Advancing Collaborative Governance

Findings from the Organizing for Ontario Health Teams Survey: Factual and Perception of Governance Surveys

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HSPN Health System Performance Network

About Us

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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Executive Summary

This report contains results from the Organizing for Ontario Health Teams (OOHT) Factual and Perception of Governance surveys administered in the first three cohorts of Ontario Health Team (OHT) applicants. The report describes the extent to which critical success factors for the implementation of collaborative governance are present to help OHTs and government act on the results.

Background

Following the enactment of the Connecting Care Act of 2019, the Ontario Ministry of Health (MOH) introduced OHTs as a new way of organising and delivering care that is more connected to patients and their local communities. OHT applicants were required to create leadership groups – defined as a group of individuals who constitute the primary decision-making group such as a leadership council, an executive team or a collaboration council that was responsible for steering the OHT towards maturity. This group acts as the governance for the OHT and we collected factual information about these groups and perceptions regarding governance from the member of these governance groups.

The OOHT Factual and Perception of Governance Surveys contained 8 and 10 substantive questions respectively, capturing key characteristics of the structure and functioning of OHT leadership groups. Both surveys were conducted online in March 2022. OHT Evaluation Leads (N = 51) responded to the Factual Governance Survey, while OHT leadership group members (N = 387) responded to the Perception of Governance Survey.

Results in Brief

The main results of the Factual Governance Survey were:

- OHTs mainly had large leadership groups with a median of 15 members and more than a third had 20-65 members.
- Leadership groups were mostly stable with about 74% of OHTs reporting less than 0-10% turnover of their members.
- Less than 8% of OHTs had engaged in initiatives to advance future governance structures.

The main results of the Perception of Governance Survey were:

- There was a consistent pattern where acute care respondents were more likely to allocate resources, report equal influence in decision-making, report high levels of shared commitment, and report more positive perceptions of OHT effectiveness as compared to primary care and community care respondents.

What we learned?

The MOH recently recommended not-for-profit organisation model for collaborative governance. As OHTs advance towards maturity, the present results may inform the successful design and implementation of future models of collaborative governance, specifically:

- While the large sizes of OHT leadership groups may add complexity to the coordination of activities, the relative stability of leadership groups may mitigate negative effects of large sizes.
- Acute care respondents were more likely to hold positive opinions on the current functioning of leadership groups as compared to primary care and community care respondents. It may be important to enhance the involvement of primary care and community care in the collaborative governance of OHTs.

A. Background

Following the enactment of the Connecting Care Act of 2019, the Ontario Ministry of Health (MOH) launched Ontario Health Teams (OHTs) as a new way of organising and delivering health and social care that is more connected to patients and their local communities. OHTs are expected to enhance connections between groups of provider organisations including health and non-health sectors, patients and caregivers that at maturity will work as one coordinated team that is clinically and fiscally responsible for delivering a comprehensive continuum of services to a defined population.

Integrated care systems are interorganizational networks that deploy formal and informal collaborative arrangement between various service providers working together to achieve policy goals that a lone organization could not (Goodwin, 2016; Kapucu & Hu, 2020). Integrated care literature suggests that systemic, organisational and network factors (e.g., collaborative governance, organisational culture, leadership style, information technology), influence the success of integrated care systems (Kirst et al., 2017; Threapleton et al., 2017). It is important to adequately understand the systemic, organisational and network factors that support integrated care so that decision makers and leaders can identify potential barriers and develop appropriate strategies to improve the implementation of integrated care in order to improve its benefits to local populations.

Collaborative governance, defined as the manner in which an interorganizational network organises itself to make decisions such as resource allocation or coordinating joint decisions (Kapucu & Hu, 2020; Provan & Kenis, 2008), is a key factor that influences the performance of interorganizational integrated care networks. The principal-agent theory suggests critical roles of governance that include setting strategic direction and controlling the behaviour of management or monitoring/overseeing the day-to-day activities of the network (Alexander, 2006). In the Ontario context, OHT partner organisations established Collaborative Decision-Making Arrangements that outlined the basis of their joint work. OHTs promoted collaborative governance of their interorganizational networks by choosing representatives of member organisations to form a leadership group. The **leadership group** consisted of individuals who constitute the primary decision-making group regarding resources, priorities, and membership for each OHT. Various terminologies used by OHTs to design the primary decision-making group include the *leadership council*, *executive team*, *collaboration council* or *core group*. This report focuses on exploring key features of these leadership groups in order to understand how Ontario Health Teams advanced collaborative governance of their interorganizational networks.

B. Objectives

The overall objective of this report was to describe and compare the structures and functioning of OHT leadership groups to guide OHTs and the MOH to identify strengths and opportunities to build important capabilities for integrating care.

To achieve this objective, two distinct and complementary surveys were carried out in 2022 to capture the features of collaborative governance that influence success. They consisted of i) a **Factual Governance Survey** focused on exploring tangible features of OHT leadership groups and ii) a **Perception of Governance Survey** focused on exploring the views of respondents on

the functioning of OHT leadership groups. The methods and findings of both surveys are presented separately.

C. The Factual Governance Survey

C. 1 Methods

C. 1.1 Survey Development and measures

The Factual Governance Survey was developed by Health System Performance Network (HSPN.ca) researchers to better understand the current structure and composition of OHT leadership groups. HSPN researchers reviewed collaborative governance literature (Kapucu & Hu, 2020; Provan & Kenis, 2008) to identify key characteristics of inter-organizational networks that shape the way they successfully carry out their routine activities. For example, the seminal study of Provan and Kunis (2008) suggests that key features like the number of organizations participating in collaborative governance models may influence the capacity of inter-organizational networks to coordinate activities or resolve interests of member organizations. Several rounds of group discussions with HSPN researchers and international experts on network governance of integrated care were carried out to identify items that were relevant to understanding the Collaborative Governance of OHTs. After initial analysis and review, 8 items were retained for the Factual Governance Survey. These items include i) the size of OHT leadership groups, ii) changes to the size of OHT leadership groups since approval, iii) the degree of turnover of members of OHT leadership groups since approval, iv) a description of how members of leadership groups were chosen, v) sectors, agencies or communities represented by members of leadership groups, vi) approaches for future governance of OHTs, vii) communication processes between OHT leadership groups and external boards and viii) communication between Boards of partner organisations of OHTs (see Appendix A).

C. 1.2 Survey Sample and data collection

For the Factual Governance survey, the named Evaluation Lead for each full applicant OHT (n=51 in March 2022) received an email with a link to a survey requesting factual information about the OHT leadership structure (the Factual Governance Survey).

C. 2 Results

C. 2.1 Survey response rates

All OHT Evaluation Leads responded to the Factual Governance Survey. However, two OHTs were excluded from the study for the following reasons, i) one Evaluation Lead provided incomplete responses to more than 50% of survey questions, and ii) another OHT was excluded because their leadership group was still emerging, so they did not have enough information to complete the survey.

C. 2.2 Factual Governance Survey findings

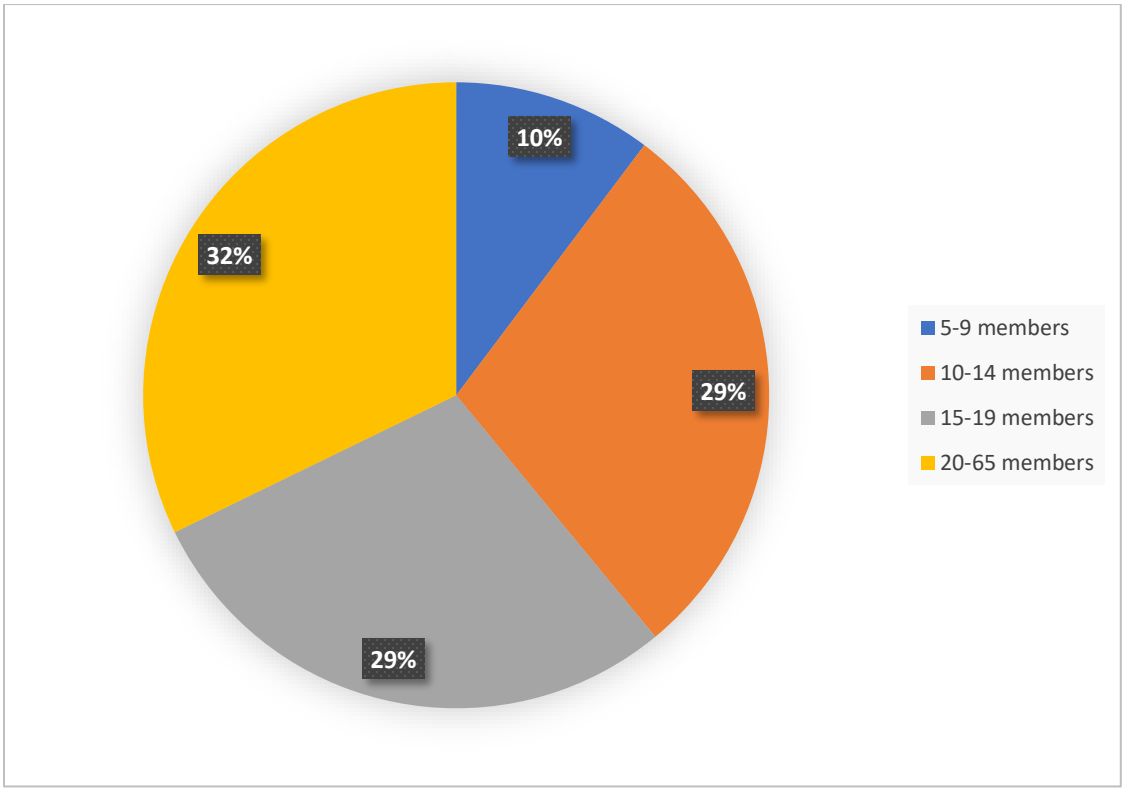
The Factual Governance Survey comprised three main domains that explored key aspects of the composition of leadership groups, i) the *Leadership Group Membership*, ii) the *Future Board Structure*, and iii) the *Communications with and amongst Governance Boards*.

C. 2.2.1 Leadership Group Membership domain

The composition of the leadership group is an essential element of successful partnering to coordinating service delivery and responding to the needs of partners in the context of complex multi-organisational systems (Provan & Kenis, 2008). Features such as the number of members, conversion or turn-over and representation may influence the ability of the governance group to efficiently make decisions and to be inclusive and representative of constituent stakeholders. The survey contained five items relating to *Leadership Group Membership*. Respondents were asked for 1) the size (number of members) of their respective OHT leadership groups, 2) to indicate changes in the number of members of their respective leadership groups since the approval of their OHT, 3) to estimate the change or turn over rate of members of their leadership group since approval of their OHT, 4) to describe how members of leadership groups were chosen, and 5) to indicate sectors, agencies and communities represented in leadership groups.

