 9-1-1 calls.
- CP is fully funded by the Province until March 31, 2026. The CP at Long-Term Care program will require funding past March 2026 to continue.
- Peel continues to advocate for long-term sustainable funding.
- The CP program has become an integral health system partner advancing upstream, community-based approaches to health, while exploring opportunities for innovation and system integration to adapt to Peel Region's aging and growing population.

DISCUSSION

1. Background

Peel's health care system continues to experience increasing pressures, resulting in overcrowded emergency departments, growing waitlists for long term care (LTC) homes, and limited access to home and community care services. Additionally, there is a rise in demand for mental health and addictions supports. These factors play a role in the increase in paramedic call volumes.

Since 2021, with dedicated funding from the Ministry of Long-Term Care and Ontario Health Central, Peel Regional Paramedic Services (PRPS) has been working to enhance its Community Paramedicine (CP) program as a key response to these pressures. The program leverages the unique skills of paramedics to deliver in-home assessments, health monitoring, education and system navigation supports, while helping to reduce 9-1-1 calls,

emergency department visits and hospital admissions. With a focus on in-home and community-based service delivery to vulnerable populations, the CP program plays an important role in advancing health equity through supporting individuals with complex health needs. Currently, these individuals face barriers to healthcare and the CP program aims to enable an equitable access to health services.

Peel's CP program is 100 per cent funded by the provincial government, with most of the funding coming from the Ministry of Long-Term Care to support the Community Paramedicine for Long-Term Care (CPLTC) program. Currently, funding for the CPLTC program is available until March 2026. Without sustainable funding, there are limitations to long-term planning and scalability for the program. Peel remains committed to advocating for stable funding to ensure the program can meet the growing community needs.

2. Community Paramedicine as an innovative model of care in Peel

The CP program in Peel is positioned as a key player in an integrated health system, bridging services across hospitals, primary care, public health, and community supports. As of 2024, the program has expanded to not only support seniors, but also supports patients 65 years and younger with complex health conditions.

The CP program continues to be delivered through two streams: Wellness Clinics and Home Visit programs. Both programs have made significant stride in providing tailored care to vulnerable populations.

a) **Wellness Clinics:** These clinics operate within the CP@Clinic model, where health assessments are conducted for seniors living at Peel Living buildings. Since 2024, CP@Clinic services have expanded from Mississauga to Brampton, and in June 2025, they will extend into Caledon. This expansion enhances health equity by ensuring vulnerable residents across Peel have access to essential healthcare and wellness support in their communities. Through this expansion, there can be a shift in health care system reliance away from acute care to preventative, community-based supports.

b) **Home Visits through the High Intensity Supports at Home (HISH) and the Community Paramedicine for Long-Term Care (CPLTC) programs:** The delivery of home visits to individuals, who have recently been discharged from hospital, managing chronic health conditions, or who are on the waitlist for long term care have played an integral role in preventing avoidable and repeat emergency department visits. This approach has enabled the stabilization of clients and supporting them to age safely in home as long as possible. Through partnering with Trillium Health Partner Solutions Team, the CP program has introduced a General Internal Medicine (GIM) medical approach which allows for tailored medical intervention for patients with multiple comorbidities. This model supports care continuity for hospital-discharged and homebound patients, integrating CP into a comprehensive health system approach to care.

3. Program Enrollment and Impact

The CP program continues to demonstrate measurable benefits for both patients and the healthcare system. In 2024, the program served 1,833 patients in the HISH and CPLTC programs.

The following highlight the program's enrollment numbers in support of delivering proactive preventative care and reducing reliance on primary hospital care:

I. *High Intensity Supports at Home (HISH).* 518 clients were registered in the program and community paramedics conducted 1,085 appointments in 2024.

II. *Community Paramedics for Long-Term Care.* Community Paramedics conducted 748 visits to Peel residents through this program.

III. *Community Paramedicine at Clinic (CP@Clinic).* In 2024, 1,760 clinic appointments were made through the CP@Clinic program. From January 1 to March 31, 2025, a total of 361 clinic appointments were made.

4. Collaborative System Integration

Partnerships are foundational to the success and actions carried out within the CP program. A strong collaboration with local health system partners, including Ontario Health Teams (OHTs), primary care providers, Peel hospitals, long-term care homes, and community care services has provided seamless care coordination, timely referrals, and integrated care planning for vulnerable residents. Additionally, the collaboration with Dr. Neil Dattani from William Osler Health System and Dr. Deana Hathout from Trillium Health Partners has enabled a medical team that has helped facilitate hospital integration and provide direct oversight and education to the CP program.

