



## **Baycrest Hospital and Apotex, Jewish Home for the Aged Long-Term Care Home 2026/2027 Quality Improvement Plan Narrative**

### **Overview**

Baycrest Hospital and the Apotex Jewish Home for the Aged provide specialized geriatric care for older adults with complex medical, cognitive and dementia-related needs. As Canada's only health system fully dedicated to aging and brain health, we bring together compassionate care, clinical excellence and leading expertise in dementia care, cognitive health and seniors' wellness.

Our integrated continuum – spanning hospital care, long-term care and community-based seniors' services – ensures every older adult benefits from evidence-based practice, geriatric medicine and a team deeply experienced in aging and brain-health care.

Grounded in more than a century of serving older adults, we work across disciplines to improve outcomes and quality of life for people living with dementia, chronic conditions and age-related health changes. Through local, national and global partnerships, Baycrest is shaping the future of hospital and long-term care for seniors.

Exceptional aging, informed by compassion, science and experience, starts here.

In alignment with Ontario Health system priorities, Baycrest focuses on improving quality and safety, strengthening dementia care, advancing equity and access and supporting care delivery beyond hospital walls. Powered by leading-edge research, education and innovation, Baycrest serves the physical, mental and spiritual needs of older persons from all backgrounds.

Baycrest's strategic goals align closely with provincial priorities to strengthen care for seniors by:

1. Providing exceptional geriatric care and experiences through high-quality, safe and person-centred care;
2. Advancing world-class dementia care to support early identification, specialized treatment and system capacity; and
3. Extending care beyond the campus to support older persons across the continuum, including community, long-term care and provincial partners.

Continuous quality improvement drives Baycrest's approach and advances Ontario's priorities of accountability, performance measurement and system integration. The hospital and Long-Term Care Home use the Quality Framework, aligned with the strategic plan, as a clear blueprint to define, pursue and measure quality. The framework places people at the centre and offers a structured approach to quality by outlining its key dimensions and the outcomes Baycrest strives to achieve through the Quadruple Aim.

# Quality Framework

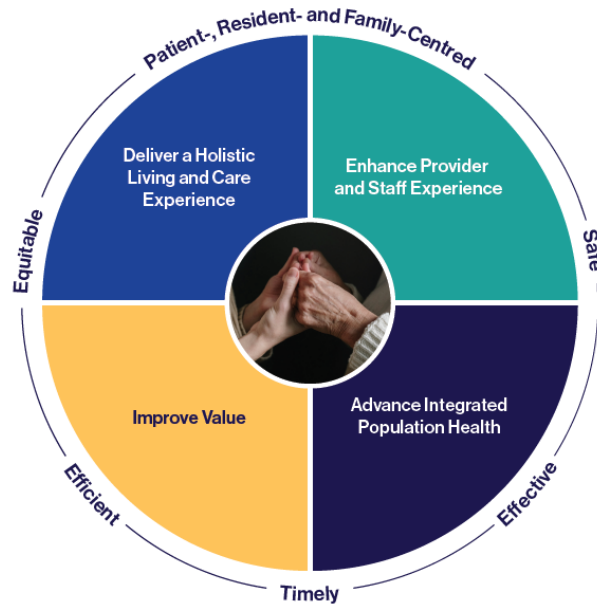
**Facilitators**

- Continuous Quality Improvement
- Innovation & Digital Enablers
- Provider Well-Being & Safety
- Staff & Volunteer Engagement and Expertise
- Collaboration with Clients, Families, Caregivers and System Partners
- Just and Learning Culture
- Best Practice, Legislation and Standards
- Accountability & Governance
- Data Transparency & Use

Guided by our values



Inclusive. Collaborative. Ambitious.  
Respectful. Excellent.



Aligned with Strategic Plan 2024-2029

Organization-wide quality initiatives, including the annual Quality Improvement Plan (QIP), are key enablers of Baycrest’s strategic goals and reinforce its contribution to a sustainable, high-performing health system for older persons.

## **Apotex**

The Apotex, Jewish Home for the Aged (Apotex), is a 472-bed long-term care facility offering a wide range of residential and specialized programs tailored to meet each resident's unique needs and preferences. Founded and grounded in the principles of Judaism, Baycrest’s faith-based approach emphasizes respect for every individual’s values and individuality.

