Ontario Health Teams Central Evaluation

Findings from the 2022 Organizing for OHTs Survey - Cohorts 1, 2 and 3

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HSPN Health System Performance Network

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About this Report

This report is a part of the Ontario Health Team (OHT) Evaluation and focuses on the results from the 2022 Organizing for Ontario Health Teams (OOHT) survey for the 51 OHTs that submitted full applications in Cohort 1, 2 and 3 and examines the differences in the results for Cohort 1 and 2 compared to the first time they complete the survey in 2020 and 2021 respectively. While the results of Cohort 1 and 2 teams approved in October 2020 and 2021 respectively reflect teams further along on their development, the Cohort 3 applicant OHTs data were captured soon after submission of the full application and, therefore, early on in their development. The results across the 51 OHTs reflects the coverage of 95% of the Ontario population as of March 2022.

This report describes the OOHT survey, administration, organization, and network contexts of all three cohorts as of May 2022. The results compare the three cohorts at 2022 as well as comparing Cohort 1 and Cohort 2 results in 2022 to 2020 and 2021 respectively. The report also presents results grouped by cohort due to the differences in the cohorts' baseline survey and approvals.

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OHT Key

Cohort 1

OHT 01	Huron Perth Area OHT
OHT 02	Central West OHT
OHT 03	East Toronto Health Partners (ETHP) OHT
OHT 04	Northumberland OHT
OHT 05	Middlesex London OHT
OHT 06	Mississauga OHT
OHT 07	Barrie and Area OHT
OHT 08	Hills of Headwaters Collaborative OHT
OHT 09	North York Toronto Health Partners OHT
OHT 10	All Nations Health Partners
OHT 11	Ottawa Health Team/Équipe Santé Ottawa
OHT 12	Chatham-Kent OHT
OHT 13	Eastern York Region & North Durham OHT
OHT 14	Niagara OHT
OHT 15	Muskoka and Area OHT
OHT 16	North Toronto Health Collaboration
OHT 17	Cambridge North Dumfries OHT
OHT 18	Peterborough OHT
OHT 19	Nipissing Wellness OHT
OHT 20	Durham OHT
OHT 21	Guelph Wellington OHT
OHT 22	Greater Hamilton Health Network OHT
OHT 23	Algoma OHT
OHT 24	Burlington OHT
OHT 25	Southlake Community OHT
OHT 26	Couchiching OHT
OHT 27	North Western Toronto OHT
OHT 28	Western York Region OHT
OHT 29	Ottawa East OHT
OHT 30	Connected Care Halton OHT

Cohort 2

OHT 31	West Toronto OHT
OHT 32	North Simcoe OHT
OHT 33	Frontenac, Lennox & Addington OHT
OHT 34	Connected Care for LLG OHT
OHT 35	Downtown East Toronto OHT
OHT 36	South Georgian Bay OHT
OHT 37	Oxford and Area OHT
OHT 38	Mid-West Toronto OHT
OHT 39	Windsor Essex OHT
OHT 40	Brantford Brant OHT
OHT 41	Sarnia Lambton OHT
OHT 42	Kitchener, Waterloo, Wellesley, Wilmot and Woolwich (KW4) OHT
OHT 43	Rainy River District OHT
OHT 44	Scarborough OHT
OHT 45	Kawartha Lakes OHT

Cohort 3

OHT 46	Hastings Prince Edward OHT
OHT 47	Ottawa West Four Rivers OHT
OHT 48	Great River OHT
OHT 49	Grey Bruce OHT
OHT 50	Elgin OHT
OHT 51	Ottawa Valley OHT

Executive Summary

This report contains results from the Organizing for Ontario Health Teams (OOHT) leadership survey administered to the first, second and third cohort of Ontario Health Team (OHT) applicants in 2022. For the first two cohorts, this report includes changes from baseline data collected in 2020 and 2021, respectively. The report describes the extent to which critical success factors for the implementation of integrated care are present to identify areas the OHTs and government should focus efforts.

Background

In April 2019, following the enactment of *The People's Health Care Act*, *2019*, the Ontario Ministry of Health (MOH) introduced OHTs as a new way of organizing and delivering care that is more connected to patients in their local communities. Organizations interested in partnering to form an OHT were invited to submit a self-assessment. Following a review of over 150 self-assessments by the MOH, 30 OHTs moved forward to submit full applications in December 2019 (Cohort 1). In September 2020, 15 OHTs submitted a full application (Cohort 2). The MOH announced the third wave of six approved OHT Candidates in September 2021 (Cohort 3).

The OOHT leadership survey captures ten domains measuring critical success factors/capabilities for integrated care, with Likert response options scored from 1-5, where a higher score indicated a high degree of a success factor. All approved candidate OHTs were surveyed between March 2022 and May 2022. The person most involved in the development of the OHT from each signatory organization was sent a link to the online OOHT survey. For Cohorts 1 and 2, signatories verified to ensure organization and/or individuals in original application were still involved and if there were new organizations/individuals' signatories (N=1,425). Invitations to a French version of the survey was also available upon request.

The 2022 results are based on 653 respondents (response rate 46%), with an average of ~13 respondents per OHT (54% average response rate across OHTs), and a mode of 54%. Respondents within teams held a variety of roles, from CEOs of organizations to patient, family, or caregivers. Just over two-thirds of survey respondents (~67%) were in executive roles.

Results in Brief

The four domains with the ***highest*** ratings across OHTs were:

- *Commitment to Improvement* (mean=3.72/5.0);
- *Team Climate* (mean=3.68/5.0);
- *Administration and Management* (mean=3.60/5.0) and;
- *Roles and Responsibilities* (mean=3.60/5.0).

All three cohorts reported high capability in skills and ability to implement integrated care through their partnerships (mean=4.17). However, only half of the OHTs (26/51) had ≥80% of respondents selecting 4 (very good) or 5 (excellent) regarding trust within their OHT.

The four domains with the ***lowest*** ratings were:

- *Financial and Other Capital Resources* (mean=2.85/5.0);
- *Clinical-Functional Integration* (mean=3.06/5.0);
- *Shared Vision* (mean=3.41/5.0) and;
- *Non-Financial Resources* (mean=3.42/5.0).

Generally, Cohort 1 had the highest mean scores, followed by Cohort 2 and Cohort 3 across all ten domains with exception of the *Financial* and the *Non-Financial Resources* domains where Cohort 2 had the highest mean scores. Cohort 3 consistently had the lowest mean scores across all domains.

As was observed in previous results of the OOHT survey, efforts/supports continue to be a need for all OHTs to build capacity for integration and basic structural resources like finances and information technology are required to allow for information to be shared across OHT members.

We also examined the variability within- and between- OHTs for each domain. The *Commitment to Improvement, Administration and Management, Leadership Approach* and *Shared Vision* had the greatest variation across OHTs relative to the variation within OHTs suggesting ***some*** OHTs (i.e., those with lower mean scores) will need more effort/supports.

For the *Clinical-Functional Integration*, *Financial and Other Capital Resources*, *Non-Financial Resources* and *Readiness for Change – Suitability* domains, the low variability across OHTs suggests similar levels of achievement and ***most*** OHTs will require effort/supports to enable successful integrated care.

Compared to previous OOHT survey results from Cohort 1 and 2, substantial decreases in mean score (> -0.8) were observed in three domains; 1) *Readiness for Change – Suitability* (e.g., I think my organization will benefit, make my role easier and personally worthwhile for my organization to adopt the change), 2) *Shared Vision* (e.g., developed goals wildly understood and support, respond to the needs of the community and include views and priorities of the people affected by OHT work) and 3) *Commitment to Improvement* (e.g., have a common vision of how to integrate care and agree to share responsibility for improved patient outcomes). The *Financial and Other Capital Resources* domain increased modestly (+0.7).

What have we learned?

- Mean scores across all domains were lower than previous OOHT survey results except for the *Financial and Other Capital Resources* domain. All OHTs have room to improve, as no OHT consistently ranked above the 80th percentile across all domains. However, two OHTs, Cambridge North Dumfries and South Georgian Bay had ≥80% of the respondents selecting 4 or 5 in six and seven of the 10 domains, respectively.
- Similar to previous OOHT survey results, the highest rated domains were *Commitment to Improvement* and *Team Climate* indicating a strong commitment to improving integration of care and responsibility for achieving improved patient outcomes with a “we are in it together attitude.” Similarly, the lowest rated domains were *Financial* and *Non-Financial Resources*.
- Compared to previous OOHT survey results from Cohort 1 and 2, *Readiness for Change – Suitability*, *Shared Vision* and *Commitment to Improvement* saw the largest decrease in mean scores. Additionally, the decrease in respondents rating the OHT leadership’s ability to foster trust highly, and respondents feeling this change will be beneficial is concerning.
- The decline in mean scores may reflect a clearer understanding of what OHTs are expected to do (i.e., perception of ability vs. perception of the expectation). The perception of the expectation for population health management is sinking in and we have to acknowledge that OHTs are now more aware of their capabilities vis à vis the expectation.
- If these attitudes, beliefs, and commitment to improving the integration of care across the system are to improve during implementation, all OHTs will need financial resources to develop expertise in using data and enable sharing of clinical information and tools for clinical coordination.
- It will be important to continue to re-assess the teams on these domains to guide OHTs, MOH and Ontario Health (OH) in determining what supports are needed for OHTs.

A. Background

In April 2019, the Ontario Ministry of Health (MOH) launched Ontario Health Teams (OHTs) as a new way of organizing and delivering care that is more connected to patients in their local communities. The OHTs are expected to bring together partners, including health and non-health sectors, patients and caregivers, in their design and work as one coordinated team to provide integrated care. They will share clinical data, use data to support and monitor outcomes and, at maturity, will be accountable for a set of outcomes within a defined budget. Over the course of three years, three cohorts of OHTs have submitted applications and have been approved to begin their work at various points; Cohort 1 applications were submitted in November 2019 and approved in December 2019, Cohort 2 applications were submitted in September 2020 and approved in November 2020 and Cohort 3 applications were submitted in April 2021 and approved in September 2021. Barrie OHT, North Simcoe OHT, and Windsor Essex OHT submitted applications in an earlier cohort but were not approved until the Cohort 3 OHT applications were approved to move forward. These three OHTs were kept in the cohort they submitted their original application. The report also presents results grouped by cohort due to the differences in the cohort's baseline survey and approvals.

The Context and Capabilities for Integrated Care (CCIC) Framework[1] was developed in the Ontario health care context to identify the factors (i.e., contexts and capabilities) most important to integrated care. The CCIC framework was used to adapt the survey questions in the CCIC Toolkit[2, 3] for the Organizing for Ontario Health Teams (OOHT) Survey and the organizational and network capabilities guided the domains used to categorize survey questions across cohorts, to capture important contextual factors to integrating care. Details can be found in HSPN's earlier OOHT Survey reports.[4, 5]

B. Objectives

The objective of the survey is to describe and compare critical success factors for implementation of integrated across the OHTs, approved to be candidate OHTs, in order to guide OHTs and the MOH/Ontario Health (OH) to identify strengths and opportunities to build important capabilities for integrating care. Secondly, we describe and compare how the critical success factors changed over time in Cohort 1 and 2.

C. Methods

C.1 Survey Instrument

The OOHT survey development has been described in our previous survey reports.[4, 5] The OOHT survey includes 41 items, measuring ten previously validated domains. Table 1 maps the priority CCIC contexts and capabilities to the corresponding domains measured by the OOHT survey. Two OOHT domains which did not map to one of the nine CCIC priority capabilities were *Commitment to Improvement* and *Administration and Management*; the first is essential to rapid change and a core building block of OHTs and the second is important for facilitating the development of other capabilities. The term "domain" is used in this report to capture a concept while we use the term "scale" to refer to the measurement of the domain using a set of questionnaire items.

Although questions related to trust were included in the *Leadership Approach* scale, we report the two trust items separately because it is foundational for successful partnering to deliver integrated care in the context of complex multi-organizational systems.[6] The survey also included five items not included in any of the scales and are reported separately. Two items were related to subdomains of *Readiness for Change*. While the three other items asked about organization or practice setting's attitude toward change, whether the respondent's organization or practice setting's shared values were compatible with those of other members of the OHT and whether the respondents' organizations or practice setting's professionals/staff had a strong sense of belonging to the OHT. The latter three questions were not included in any of the original scales in the CCIC Toolkit.

Table 1. Organizing for Ontario Health Teams Survey Domains and Mapping to CCIC Framework

CCIC Constructs	CCIC Capabilities	OOHT Domains (number of items)
BASIC STRUCTURES	Resources[ǂ]	Non-Financial Resources (4)
BASIC STRUCTURES	Resources[ǂ]; Information Technology[ǂ]	Financial and Other Capital Resources (2)
BASIC STRUCTURES	Organizational/Network Design	Administration and Management (2)
PEOPLE & VALUES	Leadership Approach[ǂ]	Leadership Approach (5)
PEOPLE & VALUES	Commitment to Learning; Network Culture[ǂ]; Delivering Care[ǂ]	Team Climate (6)
PEOPLE & VALUES	Commitment to Learning; Measuring Performance; Improving Quality	Commitment to Improvement (3)
PEOPLE & VALUES	Readiness for Change[ǂ]	Readiness for Change (Suitability (3), Change Efficacy (1), Personally Beneficial (1))
PEOPLE & VALUES: KEY PROCESSES	Partnering[ǂ]; Network Culture[ǂ]	Shared Vision (5)
PEOPLE & VALUES; KEY PROCESSES	Partnering[ǂ]; Network Culture[ǂ]	Roles and Responsibilities (2)
KEY PROCESSES	Delivering Care[ǂ]	Clinical-Functional Integration (2)

[ǂ] Indicates the seven out of nine capabilities deemed most important to implementation of integrated care in the Ontario context measured on the OOHT survey.

C.3 Survey Sample

Each OHT was asked to provide the name and email address for the person from each "signatory" organization who was most involved in the development of the OHT (signatory being defined by representatives who included their signature on the OHT application form). For OHTs in Cohort 1 and 2, OHT point of contacts were contacted to validate the list of individuals invited to complete the first OOHT survey were still involved and if new signatory members had been added. The evaluation team received contact details for 1,425 individuals; the mean number of individuals per OHT was 27, with a range of 4 to 90.

C.4 Data Collection

Data collection commenced in March 2022, with all individuals receiving an email inviting them to participate in the OOHT survey. The invitation included an information letter detailing their rights as participants and a unique link to the online survey, as well as a separate link to opt-out of the survey. A second opportunity to opt-out was offered on the introduction page of the survey. Up to four reminders were sent via email to non-responders over a six-week period. Data collection continued with these teams until the end of May 2022. Additionally, OHT points of contact were asked to encourage their members' participation if their OHT's response rate was <50% or if there were fewer than six responses after three reminders. The survey was available in both English and French. All substantive items were optional, but *Not Applicable* or *Don't know*

option was not an option for most items. If respondents left a question blank, they were alerted before moving to the next page, but were not required to respond in order to continue completing the survey.

C.5 Statistical Analyses

Likert response options were scored from 1-5, where a higher score indicated a more favourable response. At the individual level, each scale was scored as the mean of all items. Individual mean scale scores were then aggregated to the OHT-level and then again aggregated to the overall or other higher (by lead organization and geography) levels. In addition to the mean scale scores, to examine the response distribution across response options within a domain, the mean percentage response to each response option across items was calculated. We report on the number of OHTs with at least 50% and ≥80% of respondents selecting the top two boxes (4 (e.g., moderately agree) or 5 (e.g., strongly agree).

To assess the similarity of responses within OHTs, the intraclass correlation coefficient (ICC) was calculated. The ICC measures the proportion of variability between OHTs as a proportion of the total variance. A low ICC indicates that a smaller proportion of the total variation in domain scores is due to between-OHT differences. If there is a high similarity in responses amongst OHT members, the ICC will be closer to the maximum score of 1.0. Within- and between- OHT variance were also calculated. Multi-level models with respondents nested within OHTs were fit for each domain on lead organization and geography. All pairwise comparisons of lead organization and geography were tested with Bonferroni correction to account for the fact that we were making multiple comparisons, and some may be statistically significant by chance.

Changes in the domain mean scores for the OHTs in Cohorts 1 and 2 over are reported as effect size, which is the magnitude of difference between the two survey time periods. The effect size was calculated per domain for each OHT as follows: (mean at Time 2 – mean at Time 1) / standard deviation (SD) per domain.[7] A commonly used benchmark to categorize these effect sizes are defined as small (effect size=0.2), medium (effect size=0.5), large (effect size=0.8), and very large (effect size=1.3).[7, 8]

D. Results

D.1 OOHT Survey Respondents

Table 2 illustrates the survey respondent roles and the types of organizations they represent. Two thirds of all respondents (66.6%) were in executive leadership or senior management with slight variation across cohorts. Overall, clinicians represented 9.3 percent of respondents with all but three being physicians. Similar to Cohort 1, there was a small number of patients and caregivers (3.5%) and board members (3.8%), however these proportions decreased in subsequent cohorts.

Overall, the majority of survey respondents were from primary health care practice (29.35%), community health agency (24%), community support services (23%), and other (19.1%). The number of Cohort 2 respondents from community support services was significantly higher (35.3%) than Cohort 1 and 3 (19.9% and 9.8%, respectively). Representation of respondents from hospitals, public health, Patient and Family Advisory Councils (PFACs), municipal services, and French services were also among the lowest.

The frequency of Cohort 2 respondents from community support services (35.3%) were almost triple that of Cohort 3 (9.8%), and significantly higher than Cohort 1(19.9%). The proportional differences between the cohorts were minimal among primary health care practice, acute care inpatient hospitals, and community health agencies. Respondents from the other category made up a large proportion of Cohort 1, 2, and 3 (20.5%, 16.2%, and 20.5% respectively), which included government, health centres, university, palliative care, developmental services, and French planning entities.

Table 2. Number of Respondent Roles and Type of Organization(s) Overall (N=653), in Cohort 3 (N=6), Cohort 2 (N=15) and Cohort 1 (N=30)

Characteristic	Frequency (%)			
Current Role	**Overall**	**C3**	**C2**	**C1**
Chief Executive Officer, President or Executive Director	361 (55.3)	71 (63.4)	119 (58.3)	171 (50.7)
Other Senior Management (COO, CFO, Vice President, Chief of Staff)	74 (11.3)	12 (10.7)	26 (12.7)	36 (10.7)
Administrator, General Manager, Director of Care	65 (10)	7 (6.3)	18 (8.8)	40 (11.9)
Physician or Other Clinical Role	61 (9.3)	9 (8.0)	17 (8.3)	35 (10.4)
Patient/Caregiver	23 (3.5)	2 (1.8)	6 (2.9)	15 (4.5)
Board Member	25 (3.8)	2 (1.8)	6 (2.9)	17 (5.0)
Other	44 (6.8)	9 (8.0)	12 (5.9)	23 (6.8)
Type of Organization Represented				
Primary Health Care Practice	191 (29.3)	32 (28.6)	59 (28.9)	100 (29.7)
Acute Care Hospital	63 (6.8)	12 (10.7)	16 (7.8)	35 (10.4)
Mental Health Hospital	10 (1.5)	3 (2.7)	4 (2.0)	3 (0.9)
Rehabilitation or Complex Continuing Care Hospital	23 (3.5)	3 (2.7)	10 (4.9)	10 (3.0)
Long-Term Care	48 (7.4)	13 (11.6)	11 (5.4)	24 (7.1)
Home Care	80 (12.3)	14 (12.5)	19 (9.3)	47 (13.9)
Public Health	15 (2.3)	4 (3.6)	4 (2.0)	7 (2.1)
Community Support Services (including Community Mental Health)	150 (23.0)	11 (9.8)	72 (35.3)	67 (19.9)
Community Health Agency	157 (24.0)	33 (29.5)	57 (27.9)	67 (19.9)
Patient and Family Advisory Council	26 (4.0)	2 (1.8)	6 (2.9)	18 (5.3)
Hospice	20 (3.0)	7 (6.3)	1 (0.5)	12 (3.6)
Municipal Services (e.g. Paramedics, Social Services, and LTC)	14 (2.1)	1 (0.9)	3 (1.5)	10 (3.0)
French Services	6 (0.9)	2 (1.8)	3 (1.5)	1 (0.3)
Other[t]	125 (19.1)	23 (20.5)	33 (16.2)	69 (20.5)

[t] Examples of other types of organizations represented include Government, health centres, university, palliative care, developmental services, French planning entities.
Note: C1=Cohort 1; C2=Cohort 2; C3=Cohort 3.

D.2 OOHT Survey Response and Completion Rates

Of the 1,425 individuals who were emailed an invitation to the OOHT survey, 653 (337, 204 and 112 from Cohort 1, Cohort 2, and Cohort 3 respectively) submitted their survey for an overall response rate of 46%. The individual response rate by cohort varied slightly; 44%, 49% and 47% for Cohort 1, 2 and 3 respectively (Table 3). At the OHT-level, the mean response rate was 54%, ranging from 15% to 86% across the 51 OHTs. Nearly all surveys were completed in English, with two being answered in French.

The average OHT response rate for Cohort 1 and 2 were identical (55%) and Cohort 3 response rate was 51%. Less than a third of the OHTs had a response rate over 60% (19/51 OHTs). The mean completion rate of all survey items across the 653 respondents was 99.2%, ranging from 61.5% to 100%. Across survey

items, the mean percentage of off-scale responses (i.e., Not Applicable / Don't know) was 1.32% (range: 0% to 13.3%) and for missing values, 0.78% (range: 0.2% to 1.8%). The highest number of off-scale responses was for question 28, which asked about whether each OHT had connections to political decision-makers, government agencies to work effectively while question 36 ("In the long run, I feel it is worthwhile for me that the organization adopted this change) and question 12 ("We share tools for clinical coordination") had the highest number of missing values.

Table 3A. Cohort 1 Organizing for Ontario Health Teams Survey Response Rates

OHT [I]	Response Rate	OHT [I]	Response Rate
Huron Perth Area	32%	Cambridge North Dumfries	69%
Central West	15%	Peterborough	54%
East Toronto Health Partners	86%	Nipissing Wellness	51%
Northumberland	50%	Durham	63%
Middlesex London	32%	Guelph Wellington	72%
Mississauga	67%	Greater Hamilton Health Network	53%
Barrie and Area*	39%	Algoma	38%
Hills of Headwaters Collaborative	60%	Burlington	67%
North York Toronto Health Partners	43%	Southlake Community	46%
All Nations Health Partners	50%	Couchiching	56%
Ottawa Health Team	80%	North Western Toronto	67%
Chatham-Kent	69%	Western York Region	56%
Eastern York Region & North Durham	58%	Ottawa East	25%
Niagara	46%	Connected Care Halton	80%
Muskoka and Area	65%	**Overall** (Among C1 respondents / Average Across OHTs)	**44% / 55%**
North Toronto Health Collaboration	50%		

Table 3B. Cohort 2 Organizing for Ontario Health Teams Survey Response Rates

OHT [I]	Response Rate	OHT [I]	Response Rate
West Toronto	54%	Windsor Essex*	50%
North Simcoe*	75%	Brantford Brant	56%
Frontenac, Lennox & Addington	34%	Sarnia Lambton	59%
Connected Care for LLG	41%	KW4	49%
Downtown East Toronto	62%	Rainy River District	70%
South Georgian Bay	45%	Scarborough	45%
Oxford and Area	59%	Kawartha Lakes	83%
Mid-West Toronto	49%	**Overall** (Among C2 respondents / Average Across OHTs)	**49% / 55%**

Table 3C. Cohort 3 Organizing for Ontario Health Teams Survey Response Rates

OHT [I]	Response Rate	OHT [I]	Response Rate
Hastings Prince Edward	61%	Grey Bruce	61%
Ottawa West Four Rivers	40%	Elgin	44%
Great River	66%	Ottawa Valley	35%
		Overall (Among C3 respondents / Average Across OHTs)	**47% / 51%**

[I] OHTs were assigned a random number between 1 to 51 and are ordered as such. Please see page 10 for the full key.
* OHT cohort assignment is based on the timing of their application to become an OHT.

D.3 OOHT Survey Findings

Measuring the key contexts and capabilities supporting integrated care delivery early in the OHT development allows for an assessment of "readiness to integrate" and the development of targeted change management strategies that address problem areas or leverage strengths. The radar chart below (Figure 1) and Table 4 illustrate that across 51 OHTs, the four domains with the highest ratings were *Commitment to Improvement* (mean=3.71 out of 5), *Team Climate* (mean=3.68 out of 5), *Administration and Management* (mean=3.60 out of 5), and *Roles and Responsibilities* (mean=3.60 out of 5). There were three domains, *Financial and Other Capital Resources*, *Clinical-Functional Integration* and *Shared Vision*, with noticeably lower ratings across OHTs (means of 2.86, 3.06, and 3.41 respectively).

Among the ten domains, *Leadership Approach and Administration and Management* had the highest within-OHT and between-OHT variance (0.88 and 0.13, and 0.81 and 0.14, respectively) relative to the other domains (see Table 4).

A number of domains had very low between OHT variance relative to total variance and, as a result, small ICCs and they include: *Readiness for Change – Suitability* (ICC=0.02), *Financial and Other Capital Resources* (ICC=0.04), *Roles and Responsibilities* (ICC=0.08) and *Clinical-Functional Integration* (ICC=0.08). The highest between-OHT variance relative to the total variance were observed for the *Administration and Management* (ICC=0.14), *Shared Vision* (ICC=0.13), and *Leadership Approach* (ICC=0.13). Please see Table 4 for summary statistics for all domains.

No statistically significant differences were found in mean scores when testing for differences between lead organization type (hospital vs non-hospital) or geography (urban/suburban vs small community/rural). All pairwise comparisons of the combinations of lead organization and geography (e.g., hospital and urban/suburban vs non-hospital and small community/rural) were also not statistically significant different. See Appendix B for full regression and contrast estimates.

Figure 1 illustrates across the 51 OHTs, the three domains with the highest ratings were *Commitment to Improvement* (mean=3.72 out of 5)*, Team Climate* (mean=3.68 out of 5)*,* and *Administration and Management* (mean=3.60 out of 5). The three domains with lowest ratings were, *Financial and Other Capital Resources*, *Clinical-Functional Integration* and *Shared Vision* (means of 2.85, 3.06, 3.41 respectively).

Figure 1. Overall Mean, 90th Percentile Scores and Mean Scores by Geography and Lead Organization Type by OOHT Survey Domain (N=51)

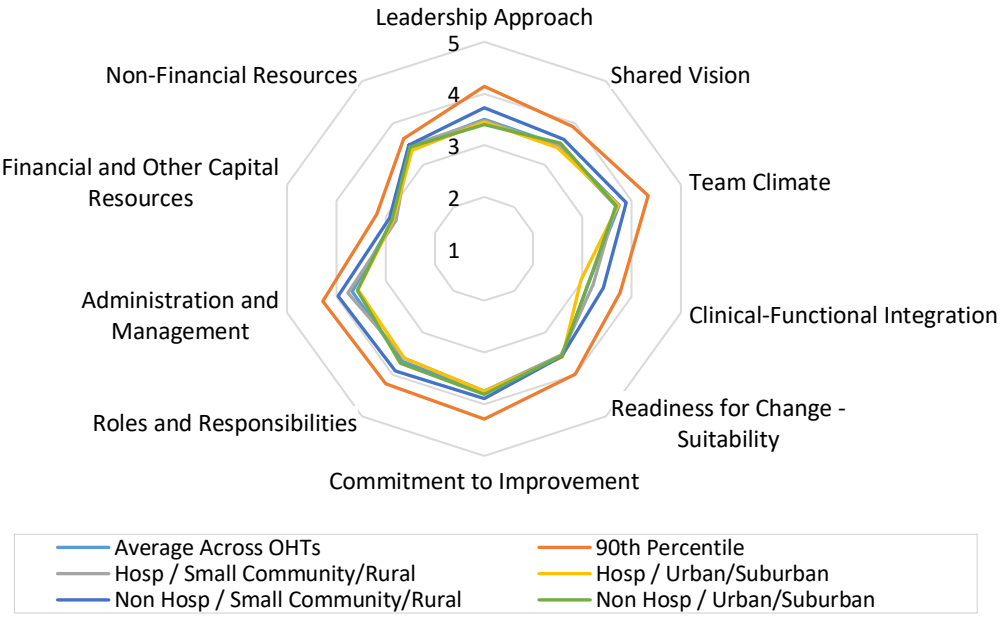


Figure 2 illustrates across the 30 OHTs in Cohort 1, the three domains with the highest ratings were *Commitment to Improvement* (mean=3.79 out of 5), *Team Climate* (mean=3.75 out of 5), and *Roles and Responsibilities* (mean=3.69 out of 5). The three domains with lowest ratings were, *Financial and Other Capital Resources*, *Clinical-Functional Integration* and *Shared Vision Non-Financial Resources* (means of 2.84, 3.13, and 3.41 respectively).

Non-hospital organizations located in small community/rural areas scored higher in all domains except *Readiness for Change – Suitability*, compared to all other lead organization/geography categories. Otherwise, means across domains were mostly similar.

Figure 2. Cohort 1 Overall Mean, 90th Percentile Scores and Mean Scores by Geography and Lead Organization Type by OOHT Survey Domain (N=30)

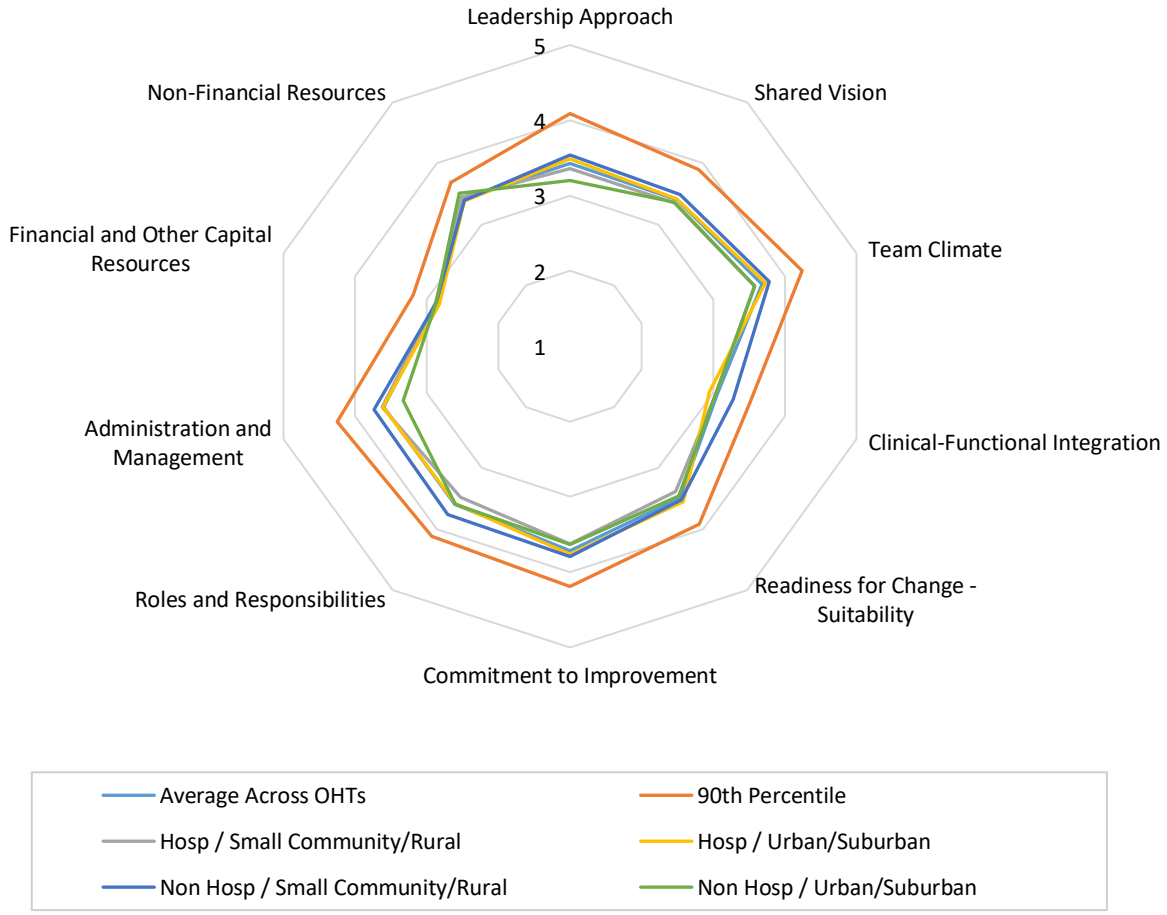


Figure 3 illustrates across 15 OHTs, the three domains with the highest ratings were *Commitment to Improvement* (mean=3.67 out of 5)*, Team Climate* (mean=3.64 out of 5)*,* and *Roles and Responsibilities* (mean=3.56 out of 5). There were three domains, *Financial and Other Capital Resources, Clinical-Functional Integration* and *Leadership Approach* with noticeably lower ratings across OHTs (means of 2.91, 3.08, and 3.36 respectively).

The mean scores for non-hospital led OHTs located in small community/rural areas in Cohort 2 scored above the 90th percentile for the *Roles and Responsibilities*, *Commitment to Improvement*, and *Clinical-Functional Integration* domains. Non-hospital led OHTs located in urban/suburban areas scored lower in all domains except *Financial and Other Capital Resources*, and *Non-Financial Resources*, compared to all other lead organization/geography types. Otherwise, means across domains were mostly similar.

Figure 3. Cohort 2 Overall Mean, 90th Percentile Scores and Mean Scores by Geography and Lead Organization Type by OOHT Survey Domain (N=15)

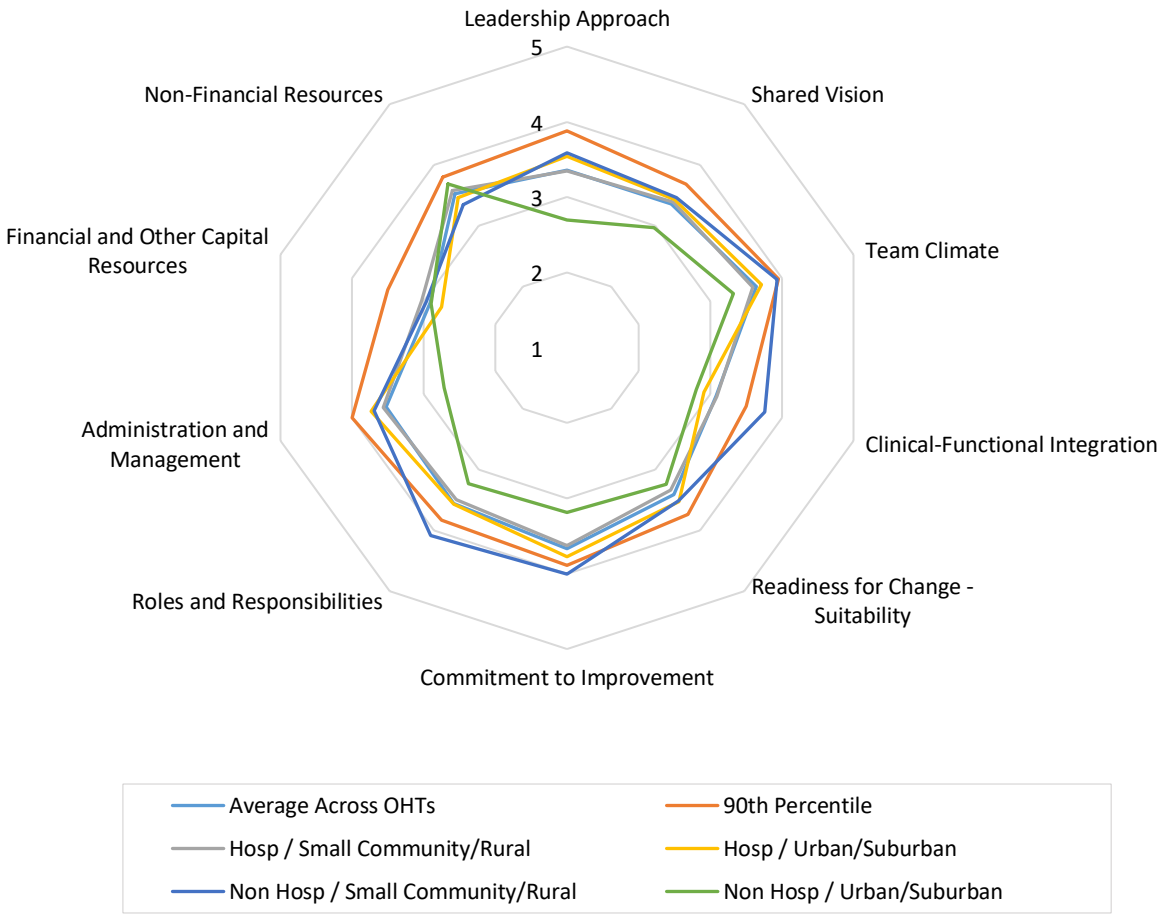


Figure 4 illustrates that across six OHTs in Cohort 3, the three domains with the highest ratings were *Commitment to Improvement* (mean=3.47 out of 5), *Team Climate* (mean=3.45 out of 5), and *Administration and Management* (mean=3.41 out of 5). The three domains with the lowest ratings were, *Clinical-Functional Integration, Financial and Other Capital Resources,* and *Shared Vision* with (means of 2.62, 2.74, 3.18 respectively).