5. Continued Advancement of Community Paramedicine in Peel

Peel's CP program continues to demonstrate leadership in advancing integrated, person-centered models of care that adapt to the complex needs of vulnerable residents. There is a continued commitment to exploring opportunities that will strengthen the CP program to better serve the community.

a) **Community Paramedicine- Mental Health and Addictions (CP-MHA).** In response to emerging and urgent need in the community, PRPS is exploring opportunities to support individuals with MHA needs and those experiencing homelessness/precarious housing in our communities. In September 2024, Peel Region submitted a proposal to the Associate Minister of Mental Health and Addictions for a new CP-MHA program to be delivered through integration with existing community-based health, housing and social programs. Building from current efforts to provide wellness clinics at the Wilkinson Shelter, this program, if funded by the province, would expand this role by having CPs lead targeted wellness clinics to assess, treat and support clients with low-acuity or chronic MHA conditions, providing connections to appropriate health, housing and social resources.

b) **Program Review:** PRPS is undertaking an operational review of the CP program to assess its impact across service streams (e.g., CP@Clinic, HISH, CPLTC), its contribution to the broader health system, service utilization trends and innovative best practices. Findings from the review will inform program enhancements and strategic planning, applying a continuous improvement lens to ensure the CP program evolves to meet community needs and system priorities.

c) **Integration across the health sector.** As OHTs continue to lead the transformation of local health systems, Peel's CP program is playing an increasingly collaborative role in supporting integration across care sectors. For example, as part of the Government of Ontario's Primary Care Action Plan, there is a mandate to ensure that every person in Ontario is attached to a publicly funded, interdisciplinary team. These teams will include a family physician or primary care nurse practitioner, allied health supports and will aim to be seamlessly integrated with prevention focused, upstream supports. Peel's CP program intersects meaningfully with primary care by delivering in-community or home monitoring, connecting high-risk individuals to primary care providers, reducing hospital reliance and enhancing accessibility to care. Peel Paramedics continue to engage with system partners who are leading and contributing to an integrated health system in Peel.

d) **Expansion of CP@ Clinic:** Currently, the wellness clinics for seniors' living at Peel Living buildings are offered at eight sites. Through increased collaboration and expansion by the end of 2025, wellness clinics will expand to 10 sites, with the goal of ultimately providing the CP@Clinic program at all Peel Living senior buildings. By embedding CP within seniors' housing, this initiative will increase access to preventative and chronic disease management services, improve seniors' quality of life and enhance connections to primary care and community resources.

RISK CONSIDERATIONS

Without sustainable provincial funding, Peel will face challenges to plan and resource programs and become innovative to respond and adapt to new or emerging client needs. Although permanently based funded, the current funding levels for the CP@Clinic and HISH program are not keeping pace with the actual cost of delivering the program. The ongoing uncertainty with funding, poses an operational risk for not only the CP program's program deliver but also, its health equity approach for reducing the disparity in accessing healthcare.

FINANCIAL IMPLICATIONS

CP program costs are funded by Ontario Health and Ministry of Long-Term Care and are included in the Regional annual operating budget. Each program has a separate stream of funding. CP at Clinic and HISH programs are supported through permanent base funding.

Community Paramedics for Long-Term Care was originally funded by the province for a three-year period starting 2021 and was extended in 2024 for a further two years with annual funding of $3 million. This funding expires on March 31, 2026. Without this funding being renewed or made base past March 31, 2026, the program may not be able to continue without an alternate funding source. In addition, the funding received by the Region must be increased each year so that inflation does not erode the capacity to deliver the program.

CONCLUSION

PRPS continues to advance upstream, community-based approaches to health, while exploring opportunities to provide integrated, wraparound care to Peel residents with complex needs. As the health system evolves, the CP programs remain a critical component in reducing emergency department visits, lowering 9-1-1 call volumes, and alleviating pressures to acute care services. Ongoing advocacy, collaboration with system partners and OHTs, coupled with the commitment to innovation will be key to the program's continued success, now and into the future.

Nancy Polsinelli, RD HBSc MPA, Commissioner of Health Services

Authored By: Natasha Hodges, Advisor Paramedic Services

Peel Region

Peel Regional Community Paramedicine Program

Supporting Vulnerable Residents: An Update on Community Paramedicine in Peel

Brian Gibson - Chief and Director of Paramedic Services
Medical Director - Dr. Sudip Saha, William Osler Health System.

