Ontario Health Teams
Central Evaluation

Findings from the 2025 OHT Leadership Survey

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HSPN

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The Health System Performance Network (HSPN) is a collaborative network of investigators, visiting scholars, post-doctoral fellows, graduate students and research staff working with health system leaders, and policymakers to improve the management and performance of our health system. Building on Ontario's established record of performance measurement created by the 1998 ground-breaking Hospital Report Research Collaborative, the HSPN was established in 2009 and has built a track record in performance measurement, research, evaluation and improvement in Ontario with expertise in multiple domains of health system performance including perspectives of patients, providers, population health, and cost. The HSPN receives funding from the Ontario Ministry of Health.

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OHT Key

OHT NAME	OHT Abbreviation	HSPN OHT
Algoma OHT[1]	Alg OHT	OHT 23
*All Nations Health Partners OHT[1]	ANHP OHT	OHT 10
Archipel OHT[1]	Arch OHT	OHT 29
Barrie and Area OHT[3]	BA OHT	OHT 07
Brantford Brant Norfolk OHT[2]	BBN OHT	OHT 40
*Burlington OHT[1]	Bur OHT	OHT 24
Cambridge North Dumfries OHT[1]	CND OHT	OHT 17
Central West OHT[1]	CW OHT	OHT 02
Chatham-Kent OHT[1]	CK OHT	OHT 12
Connected Care Halton OHT[1]	CCH OHT	OHT 30
*Couchiching OHT[1]	Cou OHT	OHT 26
Downtown East Toronto OHT[2]	DET OHT	OHT 35
*Durham OHT[1]	Dur OHT	OHT 20
*East Toronto Health Partners OHT[1]	ETHP OHT	OHT 03
Eastern York Region and North Durham OHT[1]	EYRND OHT	OHT 13
Elgin OHT[3]	Elg OHT	OHT 50
ÉSO Cochrane District OHT[5]	CD OHT	OHT 55
ÉSO Sudbury Espanola Manitoulin Elliot Lake OHT[5]	SEMEL OHT	OHT 56
*Frontenac, Lennox and Addington OHT[2]	FLA OHT	OHT 33
Great River OHT[3]	GR OHT	OHT 48
*Greater Hamilton Health Network OHT[1]	GHHN OHT	OHT 22
Grey-Bruce OHT[3]	GB OHT	OHT 49
Guelph Wellington OHT[1]	GW OHT	OHT 21
Hastings Prince Edward OHT[3]	HPE OHT	OHT 46
Hills of Headwaters Collaborative OHT[1]	HHC OHT	OHT 08
Huron Perth and Area OHT[1]	HPA OHT	OHT 01
Kawartha Lakes Haliburton OHT[2]	KLH OHT	OHT 45
Kiiwetinoong Healing Waters OHT[4]	KHW OHT	OHT 52
Kitchener, Waterloo, Wilmot, Woolwich and Wellesley[2]	KW4 OHT	OHT 42
Lanark, Leeds and Grenville OHT[2]	LLG OHT	OHT 34
Maamwesying OHT[4]	Maa OHT	OHT 54
*Middlesex London OHT[1]	ML OHT	OHT 05
Mid-West Toronto OHT[2]	MWT OHT	OHT 38
*Mississauga Health OHT[1]	MH OHT	OHT 06
Muskoka Almaguin OHT[1]	MA OHT	OHT 15
Niagara OHT[1]	Nia OHT	OHT 14
*Nipissing Wellness OHT[1]	NW OHT	OHT 19
*Noojmawing Sookatagaing OHT[4]	Noo Soo OHT	OHT 53
North Simcoe OHT[3]	Nor Sim OHT	OHT 32
North Toronto OHT[1]	NT OHT	OHT 16
North Western Toronto OHT[1]	NWT OHT	OHT 27
*North York Toronto Health Partners OHT[1]	NYTHP OHT	OHT 09
Northern York South Simcoe OHT[1]	NYSS OHT	OHT 25
Northumberland OHT[1]	Nor OHT	OHT 04
Ottawa OHT-ÉSO[1]	Ott OHT	OHT 11
Ottawa Valley OHT[3]	OV OHT	OHT 51
Ottawa West Four Rivers OHT[3]	OWFR OHT	OHT 47
Oxford OHT[2]	Oxf OHT	OHT 37
Peterborough OHT[1]	Pet OHT	OHT 18
Rainy River District OHT[2]	RRD OHT	OHT 43
Sarnia Lambton OHT[2]	SL OHT	OHT 41
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West Toronto OHT[2]	WT OHT	OHT 31
Western York Region OHT[1]	WYR OHT	OHT 28
Windsor Essex OHT[3]	WE OHT	OHT 39

[1-5] specifies the cohort of each OHT.

* specifies the initial 12 (i12) OHTs.

Executive Summary

This report contains results from the Organizing for Ontario Health Teams (OOHT) leadership survey administered to leaders of Ontario Health Teams (OHTs) in March of 2025. Where available, this report includes changes from data collected in 2022. The report describes the extent to which critical success factors for the implementation of network models of integrated care are present. The purpose of the report is to identify areas where OHTs and government should focus efforts and to support shared learning.

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, 29 OHTs were announced as part of the first wave of approved OHTs in December 2019 and July 2020 (Cohort 1). In November 2020, 13 new OHTs were approved (Cohort 2). The MOH approved the third wave of nine OHTs in September 2021 and February 2022 (Cohort 3), the fourth wave of three approved OHTs in October 2022 (Cohort 4), and the fifth (and final) wave of 4 approved OHTs in July 2023 and January 2024 (Cohort 5). In 2024, the MOH selected 12 OHTs (referred to as the initial 12 OHTs) to accelerate their progress toward maturity in the OHT model. The goal for OHTs is to ensure that everyone in Ontario can benefit from better coordinated, more integrated care (1).

Survey Focus

OHTs are formed as partnerships amongst independent health care providers and therefore constitute network model rather than a single organization. Particular operational approaches to strengthen and sustain partnerships are necessary for network models to succeed. The 2025 OOHT leadership survey is intended as a self-assessment capturing eight domains that measure critical success factors/capabilities for network models of integrated care, as well as one domain for *Overall Effectiveness*. Likert response options were scored from 1-5, where a higher score indicates a higher degree of a success factor. The eight capability domains include: *Shared Purpose*, *Shared Responsibility*, *Leadership*, *Organizational Approach*, *Organizational Context*, *Communications and Management*, *Operational Approach*, and *Readiness for Change*. The survey also includes items relating to Governance.

Survey Administration

The survey was distributed between March 3, 2025 and April 30, 2025. HSPN has conducted a similar survey in previous years (2020/2021 and 2022). This iteration includes five domains carried over from previous surveys and introduced four new domains to address the evolving evaluation needs of Ontario Health Teams (OHTs).

Respondents

The target respondents for the survey were the members of the leadership groups or councils for each OHT. These are the individuals responsible for making decisions about priorities, membership, funding allocations, and activities for the OHT. The respondent list for each OHT was provided to HSPN by the evaluation contact within each OHT. A total of 1,557 individuals were invited to participate. Survey communications were provided in French and English and surveys were available in both languages.

Fifty-five OHTs participated in the survey. The 2025 results are based on 857 respondents (response rate 55%), with an average of ~16 respondents per OHT (63% average response rate across OHTs). Just over three-quarters of survey respondents (~76%) were in executive roles (e.g. CEO or equivalent); other participants included physicians, home care leads, patient, family, and caregiver representatives.

Results in Brief

Compared to previous OOHT survey results reported in 2022, the ***Overall Effectiveness and Promise*** domain **increased** *by a statistically significant amount.* Similar mean scores as in the previous survey were

observed for 3 domains: 1) *Communications and Management (*e.g., Fostering communication amongst members)*,* 2) *Leadership (*e.g., Addressing power imbalances, communication and fostering respect, trust and inclusiveness)*,* and 3) *Readiness for Change* (e.g., I think my organization will benefit)*.* Teams are enacting many elements of Learning Health Systems (data, evidence, co-design, implementation, evaluation) captured in ***Operational Approach*** but scores for ***Organizational Context*** indicate that performance management strategies are not yet enabled within OHTs.

Six domains had ***high*** ratings (above 3.5/5.0) across OHTs:

(A) *Organizational Approach* (mean=3.85/5.0)

(B) *Shared Responsibility* (mean=3.74/5.0)

(C) *Shared Purpose* (mean=3.71/5.0)

(D) *Overall Effectiveness and Promise* (mean=3.70/5.0)

(E) *Operational Approach* (mean=3.60/5.0)

(F) *Communications and Management* (mean=3.60/5.0)

Three domains had ***low*** ratings (below 3.5/5.0):

(G) *Organizational Context* (mean=3.11/5.0)

(H) *Leadership* (mean=3.42/5.0)

(I) *Readiness for Change* (mean=3.48/5.0)

We also examined the variability within- and between-OHTs for each domain. Across all the domains, the *Leadership, Operational approach* and *Overall Effectiveness and Promise* had the greatest variation across (or between) OHTs relative to the variation within OHTs suggesting ***some*** OHTs (i.e., those with lower mean scores) may benefit from more focus and supports. Lower variability across OHTs in the *Readiness for Change and Shared Purpose* domains suggests improvement will require effort/supports across ***most*** OHTs to activate these capabilities.

Strengths and Areas for Growth

- Mean **scores for *Overall Effectiveness*** have **improved significantly** at the provincial level and within most OHTs (2022 mean: 3.45; 2025 mean: 3.70; +0.25 points). This demonstrates that OHT leadership respondents have increased their overall perception that their OHT has strengthened capacity to meet health needs and achieve objectives.
- Overall, the mean domain score for ***Shared Purpose*** increased by a small amount (+0.07 points), although results varied across individual OHTs.
- For the remaining three comparable domains, provincial mean scores were largely consistent with those from the 2022 OOHT survey, despite variability for individual OHT results.
- The **highest rated domains** were ***Organizational Approach*** (3.85/5) and ***Shared Responsibility*** (3.74/5) reflecting a strong belief in the leadership team and shared responsibility for achieving improved patient outcomes with set targets for specific measures.
- The **lowest** rated domain was ***Organizational Context*** (3.11/5). This domain consisted of 16 items, many of which **focused on performance management and accountability** arrangements, which are still in development across many OHTs.
- At the OHT level, Cohort 1 demonstrated the highest mean scores across all domains, except for *Communications and Management*, where Cohort 3 had the highest mean. None of these differences reached statistical significance, likely due to limited power. The initial 12 ('i12') OHTs demonstrated significantly higher scores as compared to other OHTs. OHTs funded through community organizations had significantly higher scores than OHTs funded through hospitals on six of nine domains (all except Communications, *Operational Approach* and *Readiness for Change*).

- There were some **standout OHTs**. The following OHTs ranked consistently over 80th percentile for all nine domains: 1) **Burlington** OHT (ranked top 6 of 55 OHTs across all domains with an average percentile of 97%), 2) **Ottawa West Four Rivers** OHT (ranked top 10/55 across all domains with an average percentile of 96%), 3) **South Georgian Bay** OHT (ranked top 10/55 across all domains with average percentile of 94%), and 4) **Couchiching** OHT (ranked top 12/55 across all domains with an average percentile of 93%).
- From qualitative comments, areas for continued development include alignment between provincial and OHT-level priorities, building capacity within a low resource environment, building engagement and capability in primary health care, negotiating power imbalances and focusing on implementation of new care models and pathways leading to improved patient care and outcomes.
- Leadership Groups grew in size from a median of 15 in 2022 to 17 in 2025. There was also a greater degree of turnover amongst OHT leadership between 2022 and 2025 as compared to the period between 2020 and 2022.
- In 2022 and 2025, most respondents to the governance section agreed that other leadership members were committed to their OHT's success, though strong agreement was higher in 2022 than in 2025.

Conclusions and Implications

With an emphasis on growth and learning, further exploration of practices amongst OHTs that are leading in their self-assessed capabilities should be undertaken to enable spread. Knowledge mobilization can be both provincial and regional as leading OHTs are found in all regions and all cohorts of OHT approval. Support and coaching for OHTs on governance, leadership and implementation should be pursued with both targeted supports for specific OHTs with lower capability and provincial supports for all OHTs to advance collective achievement. Leadership groups for individual OHTs with high proportion of responses at both positive and negative response categories are encouraged to reflect upon reasons for differences in perceptions and increase their common understanding and shared purpose. Overall, the results of this self-assessment process are highly encouraging.

A. Background

Ontario Health Teams (OHTs) are gaining momentum as they emerged from the COVID-19 pandemic and continue to solidify a future of organizing and delivering care that is more connected to patients in their local communities. Some OHTs have been provided specific mandates to advance priority areas such as *Integrated Care Pathways* or to trial *Leading Projects* in integrating home and community services in collaboration with other health sectors. All OHTs a continue to play a central role in connecting care to patients and making progress on provincial priorities, such as primary care attachment. To accomplish these goals, OHTs require a solid foundation of good governance, effective leadership, and actionable operational strategies. At this point of inflection, the HSPN Organizing for Ontario Health Teams leadership survey (OOHT) has collected input from the leadership teams of nearly all OHTs. Since its origin in 2019, the OOHT has been guided by the Context and Capabilities for Integrated Care (CCIC) Framework (2). In 2025, the OOHT represents the fourth distribution since 2019, with most OHTs having participated in three waves of data collection (2020/2021, 2022, 2024).

The survey explores a range of topics including shared commitment to improvement, team climate, roles and responsibilities, emphasis on performance management and social capital, leadership's approach to change, approach to implementation, readiness for change and overall perceptions of OHT success and future potential. The survey enables a self-assessment and to compare the varied strengths of OHTs. The survey has been modified from prior editions and builds on recent developments in the evaluation of OHTs including the HSPN Developmental Evaluation of select OHTs (3), the 2023 Governance Survey of OHTs (4) and the adoption of Learning Health System approaches to supporting the development of OHTs (5). The 2023 HSPN ***Developmental Evaluation: The Evolution of Ontario Health Teams*** reported on the context-specific approaches and how they were shaped by each OHT's unique history, context, strengths and opportunities (3). The latter report and it's subsequent companion ***Closing the gap between program implementation and system design: Exploring how implementers and system stakeholders approach the development of Ontario Health Teams*** (6) identified emergent OHT activities related to design and implementation of integrated models, establishing funding and incentive structures, and enhancing performance measurement, quality improvement and continuous learning. Therefore, in this iteration of the OOHT survey, new dimensions have been added to focus more on how OHT priorities are being operationalized, with particular attention to organizational approaches and implementation strategies. In doing so, we decided not to collect and report on some of the previously covered areas, such as resource availability and shared information systems. While these areas remain important, reductions were necessary to accommodate new areas of focus. Moreover, previous reports found that these areas showed relatively little variation across OHTs and/or limited change over time. This report also integrates the HSPN OHT governance survey (4).

This report is written for a broad audience including OHT leadership, OHT operational teams, Ontario Health and Ministry of Health planning, supports and guidance teams, and for all Ontarians interested in how Ontario's health and social care providers are organizing themselves to improve population health and deliver integrated care systems.

B. Objectives

The objective of this report is to describe and compare critical success factors regarding organizational approaches, leadership, and implementation strategies across Ontario Health Teams to identify strengths and opportunities to build important capabilities for operationalizing integrated care and advancing provincial priorities. Secondly, we describe and compare how some highlighted critical success factors changed over time for teams that have completed the prior OOHT Surveys.

C. Methods

C.1 Survey Instrument

The OOHT survey development has been described in our previous survey reports and manuscripts (7-10). The survey fills a need for self-assessment amongst OHTs on both technical and adaptive capabilities to leverage a network approach to advance integrated care and population health at the local level across Ontario. The current survey content was based primarily on the same measures as prior OOHT surveys, with some additions and substitutions to emphasise OHTs' implementation approaches more than the generative collaboration activities. The content is based on research regarding organizational change, learning and network effectiveness (9-11). The questions within each domain are drawn from survey scales that have been validated in empirical research. These sources are outlined within each section of the report. Items related to shared purpose, shared responsibilities, leadership approach, readiness for change, communication and management, and an assessment of overall effectiveness have been retained. New questions have been added to describe the Organizational Approach on alignment and adaptability, and Organization Context, including performance management and social capital (12, 13). New questions were also added to examine OHT's alignment with a Learning Health System in their Operational Approach (5). This survey consists of nine domains, five of which are consistent with the previous survey, allowing for comparison of results over time. This report includes a summary of the qualitative comments provided in an open-ended question contained in the survey relating to any additional comments that respondents felt should be included in this formative assessment of OHT progress. This report also provides information on governance previously reported separately (4).

The OOHT survey includes 47 items, measuring nine previously validated domains and 10 substantive questions capturing perception of governance. The OOHT Factual Governance Survey contains eight substantive questions, capturing key characteristics of the structure and functioning of OHT leadership groups. 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* 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 (14). Two items not included in the scales are reported separately.

C.2 Survey Sample

The respondent pool for this survey is the membership of the leadership group or collaborative councils, which serve as the effective governance bodies for OHTs. For this survey, HSPN contacted the primary evaluation contact for each OHT to obtain an up-to-date contact list for survey recipients. OHTs were asked to provide email contacts for *individuals who were the most involved in the OHT from each of the organizations who were members* of the leadership group or collaborative council. For OHTs who previously participated in the OOHT surveys, the OHT contacts were sent the existing contacts and asked to update the organizations and contact names. New OHTs validated the information from their applications.

55 of 58 OHTs provided names and contact email addresses. The evaluation team received contact details for 1557 individuals; the mean number of individuals per OHT was 28, with a range of 8 to 144, all of whom received an invitation to participate.