Hospital-led and small community/rural OHTs scored lower than the non-hospital led small community/rural OHT in all domains, except *Administration and Management*.

Figure 4. Cohort 3 Overall Mean, 90th Percentile Scores and Mean Scores by Geography and Lead Organization Type by OOHT Survey Domain (N=6)

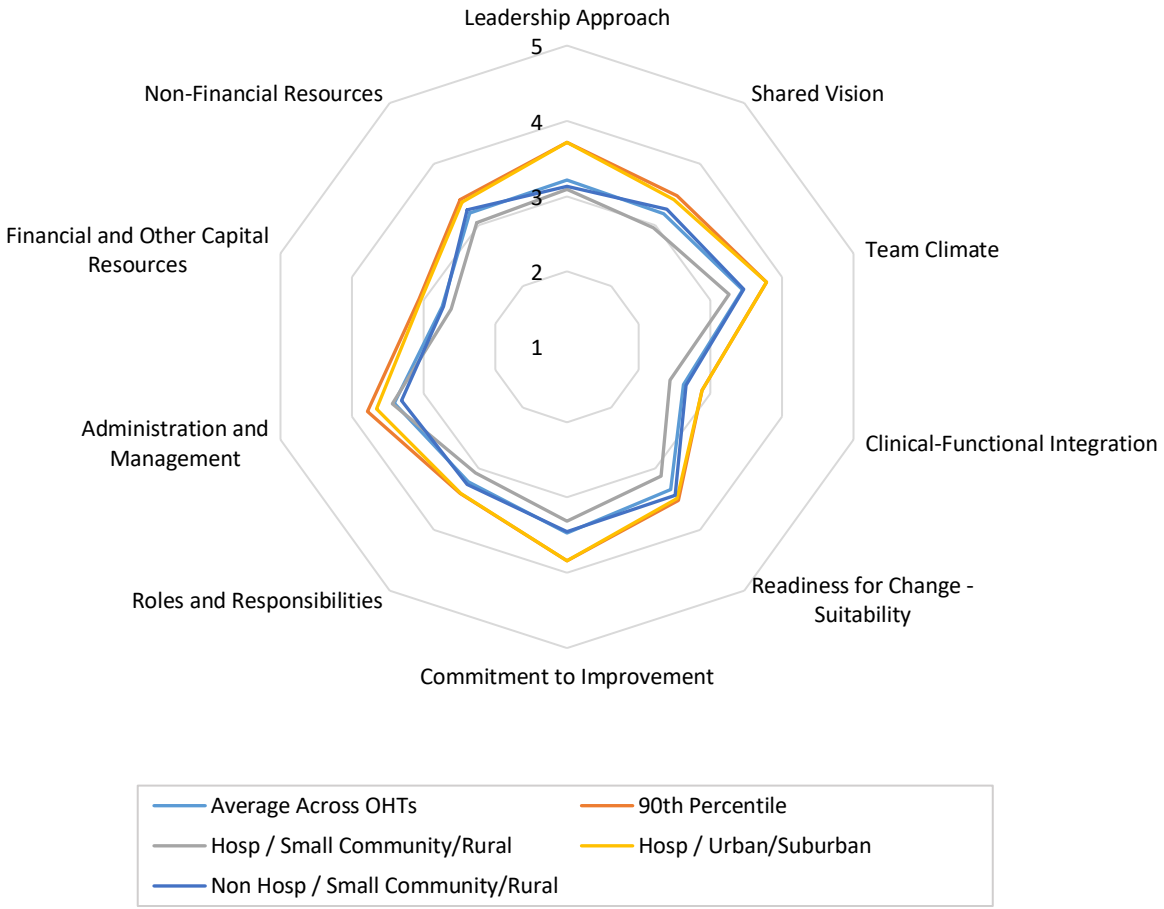


Table 4. Summary Statistics of OOHT Survey Domains Across the Ontario Health Teams (N=51)

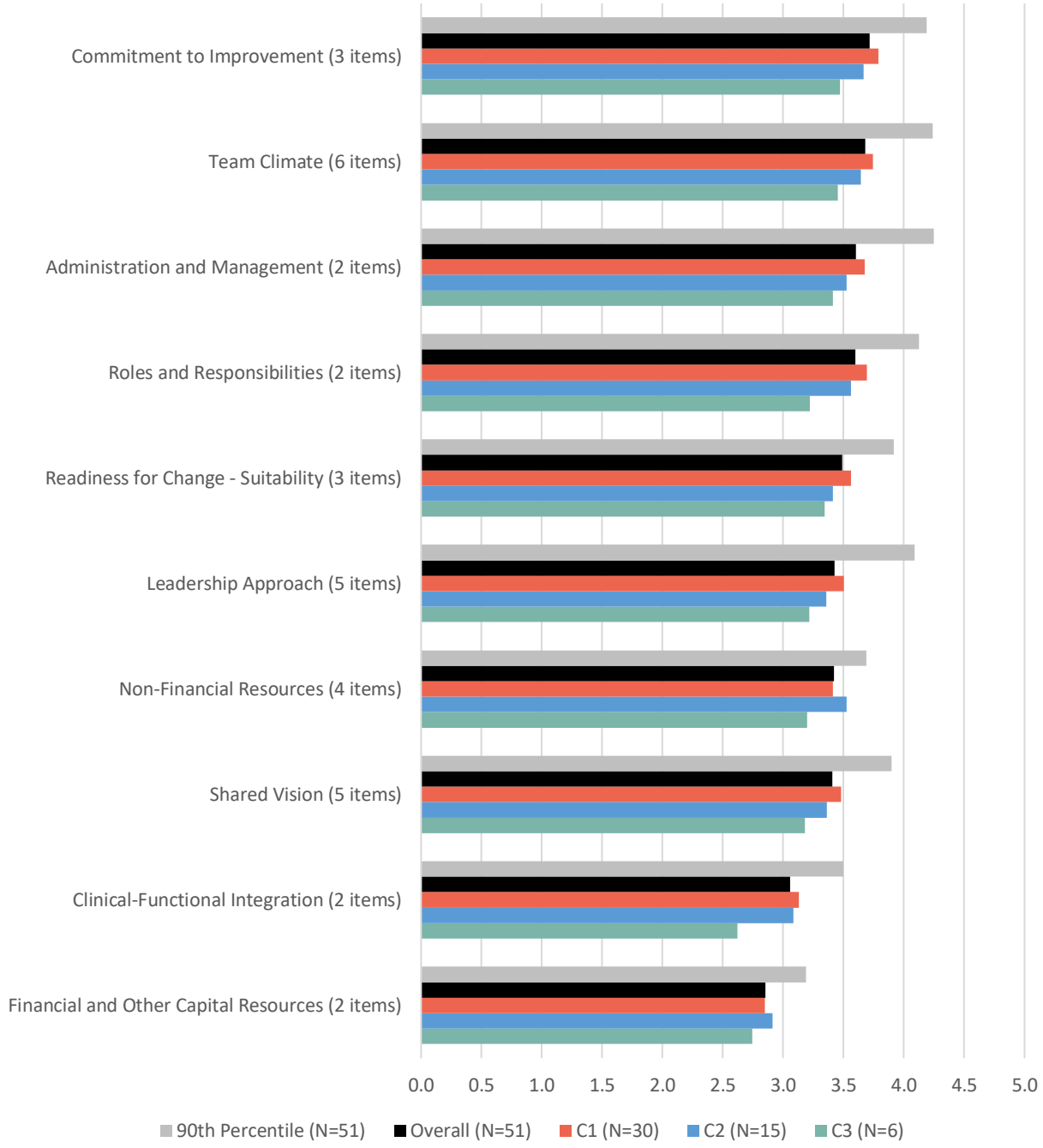
Domain	Mean Across OHTs (SD)	% 4 or 5[‡] Response Across OHTs (Range)	# of OHTs with ≥50% selecting 4 or 5[‡]	# of OHTs with ≥80% selecting 4 or 5[‡]	Between OHT Variance	Within OHT Variance	Total Variance	ICC
Leadership Approach	3.43 (0.51)	50.69% (10.9%-96%)	26	6	0.13	0.88	1.01	0.13
Shared Vision	3.41 (0.36)	46.59% (5.5%-88.9%)	23	3	0.07	0.43	0.50	0.13
Team Climate	3.68 (0.37)	59.35% (3%-93.3%)	38	6	0.06	0.57	0.63	0.09
Clinical-Functional Integration	3.06 (0.45)	32.95% (0%-100%)	9	1	0.07	0.81	0.88	0.08
Readiness for Change - Suitability	3.49 (0.30)	49.73% (19.4%-77.8%)	25	0	0.01	0.68	0.69	0.02
Commitment to Improvement	3.71 (0.39)	61.3% (19.7%-100%)	41	8	0.07	0.57	0.63	0.11
Roles and Responsibilities	3.60 (0.42)	56.4 % (13.6%-100%)	35	5	0.06	0.78	0.84	0.08
Administration and Management	3.60 (0.50)	58.32% (14.3%-100%)	37	9	0.14	0.81	0.95	0.14
Financial and Other Capital Resources	2.86 (0.29)	17.67% (0%-66.7%)	2	0	0.02	0.47	0.49	0.04
Non-Financial Resources	3.42 (0.30)	46.00% (10%-100%)	20	1	0.03	0.34	0.37	0.09

[‡] Likert response options were scored from 1 to 5, where a higher score indicated a more favourable response. We report on the number of respondents selecting the top two boxes (4 (e.g., moderately agree) or 5 (e.g., strongly agree)).

Figure 5 illustrates *Commitment to Improvement* domain had the highest overall (N=51) mean score (3.72 out of 5), and in each cohort, Cohort 1 (3.79 out of 5), Cohort 2 (3.67 out of 5) and Cohort 3 (3.47 out of 5). The domain with the lowest mean scores was the *Financial and Other Capital Resources* domain (2.85, 2.85, 2.91, and 2.74 out of 5, overall, Cohorts 1, 2, and 3 respectively).

In general, Cohort 1 had the highest mean across domains, followed by Cohort 2 and Cohort 3, except for the *Financial and Other Capital Resources* and *Non-Financial Resources* domains where Cohort 2 had the highest means.

Figure 5. Overall OHT Mean and 90th Percentile Domain Scores and Cohort Mean Domain Scores Rank Ordered from Highest to Lowest Overall Mean Score



The *Commitment to Improvement* domain had the highest average percentage of respondents selecting the top two boxes overall (61.3%), for Cohort 1 (64.7%), Cohort 2 (59.7%) and Cohort 3 (48.4%). The domains with the lowest average of respondents selecting the top two boxes were the *Financial and Other Capital Resources* (17.7%, 15.5%, 22.5%, and 16.3% overall, Cohorts 1, 2, and 3 respectively). In general, Cohort 1 had highest proportion of respondents selecting the top two boxes across domains, followed by Cohort 2 and Cohort 3, except for the *Financial and Other Capital Resources* and *Non-Financial Resources* domains, where Cohort 2 had the highest proportion of respondents selecting the top two boxes (see Figure 6).

Figure 6. Overall OHT and Cohort Average Percentage of Respondents Selecting Top-Two Boxes, by OOHT Survey Domain Ranked Order from Overall OHT Highest to Lowest Percentage Selecting the Top-two Boxes.

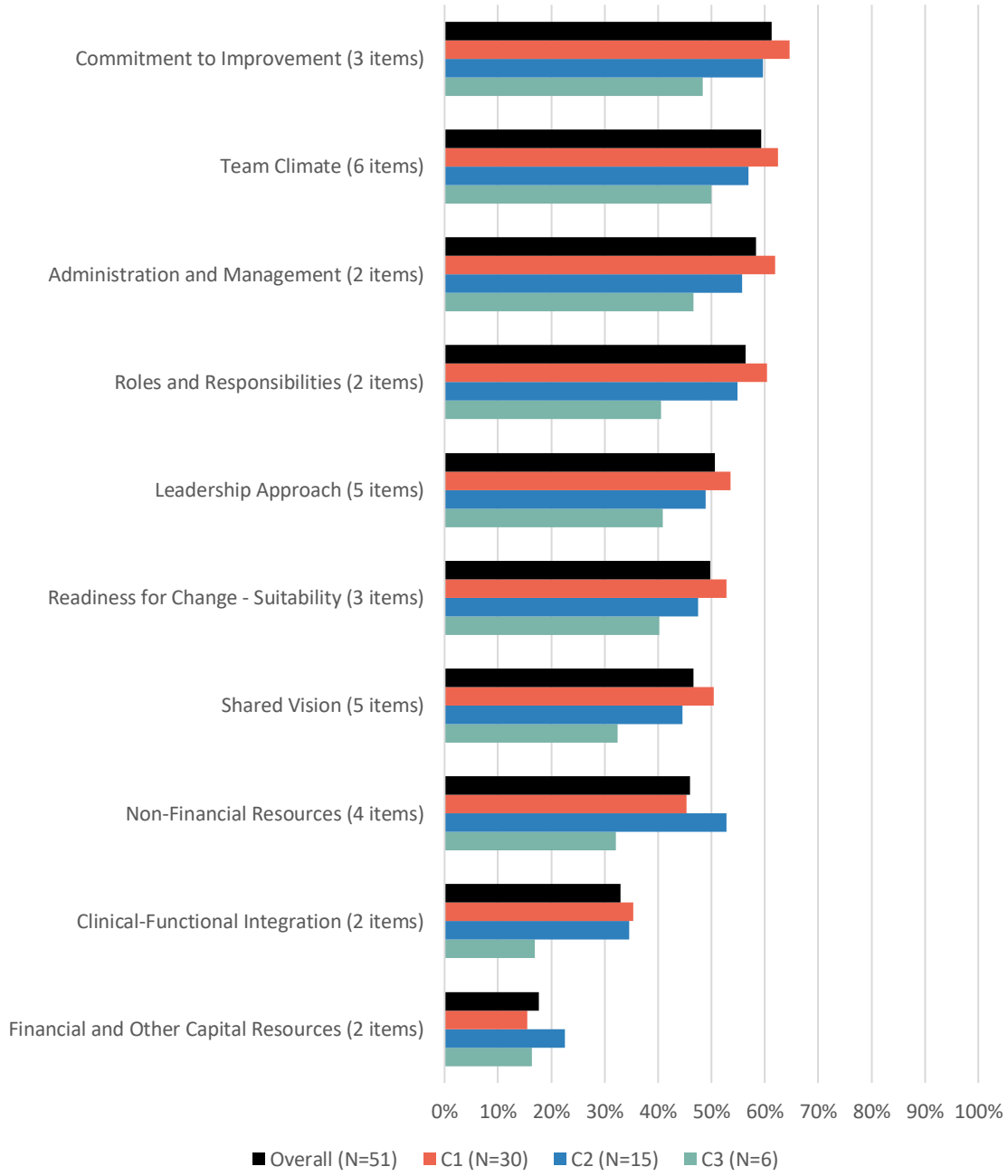
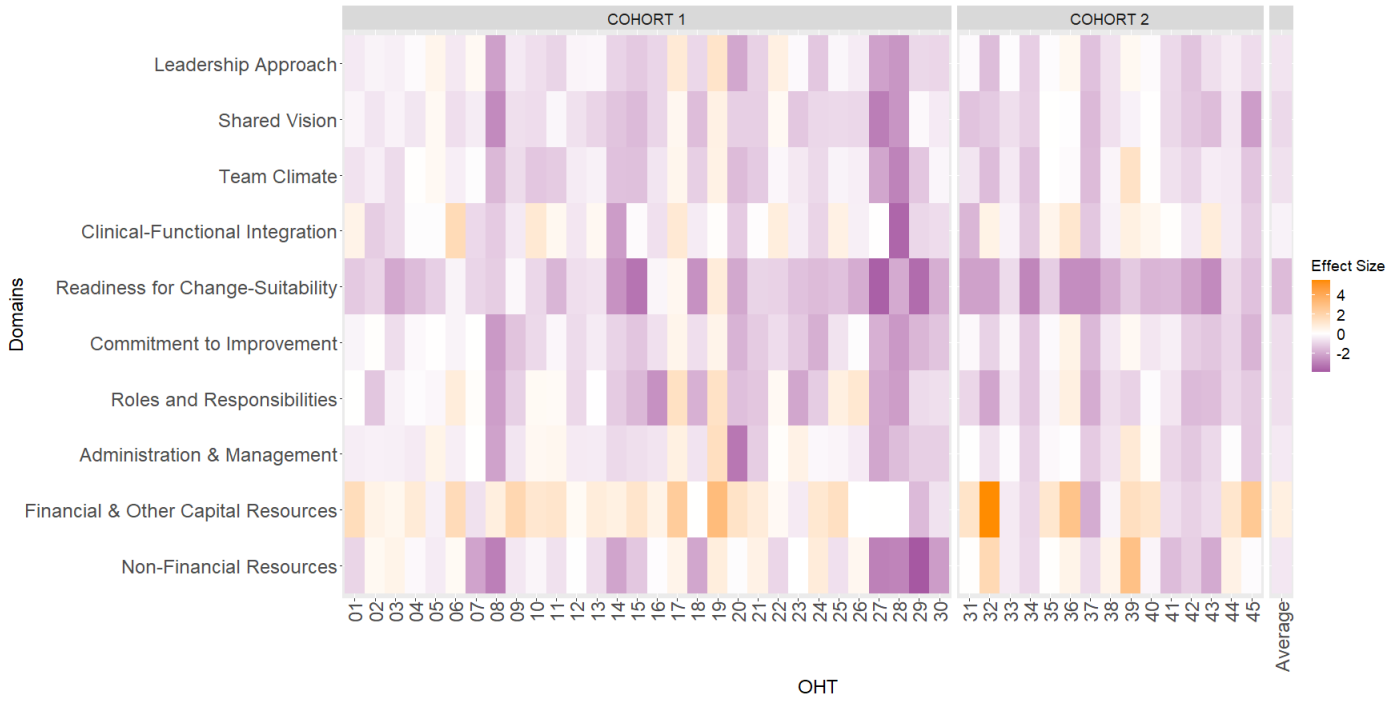


Figure 7 illustrates the changes in mean scores over time per domain for each OHT in Cohorts 1 and 2. The colour gradient runs from dark purple indicating the largest decrease to dark orange indicating the largest increase in mean scores. Overall, there was a moderate decrease (effect size=-0.61 with SD=1.12) across all domains. The average mean effect sizes from the largest decrease to the largest increase across all OHT's are as follows: *Readiness for Change – Suitability* (-1.60), *Shared Vision* (-0.88), *Commitment to Improvement* (-0.81), *Roles and Responsibilities* (-0.75), *Team Climate* (-0.72), *Leadership Approach* (-0.63), *Non-Financial Resources* (-0.57), *Administration and Management* (-0.52), *Clinical-Functional Integration* (-0.31), and *Financial and Other Capital Resources* (0.70). Three domains experienced a substantial decrease in mean score (effect size ≤-0.8), five of the 10 domains experienced a moderate decrease in mean score (effect size ≤-0.5 and >-0.8), one domain (*Clinical-Functional Integration*) had a minimal decrease in mean score (effect size ≤-0.2 and >-0.5), and only one domain had moderate increase in mean score (effect size <0.8 and ≥0.5).

Excluding the *Financial and Other Capital Resources* domain, all other domain mean scores decreased in >60% of the OHT's. The *Financial and Other Capital Resources* domain mean scores increased in most OHTs (31/45 increased and 12/45 OHTs decreased). The most consistent direction of change from Time 1 (T1), was in the *Readiness for Change – Suitability* domain, where 43/45 OHTs mean scores decreased and increased for only two OHTs; Cambridge North Dumfries OHT and Nipissing Wellness OHT.

Six out of 45 OHT's (Connected Care Halton, Connected Care for LLG, Frontenac, Lennox & Addington, KW4, Ottawa East and Oxford and Area) experienced a decrease in mean scores across all domains and two out of 45 OHT's (Cambridge North Dumfries and Nipissing Wellness OHT) experienced an increase in mean scores across all domains.

Figure 7. OHT Change in Mean Domain Scores over Time in Cohorts 1 and 2 (N=45)



Cohort 1 Response Distribution by Domain and Item-level Response Distribution

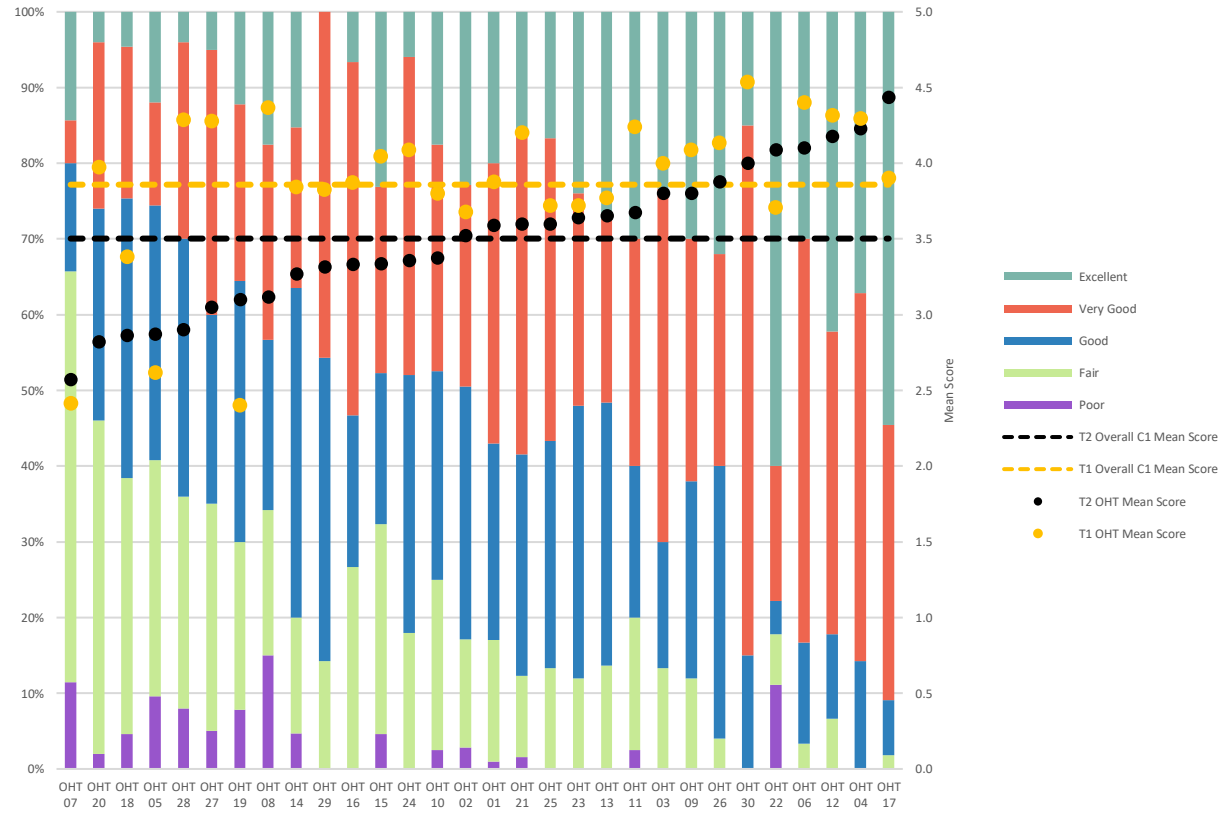
Leadership Approach

Five items[i] from the OOHT survey comprise the *Leadership Approach* domain. Respondents were asked to rate the effectiveness of their OHT's formal and informal leadership at empowering members, fostering respect and trust, creating an environment where differences of opinion could be voiced, promoting creativity and different ways at looking at things, and communicating the vision of their OHT.

For most OHTs in Cohort 1, the scores for *Leadership Approach* were lower compared to their first time filling out the OOHT survey in 2020 (T1). The average mean score of Cohort 1 was 3.50 (out of 5) and a standard deviation of 0.47; a 0.36-point decrease in the mean score compared to the 2020 (3.50 vs 3.86). Compared to T1, the lowest mean score increased (2.40 vs. 2.57) and highest mean score decreased (4.53 vs. 4.44).

Across the OHTs, the proportion of respondents selecting 4 (very good) or 5 (excellent) was 53.5% and varied from 20% to 90.9% with just over half of the OHTs (16/30) having at least 50% of respondents selecting the top two boxes. Five of the 30 OHTs; Cambridge North Dumfries, Chatham-Kent, Connected Care Halton, Northumberland and Mississauga had ≥80% of respondents selecting the top two boxes across the items included this domain (Figure 8).

Figure 8. Distribution of Cohort 1 OOHT Survey Responses to the *Leadership Approach* Domain (5 items[i]) at T2 by OHT and mean scores at T1 and T2



[i] Survey Items - Please rate the total effectiveness of your OHT's leadership in each of the following areas:

18 Empowering people/members involved in the OHT
19 Communicating the vision of the OHT
20 Creating an environment where differences of opinion can be voiced
21 Helping the OHT to be creative and look at things differently
22 Fostering respect, trust and inclusiveness amongst OHT members

Leadership Approach – Building Trust

Trust is an essential underpinning element of successful partnering to deliver better and more integrated care in the context of complex multi-organizational systems.[6] We highlight two items from the *Leadership Approach* domain related to establishing trust among partners, *Fostering respect, trust and inclusiveness* (question 22) and *Creating an environment where differences of opinion can be voiced* (question 20), below. Across the OHTs, the mean scores for these items were 3.74 with a standard deviation of 0.51, and 3.52 with a standard deviation of 0.46, respectively at T2.

The proportion of respondents selecting 4 (very good) or 5 (excellent) on *Fostering respect, trust and inclusiveness* (Figure 9) varied from 20% to 100%, with most (23/30) having at least 50% of respondents selecting the top two boxes, and only five OHTs; Cambridge North Dumfries, Connected Care Halton, Couchiching, Northumberland and Mississauga had ≥80% of respondents selecting the top two boxes. For question 20 - *Creating and environment where differences of opinion can be voiced* (Figure 10) the proportion of respondents selecting 4 (very good) or 5 (excellent) ranged from 23.1% to 100%, with most (19/30) OHTs having at least 50% of respondents selecting the top two boxes and only four OHTs; Cambridge North Dumfries, Connected Care Halton, Greater Hamilton Health Network and Northumberland had ≥80% of respondents selecting the top two boxes. Three OHTs, Cambridge North Dumfries, Connected Care Halton and Northumberland had ≥80% of respondents rating 4 or 5 on *both* items.

For question 22, the overall mean score and highest mean score at T2 decreased from 3.98 at T1 to 3.74, and 4.86 at T1 to 4.64, respectively; while the lowest OHT mean score increased from 2.12 at T1 to 2.71. The same pattern was observed for question 20 (T1 overall mean: 3.88 vs. T2: 3.52); the highest mean score (T1: 4.67 vs. T2: 4.43) and the lowest mean score increased (T1: 2.40 vs T2: 2.77).

Figure 9. Distribution of Cohort 1 OOHT Survey Responses to the Item *Fostering respect, trust, and inclusiveness amongst OHT members* at T2 by OHT and mean scores at T1 and T2, by OHT and by Cohort

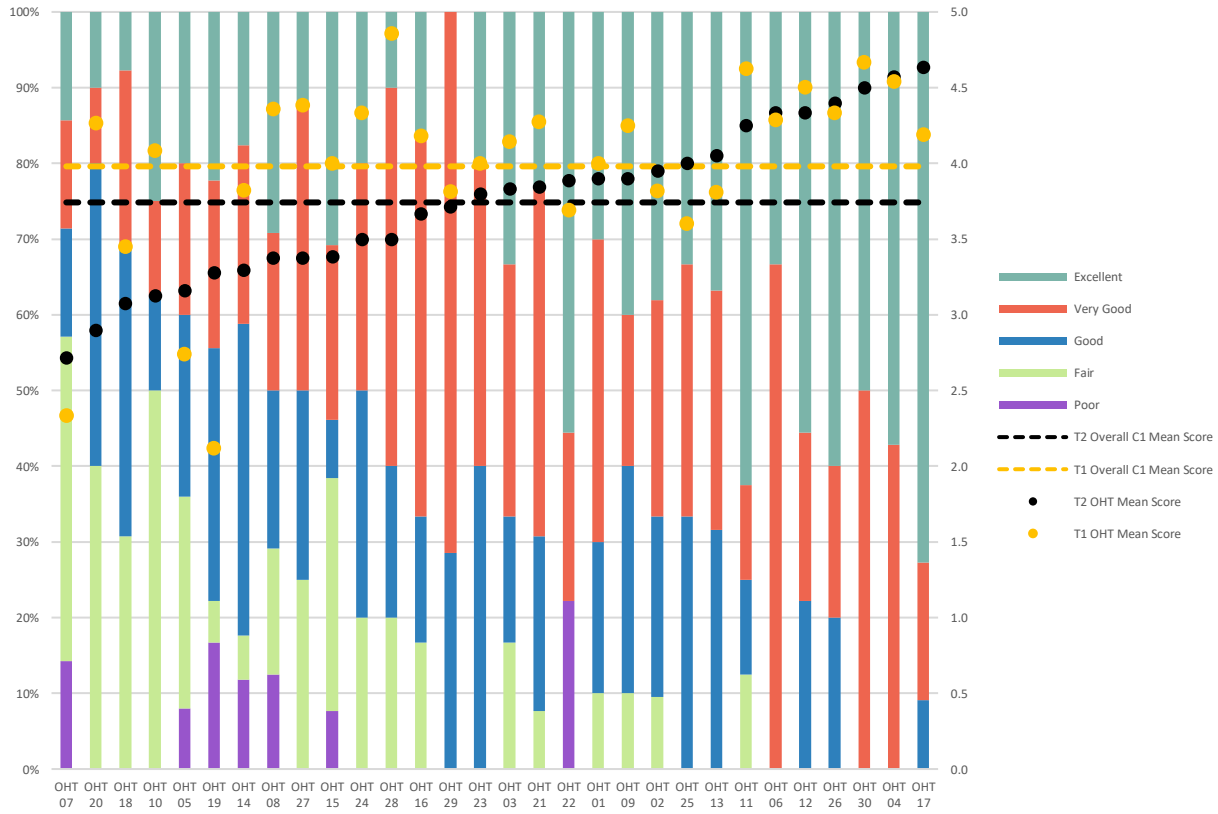
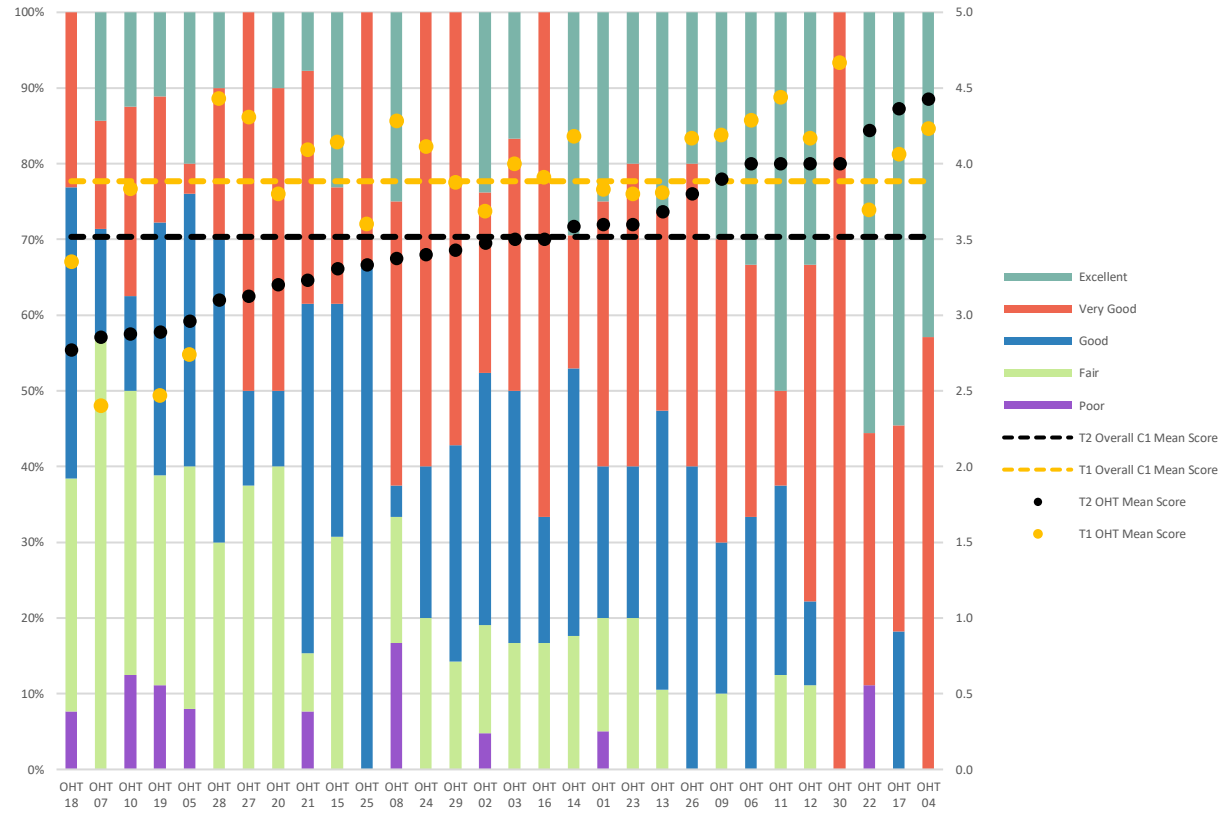


Figure 10. Distribution of Cohort 1 OOHT Survey Responses to the Item *Creating an environment where differences of opinion can be voiced* at T2 by OHT and mean scores at T1 and T2, by OHT and by Cohort



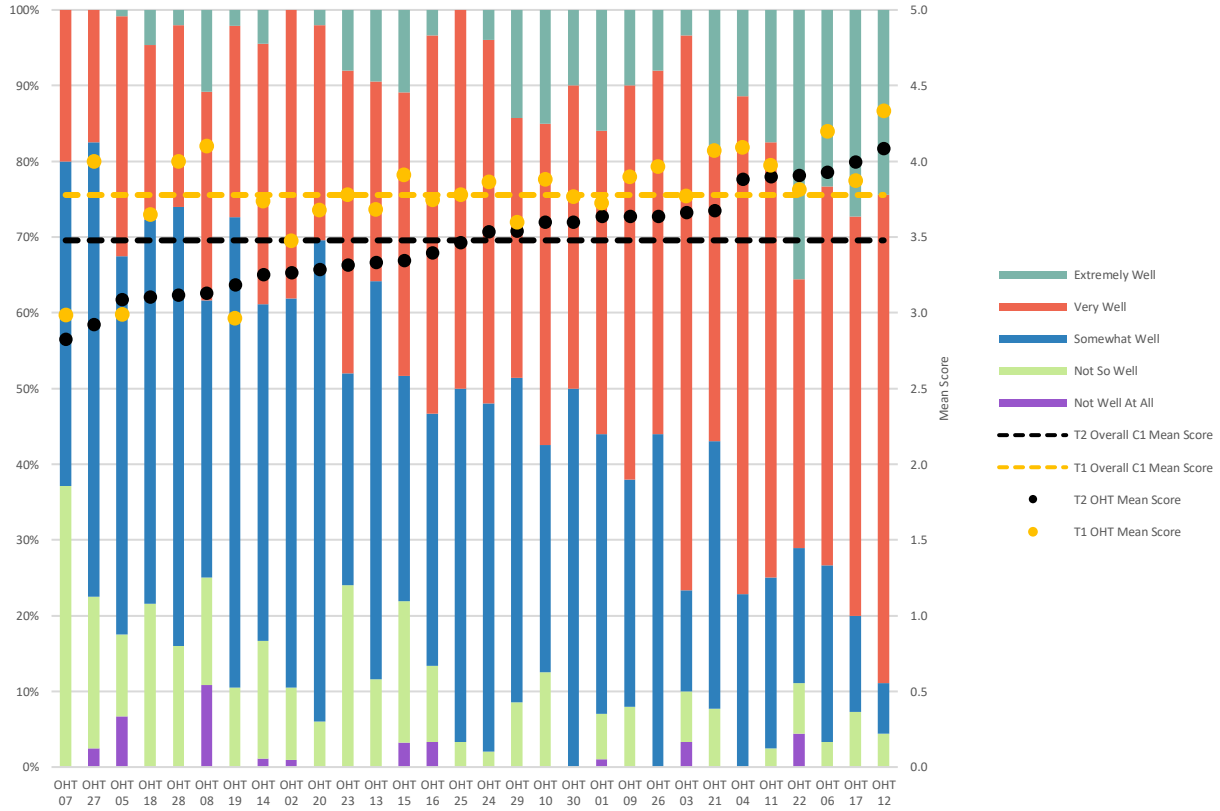
Shared Vision

A shared vision is created "by combining the perspectives, knowledge, and skills of diverse partners in a way that enables the partnership to (1) think in new and better ways about how it can achieve its goals; (2) plan more comprehensive, integrated programs; and (3) strengthen its relationship to the broader community".[9] The *Shared Vision* domain (Figure 11) is composed of 5-items[ii] and respondents were asked to rate how well the organizations and people partnering in the OHT have been able to develop widely understood and supported goals; identify how organizations and programs could help; respond to the needs of their community; include views and priorities of those impacted; and obtain support from individuals in the community.