Apotex takes pride in the sustained improvements made to enhance residents’ quality of life. Since 2020, resident responses to approximately 30% of quality of life survey questions have shown year-over-year improvement, with notable gains in residents’ social life. In 2025 alone, 40% of survey items demonstrated improvement compared to the previous year, particularly those related to respectful relationships between residents and staff and meaningful, resident-centred engagement.

## **Hospital**

Baycrest Hospital operates 262 post-acute care beds and offers inpatient, ambulatory care and community-based services for older persons. It is an active partner with the North Toronto Ontario Health Team and the North York Toronto Health Partners Ontario Health Team. Baycrest Hospital is committed to continuous improvement and recognizes that excellence in care, safety and experience requires sustained focus and learning.

Guided by organizational priorities and provincial quality expectations, the 2026-27 QIP focuses on the following key areas across Baycrest and the Apotex.

## **Advancing Equity, Diversity and Inclusion**

### **Apotex and Hospital**

In 2026, Baycrest will implement a structured Equity, Diversity and Inclusion Learning Journey, focused on leadership education, that embeds inclusive practices across the employee lifecycle. Foundational education on unconscious bias, psychological safety, antisemitism, systemic racism and cultural humility will be delivered throughout the year to support staff psychological safety, professional development and inclusive leadership capability.

## **Preventing and Addressing Workplace Violence**

### **Apotex and Hospital**

Baycrest is committed to maintaining a safe and respectful environment for everyone who works, learns, volunteers and receives care. Workplace violence has far-reaching impacts, affecting not only those directly involved but also the overall sense of safety and well-being across care settings. In 2026-27, the implementation of targeted workplace violence prevention and return-to-work improvement initiatives is expected to reduce the severity and operational impacts of workplace violence incidents across the hospital and long-term care home.

## **Ensuring Appropriate Use of Antipsychotic Medications**

### **Apotex**

Care teams often use antipsychotic medications to support residents living with dementia who experience severe responsive behaviours such as agitation, anxiety or aggression. While these medications may be appropriate in certain cases, they can be harmful when used without a clear clinical indication or when the risks outweigh the benefit. This ongoing quality improvement work focuses on consistently ensuring that clinicians prescribe antipsychotics only when clinically indicated, at the lowest effective dose, and for the shortest appropriate duration, supported by non-pharmacological approaches and interdisciplinary collaboration.

## **Reducing harm resulting from falls**

### **Apotex**

Reducing harm from falls is a critical priority for residents living in long-term care, as falls can lead to serious injury, loss of independence, functional decline, and emotional distress. While not all falls are preventable, the quality improvement goal for the next year is to prevent injuries from falls through targeted and proactive fracture risk assessments, medication reviews, individualized prevention strategies, and evidence-based recreation and exercise interventions that support residents' mobility and quality of life. Through this work, the home aims to create a safer environment while maintaining residents' autonomy and well-being.

## **Reducing Unplanned Emergency Department Transfers**

### **Apotex**

Unplanned transfers to the Emergency Department (ED) can significantly disrupt resident well-being, compromise continuity of care and negatively impact the overall care experience for residents and their caregivers. These transfers are often distressing, may expose residents to additional clinical risks and may result in functional decline. Over the coming year, Apotex will prioritize the implementation of a standardized, evidence-informed care pathway for the management of congestive heart failure, one of the leading causes of ED transfers from the home. This pathway will emphasize early identification of exacerbation symptoms and clear

escalation protocols. Through this approach, Apotex aims to meaningfully reduce the number of unplanned ED transfers over the next year.

## **Strengthening Residents' Ability to Speak Up Without Fear of Reprisal**

### **Apotex**

Baycrest is committed to upholding the rights of long-term care residents, including the right to express opinions and concerns freely and without fear of consequences. These rights are affirmed in the *Fixing Long-Term Care Act* and the *Resident Bill of Rights*. Over the coming year, quality initiatives will focus on strengthening communication practices, supporting staff responsiveness, and reinforcing trust between residents and staff to ensure residents feel safe, heard and respected.

## **Improving Pressure Injury Prevention and Management**

### **Apotex and Hospital**

Pressure injuries remain a significant risk for individuals with limited mobility, complex medical conditions or fragile skin, and can lead to serious complications and diminished quality of life. Preventing pressure injuries, especially those acquired in the hospital or in the long-term care home, is a critical safety priority for Baycrest. In the coming year, both the hospital and Apotex will focus on ensuring individuals identified as high risk have individualized prevention plans in place, strengthening early identification and intervention, and standardizing documentation to support consistent, high-quality care.

