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Governing personal health information sharing in an integrated care partnership

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Abstract

Purpose: This study examines how members of an integrated care partnership described the responsibilities and arrangements associated with workable and constrained sharing of personal health information across organizations.

Design/methodology/approach: Eighteen of 26 members of the Guelph Wellington Ontario Health Team Privacy and Security Working Group completed an email questionnaire, and all 18 later joined a 60-minute Zoom group session with four additional attendees. An adapted nominal group technique clarified and refined preliminary themes, followed by abductive analysis using institutional logics and the concept of compatibility.

Findings: Participants described sharing as more workable when the purpose, recipients, permissions and organizational responsibilities for an exchange were sufficiently defined. Safeguards, technical connections and established relationships also supported workable arrangements. The analysis distinguished legal knowledge gaps from risk aversion, technical integration from governance issues, and viewing information from contributing it.

Research limitations/implications: The study reflects one regional working group and participants' accounts were not independently verified. Patients were not recruited. Future research should follow specific sharing arrangements longitudinally and compare governance and implementation approaches across settings.

Practical implications: Managers should diagnose barriers at the level of the specific information-sharing task, distinguish authorization from technical and operational constraints, assess whether shared services support both access and contribution, and use common preparation where organizations face similar requirements.

Originality/value: The study applies institutional compatibility to specific information exchanges rather than whole organizations and distinguishes availability, authorization and operational capacity as separate conditions for participation.

Keywords: *integrated care; personal health information; institutional logics; information governance; health information sharing; Ontario, Canada*

Introduction

Health care providers in different organizations often care for the same patient, but the information needed to coordinate that care may be held in separate systems and governed by separate organizations. A clinician may need to know what happened during a recent hospital visit, which services are already involved or whether another provider changed the care plan. At the same time, each organization remains responsible for protecting personal health information (PHI) and determining when disclosure is appropriate. Information sharing therefore depends on more than connecting systems. Organizations must also agree on who may receive information, for what purpose, under what conditions and through which processes.

Research on integrated care has identified many of the difficulties involved in this work. Integrated care requires coordination across clinical activities, organizations and the wider health system (Valentijn et al., 2013). Organizational differences, professional relationships, resources and institutional conditions can all hinder integration (Auschra, 2018). Information transfer also depends on whether providers can obtain, interpret and use the information needed for care (Lim et al., 2015), while health information technology must be understood together with the people, workflows and organizations that use it (Sittig and Singh, 2010). Studies of interorganizational collaboration further show that managers use agreements, organizational relationships and other coordinating practices to support information sharing across organizational boundaries (Shaw et al., 2017; Wankah et al., 2022).

This study examines that problem within the Guelph Wellington Ontario Health Team in Ontario, Canada. In 2023, members of its Privacy and Security Working Group completed an email questionnaire about barriers to patient-centred information sharing and then discussed the preliminary findings in an online group session. Eighteen members completed the questionnaire, and all 18 attended the session along with four additional participants. The group included organizational representatives with responsibility for, or knowledge of, privacy and security practices. Participants described arrangements that supported useful sharing, including common agreements, access controls and technical integration. They also described unresolved legal review, uncertainty about privacy requirements, separate technology investments, limited organizational capacity and services that allowed providers to view information without contributing their own.

The study asks: How did working-group participants describe the responsibilities and arrangements associated with workable and constrained information sharing across the partnership? Institutional logics provide the main theoretical perspective. Institutional logics are socially established values, rules and practices that influence how people judge appropriate action (Thornton et al., 2012). This perspective is useful because participants were not only describing technical problems. They were also explaining how organizations understood their responsibilities to protect information, coordinate care and manage their own resources. The analysis therefore distinguishes institutional concerns from legal uncertainty, technical limitations and resource constraints rather than treating every barrier as the same type of problem.

The findings show that participants did not describe privacy protection and coordinated care as inherently incompatible. In arrangements they considered workable, safeguards such as defined permissions, access controls, agreements and training existed alongside useful information sharing. The important distinction was whether the purpose, recipients, permissions and responsibilities of a particular exchange had been sufficiently defined for organizations to act. The analysis therefore applies the concept of institutional compatibility at the level of a specific information exchange rather than at the level of the organization as a whole.