Overall, responses to *Shared Vision* were middling. The mean score across Cohort 1 OHTs in the 2022 survey was 3.48 (out of 5) with a standard deviation of 0.33. The proportion of respondents selecting 4 (very well) or 5 (extremely well) was 50.5% and varied from 17.5% to 88.8%. Just over half of OHTs (16/30) had at least 50% of respondents selecting the top two boxes and only two OHTs (Cambridge North Dumfries and Chatham-Kent) had ≥80% of respondents selecting 4 or 5.

Compared to T1, the overall, the highest and the lowest mean scores at T2 decreased (3.78 vs. 3.48, 4.33 vs. 4.09 and 2.96 vs. 2.83, respectively).

Figure 11. Distribution of Cohort 1 OOHT Survey Responses to the *Shared Vision* Domain (5 items[ii]) at T2 by OHT and mean scores at T1 and T2, by OHT and by Cohort



[ii] Survey Items - By working together, how well, at present, are the members of your OHT able to:
3 Develop goals that are widely understood and supported among members
4 Identify how different organizations/programs in the community could help to solve the issues the OHT is trying to address in their year one population
5 Respond to the needs and problems of the community
6 Include the views and priorities of the people affected by the OHT's work
7 Obtain support from individuals and organizations in the community that can either block the OHT's plans or help move them forward

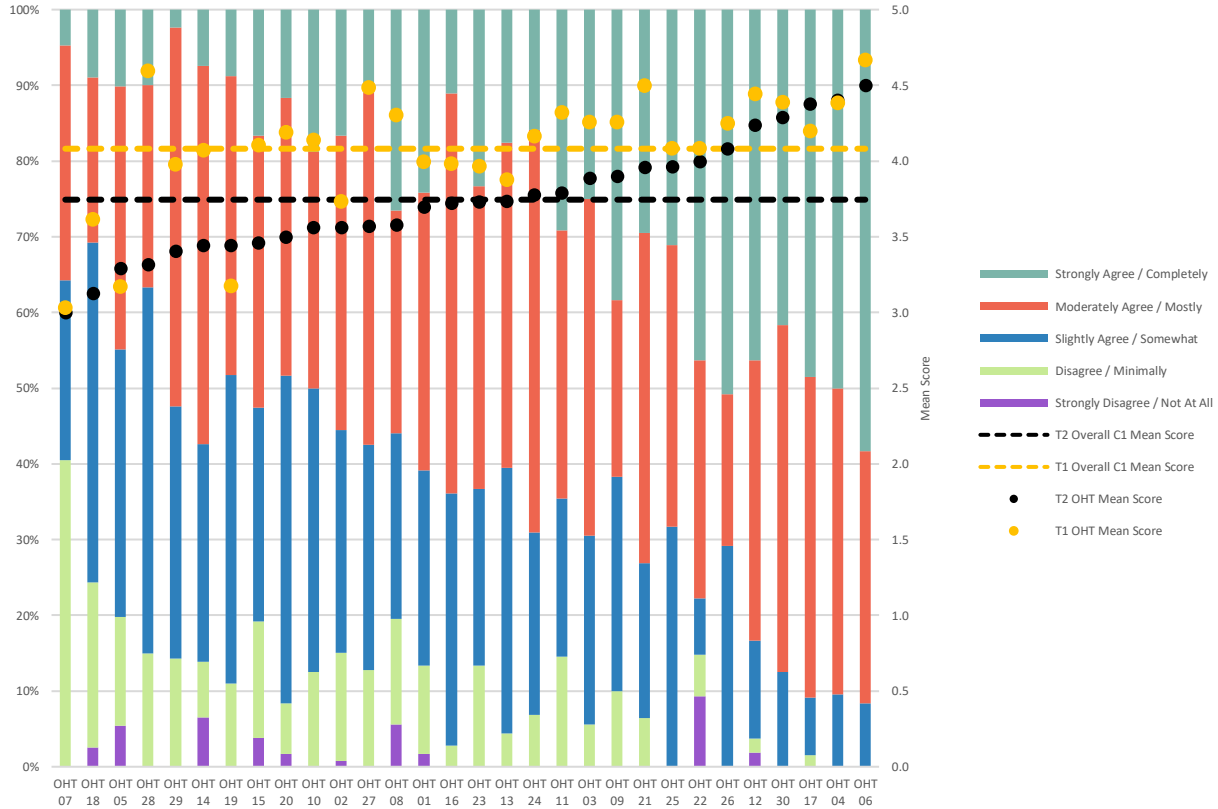
Team Climate

There are four factors associated with successful group innovations; 1) vision is clear and realistic, 2) participatory safety or climate of interpersonal interactions (e.g., "we are in it together" attitude), 3) task orientation is committed to a high standard and improving and 4) support for innovation (e.g., take the time needed to develop new ideas).[10] These factors are often measured separately, but we created a *Team Climate* domain (Figure 12) based on 6 items[iii].

Team Climate was among the highest rated domains with a Cohort 1 mean score of 3.75 (out of 5) and a standard deviation 0.38 and across the OHTs the proportion of respondents selecting 4 (moderately agree/mostly) or 5 (strongly agree/completely) was 62.4%, and varied from 30.8% to 91.7%. A large proportion of OHTs (24/30) had at least 50% of respondents selecting 4 or 5 and five OHTs; Cambridge North Dumfries, Chatham-Kent, Connected Care Halton, Northumberland and Mississauga, had ≥80% of respondents selected the top two boxes.

The overall mean score for T2 decreased from T1 (4.08 vs. 3.75), the lowest mean score was nearly identical (3.03 vs. 3.00) and the highest mean scores were lower (4.67 vs. 4.50).

Figure 12. Distribution of Cohort 1 OOHT Survey Responses to the *Team Climate* Domain (6 items[iii]) at T2 by OHT and mean scores at T1 and T2, by OHT and by Cohort



[iii] Survey Items - In this OHT:
15 We are prepared to question the basis of what the team is doing
16 We critically appraise potential weaknesses in what our OHT is planning in order to achieve the best possible outcome
17 The members of the OHT build on each other's ideas in order to achieve the best possible outcome
39 We have a 'we are in it together' attitude
40 We take the time needed to develop new ideas
41 To what extent do you think your OHT's objectives can actually be achieved

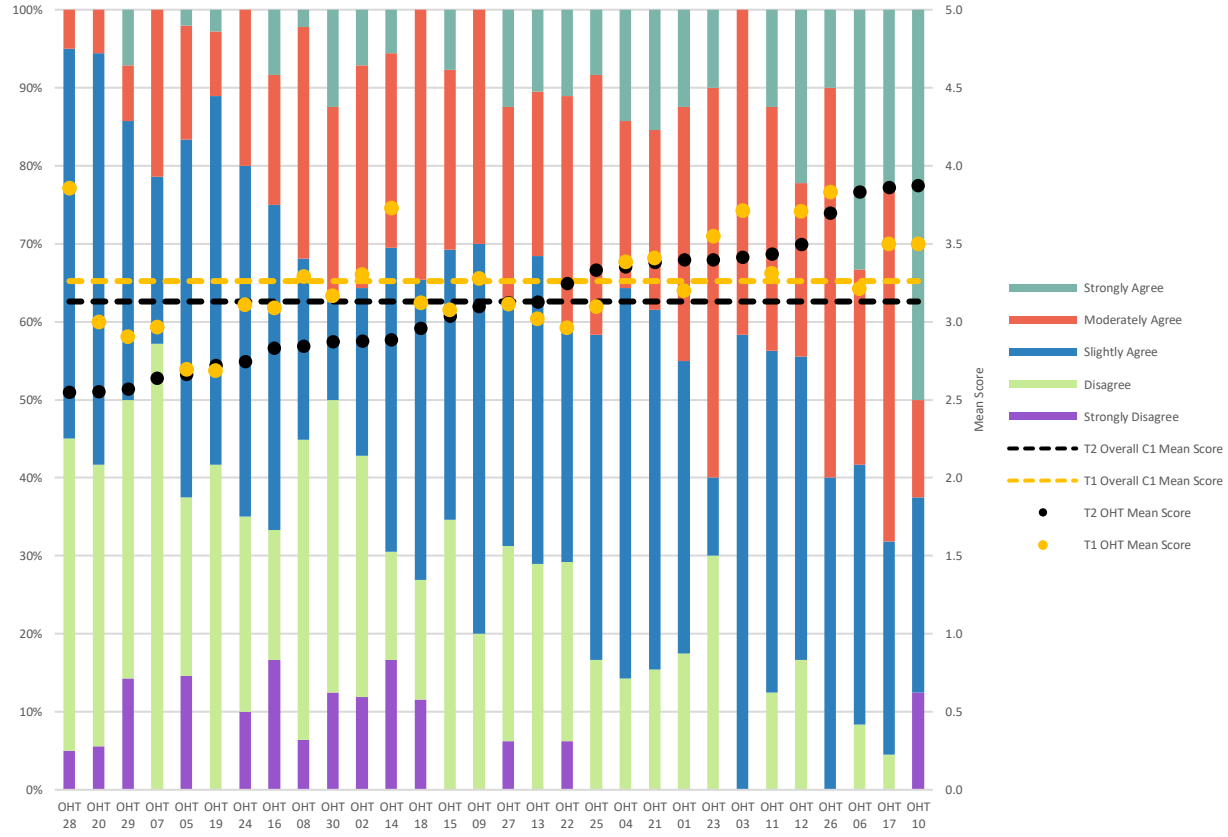
Clinical-Functional Integration

Clinical integration refers to the degree to which tools for clinical coordination are shared across organizations in the partnership and functional integration refers to the degree to which information is shared across organizations in the partnership.[11] *Clinical-Functional Integration*[iv] was the second lowest rated domain in terms of mean score 3.13 (out of 5) with a standard deviation of 0.40.

Across the OHTs (Figure 13), the proportion of respondents selecting 4 (moderately agree) or 5 (strongly agree) was 35.3% (range: 5% to 68.2%), with five OHTs having at least 50% of respondents selecting the top two boxes, and no OHT with ≥80% of respondents selecting 4 or 5 for the two items included this domain.

Compared to T1, the overall and lowest mean scores at T2 were lower (3.26 vs. 3.13 and 2.69 vs. 2.55, respectively) and the highest mean score nearly identical (3.86 vs. 3.88).

Figure 13. Distribution of Cohort 1 OOHT Survey Responses to the *Clinical-Functional Integration* Domain (2 items[iv]) at T2 by OHT and mean scores at T1 and T2, by OHT and by Cohort



[iv] Survey Items - At present in this OHT:
12 We share tools for clinical coordination
13 We share clinical information across partners

Readiness for Change

The Readiness for Organizational Change survey[12] includes three subdomains: 1) *Suitability* (original scale termed "Appropriateness"); 2) *Change Efficacy*; and 3) *Personally Beneficial*.

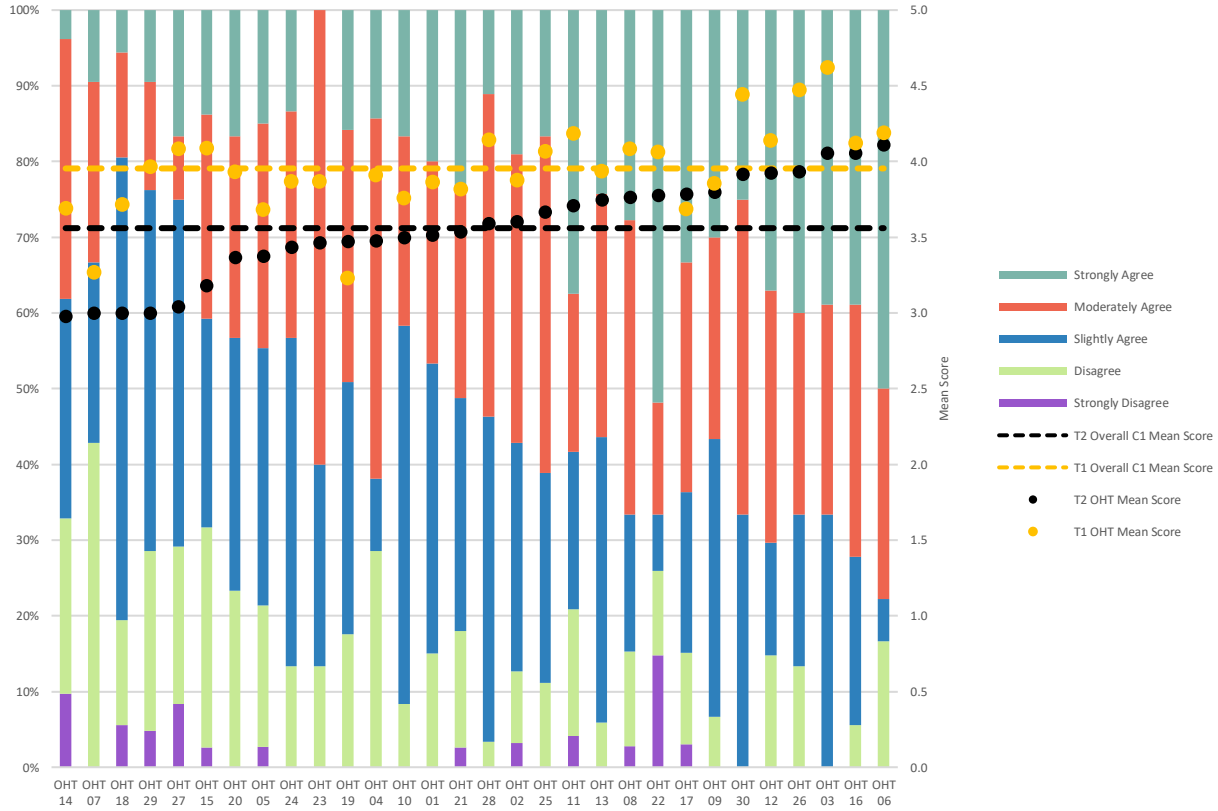
Suitability

Suitability measures whether respondents felt the change is appropriate or needed and if it will benefit the organization. Ratings of the *Suitability* subdomain were moderate (Figure 14), with a mean score across Cohort 1 OHTs of 3.56 (out of 5) with a standard deviation of 0.34. Notably, there were substantial differences in the scores for the items in this domain; respondents felt their organization will likely benefit from the change (mean=3.75) and the change will be worthwhile for them (mean=3.98), but the change will not make their role easier (mean=2.95).

Across the OHTs, the proportion of respondents selecting 4 (moderately agree) or 5 (strongly agree) was 52.8% (range: 19.4% to 77.8%), with more than half of OHTs having ≥50% of respondents selecting the top two boxes (18/30). However, none of the 30 OHTs had ≥80% of respondents selecting 4 or 5 for the three items[v] included this subdomain.

Compared to T1, the overall, lowest and highest mean scores at T2 decreased (3.95 vs. 3.56, 3.23 vs. 2.98 and 4.62 vs. 4.11, respectively).

Figure 14. Distribution of Cohort 1 OOHT Survey Responses to the *Readiness for Change – Suitability* Domain (3 items[v]) at T2 by OHT and mean scores at T1 and T2, by OHT and by Cohort



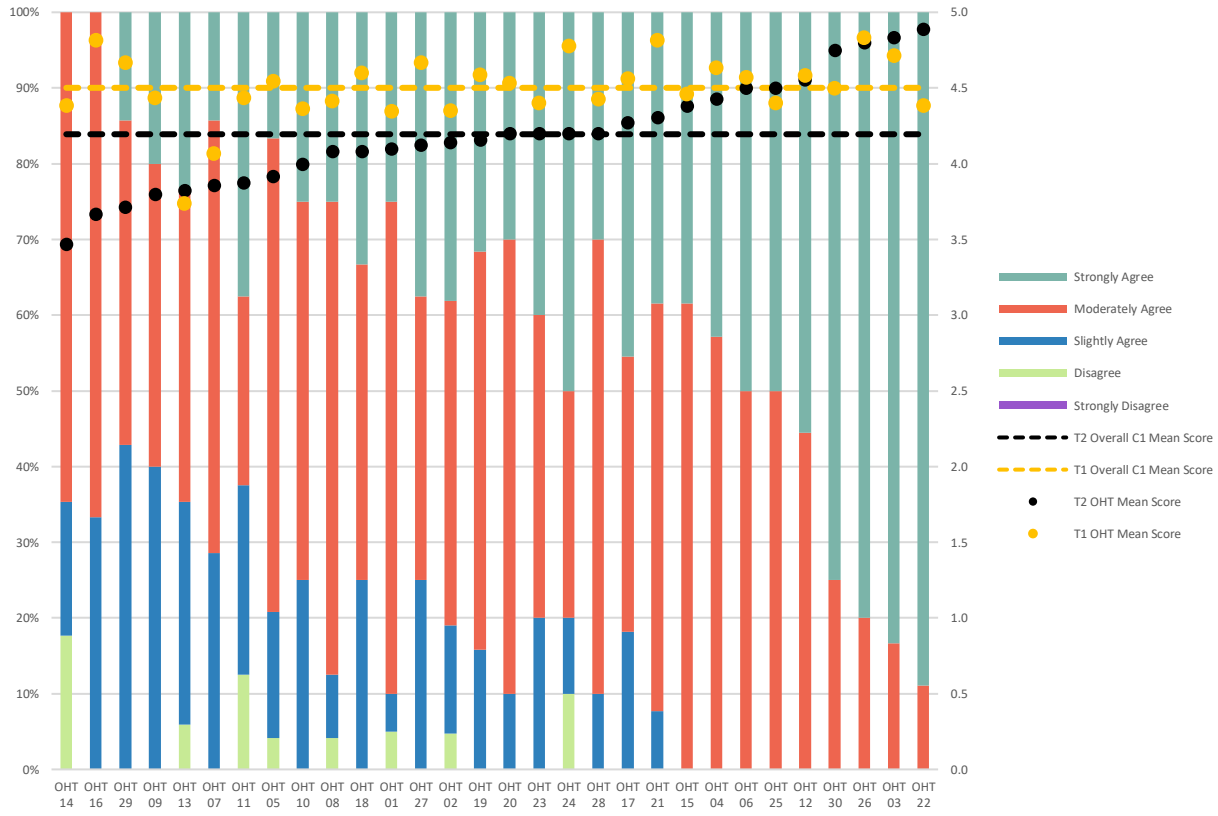
[v] Survey Items – Please think about the changes involved in creating your OHT. To what extent do you agree with the following statements:
34 I think that my organization/practice setting will benefit from this change
35 This change will make my role easier
36 In the long run, I feel it is worthwhile for me that the organization adopted this change

Change Efficacy

The OOHT survey included one item from the *Change Efficacy* subdomain of *Readiness for Change*.[12] The mean score was 4.20 (out of 5) with a standard deviation of 0.36. *Change Efficacy* is having a belief in one's ability to successfully implement change. Ratings for this item were extremely high; respondents felt they had the skills necessary to implement this change. On average, more than a third (38%) of respondents across Cohort 1 OHTs strongly agreed that they had the skills necessary to make this change work (Figure 15). Across the OHTs the proportion strongly agreeing varied from 0% to 88.9%.

Compared to T1, the overall and lowest mean scores at T2 decreased (4.50 vs. 4.19 and 3.74 vs. 3.47) while the highest mean scores were nearly identical (4.83 vs. 4.89).

Figure 15. Distribution of Cohort 1 OOHT Survey Responses to the Item *I have the skills that are needed to make this change work* at T2 by OHT and mean scores at T1 and T2, by OHT and by Cohort

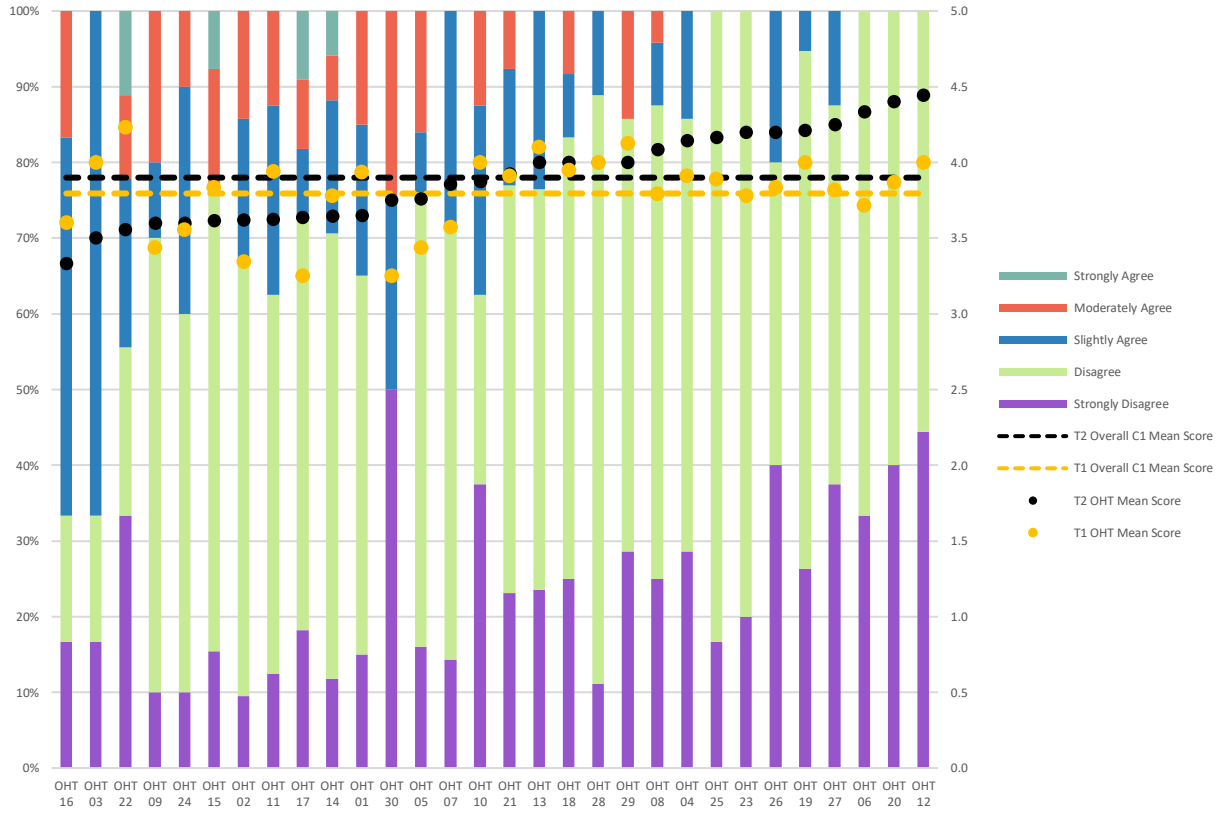


Personally Beneficial

From the *Readiness for Change* domain, the OOHT survey included one item from the *Personally Beneficial* subdomain which measured whether the change will disrupt the working relationships they have developed.[12] The mean score across OHTs was 3.90 with a standard deviation of 0.30. On average across OHTs, 75.8% of respondents disagreed or strongly disagreed that the change would disrupt their working relationships, and this varied from 33.3% to 100% across OHTs (Figure 16).

Compared to T1, the overall, lowest and the highest mean scores were all slightly higher (3.79 vs. 3.90, 3.25 vs. 3.33 and 4.23 vs. 4.44 respectively) at T2.

Figure 16. Distribution of Cohort 1 OOHT Survey Responses to the Item *This change will disrupt many of the working relationships I have developed* at T2 by OHT and mean scores at T1 and T2, by OHT and by Cohort[a]



[a] Responses were reversed when calculating the mean scores for this question (strongly agree=1, moderately agree=2, slightly agree=3, disagree=4, strongly disagree=5).

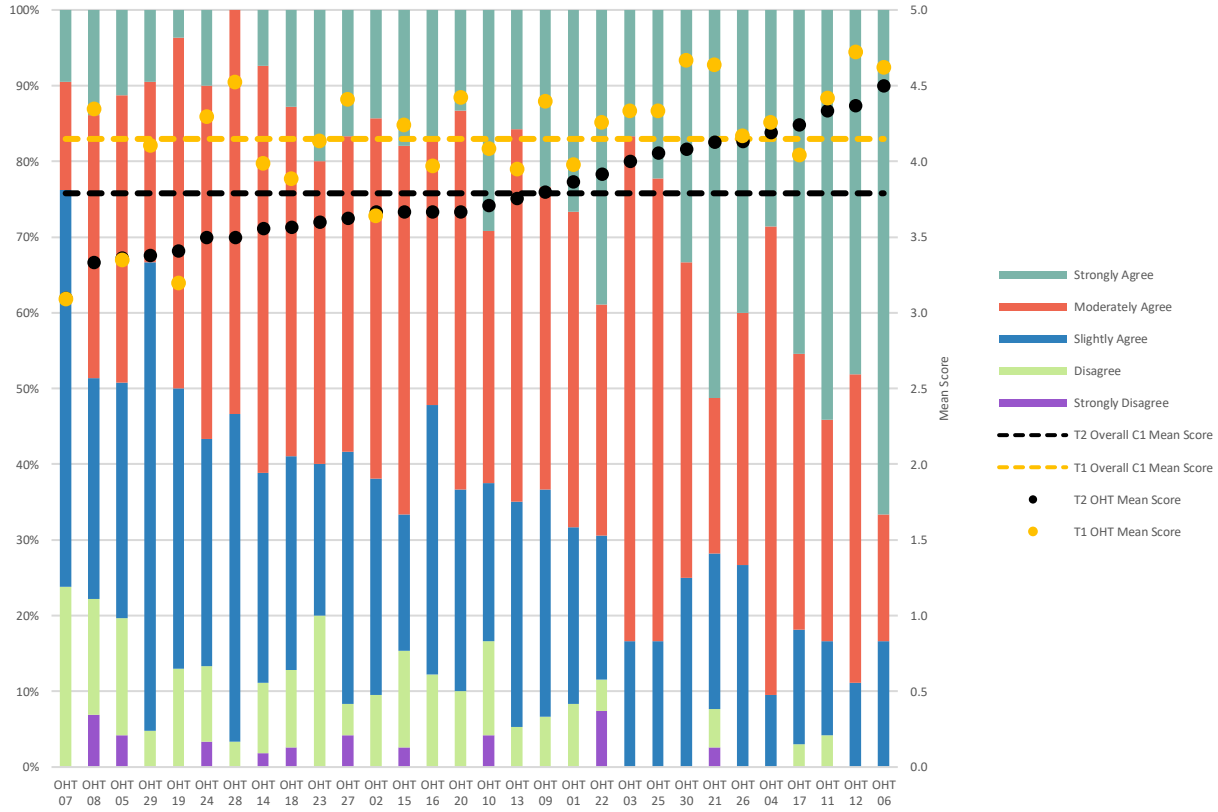
Commitment to Improvement

This is a new scale developed from three items[vi]. The first asked about a common vision for improved integration of care. The second asked about a shared responsibility for achieving improved patient outcomes. And the third item asked if they had used data to identify potential improvements in their target populations. Ratings of this domain were generally very high and Cohort 1 OHTs were committed to improvement (Figure 17); the mean score across OHTs was 3.79 (out of 5) with a standard deviation of 0.35; the highest mean score among the 10 domains.

Across the OHTs, the proportion of respondents selecting 4 (moderately agree) or 5 (strongly agree) was 64.7% (range: 23.8% to 90.5%), with a majority of OHTs with 50% of respondents (26/30) selecting the top two boxes and seven OHTs had ≥80% of respondents selecting 4 or 5 for the three items included this domain.

Compared to T1, the overall mean and highest scores at T2 decreased (4.15 vs. 3.79 and 4.72 vs. 4.50, respectively), while the lowest mean score was nearly identical (3.09 vs. 3.10).

Figure 17. Distribution of Cohort 1 OOHT Survey Responses to the *Commitment to Improvement* Domain (3 items[vi]) at T2 by OHT and mean scores at T1 and T2, by OHT and by Cohort



[vi] Survey Items – At present in this OHT:
8 We have a common vision of how to improve the integration of care
11 We have agreed to share responsibility for achieving improved patient outcomes
14 We have used data to identify the improvements for our target populations

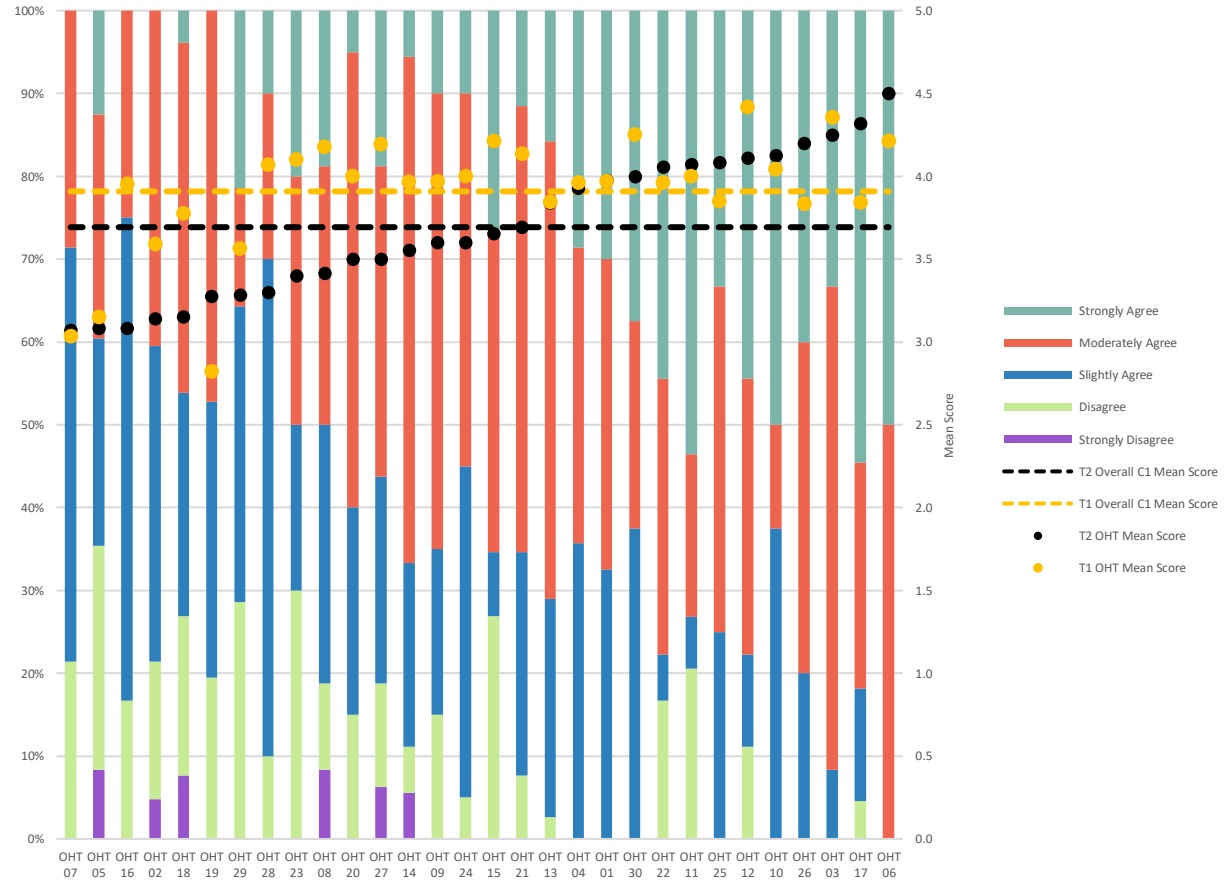
Roles and Responsibilities

The *Roles and Responsibilities* domain is based on two items[vii] from Haggerty's Measure of Network Integration survey.[11] The items ask if all partners understood the role they will play in taking responsibility for the local population and in coordinating care. *Roles and Responsibilities* describes a shared value system which "allows governance to adapt to the requirements of collaboration in the network and makes professionals and organizations aware of their interdependence in providing coordinated care and services."[13] Across most Cohort 1 OHTs, respondents understood their role in coordinating care and taking responsibility for the population. The mean score for the *Roles and Responsibilities* domain across applicant OHTs was 3.69 (out of 5) with a standard deviation of 0.42 (Figure 18).

Across the OHTs, the proportion of OHT respondents selecting 4 (moderately agree) or 5 (strongly agree) was 60.4% (range: 25% to 100%). More than two-thirds of OHTs (22/30) had over 50% of respondents selecting 4 or 5. Four OHTs; Cambridge North Dumfries, Couchiching, East York Toronto Health Partners and Mississauga had ≥80% of respondents selecting 4 (moderately agree) or 5 (strongly agree).

Compared to T1, the overall mean score at T2 decreased (3.91 vs. 3.69), while the lowest and highest mean scores were slightly higher (2.82 vs. 3.07 and 4.42 vs. 4.50, respectively).