The size of OHT leadership groups ranged from 5 to 65 members, with a median of 15 members (Figure 1). About a third (n =16; 32%) of OHTs had large leadership groups of more than 20 members, while 10% (n = 5) of OHTs had fewer than 10 members in their leadership group.

Figure 1: The number of members of OHT leadership groups



Overall, OHT leadership groups were relatively stable. Since approval, about half (49%) of OHTs reported an increase in the number of members of their leadership group, while 37% reported no increase, and 14% reported a decrease in the number of members (Figure 2A). Most OHTs (n = 36; 74%) had a relatively low turnover rate (0-10%) of their leadership group, while a few OHTs (12%) changed more than 25% of their members since approval (Figure 2B).

Figure 2A:Change in the number of members of leadership group since approval of the OHT

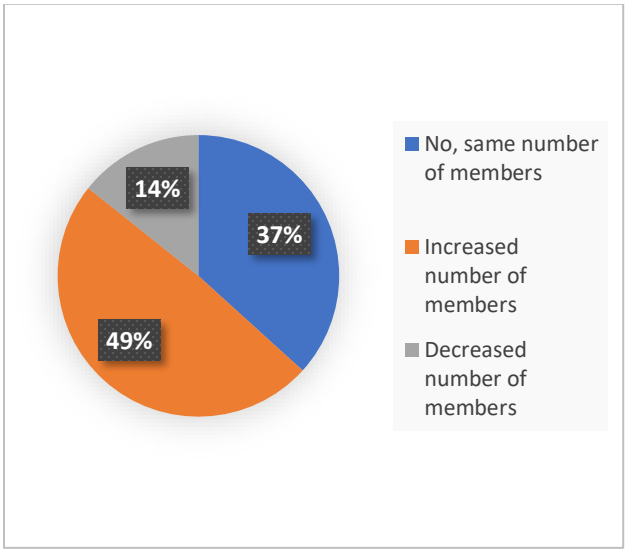
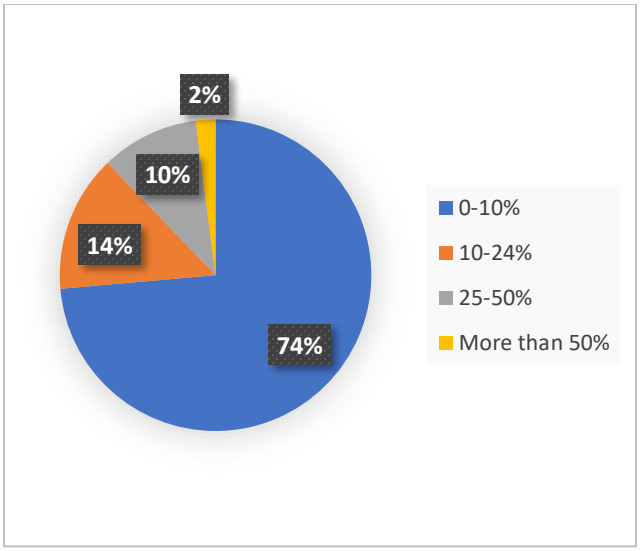
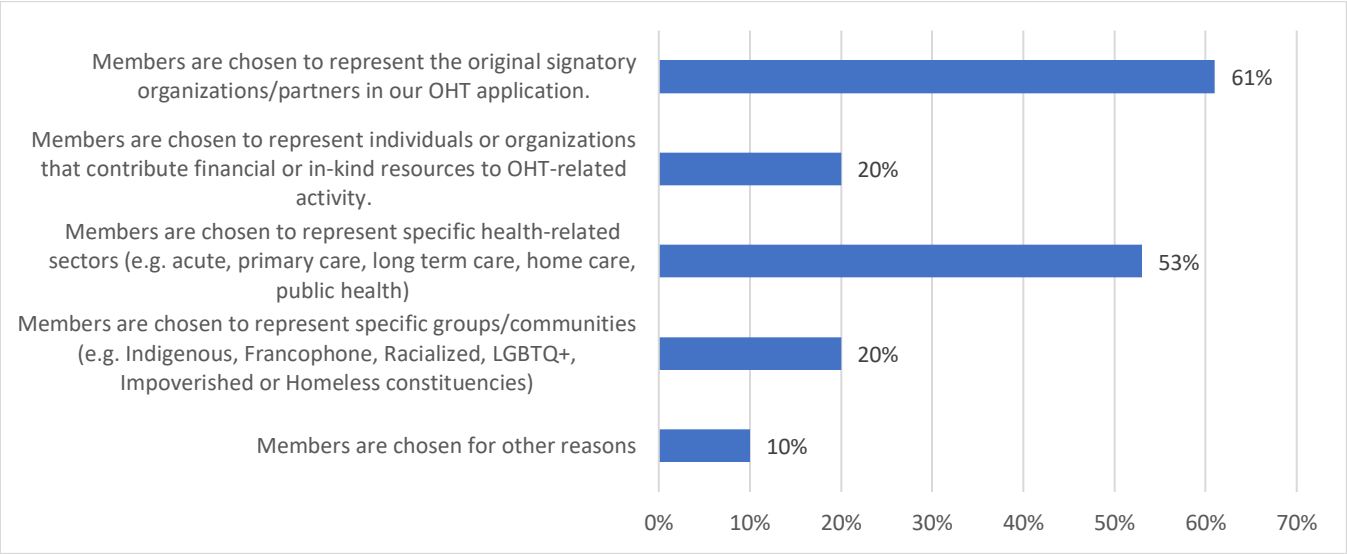


Figure 2B The turnover rate of members of OHT leadership groups



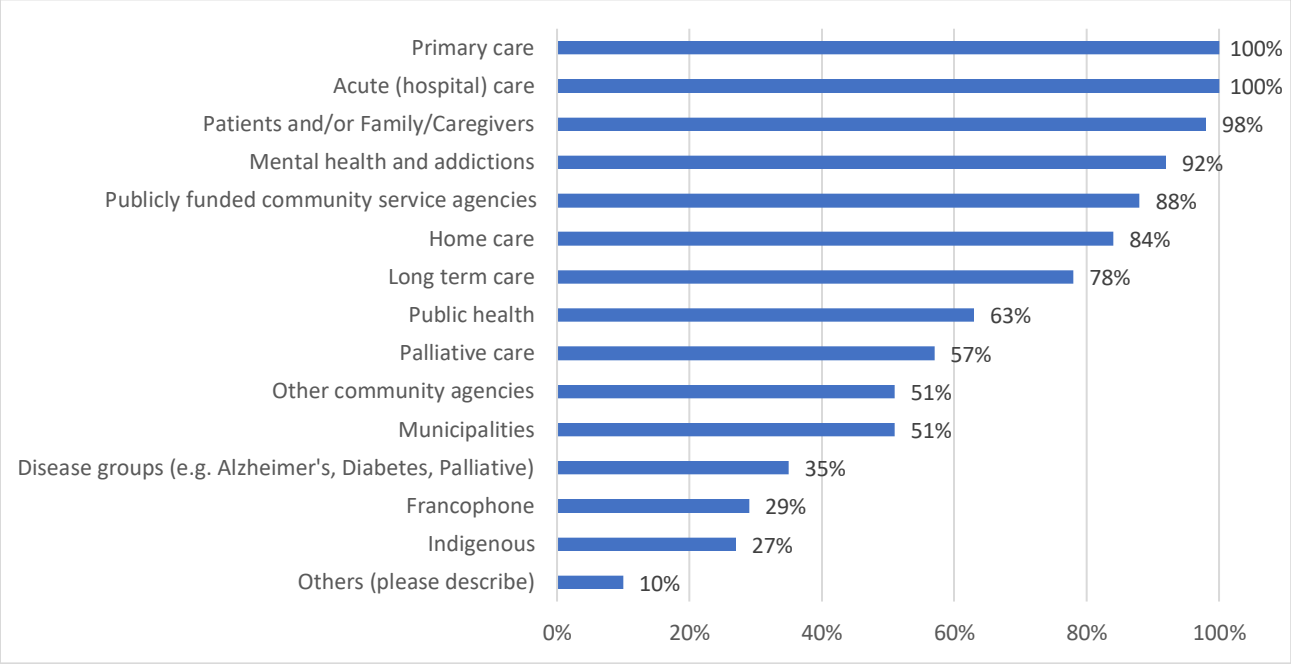
OHT leadership group members were chosen for various reasons. They were mostly chosen to represent original signatory organisations (61%), and specific health related sectors (53%). Only 20% of OHTs chose members to represent minority communities such as Indigenous, Francophones or Racialized groups (Figure 3A). All OHTs leadership groups have representatives from the acute care and primary care (100%) sectors (Figure 3B). Patient and caregivers (98%), mental health and addictions (92%), publicly funded community agencies (88%) and home care (84%) are also highly represented in OHT leadership groups. Minority groups like Francophones (29%) and Indigenous populations (27%) are poorly represented in OHT leadership groups.

Figure 3A: How OHT leadership groups members are chosen



Note: more than one option may apply so percentages add to more than 100%.

Figure 3B: Sectors represented by members of OHT leadership groups

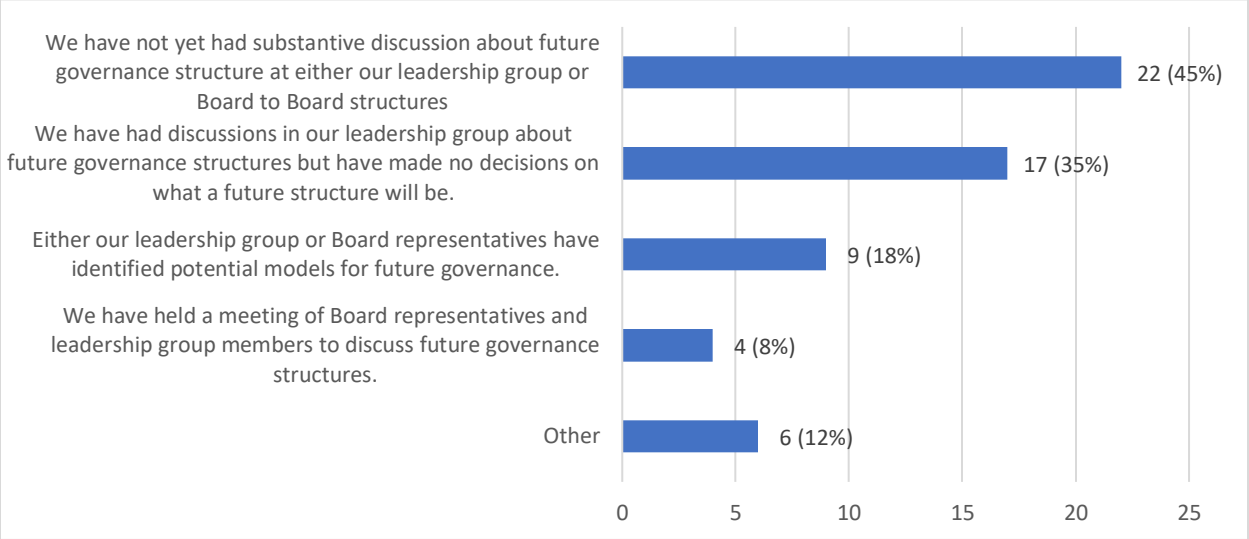


C. 2.2.2 Future board structure domain

Planning to improve or restructure governance boards is an essential element of adapting the governance structure to changing local realities (Kapucu & Hu, 2020). The *Future Board Structure* domain comprised one item. Respondents were asked to identify which statements described their future governance approach.