C.3 Data Collection

Survey data collection commenced on March 3, 2025. Initially, all individuals received an email from HSPN announcing the survey and indicating that an invitation would be forthcoming after one week. One week later, a second email was distributed to all individuals inviting them to participate. The invitation included a link to an information letter detailing their rights as participants, along with a unique link to the survey. This approach was approved as part of the review for the HSPN evaluation of OHTs by the University of Toronto Human Subjects Research Ethics Board (#38072). An opt out was offered on the introduction page of the survey. Up to 5 reminders were sent via email to non-responders over a 6-week period. Data collection

continued with these teams until April 30, 2025. Additionally, OHT points of contact were asked to encourage participation if their response rate was below 30% or if there were fewer than five responses by April 5, 2025. The survey was available in both English and French. All substantive items were mandatory.

C.4 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 levels (by lead organization and geography). To examine the response distribution across response options within a domain, the mean percentage response to each response option across items was calculated. We first calculated the proportion of respondents within each OHT that selected each response option, and then we averaged that proportion across multiple items included within each scale to report on the distribution for each domain. In addition, 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. If there is high variability across OHTs and low variability within OHTs, the data support opportunities for improvement for specific OHTs with lower scores. Capabilities with low variability within and across OHTs will require broad-based supports for all OHTs to improve. If there is a high degree of variability within OHTs, it indicates uncertainty, and OHTs should focus on developing shared purpose and approaches within their OHT. 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.

C.5 Qualitative Analysis

We used Artificial-Intelligence supported qualitative thematic analysis to analyze 254 comments that were provided as additional thoughts regarding the development and performance of OHTs. The comments were first fully de-identified of all individual names, geography and other potential identifiers leaving only '[name]' as the identifier of specific teams. We retained identifiers for the Ministry of Health and Ontario. We followed recommended practice for AI-driven qualitative analysis (15). Both Claude 4.0 and Chat GPT v4.0 were used in the analysis. The prompts were as follows:

"I have 254 de-identified comments from the respondents who completed the Organizing for Ontario Health Teams (OOHT) surveys. The purpose of the survey is to capture contextual factors important to integrating care, including partnerships, leadership, communication, resources, and organizational change. Most of these comments are a few short sentences that I would like to analyze qualitatively using thematic analysis. The comments are available in the CSV document. I would like you to perform the following tasks:

1. Familiarize yourself with the comments and provide a global summary to understand the content and context.
2. Identify and code relevant text segments with short labels that summarize each segment. Include quotes or excerpts from the comments used to come up with each code.
3. Group similar codes into potential themes.
4. Review and refine the themes to ensure they accurately represent the data, providing improvement suggestions if needed.
5. Clearly define and name each theme and sub-theme.
6. Provide quotes to support each theme."

The results were reviewed by the report lead author and synthesized to highlight five key themes.

D. Results

D.1 OOHT Survey Respondents

Table 1 illustrates the survey respondent roles and the types of organizations they represent. About 75% of all respondents were in executive leadership or senior management positions. Overall, clinicians represented 7.2% of respondents. There was a small number of patients and caregivers (4.8%) and board members (4.4%), however these proportions increased compared to 2022 survey.

Overall, the majority of survey respondents were from primary health care practice (26.4%), community health agency (24.5%), and community support services (21.6%). Representation of respondents from Community indigenous organizations, academic partners, and OHT leadership were among the lowest. Less than 2% of respondents fell into other types of organizations which included health centres, palliative care and French planning entities.

Table 1. Number of Respondent Roles and Type of Organization(s) Overall (N=857)

Characteristic	Overall (N=857)
Current Role	
Chief Executive Officer, President or Executive Director	445 (51.9%)
Administrator, General Manager, Director of Care, Clinical Leader	104 (12.1%)
Other Senior Management (COO, CFO, Vice President, Chief of Staff)	103 (12.0%)
Physician/Primary Care Provider	62 (7.2%)
Patient/Caregiver	41 (4.8%)
Board Member	38 (4.4%)
Other Administrative Role	23 (2.7%)
Other Clinical/Service Provider Role	16 (1.9%)
Academic Partner	5 (0.6%)
Other	20 (2.3%)
Type of Organization Represented	
Primary health care practice	226 (26.4%)
Community health agency	210 (24.5%)
Community support services	185 (21.6%)
Home care (Service Provider Organization)	96 (11.2%)
Acute Care hospital	94 (11.0%)
Long-term care	70 (8.2%)
Patient and Family Advisory Council or Community member	50 (5.8%)
Municipality	33 (3.9%)
Public Health	29 (3.4%)
Community specialty medical practice	27 (3.2%)
Provincial Agency	21 (2.5%)
Rehabilitation or Complex Continuing Care hospital	21 (2.5%)
Mental Health hospital	14 (1.6%)
Community cultural/language organization	10 (1.2%)
Community indigenous organization	8 (0.9%)
Academic Partner	6 (0.7%)
OHT Leadership	4 (0.5%)
Other	13 (1.5%)

D.2 OOHT Survey Response and Completion Rates

Of the 1,557 individuals who were emailed an invitation to the OOHT survey, 857 submitted their survey for an overall response rate of 55%. At the OHT-level, the mean response rate was 63%, ranging from 17% to 90% across the 55 OHTs. Nearly all surveys were completed in English, with eight being answered in French. About two thirds of the OHTs had a response rate over 60% (34/55 OHTs). (See Table 2)

The mean completion rate of all survey items across the 857 respondents was 96.4%, ranging from 25.5% to 100%. Across survey items, 5 items had an off-scale response option (Don't Know). The mean percent of off-scale responses for these 5 items was 8.5% (range: 5.6% to 11.2%). The highest number of off-scale responses was for the question (implementation 5) which asked respondents whether their OHT used formal processing with ongoing data and cycles of evaluation to assess performance. The Overall Effectiveness items ("The development of this OHT has strengthened shared capability to meet the health-related needs of your population" and "This OHT's objectives can actually be achieved") had the highest number of missing values likely because these questions were found closer to the end of the survey. (Appendix A)

Table 2. Organizing for Ontario Health Teams Survey Response Rates

OHT [1]	Number of Respondents	Response Rate	OHT [1]	Number of Respondents	Response Rate
Alg OHT	17	74%	MA OHT	13	59%
ANHP OHT	11	61%	MH OHT	14	70%
Arch OHT	11	73%	ML OHT	8	32%
BA OHT	9	53%	MWT OHT	22	54%
BBN OHT	12	67%	Nia OHT	20	61%
Bur OHT	8	89%	NooSoo OHT	32	68%
CCH OHT	6	75%	Nor OHT	9	39%
CD OHT	12	71%	Nor Sim OHT	9	82%
CK OHT	13	57%	NT OHT	11	69%
CND OHT	7	44%	NW OHT	14	47%
Cou OHT	11	79%	NWT OHT	8	67%
CW OHT	24	17%	NYSS OHT	8	80%
DET OHT	23	55%	NYTHP OHT	14	70%
Dur OHT	14	70%	Ott OHT	12	67%
Elg OHT	17	68%	OV OHT	32	71%
ETHP OHT	10	71%	OWFR OHT	12	60%
EYRND OHT	15	68%	Oxf OHT	19	70%
FLA OHT	49	40%	Pet OHT	11	73%
GB OHT	16	48%	RRD OHT	9	90%
GHHN OHT	15	88%	Scar OHT	20	54%
GR OHT	9	90%	SEMEL OHT	39	58%
GW OHT	16	64%	SGB OHT	11	85%
HHC OHT	14	56%	SL OHT	23	55%
HPA OHT	29	55%	TA OHT	20	63%
HPE OHT	17	68%	WE OHT	11	61%
KLH OHT	6	67%	WT OHT	20	51%
KW4 OHT	22	52%	WYR OHT	11	58%
LLG OHT	12	32%	Average Across OHTs	16	63%

[1] OHTs were assigned an abbreviation, the key on page 5 identifies the OHT name.

D.3 OOHT Survey Findings

Measuring the key contexts and capabilities supporting integrated care delivery 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 3 illustrate that across 55 OHTs, the four domains with the highest ratings were *Organizational Approach* (mean=3.85 out of 5), *Shared Responsibility and Accountability* (mean=3.74), *Shared Purpose* (mean=3.71), and *Overall Effectiveness and Promise* (mean=3.70). There were three domains, *Organizational Context*, *Leadership* and *Readiness for change*, with lower ratings across OHTs (means of 3.11, 3.42, and 3.48 respectively).

Compared to prior survey conducted in 2022, mean scores for *Overall Effectiveness and Promise* domain have improved significantly at the provincial level (3.45 vs 3.70) and within most OHTs. Slight improvement was observed at the provincial level for the *Shared Purpose* domain and mean scores were largely consistent with those from the previous survey for the remaining 3 domains.

Hospital supported OHTs had lower mean scores than Community-supported OHTs for all domains except *Communications and Management*, *Operational Approach*, and *Readiness for Change*. Statistically significant ($p<0.10$) differences were found in mean scores for *Shared Responsibility*, *Organizational Context*, and *Operational Approach* when testing for differences between geography (urban/suburban vs small community/rural). Urban OHTs had higher mean scores compared to rural OHTs.

Figure 1 illustrates across the 55 OHTs, the three domains with the highest ratings were *Organizational Approach* (mean=3.85 out of 5), *Shared Responsibility* (mean=3.74 out of 5), and *Shared Purpose* (mean=3.71 out of 5). The three domains with lowest ratings were, *Organizational Context*, *Leadership*, and *Readiness for Change* (means of 3.11, 3.42, 3.48 respectively).

Figure 1. Overall Mean, 90th Percentile Scores and Mean Scores by Geography and Lead Organization Type by OOHT Survey Domain (N=55)

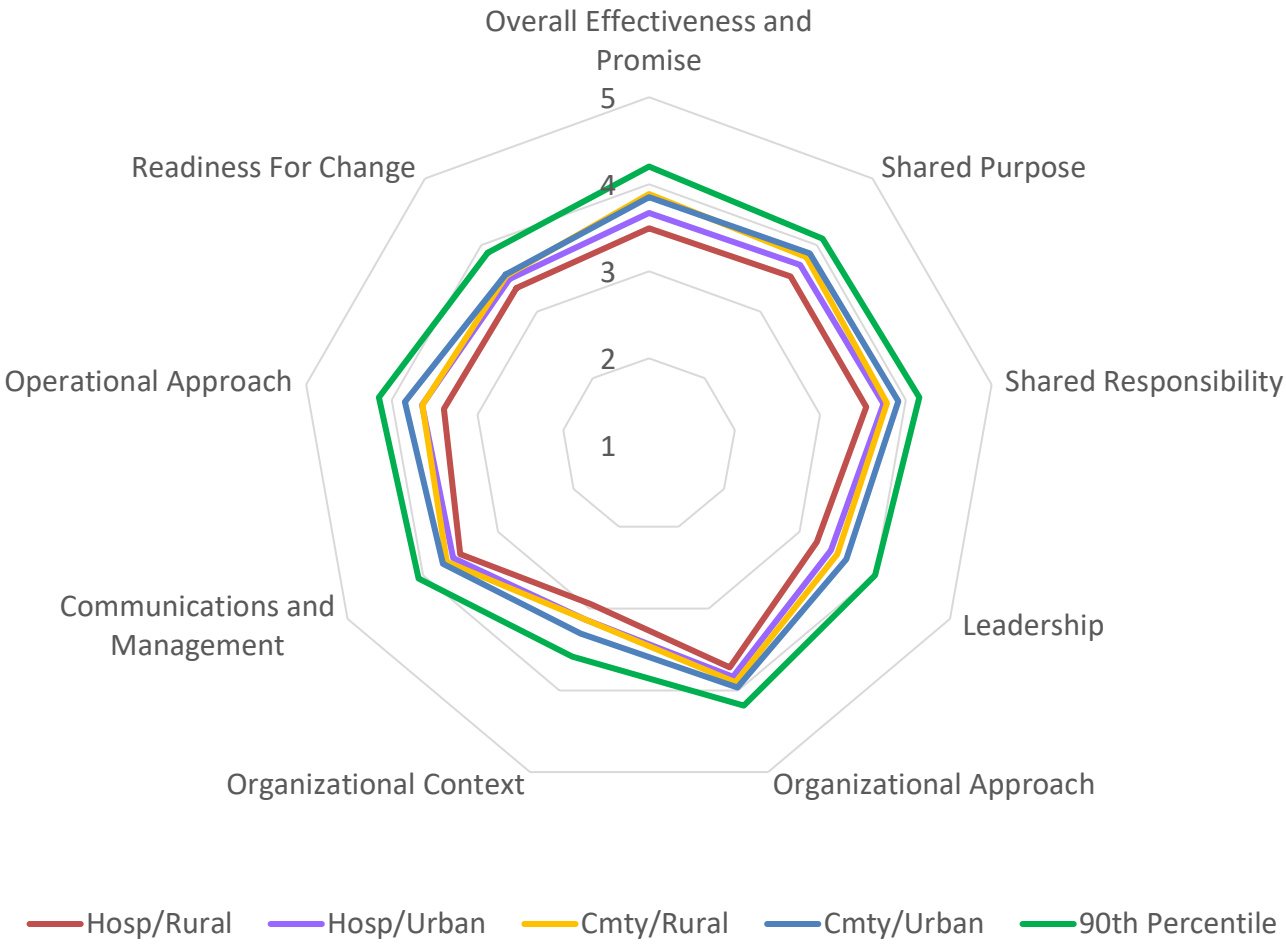


Table 3 provides summary statistics for all domains. The highest between-OHT variance relative to the total variance were observed for the *Leadership* (ICC=0.11), *Operational Approach* (ICC=0.11), and *Overall Effectiveness and Promise* (ICC=0.11). All other domains had ICC statistics less than 0.10 indicating that there remains considerable variance attributable to differences among respondents within OHTs. Among the nine domains, *Leadership* had the highest within-OHT and between-OHT variance (0.87 and 0.11) relative to the other domains.

Table 3. Summary Statistics of OOHT Survey Domains Across the Ontario Health Teams (N=55)

Domain	Mean Across OHTs (SD)	% 4 or 5[1] Response Across OHTs (Range)	# of OHTs with ≥50% selecting 4 or 5[1]	# of OHTs with ≥80% selecting 4 or 5[1]	Between OHT Variance	Within OHT Variance	Total Variance	ICC
Shared Purpose	3.71 (0.33)	67.68% (33.3% – 100%)	49	9	0.05	0.63	0.68	0.07
Shared Responsibility	3.74 (0.31)	66.73% (30.3% - 90.9%)	48	11	0.05	0.56	0.61	0.08
Leadership	3.42 (0.448)	50.85% (8.8% - 83.3%)	28	2	0.11	0.87	0.98	0.11
Organizational Approach	3.85 (0.33)	69.99% (25% - 97.6%)	50	16	0.05	0.52	0.57	0.09
Organizational Context	3.11 (0.36)	37.2% (7% - 81.3%	9	1	0.06	0.67	0.73	0.08
Communications and Management	3.60 (0.42)	56.8% (13.6% - 100%)	36	6	0.08	0.85	0.93	0.09
Operational Approach	3.60 (0.42)	58.31% (13.3% – 89.7%)	41	4	0.10	0.79	0.89	0.11
Readiness for change	3.48 (0.31)	50.9% (14.6% - 85.2%)	27	2	0.03	0.67	0.70	0.05
Overall Effectiveness	3.70 (0.38)	63.81% (14.3% – 100%)	45	10	0.08	0.63	0.71	0.11

[1] 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., Agree) or 5 (e.g., Strongly agree))

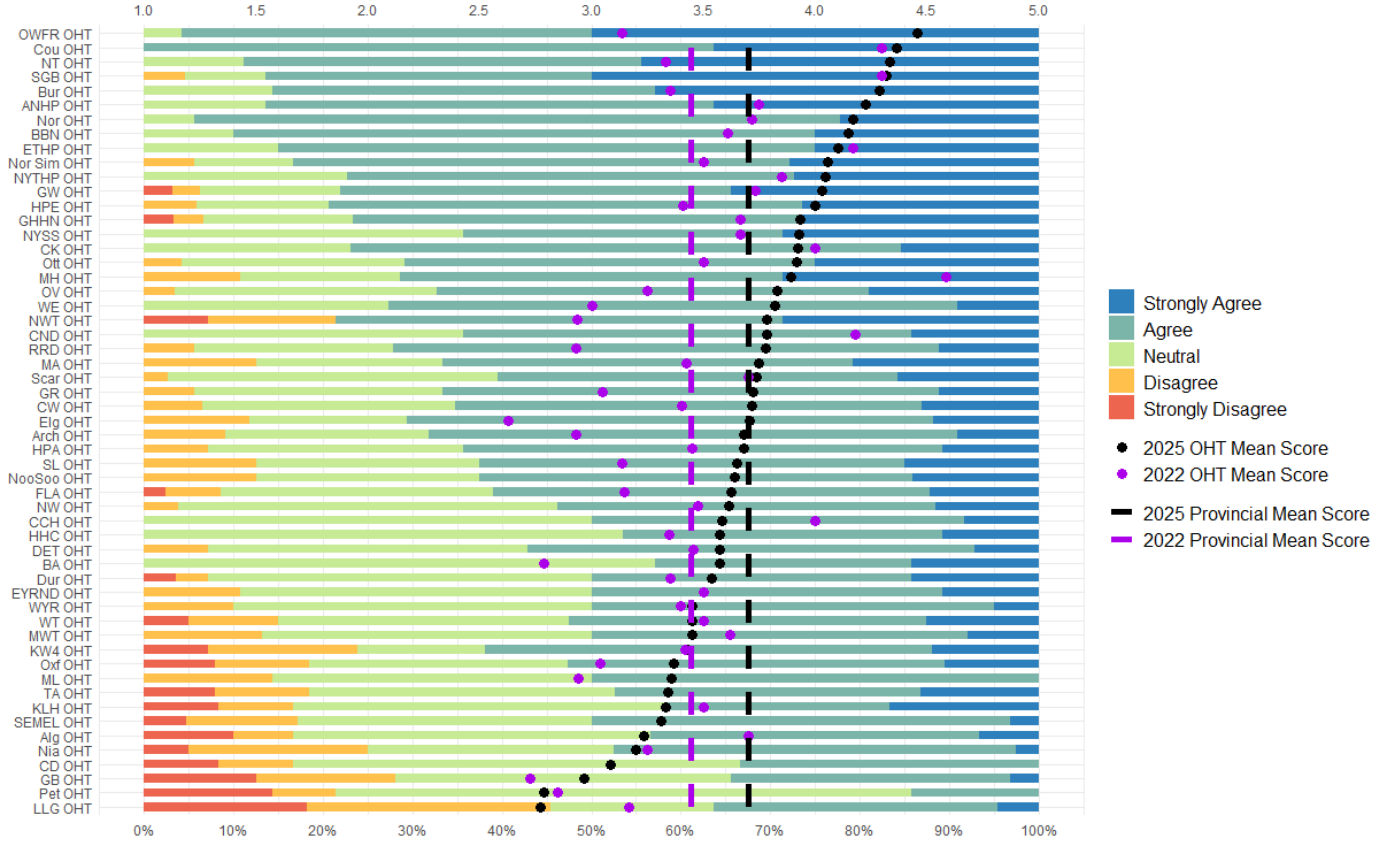
Overall Effectiveness

The summative assessment measure is based on two items with one question focused on a consensus result whether the OHT "has strengthened shared capability to meet the health-related needs of the population" and a success item from the Team Climate Inventory (16): "This OHTs objectives can actually be achieved".