Objective

Highlight CP as an innovative model of care, its role in supporting vulnerable populations, and addressing health system pressures.

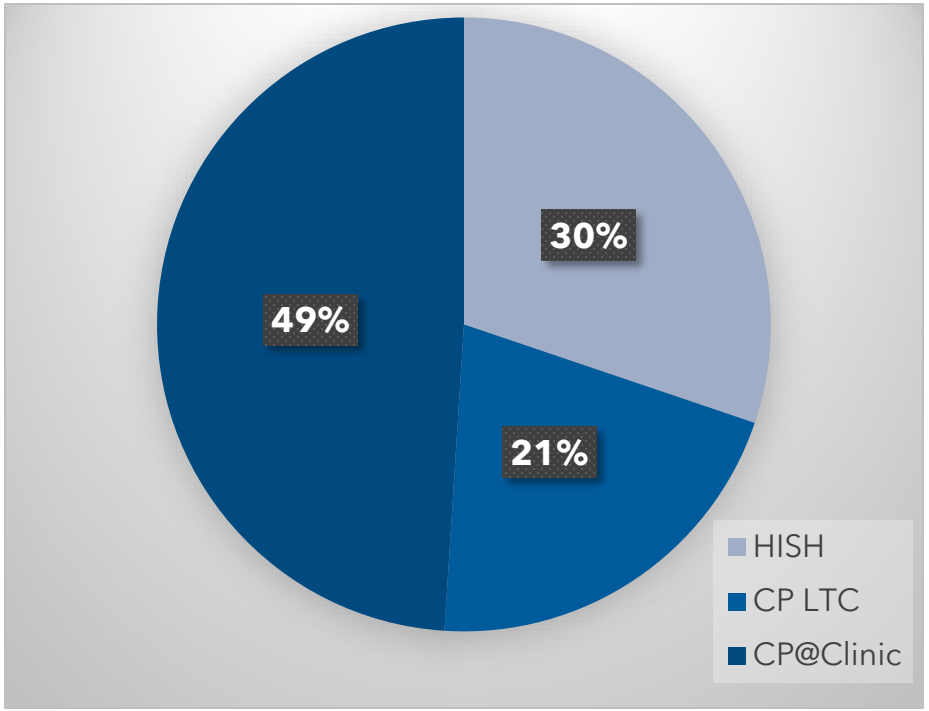
Share a patient's journey within the CP program.

To reinforce the importance of continued advancement, integration, and collaboration for CP programming.

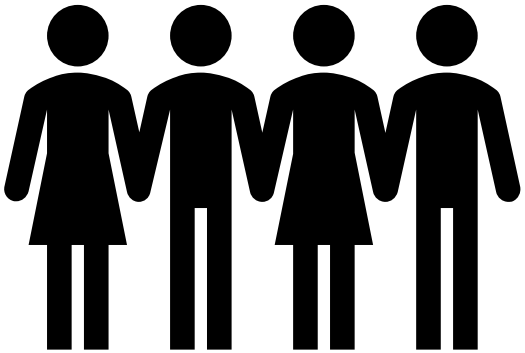
Community Paramedicine in Peel

- CP programming provides in-home and community-based service delivery to vulnerable populations.
- Supports the advancement of health equity by ensuring barriers are removed for accessing health care.
- Leveraging the unique skills of paramedics, enables a comprehensive health system approach to care.
- Collaborative system integration is foundational to the success of CP programs .

Program Enrollment and Data



1,833 patients enrolled in 2024



Lesley's CP Journey

Early 2023
Frequent weeklong hospital stays.

Nov 2023
Encounter with a Peel Regional Paramedic named, Alex. Referral made to CP program.

Dec 2023
Accepted into the CP program. Paired to Rachel Taylor, CP Paramedic.

Jan 2024-May 2025
Health supports, assessment, and referrals provided.

May 2025
Remains active within the CP Program.

Lesley's sentiments on the CP Program

"… it was a comfort to know that being with that program, I wasn't alone with all these issues."

"Every time there was an issue she would call and make sure I was ok. Basically, this whole transition from hospital to now, Rachel's been with me."

"It's a much-needed program, it's made me feel so safe and not alone,"

"But I'm not alone anymore because this program helped me so much in my journey, I know if another incident happens, I have their backing and their help."

Innovation and Future Opportunities

MHA Support	Innovative Best Practices	Local Health System Transformation	Wellness Clinics
Community Paramedicine-Mental Health and Addictions (CP-MHA).	**CP Program Review**	**Integration with Peel Primary Care Teams**	**Expansion of CP@ Clinic**

Peel Region

Thank you!