Figure 18. Distribution of Cohort 1 OOHT Survey Responses to the *Roles and Responsibilities* Domain (2 items[vii]) at T2 by OHT and mean scores at T1 and T2, by OHT and by Cohort



[vii] Survey Items – At present in this OHT:
9 We understand the role we will play in taking responsibility for the local population
10 We understand the role we will play in coordinating care

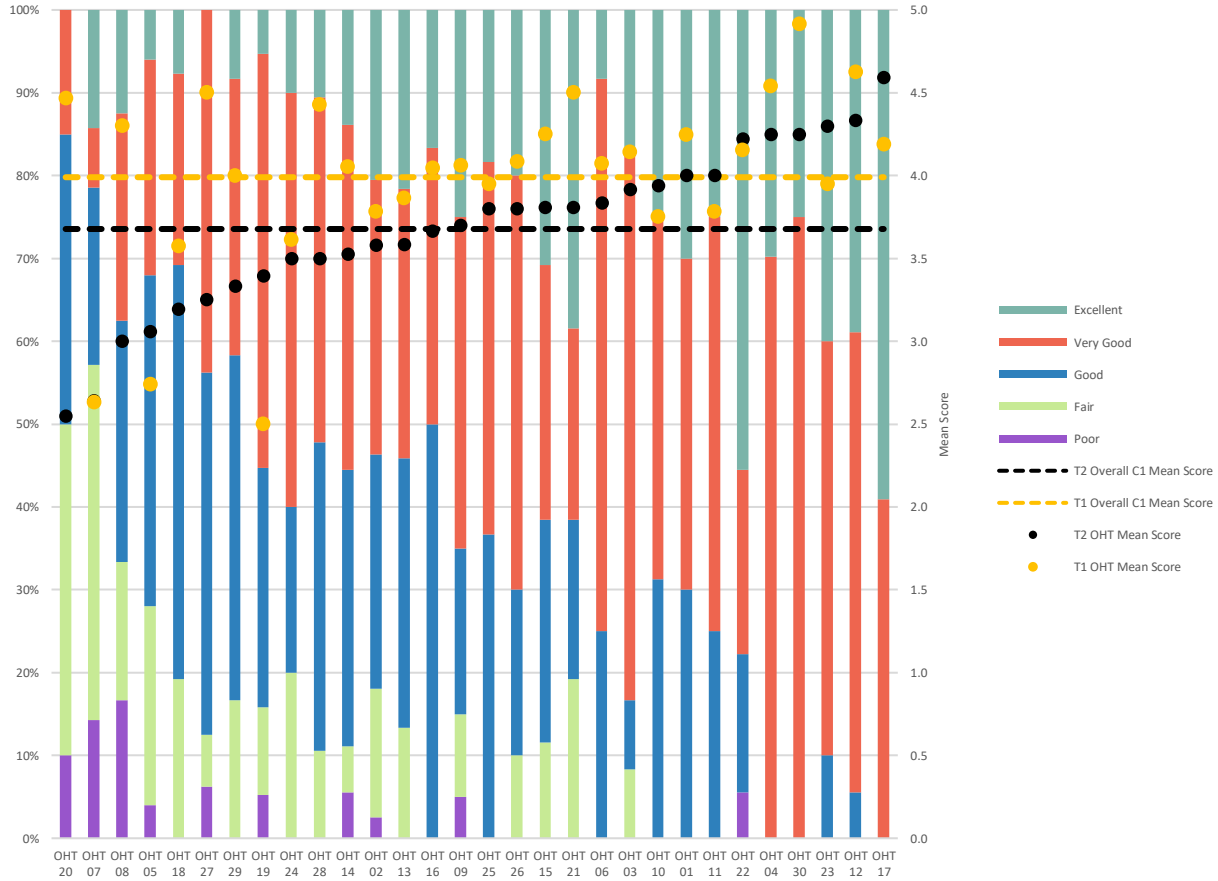
Administration and Management

Administration and Management describes functions, such as communication strategies and mechanisms for coordinating partnership activities, that allow for meaningful engagement of multiple, independent organizations within the partnership.[14] The *Administration and Management* domain was composed of 2 items[viii] asking respondents to rate their OHT's effectiveness in communicating among members and organizing activities such as meetings and projects. Ratings of the *Administration and Management* domain were high, mean score across OHTs was 3.68 (out of 5) with a standard deviation of 0.49 (Figure 19).

Across the OHTs, the proportion of OHT respondents selecting 4 (very good) or 5 (excellent) was 62% (range: 15% to 100%), with most OHTs (23/30) having at least 50% of respondents selecting 4 or 5. However, only six OHTs had ≥80% of respondents selecting 4 or 5 for the two items included this domain.

Compared to T1, the overall mean and highest mean scores decreased (3.99 vs. 3.68 and 4.92 vs. 4.59, respectively), while the lowest mean score increased slightly at T2 (2.50 vs. 2.55).

Figure 19. Distribution of Cohort 1 OOHT Survey Responses to the *Administration and Management* Domain (2 items[viii]) at T2 by OHT and mean scores at T1 and T2, by OHT and by Cohort



[viii] Survey Items – Please rate the effectiveness of your OHT in carrying out the following activities:
23 Communicating among members
24 Organizing OHT member activities, including meetings and projects

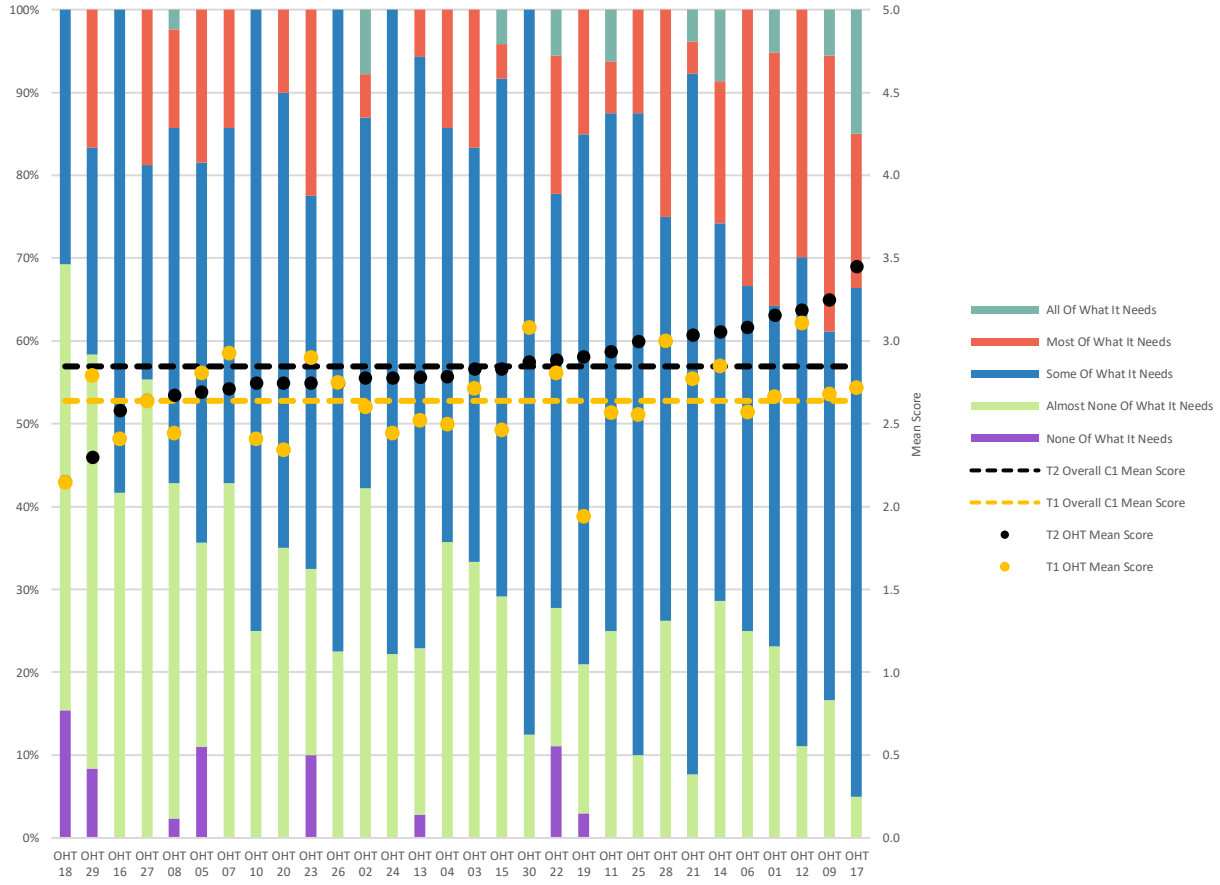
Financial and Other Capital Resources

Financial and in-kind resources have been described as the "basic building blocks" for successful partnerships and the importance of having sufficient money and other resources (e.g., equipment such as computers) has been emphasized by multiple partnerships.[14] The *Financial and Other Capital Resources*[ix] domain was created from two questions; 1) does the OHT have sufficient money, and 2) tools and technology such as digital health solutions and information portals. The ratings on this domain were the lowest (Figure 20). The mean score across OHTs was 2.85 (out of 5) with a standard deviation of 0.26.

Across the OHTs the proportion of OHT respondents selecting 4 (most of what it needs) or 5 (all of what it needs) was 15.5% and varied from 0% to 38.9%. No OHT had at least 50% of respondents selecting 4 or 5 for the two items included this domain.

Compared to T1, the overall, the lowest and highest mean scores all increased at T2 (2.64 vs. 2.85, 1.94 vs. 2.15 and 3.11 vs. 3.45, respectively).

Figure 20. Distribution of Cohort 1 OOHT Survey Responses to the *Financial and Other Capital Resources* Domain (2 items[ix]) at T2 by OHT and mean scores at T1 and T2, by OHT and by Cohort



[ix] Survey Items – For each of the following types of resources, to what extent does your OHT have what it needs to work effectively:
29 Money
30 Tools and technologies

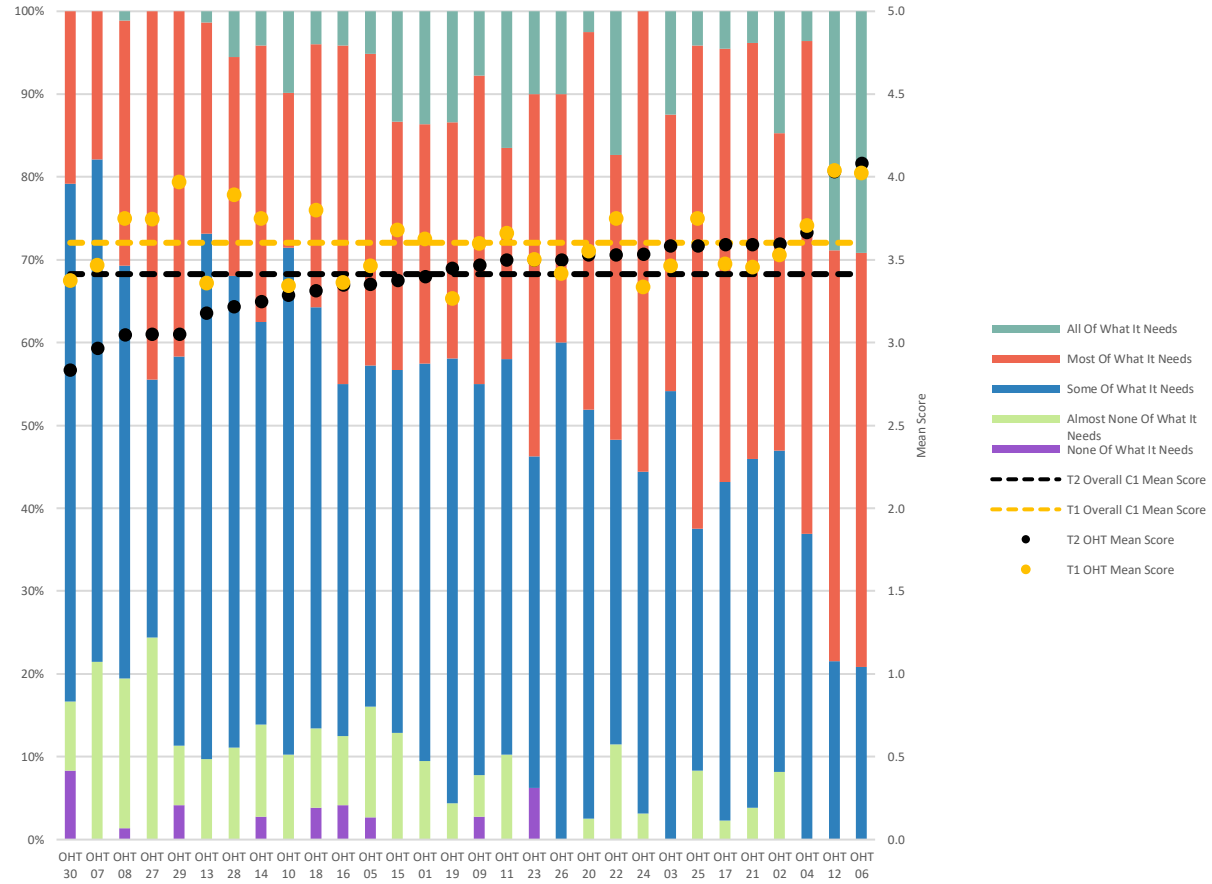
Non-Financial Resources

In addition to the basic financial resources required for a successful partnership, OHTs will require a broad array of skills and expertise, access to information and connections to political decision makers and other to support the legitimacy of the partnership.[14] There were four questions[x] about sufficiency of these non-financial resources. Ratings for the *Non-Financial Resources* domain were low, with a mean score across OHTs of 3.41 (out of 5) with a standard deviation of 0.28 (Figure 21).

Across the OHTs, the mean proportion of OHT respondents selecting 4 (most of what it needs) or 5 (all of what it needs) was 45.4% and varied from 17.9% to 79.2%. One-third (10/30) of the OHTs had at least 50% of respondents selecting 4 or 5. No OHT had ≥80% of respondents selecting 4 or 5 for the four items included this domain (Figure 21).

Compared to T1, the overall and lowest mean scores, at T2 decreased (3.60 vs. 3.41, and 3.26 vs 2.83) while the highest mean scores were nearly identical (4.04 vs. 4.08).

Figure 21. Distribution of Cohort 1 OOHT Survey Responses to the *Non-Financial Resources* Domain (4 items[x]) at T2 by OHT and mean scores at T1 and T2, by OHT and by Cohort



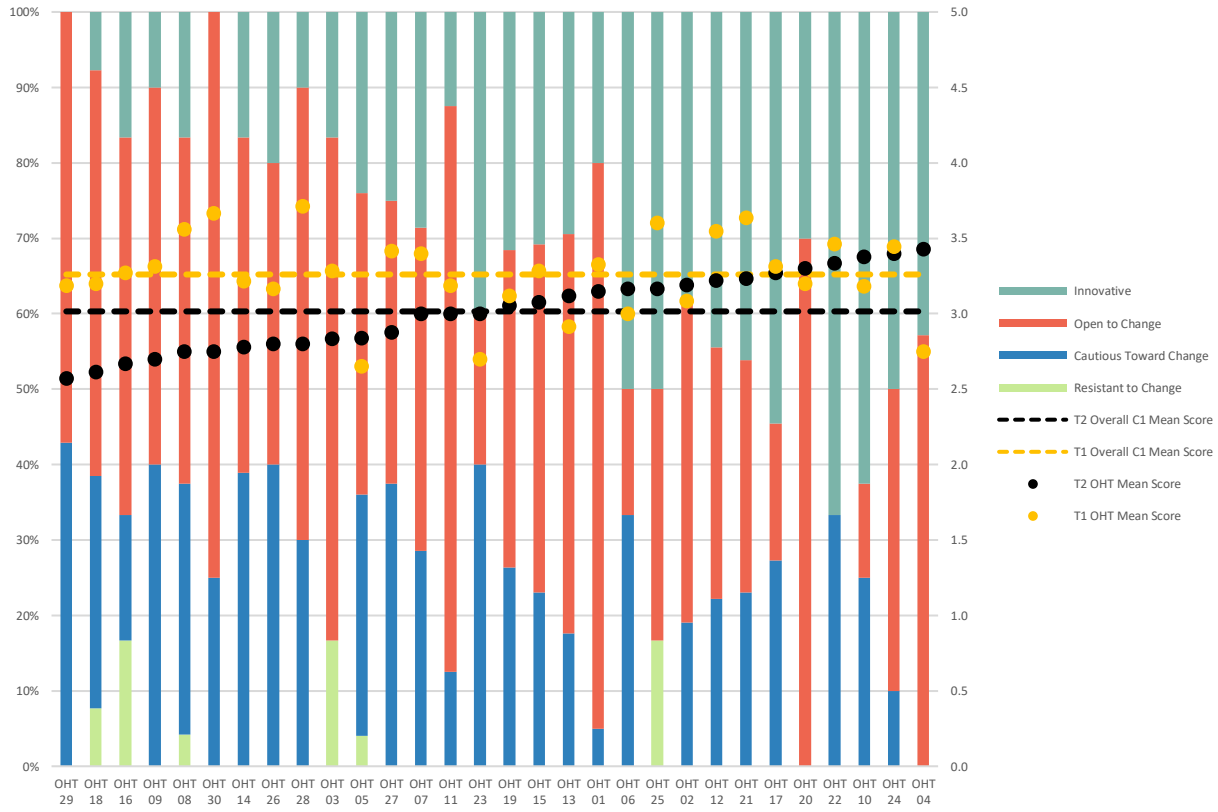
[x] Survey Items – For each of the following types of resources, to what extent does your OHT have what it needs to work effectively:
25 Skills and expertise
26 Data and information
27 Ability to identify target population criteria and deliver interventions
28 Connections to political decision-makers, government agencies

Other OOHT Survey Items

There were three additional items that were not part of the ten domains. Question 31 asked respondents to select the response that described their organization or practice setting's attitude toward change. Almost one-third of Cohort 1 OHTs (9/30) can be considered as either innovative or open to change, with at least 80% of respondents selecting 3 or 4 (Figure 22). In particular, across the OHTs in Cohort 1, 29.7% of respondents described their organization as innovative, 44.3% as open to change, 23.8% cautious toward change and 2.2% as resistant to change (see Appendix A). Six OHTs had respondents reporting that their organizations were resistant to change.

Compared to T1, the overall mean score for T2 was lower (3.26 vs. 3.02). The lowest mean and the highest mean had both decreased (2.65 vs. 2.57 and 3.71 vs. 3.43 respectively).

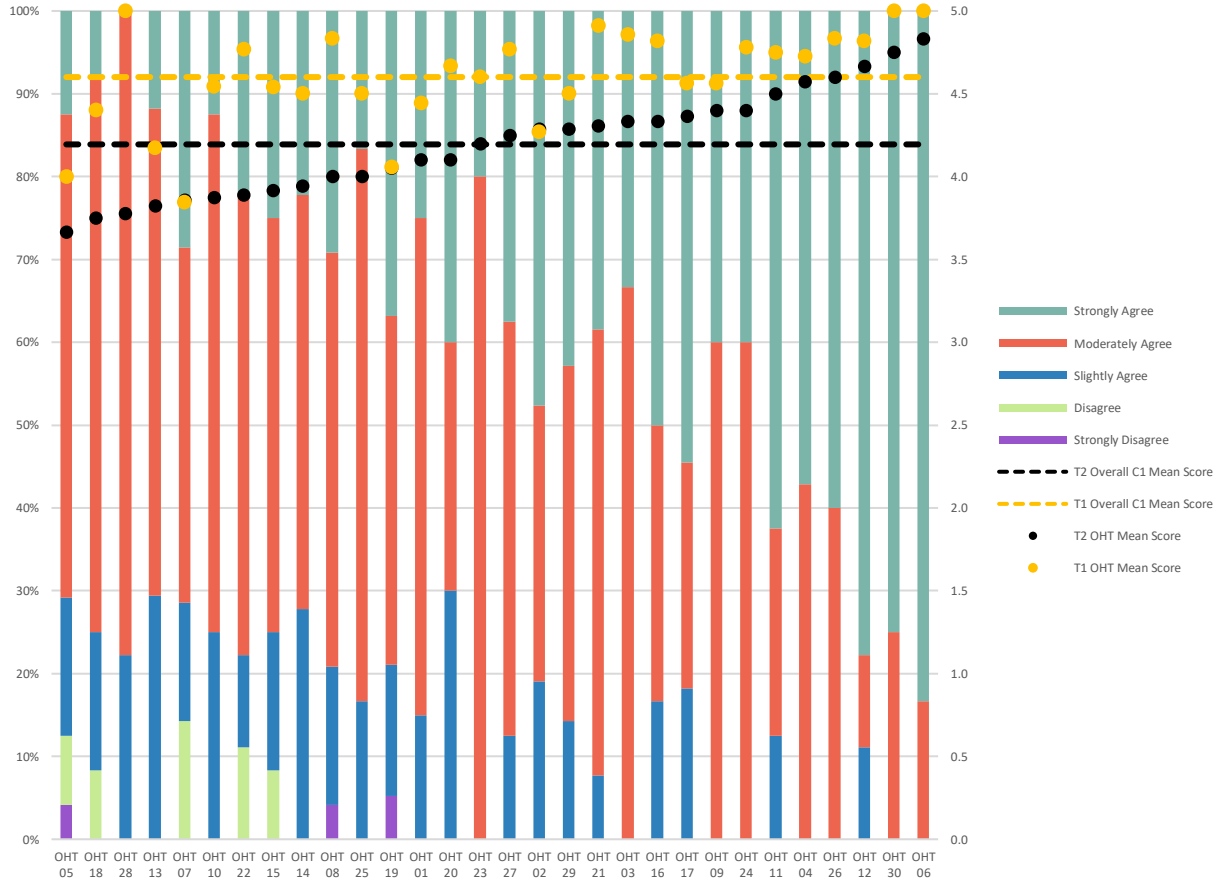
Figure 22. Distribution of Cohort 1 OOHT Survey Responses to the Item *Organization or practice setting's attitude toward change* at T2 by OHT and mean scores at T1 and T2, by OHT and by Cohort



Question 32 asked if the respondent's organization or practice setting's shared values were compatible with those of other members of the OHT. Ratings on this question were, generally, very high (mean score 4.19 (out of 5)) and a standard deviation of 0.32 (Figure 23). Across the OHTs, the proportion of OHT respondents selecting 4 (moderately agree) or 5 (strongly agree) varied from 70% to 100%. Almost two-thirds of OHTs (18/30) had ≥80% of respondents selecting the top two boxes and eight OHTs had 100% of their respondents selecting the top two boxes.

Compared to T1, the overall, lowest, and highest mean score for T2 were all lower (4.60 vs. 4.19, 3.85 vs. 3.67 and 5.0 vs. 4.83 respectively).

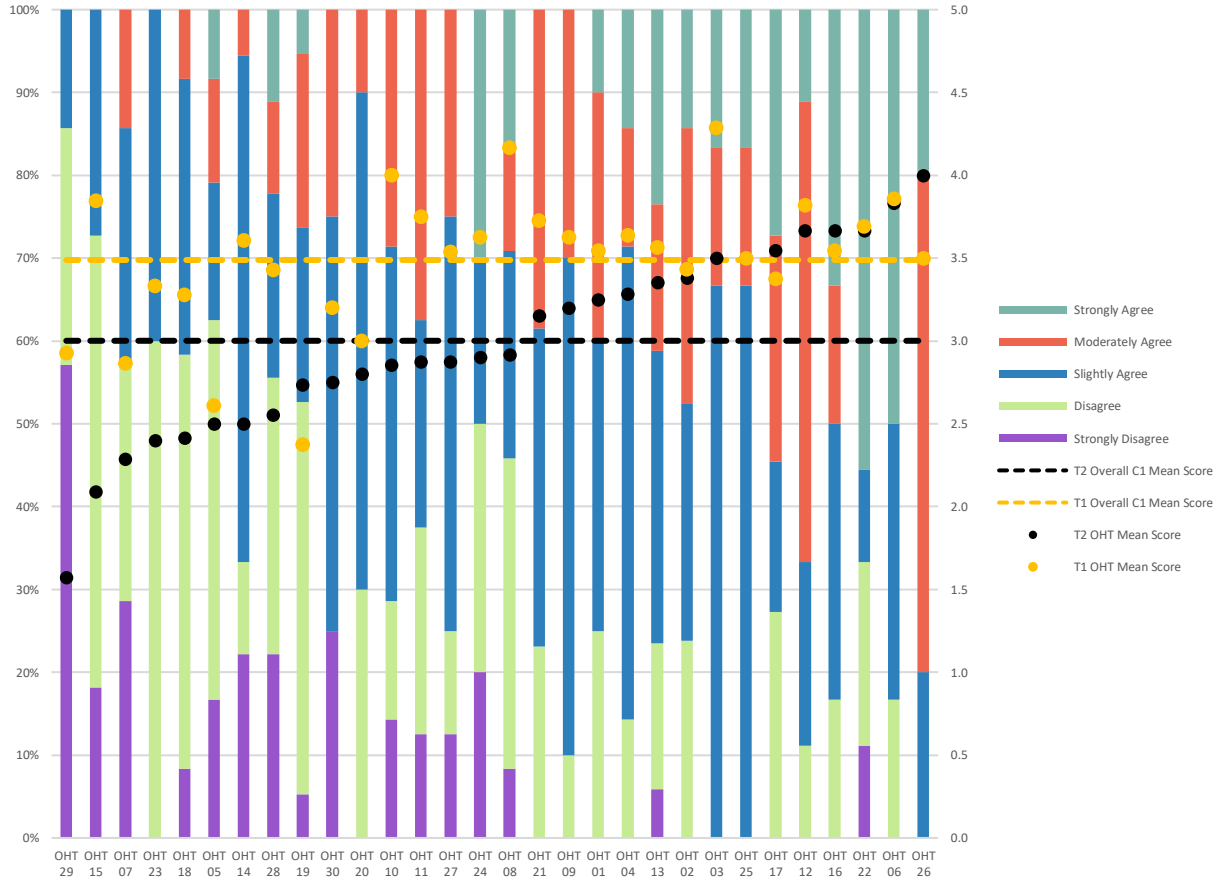
Figure 23. Distribution of Cohort 1 OOHT Survey Responses to the Item *Your organization's shared values are compatible with those of other OHT members* at T2 by OHT and mean scores at T1 and T2, by OHT and by Cohort



When asked, in question 33, if the professionals/staff in the respondent's organization or practice setting had a strong sense of belonging to the OHT, ratings were relatively low (Figure 24); the mean score across OHTs was 3.00 (out of 5) with a standard deviation of 0.57. Across the OHTs, the proportion of OHT respondents selecting 4 (moderately agree) or 5 (strongly agree) varied from 0% to 80%, with only six OHTs having at least 50% of respondents selecting the top two boxes and one OHT (Couchiching) with 80% selecting 4 or 5.

Compared to T1, the overall mean score for T2 was much lower (3.49 vs. 3.00), the lowest mean score was drastically lower (2.38 vs. 1.57) and the highest mean score was lower (4.29 vs. 4.00).

Figure 24. Distribution of Cohort 1 OOHT Survey Responses to the Item *Your organization's staff have a strong sense of belonging to your OHT* at T2 by OHT and mean scores at T1 and T2, by OHT and by Cohort



Cohort 2 Response Distribution by Domain and Item-level Response Distribution

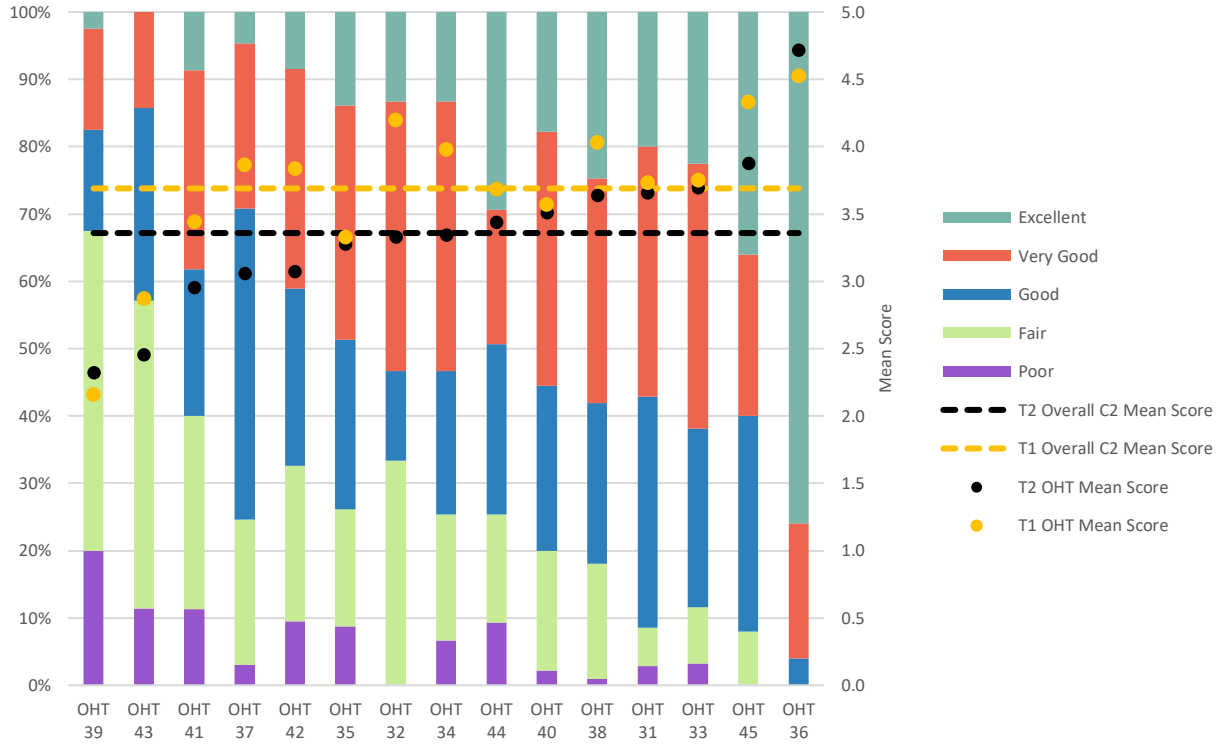
Leadership Approach

Five items[i] from the OOHT survey comprise the *Leadership Approach* domain. Respondents were asked to rate the effectiveness of their OHT's formal and informal leadership at empowering members, fostering respect and trust, creating an environment where differences of opinion could be voiced, promoting creativity and different ways at looking at things, and communicating the vision of their OHT. For Cohort 2 OHTs, the most recent scores for *Leadership Approach* were low (ranked 6th out of the 10 domains), mean score across OHTs was 3.36 (out of 5) with a standard deviation of 0.58.

Across the OHTs, the proportion of respondents selecting 4 (very good) or 5 (excellent) was 48.9% and varied from 14.3% to 96% with eight of the 15 OHTs having at least 50% of respondents selecting the top two boxes. Only one of the 15 OHTs (South Georgian Bay) had ≥80% of respondents selecting the top two boxes across the items included this domain (Figure 25).

Compared to T1, the overall mean score for T2 had decreased (3.69 vs. 3.36), while the lowest mean score and highest mean score had increased (2.16 vs. 2.33, and 4.53 vs. 4.72 respectively).

Figure 25. Distribution of Cohort 2 OOHT Survey Responses to the *Leadership Approach* Domain (5 items[i]) at T2 by OHT and mean scores at T1 and T2



[i] Survey Items - Please rate the total effectiveness of your OHT's leadership in each of the following areas:
18 Empowering people/members involved in the OHT
19 Communicating the vision of the OHT
20 Creating an environment where differences of opinion can be voiced
21 Helping the OHT to be creative and look at things differently
22 Fostering respect, trust and inclusiveness amongst OHT members

Leadership Approach – Building Trust

Trust is an essential underpinning element of successful partnering to deliver better and more integrated care in the context of complex multi-organizational systems.[6] We highlight two items from the *Leadership Approach* domain related to establishing trust among partners, *Fostering respect, trust and inclusiveness* (question 22) and *Creating an environment where differences of opinion can be voiced* (question 20), below. Across the Cohort 2 OHTs, the mean scores for these items were 3.54 with a standard deviation of 0.70, and 3.43 with a standard deviation of 0.55, respectively.

The proportion of respondents selecting 4 (very good) or 5 (excellent) on *Fostering respect, trust and inclusiveness* (Figure 26) varied from 13% to 100%, with most OHTs (10/15) having at least 50% of respondents selecting the top two boxes, but only three (Downtown East Toronto, Kawartha Lakes and South Georgian Bay) had ≥80% of respondents selecting the top two boxes on the two items. For question 20 - *Creating and environment where differences of opinion can be voiced* (Figure 27) the proportion of respondents selecting 4 (very good) or 5 (excellent) ranged from 25% to 100%, with more than half (9/15) of OHTs having at least 50% of respondents selecting the top two boxes but only one OHT (South Georgian Bay) had ≥80% (100%) of respondents selecting the top two boxes.

For question 22, across cohorts, the overall mean score in Cohort 2 was lower compared to the first time they completed the survey (3.80 vs. 3.54), while the lowest and highest mean scores across the OHTs had increased (1.80 vs. 2.13 and 4.67 vs. 5.00, respectively). The same pattern was observed for question 20 (3.71 vs. 3.43) along with the lowest (2.00 vs 2.50) and highest mean scores (4.50 vs 4.80) as well.