## **Ensuring Patients are Kept Well-Informed Throughout Their Stay**

### **Hospital- Inpatient**

Supporting meaningful information exchange continues to be a central priority in enabling patient and family partnership. Inpatient units will advance and sustain prior improvement efforts such as timely communication of discharge dates for units where applicable while also implementing a new patient experience survey and enhancing Baycrest's patient measurement system to generate more reliable and actionable insights.

## **Managing Risk of Inpatient Falls**

### **Hospital- Inpatient**

With ongoing prevalence of inpatient falls incidents, Baycrest works to follow health system best practices with managing falls risk. These efforts include a focus on a leading-edge therapeutic falls approach – one that clarifies and balances an appropriate amount of risk of falls while allowing for (and not preventing) recovery of mobility in patients. Implementing an updated, validated falls risk assessment (screening) tool (FRAT) is planned to improve managing falls risk, along with running falls safety huddles that have inter-disciplinary staff identify and enact proportionate, preventative measures.

## **Increasing Enrollment to Team-based Primary Care in a Community Setting**

### **Hospital- Ambulatory**

The Neighbourhood Care Team (NCT) is a Primary Care Geriatric Integrated Team that unites health care organizations, providers, and their clients (patients, families, and caregivers), to improve the integration and coordination of care and operate as 'one team' in the eyes of the patient. The NCT care model addresses the needs of a population of older adults congregated in a residential building who want to age in place in the community. This QIP will evaluate the feasibility of expanding the NCT model to a Naturally Occurring Retirement Community (NORC).

## Access and Flow

### Apotex

At Apotex, system access and flow continue to be strengthened through collaborative partnerships and enhanced clinical capacity that support timely access to long-term care and the provision of individualized, person-centred care.

Apotex collaborates closely with Ontario Health at Home to ensure that applicants experience timely, coordinated, and compassionate admissions. With support from the Advanced Practice Lead for Responsive Behaviours and Behavioural Supports Ontario, applicants with highly complex dementia-related needs receive specialized transition support, enabling expedited admissions and safe early stabilization. Ongoing collaboration with the Baycrest Virtual Behavioural Medicine Program offers on-site virtual support for highly complex residents with challenging dementia-related responsive behaviours, potentially reducing the need for a FORM 1 transfer to the ED.

In addition to the existing partnership with the LTC+ program at Sunnybrook Hospital, which provides direct access to a suite of services including general internal medicine, another partnership has been established to support direct admission, thereby bypassing the ED and potentially reducing ED wait times.

These partnerships help alleviate hospital pressures and promote continuity, efficiency, and improved patient flow across the broader system. At Apotex, partnership opportunities and internal workflows, including occupancy management and readiness processes, are continually evaluated to ensure that eligible residents are admitted promptly and that individualized care needs can be met in the home.

Apotex values its collaboration with the Sunnybrook Nurse-Led Outreach Team (NLOT). Through on-site supports such as antiviral and antibiotic IV therapy, staff capacity building, and early identification of acute changes, NLOT is helping to strengthen Apotex nurses' knowledge and skills, prevent unnecessary ED transfers, and promote earlier return for hospitalized residents whose specialized needs can be met in the home.

Apotex enhanced its skin and wound care program and established a specialized team. Timely, resident-centred bedside care reduces reliance on external referrals, supports improved clinical outcomes, and helps ease demands on the broader health system.

Apotex is currently engaged in a research study that has enabled IPAC Leads and Nurses to develop the skills necessary to perform real-time testing of symptomatic residents to identify respiratory viruses quickly. Early detection can minimize transmission risk and enable timely intervention, which can result in ED avoidance—particularly important during high-pressure periods such as influenza season.

### Hospital

Baycrest continues to align utilization, access, and patient flow strategies with provincial ALC leading practices and the Home First operational direction, ensuring timely transitions while delivering holistic, person-centred care.

ALC performance remains stable and actively managed. In 2025, Baycrest averaged 37 open ALC cases at any given time. While Q3 year-to-date activity reflected 39 open cases, focused discharge planning and introduction of Hospital to Home resulted in a reduction to 34 in early Q4. ALC throughput remains strong at 1.23 (Q3 YTD), exceeding the provincial target of >1.0, reflecting sustained improvements in transition planning and system flow.