Questions?

Region of Peel
working with you

REPORT
Meeting Date: 2025-06-05
Health System Integration Committee

For Information

REPORT TITLE: **Advancing Integrated Team Based Primary Care in Peel**

FROM: Nancy Polsinelli, RD HBSc MPA, Commissioner of Health Services

OBJECTIVE

To provide an update on expansion of integrated primary care and Peel Region's role in advancing integrated, team based primary care partnerships, improving primary care attachment, and addressing equity gaps for Peel residents.

REPORT HIGHLIGHTS

- Many residents in Peel are not securely attached to primary care, underscoring the need for new and expanded models in priority areas.
- Ontario has committed $1.8 billion over five years to expand primary care access, including funding for new Interprofessional Primary Care Teams (IPCT). Central West and Mississauga Health Ontario Health Teams (OHTs) jurisdictions are identified as high-needs areas eligible for the first round of call for proposals.
- Peel Region will support system integration through targeted attachment strategies, coordinated referral pathways, and co-deigned models with primary care and community partners.
- Enhanced partnerships with Ontario Health Teams, local Primary Care Teams and Peel Region's Health and Human Services, can further enable integrated, accessible care for Peel residents, especially for priority populations.

DISCUSSION

1. Background

Primary care is a critical foundation of Ontario's health care system, often serving as the first point of contact for individuals seeking medical support. It refers to a range of services delivered in the community by health professionals—such as family physicians, nurse practitioners, and interprofessional health teams. When delivered effectively, primary care offers continuous, comprehensive, and coordinated services that are centred on individuals and families. It supports people across all stages of life, promoting better health outcomes and a more efficient health system.

Ontario's primary care system includes a range of practice models that differ in their structure, use of interdisciplinary teams, and payment or compensation methods. Interprofessional team-based models such as Family Health Teams, Community Health Centres, and Nurse Practitioner-Led Clinics offer integrated, coordinated care by combining the efforts of physicians, nurse practitioners and allied health. Models such as Fee-for-

Service, Family Health Organizations, Family Health Groups, and the Comprehensive Care Model traditionally operate independently with varying degrees of collaboration or integration with other providers. Collectively, these models support different population needs, provider preferences, and policy goals.

While there are a multitude of primary care models in Peel, relatively few residents are connected to a team-based primary care practice. According to Ontario Health, in 2022, over 374,000 residents within Ontario Health's Central Region, which Peel Region falls within, remain uncertainly attached to a Primary Care Provider, limiting their access to preventive care and increasing reliance on emergency departments. Within Peel specifically, 31 percent of Hills of Headwaters Collaborative patients have access to team-based care. Access is even more limited in Mississauga and Brampton, whereby only 10 percent of Mississauga OHT patients and 8 percent of Central West OHT patients are connected to team-based care – the lowest rates across Ontario Health's Central Region. This highlights a critical gap in the system's capacity to provide equitable, integrated, and comprehensive care.

2. Ontario's Primary Care Action Plan

To fill gaps in access to Primary Care, the Government of Ontario announced the Primary Care Action Plan, a cornerstone initiative under *Your Health: A Plan for More Connected and Convenient Care* in January 2025. The plan is guided by the Primary Care Action Team, chaired by Dr. Jane Philpott, with a mandate to ensure that every person in Ontario is attached to a publicly funded, interdisciplinary team. These teams will include a family doctor or primary care nurse practitioner, allied health supports and present an opportunity for seamless integration with prevention focused, upstream supports.

The Action Plan is grounded in six principles of care, which the government will embed in legislation through the *Primary Care Act, 2025*, that if passed, would establish six core objectives/guarantees:

1. Province-wide coverage access to a clinician or team
2. Connected and coordinated across health and social supports
3. Convenient and timely access
4. Inclusive and barrier-free care
5. Empowered patients and providers through digital integration
6. Responsive systems that reflect local health system needs

To implement the Primary Care Action Plan the provincial government has introduced the *Primary Care Act,* 2025 and is investing $2.1 billion over four years to improve access to team-based primary care across Ontario. This includes establishing up to 17 new or expanded community-based primary care teaching clinics. In 2025-26, $235 million will support up to 80 new or expanded primary care teams, with a target of attaching 300,000 more people to primary care within the year. The Province has confirmed that Toronto Metropolitan University (TMU) will receive operational support to open a teaching clinic in Brampton, helping to expand interprofessional care and medical training in high-needs communities in the region.