The overall average perception of OHT effectiveness and potential increased by a statistically significant amount from 3.45 in 2022 to 3.70 in 2025. Figure 2 shows that scores increased for most OHTs with many OHTs now scoring middle range after large improvements in these scores. Ottawa West Four Rivers is one OHT with a very large increase in this domain and now reports the highest level of perceived effectiveness amongst all OHTs in the province.

i12 OHTs scored significantly higher than others in this overall self-assessment scale. Cohort 1 reported higher scores for this domain, though these differences were not statistically significant. OHTs approved in cohort 3 increased by the most (0.57 increase; see Appendix C).

Figure 2. Distribution of OOHT Survey Responses to the Overall Effectiveness and promise Domain (2 items) at 2025 by OHT and mean scores at 2022 and 2025



Survey Items – To what extent do you agree with these statements? Generally, in this OHT:
The development of this OHT has strengthened shared capability to meet the health-related needs of your population.
This OHT's objectives can actually be achieved.

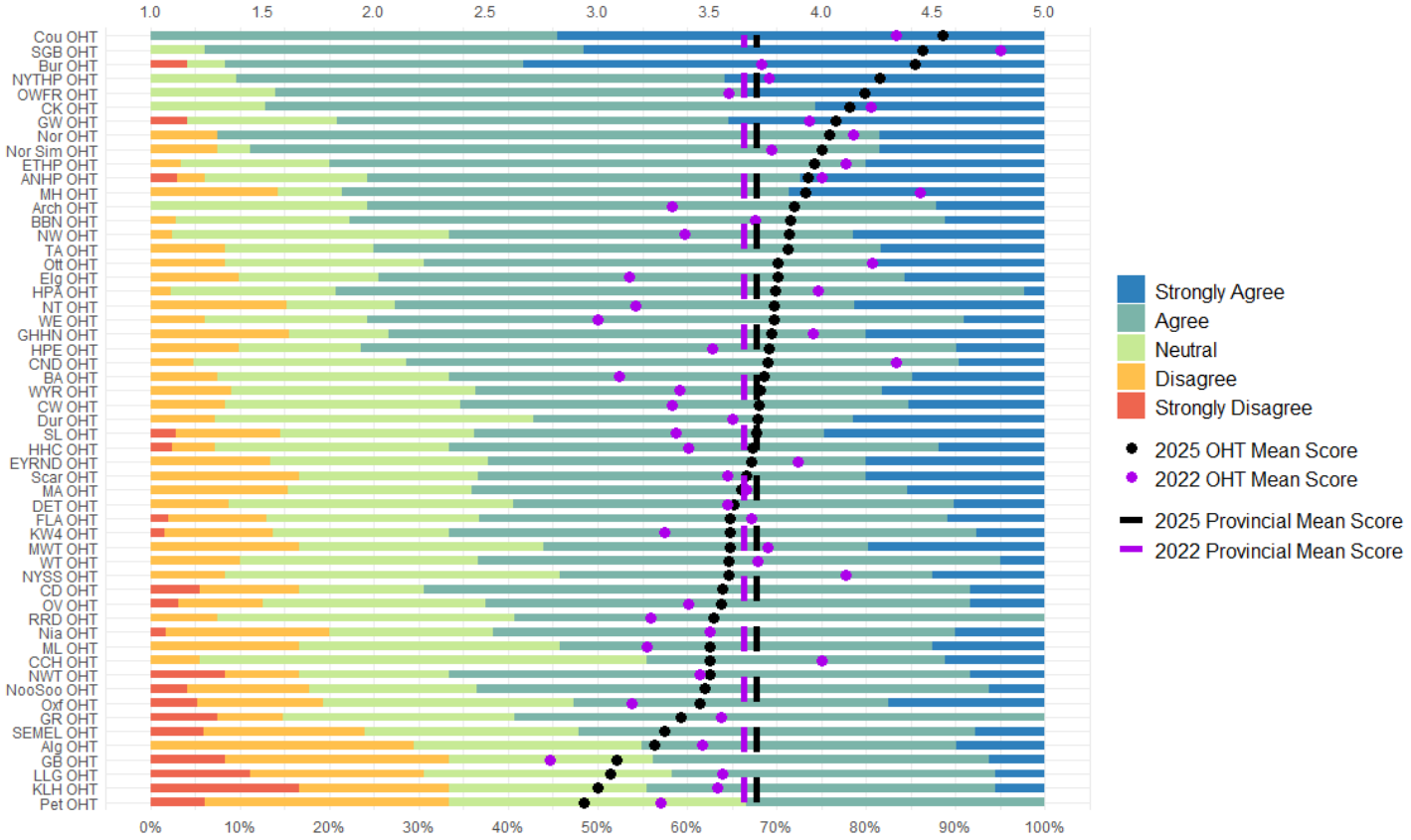
Shared Purpose

Shared purpose refers to the extent to which network members are guided by common values and goals. It is essential for health system transformation, as it reinforces interdependence and commitment to coordinated care across organizations. A shared value system allows governance to adapt to the collaborative requirements in the network.

This scale is based on three items from the Haggerty et al. Measure of Network Integration (11) which assesses the degree to which organizations share common goals and a collective understanding of their work together.

Across the OHTs (Figure 3), the proportion of respondents selecting 4 (moderately agree) or 5 (strongly agree) was 67.7% (range: 33.3% to 100%), at least 80% of respondents selected the top two boxes in 9 OHTs. Many of the teams with lower scores have declined in this assessment since the previous survey. Cohort 1 reported higher scores for this domain, though these differences were not statistically significant; i12 OHTs scored significantly higher than others on most domains.

Figure 3. Distribution of OOHT Survey Responses to the Shared Purpose Domain (3 items) at 2025 by OHT and mean scores at 2022 and 2025



Survey Items - At present in [OHT]:
We have a common vision of how to improve the integration of care.
We understand the role we will play in taking responsibility for the attributed population.
We understand the role we will play in coordinating care.

Shared Responsibility and Accountability

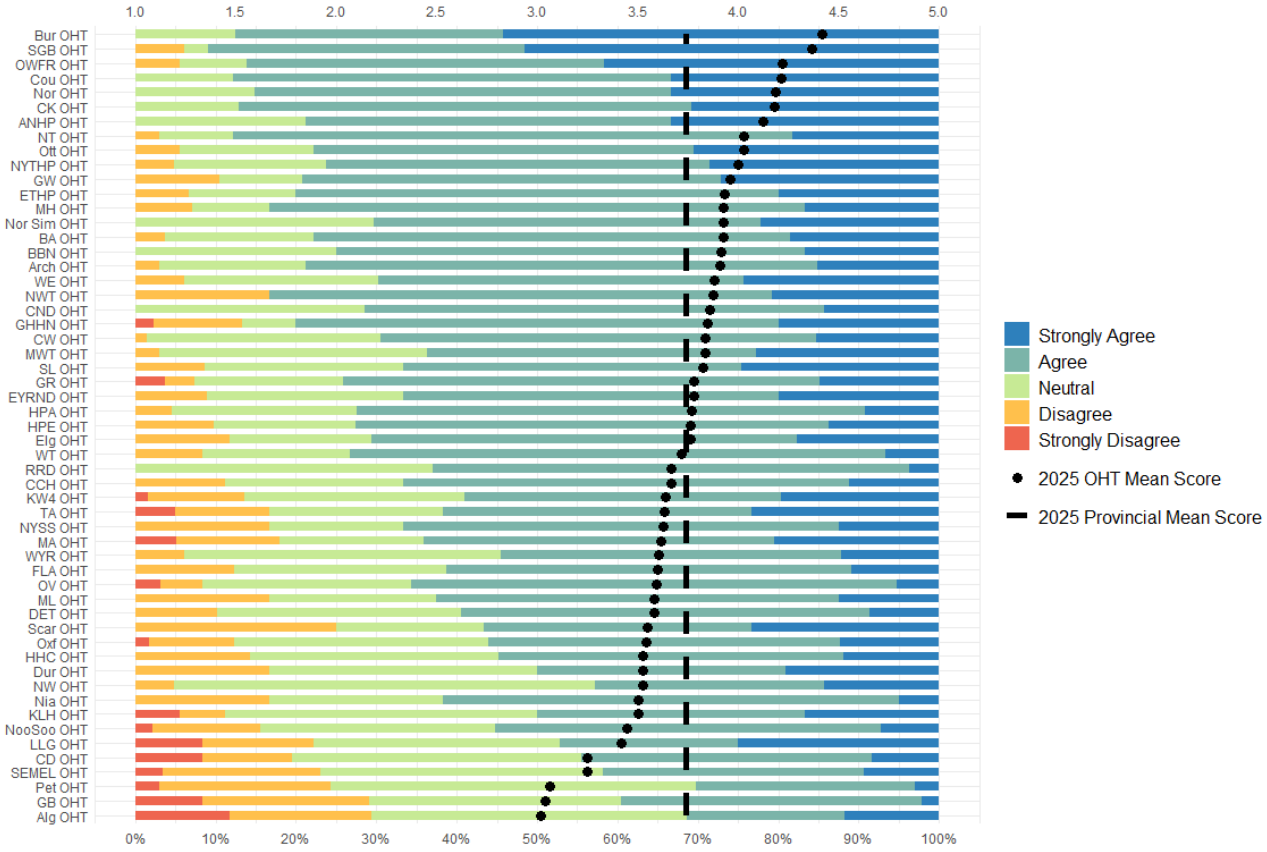
Shared responsibility and accountability refer to the extent to which partner organizations can collectively commit to improving patient care outcomes and hold themselves accountable for their performance. In integrated care models, shared accountability strengthens the alignment across organizations and supports system-wide improvement by ensuring everyone is working toward common goals.

This domain is based on a new scale (3 items) adapted from Haggerty et al. (11). The items assess whether OHT members demonstrate a shared commitment to improving care outcomes, have selected specific measures to assess their program, and have set targets for their OHT using specific measures.

Across the OHTs (Figure 4), the proportion of respondents selecting 4 (moderately agree) or 5 (strongly agree) was 66.7% (range: 30.3% to 90.0%); 48/55 OHTs had at least 50% of respondents selecting the top two boxes; 11/55 OHTs had at least 80% of respondents selecting the top two boxes.

Cohort 1 reported higher scores for this domain, though these differences were not statistically significant; i12 OHTs scored the same as other OHTs on this domain.

Figure 4. Distribution of OOHT Survey Responses to the Shared Responsibility Domain (3 items) by OHT and mean scores at 2025



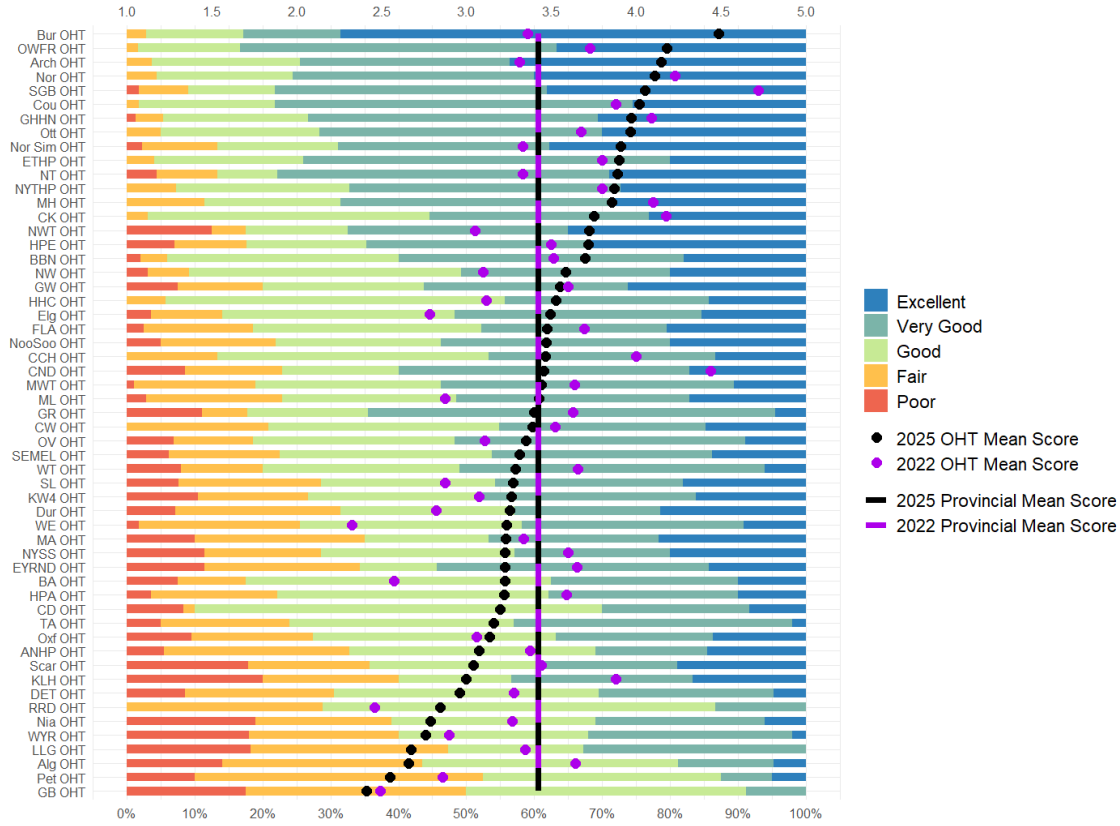
Survey Items - At present in [ohtname]:
We have agreed to share responsibility for achieving improved patient outcomes..
We have selected measures to assess our progress.
We have set targets for our OHT using specific measures.

Leadership

Leadership approach refers to the ability of formal and informal leaders to foster a collaborative, inclusive, and forward-thinking environment. Effective leadership is essential for OHT success as it helps align diverse partners, build trust among members, and to create the conditions needed for team problem solving and innovation. Five items from the OOHT survey comprise the Leadership Approach domain, based on items adapted from the 'Leadership' subscale in the Partnership Self-Assessment Tool - Short version (PSAT-S) (17). Respondents were asked to rate the effectiveness of their OHT's formal and informal leadership at addressing power imbalances among OHT members, communicating the vision, creating an environment where differences of opinion can be voiced, fostering respect and trust, and promoting creativity and different perspectives.

Across the OHTs (Figure 5), the proportion of respondents selecting 4 (moderately agree) or 5 (strongly agree) was 50.9% (range: 8.8% to 83.3%), with 28/55 OHTs having at least 50% of respondents selecting the top two boxes. Two of the 55 OHTs; Burlington OHT and Ottawa West Four Rivers OHT had ≥80% of respondents selecting the top two boxes across the items included this domain. Provincial results are identical to the 2022 survey. Cohort 1 reported higher scores for this domain, though these differences were not statistically significant; i12 OHTs scored significantly higher than others on this domain.

Figure 5. Distribution of OOHT Survey Responses to the Leadership Domain (5 items) at 2025 by OHT and mean scores at 2022 and 2025



Survey Items - Please rate the total effectiveness of your OHT's leadership team in each of the following areas:
Addressing power imbalances among people/members involved in the OHT.
Communicating the vision of the OHT.
Creating an environment where differences of opinion can be voiced.
Helping the OHT be creative, look at things differently, and take risks.
Fostering respect, trust and inclusiveness amongst OHT members.

Leadership – 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. We highlight two items from the *Leadership* domain related to establishing trust among partners, creating an environment where differences of opinion can be voiced (Leader 3), and fostering respect, trust and inclusiveness (Leader 5) below. Across the OHTs, the mean scores for these items were 3.57 and 3.6 respectively in 2025. For the first item (creating an environment where differences of opinion can be voiced) (Figure 6), the proportion of respondents selecting 4 (very good) or 5 (excellent) ranged from 12.5% to 87.5%, with most (36/55) OHTs having at least 50% of respondents selecting the top two boxes and eight OHTs with ≥80% of respondents selecting the top two boxes.

The proportion of respondents selecting 4 (very good) or 5 (excellent) on fostering respect, trust and inclusiveness (Figure 7) varied from 6% to 100%, with most (39/55) having at least 50% of respondents selecting the top two boxes, and eight OHTs had ≥80% of respondents selecting the top two boxes. Five OHTs; Burlington OHT, Couchiching OHT, South Georgian Bay OHT, Ottawa OHT and Ottawa West Four Rivers OHT had ≥80% of respondents rating 4 or 5 on both items. These item-level results show a higher degree of divergence of opinion where there are more respondents within each OHT having both very positive and very negative responses.