Most leadership groups have not have any substantive discussions (45%) or have not made any decisions (35%) about future governance structures (Figure 4). About 18% of OHT leadership groups had identified future governance models.

Figure 4: OHT plans for future board governance structures (N = 49)



C. 2.2.3 Communications with and amongst Governance Boards

Interorganizational communication is an essential element of successful partnering by exchanging information and co-creating meaning between partner organizations (Kapucu & Hu, 2020). The *Governance Boards communication* domain comprised 2 items. Respondents were asked 1) to identify the communication processes between their OHT leadership group and the Boards of member organisations and 2) to identify how the Boards of member organisations communicate together.

Most OHTs (88%) do not have any standard communication or reporting processes between the leadership group and their respective Boards, while about 12% of OHTs have established standard communication and reporting processes to share information with external boards (Figure 5A). There was no direct communication between the Boards of OHT member organisations of most (77%) OHTs, while about a quarter (23%) of OHTs had some sort of mechanism for regular meetings between Boards of member organisations (Figure 5B).

Figure 5A: Communication between OHT leadership groups with Boards of member organizations

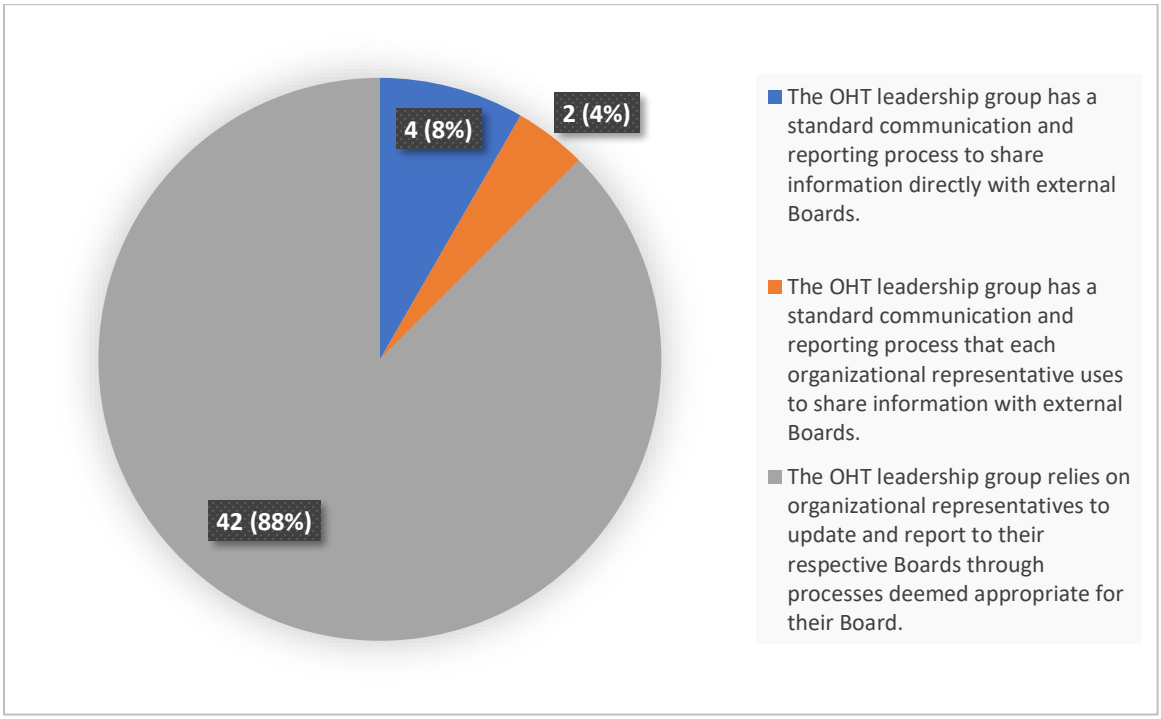
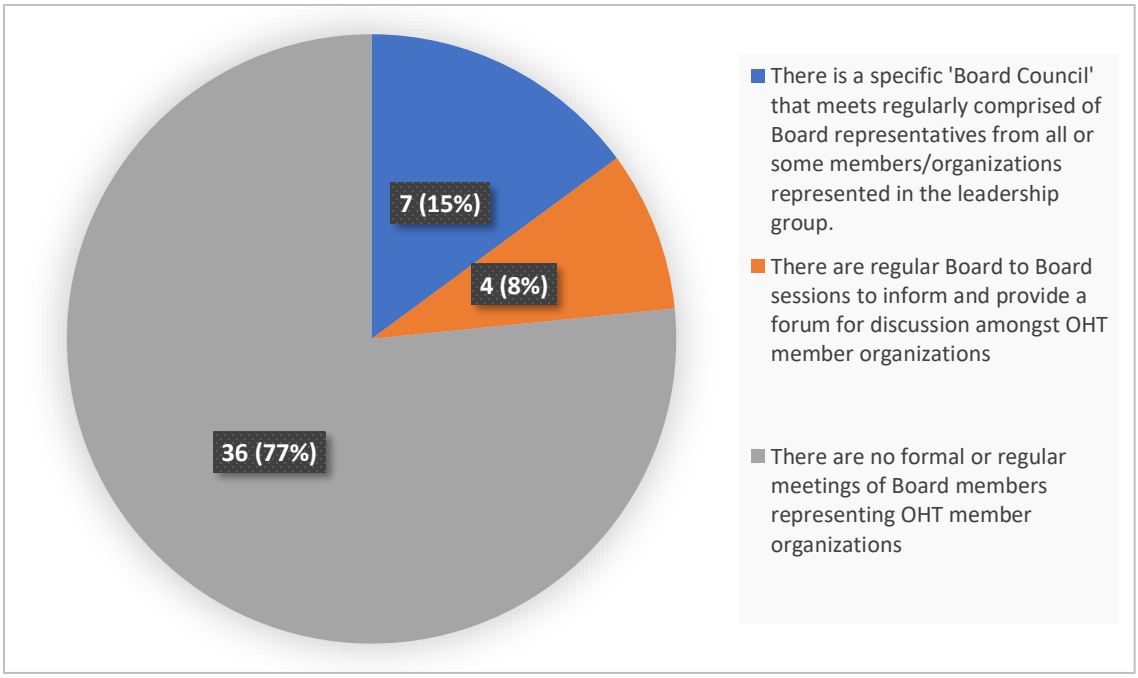


Figure 5B: Direct communication between Boards of member organizations



C. 2.2.4 Synthesis of Factual governance survey results

Summarily, the Factual Governance survey shows that OHTs have relatively large leadership groups with a median of 15 members and about a third have more than 20 members. About 50%

of OHTs have increased the number of members of their leadership group since approval, and these leadership groups are relatively stable with only about a quarter of OHTs having more than a 10% turnover over a two-year period. OHT leadership group membership was largely selected to represent original signatory organizations and health provider sectors, with some representation according to special groups and financial contributories. Eleven different provider groups and sectors are represented in the leadership of more than half of all OHTs.

About a third of OHTs are advancing towards future governance structures, about a third are discussing options for future governance and about a third are not having future governance discussions yet. Most communication to and between Governance Boards of participating organisations is ad-hoc, with about 85% of OHTs relying on organisational representatives to update and report to respective Governance Boards. Only about a quarter of OHTs have either Board Councils or Board-to-Board OHT discussions.

D. The Perception of Governance Survey

D. 1 Methods

D. 1.1 Survey Development and measures

The Perception of Governance Survey was developed by Health System Performance Network (HSPN.ca) researchers to better understand the functioning of OHT leadership groups. HSPN researchers reviewed collaborative governance literature (Kapucu & Hu, 2020; Michgelsen, 2021; Provan & Kenis, 2008) to identify key features of inter-organizational networks that shape the way they successfully carry out their routine activities. For example, Michgelsen (2021) suggests that effective decision-making strategies are essential to the functioning of integrated care systems. Several rounds of group discussions with HSPN experts and international experts in integrated care governance were carried out to identify items that were relevant to understanding the Collaborative Governance of OHTs. After analysis and review, 10 items were retained, including i) the kinds of decisions made primarily by the OHT leadership group, ii) main decisions made on behalf of their organisations in regard to the implementation of the OHT, iii) the decision-making approach of leadership groups, iv) the decision-making power of leadership groups, v) the level of commitment between the goals of the OHT and the interests of partner organisations, vi) the level of commitment of other members of the leadership group to the success of the OHT, vii) the frequency of measurement of progress of the OHT, viii) the effectiveness of the OHT leadership group in making decisions, ix) the effectiveness of the OHT in strengthening shared capabilities to meet the needs of their population, and x) the extent to which OHT goals can be achieved (Appendix B).

D. 1.2 Survey Sample and data collection

For the Perception of Governance survey, the Evaluation Lead for each of the 51 full applicant OHTs was asked to provide the name and email address for the most involved individuals representing each signatory (organization) to the OHT application along with additions for partners newly engaged in the leadership for the OHT since application. Data collection commenced March 2022 with all OHT stakeholders receiving an email inviting them to participate in the Organizing for Ontario Heath Teams (OOHT) Survey which included the Perception of Governance Survey items. 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. Up to four reminders were sent via email to non-responders over a six-week period. The Perception of Governance Survey items were a subset of the overall OOHT respondents. Specifically, the OOHT survey respondents were asked to identify whether they were part of the leadership group with the primary decision-making responsibility regarding A) resources, B)

priorities and C) membership for the OHT. If they answered yes to this question, then they were presented with the remaining Perception of Governance Survey.

D. 2 Results

D. 2.1 Survey respondents and response rates

Of the 1423 individuals e-mailed an invitation to the OHT leadership survey (including the Perception of Governance Survey items), 651 submitted their survey for an overall response rate of 46%. Of the 651 individuals that submitted their survey response, 387 were members of the leadership group of their respective OHTs and were asked to respond to all governance questions.

Table 1 illustrates the leadership group respondents' roles within their organizations. The majority of respondents (59.2%) were in executive leadership roles (e.g., Chief Executive Officer, President and Executive Director). Approximately 21% of respondents were in senior management (e.g., Vice President) or director or managerial roles. Eight percent of respondents were clinicians with most being physicians. There was a small number of patients and caregivers and other roles noted (e.g., board member, academic partners, or community representatives.