Figure 26. Distribution of Cohort 2 OOHT Survey Responses to the Item *Fostering respect, trust, and inclusiveness amongst OHT members* at T2 by OHT and mean scores at T1 and T2, by OHT and by Cohort

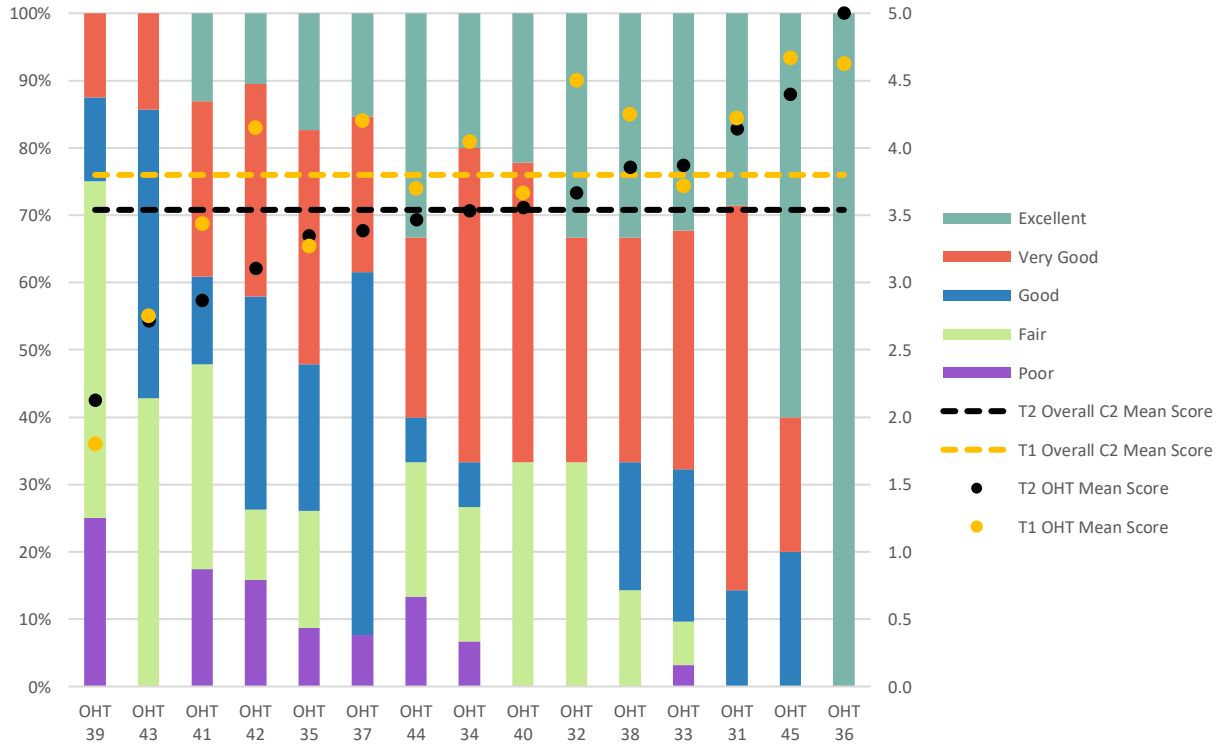
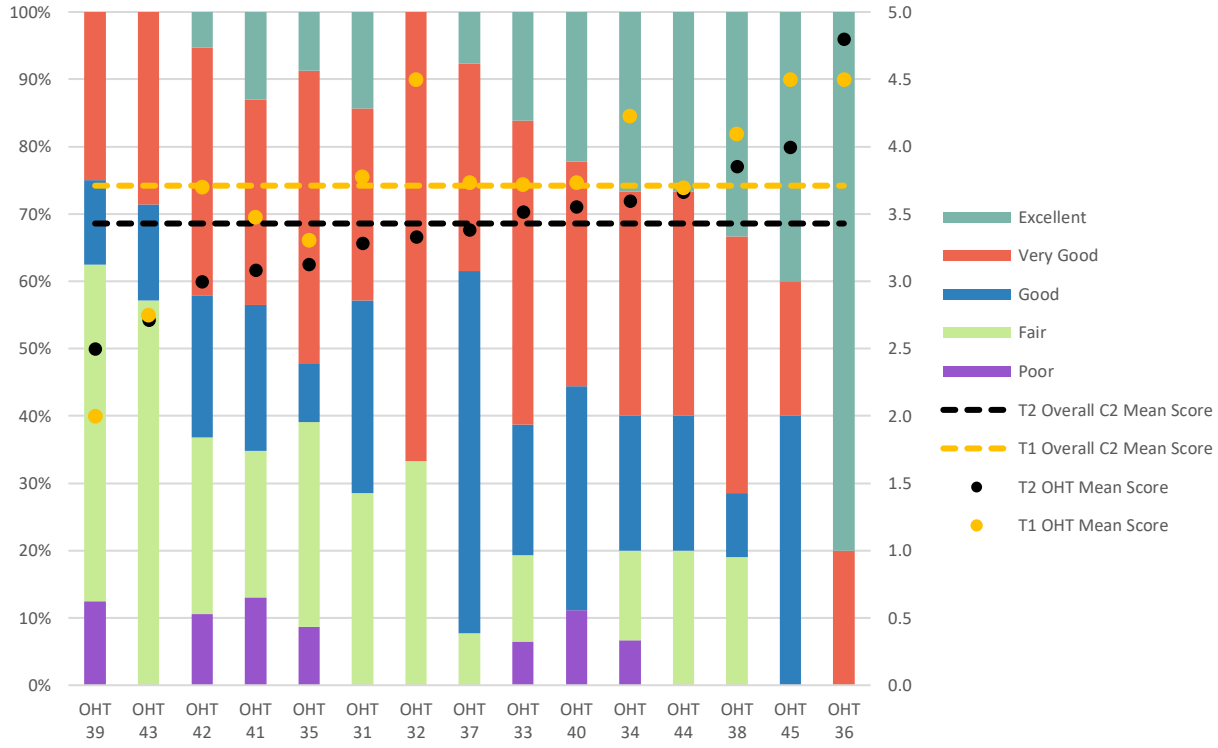


Figure 27. Distribution of Cohort 2 OOHT Survey Responses to the Item *Creating an environment where differences of opinion can be voiced* at T2 by OHT and mean scores at T1 and T2, by OHT and by Cohort



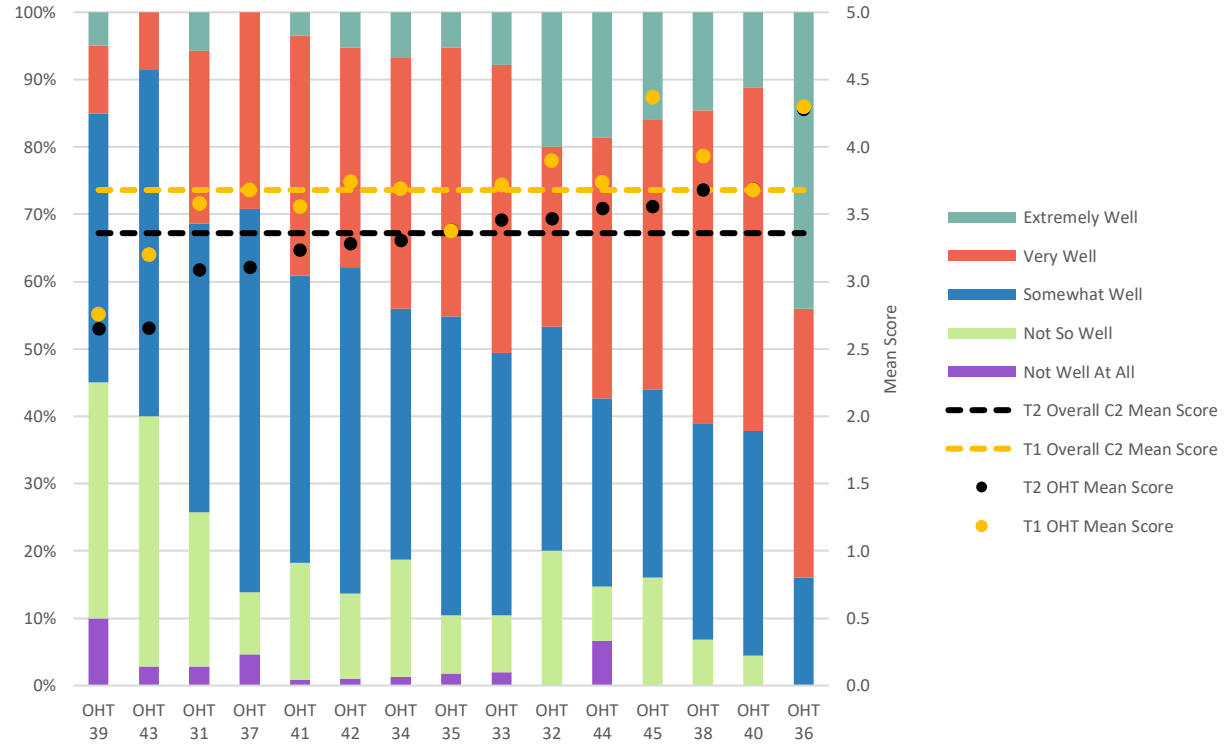
Shared Vision

A shared vision is created "by combining the perspectives, knowledge, and skills of diverse partners in a way that enables the partnership to (1) think in new and better ways about how it can achieve its goals; (2) plan more comprehensive, integrated programs; and (3) strengthen its relationship to the broader community".[9] The *Shared Vision* domain (Figure 28) was composed of 5-items[ii] and respondents were asked to rate how well the organizations and people partnering in the OHT have been able to develop widely understood and supported goals; identify how organizations and programs could help; respond to the needs of their community; include views and priorities of those impacted; and obtain support from individuals in the community.

Overall, responses to *Shared Vision* were middling. The mean score across Cohort 2 OHTs for *Shared Vision* was 3.36 (out of 5) with a standard deviation of 0.41. Across the OHTs, the proportion of respondents selecting 4 (very well) or 5 (extremely well) across the five items was 44.6% and varied from 8.6% to 84% with less than half of OHTs (6/15) having at least 50% of respondents selecting the top two boxes. Only one OHT (South Georgian Bay) had ≥80% of respondents selecting 4 or 5.

Compared to T1, the overall and lowest mean score for T2 had decreased (3.68 vs. 3.36 and 2.76 vs. 2.65, respectively) and highest mean scores were nearly identical (4.30 vs. 4.28).

Figure 28. Distribution of Cohort 2 OOHT Survey Responses to the *Shared Vision* Domain (5 items[ii]) at T2 by OHT and mean scores at T1 and T2, by OHT and by Cohort



[ii] Survey Items - By working together, how well, at present, are the members of your OHT able to:
3 Develop goals that are widely understood and supported among members
4 Identify how different organizations/programs in the community could help to solve the issues the OHT is trying to address in their year one population
5 Respond to the needs and problems of the community
6 Include the views and priorities of the people affected by the OHT's work
7 Obtain support from individuals and organizations in the community that can either block the OHT's plans or help move them forward

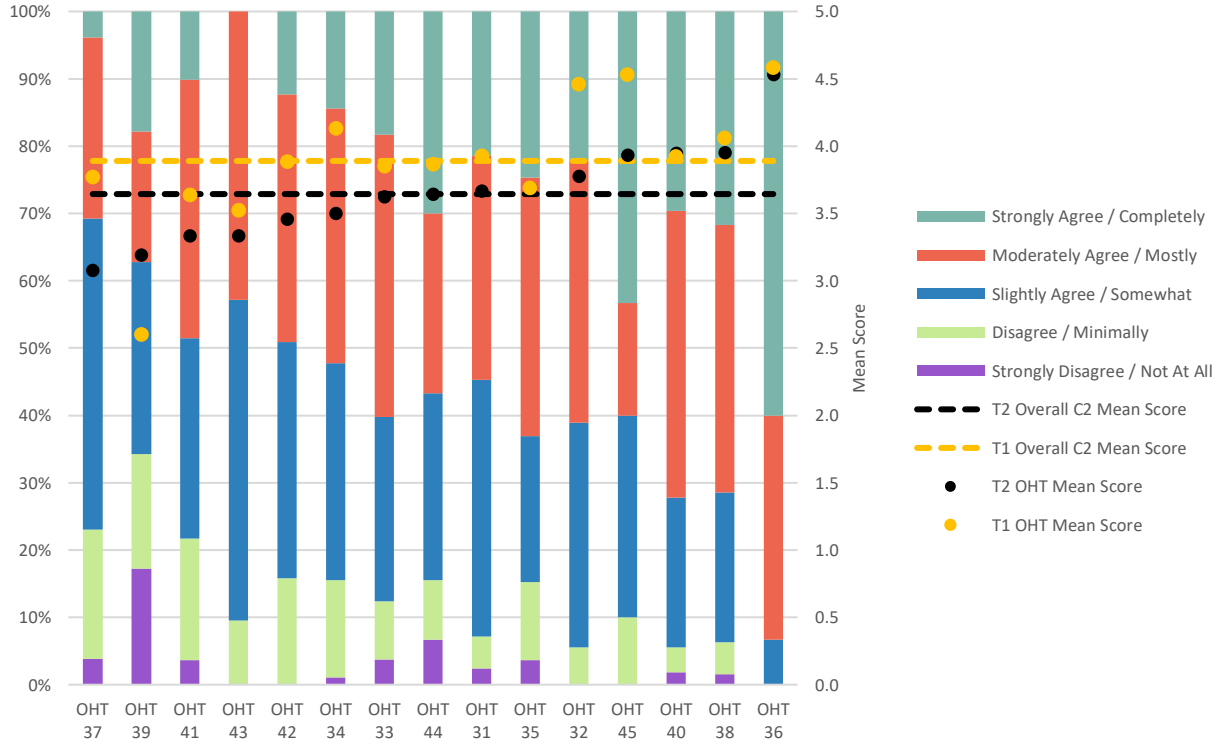
Team Climate

There are four factors associated with successful group innovations; 1) vision is clear and realistic, 2) participatory safety or climate of interpersonal interactions (e.g., "we are in it together" attitude), 3) task orientation is committed to a high standard and improving and 4) support for innovation (e.g., take the time needed to develop new ideas).[10] These factors are often measured separately, but we created a *Team Climate* domain (Figure 29) based on 6 items[iii].

Team Climate was among the highest rated domains among cohort 2 OHTs; mean score of 3.64 (out of 5) and a standard deviation 0.36. Across the OHTs, the proportion of respondents selecting 4 (moderately agree/mostly) or 5 (strongly agree/completely) across the items was 56.9%, and varied from 30.7% to 93.3% with all but five OHTs (10/15) having at least 50% of respondents selecting 4 or 5. Only one OHT (South Georgian Bay) had ≥80% of respondents selected the top two boxes.

Compared to T1, the overall mean score for T2 was lower (3.89 vs. 3.64), the lowest mean score increased (2.60 vs. 3.08) and the highest mean scores were similar (4.58 vs. 4.53).

Figure 29. Distribution of Cohort 2 OOHT Survey Responses to the *Team Climate* Domain (6 items[iii]) at T2 by OHT and mean scores at T1 and T2, by OHT and by Cohort



[iii] Survey Items - In this OHT:
15 We are prepared to question the basis of what the team is doing
16 We critically appraise potential weaknesses in what our OHT is planning in order to achieve the best possible outcome
17 The members of the OHT build on each other's ideas in order to achieve the best possible outcome
39 We have a 'we are in it together' attitude
40 We take the time needed to develop new ideas
41 To what extent do you think your OHT's objectives can actually be achieved

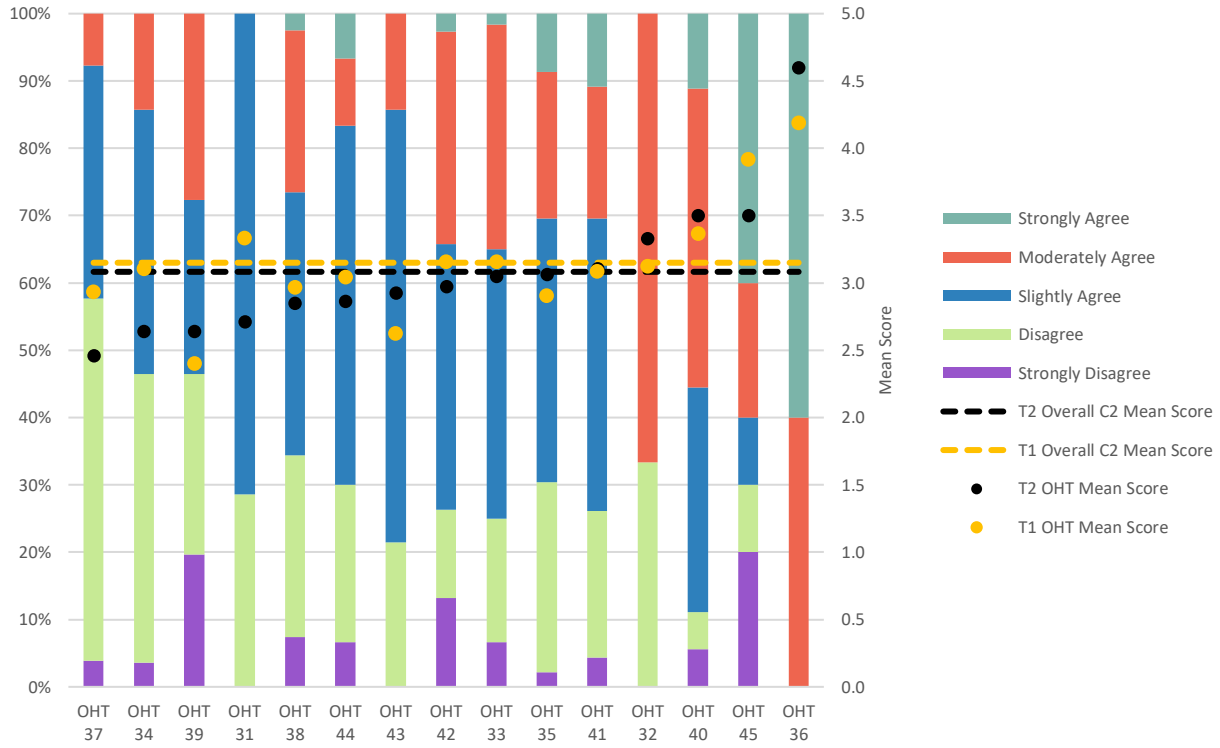
Clinical-Functional Integration

Clinical integration refers to the degree to which tools for clinical coordination are shared across organizations in the partnership and functional integration refers to the degree to which information is shared across organizations in the partnership.[11] *Clinical-Functional Integration*[iv] was the second lowest rated domain in terms of mean score 3.08 (out of 5) with a standard deviation of 0.52.

Across the OHTs (Figure 30), the proportion of respondents selecting 4 (moderately agree) or 5 (strongly agree) was 34.6% (range: 0% to 100%), with four OHTs having at least 50% of respondents selecting the top two boxes, and one OHT (South Georgian Bay) with ≥80% of respondents selecting 4 or 5 for the two items included this domain.

Compared to T1, the overall mean and the lowest mean score for T2 were similar (3.15 vs. 3.08 and 2.40 vs. 2.46, respectively) and the highest mean score higher (4.19 vs. 4.60).

Figure 30. Distribution of Cohort 2 OOHT Survey Responses to the *Clinical-Functional Integration* Domain (2 items[iv]) at T2 by OHT and mean scores at T1 and T2, by OHT and by Cohort



[iv] Survey Items - At present in this OHT:
12 We share tools for clinical coordination
13 We share clinical information across partners

Readiness for Change

The Readiness for Organizational Change survey[12] includes three subdomains: 1) *Suitability* (original scale termed "Appropriateness"); 2) *Change Efficacy*; and 3) *Personally Beneficial*.

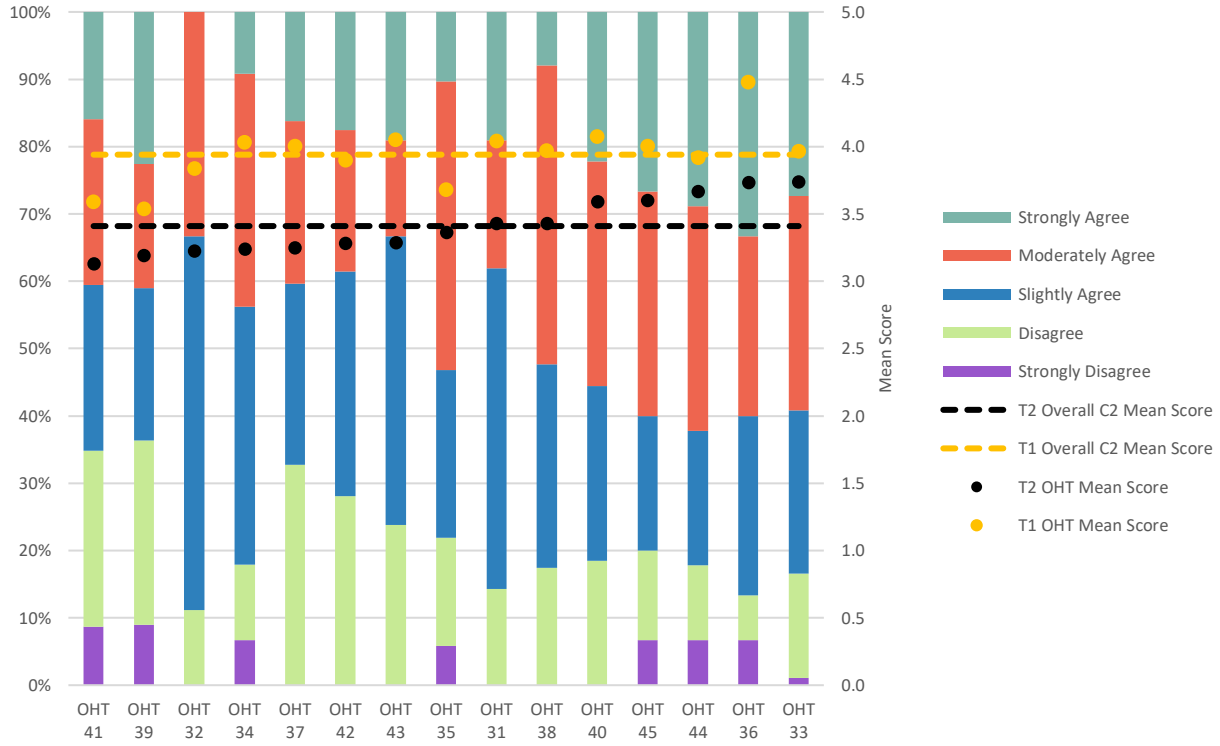
Suitability

Suitability measures whether respondents felt the change is appropriate or needed and if it will benefit the organization. Ratings of the *Suitability* subdomain were moderate (Figure 31), with a mean score across Cohort 2 OHTs of 3.41 (out of 5) with a standard deviation of 0.21. Notably, there were substantial differences in the scores for the items in this domain; respondents felt their organization will likely benefit from the change (mean=3.66) and the change will be worthwhile for them (mean=3.81), but the change will not make their role easier (mean=2.76).

Across the OHTs, the proportion of respondents selecting 4 (moderately agree) or 5 (strongly agree) was 47.4% (range: 33.3% to 62.2%), with about half of OHTs (7/15) having ≥50% of respondents selecting the top two boxes. However, none of the 15 OHTs had ≥80% of respondents selecting 4 or 5 for the three items[v] included this subdomain.

Compared to T1, T2's overall mean score, lowest mean score and highest mean score were lower (3.94 vs. 3.41, 3.53 vs. 3.13, and 4.48 vs. 3.74, respectively).

Figure 31. Distribution of Cohort 2 OOHT Survey Responses to the *Readiness for Change – Suitability* Domain (3 items[v]) at T2 by OHT and mean scores at T1 and T2, by OHT and by Cohort



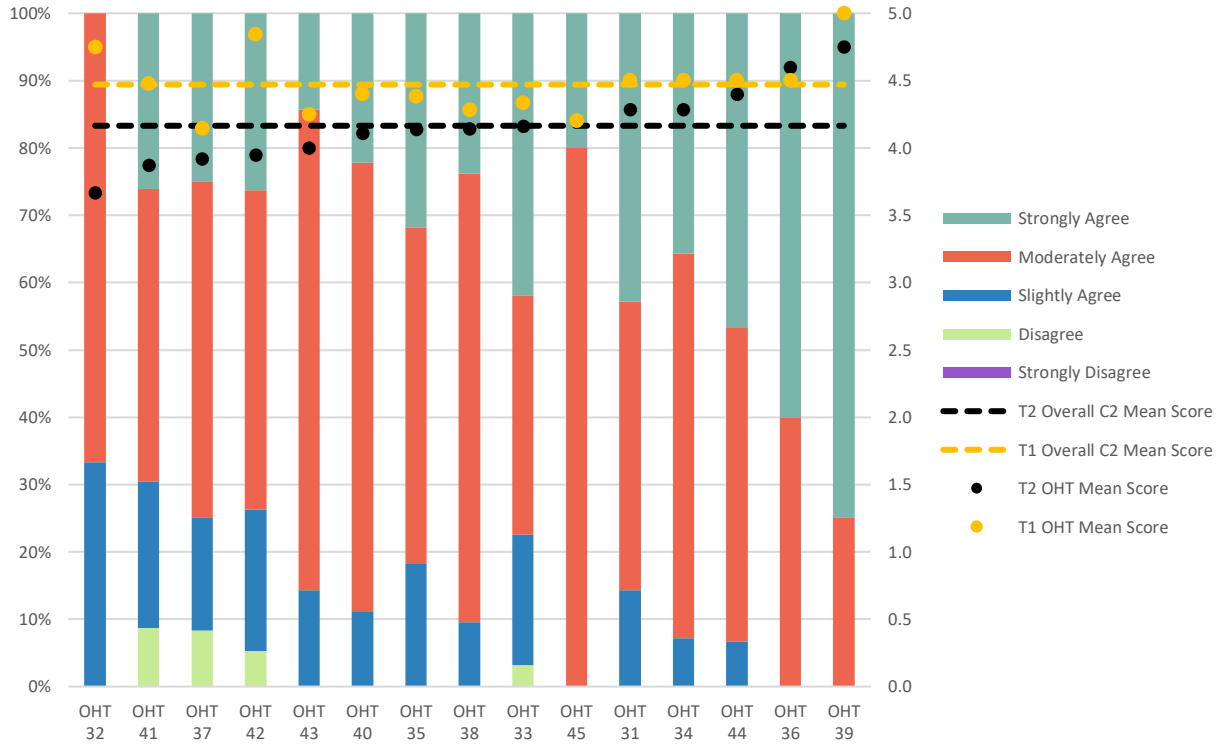
[v] Survey Items – Please think about the changes involved in creating your OHT. To what extent do you agree with the following statements:
34 I think that my organization/practice setting will benefit from this change
35 This change will make my role easier
36 In the long run, I feel it is worthwhile for me that the organization adopted this change

Change Efficacy

The OOHT survey included one item from the *Change Efficacy* subdomain of *Readiness for Change*.[12] The mean score was high, 4.16 (out of 5) with a standard deviation of 0.28. *Change Efficacy* is having a belief in one's ability to successfully implement change. On average, a high percentage (85.4%) of respondents across OHTs moderately agreed or strongly agreed that they had the skills necessary to make this change work (Figure 32). However, across the OHTs the proportion strongly agreeing varied from 0% to 75%.

Compared to T1, the overall mean scores, lowest mean scores, and highest mean scores all decreased (4.47 vs. 4.16, 4.14 vs. 3.67 and 5.0 vs. 4.75, respectively) at T2.

Figure 32. Distribution of Cohort 2 OOHT Survey Responses to the Item *I have the skills that are needed to make this change work* at T2 by OHT and mean scores at T1 and T2, by OHT and by Cohort

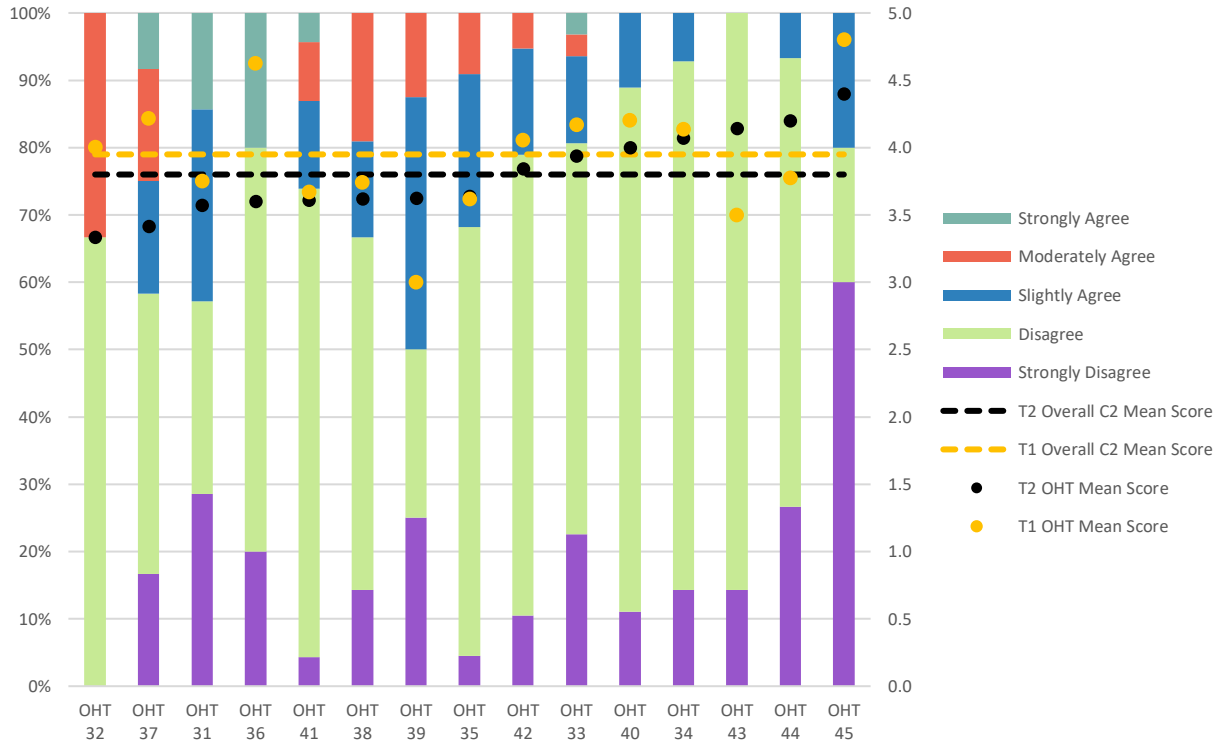


Personally Beneficial

From the *Readiness for Change* domain, the OOHT survey included one item from the *Personally Beneficial* subdomain which measured whether the change will disrupt the working relationships they have developed.[12] The mean score across OHTs was 3.80 (out of 5) with a standard deviation of 0.31 Respondents do not feel this change will disrupt their relationships on average across OHTs, 75.7% of respondents disagreed or strongly disagreed that the change would disrupt their working relationships, and this varied from 50% to 100% across OHTs (Figure 33).

Compared to T1, the overall mean score for T2 was slightly lower (3.95 vs. 3.80), the lowest mean score higher (3.00 vs. 3.33) and the highest mean score lower (4.80 vs. 4.40).

Figure 33. Distribution of Cohort 2 OOHT Survey Responses to the Item *This change will disrupt many of the working relationships I have developed* at T2 by OHT and mean scores at T1 and T2, by OHT and by Cohort[a]



[a] Responses were reversed when calculating the mean scores for this question (strongly agree=1, moderately agree=2, slightly agree=3, disagree=4, strongly disagree=5).

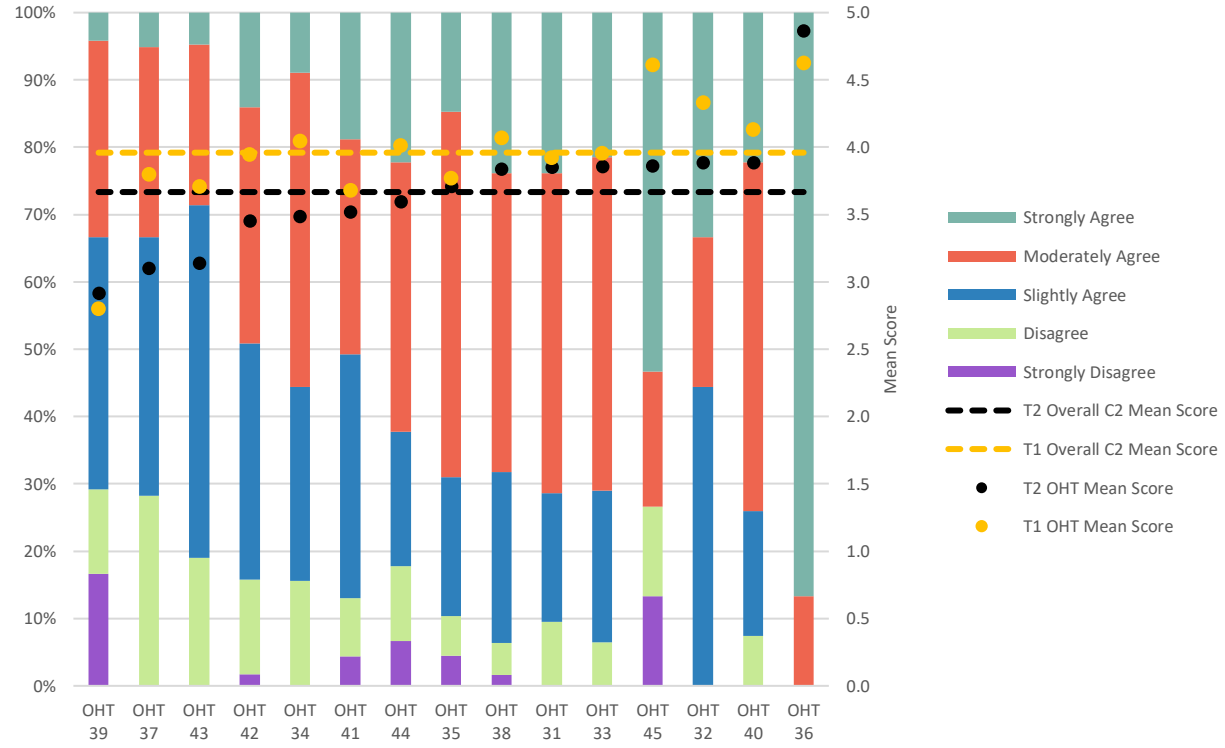
Commitment to Improvement

This is a new scale developed from three items[vi]. The first asked about a common vision for improved integration of care. The second asked about a shared responsibility for achieving improved patient outcomes. And the third item asked if they had used data to identify potential improvements in their target populations. Ratings of this domain were generally very high and OHTs were committed to improvement (Figure 34); the mean score across Cohort 2 OHTs was 3.67 (out of 5) with a standard deviation of 0.46.

Across the OHTs, the proportion of respondents selecting 4 (moderately agree) or 5 (strongly agree) was 59.7% (range: 28.6% to 100%), with most OHTs (11/15) with at least 50% of respondents selecting the top two boxes. Only one OHT (South Georgian Bay) had ≥80% of respondents selecting the top two boxes in the *Commitment to Improvement* domain (Figure 34).

Compared to T1, the overall mean score for T2 was lower (3.96 vs. 3.67), while the lowest and highest mean scores were higher (2.80 vs. 2.92 and 4.63 vs. 4.87, respectively).

Figure 34. Distribution of Cohort 2 OOHT Survey Responses to the *Commitment to Improvement* Domain (3 items[vi]) at T2 by OHT and mean scores at T1 and T2, by OHT and by Cohort



[vi] Survey Items – At present in this OHT:
8 We have a common vision of how to improve the integration of care
11 We have agreed to share responsibility for achieving improved patient outcomes
14 We have used data to identify the improvements for our target populations

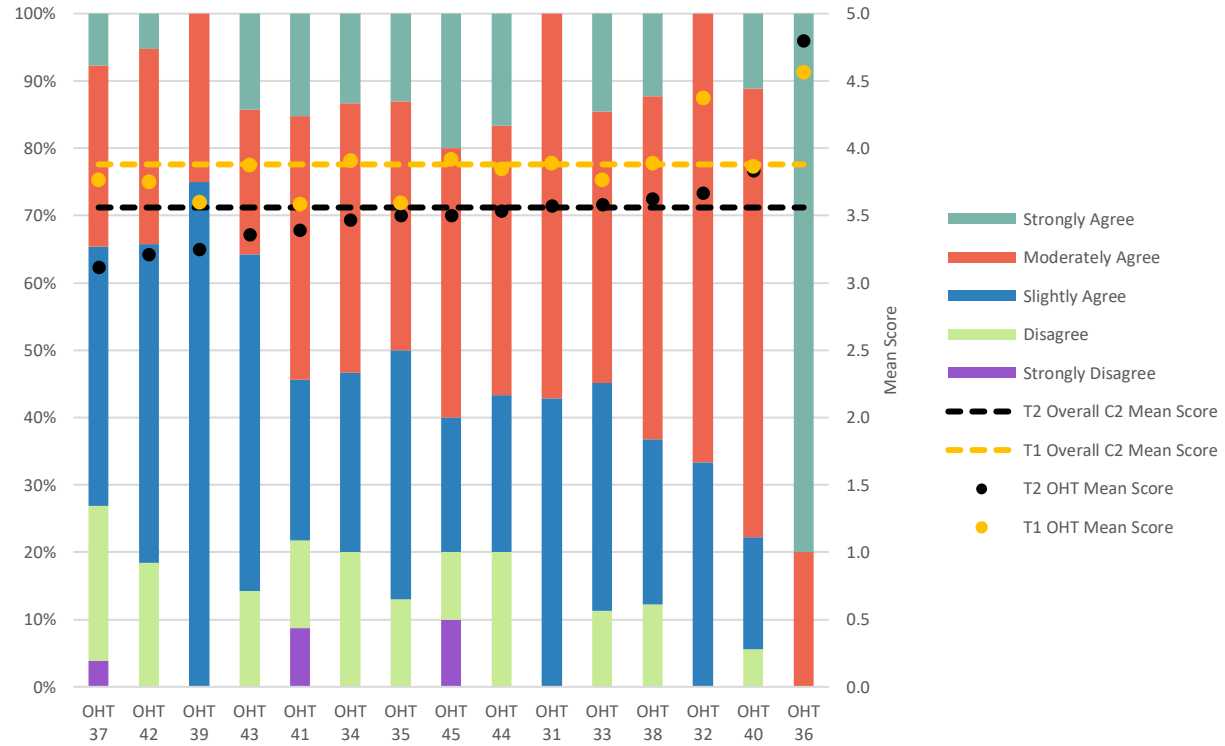
Roles and Responsibilities

The *Roles and Responsibilities* domain is based on two items[vii] from Haggerty's Measure of Network Integration survey.[11] The items ask if all partners understood the role they will play in taking responsibility for the local population and in coordinating care. *Roles and Responsibilities* describes a shared value system which "allows governance to adapt to the requirements of collaboration in the network and makes professionals and organizations aware of their interdependence in providing coordinated care and services."[13] Across most Cohort 2 OHTs, respondents understood their role in coordinating care and taking responsibility for the population. The mean score for the *Roles and Responsibilities* domain across Cohort 2 OHTs was 3.56 (out of 5) with a standard deviation of 0.39 (Figure 35).