The findings also identify a separate implementation problem. Access to a shared service does not necessarily mean that an organization can perform every information-sharing task required for care. Participants described situations in which providers could view information but could not contribute information through the same system. The paper develops three distinctions to explain this form of partial participation: availability, whether the required information can reach the setting where it is needed; authorization, whether a person or organization is permitted to receive or contribute it; and operational capacity, whether the necessary systems, staff and work processes can complete the

exchange. Together, these findings provide a more precise way to examine why some interorganizational information-sharing arrangements proceed while others remain incomplete.

Institutional expectations and information governance

How participants interpreted responsibility

An institutional perspective helps explain how people understand what appropriate action requires of them. Institutional logics provide socially established values, assumptions and rules through which people interpret situations and determine appropriate action (Thornton et al., 2012). In this study, participants referred to several responsibilities when describing information sharing, including protecting confidentiality, supporting coordinated care and managing organizational resources responsibly. These responsibilities provided different considerations when deciding whether and how information should be shared.

These judgments are different from purely technical constraints. Health information exchange depends on the interaction of technology, people, workflows and organizational conditions, and an exchange may therefore fail because a system cannot transmit the required information even when those involved agree that sharing would be appropriate (Sittig and Singh, 2010). An institutional problem is different. It arises when people are uncertain about what responsible action requires or when different institutional expectations point toward different courses of action (Greenwood et al., 2011; Besharov and Smith, 2014).

Greenwood et al. (2011) describe institutional complexity as a situation in which multiple institutional logics prescribe incompatible actions. The presence of several responsibilities does not automatically create this kind of conflict. A participant may believe that protecting confidentiality and coordinating care can both be achieved when information is shared with an appropriate recipient for an appropriate purpose. Participants may also agree that both responsibilities matter but disagree about whether a particular arrangement satisfies them. The analysis therefore distinguishes the responsibilities participants describe from their judgments about specific information-sharing arrangements.

Besharov and Smith (2014) make a related distinction between compatibility and centrality. Compatibility concerns whether different institutional logics prescribe actions that can be carried out together, while centrality concerns how important those logics are within an organization. Their framework was developed to classify organizations. This study uses only the concept of compatibility and applies it more narrowly to specific exchanges between organizations. It does not classify the participating organizations or assign them to Besharov and Smith's organizational types.

Privacy concerns also need to be interpreted carefully. Anthony and Stablein (2016) show that health professionals understand information control through professional practices and responsibilities as well as formal rules. A concern about disclosure may therefore reflect a judgment about responsible professional conduct, uncertainty about legal requirements or both. The available evidence does not allow the researcher to infer the motives of a professional group from another participant's description of that group. Comments about physicians, executives or other groups are therefore treated as the speaker's perceptions unless the passage describes first-person experience.

How organizations put information sharing into practice

Institutional expectations matter because organizations must translate broad responsibilities into concrete arrangements. Reay and Hinings (2009) show how people managed competing institutional logics in a health care setting, while Smets and Jarzabkowski (2013) show how everyday practices can reshape the relationship among institutional expectations. Their work suggests that privacy and coordination should be examined within specific practices rather than assumed to be inherently incompatible.

Research on integrated care makes a similar point. Shaw et al. (2017) examine how partnership is put into practice during patient transitions. Wankah et al. (2022) describe managerial practices such as negotiated agreements, new

roles and co-location of staff, including agreements that supported access to clinical records across organizations. Roth (2025) reviews how managers respond to institutional diversity in integrated care. Together, these studies show that collaboration across organizational boundaries depends on how managers define responsibilities, allocate authority and organize day-to-day work.

The present analysis therefore examines the arrangements through which participants described information sharing taking place. Agreements can define who participates and how information may be used. Access controls can restrict users to particular records or functions. Training can help staff understand how to apply the rules, while audits can assess whether those rules are being followed. These arrangements show how organizations can support information sharing while maintaining safeguards for PHI. Their presence does not establish that an arrangement was legally sufficient, nor does it show that any single feature caused the arrangement to work.

Distributed authority, costs and capacity

Information governance includes the decisions, rules and responsibilities through which organizations manage information. In an integrated care partnership, organizations may need to coordinate shared activities while retaining separate authority over their records, staff and budgets. Provan and Kenis (2008) show how networks can coordinate work among otherwise independent organizations without transferring all authority to one organization. A centrally prepared agreement, for example, can establish common terms for participation while each organization continues to manage its own records and internal operations.