Access to inpatient services has expanded year over year. Q3 YTD volumes position Baycrest to serve approximately 1,310 patients by fiscal year-end—an increase of more than 150 patients compared to the prior year—demonstrating enhanced system capacity while maintaining care quality. Increase in occupancy is mainly attributed to decreased length of stay. Occupancy remains high at 96.7%, surpassing the provincial benchmark of 95%. This indicates effective bed utilization while preserving patient flow and minimizing avoidable delays.

In 2025, supported by Ontario Health, Baycrest implemented the Hospital to Home (H2H) Program in partnership with Bayshore HealthCare, strengthening transitional pathways and extending person-centred care beyond hospital walls.

Since launch on November 13, more than 50 referrals have been completed. The program has enhanced Baycrest's ability to safely discharge higher-acuity patients who may otherwise have experienced prolonged hospitalization. Through strong interprofessional collaboration and coordinated discharge planning, H2H reduces transition barriers while maintaining continuity, safety, and alignment with Home First principles. Baycrest is actively advancing toward an ambitious fiscal year H2H utilization target of 100 referrals, reflecting strong clinical engagement and organizational commitment to optimizing transitional care and patient flow.

## Equity and Indigenous Health

Baycrest is committed to advancing equity, diversity, inclusion and health equity through a comprehensive, phased approach that strengthens workplace culture, staff experience, and organizational capacity. This work is grounded in education, employee voice, and shared accountability, and aligns with broader health equity and reconciliation priorities.

In 2026, Baycrest will implement a structured Equity, Diversity and Inclusion (EDI) Learning Journey that embeds inclusive practices across the employee lifecycle. Foundational education on unconscious bias, psychological safety, antisemitism, systemic racism, and cultural humility will be delivered early and throughout the year and reinforced through leadership forums, point-of-care training, and recognition initiatives. This approach supports staff psychological safety, professional development, and inclusive leadership capability.

Ongoing engagement and feedback remain central to Baycrest's EDI strategy. Regular staff listening activities, monthly Health Equity Committee meetings, and bi-monthly Cultural Advisory Panel sessions provide mechanisms for continuous dialogue, informed decision-making, and shared accountability. In 2026, Baycrest will also establish an EDI Community of Practice to strengthen collaboration and applied learning across teams.

Cultural recognition and learning activations, including Black History Month, Asian Heritage Month, Pride, National Indigenous Peoples Day, Truth and Reconciliation, and Holocaust Remembrance, are intentionally integrated throughout the year to foster belonging, respect, and awareness. These efforts are supported by refreshed digital platforms, departmental toolkits,

and accreditation-aligned practices. Through continuous measurement and improvement, Baycrest reinforces its commitment to an equitable, inclusive, and culturally safe workplace.

## Patient/Client/Resident Experience

### Apotex

Providing exceptional care and experience is one of the home's strategic goals. **The *Fixing Long-Term Care Act, 2021* places resident experience at the centre of long-term care.** It affirms that a long-term care home is primarily the residents' home and mandates that care be delivered in a way that upholds dignity, choice, safety, and quality of life. The Act's Resident Bill of Rights guarantees residents the freedom to express their views, participate in decisions about their care, pursue meaningful activities, and raise concerns without fear of reprisal. It also ensures their right to respectful relationships, privacy, individualized support, and full involvement in care planning. Taken together, the legislation sets clear expectations that homes create an environment where residents feel heard, valued, and empowered, and where their lived experience directly informs care and service delivery.

Apotex integrates experience-based feedback into its improvement initiatives through a range of councils, surveys, and feedback mechanisms. Active forums such as the Resident Advisory Council, Family Advisory Council, and Client Food Committee foster collaboration and encourage innovative ideas to enhance the resident and family experience.

Leadership also gathers formal feedback through the internationally validated interRAI Resident and Family Quality of Life surveys, with over 200 responses collected last year. Results are shared with residents, families, staff, and advisory councils, informing meaningful change. For transparency, these findings are publicly accessible through the Apotex website and displayed throughout the home. Additionally, themes from the complaints process are reviewed quarterly by the Apotex Quality Committee to identify emerging issues and drive improvement.