Figure 6. Distribution of OOHT Survey Responses to the Item Creating an environment where differences of opinion can be voiced at 2025 by OHT and mean scores at 2022 and 2025

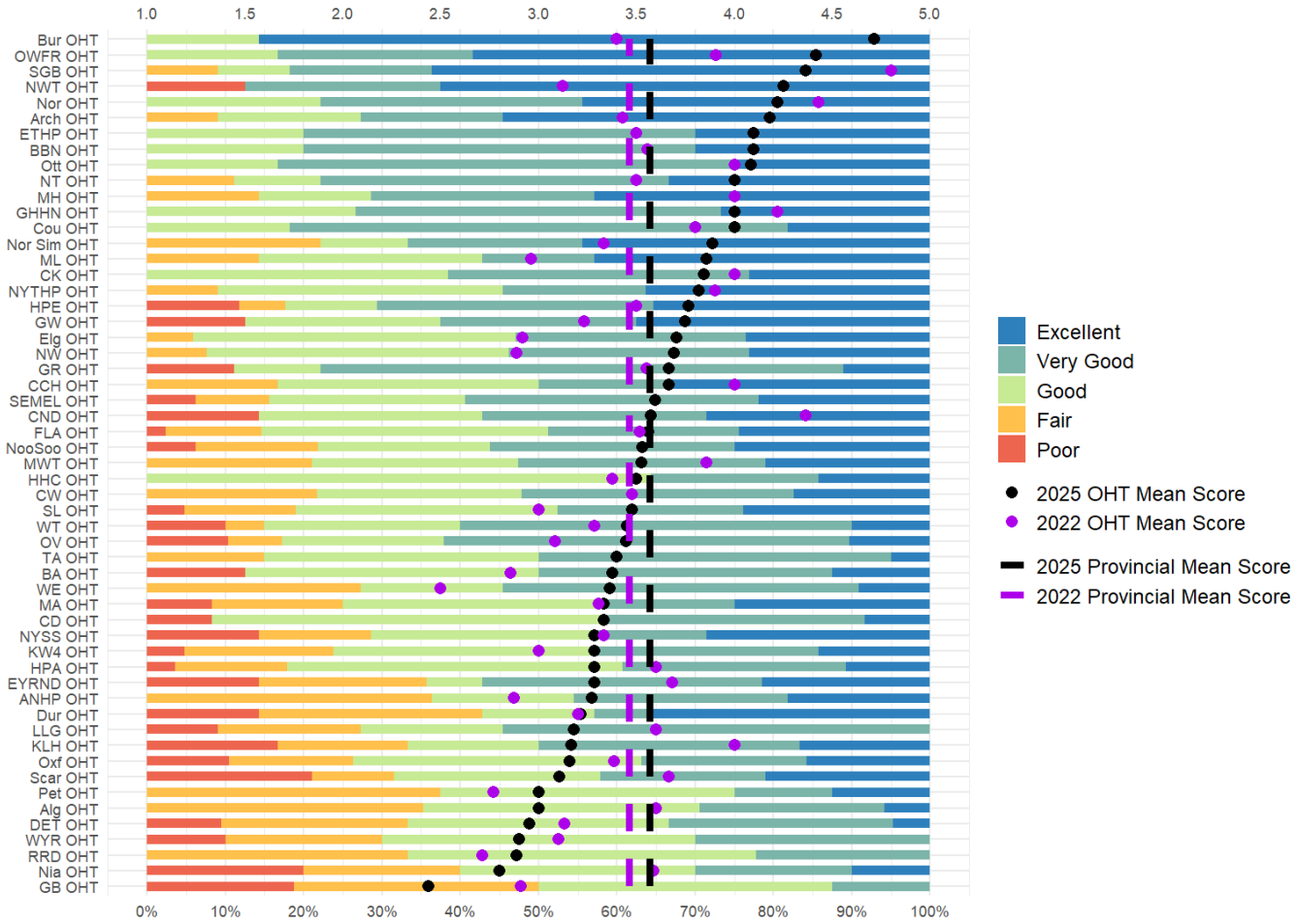
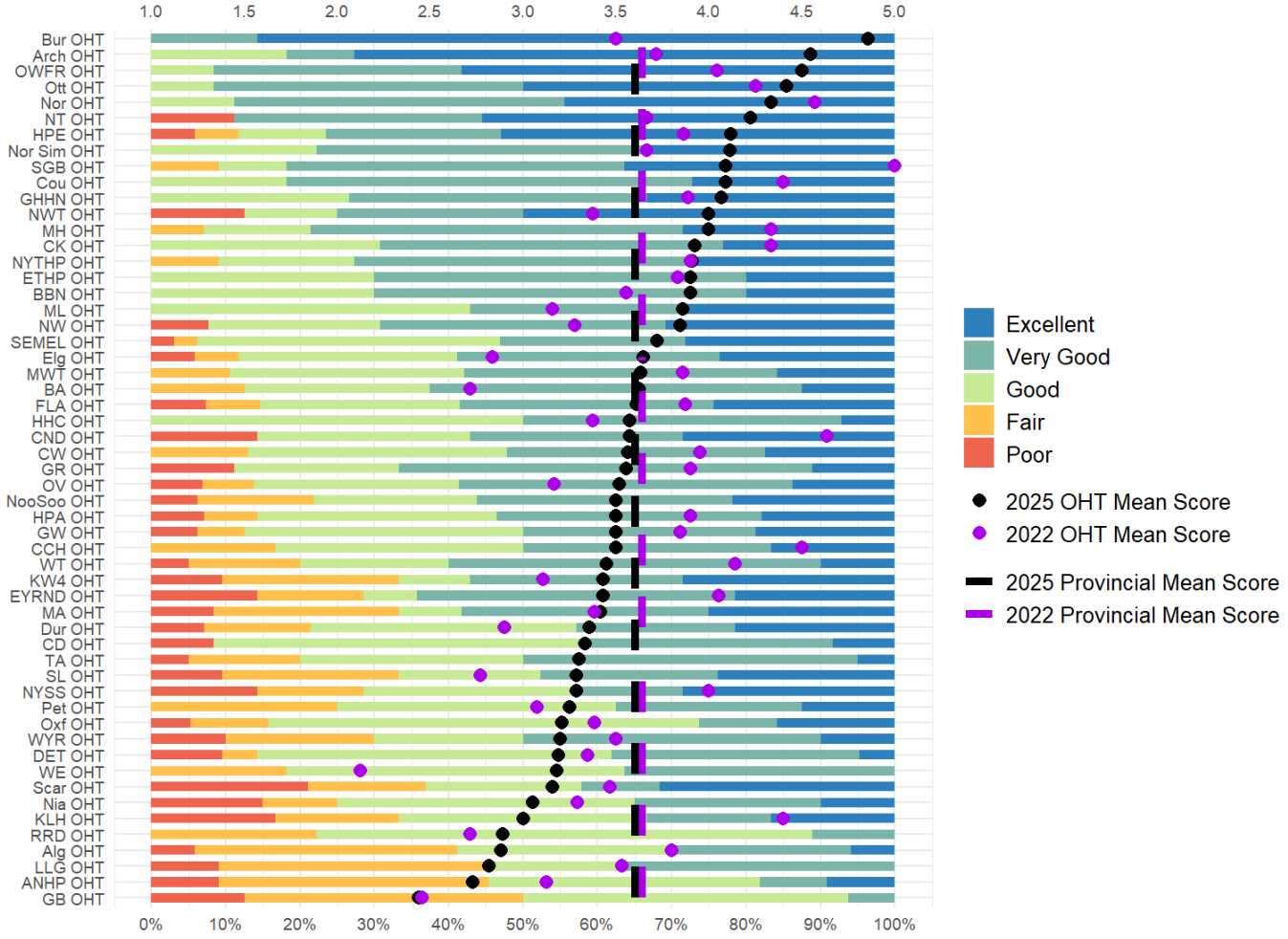


Figure 7. Distribution of OOHT Survey Responses to the Item Fostering respect, trust, and inclusiveness amongst OHT members at 2025 by OHT and mean scores at 2022 and 2025

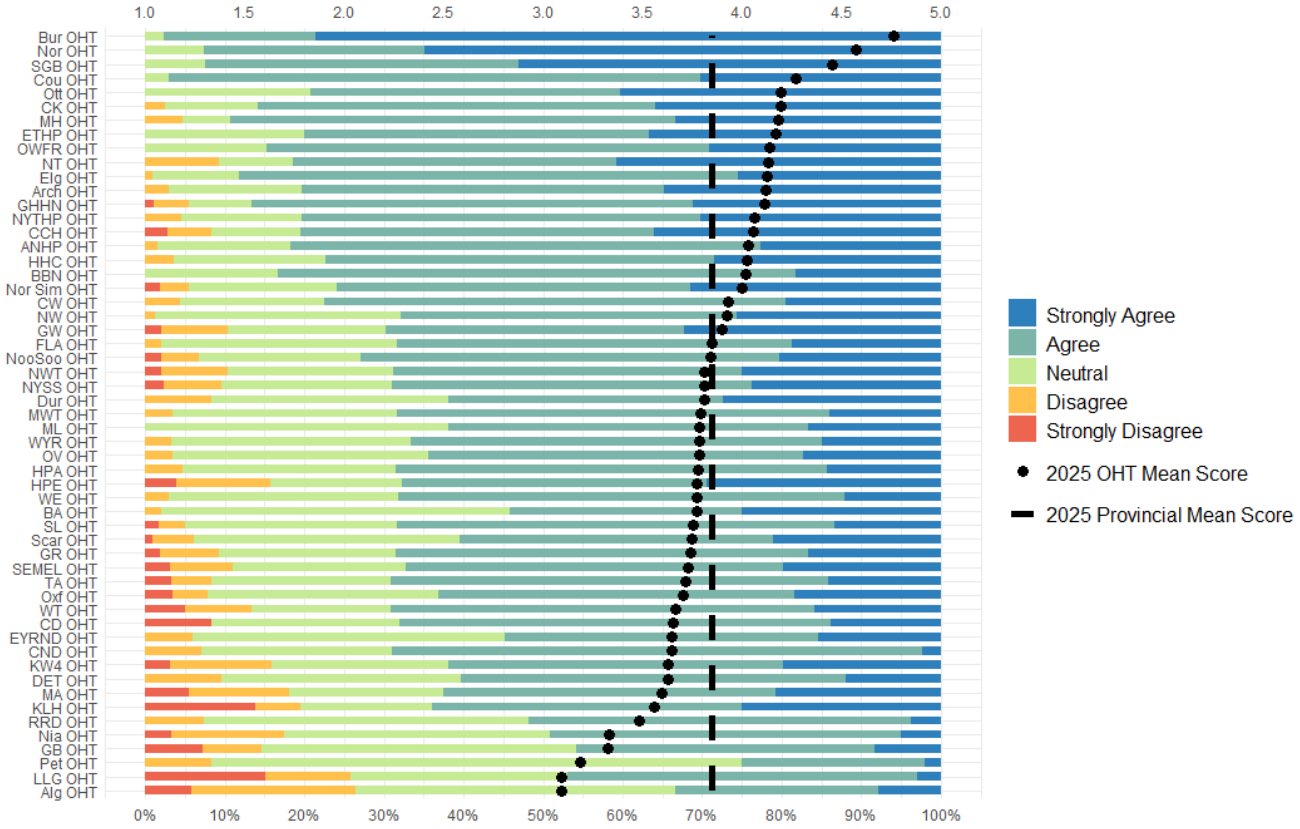


Organizational Approach

Organizational Ambidexterity (OA) refers to an organization's ability to balance two essential and competing capacities of alignment and adaptability(12, 13). The first 3 items measure alignment and assess coherence across systems and leadership, and the absence of waste or contradicting efforts. The latter 3 items measure adaptability or the organization's capacity to challenge outdated practices, shift priorities, and respond flexibly to new demands through creative problem solving and experimentation (12, 18). The balance between these two distinct activities is key to optimizing organizational performance(19, 20). An imbalance can result in the inability to respond to new challenges or the constant search for unrewarding change initiatives for the sake of change (18). This domain is based on six items adapted from Gibson and Birkinshaw (12) and Andriopoulos (13) which captures two sub-domains. The first three items measure the alignment sub-domain. The domain reflects the organization's ability to sustain current performance while adapting to future challenges.

Across the OHTs (Figure 8), the proportion of respondents selecting 4 (moderately agree) or 5 (strongly agree) was 70% (range: 25 to 97.6%), with 50/55 OHTs and 16/55 OHTs with at least 50% and 80% of respondents selecting the top two boxes respectively. Cohort 1 reported higher scores for this domain, though these differences were not statistically significant; i12 OHTs scored significantly higher than others on this domain.

Figure 8. Distribution of OOHT Survey Responses to the Organizational Approach Domain (6 items) by OHT and mean scores at 2025



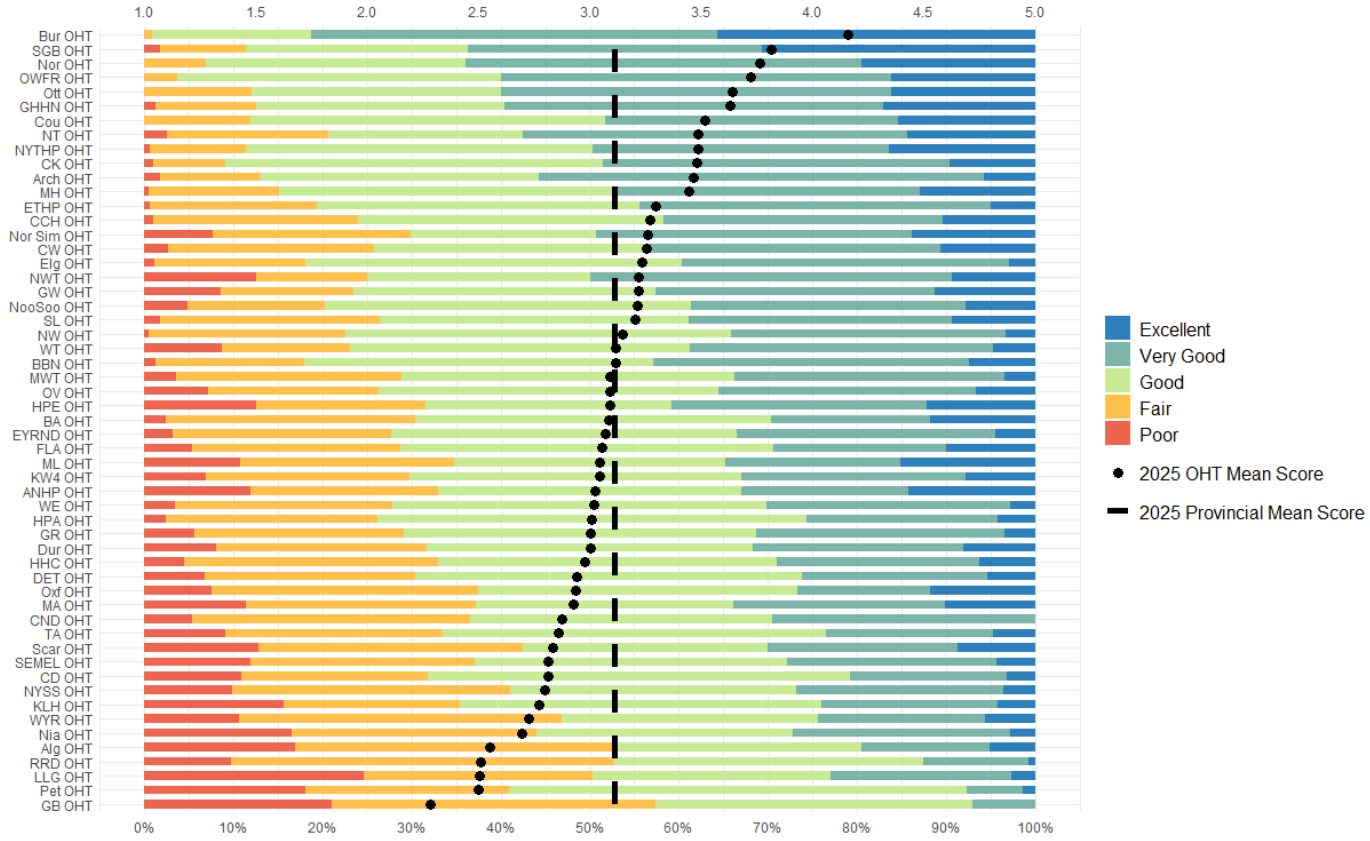
Survey Items – To what extent do you agree with the following statements regarding your OHT?
The leadership team in this OHT works coherently to support the overall objectives of the OHT.
The leadership team in this OHT does not waste resources on unproductive activities.
People in this OHT do not end up working at cross-purposes because our leadership team gives them clear objectives.
The leadership team in this OHT encourages people to challenge outmoded traditions and practices.
The leadership team in this OHT is flexible enough to allow the OHT to respond quickly to changes in context.
The leadership team evolves rapidly in response to shifts in our OHT priorities.

Organizational Context

Organizational context refers to the systems, processes, and cultural elements that shape behavior within a business unit and enable individuals to exercise judgment in balancing alignment and adaptability(12). A strong organizational context promotes initiative, cooperation, and learning, which are critical factors to enable innovation and responsiveness in transforming the health system. This domain includes two sub-domains: a. performance management and b. social context, using items adapted from Gibson and Birkinshaw's empirical research using Goshal and Bartlett's organizational theory for quality management (12, 21). The performance management sub-domain (7 items) captures elements that promote discipline and stretch, such as setting clear expectations and encouraging ambition. The social context sub-domain (9 items) captures support and trust, which are key elements that foster psychological safety, collaboration, and adaptability.