Some barriers can also be explained by differences in resources and organizational capacity. Feiock (2013) uses the concept of institutional collective action to examine collaboration among actors that retain separate authority and face different costs and benefits. An organization may support an information-sharing initiative but still lack the money required for a technical interface or the staff time needed for implementation. Kazlauskaitė et al. (2025) similarly show that sector and resource availability can affect information transfer in long-term care. These constraints may prevent participation even when organizations agree that sharing is appropriate.

The researcher initially organized the material around three broad orientations: protecting information, supporting partnership and using organizational resources responsibly. These categories were used to structure the analysis, not to assume that three distinct institutional logics were present. Financial concerns illustrate the distinction. A participant might describe an organization as unable to afford an interface, question who should bear the cost of implementation or argue that resources should be protected for other priorities. These statements do not have the same meaning. A lack of money is a capacity constraint, while disagreement over how resources ought to be used may reflect competing institutional expectations. Resource concerns were therefore interpreted as evidence of institutional conflict only when participants connected them to different views about what responsible organizational action required.

Research setting and methods

The Privacy and Security Working Group had 26 members. All 26 were invited to complete the questionnaire. Member organizations selected representatives who were familiar with their privacy and security practices. Participants included primary care office managers, privacy and security leads at community agencies, chief executive officers and operations leads. Eighteen members completed the questionnaire. All 18 questionnaire respondents later attended the group session, along with four additional attendees, for a total of 22 participants in the session.

The researcher distributed the questionnaire by email in July 2023 and received responses during July, August and September, before the group session. The questionnaire contained four open-ended questions about effective information sharing, priorities for improvement, an ideal future arrangement and barriers to achieving it. The final question listed culture, knowledge, technology, cost and legislation as examples of possible barriers. Including these examples may have directed additional attention to those topics.

The researcher coded the questionnaire responses and organized them into preliminary categories. These findings were then circulated to participants before the group session. Participants were asked to identify inaccuracies, omissions and alternative interpretations. The purpose of the second phase was therefore to clarify and refine the initial analysis using discussion among people who had first had an opportunity to provide their views independently.

The group met through Zoom for 60 minutes on 18 September 2023. The researcher used an adapted nominal group technique (McMillan et al., 2016). The questionnaire served as the individual idea-generation stage because respondents answered the four questions before taking part in group discussion. During the round-table session, all attendees were given opportunities to comment on the preliminary findings. The discussion was used to clarify meanings, identify missing issues and reconsider how some responses had been grouped.

How the group session refined the original analysis

The group discussion changed the preliminary analysis in several ways. Participants introduced issues that had not appeared in the questionnaire responses, distinguished between themes that had initially been grouped together, and clarified how some findings should be interpreted. After the session, the researcher reviewed the Zoom transcript alongside the questionnaire responses and revised the thematic analysis for the final 2023 report. These refinements were part of the original study. The institutional interpretation developed for this article was conducted later, using the findings that had already been refined through that process.

Table I summarizes the main changes between the preliminary and final analysis. It shows how participant discussion affected the organization and interpretation of the findings.

Table I Changes to the thematic interpretation following group discussion

Preliminary interpretation	Refined interpretation	Effect on the analysis
Shared Databases	Shared PHI	Focused the analysis on the information moving between organizations rather than on the system that stored it.
Direct Interorganizational Connections	Real-time, Synchronous Communication. Participants also added OCEAN eReferrals and described ClinicalConnect as a central repository of visit information available through a low-barrier read-only arrangement.	Separated direct communication, repository access and electronic referral as different functions.
A single shared database as the future vision	Several architecture options, including databases hosted by partner organizations and a curated table of contents that providers and patients could use to locate information.	Expanded the future vision beyond one centralized system and allowed for coordinated access across existing assets.
Patients were implicit in general comments about information processes	Timely patient access to one's own PHI became an explicit part of the future vision and a separate barrier.	Made the patient-facing information task explicit in the final analysis.
Culture and Knowledge as one barrier; Electronic medical record (EMR) integration mainly as an improvement suggestion	Knowledge gaps concerning PHIPA, consent, circle of care and data ownership were separated from fear and risk aversion. Inadequate EMR integration became a barrier in its own right.	Separated uncertainty about rules, risk response and technical integration as different explanations.
Financial Issues and Who Should Pay as a named barrier	Funding concerns remained in the evidence but were interpreted alongside leadership, coordination and implementation capacity.	Placed cost within the broader question of who organizes, funds and supports shared work.

Source: preliminary questionnaire analysis, group-session transcript and notes, final report.