Through its participation in the Seniors Quality Leap Initiative, an international consortium dedicated to advancing quality of life in long-term care, the Apotex compares its resident and family quality of life results against international benchmarks. This broader perspective highlights strengths, identifies areas for improvement, and helps guide targeted quality improvement strategies.

By combining resident-generated data, structured feedback mechanisms, and ongoing dialogue, Apotex reinforces its commitment to ensuring that every resident feels heard, respected, and empowered, ultimately enhancing the quality, responsiveness, and transparency of care within the home.

### Hospital

The hospital gathers feedback on care experiences through internally designed surveys administered across inpatient units. Participation in these surveys is voluntary, with responses remaining anonymous and confidential. The surveys evaluate key aspects of the care journey, such as access to services, quality of care, the care environment, and inpatient services including activities. Findings are reviewed to highlight trends and identify opportunities for improvement, which directly inform the hospital's annual QIP. A continued priority is fostering

strong partnerships with clients and families through clear, consistent communication beginning at admission and continuing throughout the hospital stay.

To enhance the client experience measurement consistency and support provincial comparison, the hospital is implementing the Ontario Hospital Association's (OHA) standardized client experience survey within rehabilitation and mental health units. This transition strengthens the client experience measurement framework by enabling more reliable benchmarking and deeper insight into client and caregiver perspectives.

Ambulatory clients are invited to complete a satisfaction survey following their visit. A Net Promoter Score (NPS) is based on this question: "On a scale of 1 – 10, how likely is it that you would recommend this clinical service to somebody else in the same situation?" A NPS above 0 is favorable as it indicates a service has more promoters than detractors. In Q3 2025/26, the Ambulatory NPS was +40. Ambulatory Leaders continue to promote the survey in clinics and actively monitor results for continuous improvement.

Client Family Partners (CFPs) remain central to improvement efforts, contributing lived experience expertise to interprofessional committees and initiatives. Their input shaped the hospital's 2024–2029 Strategic Plan and continues to guide the identification of quality priorities and improvement strategies. The hospital further reinforces this approach by engaging directly with current patients and families through surveys and individual conversations to inform, test, and refine change initiatives.

## Provider Experience

Baycrest is advancing a focused set of people-centred initiatives to strengthen recruitment, retention, workplace culture and the overall staff experience. Priorities include modernizing Baycrest's recruitment and employer brand to better reflect the purpose, values and commitment to equity, diversity and inclusion, while streamlining hiring processes to improve candidate and manager experience. Baycrest is enhancing onboarding and early-career supports to help new employees integrate quickly and build meaningful connections across teams. To support retention and engagement, Baycrest is expanding leadership development and people-leader capability, strengthening career pathways and internal mobility, and introducing more consistent learning and development opportunities. Baycrest is also investing in employee well-being and psychological safety through targeted wellness supports, improved workload and staffing practices, and regular listening mechanisms that give staff meaningful opportunities to share feedback and shape solutions. Together, these initiatives are designed to create a respectful, inclusive and high-performing workplace where people feel supported, valued and able to do their best work in service of Baycrest's residents, patients, families and communities.

## Safety

Safety remains a core priority at Baycrest, aligned with the 2024–2029 Strategic Plan and embedded in Strategic Goal #1: *Provide Exceptional Geriatric Care & Experience*, which emphasizes high-quality, safe care through continuous improvement and innovation. To support this goal, Baycrest has implemented the Client Safety Plan 2024–2029, focused on five key areas: strong leadership commitment to safety; consistent safety terminology; standardized

processes for accountability and learning; incorporation of Safety II principles to understand how care succeeds; and shared responsibility for safety among staff, physicians, clients, and families.

Baycrest's approach integrates foundational safety practices such as leadership support and use of the Canadian Incident Analysis Framework along with aspirational Safety II concepts that emphasize early risk identification, adaptability, and system resilience. Safety is measured not only by the absence of harm, but by how effectively teams anticipate risk, respond early, and prevent escalation. Rather than focusing solely on harm that occurred, Baycrest teams emphasize learning from how escalation, early identification, and team coordination successfully protected patients and residents from worsening outcomes. Attention is given to medication safety, skin integrity, and safe care transitions, with a focus on learning from successful interventions rather than harm alone.

A priority under Strategic Goal #1 is reducing Baycrest-acquired Stage III and IV pressure injuries. Ontario Health's Never Events framework applies to 11 types of events across Baycrest's hospital programs, with pressure injuries remaining the most frequently reported. This reinforces the organization's continued focus on prevention and early detection.