Table 1: Roles of OHT respondents to the Perception of Governance Survey (N = 387)

Current Role	Frequency	% of Respondents
Chief Executive Officer, President or Executive Director	229	59.2
Other Senior Management (COO, CFO, Vice President, Chief of Staff)	49	12.7
Administrator, General Manager, Director of Care, Clinical Leader	30	7.8
Physician or other clinical roles	30	7.8
Patient/Caregiver	20	5.2
Board Member	11	2.8
Academic Partner	3	0.8
Others	15	3.9
Total	**387**	**100**

D. 2.2 Perception of Governance Survey findings

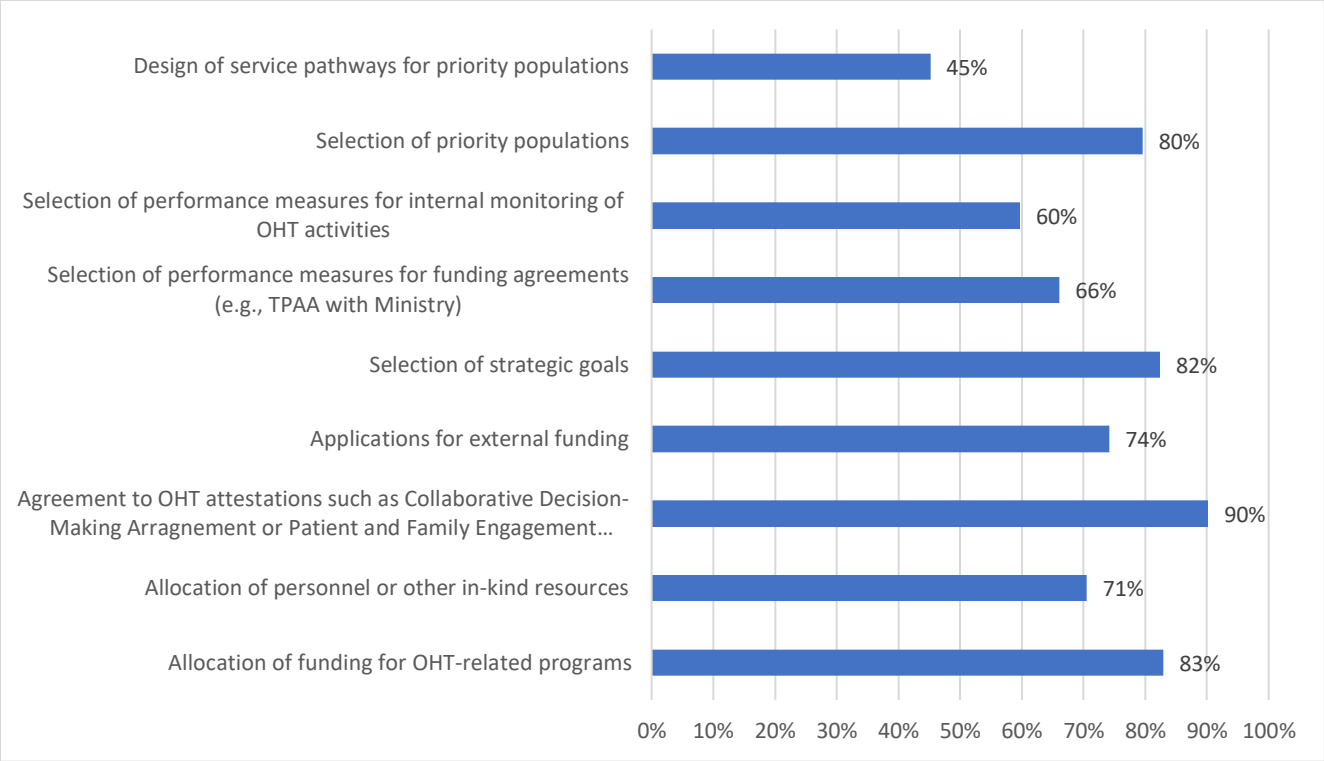
The Perception of Governance Survey comprised four domains that captured key aspects of the functioning of OHT leadership groups, including i) the *Decision-Making* domain, ii) the *Commitment* domain, iii) the *Measurement* domain and the iv) the *Effectiveness* domain.

D. 2.2.1 Decision-Making

The decision-making process is an essential element of good governance where partner organisations collectively chose between various options for those actions that give the best outcomes for their network (Michgelsen, Glimmerveen, Pittens, & Minkman, 2022). The *Decision-Making* domain comprised 4 items. Respondents were asked to identify 1) the main kinds of decisions made by their OHT leadership group, 2) the Decision-Making Capacity of the leadership group, 3) the Decision-Making Approach, and 4) the Decision-Making Power of their leadership group.

OHT leadership groups mainly took strategic decisions that provided direction and resources to support the functioning of the inter-organizational network. The top four decisions taken by OHT leadership groups as rated by respondents included i) the development of Agreements to OHT attestations (90%), ii) the allocation of funding to OHT related programs (83%), iii) the selection of strategic goals (82%), and iv) the selection of priority populations (figure 6).

Figure 6: The main kinds of decisions primarily made by OHT leadership groups



On behalf of their organisations, most OHT leadership groups could develop agreements to OHT attestations (80%) and allocation of personnel or other in-kind resources (75%) (Figure 7A). A greater proportion of acute care respondents felt that they had the capacity to mobilise personnel and other in- kind resources, as well as allocation of cash resources to support their OHTs (Figure 7B).

Figure 7A: Decision making capacity

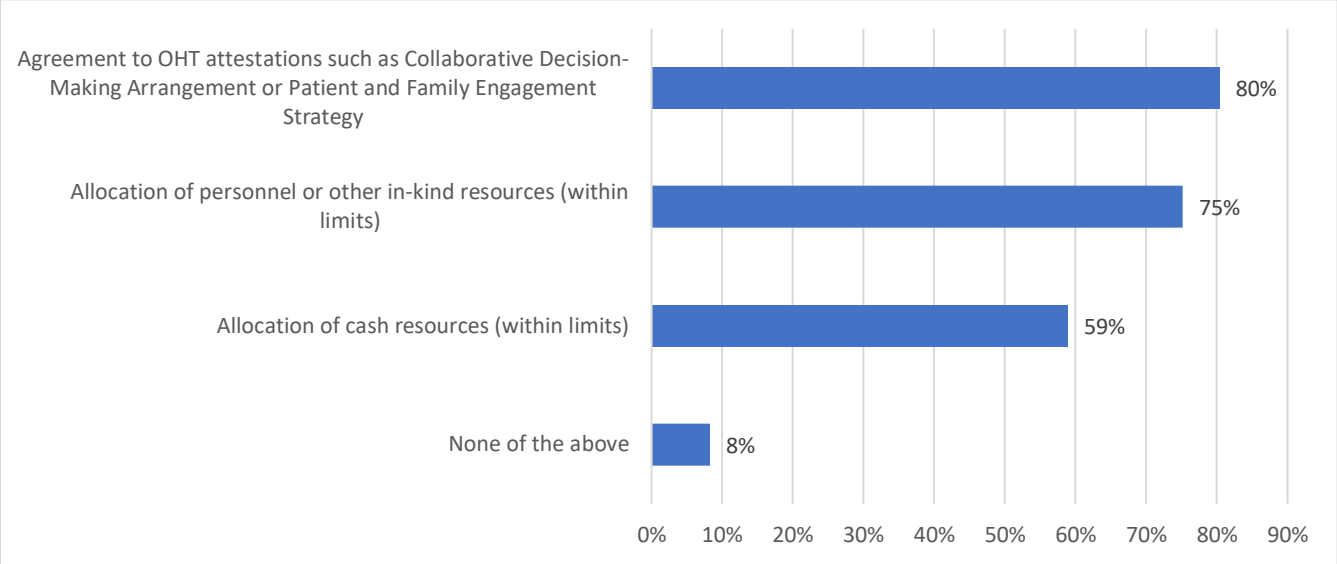
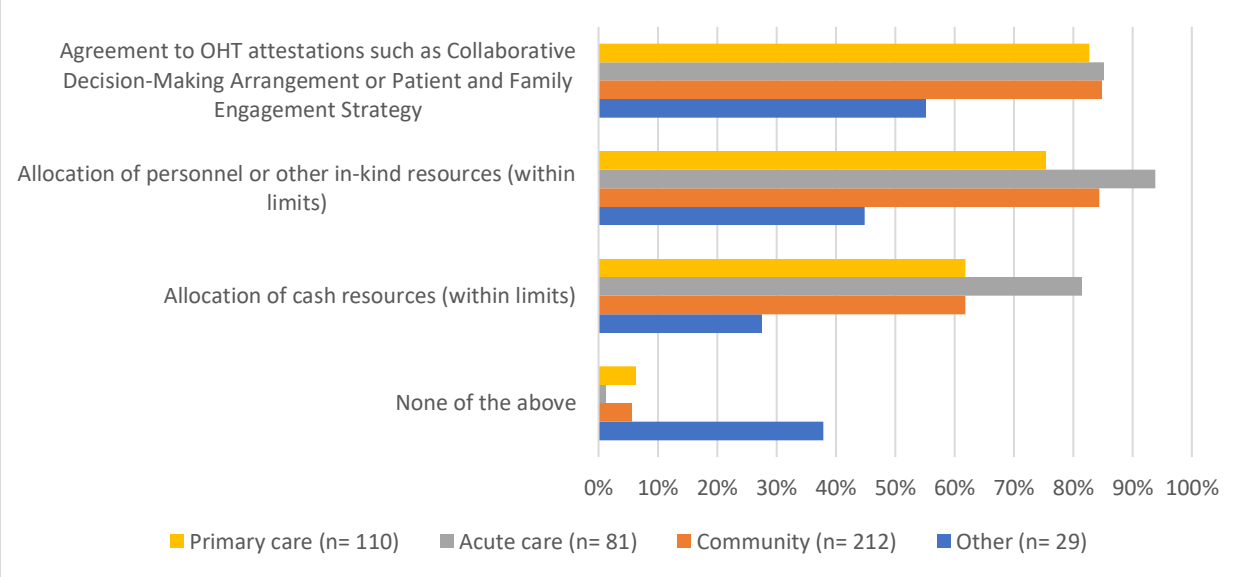


Figure 7B: Decision making capacity by sector



The majority of respondents reported that most decisions were made by consensus agreement amongst members (81%), while about 12% reported that decisions were made by membership vote (Figure 8A). Respondents from the Acute care sector were more likely to report that decisions are made by consensus agreement as compared to respondents from the primary care and community sectors (Figure 8B).