During manuscript preparation, the researcher returned to four records from the original inquiry: the invitation, consent information and questionnaire (S1); the preliminary questionnaire analysis circulated before the group session (S2); the group-session notes (S3); and the final findings report (S4). The complete questionnaire responses and Zoom transcript had already informed the original 2023 analysis. The later theory-informed analysis therefore

focused on source-linked passages retained in these records, the documented changes between the preliminary and final themes, and the evidentiary strengths and limitations of each source.

Theory-informed analysis

The theory-informed analysis used abductive reasoning, moving between the empirical material and plausible theoretical explanations (Timmermans and Tavory, 2012). Participants' accounts were treated as interpretations of policies, technologies and organizational relationships rather than as independently verified descriptions of events. This allowed the analysis to examine how participants understood appropriate and responsible action while remaining cautious about claims that could not be confirmed from the study records (Thornton et al., 2012).

The researcher first documented the purpose, date and evidentiary status of each source. Source-linked passages were then coded for the activity being described, the explanation offered, the arrangement involved and the type of constraint or support identified. The analysis distinguished participants' reported experiences from aspirations, comments about other people and the researcher's own recommendations. The documented revisions between the preliminary and final 2023 themes were also reviewed to identify where the group discussion had changed the interpretation. Repeated material was traced back to its original source rather than treated as additional evidence. An evidence matrix was used to record the source, interpretation and main alternative explanation for each comparison.

The researcher then compared arrangements that participants described as workable with those they described as constrained. Greater weight was given to passages in which participants explicitly connected a particular arrangement with an outcome. For example, one respondent directly associated centrally prepared agreements and vendor integration with easier participation. This approach is consistent with thematic analysis because it looks for patterns of meaning while recognizing that the original study had already organized and interpreted the material (Braun and Clarke, 2006, 2021).

The interpretation was revised when the emerging explanation did not account for the full range of participants' accounts. The initial analysis placed substantial emphasis on uncertainty about privacy requirements and reluctance to disclose information. Other evidence showed that this explanation was incomplete. Some participants described information being shared too broadly or safeguards being inadequate, while others described appropriate access being restricted. The issue was therefore not simply a tendency to withhold information. Participants were making judgments about when sharing was appropriate and under what conditions it should occur (Anthony and Stablein, 2016).

This evidence also narrowed the role of the institutional explanation. Participants described workable arrangements that included access restrictions, privacy agreements, training and audits, showing that privacy safeguards could operate within effective information-sharing arrangements. At the same time, some barriers were better explained by technical or organizational constraints. Participants described limited staff and financial capacity, poor-quality scanned documents and substantial investments in existing systems. These issues were therefore retained as financial, technical or operational explanations rather than interpreted as institutional conflict (Sittig and Singh, 2010).

Accounts of read-only access provided a further distinction. In some cases, being able to view information was useful for tasks such as reviewing a patient's history, even when the same system did not allow staff to contribute information needed elsewhere in the care process. The analysis therefore treated information sharing as a set of distinct activities with different requirements, rather than assuming that access to a shared system meant that all information-sharing needs had been met.

Researcher role and ethics

At the time of the study, the researcher was a Professor of Business Analytics at Conestoga College and conducted the original coding alone prior to the focus group validation process. The author considered evidence that challenged

the proposed explanation, separated participant statements from researcher recommendations and used contextual knowledge as background rather than independent evidence.

Conestoga College's Research Ethics Board approved the study on 2 June 2023 under approval number 495. Participants provided signed informed consent, and no participants withdrew. The approved protocol and consent covered recording, transcription, retention and further use of study material, including anonymous responses in publications. The quotations were anonymized and vetted by participants for publication. The author confirmed that the quotations and organizational details included here remained appropriate for publication.

The author uses anonymized quotations from the retained questionnaire compilation by creating participant codes and a doubly secured participant name and code index file. Identified organizations or professions are named only when needed to explain an arrangement, and participants' claims about other people's motives are treated as perceptions rather than findings. The author used the Consolidated Criteria for Reporting Qualitative Research and the Standards for Reporting Qualitative Research to inform reporting decisions (Tong et al., 2007; O'Brien et al., 2014).

Legal context for PHI sharing in Ontario

Ontario's *Personal Health Information Protection Act, 2004* (PHIPA) governs how health information custodians collect, use and disclose personal health information. A health information custodian is a person or organization that has custody or control of personal health information in circumstances covered by the Act (Information and Privacy Commissioner of Ontario, 2015). This legal framework is directly relevant to the study because all organizations represented in the Privacy and Security Working Group were health information custodians. Participants were therefore discussing information sharing among organizations that operated under the same provincial privacy legislation while remaining individually responsible for the personal health information under their custody or control.