Ontario Health Teams (OHTs) as the vehicle for local system integration, are playing a leadership role in primary care expansion. Working closely with Primary Care Networks (PCNs) – which are established within each OHT to connect and support primary care

providers – OHTs are facilitating a collaborative approach to expand and enhance integrated primary care teams, reduce silos, improve system navigation, and accelerate access to care for Ontarians.

a) Integrated Primary Care Expansion in Peel

OHTs and PCNs will coordinate and support the development of new and expanded team-based primary care with local health system providers to close access gaps and strengthen connections to broader health and social services. In April 2025, a targeted call for proposals was launched to establish or expand Interprofessional Primary Care Teams (IPCTs) in high-need communities identified through postal code data. Two of Peel Region's Ontario Health Teams (OHTs) - Central West and Mississauga Health — were invited to submit proposals under this first round of eligibility. No postal codes within the Hills of Headwaters Collaborative OHT were identified for the first round. Funding decisions from the province are anticipated in summer 2025, with a second round of proposals expected to open in September 2025. The expansion of IPCTs in Peel offers an opportunity to build teams that support primary care practitioners with interdisciplinary expertise – ranging from mental health and nutrition to home care and social supports (i.e. housing) – enhancing care delivery by addressing the social determinants of health.

Peel Region will support opportunities for a collaborative approach to understanding alignment between primary care, health, and social services, recognizing the potential of IPCTs to strengthen system integration and improve care for residents in high-need communities.

b) Peel Region's role in Integrated Primary Care

Peel Region remains committed to advancing integrated, community-based health care by working closely with Peel OHTs and local community agencies. Primary care is a key avenue to support this integration, serving as a central point for connecting residents to a broader network of health and social services. Through active participation in planning tables and advisory groups, the Region contributes to shaping local primary care priorities, supporting data and digital infrastructure, and enhancing system coordination. For additional context, Appendix I provides a schematic of services provided by Peel Region, highlighting their connection to primary care and their role within the broader health system.

While traditional primary care is often associated with family physicians and nurse practitioners, many Regionally delivered and funded services—including Seniors Services, Community Paramedicine, and Public Health—share common objectives and intersect meaningfully with primary care delivery. In some cases, Peel Region is involved in the direct delivery of primary care to priority populations such as frail seniors or the homeless population. Examples of programs the Region leads or supports in collaboration with partners include:

- Delivery of specialized supports, and primary care oversight for seniors living in the community through the Integrated Care Clinic within the Seniors Health and Wellness Village at Peel Manor. This model offers primary care oversight and ongoing health management for older adults, aligning with the primary care goal of providing comprehensive, continuous care for older adults.

- The Community Paramedicine program delivers in-community or home monitoring and connections to primary care providers, particularly for high-risk or medically complex individuals, enhancing accessibility and reducing hospital reliance.
- Public Health services, including immunization programs, smoking cessation, sexual health clinics, parent-child supports, disease prevention, early intervention, and health promotion, which mirror and compliment key functions of primary care.
- The Community Healthcare model for homeless health. WellFort Community Health Services is Peel's lead health care services provider for homeless health care. WellFort provides essential primary care services for individuals experiencing homelessness in Peel at the Dundas Medical Shelter, as well as other locations throughout Peel where homeless and precariously housed individuals seek services, such as shelters and drop-ins. This model emphasizes the connection between health and housing and the need for health supports in order for clients to achieve better housing outcomes and a higher quality of life; the co-design of this model with the community will continue to evolve as new opportunities and challenges emerge.

3. Furthering Health System Integration through Primary Care Partnership

Expansion of primary care with a focus on integration presents an opportunity to explore enhanced coordination and collaboration between Regional services and local primary care teams, in alignment with the provincial call for proposals for Interprofessional Primary Care Teams. This integration not only strengthens system coordination but also creates more accessible, equitable and responsive care for residents, particularly those facing barriers to access. As an anchor institution in the community and health and social service provider, Peel Region is well positioned to contribute to integrated models that are responsive to Peel's diverse populations. Key areas of focus that the Region will explore and advance include:

- **Supporting targeted attachment and data-driven planning**: leveraging data expertise and existing service touchpoints to identify residents without regular access to primary care – and sharing this insight to support patient attachment and the planning and location of team-based models.
- **Enhancing integrated service delivery and referral pathways**: between primary care and Regional health and social services to create smoother transitions and more responsive service delivery.
- **Exploring collaborative models and co-location opportunities**: contributing to co-designed models with community input where possible and exploring opportunities for co-located services and cross-sector collaboration to support equity-deserving populations.