Across the OHTs the proportion of OHT respondents selecting 4 (moderately agree) or 5 (strongly agree) was 54.9% (range: 25% to 100%). Most OHTs (11/15) had over 50% of respondents selecting 4 or 5. However, only one OHT (South Georgian Bay) with ≥80% of respondents selecting 4 (moderately agree) or 5 (strongly agree).

Compared to T1, the overall and the lowest mean score for T2 decreased (3.88 vs. 3.56 and 3.59 vs. 3.12), respectively and highest mean score was higher (4.56 vs. 4.80).

Figure 35. Distribution of Cohort 2 OOHT Survey Responses to the *Roles and Responsibilities* Domain (2 items[vii]) at T2 by OHT and mean scores at T1 and T2, by OHT and by Cohort



[vii] Survey Items – At present in this OHT:
9 We understand the role we will play in taking responsibility for the local population
10 We understand the role we will play in coordinating care

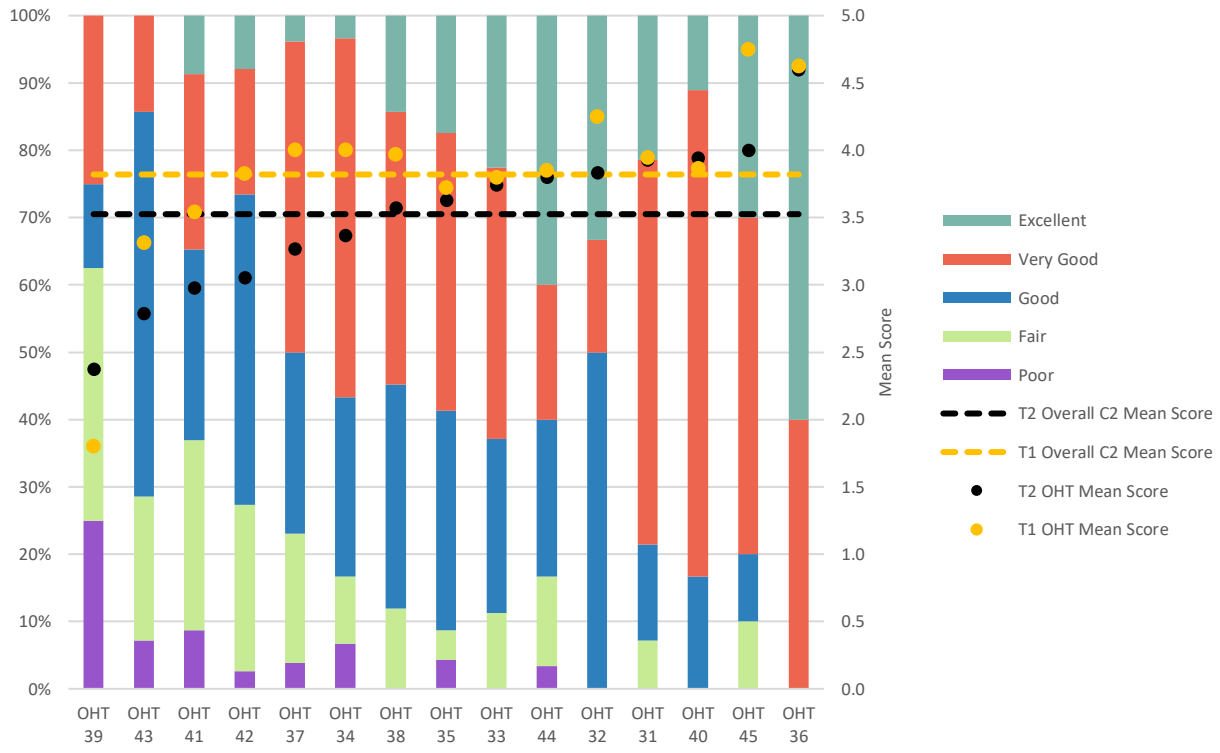
Administration and Management

Administration and Management describes functions, such as communication strategies and mechanisms for coordinating partnership activities, that allow for meaningful engagement of multiple, independent organizations within the partnership.[14] The *Administration and Management* domain was composed of 2 items[viii] asking respondents to rate their OHT's effectiveness in communicating among members and organizing activities such as meetings and projects. Ratings of the *Administration and Management* domain were moderately high, mean score across cohort 2 OHTs was 3.53 (out of 5) with a standard deviation of 0.56 (Figure 36).

Across the OHTs, the proportion of OHT respondents selecting 4 (very good) or 5 (excellent) was 55.7% (range: 14.3% to 100%), with most OHTs (11/15) having at least 50% of respondents selecting 4 or 5. Three OHTs (Brantford Brant, Kawartha Lakes and South Georgian Bay) had ≥80% of respondents selecting 4 or 5 for the two items included this domain.

Compared to T1, the overall mean score and highest mean score decreased at T2 (3.82 vs. 3.53, and 4.75 vs. 4.60 respectively). The lowest mean score increased at T2 (1.80 vs 2.38).

Figure 36. Distribution of Cohort 2 OOHT Survey Responses to the *Administration and Management* Domain (2 items[viii]) at T2 by OHT and mean scores at T1 and T2, by OHT and by Cohort



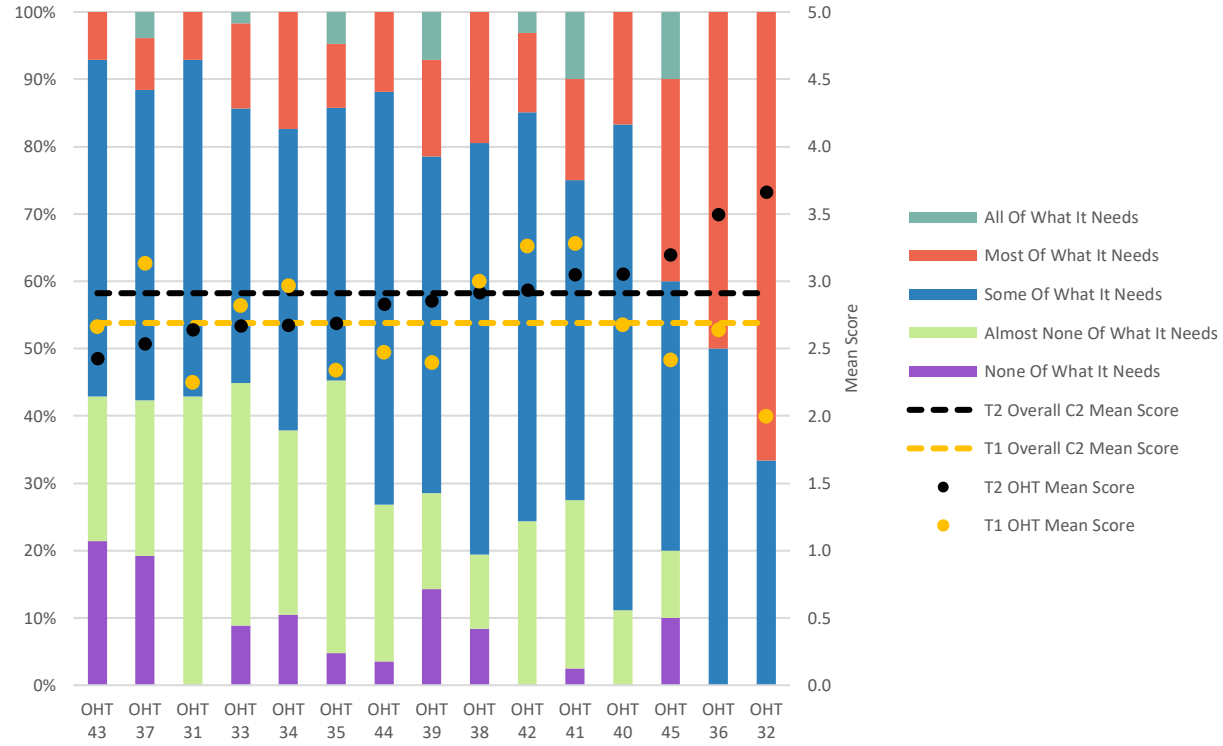
[viii] Survey Items – Please rate the effectiveness of your OHT in carrying out the following activities:
23 Communicating among members
24 Organizing OHT member activities, including meetings and projects

Financial and Other Capital Resources

Financial and in-kind resources have been described as the "basic building blocks" for successful partnerships and the importance of having sufficient money and other resources (e.g., equipment such as computers) has been emphasized by multiple partnerships.[14] The *Financial and Other Capital Resources*[ix] domain was created from two questions; 1) does the OHT have sufficient money, and 2) tools and technology such as digital health solutions and information portals. The ratings on this domain were particularly low (Figure 37). The mean score across Cohort 2 OHTs was 2.91 (out of 5) with a standard deviation of 0.34. This was the lowest rated domain.

Across the OHTs the proportion of OHT respondents selecting 4 (most of what it needs) or 5 (all of what it needs) was 22.5% and varied from 7.1% to 66.7%. Compared to T1, the overall mean score, the lowest and highest mean score for T2 were higher (2.69 vs. 2.91, 2.00 vs. 2.43 and 3.28 vs. 3.67, respectively).

Figure 37. Distribution of Cohort 2 OOHT Survey Responses to the *Financial and Other Capital Resources* Domain (2 items[ix]) at T2 by OHT and mean scores at T1 and T2, by OHT and by Cohort



[ix] Survey Items – For each of the following types of resources, to what extent does your OHT have what it needs to work effectively:
29 Money
30 Tools and technologies

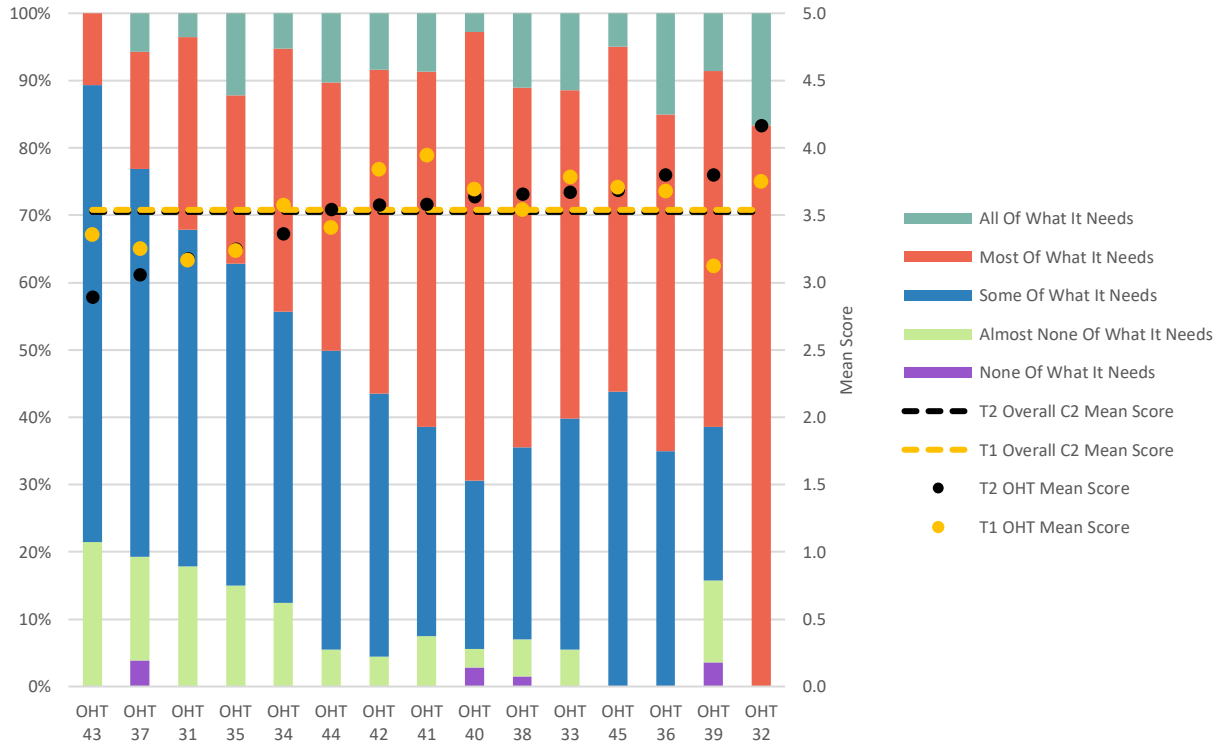
Non-Financial Resources

In addition to the basic financial resources required for a successful partnership, OHTs will require a broad array of skills and expertise, access to information and connections to political decision makers and other to support the legitimacy of the partnership.[14] There were four questions[x] about sufficiency of these non-financial resources. Ratings for the *Non-Financial Resources* domain were moderate, with a mean score across Cohort 2 OHTs of 3.53 (out of 5) with a standard deviation of 0.33 (Figure 38).

Across the OHTs, the mean proportion of OHT respondents selecting 4 (most of what it needs) or 5 (all of what it needs) was 52.8% and varied from 10.7% to 100%. Two-thirds (10/15) of the OHTs had at least 50% of respondents selecting 4 or 5. Only one OHT (North Simcoe) had ≥80% of respondents selecting 4 or 5 for the four items included this domain (Figure 38).

Compared to T1, the overall mean score for T2 was nearly identical (3.54 vs. 3.53), the lowest mean score was lower (3.13 vs. 2.89) and the highest mean score increased (3.95 vs. 4.17).

Figure 38. Distribution of Cohort 2 OOHT Survey Responses to the *Non-Financial Resources* Domain (4 items[x]) at T2 by OHT and mean scores at T1 and T2, by OHT and by Cohort



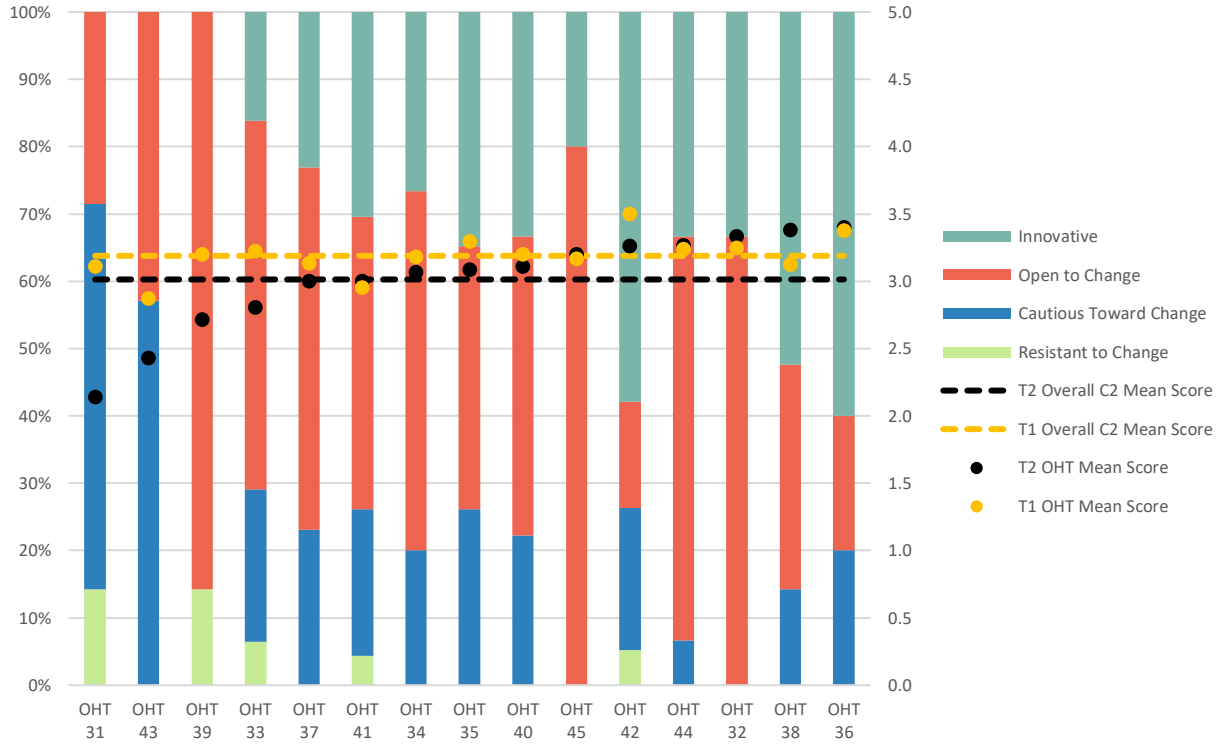
[x] Survey Items – For each of the following types of resources, to what extent does your OHT have what it needs to work effectively:
25 Skills and expertise
26 Data and information
27 Ability to identify target population criteria and deliver interventions
28 Connections to political decision-makers, government agencies

Other OOHT Survey Items

There were three additional items that were not part of the ten domains. Question 31 asked respondents to select the response that described their organization or practice setting's attitude toward change. Around half of Cohort 2 OHTs can be considered as either innovative or open to change as 7/15 OHTs had at least 80% of respondents selecting the top two boxes (3 or 4) (Figure 39). In particular, across Cohort 2, 28.1% of respondents described their organization as innovative, 48.1% as open to change, 20.8% cautious toward change and 3% as resistant to change (see Appendix A). Five OHTs had respondents reporting that their organization was resistant to change.

Compared to T1, the overall mean score for T2 was lower (3.19 vs. 3.01 out of 4). The lowest mean and the highest mean had both decreased as well (2.88 vs. 2.14 and 3.50 vs. 3.40 respectively).

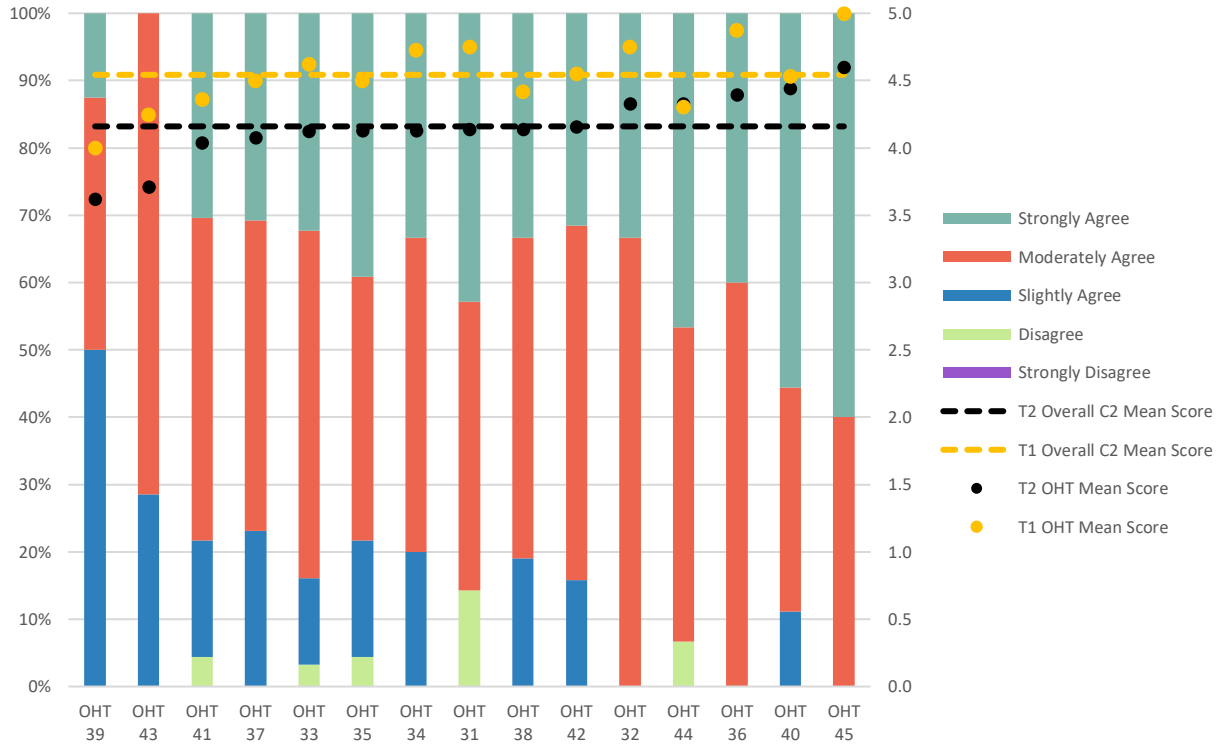
Figure 39. Distribution of Cohort 2 OOHT Survey Responses to the Item *Organization or practice setting's attitude toward change* at T2 by OHT and mean scores at T1 and T2, by OHT and by Cohort



Question 32 asked if the respondent's organization or practice setting's shared values were compatible with those of other members of the OHT. Ratings on this question were, generally, very high with a mean score across OHTs of 4.16 (out of 5) and a standard deviation of 0.25 (Figure 40). Across the OHTs, the proportion of OHT respondents selecting 4 (moderately agree) or 5 (strongly agree) varied from 50% to 100%. Two-thirds of OHTs (10/15) had ≥80% of respondents selecting the top two boxes and three OHTs (Kawartha Lakes, KW4 and South Georgian Bay) had 100% of their respondents in moderate or strong agreement their organization or practice setting's shared values were compatible with those of other OHT members (selected 4 or 5).

Compared to T1, the overall mean score (4.54 vs. 4.16), lowest mean score (4.00 vs. 3.63), and highest mean score (5.00 vs. 4.60) all decreased at T2.

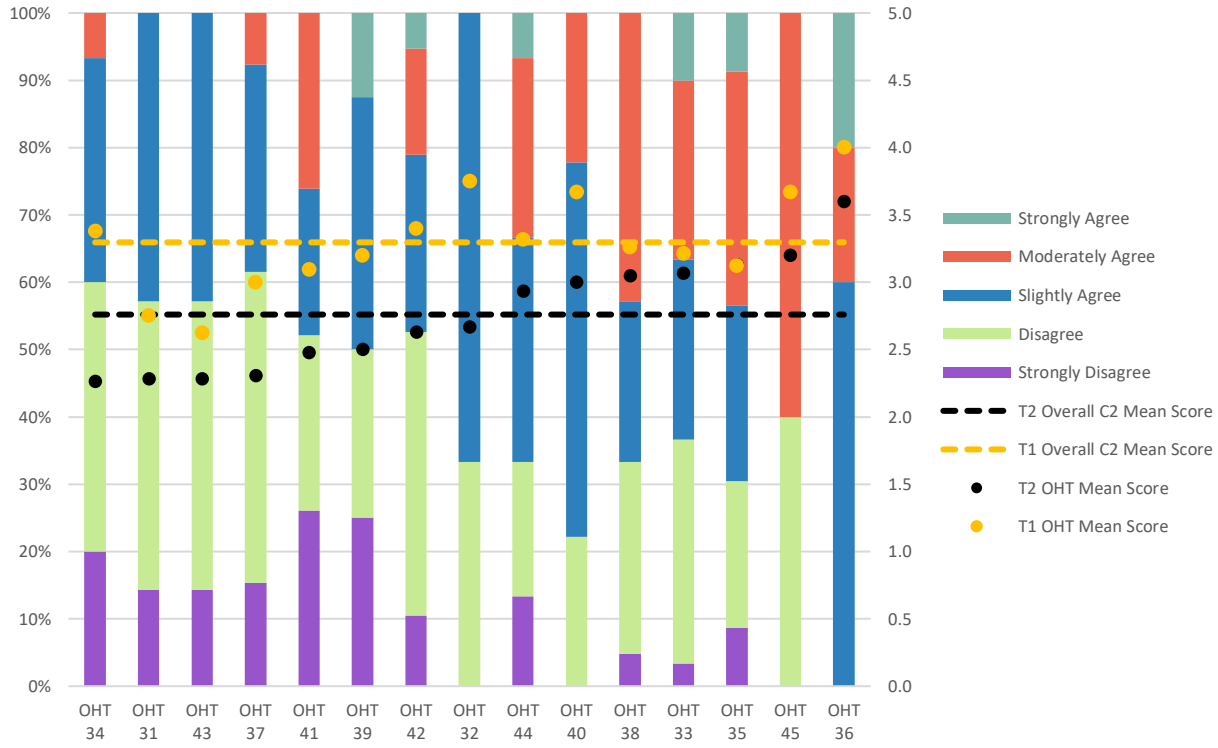
Figure 40. Distribution of Cohort 2 OOHT Survey Responses to the Item *Your organization's shared values are compatible with those of other OHT members* at T2 by OHT and mean scores at T1 and T2, by OHT and by Cohort



When asked, in question 33, if the professionals/staff in the respondent's organization or practice setting had a strong sense of belonging to the OHT, ratings were relatively low (Figure 41); the mean score across OHTs was 2.76 (out of 5) with a standard deviation of 0.41. Across the OHTs, the proportion of OHT respondents selecting 4 (moderately agree) or 5 (strongly agree) varied from 0% to 60%, with only one OHT having at least 50% of respondents selecting the top two boxes. None of the OHT had ≥80% selecting 4 or 5.

Compared to T1, the overall mean score (3.30 vs. 2.76), lowest mean score (2.63 vs. 2.27) and highest mean score (4.00 vs. 3.60) for T2 were all lower.

Figure 41. Distribution of Cohort 2 OOHT Survey Responses to the Item *Your organization's staff have a strong sense of belonging to your OHT* at T2 by OHT and mean scores at T1 and T2, by OHT and by Cohort



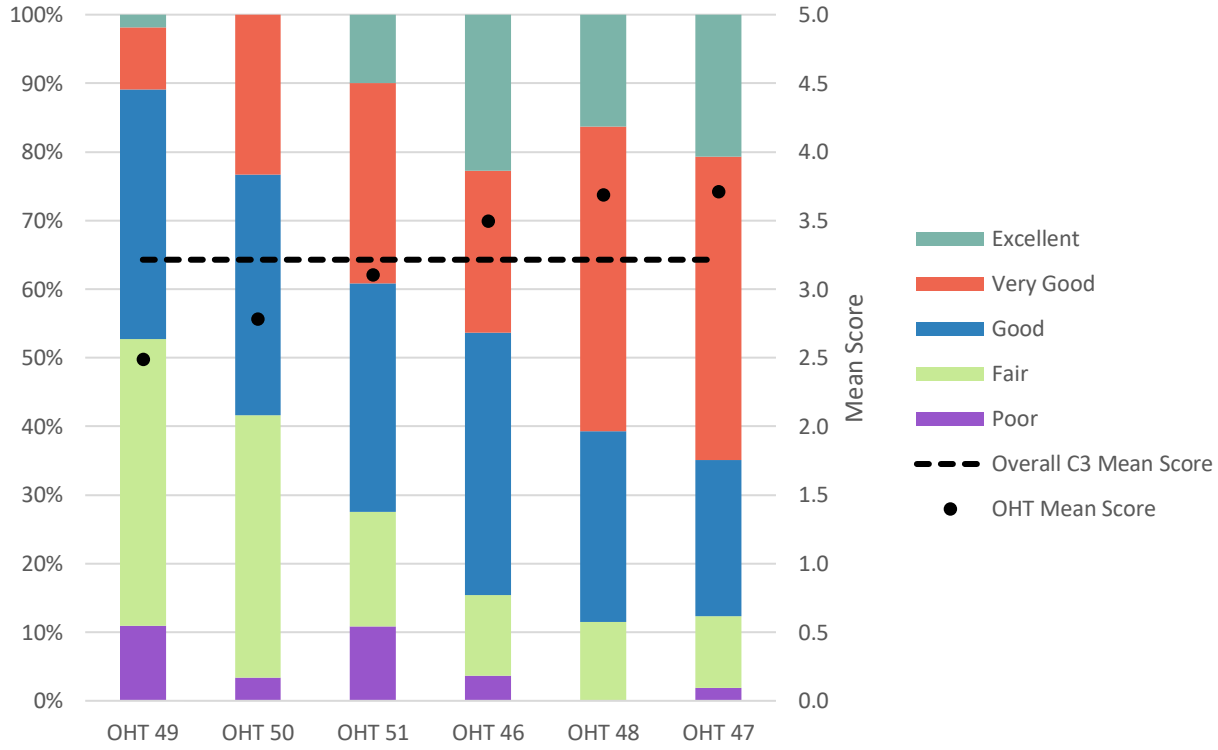
Cohort 3 Response Distribution by Domain and Item-level Response Distribution

Leadership Approach

Five items[i] from the OOHT survey comprise the *Leadership Approach* domain. Respondents were asked to rate the effectiveness of their OHT's formal and informal leadership at empowering members, fostering respect and trust, creating an environment where differences of opinion could be voiced, promoting creativity and different ways at looking at things, and communicating the vision of their OHT. For most Cohort 3 OHTs, the scores for *Leadership Approach* were somewhat low, mean score across OHTs was 3.21 (out of 5) with a standard deviation of 0.51.

Across the OHTs, the proportion of respondents selecting 4 (very good) or 5 (excellent) was 40.9% and varied from 10.9% to 64.9% with a third of OHTs (2/6) having at least 50% of respondents selecting the top two boxes and none of the OHTs had ≥80% of respondents selecting the top two boxes across the items included this domain (Figure 42).

Figure 42. Distribution of Cohort 3 OOHT Survey Responses to the *Leadership Approach* Domain (5 items[i]) and Mean Scores by OHT and Cohort Mean Score



[i] Survey Items - Please rate the total effectiveness of your OHT's leadership in each of the following areas:
18 Empowering people/members involved in the OHT
19 Communicating the vision of the OHT
20 Creating an environment where differences of opinion can be voiced
21 Helping the OHT to be creative and look at things differently
22 Fostering respect, trust and inclusiveness amongst OHT members

Leadership Approach – Building Trust

Trust is an essential underpinning element of successful partnering to deliver better and more integrated care in the context of complex multi-organizational systems.[6] We highlight two items from the *Leadership Approach* domain related to establishing trust among partners, *Fostering respect, trust and inclusiveness* (question 22) and *Creating an environment where differences of opinion can be voiced* (question 20), below. Across the Cohort 3 OHTs, the mean scores for these items were 3.38 with a standard deviation of 0.66, and 3.31 with a standard deviation of 0.41, respectively.

The proportion of respondents selecting 4 (very good) or 5 (excellent) on question 22 (Figure 43) varied from 16.7% to 81.8%, with half of the OHTs (3/6) having at least 50% of respondents selecting the top two boxes, and just one OHT (Ottawa West Four Rivers) had ≥80% of respondents selecting the top two boxes on the two items. For question 20 (Figure 44), the proportion of respondents selecting 4 (very good) or 5 (excellent) ranged from 25% to 71.4%, with half (3/6) OHTs having at least 50% of respondents selecting the top two boxes, and none of the OHTs had ≥80% of respondents selecting the top two boxes.