Key enablers include enhancements to the Safety Event Reporting System, which now supports simpler, near real-time reporting of hospital-acquired pressure injuries. These improvements enable earlier visibility of risk, structured interprofessional huddle reviews, and aggregated learning from safety events. Consistent safety review forums, including wound rounds and interprofessional rounds, continue to support shared clinical understanding and timely, targeted prevention planning.

Process mapping identified opportunities to improve detection and validation of pressure injuries. In response, Baycrest implemented automated flagging within the clinical information system to alert teams to newly documented injuries in real time. Interprofessional collaboration, led by the Wound Care Advanced Practice Leader, supports accurate staging, timely intervention, and prevention planning. A pilot unit is testing a standardized review workflow prior to broader implementation.

Overall, Baycrest's ongoing enhancements to incident reporting and governance reflect a strong commitment to a learning-focused, responsive safety culture. Through trend analysis, root-cause review, and cross-organizational collaboration, Baycrest continues to strengthen safety and improve outcomes for patients, residents, families, staff and visitors.

## Palliative Care

### **Apotex**

The Apotex integrates palliative care throughout the entire illness trajectory by embedding a resident- and family-centred approach into every stage of care—from diagnosis of a life-limiting illness to end-of-life and bereavement. Care teams address physical, emotional, spiritual, and social needs using an interprofessional model aligned with the Palliative Care Health Services Delivery Framework and the Quality Standard for Palliative Care. This ensures timely conversations about goals of care, shared decision-making, and coordinated transitions.

The interprofessional team in Apotex, consisting of physicians, nurses, social workers, spiritual care providers, recreationists, and pharmacists collaborates to manage pain, restlessness,

anxiety, and other palliative and end of life symptoms. This supports the standard of comprehensive, holistic assessment and management. By reducing symptom burden, especially pain management, residents experience greater comfort, maintain independence longer, and families gain reassurance and guidance. Moreover, as death approaches, the focus shifts to maximizing comfort, preventing suffering, and respecting cultural and spiritual preferences.

Spiritual care is a core component of high-quality palliative and end-of-life care in Apotex. It is integrated as part of a holistic, person-centred approach and is delivered by interdisciplinary teams led by the Spiritual Care Team. Once a resident is identified palliative or end of life, referral is made to the Spiritual Care Team to follow up (with POA/SDM consent). The team offers one-on-one visits to provide comfort care, facilitating religious rites and rituals and providing emotional support the resident and their family members. This acknowledges the resident's body, spirit and their faith or lack thereof, promoting dignity, comfort and meaning at the end of life.

Ongoing palliative and end of life care education sessions are being conducted among nursing staff members (PSWs and nurses included). A quarterly education session is being held to build foundational knowledge on illness trajectories, family communication, symptom recognition, pain management, and goals-of-care conversations. These education opportunities foster a knowledgeable, compassionate workforce capable of delivering high-quality palliative and end-of-life care for residents in Apotex.

## **Hospital**

Baycrest Hospital remains committed to providing a palliative approach to care throughout a patient's care journey, including end-of-life care, in alignment with its strategic priority to Provide Exceptional Geriatric Care & Experiences. Recognizing the complex needs of frail older adults, palliative principles are embedded on all inpatient units through an interprofessional model that promotes quality of life, symptom management, psychosocial well-being, and family engagement.

Consistent with Quality Statement 5 of the Ontario Health Quality Standard, Baycrest prioritizes individualized, person-centred care plans developed collaboratively with patients, families, substitute decision-makers (SDMs), primary care providers, and the interprofessional team.

In 2025/26, Baycrest completed a comprehensive current-state and gap analysis of its Plan for Life-Sustaining Treatment (PLST) practices and policy, assessing alignment with provincial standards, legislation, and accreditation requirements. This review identified opportunities to strengthen clarity, consistency, and patient engagement in goals-of-care discussions.

In response, a new Goals of Care framework will be implemented in 2026/27, including a revised policy replacing PLST, a standardized order set, structured conversation guides for capable patients and SDMs of incapable patients, and a comprehensive interprofessional education plan. These tools will enhance engagement, promote high-quality conversations, and reinforce that goals-of-care discussions are dynamic and evolve with changes in health status.

