Leadership Team Report

September 2026

Mission Moment

Building Confidence Through Outpatient Rehabilitative Care

When balance challenges began making Shirley fearful of moving around her own home, everyday activities became uncertain. Through St. Joseph's Care Group's Seniors' Outpatient Assessment & Rehabilitation (SOAR) Program, she found a team that listened to what was important to her, and worked alongside her to rebuild her confidence. With personalized rehabilitation and connections to other supports, Shirley gradually became more active, independent and comfortable in her daily life.

For Rehabilitation Assistant Logan Krys, this is what makes the work meaningful: helping people understand what has changed, discover what they can do, and take their next step with confidence. Today, Shirley faces new challenges not with fear, but with determination: "I'll get there."

Submitted by Seniors Outpatient Assessment & Rehabilitation Program
Full story featured in the Ontario Hospital Association's August 2026 Health System News

Priority 1: Drive High-Quality People-Centred Care

Improving Health System Flow: Creating the Right Pathways Across the Continuum

People-centred care means care that meets people where they are in their health journey. It's providing the right care, in the right place, at the right time. When someone remains in a care setting that no longer matches their needs, it can delay their next step, limit access for others, and add pressure across the health system. Optimizing health system flow helps people move forward in their care journey while making better use of the capacity available across the system.

As a multisector healthcare provider, SJCG brings together different sectors of care and support within one organization. This creates opportunities to look at how people move between services, where connections can be strengthened and how we can make the best use of available capacity to respond to changing client needs.

Over the past year, we have improved client flow by reorganizing our reporting structure and establishing a dedicated Director position accountable for related performance measures, including occupancy and alternate level of care (ALC) rates. We have also deepened our relationships with acute care and Ontario Health partners, using shared data and local insight to inform decisions about capacity, transitions and system flow.

This approach is translating into tangible changes across our continuum. At Hogarth Riverview Manor, the first 32 of 64 beds previously held in abeyance were returned to service as long-term care (LTC) in August, with the remaining 32 beds planned in the coming weeks. This created additional LTC capacity for clients waiting in hospital for an appropriate placement and contributed to a reduction in the ALC-LTC rate at St. Joseph's Hospital from 23% to 18%.

At the same time, SJCG created 14 net new Community Transitional Care beds at Aspen Place, located within Hogarth Riverview Manor. These beds support people who no longer require the intensity of hospital care but still

need support while waiting for space to become available in the community. Together, these changes increase capacity outside hospital and provide more options for matching people to the care environment that best meets their needs.

At St. Joseph's Hospital, 4 South Transitional Care will launch a new model in October for clients who no longer require acute care but are not yet ready to return home. The model will serve clients whose destination is home but who need restorative care following an acute care stay, helping them regain function and independence before returning to the community.

The redesigned Frailty Identification for Transitions (FIT) for Geriatric Assessment & Rehabilitative Care (GARC) initiative is strengthening another pathway. Working alongside Thunder Bay Regional Health Sciences Centre's patient-flow team, the initiative is improving the identification of frail older adults who are ready for rehabilitation and connecting them with the SJCG program that best meets their needs.

Together, these examples demonstrate how SJCG is continuing to strengthen flow across the continuum not simply by moving clients from one setting to another, but by creating capacity, connecting services and matching care to what people need next. This supports better experiences and outcomes for clients while helping SJCG contribute to capacity and flow across the broader health system.

More Beds, Better Care: How the Legislation Looks in Practice

The *More Beds, Better Care Act,* 2022, sometimes referred to as 'Bill 7,' established a provincial framework for transitioning people who are designated Alternate Level of Care (ALC) to long-term care (LTC) when hospital-level care is no longer required. For SJCG, the legislation has become part of the day-to-day process of discharge planning, LTC placement and client and family communication.

In practice, the process begins with determining the most appropriate discharge destination. Consistent with the Ministry of Health's Home First approach, clients who can safely return home are supported to do so, including waiting at home for LTC where appropriate. When LTC is determined to be the appropriate setting, SJCG works with Ontario Health atHome, the client, substitute decision-maker, family and caregivers to support placement and transition.

For clients identified as ALC to LTC, the legislation provides the Ontario Health atHome placement coordinator with authority to determine LTC eligibility, select a LTC home, and authorize admission. Where an appropriate placement is identified, SJCG supports the client's transition from hospital. Where the placement is not the client's preferred home, clients and families are provided information about their options, including the ability to pursue a transfer when a preferred bed becomes available. If an eligible client declines an authorized placement and remains in hospital, the legislated daily fee applies.