Participation in the same Ontario Health Team did not, by itself, permit information to be shared among member organizations. Whether a custodian could rely on implied consent depended on the circumstances of the exchange, including the purpose for which the information was being shared, the organizations involved, the recipient of the information and whether the patient had withheld or withdrawn consent. Ontario guidance uses the term *circle of care* to describe circumstances in which certain health information custodians may rely on implied consent to collect, use or disclose personal health information for the purpose of providing health care. PHIPA itself does not define the term (Information and Privacy Commissioner of Ontario, 2015). These requirements were especially relevant to the working group because its members were trying to coordinate information sharing across organizational boundaries while each organization retained its own responsibilities under PHIPA.

The distinction between the legal rules and participants' understanding of those rules is important for interpreting the findings. Health professionals do not make information-sharing decisions solely by consulting formal rules. Their professional responsibilities and established practices also shape how they understand appropriate control over patient information (Anthony and Stablein, 2016). Several participants in this study described uncertainty about what PHIPA permitted and how concepts such as consent and circle of care should be applied. Their comments therefore provide evidence about how participants understood and applied privacy requirements, but they do not establish whether those interpretations were legally correct. The study did not examine the circumstances of individual disclosure decisions in enough detail to determine whether a particular restriction, approval process or legal review was required. The findings instead show how uncertainty about privacy requirements affected participants' accounts of information sharing. The same limitation applies to their broader comments about ownership of health information and patients' rights of access.

Findings

Participants focused on information flows rather than one shared system

Participants wanted relevant information to be available to providers involved in a person's care. One respondent described the desired patient experience:

> *"From the client perspective, I would like them to experience that each service provider they access already has their information, and only needs to ask additional or clarifying questions." (S2, Question 3)*

The respondent described an aspiration for continuity across services from a provider's perspective. Patients were not recruited as a separate participant group, so this statement cannot be treated as direct evidence of patient preferences or experiences.

In the preliminary questionnaire analysis, the researcher organized current-state examples partly around the technologies that connected organizations, using categories such as Shared Databases and Direct Interorganizational Connections. During the group discussion, participants redirected attention to the information task being performed. The researcher renamed Shared Databases as Shared PHI and Direct Interorganizational Connections as Real-time, Synchronous Communication. Participants also added OCEAN eReferrals, which had not appeared in the questionnaire responses, and described ClinicalConnect as a central repository of visit information available through a relatively low-barrier read-only arrangement. The revised categories focused on how information moved rather than on which system stored it. OCEAN eReferral is an electronic referral system used in Ontario to send and track referrals between health care providers (Ontario Health, n.d.). ClinicalConnect is a secure clinical viewer that gives authorized providers access to patient information from multiple health care organizations and data sources (Hamilton Health Sciences, n.d.).

During the future-state discussion, participants expanded the original vision beyond a single shared database. Some favoured one shared electronic medical record, while others preferred linked or partner-hosted repositories that could preserve existing organizational investments. One participant wrote, "Systems can be different, but they need to be built with interoperability in mind" (S2, Question 3). Participants also proposed a curated table of contents that would help providers and patients locate relevant information, and they made timely patient access to one's own PHI an explicit objective. Proposed access rules varied, including read-only access and access limited to information needed for care, sometimes paired with shared privacy training and consent management. Participants therefore agreed on the need for coordinated access without reaching a documented consensus on one system, custodian or implementation design.

Knowledge gaps and risk aversion created different barriers to disclosure

Several written accounts linked uncertainty about privacy rules with hesitation to share information. One respondent described this directly:

> *"I think the biggest barrier is knowledge of the legislation and fear of doing something they should not. I certainly do not have a fulsome knowledge of privacy legislation which makes me apprehensive about how to best share information" (S2, Question 4)*

The respondent raised two concerns that participants later separated during the group discussion. The first was a knowledge gap concerning PHIPA, consent management, circle of care and understandings of data ownership. The second was fear and risk aversion, including accounts in which people defaulted to non-sharing when they were uncertain. These are different problems. Education can address a knowledge gap, while risk aversion may persist even after the rules are explained. The quotation does not document a specific refused disclosure, and the available evidence is insufficient to determine whether the participant's legal interpretation was correct.