Across the OHTs (Figure 9), the proportion of respondents selecting 4 (moderately agree) or 5 (strongly agree) was 37.2% (range: 7% to 81.3%), with 9/55 OHTs with at least 50% of respondents selecting the top two boxes. Only Burlington OHT had ≥80% of respondents selecting the top two boxes across the items included this domain. Cohort 1 reported higher scores for this domain, though these differences were not statistically significant; i12 OHTs scored significantly higher than others on this domain.

Figure 9. Distribution of OOHT Survey Responses to the Organizational Context Domain (16 items) by OHT and mean scores at 2025



Survey Items – Please rate how well the members of your OHT are able to:
Set challenging/aggressive goals.
Issue creative challenges to organizations, instead of narrowly defining tasks.
Be more focused on getting the job done well than gaining personal recognition.
Make a point of challenging their people to excel.
Reward or correct actions based on rigorous measurement of performance against goals.
Hold people accountable for their performance.
Use feedback to improve performance.
Devote considerable effort to developing their teams.
Give everyone sufficient authority to do their jobs well.
Push decisions down to the lowest appropriate level.
Give ready access to information that others need.
Work hard to develop the capabilities needed to execute our overall strategy/vision.
Base decisions on facts and analysis, not politics.
Treat failure (in good effort) as a learning opportunity, not something to be ashamed of.
Are willing and able to take prudent risks.
Set realistic goals

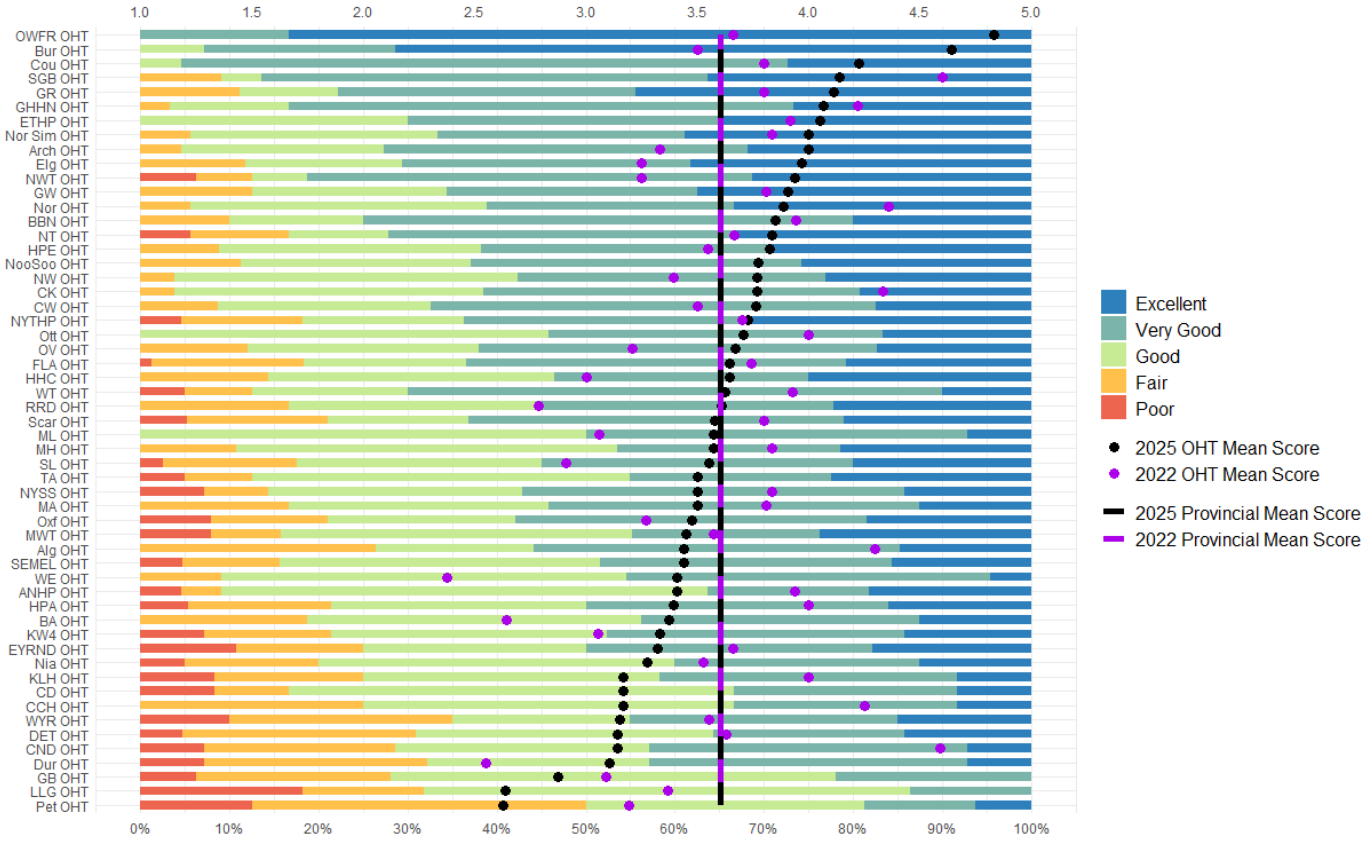
Communications and Management

Communication 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 (22). These functions are critical to enable collaboration and ensuring smooth operation of integrated care initiatives.

The Communications and Management domain was composed of 2 items adapted from the 'Administration and Management' sub-scale from the PSAT-S. The items asked respondents to rate their OHT's effectiveness in fostering communication amongst members and organizing OHT member activities such as meetings and projects.

Across the OHTs (Figure 10), the proportion of respondents selecting 4 (moderately agree) or 5 (strongly agree) was 56.8% (range: 13.6% to 100%), with 36/55 OHTs with at least 50% of respondents selecting the top two boxes. Six of the 55 OHTs had ≥80% of respondents selecting the top two boxes across the items included this domain. Cohort 3+ reported higher scores for this domain, though these differences were not statistically significant; i12 OHTs scored higher than others on this domain but not significantly.

Figure 10. Distribution of OOHT Survey Responses to the Communications and Management Domain (2 items) at 2025 by OHT and mean scores at 2022 and 2025



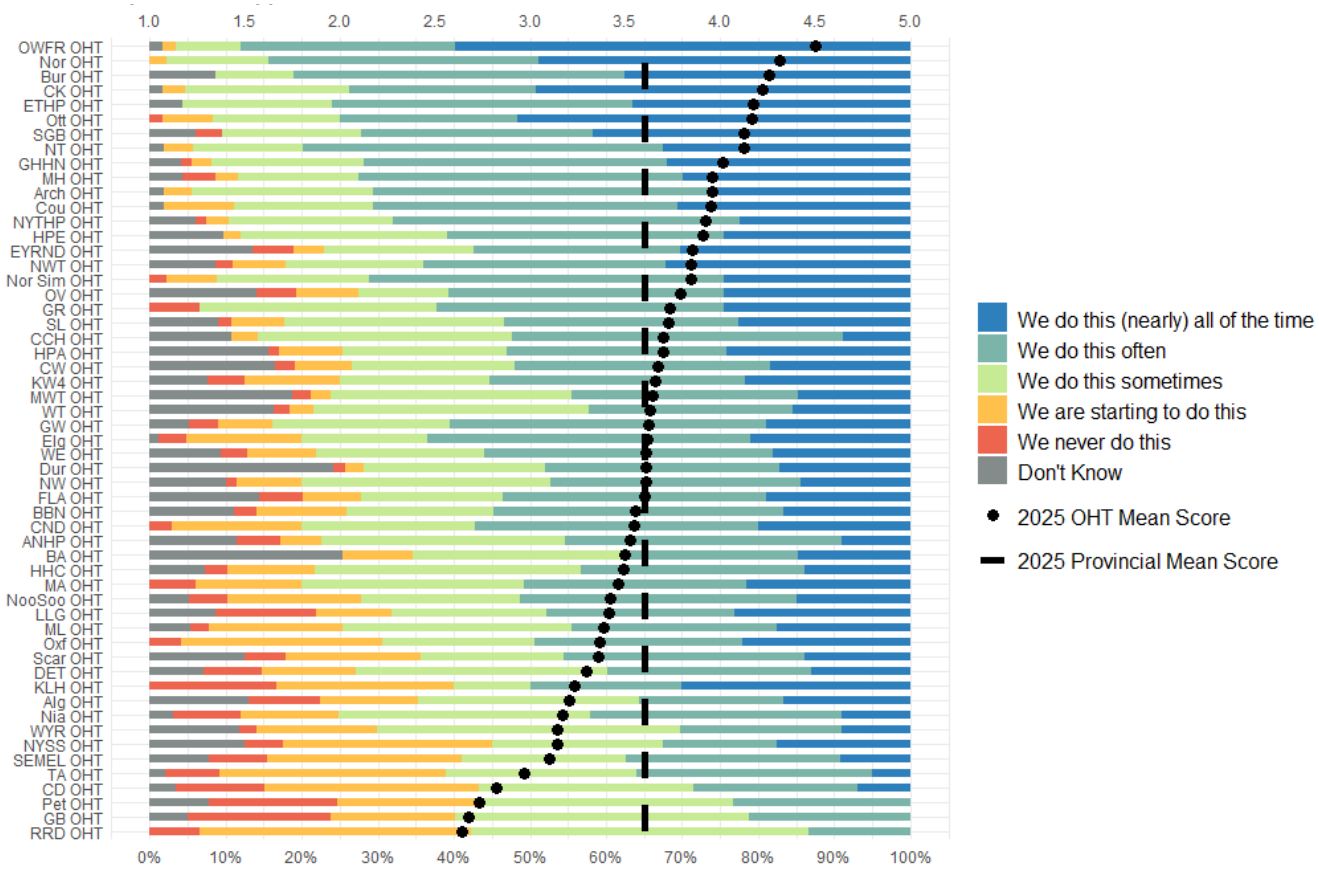
Survey Items – Please rate the effectiveness of your OHT in carrying out the following activities:
Fostering communication amongst members.
Organizing OHT member activities, including meetings, working groups and projects

Operational Approach

The Operational Approach domain draws off the Learning Health Systems concept, which was introduced as a step towards moving beyond the traditional approach of research passively informing care delivery and moving towards an approach that incorporates research within care delivery (5). This framework consists of 5 “Learning Gears” that represent the various types of research methods and evidence synthesis that are needed to drive continuous learning, improvement and equity across all levels of the health system(5). This domain is new to the survey and the respective items were the only ones in the survey that allowed for a ‘don’t know’ response which was commonly selected by respondents.

This scale measured the frequency with which OHT respondents reported each activity. Across the OHTs (Figure 11), the proportion of respondents selecting 4 (often) or 5 ('nearly' always) was 58.3% (range: 13.3% to 89.7%), with 41/55 OHTs with at least 50% of respondents selecting the top two boxes. Four of the 55 OHTs; Ottawa West Four Rivers OHT, Burlington OHT, Northumberland OHT, and North Toronto OHT had ≥80% of respondents selecting the top two boxes across the items included this domain. Cohort 1 reported higher scores for this domain, though these differences were not statistically significant; i12 OHTs scored higher than others but not significantly on this domain.

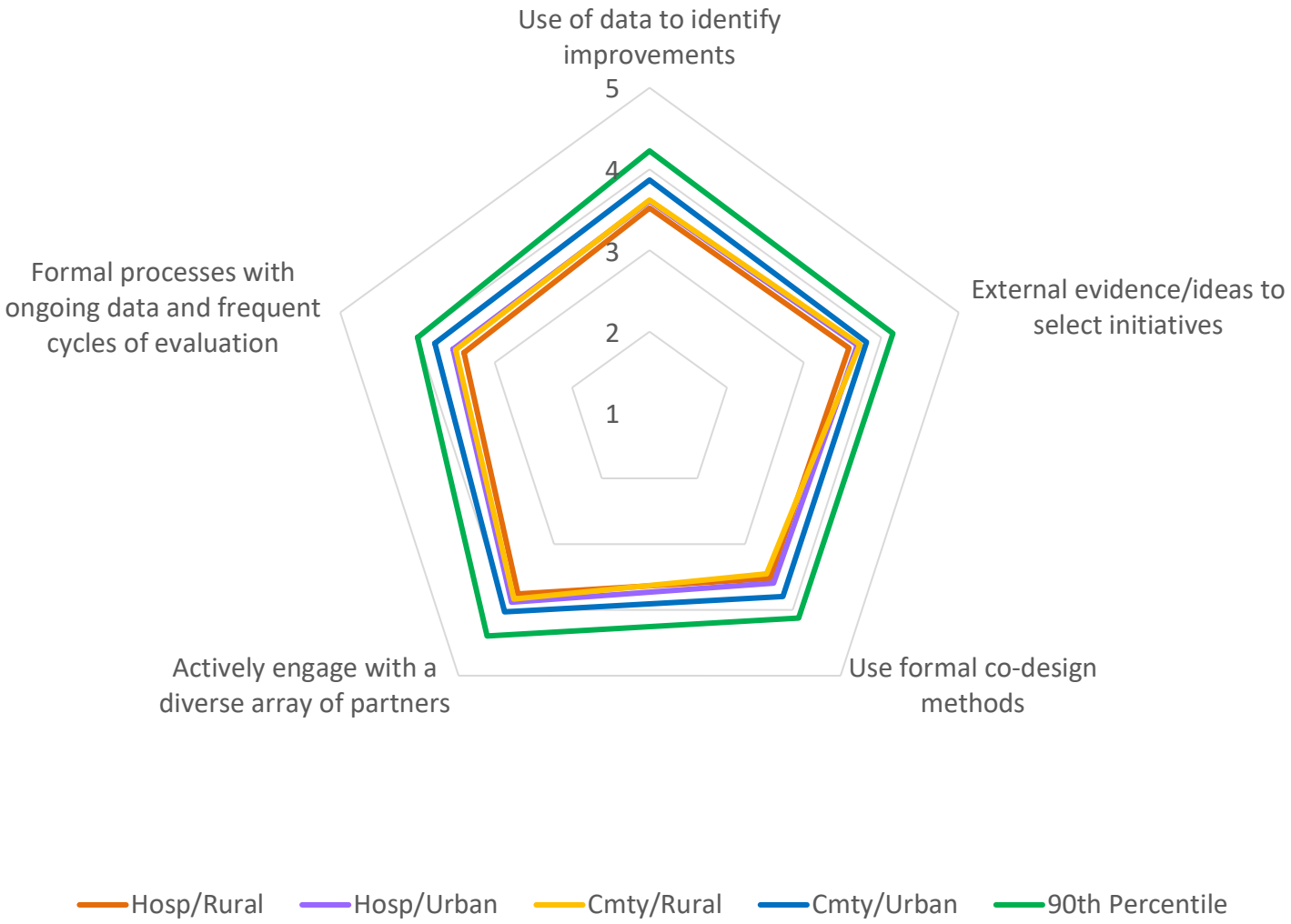
Figure 11. Distribution of OOHT Survey Responses to the Operational Approach Domain (5 items) by OHT and mean scores at 2025



Survey Items – At present, in [ohtname]:
We use data to identify where improvements can be achieved in our attributed population.
We use external evidence and ideas to select and guide initiatives.
We use formal co-design methods such as structured deliberations and techniques with a diverse array of partners including patients and family and service/care providers in the co-design/co-creation of solutions.
We engage with a diverse array of partners to understand what drives behaviour and address foreseeable barriers to the implementation of programs.
We use formal processes with ongoing data and frequent cycles of evaluation and feedback to assess performance against our objectives.

Figure 12 illustrates the mean scores of items related to *Organizational Approach* domain by lead organization, geography and the provincial 90th percentile. Across the 55 OHTs, the question with the highest rating was *Actively engage with diverse array of partners* (mean=3.82 out of 5). The question with lowest ratings was *Use formal processes with ongoing data and frequent cycles of evaluation* (means of 3.51 out of 5). Community supported organizations located in Urban/Suburban areas higher in all questions compared to all other lead organization/geography categories.