CONCLUSION

Peel Region is committed to being a proactive and strategic partner in the pursuit of integrated primary and community-based care, by offering its expertise in population health, fostering collaboration and system integration, and co-designing proposals that align with Regional priorities and population health goals. As both a health and social service provider and community leader, the Region is uniquely positioned to bridge health, social, and community supports through strong partnerships with Ontario Health, local OHTs, and primary care

providers across Peel. As Ontario advances its strategy to expand access to primary care through attachment strategies and growth of team-based models, the Region is committed to leveraging its cross-sector expertise to improve care pathways and reduce system fragmentation, shaping more connected, equitable and holistic care for Peel residents.

APPENDICES

Appendix I – Municipal Role in Health Services – Peel Region Perspective

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Nancy Polsinelli, RD HBSc MPA, Commissioner of Health Services

Authored By: Marlon Rhoden, Advisor, Strategic Public Policy

Peel Region
working with you

Municipal role in Health Services - **Peel Region Perspective**

Ministry of Health

Overall system oversight. Accountability agreements and funding to Ontario Health, boards of health and municipalities for paramedic services.

Ontario Health (Agency)

Oversees health care planning and delivery. Funding and accountability agreements with providers. Mandate to connect, coordinate and modernize health care system. Mental Health and Addictions Centre of Excellence oversees delivery and quality of MHA services.

Ministry of Long-Term Care

Oversight of LTC home system policy and funding through Ontario Health.

Public Health

Regional Council is Board of Health for Peel

- Ontario Public Health Standards programs
- Population Health Assessment and Public Health Emergency Management
- Healthy Babies Healthy Children funding by Ministry of Children, Community and Social Services

Paramedic Services

Peel Region is responsible for provision of land ambulance for Peel

- Operates 911 ambulance response
- Community Paramedicine programs (funded by Ontario Health and MLTC)
- Other community programs (e.g. Lay Responder support program, Public Access Defibrillator)

Primary Care

- Primary Care Practitioners and Teams
- Community Health Centres
- Integrated Primary Care Teams

❖ Referral to specialist care

- Integrated Care Clinic at the Seniors Health and Wellness Village
- Community Paramedicine
- Homeless Health Model at Shelters and Drop-Ins

Hospitals

- Trillium Health Partners – Mississauga and Credit Valley Sites
- William Osler Health System – Brampton Civic Site
- Headwaters Health Care Centre

- Peel Paramedics partnerships on offload delay strategies: e.g. Offload Nurses, Fit2Sit
- Community Paramedicine supports to ED patients

Home and Community Support Services

- Home Care
- Community Support Services
- Ontario Health @Home

- Peel Region operates 5 Adult Day Programs
- Respite care bed(s)

Mental Health and Addictions

- Community Mental Health and Addictions organizations and agencies
- Child and Youth Mental Health (CYMH) Providers
- Hospital Inpatient and Outpatient Programs
- CarePoint Health (Ontario Structured Psychotherapy lead agency)

- Community Safety and Well-Being Plan
- Peel Opioid Strategy
- Harm Reduction and Prevention
- Homeless and Addiction Recovery Treatment Hubs (HART Hub)

Long-Term Care

- 4,061 beds (2020) across 28 homes in Peel

- Regional Council has legislated role as Committee of Management for Regional LTC homes
- 703 beds across 5 LTC homes (2022)
- Leader in Emotion-focused care
- Seniors Health and Wellness Village at Peel Manor

Ontario Health Teams*

Comprised of sectors above with social service agencies and specialty care providers

3 OHTs in Peel

- Central West
- Mississauga Health (Accelerated)
- Hills of Headwaters Collaborative

OHT Mandate

OHTs work to integrate services across the health system, bringing together various healthcare providers and organizations to deliver coordinated care in a defined geographic area.

Peel Region role / engagement

- Member of each Peel OHT Collaboration Council
- Participate on and support OHT planning tables and working groups (e.g. health equity, data, seniors, etc.)
- Partner on various initiatives (e.g. respiratory season preparedness and response)
- Facilitate coordination across OHTs
- Provide support based on evolving needs (e.g. IT, data and analytics, communication, etc.)
- Facilitate community engagement

→ Funding flow

▭ Peel Region programs and services

* NOTE: Additional changes may be required as more health services are integrated into Ontario Health Teams