Concern also ran in the opposite direction. One respondent wrote about privacy education:

> *"Sometimes the belief is that you can share information too broadly, sometimes people are denied access to the information they need when they shouldn't be." (S2, Question 2)*

A further account contrasted organizations with strict privacy practices with organizations perceived to give too little attention to protection. Participants therefore described errors in both directions: information could be shared too broadly or withheld when access was appropriate. Any explanation of the barrier must account for how staff judged the terms of a specific exchange, including when access should be limited.

One respondent described care plans created in primary care records and an automated process for publishing them to a central database. The respondent reported that "the mechanism is held up in legal reviews" (S2, Question 2). Technical preparation had therefore occurred while review remained unresolved. The available records do not name the reviewers, explain the issues they considered or report the outcome. Technical readiness and completion of review were therefore separate stages in this example. The evidence is insufficient to determine whether the proposed disclosure was lawful or whether the review was necessary.

Separate systems and local technology investments limited integration

The group discussion identified inadequate electronic medical record integration as a distinct barrier to information sharing. Participants described organizations using separate systems that did not connect well with one another, while also having substantial investments in their existing technologies. These local systems and investments made it more difficult to develop common information-sharing arrangements across the partnership. One respondent wrote:

> *"Almost every agency is buying their own technology/software for patient records and there isn't a single, shared system or coordinated approach to acquiring technology/software." (S2, Question 4)*

Other accounts focused on the resources already committed to existing systems. Participants described investments of money, staff time and training that would have to be supplemented or replaced to support new information-sharing arrangements. Smaller organizations were also described as having limited staff capacity and difficulty paying for specialized technical support. These constraints could limit participation even when an organization supported greater information sharing. Importantly, participants described both an inability to invest and an unwillingness to invest. These represent different problems and should not be interpreted in the same way.

One respondent summarized the issue as "the question of 'who should pay'" (S2, Question 2). The comment referred to a conversation with a physician group and was therefore second-hand; it cannot establish that group's motives. It does, however, illustrate a broader implementation problem. One organization may be expected to pay for an interface or undertake implementation work even though the benefits of improved information sharing extend to other providers and patients. Because the study did not collect budget or cost data, it cannot determine how these costs and benefits were actually distributed.

Following the group discussion, financial issues and questions about who should pay were no longer treated as a separate barrier. Instead, participants' comments about funding were considered alongside leadership, coordination and implementation capacity. Their concerns extended beyond the availability of money to questions about who would organize shared work, who would commit resources and whether information sharing would be incorporated into organizational priorities. Funding therefore remained important, but it was understood as part of the broader challenge of coordinating and supporting shared work across independent organizations.

Workable sharing relied on defined arrangements, safeguards and relationships

Participants described effective information sharing as depending on both organizational arrangements and technical support. During the group discussion, they described ClinicalConnect as a central repository that allowed participating providers to view information from multiple care settings. One respondent linked the effectiveness of this arrangement to the fact that much of the contractual and technical work had been completed centrally:

> *"This was most effective since the agreements were centrally arranged and vetted, and functionality centrally integrated by PointClick Care." (S2, Question 1)*

The same respondent explained that local participation largely involved signing the prepared agreement and activating the integration. In this example, the organization did not have to negotiate the arrangement or develop the technical connection independently. The contractual and technical components were provided together, so the study cannot determine their separate effects. The account nevertheless shows how completing common preparatory work centrally could reduce the work required from individual organizations.

Participants also described safeguards as part of arrangements they considered effective. One respondent described a shared client database in which access differed according to program needs, external services signed privacy pledges and memoranda of understanding, and users received training and were subject to audits. Another described access to a primary care record through a shared care agreement. In these examples, privacy protections did not prevent information sharing. Instead, access rules, agreements, training and oversight helped define how sharing would occur.

The amount of preparation completed before local implementation differed across the examples. In the ClinicalConnect account, the agreement and technical integration had already been established, leaving the participating organization with a relatively defined implementation process. In the care-plan example described earlier, the technical mechanism had been developed but legal review remained unresolved. These examples involve different organizations, information-sharing tasks and risks, so they do not show that central preparation would necessarily have resolved the care-plan delay. They do, however, illustrate the importance of identifying which elements of an information-sharing arrangement have already been resolved and which still require organizational agreement or review.