Figure 43. Distribution of Cohort 3 OOHT Survey Responses to the Item *Fostering respect, trust, and inclusiveness amongst OHT members* and Mean Scores by OHT and Cohort Mean Score

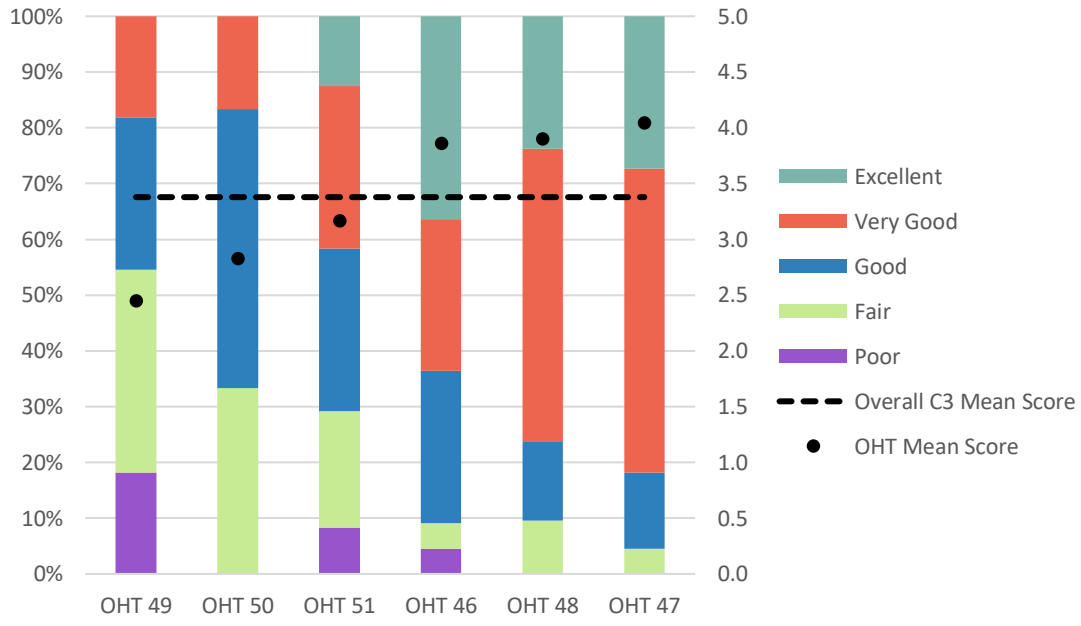
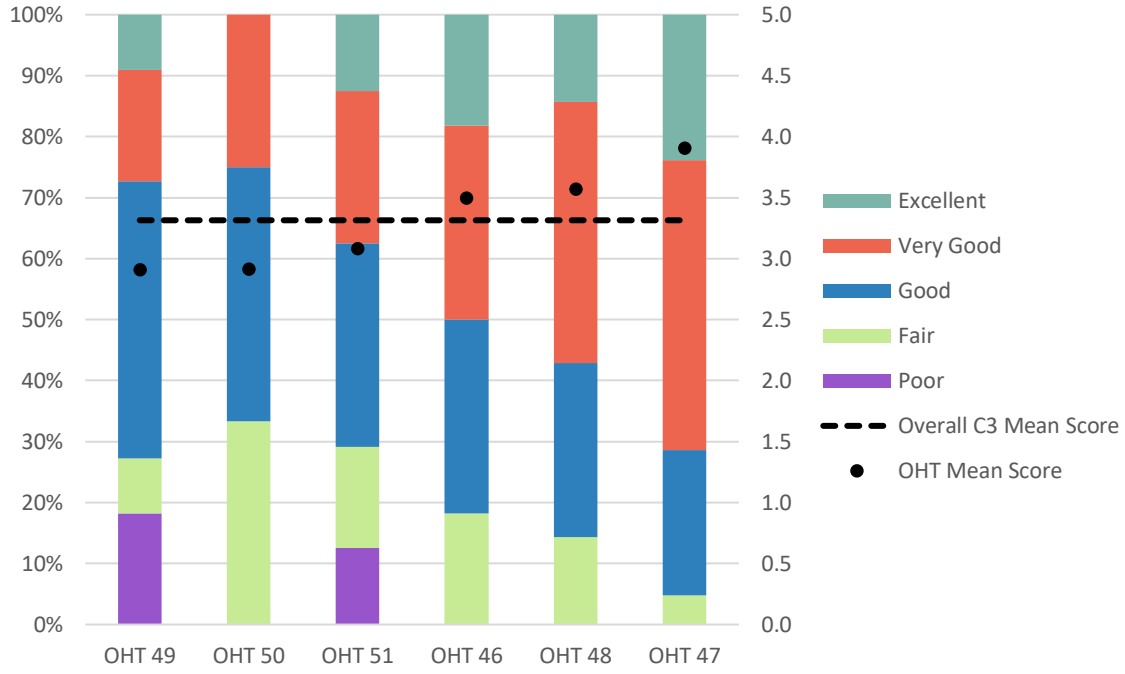


Figure 44. Distribution of Cohort 3 OOHT Survey Responses to the Item *Creating an environment where differences of opinion can be voiced* and Mean Scores by OHT and Cohort Mean Score

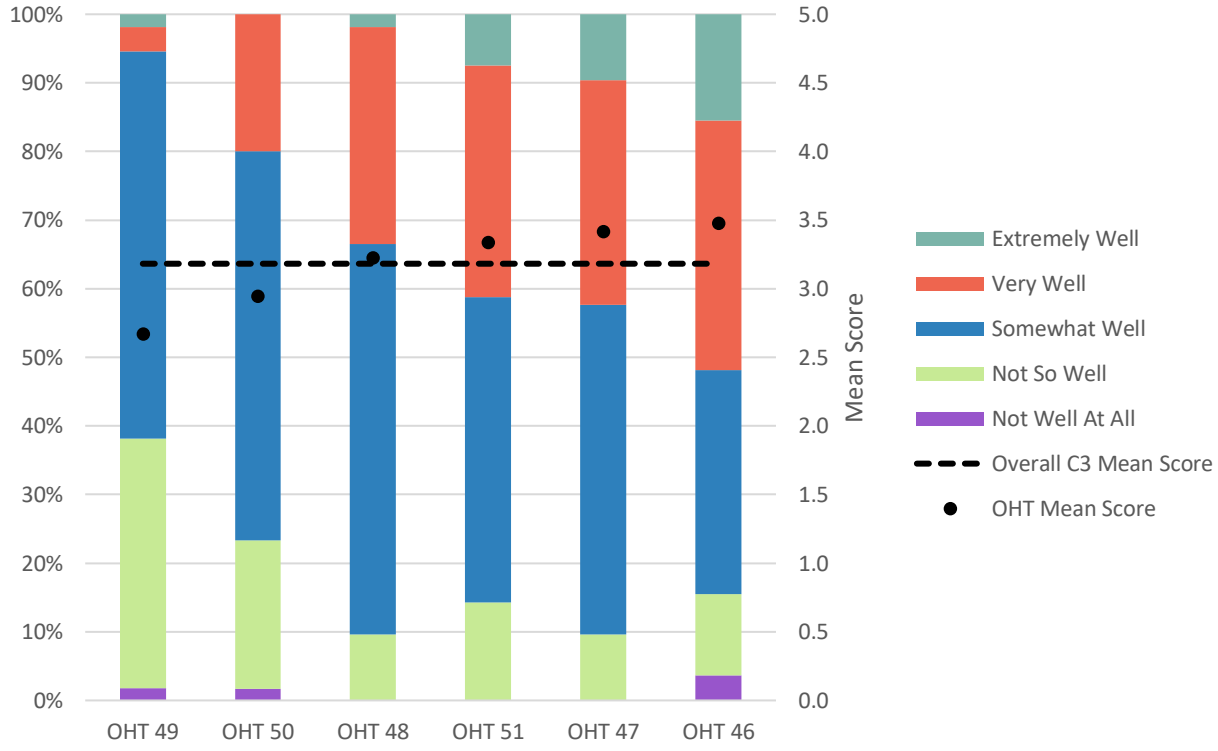


Shared Vision

A shared vision is created "by combining the perspectives, knowledge, and skills of diverse partners in a way that enables the partnership to (1) think in new and better ways about how it can achieve its goals; (2) plan more comprehensive, integrated programs; and (3) strengthen its relationship to the broader community".[9] The *Shared Vision* domain (Figure 45) was composed of 5-items[ii] and respondents were asked to rate how well the organizations and people partnering in the OHT have been able to develop widely understood and supported goals; identify how organizations and programs could help; respond to the needs of their community; include views and priorities of those impacted; and obtain support from individuals in the community.

Overall, responses to *Shared Vision* were moderate. The mean score across cohort 3 OHTs for *Shared Vision* was 3.18 (out of 5) with a standard deviation of 0.31. Across the OHTs, the proportion of respondents selecting 4 (very well) or 5 (extremely well) across the five items was 32.4% and varied from 5.5% to 51.8% with only one OHT having at least 50% of respondents selecting the top two boxes.

Figure 45. Distribution of Cohort 3 OOHT Survey Responses to the *Shared Vision* Domain (5 items[ii]) and Mean Scores by OHT and Cohort Mean Score



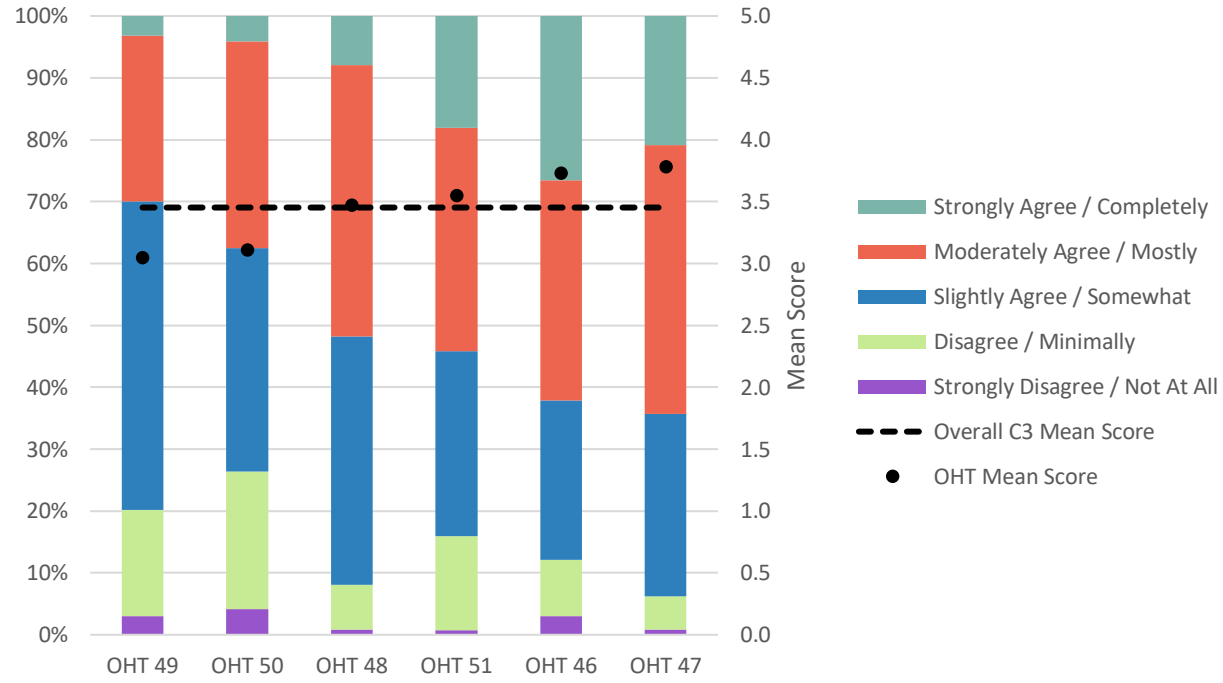
[ii] Survey Items - By working together, how well, at present, are the members of your OHT able to:
3 Develop goals that are widely understood and supported among members
4 Identify how different organizations/programs in the community could help to solve the issues the OHT is trying to address in their year one population
5 Respond to the needs and problems of the community
6 Include the views and priorities of the people affected by the OHT's work
7 Obtain support from individuals and organizations in the community that can either block the OHT's plans or help move them forward

Team Climate

There are four factors associated with successful group innovations; 1) vision is clear and realistic, 2) participatory safety or climate of interpersonal interactions (e.g., "we are in it together" attitude), 3) task orientation is committed to a high standard and improving and 4) support for innovation (e.g., take the time needed to develop new ideas).[10] These factors are often measured separately, but we created a *Team Climate* domain (Figure 46) based on 6 items[iii].

Team Climate was among the highest rated domains among the OHTs in cohort 3 with a mean score of 3.45 (out of 5) and a standard deviation 0.31. Across the OHTs, the proportion of respondents selecting 4 (moderately agree/mostly) or 5 (strongly agree/completely) across the 6 items varied from 30% to 64.3% with all but two OHTs (4/6) having at least 50% of respondents selecting 4 or 5. None of the OHTs had ≥80% of respondents selected the top two boxes.

Figure 46. Distribution of Cohort 3 OOHT Survey Responses to the *Team Climate* Domain (6 items[iii]) and Mean Scores by OHT and Cohort Mean Score



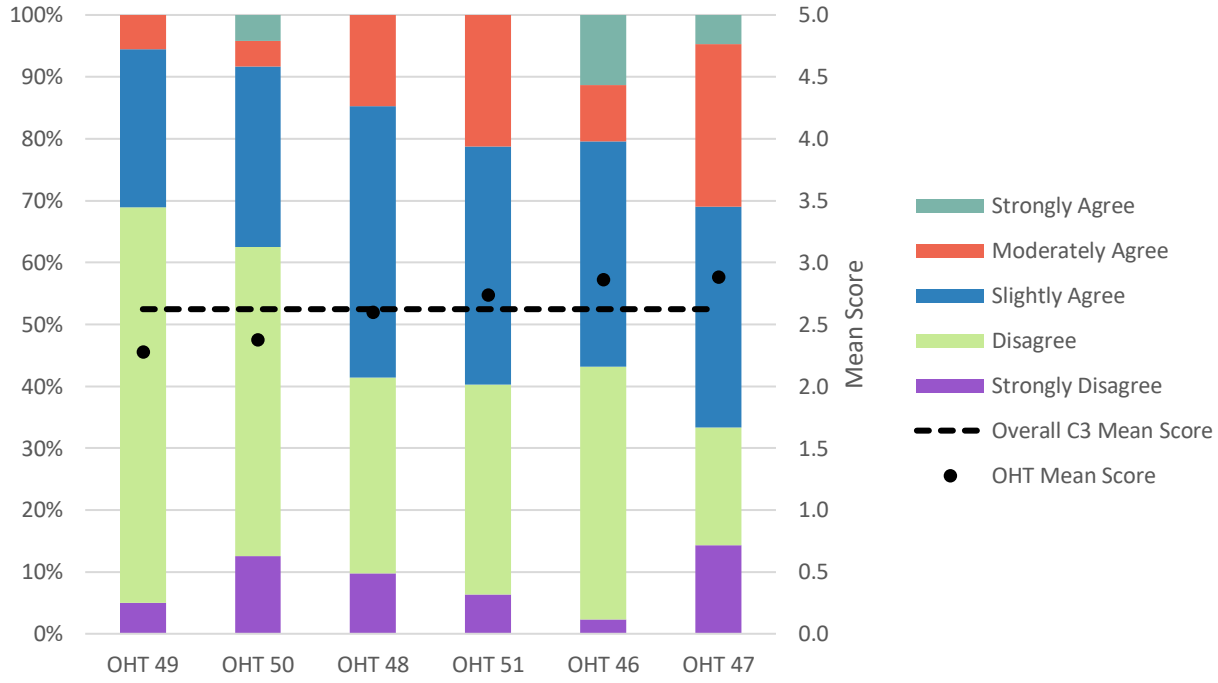
[iii] Survey Items - In this OHT:
15 We are prepared to question the basis of what the team is doing
16 We critically appraise potential weaknesses in what our OHT is planning in order to achieve the best possible outcome
17 The members of the OHT build on each other's ideas in order to achieve the best possible outcome
39 We have a 'we are in it together' attitude
40 We take the time needed to develop new ideas
41 To what extent do you think your OHT's objectives can actually be achieved

Clinical-Functional Integration

Clinical integration refers to the degree to which tools for clinical coordination are shared across organizations in the partnership and functional integration refers to the degree to which information is shared across organizations in the partnership.[11] *Clinical-Functional Integration*[iv] was the lowest rated domain, for Cohort 3, in terms of mean score 2.62 (out of 5) with a standard deviation of 0.25.

Across the OHTs (Figure 47), the proportion of respondents selecting 4 (moderately agree) or 5 (strongly agree) was 16.9% (range: 5.6% to 31.0%), with no OHTs with at least 50% of respondents selecting the top two boxes.

Figure 47. Distribution of Cohort 3 OOHT Survey Responses to the *Clinical-Functional Integration* Domain (2 items[iv]) and Mean Scores by OHT and Cohort Mean Score



[iv] Survey Items - At present in this OHT:
12 We share tools for clinical coordination
13 We share clinical information across partners

Readiness for Change

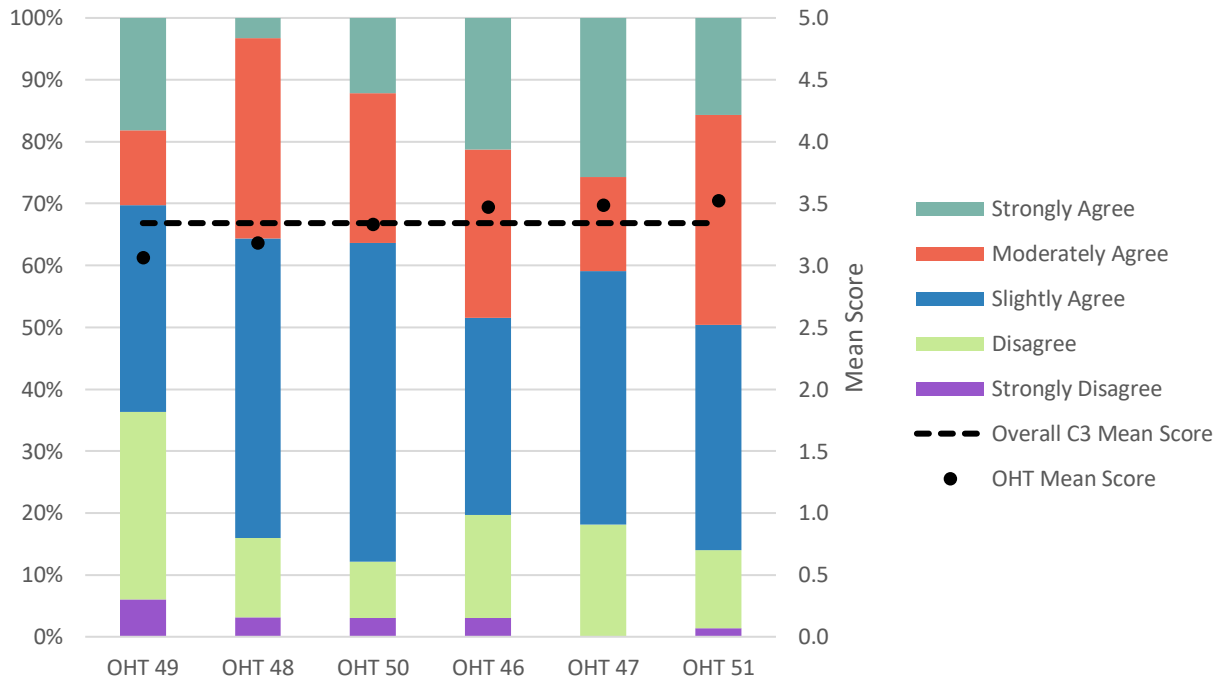
The Readiness for Organizational Change survey[12] includes three subdomains: 1) *Suitability* (original scale termed "Appropriateness"); 2) *Change Efficacy*; and 3) *Personally Beneficial*.

Suitability

Suitability measures whether respondents felt the change is appropriate or needed and if it will benefit the organization. Ratings of the *Suitability* subdomain were moderate (Figure 48), with a mean score across Cohort 3 OHTs of 3.34 (out of 5) with a standard deviation of 0.19. Notably, there were substantial differences in the scores for the items in this domain; respondents felt their organization will likely benefit from the change (mean=3.48) and the change will be worthwhile for them (mean=3.77), but the change will not make their role easier (mean=2.77).

Across the OHTs, the proportion of respondents selecting 4 (moderately agree) or 5 (strongly agree) was 40.2% (range: 30.3% – 49.6%).

Figure 48. Distribution of Cohort 3 OOHT Survey Responses to the *Readiness for Change – Suitability* Domain (3 items[v]) and Mean Scores by OHT and Cohort Mean Score

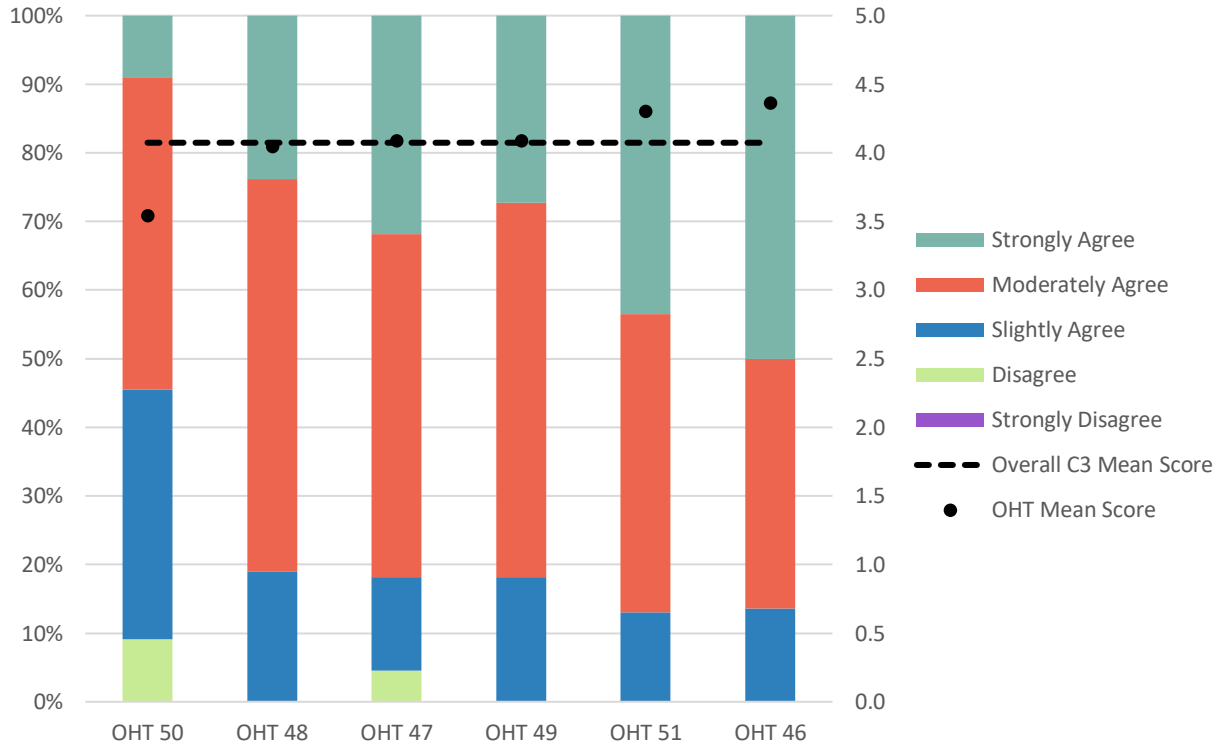


[v] Survey Items – Please think about the changes involved in creating your OHT. To what extent do you agree with the following statements:
34 I think that my organization/practice setting will benefit from this change
35 This change will make my role easier
36 In the long run, I feel it is worthwhile for me that the organization adopted this change

Change Efficacy

The OOHT survey included one item from the *Change Efficacy* subdomain of *Readiness for Change*.[12] The mean score was 4.07 (out of 5) with a standard deviation of 0.29. *Change Efficacy* is having a belief in one's ability to successfully implement change. Ratings for this item were extremely high; respondents felt they had the skills necessary to implement this change. On average, around a third (30.9%) of respondents across Cohort 3 OHTs strongly agreed that they had the skills necessary to make this change work (Figure 49). Across the OHTs the proportion moderately or strongly agreeing varied from 54.5% to 87.0%.

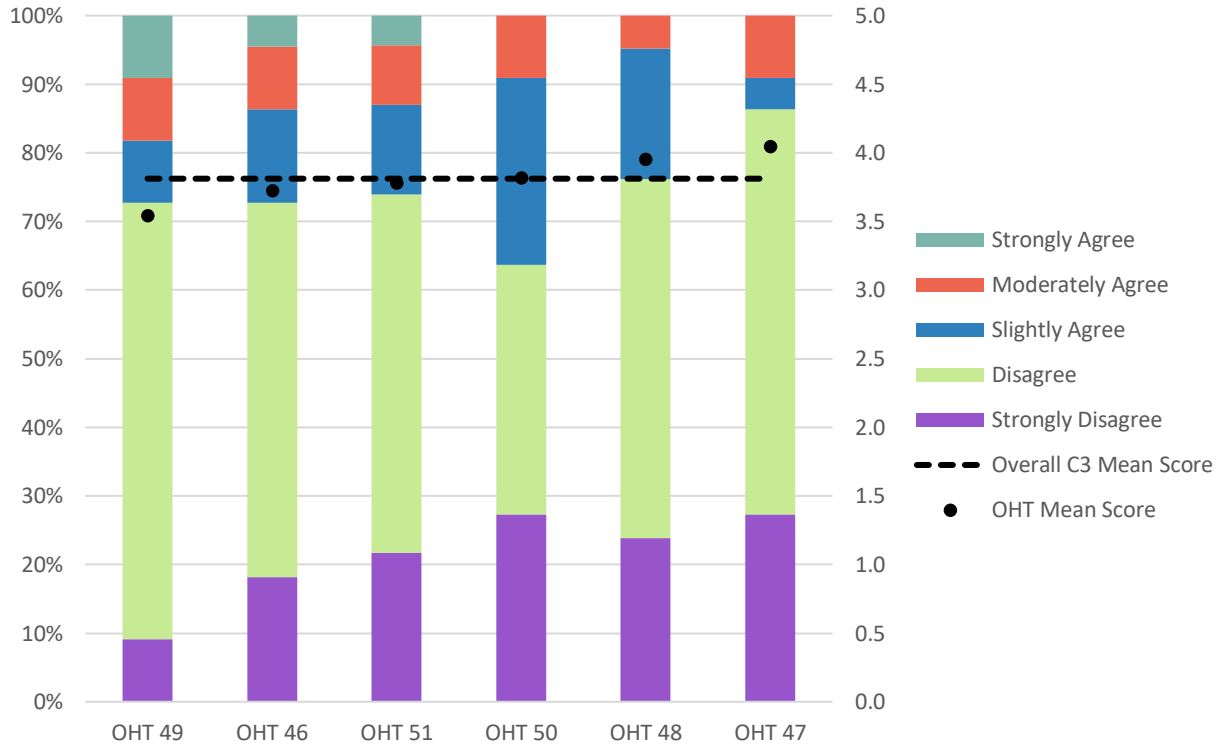
Figure 49. Distribution of Cohort 3 OOHT Survey Responses to the Item *I have the skills that are needed to make this change work*, and Mean Scores by OHT and Cohort Mean Score



Personally Beneficial

From the *Readiness for Change* domain, the OOHT survey included one item from the *Personally Beneficial* subdomain which measured whether the change will disrupt the working relationships they have developed.[12] The mean score across OHTs was 3.81 with a standard deviation of 0.18. On average across OHTs, 74.3% of respondents disagreed or strongly disagreed that the change would disrupt their working relationships, and this varied from 63.6% to 86.4% across OHTs (Figure 50).

Figure 50. Distribution of Cohort 3 OOHT Survey Responses to the Item *This change will disrupt many of the working relationships I have developed*, and Mean Scores by OHT and Cohort Mean Score[a]



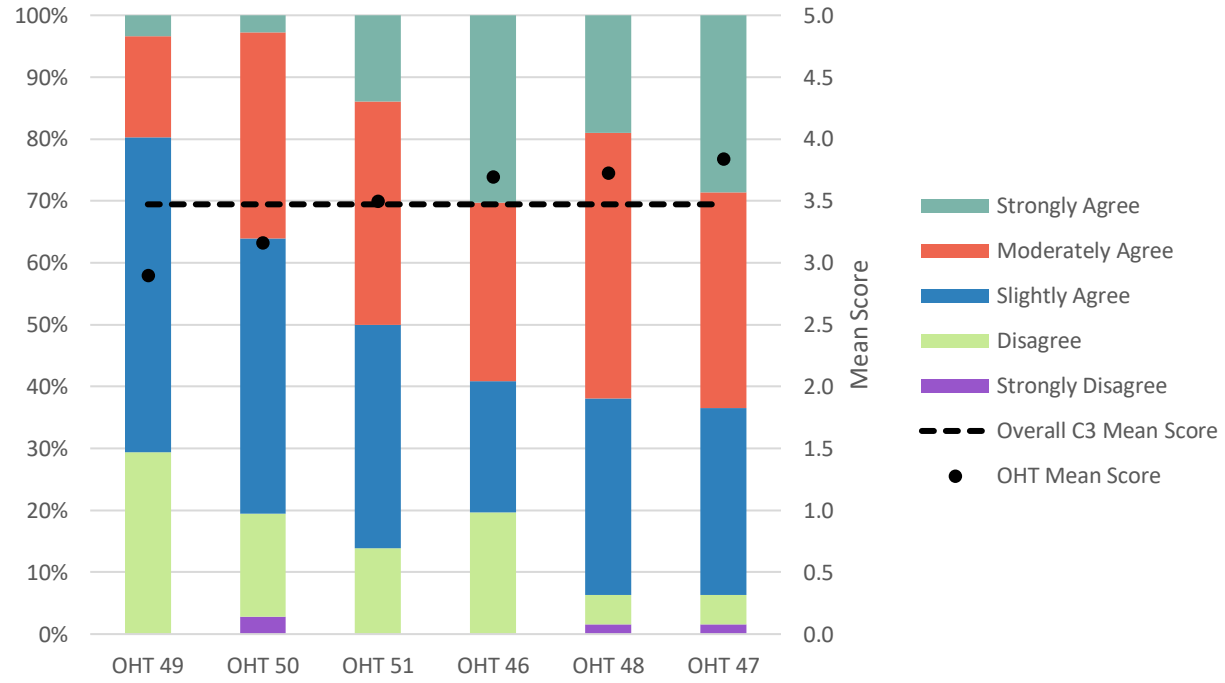
[a] Responses were reversed when calculating the mean scores for this question (strongly agree=1, moderately agree=2, slightly agree=3, disagree=4, strongly disagree=5).

Commitment to Improvement

This is a new scale developed from three items[vi]. The first asked about a common vision for improved integration of care. The second asked about a shared responsibility for achieving improved patient outcomes. And the third item asked if they had used data to identify potential improvements in their target populations. For Cohort 3, this domain was the highest rated and OHTs were committed to improving the integration of care (Figure 51); the mean score across OHTs was 3.47 (out of 5) with a standard deviation 0.37; the highest mean score among the 10 domains.

Across the OHTs the proportion of OHT respondents selecting 4 (moderately agree) or 5 (strongly agree) was 48.4% (range: 19.7% to 63.5%). Four OHTs (4/6) had ≥50% of respondents selecting 4 or 5. However, none of the OHTs had ≥80% of respondents selecting 4 (moderately agree) or 5 (strongly agree).

Figure 51. Distribution of Cohort 3 OOHT Survey Responses to the *Commitment to Improvement* Domain (3 items[vi]) and Mean Scores by OHT and Cohort Mean Score



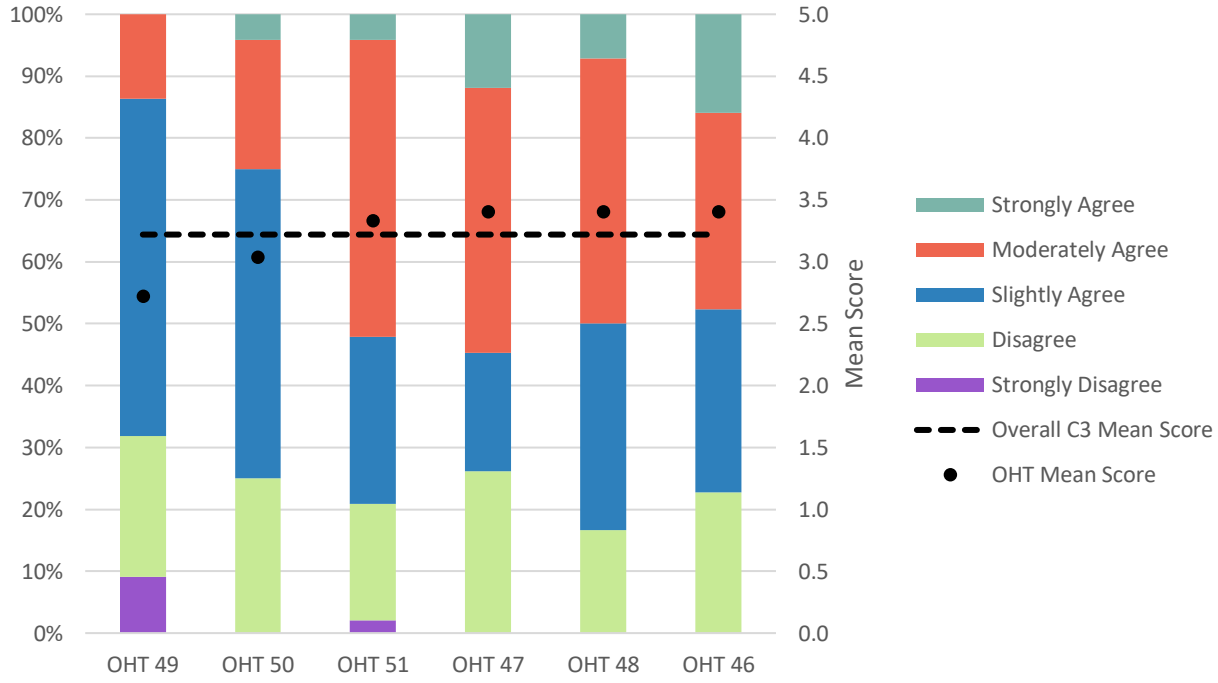
[vi] Survey Items – At present in this OHT:
8 We have a common vision of how to improve the integration of care
11 We have agreed to share responsibility for achieving improved patient outcomes
14 We have used data to identify the improvements for our target populations

Roles and Responsibilities

The *Roles and Responsibilities* domain is based on two items[vii] from Haggerty's Measure of Network Integration survey.[11] The items ask if all partners understood the role they will play in taking responsibility for the local population and in coordinating care. *Roles and Responsibilities* describes a shared value system which "allows governance to adapt to the requirements of collaboration in the network and makes professionals and organizations aware of their interdependence in providing coordinated care and services."[13] Across most OHTs, respondents somewhat understood their role in coordinating care and taking responsibility for the population. The mean score for the *Roles and Responsibilities* domain across OHTs was 3.22 (out of 5) with a standard deviation of 0.28.

Across the OHTs, the proportion of OHT respondents selecting 4 (moderately agree) or 5 (strongly agree) was 40.5% (range: 13.6% to 54.8%), with half of OHTs (3/6) having at least 50% of respondents selecting 4 or 5. None of the OHTs (0/6) had ≥80% of respondents selecting 4 or 5 for the two items included this domain (Figure 52).

Figure 52. Distribution of Cohort 3 OOHT Survey Responses to the *Roles and Responsibilities* Domain (2 items[vii]) and Mean Scores by OHT and Cohort Mean Score



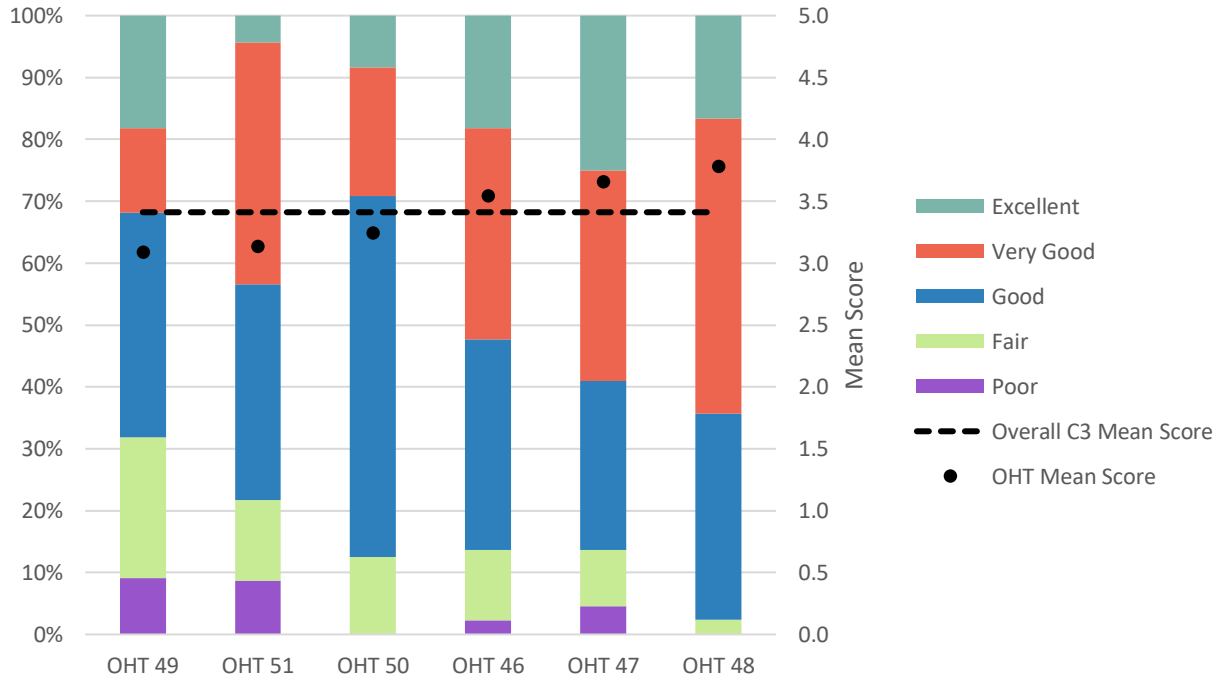
[vii] Survey Items – At present in this OHT:
9 We understand the role we will play in taking responsibility for the local population
10 We understand the role we will play in coordinating care

Administration and Management

Administration and Management describes functions, such as communication strategies and mechanisms for coordinating partnership activities, that allow for meaningful engagement of multiple, independent organizations within the partnership.[14] The *Administration and Management* domain was composed of 2 items[viii] asking respondents to rate their OHT's effectiveness in communicating among members and organizing activities such as meetings and projects. Ratings of the *Administration and Management* domain were moderately high, mean score across Cohort 3 OHTs was 3.41 (out of 5) with a standard deviation of 0.29 (Figure 53).

Across the OHTs the proportion of OHT respondents selecting 4 (very good) or 5 (excellent) was 46.7% and varied from 29.2% to 64.3% (see Figure 51). Half of the OHTs (3/6) had at least 50% of respondents selecting 4 or 5 for the two items included this domain.