Figure 8A: Decision-making approach

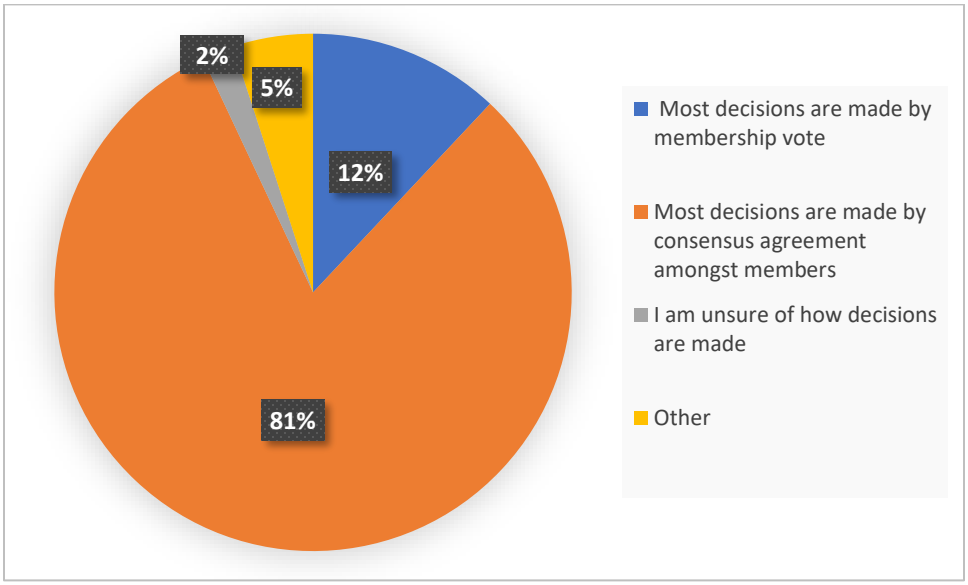
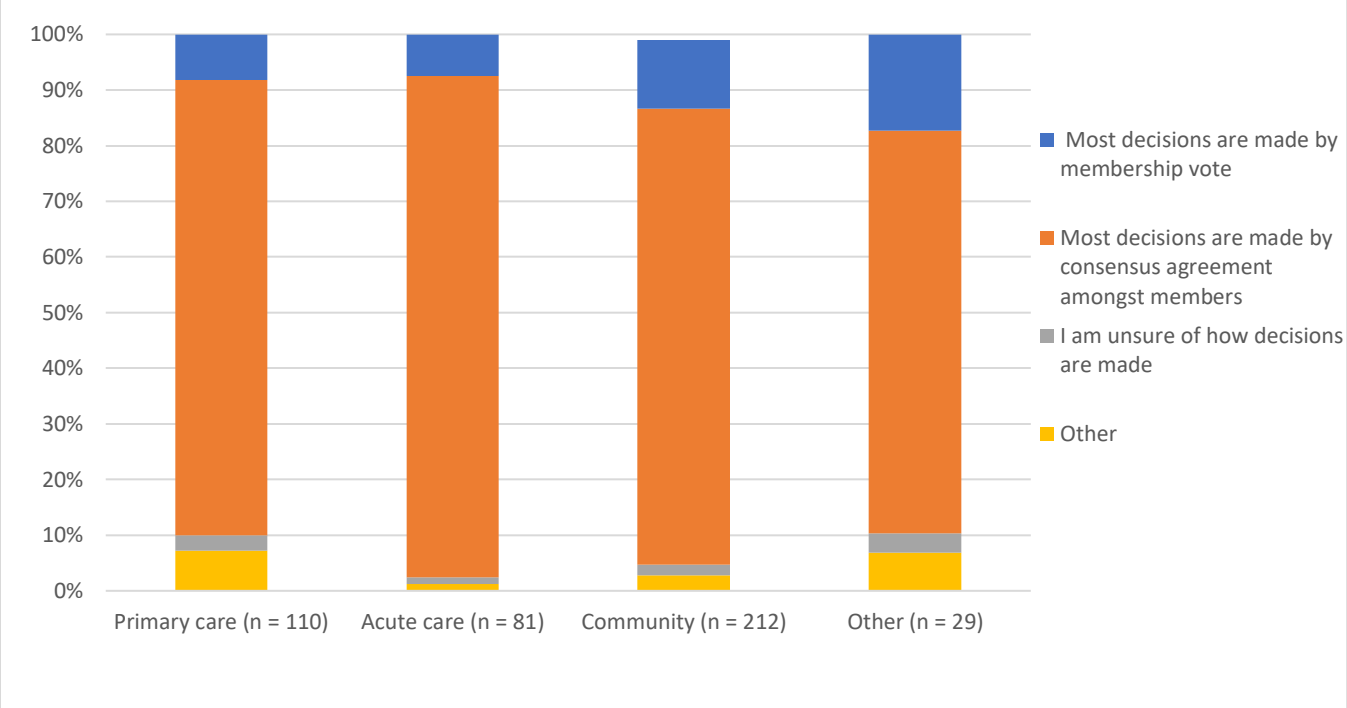


Figure 8B: Decision-making approach by sector



Regarding decision-making power, more than half of our respondents (56%) felt that some members carried more influence than others in decisions, while over a third of respondents (38%) felt that all members had an equal influence in decisions (Figure 9A). A few respondents (4%) felt that one or two members were making most decisions. Acute care respondents were more likely to think that that all members had an equal influence over decisions, while primary care and community care respondents were more likely to think that some members carried more influence than others in decisions (Figure 9B).

Figure 9A: Decision-making power

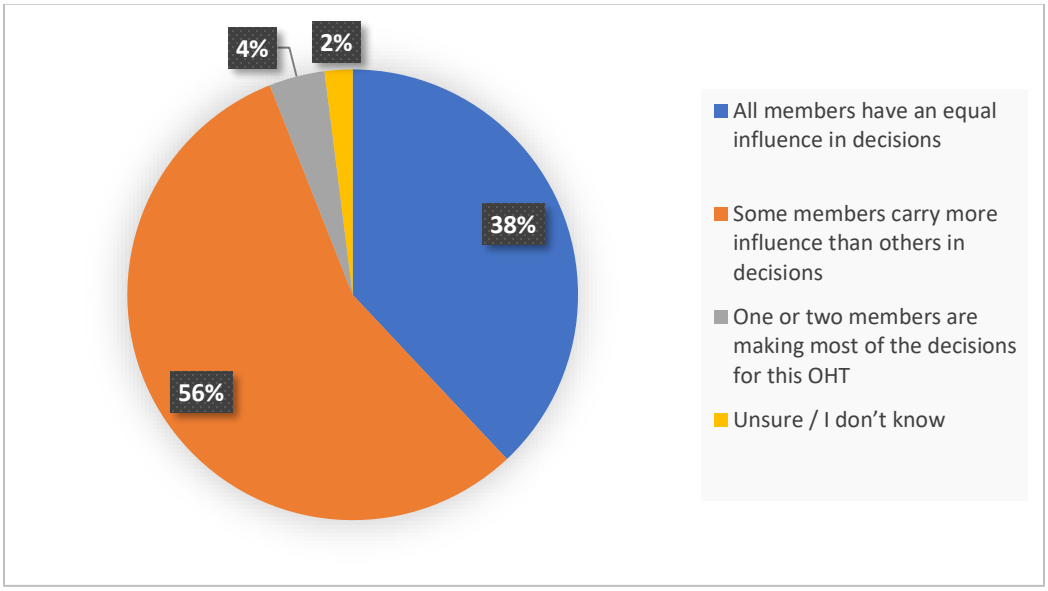
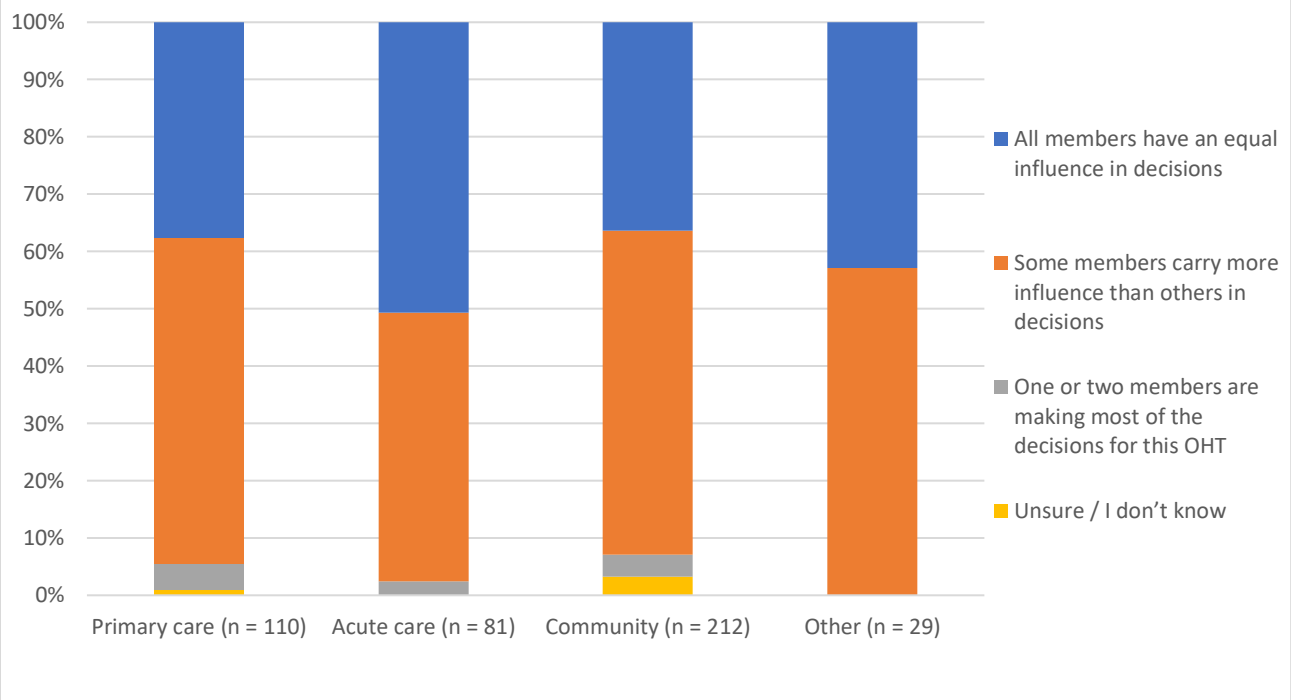


Figure 9B: Decision making power by sector



D. 2.2.2 Commitment

Leadership commitment is an essential element of successful partnering to investing time and efforts to guide transformational change in complex multi-organizational systems (Kapucu & Hu, 2020). The *Commitment* domain comprised of 2 items. Respondents were asked 1) to describe the level of commitment between the goals of the OHT and the interests of their own organizations, and 2) to rate the level of commitment of other leadership group members to the success of their OHT.

Most respondents reported that they tried to balance the goals of the OHT with the interests of their organizations (70%) (Figure 10A). Acute care respondents were most likely to report that they balanced the goals of the OHT with the interests of their organizations as compared to primary care and community respondents who were slightly more likely to report commitment to their own organization (Figure 10B).