Participants also described information sharing that depended more heavily on professional relationships and direct communication. Examples included telephone conversations between physicians and secure messaging among providers. One respondent attributed much of the information sharing they had experienced to relationship building, while also noting how difficult it was to maintain those relationships across a large number of clinicians and organizations (S2, Question 1). A shared database was therefore not necessary for every useful exchange. At the same time, the available evidence does not show whether relationship-based approaches provided all of the information needed for care or whether they could be sustained at a larger scale.

The group-session notes also record a question about whether numerous separate data-sharing agreements were necessary (S3). The note provides too little context to determine what prompted the concern, but it points to the amount of work that may be repeated when organizations develop similar arrangements independently. Considered alongside the ClinicalConnect example, it raises an important implementation question: which parts of an information-sharing arrangement can be prepared once for participating organizations, and which decisions must still be made separately for each exchange?

Access to information did not always support contribution

Participants distinguished between being able to view information and being able to contribute information through the same system. In one primary care at home example, read-only access to a community care system was described as useful for identifying other providers involved in a patient's care and reviewing the patient's history (S2, Question 1). In that case, read access was sufficient for the task staff needed to complete.

A respondent from long-term care described a different limitation:

> *"For example, Long-term care homes are granted access to Clinical Connect, and long-term care homes can only access but have no capabilities to share our information." (S2, Question 2)*

The participant went on to describe nurses printing or copying information when a resident was transferred to acute care. Staff could review information from other organizations, but they still relied on a manual process to send

information from the long-term care home. The group-session notes also refer to an inability to contribute information to ClinicalConnect, although the note is too brief to determine whether it describes a separate example.

These accounts show that receiving information and contributing information are different functions. The available records do not identify why contribution was unavailable. The limitation may have reflected permissions, technical integration, contractual scope or another factor. The evidence therefore supports a narrower conclusion: access to a shared system can support one part of a care process while leaving another information-sharing task unresolved.

Participants made a similar distinction between communication and shared documentation. One respondent described secure messaging as useful for asking questions between providers, but noted that it did not create a common record showing who was involved in care or what had been provided. Across these examples, participants described three distinct capabilities: communicating directly with another provider, viewing information held in a shared or connected system, and adding information to a shared care record. Table II summarizes these arrangements and the limits of the comparisons.

Table II Reported arrangements and the limits of the comparison

Arrangement	What the participant described	Why it matters analytically	What remains unresolved
ClinicalConnect integration	Centrally prepared agreements and vendor integration made local participation straightforward	Common preparation was associated with workable exchange	The separate effects of agreements and technical support
Shared client database	Restricted access accompanied privacy pledges, training and audits	Protection procedures operated within an arrangement participants considered useful	Actual compliance and outcomes
Publication of shared care plans	An automated process reportedly awaited legal review	Technical preparation had occurred while review remained unresolved	The substance and necessity of the review
Long-term care access	Staff could view information but printed or copied information for transfer	Viewing and contributing supported different tasks	Why contribution was unavailable
Telephone and secure messaging	Direct connections supported communication between providers	Information could be exchanged without one shared database	Completeness, continuity and scalability

Source: S2, Questions 1 and 2. The table summarizes participants' reported examples from one regional study.

Discussion

Compatibility depended on how specific information-sharing arrangements were defined

Compatibility depended on how specific information-sharing arrangements were defined

The findings suggest that privacy protection and care coordination should not be treated as competing requirements in the abstract. Participants described arrangements in which both could be supported at the same time, provided that the terms of the information exchange were sufficiently clear. In particular, they referred to the purpose of the exchange, the intended recipient, the permissions that applied and the responsibilities of the organizations involved. These details mattered because they shaped whether participants regarded a particular exchange as appropriate and workable.

This shifts the analysis away from asking whether an organization generally supports or resists information sharing. Instead, the relevant question is whether the responsibilities associated with a particular exchange can be carried out together. Besharov and Smith (2014) define compatibility in terms of whether different institutional logics prescribe actions that can be pursued consistently. In this study, that idea is applied more narrowly to specific information-sharing arrangements. Privacy protection and care coordination may be compatible when the purpose of the

exchange is understood, the intended recipient is appropriate, the necessary permissions are established and organizational responsibilities are clear.

The workable examples illustrate this point. Participants described arrangements in which privacy safeguards were built into the process of sharing information rather than treated as an alternative to sharing. Access restrictions, privacy agreements, training, audits and defined permissions established conditions under which information could be exchanged. In the ClinicalConnect example, a respondent linked centrally prepared agreements and technical integration with relatively straightforward local participation. The arrangement had already addressed important questions about participation before the organization was asked to implement it.