What this looks like at St. Joseph's Care Group

Clear and timely communication of St. Joseph's Hospital's discharge policy and LTC placement process is provided to clients, substitute decision makers, families, and caregivers on admission. This includes written information outlining the LTC placement process as well as verbal and written communication regarding any fees that may apply during the client's hospital stay. Where an eligible client declines an authorized LTC placement and remains in hospital, St. Joseph's Hospital charges the $400 daily fee required by the legislation, in addition to the applicable provincial LTC co-payment.

Since January 2022, SJCG has supported hundreds of transitions from hospital to LTC, including placements where a client's preferred home was not immediately available.

Discharges from St. Joseph's Hospital to Long-Term Care	
Total clients discharged to LTC	562
Discharged to an LTC home that was either on their preferred homes list but **not** their first choice, or was not on their preferred homes list*	346
Transfer declined by client or substitute decision maker	12

**In Ontario, eligible clients can choose up to five (5) LTC homes as their preferred homes, and can rank their first choice home.*

The experience at SJCG's LTC homes provides another perspective on what happens after a client becomes a resident of a home that was not their first choice.

Admissions to SJCG's Bethammi Nursing Home & Hogarth Riverview Manor under the legislation	
Total admissions (includes preferred and non-preferred)	1,007
Admitted to non-preferred home	39
Residents still residing in non-preferred home or have passed away	30
Residents later transferred to preferred home when space became available	9

Together, these experiences illustrate the realities of LTC capacity. The first available appropriate placement may not be the client's preferred home, but it provides an opportunity to leave hospital and receive care in a setting designed to meet their needs. For some clients, the wait for a preferred home may extend beyond their lifetime.

SJCG's role is to ensure the process is implemented consistently with provincial requirements, while maintaining clear communication, supporting informed decision-making and coordinating safe transitions.

Priority 2: Nurture Our People

From Management Practices to a Culture of Support

Good management is built through the small, consistent actions we take every day.

Following February's Leadership Boot Camp with Bruce Tulgan, internationally recognized author, speaker and management expert, St. Joseph's Care Group launched the Leadership Fundamentals series, an eight-month journey focused on putting eight practical management practices into action. Each month, leaders receive a focused resource and an opportunity to consider how the practice can be applied within their teams.

Technology is helping us turn a leadership program into an organization-wide conversation. Through a Teams group accessible to more than 100 SJCG managers, leaders across our sites and sectors can connect beyond the physical boundaries of our organization and the demands of the workday. The online asynchronous format makes it possible to share ideas, ask questions and learn from one another when their schedules allow.

Managers use the space to bring real questions and experiences to one another. Conversations range from practical ideas for staying connected with their teams to questions about how to apply a management practice in a particular situation. Managers can test an idea, seek perspective, learn from a colleague's experience or simply find reassurance that they are not navigating a challenge alone. The result is a shared source of practical knowledge and support that managers can draw on when they need it.

Leadership Fundamentals is becoming more than a series of management lessons. It is creating a culture of peer learning and support where newer managers can learn from experienced colleagues, seasoned leaders can discover new approaches, and managers can turn learning into practice together. By creating these connections, we are helping foster the inclusive, supportive and healthy culture where people want to work, contribute and lead. When managers have the support and confidence to lead well, they create stronger teams and better conditions for delivering high-quality care and service to the clients and communities we serve.

Priority 3: Lead and Enhance Regional Specialized Care

Adapting to an Emerging Regional Need

Wildfire evacuations across Northwestern Ontario this summer provided an opportunity for St. Joseph's Care Group to adapt its services and expertise to an emerging regional need.

Beginning July 2, SJCG hosted evacuees from Kasabonika First Nation, followed by evacuees from Eabametoong First Nation as evacuations expanded across the region. In total, eight evacuees were supported through SJCG services, including at Hogarth Riverview Manor and St. Joseph's Hospital.

The response extended beyond accommodation and clinical care. SJCG drew on its organizational expertise to ensure supports were available as needs emerged. Information about available health and social services was made available through Getting Appropriate Personal & Professional Supports (GAPPS), while N'doo'owe Binesi provided culturally grounded supports to members of Namaygoosisagagun First Nation, including drumming with the Community Healing Drum and connection with Knowledge Keepers.

The experience is also informing SJCG's ongoing preparedness for future evacuations. Work is underway to establish a standard process for responding to evacuees and to develop an organization-wide inventory of available spaces and the supports associated with each, allowing future placements to be matched more effectively to individual care needs.

The wildfire response demonstrated that regional specialized care is not only about the services we provide every day, but also our capacity to mobilize those services and expertise when circumstances change across the region.

The impact of this summer's fires continues for the individuals, families and communities who were displaced, and SJCG recognizes that the effects will extend well beyond the immediate evacuation period. Our response was one small part of a much larger regional effort to support communities through an ongoing and difficult experience.