Figure 10A: The level of commitment between the goals of the OHT and the interests of organizations

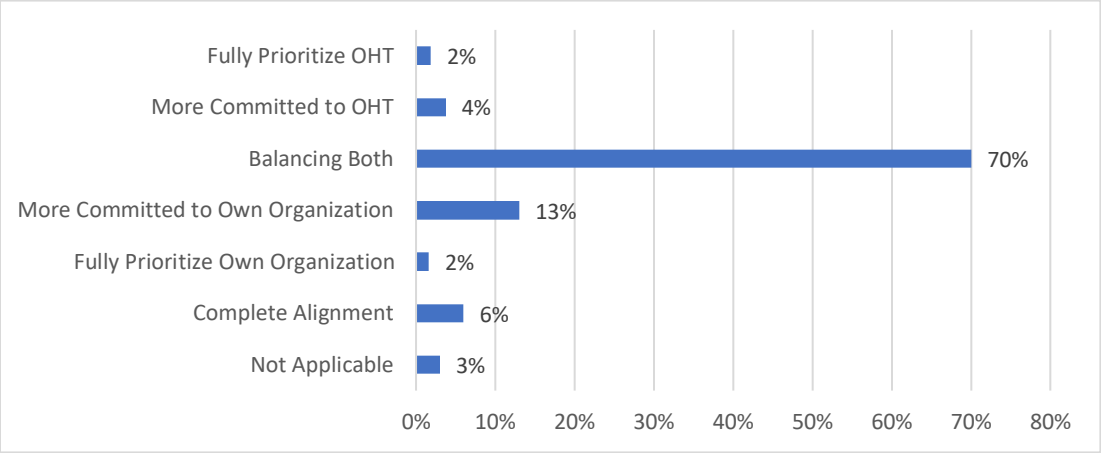
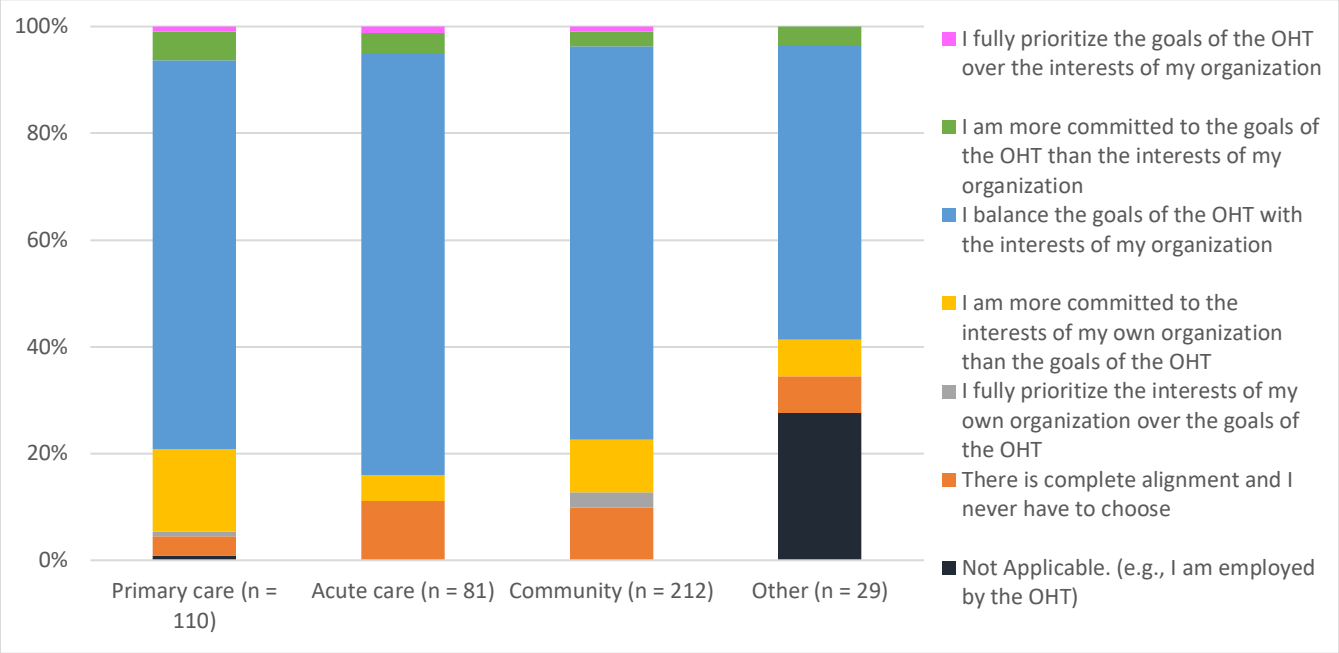


Figure 10B: Commitment by sector



Most respondents strongly (45%) to moderately (33%) agreed that other members of the leadership group were committed to the success of their OHT (Figure 11A). Acute care respondents were more likely to strongly to moderately agree that other members of the leadership group were committed to the success of the OHT than primary care and community respondents (Figure 11B).

Figure 11A: Level of commitment of other members to the success of OHTs

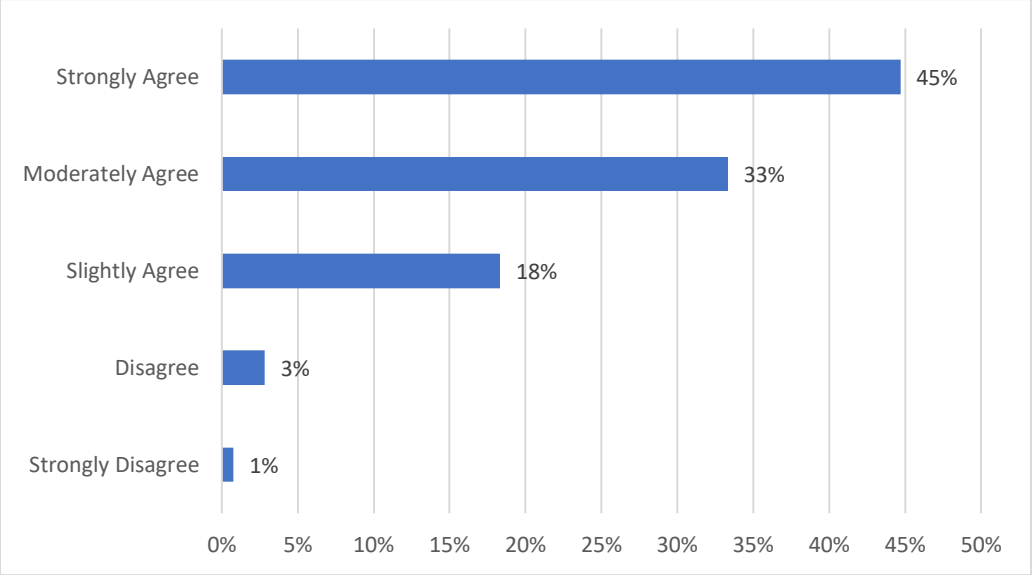
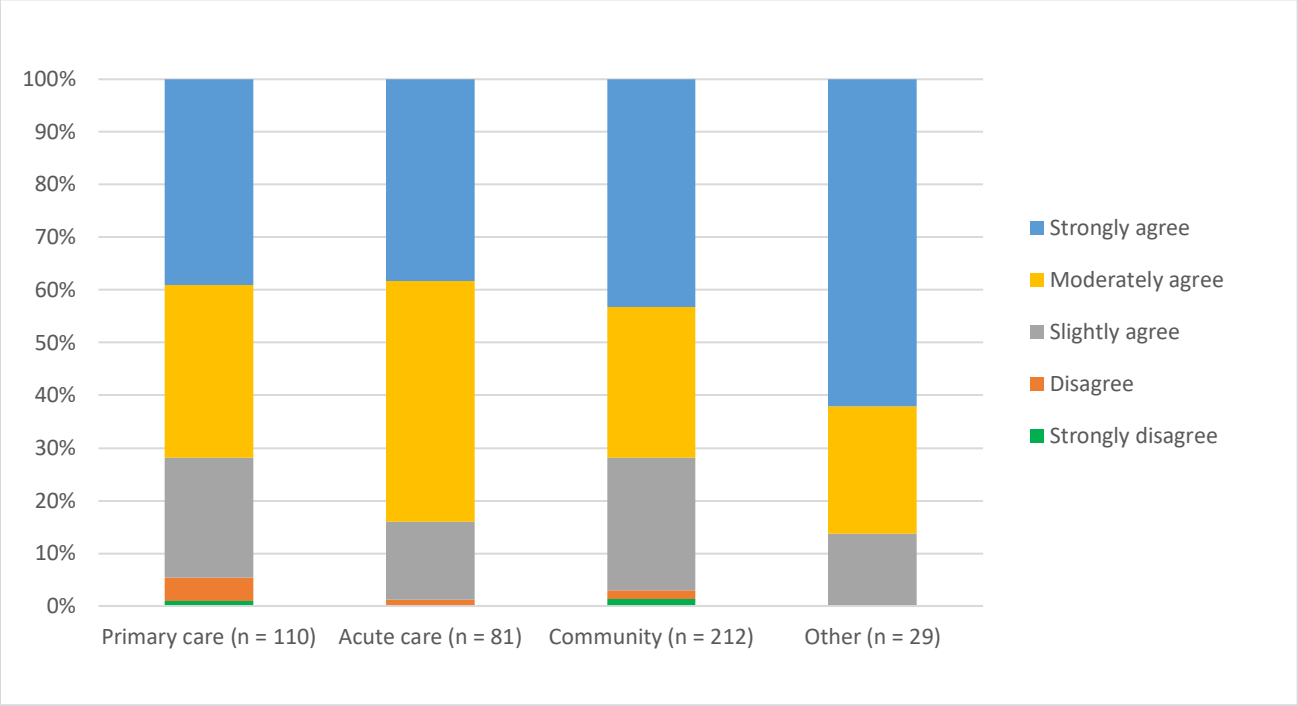


Figure 11B: Others' commitment by sector

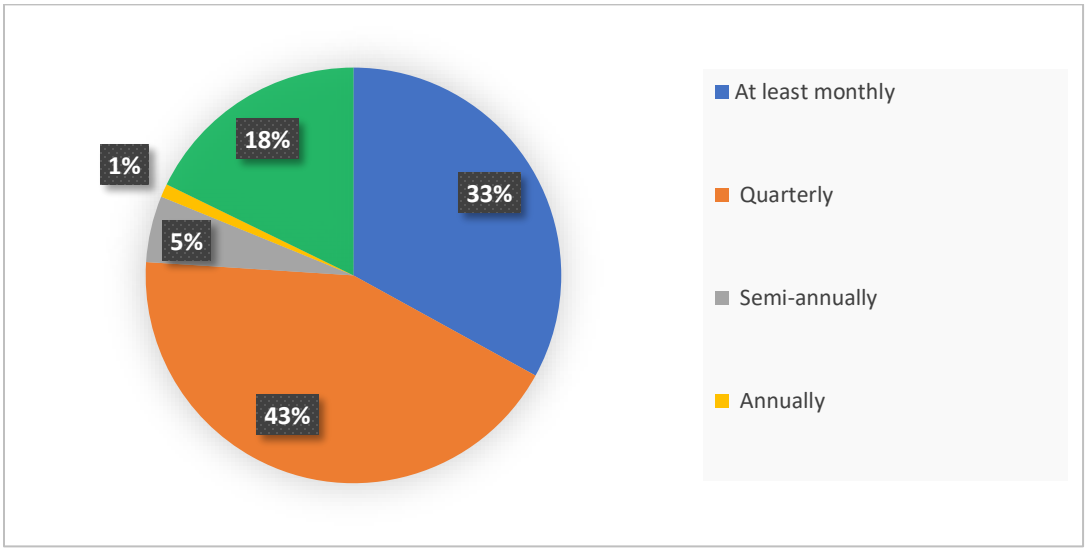


D. 2.2.3 Measurement

Measurement is an essential element of successful and transparent collaborative practices where partners jointly assess progress, identify areas of poor performance and develop strategies for improvement (Kapucu & Hu, 2020). The *Measurement* domain consists of one item. Respondents were asked to identify the frequency of measurements of OHT specific aims.