Figure 53. Distribution of Cohort 3 OOHT Survey Responses to the *Administration and Management* Domain (2 items[viii]) and Mean Scores by OHT and Cohort Mean Score



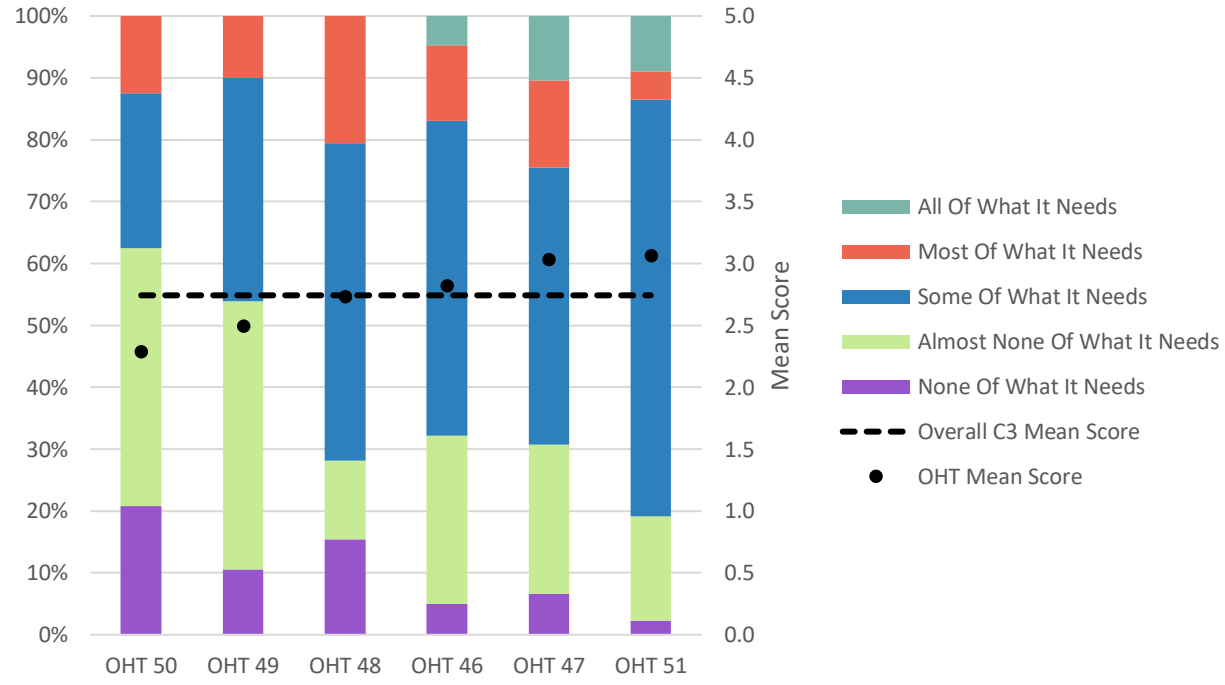
[viii] Survey Items – Please rate the effectiveness of your OHT in carrying out the following activities:
23 Communicating among members
24 Organizing OHT member activities, including meetings and projects

Financial and Other Capital Resources

Financial and in-kind resources have been described as the "basic building blocks" for successful partnerships and the importance of having sufficient money and other resources (e.g., equipment such as computers) has been emphasized by multiple partnerships.[14] The *Financial and Other Capital Resources*[ix] domain was created from two questions; 1) does the OHT have sufficient money, and 2) tools and technology such as digital health solutions and information portals. The ratings on this domain were particularly low (Figure 54). The mean score across Cohort 3 OHTs was 2.74 (out of 5) with a standard deviation of 0.30. This was the second lowest rated domain.

Across the OHTs, the mean proportion of OHT respondents selecting 4 (most of what it needs) or 5 (all of what it needs) was 16.3% and varied from 10% to 24.5%. None of the OHTs had at least 50% of respondents selecting 4 or 5.

Figure 54. Distribution of Cohort 3 OOHT Survey Responses to the *Financial and Other Capital Resources* Domain (2 items[ix]) and Mean Scores by OHT and Cohort Mean Score



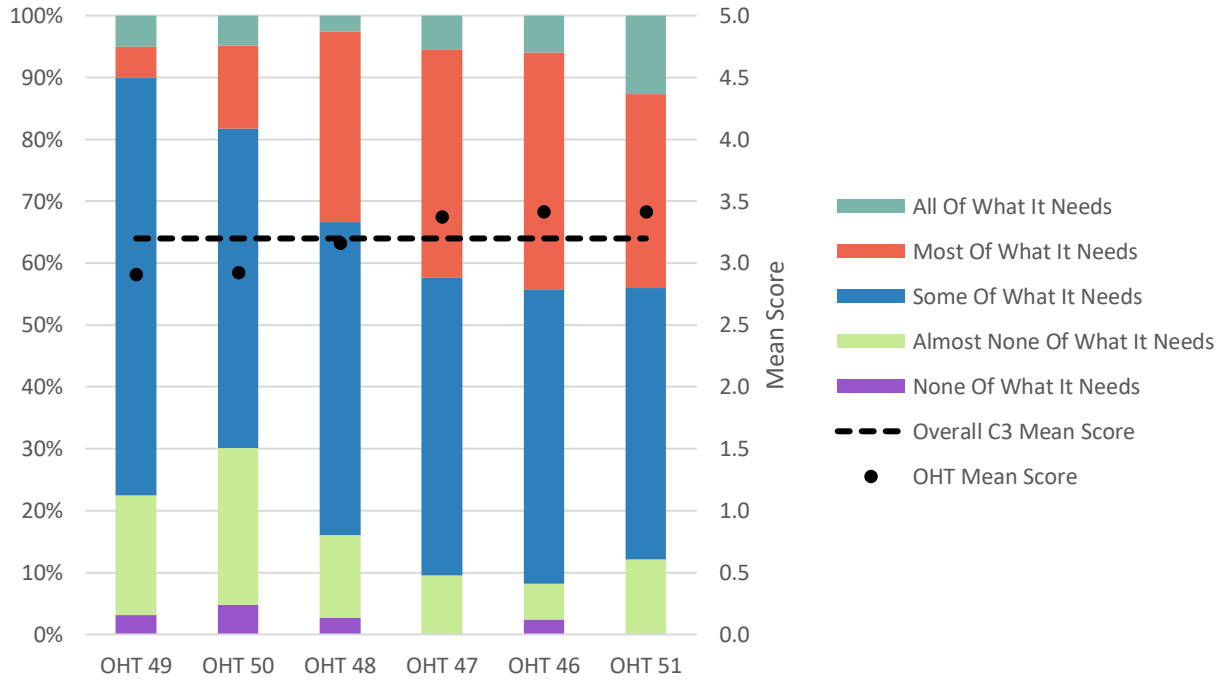
[ix] Survey Items – For each of the following types of resources, to what extent does your OHT have what it needs to work effectively:
29 Money
30 Tools and technologies

Non-Financial Resources

In addition to the basic financial resources required for a successful partnership, OHTs will require a broad array of skills and expertise, access to information and connections to political decision makers and other to support the legitimacy of the partnership.[14] There were four questions[x] about sufficiency of these non-financial resources. Ratings for the *Non-Financial Resources* domain were low, with a mean score across cohort 3 OHTs of 3.2 (out of 5) with a standard deviation of 0.64 (Figure 55).

Across the OHTs, the mean proportion of OHT respondents selecting 4 (most of what it needs) or 5 (all of what it needs) was 32.1% and varied from 10% to 44.3%. None of the OHTs had at least 50% of respondents selecting 4 or 5 (Figure 55).

Figure 55. Distribution of Cohort 3 OOHT Survey Responses to the *Non-Financial Resources* Domain (4 items[x]) and Mean Scores by OHT and Cohort Mean Score

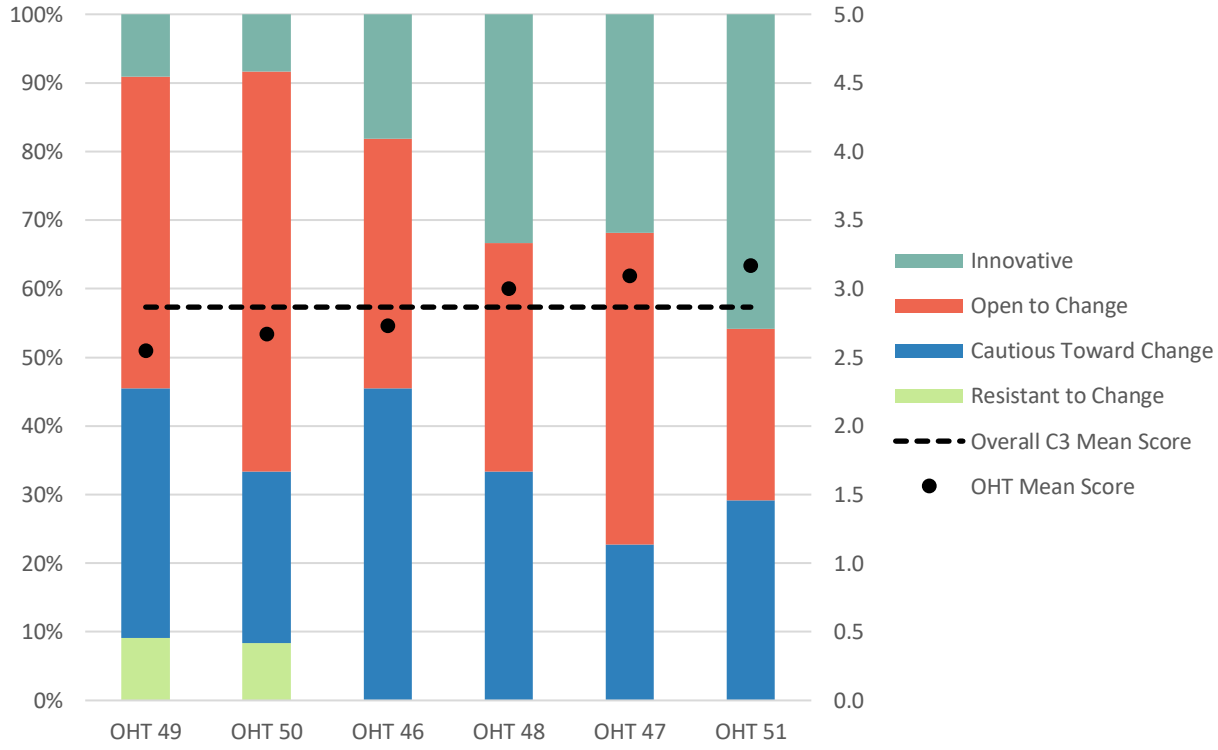


[x] Survey Items – For each of the following types of resources, to what extent does your OHT have what it needs to work effectively:
25 Skills and expertise
26 Data and information
27 Ability to identify target population criteria and deliver interventions
28 Connections to political decision-makers, government agencies

Other OOHT Survey Items

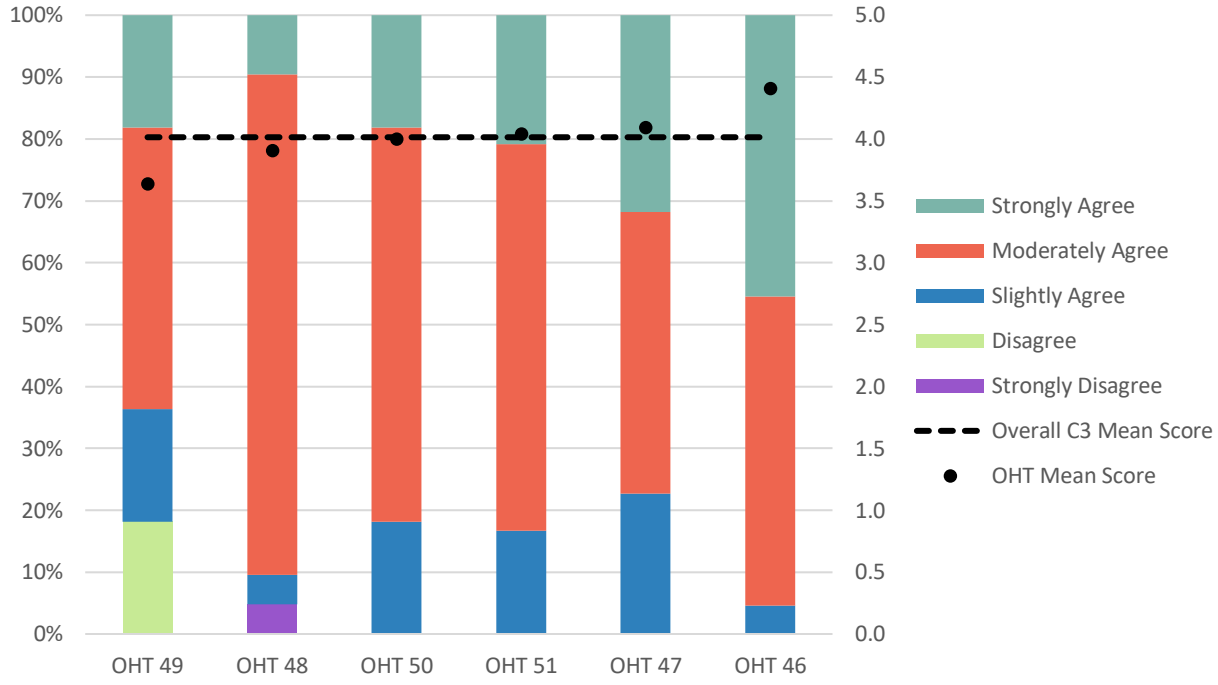
There were three additional items that were not part of the ten domains. Question 31 asked respondents to select the response that described their organization or practice setting's attitude toward change. All six OHTs had at least 50% of respondents selecting 3 or 4, but none of the OHTs having 80% of respondents selecting 3 or 4 (Figure 56). In particular, across Cohort 3, 24.4% of respondents described their organization as innovative, 40.7% as open to change, 32% cautious toward change and 2.9% as resistant to change (see Appendix A). Two OHTs had respondents reporting that their organizations were resistant to change.

Figure 56. Distribution of Cohort 3 OOHT Survey Responses to the Item *Organization or practice setting's attitude toward change* and Mean Scores by OHT and Cohort Mean Score



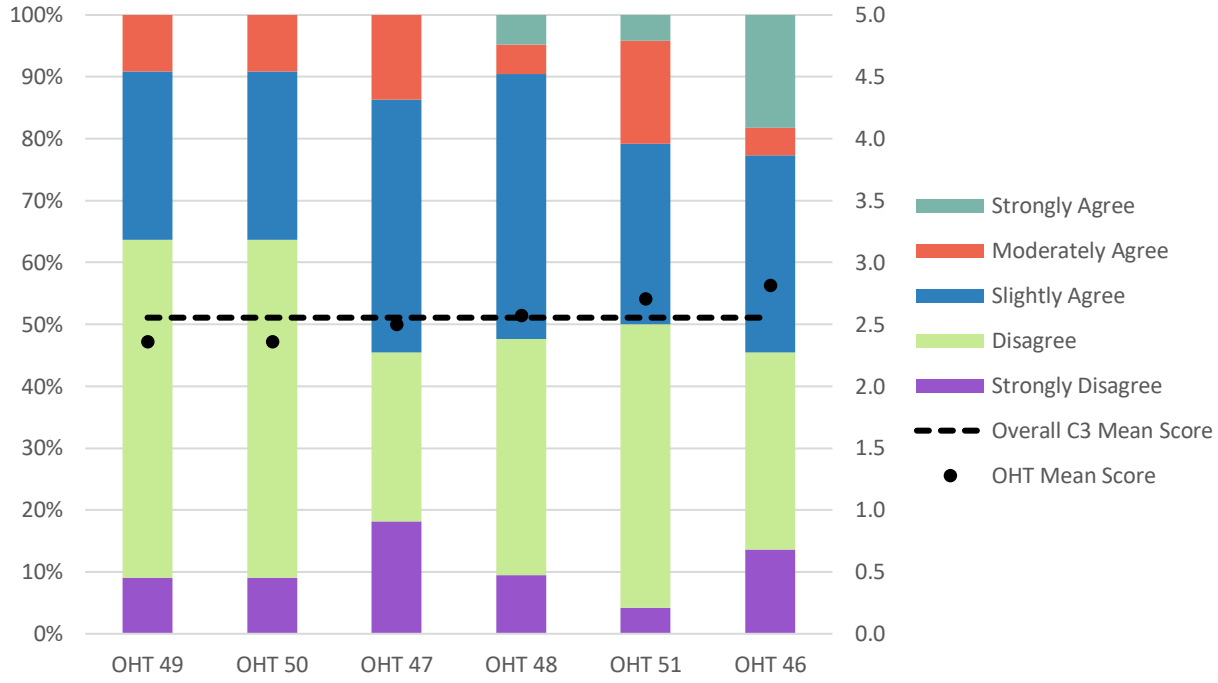
Question 32 asked if the respondent's organization or practice setting's shared values were compatible with those of other members of the OHT. Ratings on this question were, generally, very high with a mean score across OHTs of 4.01 (out of 5) and a standard deviation of 0.25 (Figure 57). Across the OHTs, the proportion of OHT respondents selecting 4 (moderately agree) or 5 (strongly agree) varied from 63.6% to 95.5%. Most OHTs (4/6) had ≥80% of respondents selecting the top two boxes and none of the OHT had 100% of their respondents in strong agreement their organization or practice setting's shared values were compatible with those of other OHT members.

Figure 57. Distribution of Cohort 3 OOHT Survey Responses to the Item *Your organization's shared values are compatible with those of other OHT members*, by OHT and Mean Scores by OHT and Cohort Mean Score



When asked, in question 33, if the professionals/staff in the respondent's organization or practice setting had a strong sense of belonging to the OHT, ratings were relatively low (Figure 58); the mean score across OHTs was very low 2.55 (out of 5) with a standard deviation of 0.18. Across the OHTs, the proportion of OHT respondents selecting 4 (moderately agree) or 5 (strongly agree) varied from 9.1% to 22.7%, with none of the OHTs having at least 50% of respondents selecting the top two boxes.

Figure 58. Distribution of Cohort 3 OOHT Survey Responses to the Item *Your organization's staff have a strong sense of belonging to your OHT*, by OHT and Mean Scores by OHT and Cohort Mean Score



E. Discussion

Measuring the contexts and capabilities critical to successful implementation of integrated care early in the OHT development allows for an assessment of "readiness to integrate" and the development of targeted change management strategies to address problem areas and leverage strengths. Follow up measurement of the contexts and capabilities is needed to determine where further or new efforts/supports are needed. Furthermore, since Cohort 1 and 2 were approved to become OHTs, the COVID-19 pandemic impacted the work laid out in their applications and for some OHTs, it resulted in new partners to be brought into the OHT membership to manage the pandemic and some cases the OHTs changed the area of the work due to the pandemic.[15] Additionally, the concepts of population health management became better understood and an expectation of the work of OHTs. It is noteworthy, the response rate for the 2022 OOHT survey was much lower compared to earlier OOHT survey releases, 54% compared to 77% for Cohort 1 and 70% for Cohort 2 which may also have impacted our findings.

Among the 51 OHTs the critical success factors for integrated care with the highest degree of capability were:

1) *Commitment to Improvement* (mean=3.72 out of 5), which had the second highest number of OHTs (8/51) where ≥80% of responses moderately agreed or strongly agreed (4 or 5).
2) *Team Climate* (mean=3.68 out of 5), with the third highest number of OHTs (6/51) where ≥80% of responses moderately agree/mostly or strongly agree/completely (4 or 5).
3) *Administration and Management* (mean=3.60 out of 5), with the highest number of OHTs (9/51) where ≥80% of responses were very good or excellent (4 or 5).
4) *Roles and Responsibilities* (mean=3.60 out of 5), with five of the 51 OHTs having ≥80% of respondents selecting responses moderately agreed or strongly agreed (4 or 5).

All domain scores except for the *Financial and Other Capital Resource* domain decreased for the OHTs in Cohorts 1 and 2 compared to the first time they completed the survey two and one year earlier, respectively. Cohort 3 consistently had the lowest scores across all domains and Cohort 1 had the highest scores for all domains except for the *Financial and Other Capital Resources* and *Non-Financial Resources,* where Cohort 2 had the highest scores.

It is worth noting that while *Administration and Management* had a high domain score (mean=3.60) and was the domain with the highest number of OHTs (9/51) where ≥80% of responses moderately agreed or strongly agreed (4 or 5), it also had one of the highest between-OHT variation indicating that some OHTs had better results than others and that sharing practices from these higher performing OHTs could contribute to improvements amongst lower-scoring OHTs in this domain. Conversely, *Readiness for Change* had an unremarkable mean score (mean=3.49), but had the lowest between-OHT variance indicating similar levels of readiness across most OHTs. However, a very low rating (mean=3.00, 2.76 and 2.55 for Cohort 1, 2 and 3, respectively) was observed when respondents were asked if the professionals/staff in the respondent's organization or practice setting had a strong sense of belonging to the OHT; particular focus will need to be placed on engaging the professionals/staff within organizations moving forward.

Leadership Approach did not rate highly; the overall average score ranked 6th out of the ten domains capturing critical success factors for integrated care, with a mean score of 3.43 and a high standard deviation (0.51). Successful partnerships require *boundary-spanning* leaders, formal and informal, who are able to bridge diverse interests, establish trusting relationships and find common ground to manage conflict,[14] but our survey reveals only six OHTs, five in Cohort 1 (Cambridge North Dumfries, Chatham-Kent, Connected Care Halton, Northumberland and Mississauga) and one in Cohort 2 (South Georgian Bay) had ≥80% of their member respondents indicating effective OHT leadership (scores of 4 (moderately agree) or 5 (strongly agree)). However, many OHTs, supports and opportunities are needed to build trust among all members and will be critical to successfully bring together partners, including health and non-health sectors, patients, and caregivers, in their design and work as one coordinated team.

Clinician Engagement, the third of the most important critical success factor highlighted by Evans *et al.*, was assessed through our document review of the all three cohort applications and found to not yet have a critical mass of primary care participation given most have partnered primary care enrollment model teams/practices (e.g., FHOs, FHTs and FHGs).[16, 17]

Of the ten domains measuring critical factors for integrated care, eight had at least one OHT with ≥80% of the respondents selecting 4 or 5. The *Financial and other Capital Resources* and *Readiness for Change - Suitability* domains were the two domains which did not have any OHT where ≥80% of the respondents selected 4 or 5 (had most or all of what it needs in terms of resources and strongly or moderately agree, respectively). The *Non-Financial Resources* and *Clinical Functional Integration* domains only had one OHT (North Simcoe and South Georgian Bay, respectively) where ≥80% of the respondents selected 4 or 5 (had most or all of what it needs in terms of resources and strongly or moderately agree, respectively).

The *Financial and other Capital Resources*, *Clinical Functional Integration* and *Non-Financial Resources* domains were among the lowest means and among the lower degree of variation across OHTs relative to other domains. *Financial* and *Non-Financial Resources* also had relatively low within OHT variance suggesting that across the board, survey respondents felt that *Financial* and *Non-Financial Resources* were lacking. Although *Clinical-Functional Integration*, had little variance across OHTs, it had one of the highest within OHT variance of any of the ten domains. All OHTs will need to expand partners' clinical and functional integration capabilities across all members to be successful. Within OHTs, some partners share tools for clinical coordination, as well as clinical information, but these capabilities do not appear to be consistent across all partners (i.e., wide variation within an OHT).

All OHTs have room to improve. Ranked by mean score, one OHT; Chatham-Kent, was consistently above the 80th percentile across all domains. If we exclude the *Financial* and *Non-Financial Resource* domains which had the lowest mean scores, two OHTs (Chatham-Kent and Cambridge North Dumfries OHT) ranked above the 80th percentile in each the remaining eight domains. There were 10 OHTs where not a single domain had ≥80% of the respondents selecting 4 or 5. There are supports, such as practice guides, webinars/podcasts, communities of practice, workshops, and coaching, available to help all OHTs in their development.

OHTs lack financial resources to make necessary investments in digital health solutions, information portals and technology to efficiently share information across OHT members. The recent government funding to support OHTs advance OHT implementation and the investments being made to support digital and data sharing capacity as well as modernizing the home and community care legislation are essential for improving integrated care and, population health management.

F. Conclusions and Implications

Integrated care initiatives develop over time and it is important to assess and reassess the teams on many of these domains to determine whether beliefs, attitudes and commitments are sustained as teams begin to implement their year one target population integrated care plans.

Minkman, argues integrated care initiatives begin with an initiation and design phase, proceed to the execution and experimentation phase, followed by expansion and monitoring, and finally, at maturity where there is consolidation and transformation.[18] This release of the OOHT survey results capture different points the OHTs' journey to transforming siloed to integrated care as well as having gone through a pandemic for almost two years that side-railed the work for many OHTs and in particular the OHTs in Cohort 1. Cohort 1 began working together in 2019 and Cohort 2 began working together in 2020, however these two cohorts could still be considered to be in an initiation and design phase as a result of the pandemic.

All cohorts rated themselves strongest in the *Commitment to Improvement*, *Team Climate,* members knowing their *Roles and Responsibilities* for their populations and *Administration and Management;* organizing and communicating among their members. However, compared to earlier survey results the mean scores are lower and modest variation in the scores across/between OHTs relative to the within-OHT scores suggesting widespread commitment to the OHT model and belief that this change will be beneficial. The greater extent of variation for *Administration and Management and Commitment to Improvement* suggests supports to address these areas can be targeted to OHT's with mean scores at the lower end of the scale.

Compared to earlier survey results, the *Readiness for Change – Suitability* domain saw the largest decrease in mean score (effect size=-1.6) with minimal variation across OHTs. This is concerning given the efforts needed for this transformational change initiative following a pandemic that has pushed the capacity of many OHT member organizations. It is also discouraging to see the continued lack of physician engagement at OHT leadership levels. Radical policy efforts are needed in the primary care sector to advance the work of the OHTs.

Leadership Approach did not rank highly (6th out of 10) as was the case in previous survey results. The two items specifically addressing trust among OHT members had lower mean scores in 2022 compared to earlier results from Cohort 1 and 2(3.6 vs 3.98 and 3.80, respectively and 3.4 vs 3.88 and 3.71, respectively). This is concerning given trust is considered an essential underpinning element of successful partnering to deliver integrated care in the context of complex multi-organizational systems.[6] Furthermore, given only 6/51 OHTs had ≥80% of their member respondents indicating effective OHT leadership suggests efforts are needed across the most OHTs to develop *boundary-spanning* leaders, able to bridge diverse interests, establish trusting relationships and find common ground to manage conflict.[14]

Additional *Financial* and *Non-Financial Resources* and improved *Clinical-Functional Integration* are required for all OHTs to be best positioned to succeed as a partnership in integrating care. All OHTs have room to grow as they continue to progress and start implementing their initiative. Resources, including ongoing government funding, are needed and supports, such as practice guides, webinars/podcasts, communities of practice, workshops, and coaching, are available to help in their development.

At three-years into the initiative, it may be discouraging to see most domain scores have decreased for Cohorts 1 and 2. However, this may reflect the recalibration of members' perceptions of their team's capabilities after spending one to two years working together developing their plans and processes to make this transformational health system to change, responding to a pandemic and, a deeper understanding of population health management. The lower scores may actually reflect a clearer understanding of what OHTs are expected to do (i.e., perception of capabilities vs the perception of the expectation). The results of the 2022 OOHT survey may in fact be a more realistic baseline of the capabilities and capacity of OHTs to deliver integrated care and population health management.

What is encouraging is *Commitment to Improvement* and *Team Climate* remain the top-rated domains and we do have some bright light OHTs (Cambridge North Dumfries, Nipissing, and South Georgian Bay) that saw improved scores across many domains. Sharing the learnings/experiences of these OHTs may be helpful.

It will be important to contiune re-assessing OHTs using the same survey given, integrated care initiatives progress through several phases towards maturity, to inform the MOH and OH on the resources and supports OHTs need to be successful.[18] The members in the OHTs have a strong commitment to this transformative change but need the policies in place to mobilize their efforts and commitment to improve the health outcomes of their attributed populations.

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Appendix A – OOHT Survey Item-Level Response Distributions among 51 OHTs

Item	Item Text	1 (%)			2 (%)			3 (%)			4 (%)			5 (%)		
		C3	C2	C1	C3	C2	C1	C3	C2	C1	C3	C2	C1	C3	C2	C1
3	Develop goals that are widely understood and supported among members	0	1	0	8	9	5	49	37	35	36	40	47	7	13	13
4	Identify how different organizations/programs in the community could help	1	2	1	19	17	10	51	42	38	25	32	43	4	6	9
5	Respond to the needs and problems of the community	1	2	2	21	16	11	56	38	40	16	32	36	6	12	11
6	Include the views and priorities of the people affected by the OHT's work	2	2	2	23	17	11	38	34	42	29	33	35	7	13	11
7	Obtain support from individuals and organizations in the community	2	4	1	15	16	14	52	40	36	25	31	42	6	9	6
8	We have a common vision of how to improve the integration of care.	0	4	1	9	10	6	41	26	23	36	39	44	15	21	25
9	We understand the role we will play in taking responsibility for the local population	2	1	2	17	10	10	37	28	25	36	46	38	8	16	26
10	We understand the role we will play in coordinating care	2	2	1	27	11	13	34	38	28	31	34	37	6	14	20
11	We have agreed to share responsibility for achieving improved patient outcomes	1	3	0	11	9	8	28	24	22	35	37	41	25	26	29
12	We share tools for clinical coordination	6	5	5	44	21	22	32	35	36	16	31	27	3	9	10
13	We share clinical information across partners	11	8	5	36	26	23	38	36	38	11	20	23	4	10	10
14	We have used data to identify the improvements for our target populations	2	2	2	25	13	9	38	30	34	26	31	37	9	24	17
15	We are prepared to question the basis of what the team is doing	2	2	1	15	9	10	37	30	26	34	38	37	12	21	25
16	We critically appraise potential weaknesses in what our OHT is planning	4	4	2	21	21	14	41	28	32	28	29	32	6	19	20
17	The members of the OHT build on each other's ideas	1	3	1	8	9	6	38	28	25	36	32	38	17	28	30
18	Empowering people/members involved in the OHT	4	6	2	18	18	19	39	27	26	26	34	36	13	15	16
19	Communicating the vision of the OHT	5	5	4	23	24	18	30	27	29	35	25	29	7	19	20
20	Creating an environment where differences of opinion can be voiced	5	5	3	16	21	18	34	20	25	32	34	35	13	20	20
21	Helping the OHT to be creative and look at things differently	6	8	3	33	21	21	32	31	27	19	25	32	10	16	16
22	Fostering respect, trust and inclusiveness amongst OHT members	5	7	3	18	19	13	27	18	21	33	29	31	17	28	31
23	Communicating among members	4	6	3	15	16	13	37	26	27	31	39	40	12	14	18
24	Organizing OHT member activities, including meetings and projects	4	3	2	9	11	7	38	28	24	32	36	42	18	23	24
25	Skills and expertise	0	1	0	8	3	3	49	28	38	38	58	50	6	9	8
26	Data and information	0	0	0	12	13	9	62	43	57	23	40	28	3	4	6
27	Ability to identify target population criteria and deliver interventions	5	1	3	17	8	11	49	41	42	20	41	37	8	9	7
28	Connections to political decision-makers, government agencies	3	2	2	21	9	7	46	40	46	23	38	34	7	11	11
29	Money	7	3	1	21	19	21	51	52	58	15	22	17	6	4	3
30	Tools and technologies	13	11	3	35	22	34	41	48	52	9	18	10	2	2	2

Item	Item Text	1 (%)			2 (%)			3 (%)			4 (%)			5 (%)		
		C3	C2	C1	C3	C2	C1	C3	C2	C1	C3	C2	C1	C3	C2	C1
31	Organization or practice setting's attitude toward change	3	3	2	32	21	24	41	48	44	24	28	30	0	0	0
32	Your organization's shared VALUES are compatible with those of other OHT members	1	0	0	3	2	2	14	14	13	58	49	48	24	35	37
33	Your organization's STAFF have a strong sense of belonging to your OHT	11	10	10	42	31	24	33	35	35	10	19	19	5	4	12
34	I think that my organization/practice setting will benefit from this change	1	3	1	9	8	7	50	32	33	22	34	36	18	22	24
35	This change will make my role easier	6	7	5	37	39	34	36	32	32	16	17	21	5	6	9
36	I feel it is worthwhile for me that the organization adopted this change	2	1	1	4	8	4	35	29	26	34	35	34	25	27	35
37	I have the skills that are needed to make this change work	0	0	0	2	2	2	19	13	14	48	53	46	31	33	38
38	This change will disrupt many of the working relationships I have developed	21	18	24	53	58	52	14	14	16	8	7	7	3	3	1
39	We have a 'we are in it together' attitude	2	5	1	9	5	7	30	30	22	35	31	33	24	30	36
40	We take the time needed to develop new ideas	2	3	2	15	8	11	30	33	27	38	34	41	16	22	19
41	To what extent do you think your OHT's objectives can actually be achieved?	3	2	1	9	9	8	35	31	29	48	42	45	5	17	18

Note: C1=Cohort 1; C2=Cohort 2; C3=Cohort 3.

Appendix B – Multi-Level Regression Estimates and Pairwise Comparisons of Lead Organization and Geography

	Leadership Approach	Shared Vision	Team Climate	Clinical-Functional Integration	Readiness for Change - Suitability	Commitment to Improvement	Roles and Responsibilities	Administration and Management	Financial and Other Material Resources	Non-Financial Resources
Regression Estimates										
Intercept	3.48***	3.46***	3.72***	3.16***	3.49***	3.73***	3.67***	3.69***	2.86***	3.38***
Hospital Led (1=Yes, 0=No)	-0.15	-0.13	-0.19	-0.17	-0.12	-0.13	-0.21	-0.13	-0.05	0.01
Geography (1=Urban, 0=Rural)	-0.28	-0.09	-0.13	-0.12	-0.06	-0.10	-0.12	-0.36	0.02	0.12
Hospital * Geography	0.42	0.16	0.29	0.07	0.21	0.24	0.20	-0.39	-0.02	-0.10
Random Effects Parameters										
OHT										
Variance (Intercept)	-1.04***	-1.38***	-1.51***	-1.34***	-2.32***	-1.39***	-1.39***	-1.03***	-1.96***	-1.79***
Variance (Residual)	-0.07*	-0.42***	-0.28***	-0.10***	-0.19***	-0.28***	-0.13***	-0.10***	-0.37***	-0.54***
Comparisons (Differences) between Lead Organization Types and Geographies										
Hospital vs Community	0.06	-0.05	-0.04	-0.14	-0.02	-0.02	-0.11	0.07	-0.06	-0.04
Urban vs Rural	-0.07	-0.00	0.02	-0.09	0.05	0.02	-0.01	-0.17	0.02	0.07
Comparisons (Differences) between All Combinations of Lead Organization Type and Geography										
Community Urban vs Community Rural	-0.28	-0.09	-0.13	-0.12	-0.06	-0.10	-0.11	-0.36	0.02	0.12
Hospital Rural vs Community Rural	-0.15	-0.13	-0.19	-0.17	-0.12	-0.13	-0.21	-0.13	-0.05	0.01
Hospital Urban vs Community Rural	-0.01	-0.05	-0.03	-0.22	0.03	0.01	-0.12	-0.10	-0.04	0.03
Hospital Rural vs Community Urban	0.13	-0.04	-0.06	-0.05	-0.06	-0.04	-0.09	0.24	-0.07	-0.12
Hospital Urban vs Community Urban	0.27	0.04	0.10	-0.10	0.09	0.10	-0.01	0.26	-0.06	-0.09
Hospital Urban vs Hospital Rural	0.14	0.08	0.16	-0.05	0.15	0.14	0.09	0.03	0.01	0.02

Notes: * p < 0.05; ** p < 0.01; *** p < 0.001. P-values adjusted for multiple comparisons using Bonferroni's method.