Figure 12. Overall Mean, 90th Percentile Scores and Mean Scores by Geography and Lead Organization Type by Organizational Approach items (N=55)

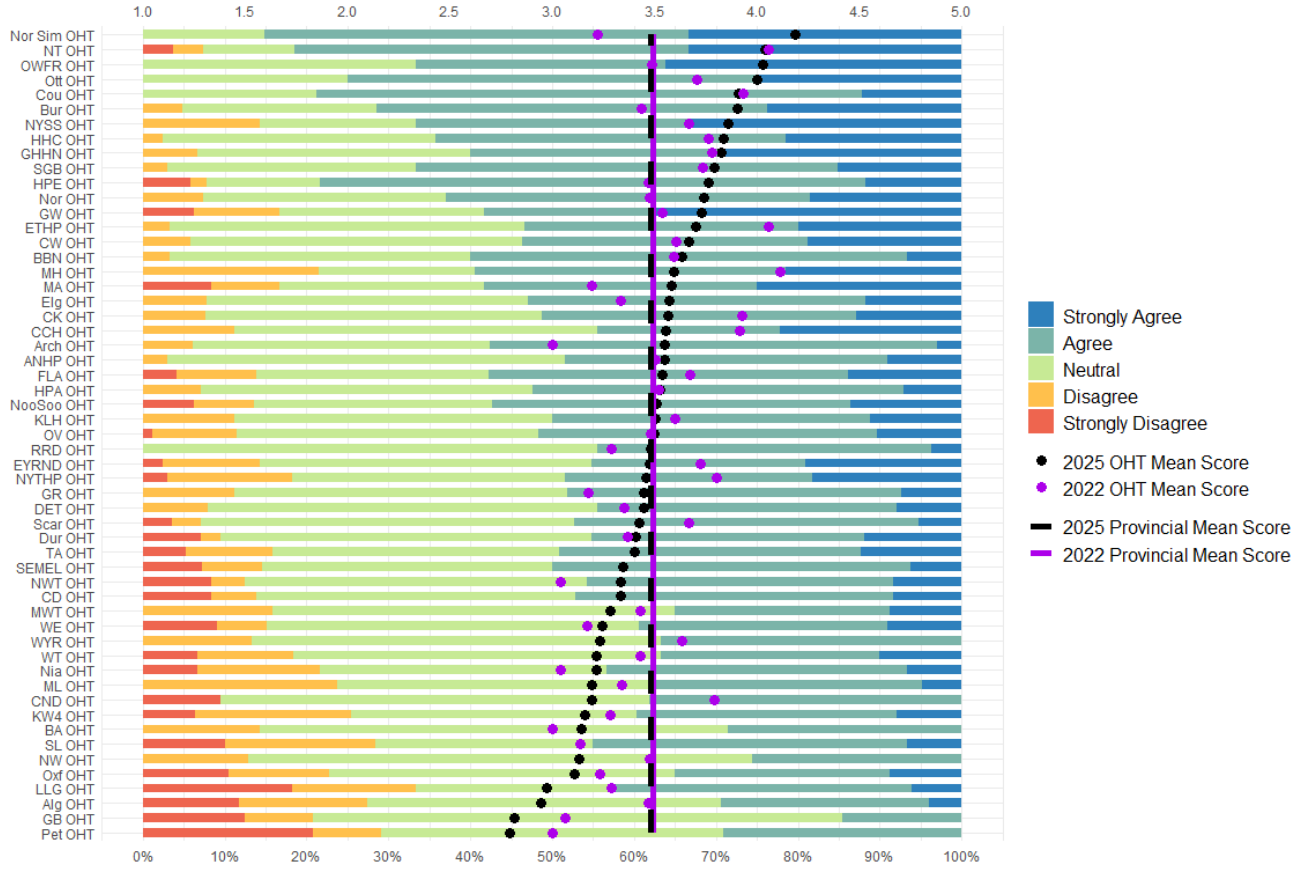


Readiness for Change

Readiness for change is widely recognized as a key factor in gaining initial support for organizational transformation (23). It reflects the degree to which individuals believe that a change is needed, beneficial, and worth the effort. In the context of the healthcare system, where purposeful and system-wide change is being introduced, fostering readiness is essential. Without it, differences in beliefs between leadership and organizational members can create resistance. Readiness for change increases the likelihood of successful and sustained transformation. The Readiness for Change domain includes three items adapted from the 'appropriateness' factor in the instrument developed by Holt et al. to gauge readiness for organizational change at an individual level (23). The first item asked respondents whether they felt their organization would benefit from the change. The second explored whether the change will make their role easier. The third asked whether the respondents feel that adopting the changes will be worthwhile in the long term.

Across the OHTs (Figure 13), the proportion of respondents selecting 4 (moderately agree) or 5 (strongly agree) was 50.9% (range: 14.6% to 85.2%), with 27/55 OHTs with at least 50% of respondents selecting the top two boxes. Two of the 55 OHTs; North Simcoe OHT and North Toronto OHT had ≥80% of respondents selecting the top two boxes across the items included this domain. Overall results were similar to previous years (average of 49.7%, range: 19.4%-77.8%). Cohort 1 reported higher scores for this domain, though these differences were not statistically significant; i12 OHTs did not score higher on this domain.

Figure 13. Distribution of OOHT Survey Responses to the Readiness for Change Domain (3 items) at 2025 by OHT and mean scores at 2022 and 2025

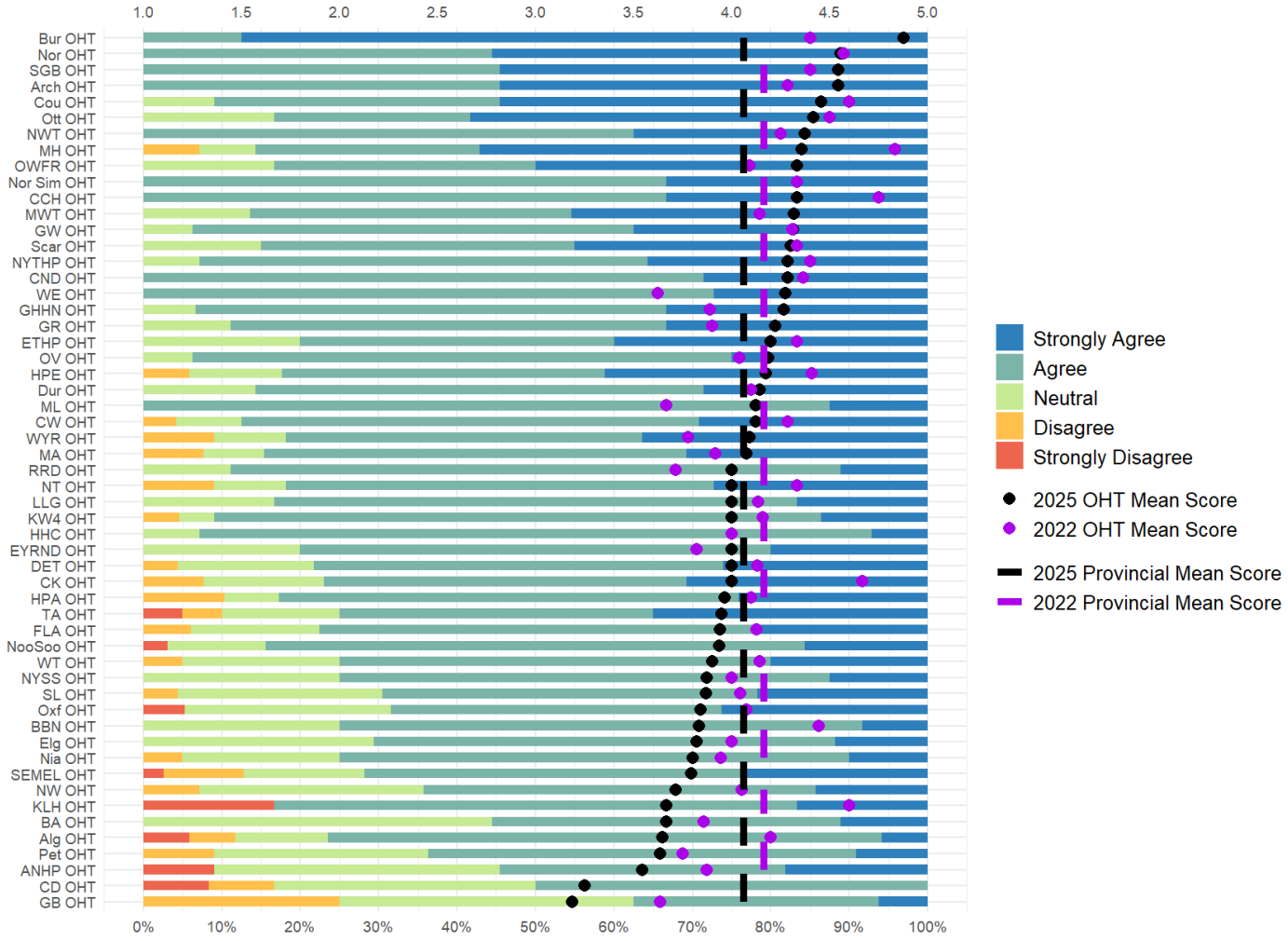


Survey Items –To what extent do you agree with the following statements:
I think that my organization/practice setting will benefit from this change
This change will make my role easier
In the long run, I feel it is worthwhile for me that the organization/practice adopted this change

Other OOHT Survey Items

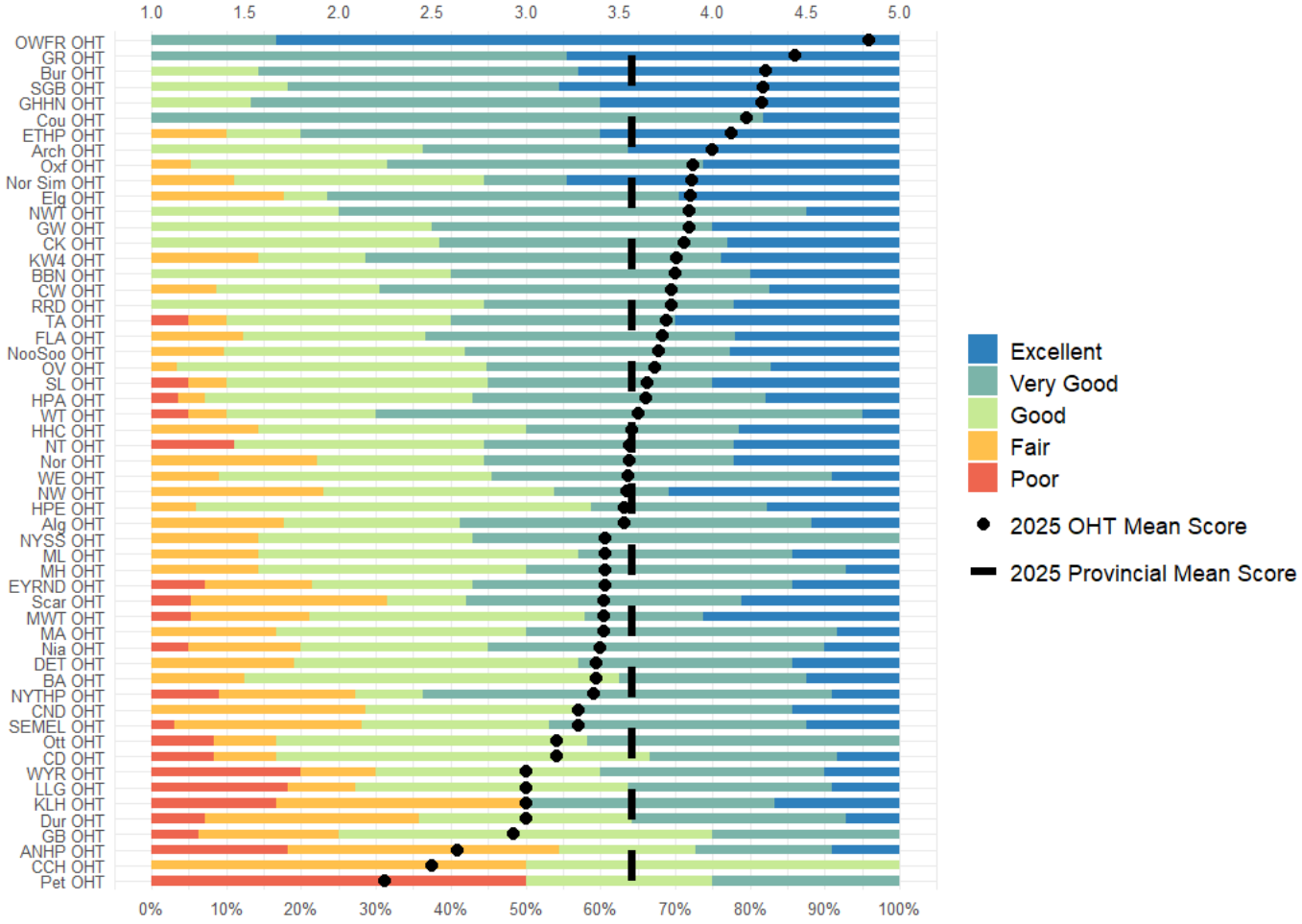
There were two additional items that were not part of the nine domains. The first question asked if the respondent's organization or practice setting's shared values were compatible with those of other members of the OHT. Ratings on this question were generally very high with a mean score 4.06 out of 5 (Figure 14). Across the OHTs, the proportion of OHT respondents selecting 4 (moderately agree) or 5 (strongly agree) varied from 38% to 100%. More than two-thirds of OHTs (36/55) had ≥80% of respondents selecting the top two boxes and ten OHTs had 100% of their respondents selecting the top two boxes. Compared to 2022, the overall mean score in 2025 was slightly lower (4.16 vs 4.06). The lowest mean decreased (3.63 in 2022 vs 3.19 in 2025) and the highest mean has increased in 2025 compared to 2022 (4.83 vs 4.88).

Figure 14. Distribution of OHT Survey Responses to the Item Your organization's shared values are compatible with those of other OHT members at 2025 by OHT and mean scores at 2022 and 2025, by OHT



The second question asked whether their OHT shares communications about its activities and context to members. Ratings on this question were moderately high (mean score 3.57 out of 5) and a standard deviation of 0.53 (Figure 15). Across the OHTs, the proportion of OHT respondents selecting 4 (moderately agree) or 5 (strongly agree) varied from 0% to 100%. Only 7/55 had ≥80% of respondents selecting the top two boxes.

Figure 15. Distribution of OHT Survey Responses to the Item Communicating information about the OHT activities and context to members by OHT and mean scores at 2025



D.4. Qualitative Responses

The survey also ended with an open-ended question that asked respondents whether they had anything to add that was not covered and is important to share. While the responses will receive full attention in a subsequent analysis and report, we summarize here the themes from an AI-supported thematic summary.

Theme 1. Addressing Power Asymmetries

Many comments described how power asymmetries were experienced by OHT members. Some respondents felt that larger (mostly acute) organizations were driving the efforts, while others felt that their OHT supported inclusive consensus-based decision-making.

> "We have brought concerns forward regarding our feeling of being left out many times, since inception of the OHT and nothing was addressed. We feel we are just a token member and don't have a voice as if we speak we would be ostracized. Only big organizations are recognized as having knowledge or expertise."

> "It can sometimes be challenging with hospitals and the power they come to the table with. The overall model helps with this but it remains a challenge that won't be changed until our provincial focus changes."

> "We need to ensure that the voice of primary care does not take over. When we choose to invest in one area (i.e. AI) the platform needs to be applicable to all the collaboration"

> "We have a planning table made up of all the organizations and family/patient members who make all the decisions using a consensus model."

A related theme was variation across OHTs experienced by some provincial or regional organizations that crossed OHT borders. This was most commonly expressed from a home care perspective.

> "There are significant differences among OHTs in how Home Care Service Providers engage with them. ... Some OHTs have advised that Home Care Service Providers are already represented and therefore additional participation is not necessary. ... Furthermore, there is no established mechanism to ensure that all Service Providers receive relevant OHT information, despite its potential implications for Home Care providers operating in the region."

Theme 2. Capacity, Resources and Competing Priorities

A common challenge expressed by a variety of respondents related to capacity at the leadership and the workforce levels which also varied across sectors.

> "Being a part of OHT meetings, committees, etc. is a full-time job and not feasible for our small organization. This leaves me with concerns that we will be left out of important conversations and will not be thought of when funding decisions are made."

> "With no continued investment in capacity building and no strategic road map for OHTs with support.....we will make progress but not enough. All the quality and improvement resources and capacity building in the system are gone..."

> "The "forced" partnerships, the competing for money, the additional work this has placed on the leaders of primary care teams is taking its toll. The lack of compensation increases for community health care despite the increased workloads is causing a human resources HR crisis that directly impacts OHT work."

Theme 3. System Direction and Mandate from the Ministry of Health and Ontario Health

Several comments highlighted a perceived tension between provincial healthcare policy direction and local OHT priorities. Respondents indicated a sense that there was insufficient clear and consistent provincial guidance at the same time as the provincial ministry and agencies exercised controls that limited local innovation and decision making. Respondents felt OHTs lacked sufficient mandate and autonomy to enact local change.

> "There continues to be a divide between the changing focus and expectations of Ontario Health and the OHT's continuous advocacy that may or may not align with Ontario Health's ever changing priorities. This includes the Ontario Health priority around the hospitals."

> "The OHT leadership team and Board know what is needed in the community to improve health outcomes - is hindered by lack of Ministry's commitment to fully mature state; is also hindered as small bits of one time funding come in that carry lots of paperwork and administrative burden - these available funding streams are not always aligned with what we would prioritize locally. We are falling short of impacting patient care at a population health level because we do not have authority/operational levers to influence these measures. Feels like we are stalled and not moving to the next phase, despite appetite and knowledge of what the next steps are locally"

> "If the OHT had the authority we could make great changes. Too much provincial direction that is not in the best interests of change but will maintain status quo. And given the state of our healthcare system that is not ok."

Theme 4. Primary Care Advancement

Many comments pointed to a lack of consensus regarding primary care engagement, leadership and planning. Primary care physicians do not have a history of strong engagement in health system integration efforts in Ontario, and a culture of engagement and system (co-) leadership has yet to be substantiated. Primary care is hence both the backbone and the bottleneck. The emergence of Primary Care Networks (PCNs) may help, if they are well organized and structured to fit the OHT model (24).

> "Engagement has been spotty. It's been unclear what the goals are, or how my team and the population we serve can benefit. Recent work focused on building primary care teams and PCNs is adding value."

> "The OHT does not understand what a primary care network is or how to form one, especially the leadership of a primary care network."

> "We are an OHT in flux and development. If you asked me these questions a year ago, I would be answering very differently as they had no meaningful engagement with family docs. Under [name's] leadership there has been a huge shift BUT more work with the partners needs to be done. We are led by community health centres and hospitals. It should be led by primary care voices that are not community health centres (very different reality that does not foster engagement) This change has to happen slowly. I don't think we are aligned as the leadership table has more partners in the community and not enough docs. I feel that it is important to engage the docs first and then we can accomplish what the OHT has to do. Without engagement we can't move the OHT forward. So if you ask me to fill this in 6 months, I will probably be more optimistic"

Theme 5. Implementation Deficits

To date, OHTs have been experienced as being largely planning tables. Many of the structural deficits and organizational silos that OHTs were intended to address remain in place without a clear path to structural change. Some respondents suggested opportunities to reallocate existing resources to better support OHT

progress. While technical changes including data sharing of clinical information were commonly referenced, many respondents also indicated the importance of adaptive changes including development of trusting relationships amongst providers, fostered by open communication and enabled by time.