Most respondents reported their leadership group measured progress quarterly (43%) or at least monthly (33%) (Figure 12). About 18% of respondents reported that their leadership groups do not regularly monitor the progress of their OHTs.

Figure 12: The Frequency of measurement of OHT specific aims



D. 2.2.4 Effectiveness

Effectiveness underlies the importance of leadership groups to jointly work together to achieve network goals (Kapucu & Hu, 2020). The *Effectiveness* domain comprised 3 items. Respondents were asked to 1) rate the total effectiveness of leadership groups in making key decisions, 2) rate the extent to which the development of their OHT strengthened shared capability to meet health-related needs of their population, and 3) rate the extent to which their OHT objectives could actually be achieved.

Most respondents thought that effectiveness of their leadership group in making key decisions was very good (39%) or good (31%) (Figure 13A). Acute care respondents were more likely to think that the effectiveness of the leadership group was excellent or very good, while primary care respondents were more likely to think that the effectiveness of the leadership group was fair or poor (figure 13B).

Figure 13A: Effectiveness of leadership group in making key decisions.

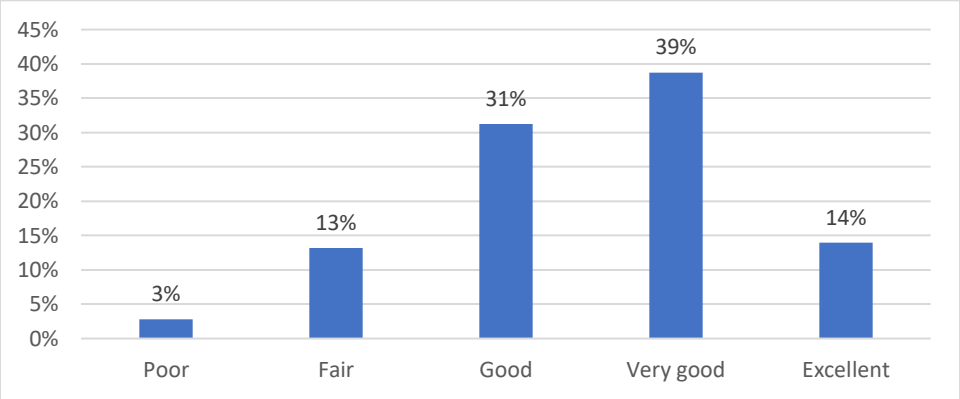
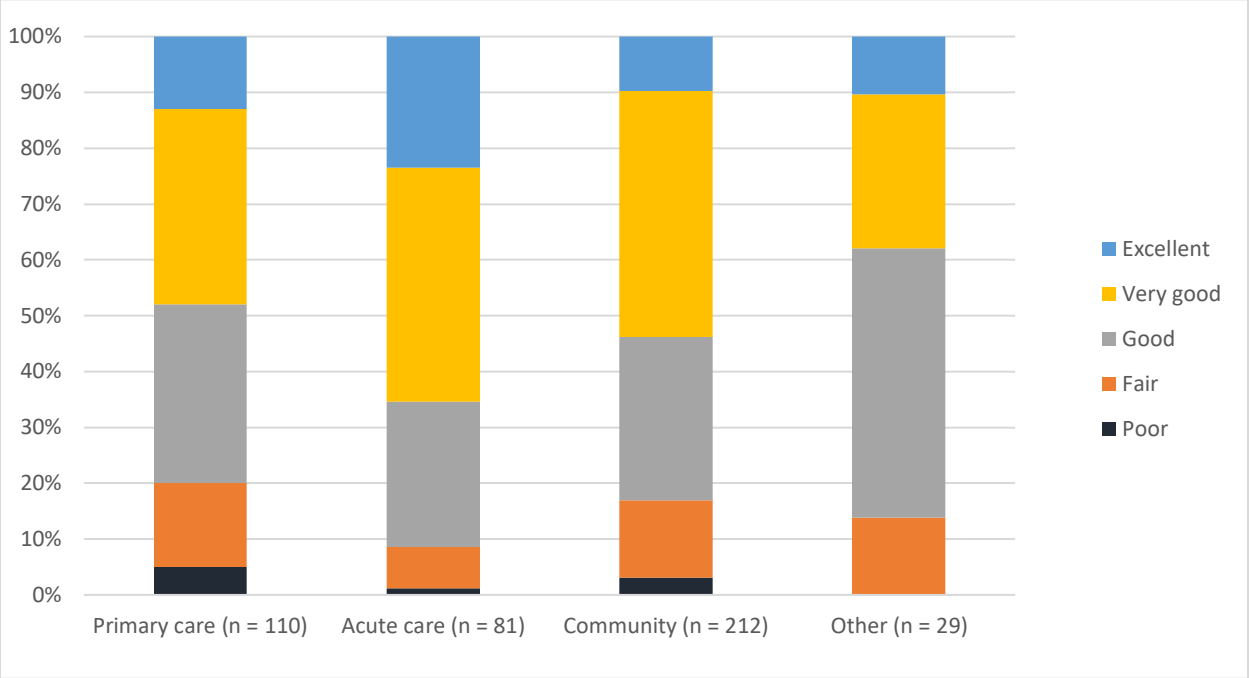


Figure 13B: Leadership effectiveness by sector



Most respondents thought that the development of their OHT had somewhat (38%) or mostly (32%) strengthened shared capability to meet the health-related needs of their population (Figure 14A). Acute care respondents were most likely to report that the OHT completely or mostly effective in addressing the health needs of their populations (Figure 14B)

Figure 14A: OHT effectiveness in meeting health needs of their population.

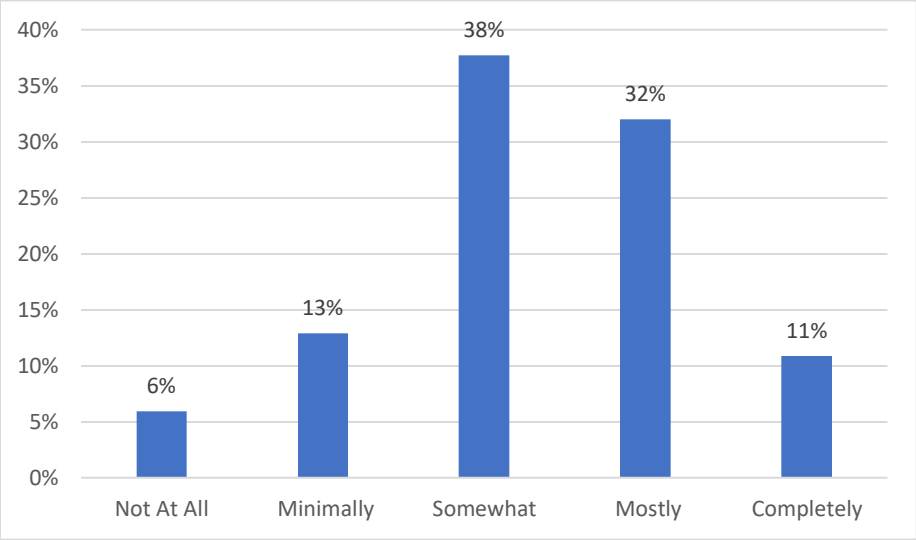
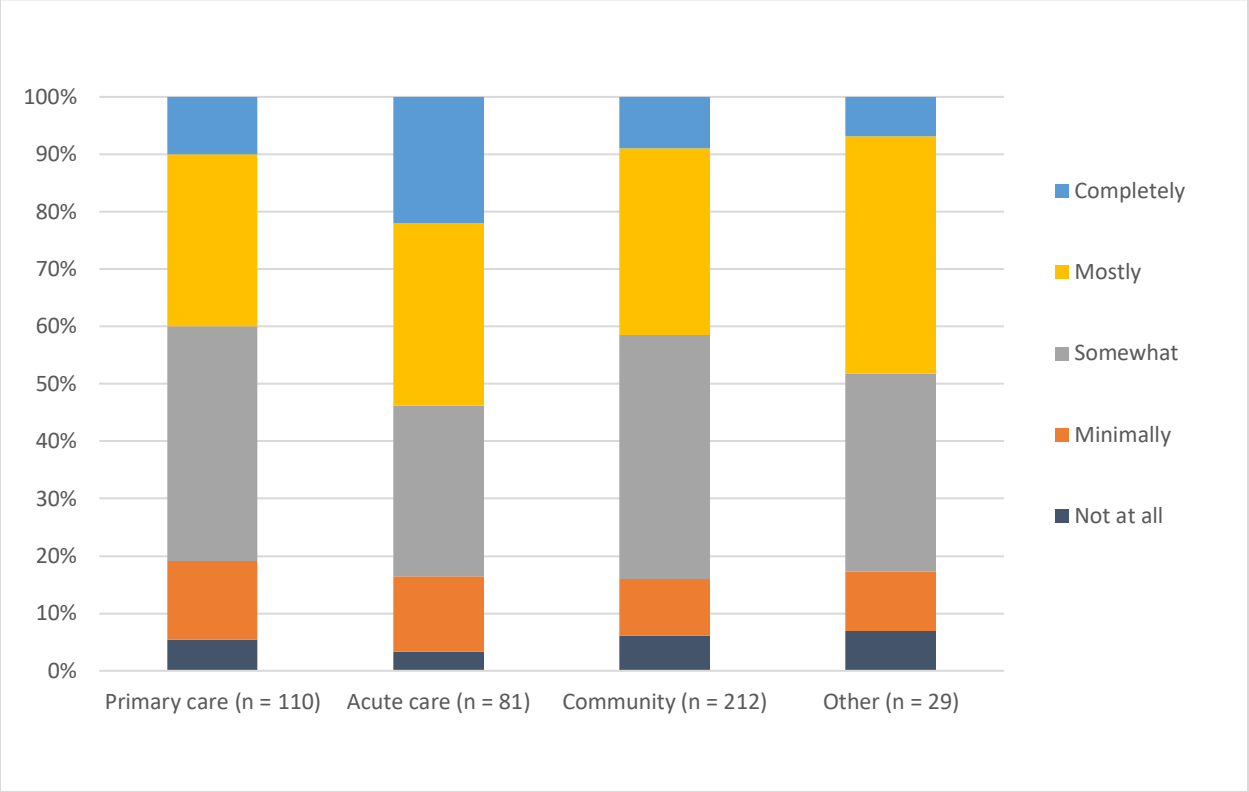
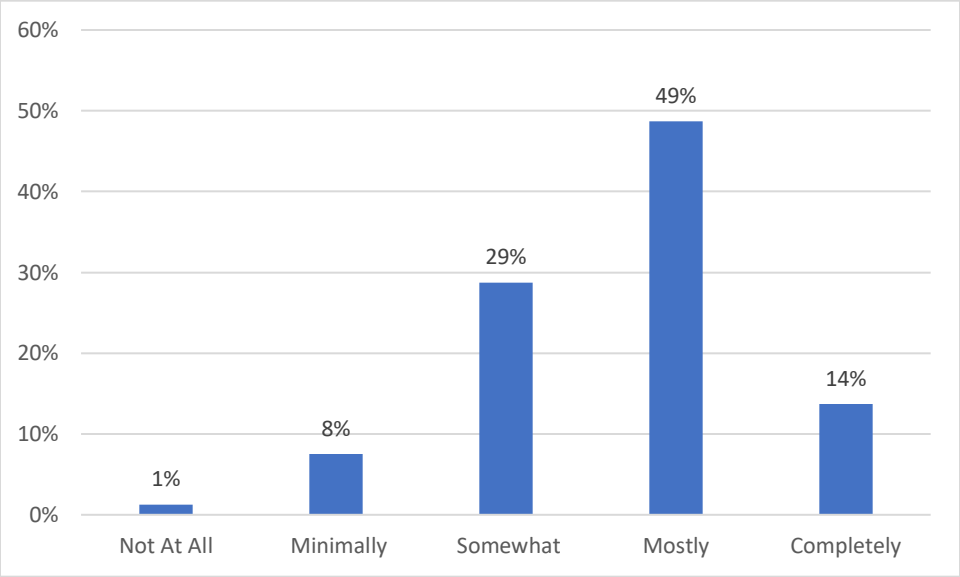