Documentation practices within the Health Information System (HIS) are being strengthened to ensure goals-of-care decisions are clearly recorded, visible, and accessible across disciplines, improving consistency, transitions of care, and future HIS readiness. Providing culturally

responsive and inclusive end-of-life care remains a priority. Ongoing efforts focus on inclusive language, equitable practices, and greater awareness of cultural dimensions of serious illness and dying.

In the ambulatory clinics, palliative care for people with neurodegenerative illness (such as Parkinson's Disease) is provided through a first-of-its-kind neuro-palliative outpatient clinic. Patients and caregivers have access to supportive care, links to community supports where needed, and increases in their capacity for future decision-making based on illness understanding and goals of care.

## Population Health Management

As a founding partner of both the North Toronto Ontario Health Team (NT OHT) and the North York Toronto Health Partners (NYTHP), Baycrest remains deeply committed to advancing population health and equity-based approaches to care for communities served. Baycrest's intention is to support interoperability between neighbouring OHTs and uses the same eight-step approach to Population Health Management and Equity (PHME) to adapt services to proactively meet health and social needs of the community. This approach leverages data from a wide range of partners, including hospitals, primary care physicians and community support and social services, to ensure understanding of health and social determinants impacting individuals in the region. Baycrest collaborates with patients, families, caregivers and community members to co-design new and/or improve care models that are meaningful and tailored to their needs. The PHME approach drives the NT OHT and NYTHP's strategic priorities while enabling Baycrest's strategic goal to *Extend Care Beyond Our Campus to Support Older Persons Locally & Provincially* (to age in place) by developing scalable models in collaboration with partners. Baycrest's "North Star" (the main indicator of performance) for expanding care beyond the campus is: one million cumulative nursing home bed days avoided by March 31, 2029.

Primary care is the foundation of a strong health care system and plays a critical role in improving population health and coordinating care across the continuum. In the past year, Baycrest has supported primary care strategies together with partners to ensure all North Toronto and North York residents access team-based care by: (1) creating Integrated Health Hubs (Hub), (2) expanding team-based care for local primary care physicians and (3) developing Neighbourhood Care Teams in Toronto Seniors Housing Corporation buildings.

### *Neighbourhood Care Team*

The Neighbourhood Care Team (NCT) is integrated care model within Toronto Seniors Housing Corporation buildings. NCT re-organizes existing providers into 'one team' to provide primary care, community support, and access to specialists to address tenants' health and social needs so that they can age well at home. The aim of the NCT, to reach 1,500 or more Toronto Senior Housing Corporation tenants by March 2025, was met. Baycrest was invited by North York Toronto Health Partners and the NORC Innovation Lab to expand the NCT model to a non-TSHC building at 100 Upper Madison Avenue.

Through the leadership of a Baycrest Clinical Manager Baycrest is applying the standard NCT approach to organizing existing care providers with new buildings into 'one team' in the eyes of the patient. This approach includes need assessments through Wellness Clinics and surveys.

Needs inform the co-design of the care with residents. In consultation with Care Coordinators, who determine eligibility for nursing homes, it is estimated that approximately 10% of tenants are eligible for a nursing home but are aging at home with supports.

Baycrest continues to serve as an active hospital partner to both the NT OHT and NYTHP and remains committed to using its PHME approach to address identified healthcare gaps and improve health outcomes across the community it serves.

## Executive Compensation

Baycrest has a long history of utilizing a performance management framework and performance-based compensation strategy for the Senior Executive Team. Each year, the Board and Senior Executive Team reflect on the performance of the organization and consider what incentives will best support accountability and continuous improvement. This strategy involves the creation of team (40%) and individual (60%) based goals, which include both process, and outcome measures to ensure a balanced approach to performance that adequately reflects the organization's values, strategic priorities and annual objectives. In accordance with the requirements of the Excellent Care for All Act, 2010, Senior Executive Team compensation is linked to performance on selected QIP indicators.

Executives who have 40% of their performance/at risk compensation linked to achieving team goals, including the identified QIP indicators, are as follows:

- President and Chief Executive Officer
- Vice President, Clinical Services, Clinical Support and Chief Nursing Executive
- Vice President, Medical Services and Chief of Staff
- Vice President, Digital Transformation, Chief Information Officer and Chief Privacy Officer
- Vice President, Finance and Chief Financial Officer