> "I think the OHTs have a challenging task, and that getting buy-in from all of the signatories is there in theory, but the implementation is quite the challenge and I think this is where we get skeptical. I think there is redundancy between Ontario Health regions and OHTs too - and I think it would be great for SSPDI teams and PAFA teams to move out of Ontario Health to the OHTs to remove them from the bureaucracy of Ontario Health so that they can actually do the work they need to do without as many rules. The OHTs could leverage the expertise of these groups."

> "Perhaps there is nothing to share with respect to actions and results? The overall goal of the OHT is good; but the implementation of actions to improve collaboration has not transpired - yet."

> "The low rules and disorganized environment that was largely unsuccessful during the implementation of Health Links, remains unsuccessful with OHTs."

> "It really does feel like there are two paths to OHT development. There is the integrated patient care team path that is about home care and primary care at the start and expanding from there - an approach rooted in community consultation. There is also an accountability-based path that has come down from Ontario Health - use these assets, improve these disease-specific pathways. I think that has led to a place where the organizational leaders are trying to balance the goals - and it results in less consultation with the clinicians practicing in the community because there is not a clear message to convey to them about where the OHT is headed."

For a range of reasons, many respondents indicated very positive experiences overall.

> "Very impressed with the leadership at the OHT at all levels. The team represents the OHT well and staff show up as positive and engaged."

> "I feel that our local system continues to benefit greatly from the leadership of the [name] OHT. The key in this next phase will be strong levers of integration and a clear directive for the path forward."

D.5 Governance Results

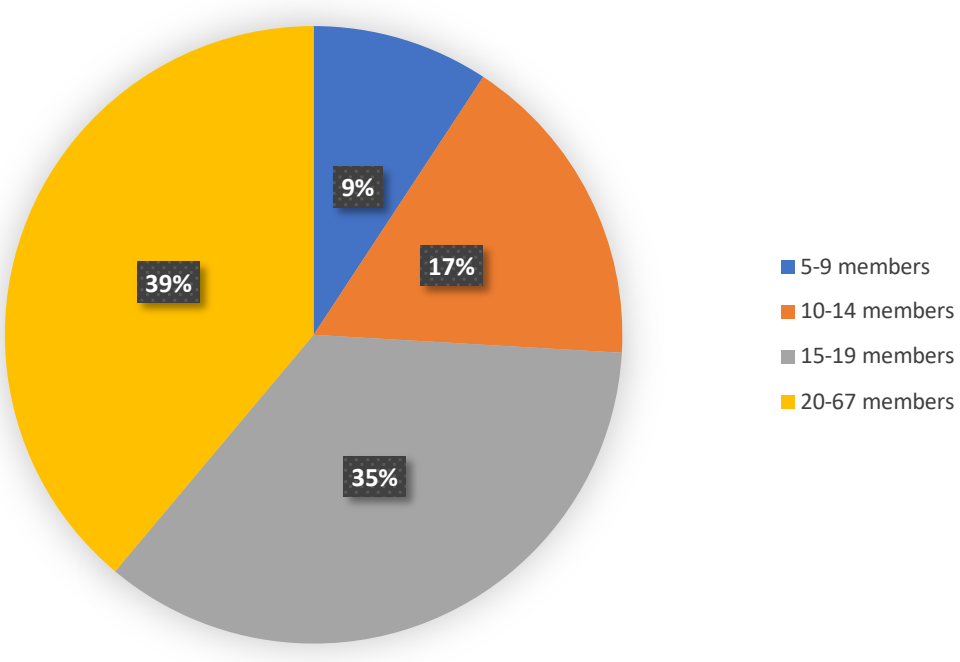
This domain is comprised of data from HSPN's Advancing Collaborative Governance (4), which includes results from the distinct and complementary OOHT Factual Governance Survey and the Perception of Governance Survey. The Factual Governance Survey focuses on the structural and procedural features of OHT leadership groups, while the Perception of Governance Survey captures respondent views on the functioning of OHT leadership groups. Together, this domain captures the features of collaborative governance that influence success.

Collaborative governance refers to the manner in which an interorganizational network organizes itself to make collective decisions, such as resource allocation or coordinating joint decisions (25, 26), and is a key factor which influences the performance of interorganizational integrated care networks. OHTs promote collaborative governance by choosing representatives of member organizations to form a leadership group, who constitute the primary decision-making regarding resources, priorities, and membership for each OHT.

Leadership Group Size and Turnover

The size of OHT leadership groups ranged from 8 to 67 members (Figure 16). About a third (n=21; 39%) of OHTs had large leadership groups of more than 20 members, while 9% (n=5) of OHTs had fewer than 10 members in their leadership group. This is a very large number to engage in collaborative decision-making which is the dominant approach reported across OHTs. The median number of members in 2025 was 17, which is higher than the number reported in 2022 (15 members).

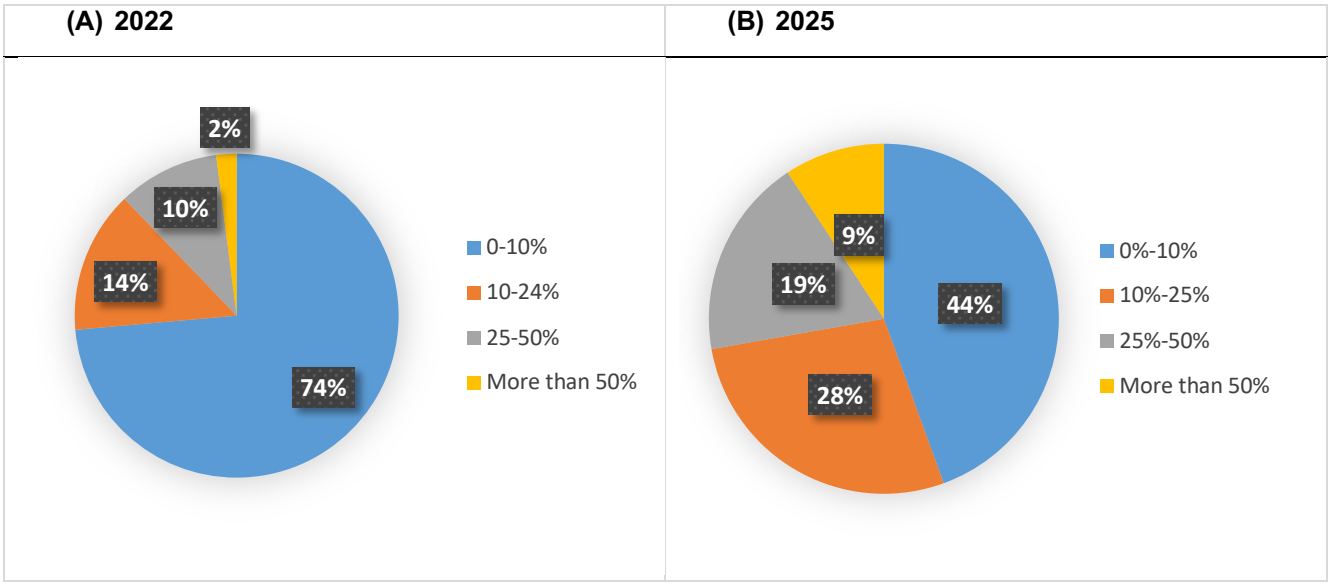
Figure 16. The number of members of OHT leadership groups



Leadership Turnover

OHT evaluation contacts reported on the proportion of leadership group that had changed between the last HSPN OOHT survey in 2022 and 2025. Overall, OHT leadership groups had more turnover in the period from 2022 to 2025 than they did in the period between approval as candidate OHTs and the 2022 survey. In 2022 Most OHTs (74%) had a relatively low turnover rate (0-10%) of their leadership group, while this declined to just 44% in 2025 (Figure 17A and 17B). Similarly, there were four times more OHT's that reported a >50% turnover rate in 2025 compared to previous years (9% vs 2%). While changes are to be expected, planful approaches to turnover in the leadership groups can help to enable consistency which can prevent unnecessary changes in direction or delays as decisions are re-evaluated.

Figure 17. The turnover rate of OHT leadership groups in 2022 and 2025



Decision Making Authority, Influence, and Commitment

We asked leaders to what extent they could make independent decisions on behalf of their home organizations. Most OHT leaders could develop agreements to OHT attestations and allocation of personnel or other in-kind resources in both 2022 and 2025 (Figure 18Aand 18B). There is a decline in the proportion of acute care respondents reporting that they had the authority to mobilise personnel and other in- kind resources from 94% in 2022 to just 57% in 2025. In contrast, primary care and other sectors indicated an increased authority to allocate in-person and cash resources to the OHT.

Figure 18. Decision making authority by sector in 2022

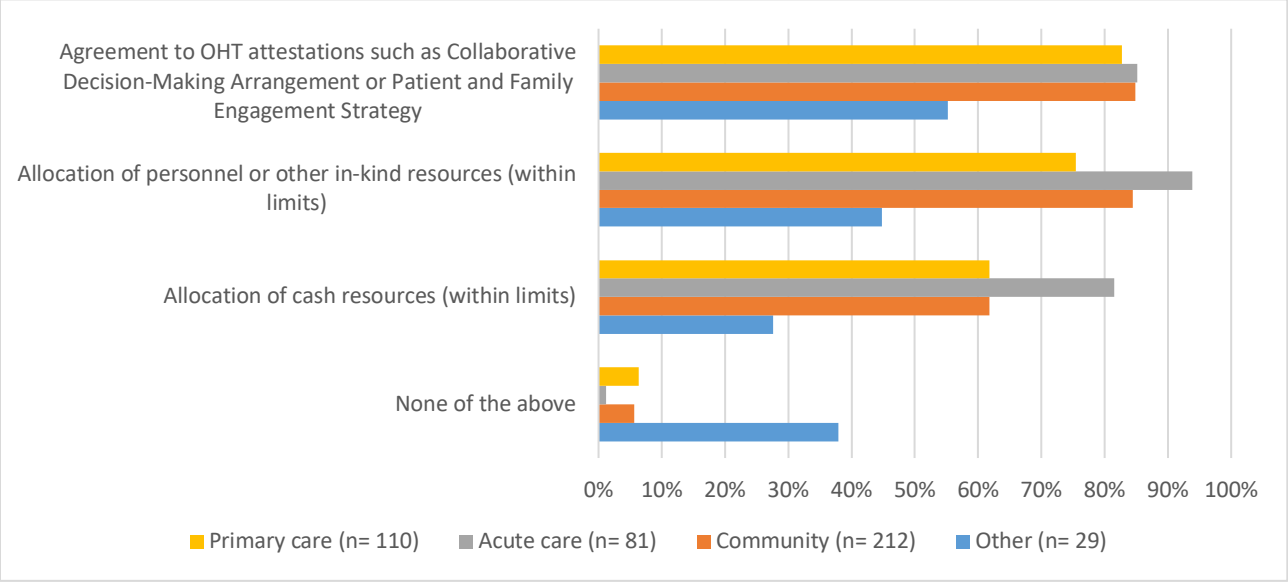
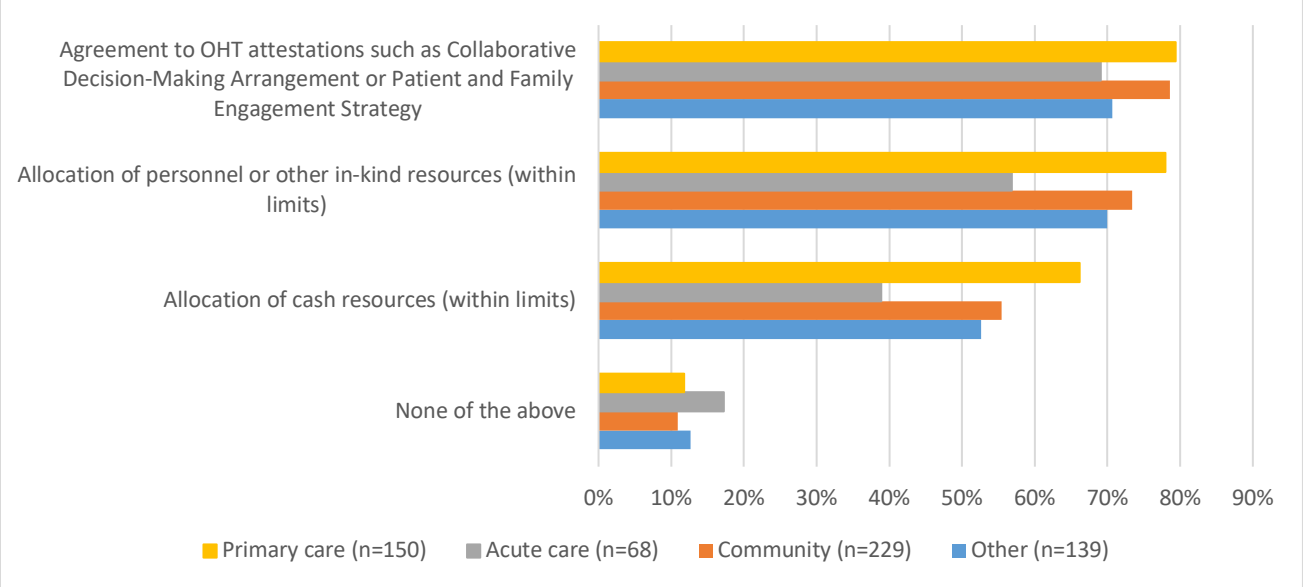


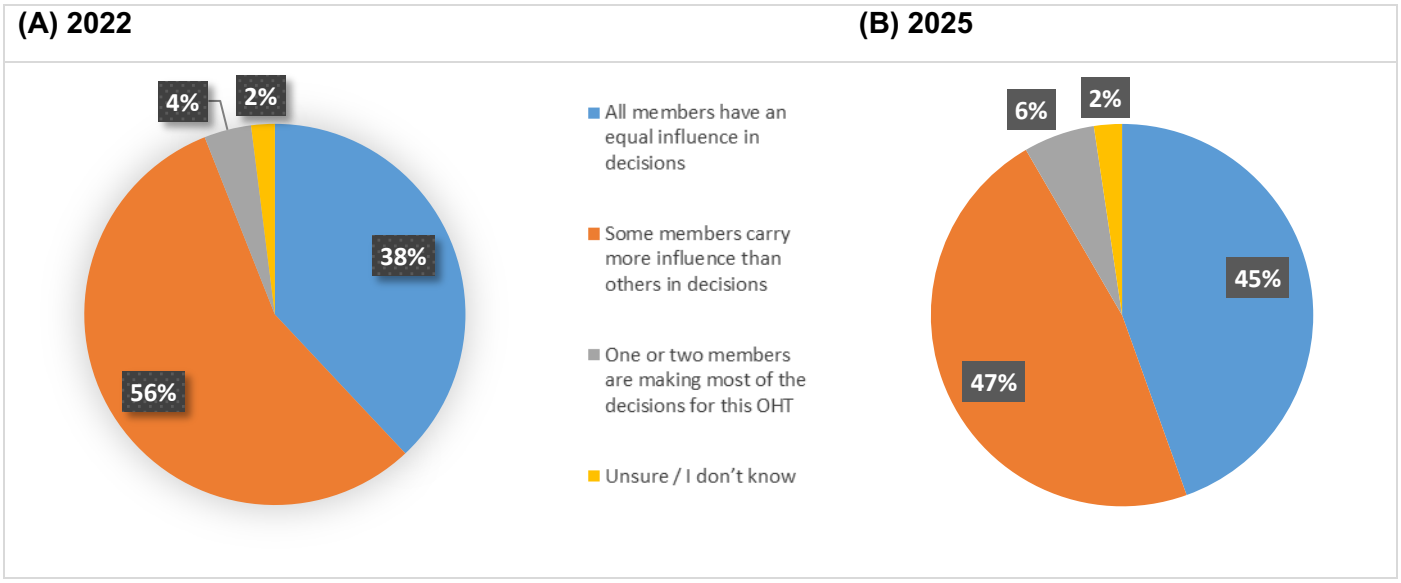
Figure 19. Decision making authority by sector in 2025



Decision Making Influence

When there are large groups making decisions, consensus decision-making takes more time but is very important in a network and partnership model. If there is a high degree of trust amongst the membership (e.g. belief that others have a primary interest in the OHT) then decisions can be made efficiently by a smaller number of participants. If there is low trust and low decision-making authority, decision-making becomes slow, particularly in larger groups. (25, 26)

Figure 20. Decision-making power in 2022 and 2025



Commitment to the OHT: Self-report and Peer Appraisal

In both years, most respondents reported balancing the goals of the OHT with the interests of their organizations (Figure 20A and 20B). A slightly higher proportion identified that they are balancing these interests in 2022 as compared to 2025. There has been an increase in the proportion of respondents indicating that they prioritize the OHT over their own organization and a decrease in those indicating that they prioritize their own organization amongst respondents in primary care and community sectors.

Most respondents strongly to moderately agreed that other members of the leadership group were committed to the success of their OHT in 2022 and 2025 (Figure 20A, 20B). However, a larger proportion of respondents strongly agreed to this statement in 2022 compared to 2025 (45% vs 22%). Other analysis has shown that OHTs with larger leadership groups (> 18 members) were less likely to report that other members of the leadership group were committed to the success of the OHT.