Figure 14B: OHT effectiveness by sector



Most respondents thought that their OHT could mostly (49%) or somewhat (29%) achieve their objectives (Figure 15).

Figure 15: The capacity to effectively achieve OHT objectives.



D. 2.2.5 Summary of Perception of Governance Survey results

In summary, the Perception of Governance Survey reveals that most OHT leadership groups primarily make decisions on agreements to OHT attestations, funding allocations and selection of strategic goals through consensus agreement amongst members. However, respondents working in acute care were more likely to say that decision were made by consensus as compared to primary care and community-based respondents. While more than half of respondents thought that some members had more influence in decision-making, acute care respondents were more likely to feel that all members had equal influence in decisions. Furthermore, hospital-based respondents seemed to be more committed and less skeptical of other members commitment to the OHT. Hospital respondents reported more positive perceptions of the overall effectiveness of OHTs.

E. Discussion

Good collaborative governance is an essential feature of inter-organizational networks in order to successfully address the diverse needs of individuals and population groups they serve (Michgelsen 2022). These innovative governance models should be led by leadership groups that steer respective OHTs towards maturity. This report synthesises the current state of collaborative governance by exploring key features of the structure and functioning of OHT leadership groups. The findings of this report are discussed in comparison to international literature, and we suggest areas for improving policies and network practices to advance collaborative governance of OHTs.

International literature suggests that the size of a network is an important determinant of successful collaborative governance (Provan & Kenis, 2008). The network size has mostly been framed as the number of participating organizations (Provan & Kenis, 2008) - as the network grows and the number of partner organization increases so too does the number of potential relationships increase exponentially. It is extremely challenging to govern complex networks because it is difficult to adequately coordinate activities across multiple organizations, responding to their unique needs while pursuing collective action (Provan & Kenis, 2008). With more participants, it is more difficult to solidify ‘strong ties’ between all network members. Although there is no consensus on the “correct size” of networks, studies seem to agree that collaborative governance becomes inefficient when coordinating across 10 or more organizations (Burn, 2004; Faerman, McCaffrey, & Slyke, 2001). In this report, our findings showed that OHT leadership groups members were mostly chosen to represent original signatory organizations. Furthermore, OHTs had relatively large leadership groups, ranging from 5-65 individuals with a median of 15 members. In many instances the largest numbers related to individual physicians with solo practice participating as signatories to the OHT application. In accordance with international literature, effective collaborative governance may be challenging with large OHT leadership groups. Nonetheless, these OHT leadership groups were relatively stable with about 63% reporting having decreased or same number of members, and 74% of OHTs reporting to have less than 10% turnover of their leadership groups. This relative stability of leadership groups contributes to conserving organisational memory and administrative procedures (Kapucu & Hu, 2020) that may mitigate the negative effects of large leadership groups.

In November 2022, the MOH communicated new direction consisting of encouraging OHTs to establish not-for-profit corporations as the main collaborative governance model (Ministry of Health, 2022). As OHTs advance in their paths to maturity, it is essential that they have the capacity to innovate, re-create or restructure governance as suits their local contexts, as well as the capacity to ensure good communication between Board members. In this respect we found

that only 18% of OHTs have identified future models of governance. This finding may be due to the fact that most OHTs were at early stages of development and were still figuring out how to organise themselves. Similarly, we found that 88% of OHTs had not yet developed communication and reporting processes between their leadership groups and the respective Boards of their home organizations. Furthermore, 77% of OHTs report that there was no direct communication between the Boards of OHT member organizations. Wider implementation science literature suggests that the lack of innovativeness of OHTs and limited communication between Boards of partner organisations are negative factors to organizational change that need to be adequately addressed to ensure the successful implementation of OHTs (Damschroder et al., 2009; Greenhalgh, Robert, Macfarlane, Bate, & Kyriakidou, 2004).

Our findings show that the main decisions taken by OHT leadership groups include agreements to OHT attestations, allocation of funding, selection of strategic goals and selection of priority populations. These decisions were mostly (81% of OHTs) carried out by consensus agreements amongst members, and about 60% of OHTs reported that some members carry more influence than others or one or two members make most decisions. Shared decision-making is probably one of the most complex component of collaborative governance. In a recent systematic review, Michgelsen et al. (2022) identified three main decision-making dilemmas that are encountered by integrated care systems, namely i) pursing autonomy or interdependence in the actions of partner organisations, ii) engaging in decision-making of a small coherent group of organisations to achieve similar goals or embracing a large diverse group of organisations with different viewpoints and historical relationships, and iii) engaging in decision-making that reflect the self-interests of organisations or decision-making that reflects the common goals of the network. OHT leadership group members probably had to navigate these decision-making dilemmas since they can not fully separate themselves from their affiliations with heir respective home organizations.

Committed leadership is an important enabler of organisational change (Damschroder et al., 2009; Threapleton et al., 2017). Committed leaders would dedicate time and resources to advance the goals of their network (Threapleton et al., 2017). Our findings suggest that there was a high level of commitment of OHT leadership group leaders, with about 70% of respondents reporting that they were committed to balancing the goals the OHT with the interests of their organisations, and more than 78% of respondents strongly or moderately agreed that other leadership group members were committed to the success of their OHT. It is important to maintain or improve on such high levels of commitment.

Sectoral analysis of the Perception of Governance Survey revealed a consistent pattern where acute care respondents were more likely to allocate resources, report equal influence in decision-making, report high levels of shared commitment, and report more positive perceptions of OHT effectiveness as compared to primary care and community care respondents (see figures 7B, 8B, 9B, 10B, 11B, 13B and 14B). This pattern may reflect the fact that acute care organizations (hospitals) control the most financial, material and human resources among OHT partner organisations. They may be the biggest contributing partner and the current orientation of collaborative governance may align with their interests. By extension, this pattern may also reflect the fact that primary care and community care partner organisations are still struggling to influence the orientation of their integrated care networks. International literature suggests that organisations may lose interest and actively resist transformations that do not align with their interests (Threapleton et al., 2017).

F. Conclusion and Implications

Collaborative governance is a critical component of successful integrated care systems. Our survey results capture key features of the structure and functioning of collaborative governance that may inform improvement of OHTs. As the MOH provides guidance for future not-for-profit collaboration models for OHTs, the findings of this report suggest that they should consider:

- Clarity on the size of OHT leadership groups given that larger sizes can increase complexity of coordinating services across partners.
- Encouraging OHTs to limit the turnover of leadership group members so as to ensure stability.
- Investing in mechanisms to support information exchange between OHTs leadership groups and their respective Boards of partner organisations.
- Supporting consensus approaches of decision-making that is currently prevalent in OHTs.
- Enhancing the engagement of primary care and community organisations in collaborative governance of OTHs.

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Appendices

Appendix A – Factual Governance Survey questions

1. How many members are currently included un your leadership group?
2. Since approval of your OHT, has the number of members of your leadership group changed?
3. Which of the following reflect the membership of your leadership group? How would you describe the membership of your leadership group?
4. Please indicate what sectors and agencies/communities are represented as members of your leadership group.
5. To what extent have the individuals that participate in your leadership group changed/turned over (amongst members that have a continuing membership on the leadership group since it was originally formed)?
6. We are interested in how the OHT leadership group keeps OHT member health service provider/agency Board of Directors ('Boards') up to date on decisions (regarding e.g. resources, priorities and membership) of the OHT. What communication processes does your OHT leadership group use with member health service provider/agency Boards ("external Boards")?
7. Are there specific ways that the Boards of OHT member health service provider/agencies communicate directly among themselves?
8. In terms of governance for the OHT, which of the following statements best described your approach?

Appendix B – Perception of Governance Survey questions

1. What kinds of decisions are primarily made by the OHT leadership group?
2. What decisions are you able to make on behalf of your organization in regard to the implementation of the OHT?
3. What option best describes how decisions are made in the leadership group about key decisions such as membership, resource allocation, or strategic priorities?
4. Which option best describes how you perceive the balance of power regarding decisions in your OHT?
5. OHT participants have a shared role between their host organization and the OHT. How would you describe your level of commitment between the goals of the OHT and the interests of your organization?
6. To what extent do you agree or disagree with the following statement? The other members of the leadership group are fully committed to the success of the OHT.
7. How often does the leadership group review measures to track progress toward your OHT's specific aims?
8. Please rate the total effectiveness of your OHT's leadership group: In making key decisions regarding topics such as membership, resource allocation, or strategic priorities?
9. To what extent do you think this statement is true? The development of your OHT has strengthened shared capability to meet the health-related needs of your population.
10. To what extent do you think this statement is true? Your OHT's objectives can actually be achieved.