Figure 21. Commitment by sector in 2022 and 2025

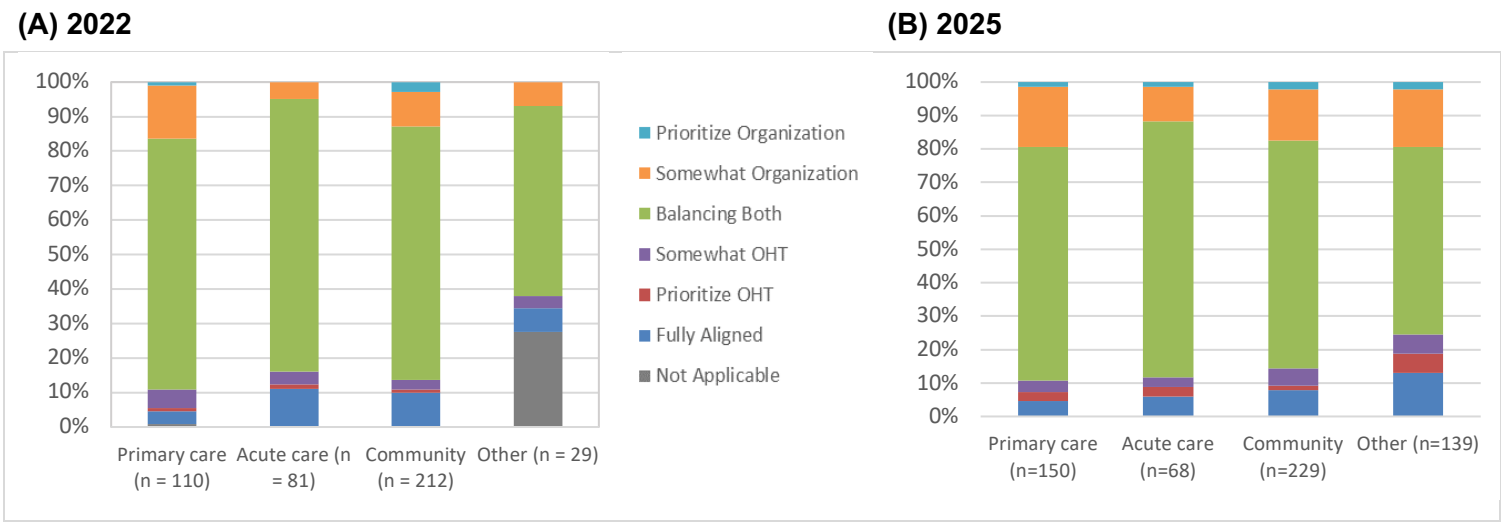
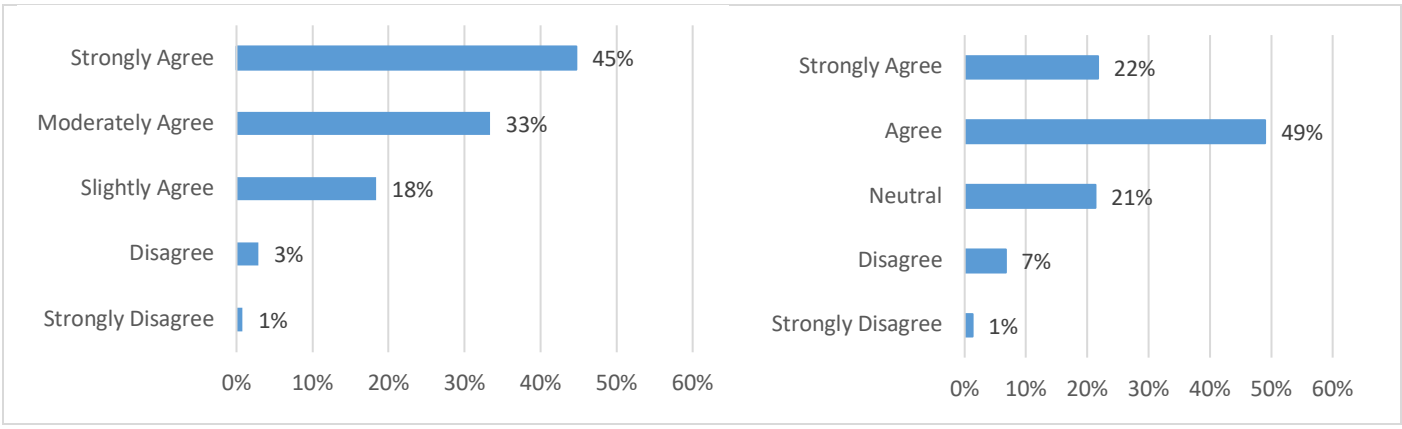


Figure 22. Level of commitment of other members to the success of OHT in 2022 and 2025



E. Discussion

Continuing to measure the contexts and capabilities critical to successful implementation of integrated care as OHTs continue to develop, allows us to assessm “readiness to integrate”. The self-assessment results provided in this report are intended to inform the development of targeted system supports to leverage strengths, share success and build capability where needed.

It is noteworthy, the response rate for the 2025 OOHT survey was higher compared to earlier OOHT survey release in 2022, 55% compared to 46% for which may also have impacted our findings. There is still a potential for response bias if non-respondents have differing views to those presented in this report.

Based on this report, the most important strength to be leveraged is **Overall Effectiveness.** OHTs should celebrate the growing confidence and support of individuals and local community involved in implementing the OHT model after 5 years of development. Very strong results for **Shared Purpose, Shared Responsibility** and **Organizational Approach** also indicate a strong sense of collaboration and partnership and developing new models of care.

Within the *Organizational Context* domain, questions revolving around “reward or correct actions based on rigorous measurement of OHT performance against goals” and “hold people accountable for their performance” were rated the lowest amongst all survey items (2.69/5 and 2.76/5 respectively). This is an area for growth among OHTs where there are currently few levers of external accountability, there has to be a locally driven shared accountability.

There continue to be opportunities to improve *Leadership.* The overall average score for this domain ranked second lowest among the critical success factors for integrated care, with a mean score of 3.42. Perceptions of lower ability to address power imbalances is concerning given that one of the factors that determine the effectiveness of an interprofessional team is the balance of power amongst different professionals (27). One of the lowest rated items in the survey is contained within this scale which relates to addressing power imbalances which is an area that all OHT leadership councils should be attentive to. *Leadership* also had the highest between-OHT variation of all domains (ranging from 2.5 to 4.5 / 5.0) 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. Successful partnerships require *boundary-spanning* leaders, formal and informal, who can bridge diverse interests, establish trusting relationships and find common ground to manage conflict (28).

Of the eight domains measuring critical factors for integrated care, all had at least one OHT with ≥80% of the respondents selecting the highest two levels on associated items (4 or 5). *Organizational Context* and *Leadership* had the fewest OHTs with ≥80% of respondents selecting 4 or 5. Burlington OHT met this threshold for *Organizational Context* and Burlington OHT and Ottawa West Four Rivers OHT for *Leadership*. This is an example of leading OHTs to learn from.

All OHTs have room to improve. However, ranked by mean score, four OHTs: Burlington OHT, Ottawa West Four Rivers OHT, South Georgian Bay OHT, and Couchiching OHT were consistently above the 80th percentile across all domains. There are supports, such as practice guides, webinars/podcasts, communities of practice, workshops, and coaching, available to help all OHTs in their development (1, 29).

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 continue to implement their integrated care plans.

Minkman describes integrated care initiatives as progressing through an initiation and design phase, execution and experimentation phase, followed by expansion and monitoring, and finally, at maturity where there is consolidation and transformation (30). With the growth in the number of approved OHTs from 2019 to 2023, this release of the OOHT survey results captures different stages in the OHTs' journey to transforming siloed to integrated care. It is worth mentioning that OHTs were focused on pandemic response for almost three years (2020-2022), which reoriented the work for many OHTs and in particular the OHTs in Cohorts 1 and 2.

It is encouraging to see a statistically significant improvement in the *Overall Effectiveness* domain. This reflects the perceptions of leadership that the OHT is heading towards the right direction with growing capacity to meet health needs of their population and achieve objectives. In the previous report, most domain scores had decreased from baseline surveys, which may have been a recalibration of members' perceptions of their team's capabilities after spending one to two years working together. In this survey, the stable scores in the remaining four domains may suggest that OHTs are continuing to refine plans and processes to support the transformational health system change. It may also reflect that many OHTs are still in the execution/experimentation phase, to be followed by expansion and monitoring in upcoming years (30).

There were synergies between the qualitative and quantiative results of the survey. For example, the Readiness for Change survey items were rated relatively low with particular ambiguity (the largest number of respondents chose the neither agree nor disagree option) for the item that "the changes will make my role easier". Qualitative comments indicated that the value proposition of OHTs is not always clearly articulated leading to a distancing from engagement in the OHT. Similarly the lowest ratings in the entire survey were in the Organizational Context domain and related to elements of performance management that the OHTs have yet to be empowered with including "using feedback to improve performance", "hold people accountable for their performance", "reward or correct actions based on rigorous measurement of OHT peformance against goals". This in spite of relatively high ratings indicating that OHTs had "selected measures to monitor peformance" and "set targets for our OHT using specific measures".

It will be important to continue re-assessing OHTs using the same survey. Integrated care initiatives progress through several phases towards maturity, and continued monitoring will inform the Ministry of Health and Ontario Health to focus the resources and supports in areas that OHTs need to be successful (30). OHT members' leaders have a strong commitment to this transformative change but may lead to additional 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 55 OHTs

Item Text	Scale	Number of respondents in each level						
		1	2	3	4	5	DK	Miss
The development of this OHT has strengthened shared capability to meet the health-related needs of your population	Overall Effectiveness	21	72	197	350	157	0	54
This OHTs objectives can actually be achieved	Overall Effectiveness	17	46	242	393	99	0	54
We have a common vision of how to improve the integration of care	Shared Purpose	13	78	149	462	149	0	0
We understand the role we will play in taking responsibility for the attributed population	Shared Purpose	18	82	197	421	133	0	0
We understand the role we will play in coordinating care	Shared Purpose	17	107	189	424	114	0	0
We have agreed to share responsibility for achieving improved patient outcomes	Shared Responsibility	15	62	147	459	168	0	0
We have selected measures to assess our progress	Shared Responsibility	10	97	222	392	130	0	0
We have set targets for our OHT using specific measures	Shared Responsibility	11	87	251	373	129	0	0
Addressing power imbalances among people/members involved in the OHT	Leadership	75	170	245	232	82	0	47
Communicating the vision of the OHT	Leadership	33	113	234	280	144	0	47
Creating an environment where differences of opinion can be voiced	Leadership	46	104	224	250	180	0	47
Helping the OHT be creative, look at things differently, and take risks	Leadership	50	139	252	257	106	0	47
Fostering respect, trust and inclusiveness amongst OHT members	Leadership	47	86	223	266	182	0	47
The leadership team in this OHT works coherently to support the overall objectives of the OHT	Organizational Focus	12	25	120	411	235	0	48
The leadership team in this OHT does not waste resources on unproductive activities	Organizational Focus	14	47	176	369	197	0	48
People in this OHT do not end up working at cross-purposes because our leadership gives them clear objectives	Organizational Focus	16	42	252	373	120	0	48
The leadership team in this OHT encourages people to challenge outmoded traditions and practices	Organizational Focus	20	62	199	374	148	0	48
The leadership team in this OHT is flexible enough to allow the OHT to respond quickly to changes in context	Organizational Focus	11	44	188	384	176	0	48
The leadership team evolves rapidly in response to shifts in our OHT priorities	Organizational Focus	11	44	203	370	175	0	48
set challenging/aggressive goals	Organizational Context	35	202	313	217	56	0	28
issue creative challenges to organizations within the OHT, instead of narrowly defining tasks	Organizational Context	73	226	288	191	46	0	27
be more focused on getting their job done well than on gaining personal recognition	Organizational Context	36	120	250	276	140	0	29
make a point of challenging their people to excel	Organizational Context	44	189	316	220	53	0	29
reward or correct actions based on rigorous measurement of OHT performance against goals	Organizational Context	108	255	278	154	24	0	32
hold people accountable for their performance	Organizational Context	97	233	308	142	39	0	32
use feedback to improve performance	Organizational Context	72	174	312	197	62	0	34
devote considerable effort to developing their teams	Organizational Context	41	162	293	242	79	0	34
give everyone sufficient authority to do their jobs well	Organizational Context	42	156	312	231	76	0	34
push decisions down to the lowest appropriate level	Organizational Context	91	217	319	159	31	0	34

give ready access to information that others need	Organizational Context	45	160	282	240	90	0	34
work hard to develop the capabilities needed to execute our overall strategy/vision	Organizational Context	33	148	281	265	89	0	35
base decisions on facts and analysis, not politics	Organizational Context	68	135	274	242	98	0	34
treat failure (in good effort) as a learning opportunity, not something to be ashamed of	Organizational Context	20	120	318	282	77	0	34
are willing and able to take prudent risks	Organizational Context	46	184	276	248	63	0	34
set realistic goals	Organizational Context	40	137	305	269	66	0	34
Fostering communication amongst members	Communications and Management	38	117	256	271	120	0	49
Organizing OHT member activities, including meetings, working groups and projects	Communications and Management	13	79	189	299	222	0	49
We use data (any of administrative, medical records, surveys, qualitative) to identify where improvements can be achieved in our attributed population	Operational approach	22	105	233	265	155	71	0
We use external evidence and ideas to select and guide initiatives (e.g. use or adapt what has worked elsewhere to solve problems within our context)	Operational approach	22	97	206	315	166	45	0
We use formal co-design methods such as structured deliberations and techniques (e.g. dialogues with partners, Delphi panels, future state mapping) with a diverse array of partners including patients and family and service/care providers in the co-design/co-creation of solutions	Operational approach	55	93	203	259	149	92	0
We actively engage with a diverse array of partners (patients & family, frontline providers, system leaders, researchers) to understand what drives behaviour and address foreseeable barriers to the implementation of programs	Operational approach	40	71	148	289	251	52	0
We use formal processes with ongoing data and frequent cycles of evaluation and feedback to assess performance against our objectives	Operational approach	55	102	215	247	149	83	0
I think that my organization/practice setting will benefit from the changes	Readiness for change	30	51	251	353	116	0	50
The changes will make my role easier	Readiness for change	43	130	372	195	61	0	50
In the long run, I feel it is worthwhile for me that my organization/practice adopted the changes	Readiness for change	23	33	257	363	125	0	50
My organizations/practice settings shared VALUES are compatible with those of other members in my OHT	Other	8	31	121	460	231	0	0
Communicating information about the OHT activities and context to members	Other	26	91	227	299	159	0	49

Appendix B – Summary Statistics Domains Across the Ontario Health Teams by Lead Organization and Geography (N=55)

Domain	Mean Across OHTs (SD)			Mean Across OHTs (SD)		
	Hosp (N=38)	Non Hosp (N=17)	p value	Small Community/Rural (N=28)	Urban/Suburban (N=27)	p value
Shared Purpose	3.63 (0.31)	3.90 (0.32)	**0.004**	3.66 (0.40)	3.77 (0.24)	0.229
Shared Responsibility	3.68 (0.28)	3.88 (0.32)	**0.020**	3.67 (0.36)	3.81 (0.22)	0.080
Leadership	3.35 (0.44)	3.59 (0.44)	0.064	3.33 (0.45)	3.52 (0.44)	0.122
Organizational Focus	3.79 (0.29)	3.98 (0.37)	**0.049**	3.79 (0.37)	3.91 (0.27)	0.167
Organizational Context	3.06 (0.33)	3.23 (0.42)	0.099	3.01 (0.37)	3.21 (0.34)	**0.034**
Communications and Management	3.55 (0.42)	3.73 (0.40)	0.140	3.56 (0.41)	3.66 (0.42)	0.383
Operational approach	3.55 (0.39)	3.72 (0.46)	0.183	3.49 (0.45)	3.72 (0.35)	**0.037**
Readiness for change	3.44 (0.32)	3.57 (0.28)	0.153	3.44 (0.34)	3.53 (0.28)	0.292
Overall Effectiveness and Promise	3.61 (0.37)	3.91 (0.34)	**0.005**	3.65 (0.44)	3.75 (0.32)	0.301

Appendix C – Summary Statistics of Domains Across the Ontario Health Teams by Cohort and i12 vs others (N=55)

Domain	Mean Across OHTs (SD)				Mean Across OHTs (SD)		
	Cohort 1 (N=29)	Cohort 2 (N=13)	Cohort 3+ (N=13)	p value[1]	i12 (N=12)	Other (N=43)	p value
Shared Purpose	3.79 (0.32)	3.63 (0.35)	3.60 (0.32)	0.116	3.91 (0.34)	3.65 (0.31)	**0.015**
Shared Responsibility	3.80 (0.31)	3.73 (0.24)	3.57 (0.34)	0.286	3.84 (0.31)	3.71 (0.30)	0.186
Leadership	3.52 (0.48)	3.22 (0.42)	3.39 (0.42)	0.138	3.70 (0.39)	3.35 (0.44)	**0.015**
Organizational Focus	3.93 (0.36)	3.69 (0.39)	3.80 (0.21)	0.104	4.07 (0.27)	3.79 (0.32)	**0.007**
Organizational Context	3.20 (0.38)	2.96 (0.39)	3.04 (0.33)	0.145	3.33 (0.34)	3.05 (0.35)	**0.014**
Communications and Management	3.62 (0.41)	3.45 (0.43)	3.69 (0.49)	0.352	3.80 (0.40)	3.55 (0.41)	0.071
Operational approach	3.71 (0.39)	3.44 (0.38)	3.50 (0.50)	0.119	3.79 (0.30)	3.55 (0.43)	0.089
Readiness for change	3.53 (0.31)	3.33 (0.31)	3.48 (0.36)	0.169	3.56 (0.25)	3.46 (0.32)	0.329
Overall Effectiveness and Promise	3.77 (0.37)	3.55 (0.49)	3.65 (0.41)	0.246	3.88 (0.33)	3.65 (0.38)	0.057

1 p-value for any difference between any two cohorts (one-way ANOVA)