The care-plan example illustrates the difference when some of those questions remain unresolved. In that case, the technical mechanism for sharing information had reportedly been developed, but legal review had not been completed. Technical readiness therefore did not mean that the exchange was ready to proceed. The organizations still needed to resolve whether the proposed use of the information was acceptable under the applicable legal and organizational requirements. Comparing these examples does not establish that centralized preparation caused one arrangement to succeed or that it would have resolved the other. It does show that technical capability alone was not sufficient. Organizations also needed a basis for determining why the information should be shared, with whom and under what conditions.

This is the sense in which the study uses the idea of a shared basis for justified disclosure. The phrase refers to the terms through which participants could explain why a particular information exchange was appropriate: its purpose, recipient, permissions and associated responsibilities. It is an interpretive label developed for this analysis, not a validated construct or a legal test. Its value is in making explicit the organizational questions that appeared to distinguish more settled arrangements from those that remained uncertain.

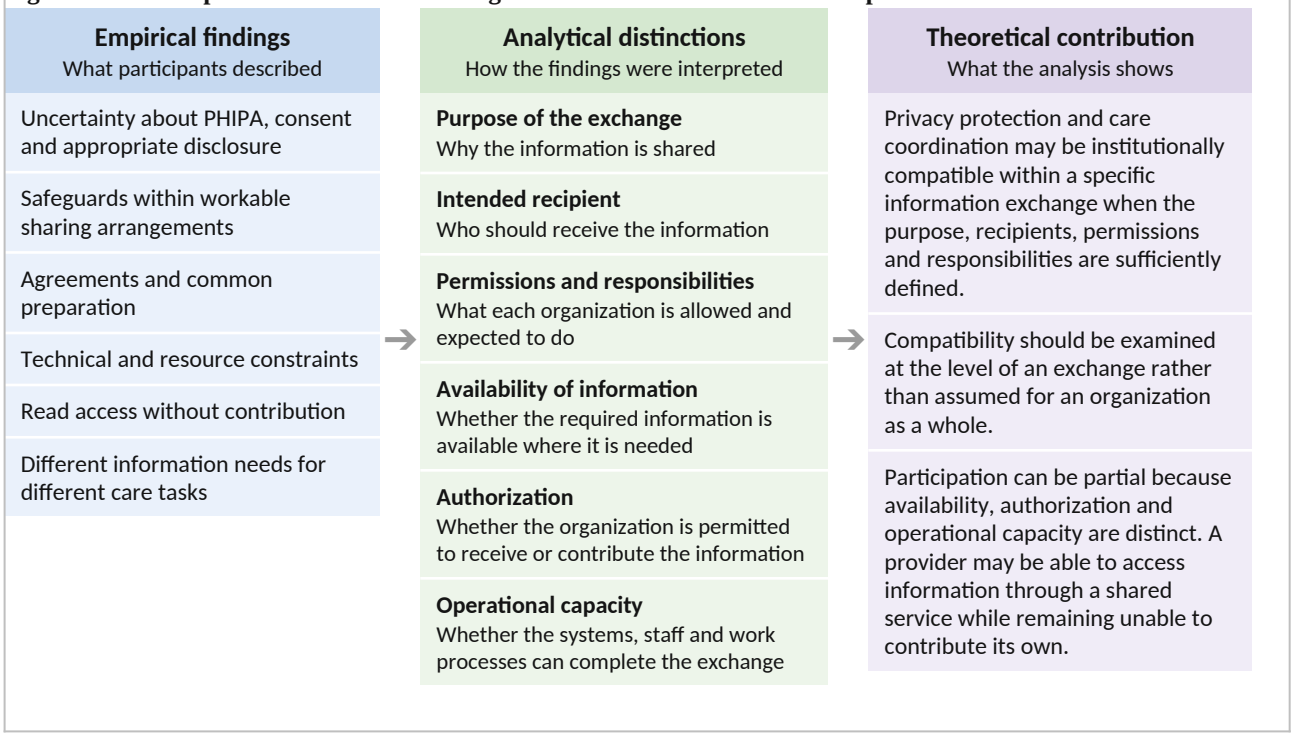
Applying institutional compatibility at the level of a specific exchange also helps clarify the contribution of the findings. Smets and Jarzabkowski (2013) show that institutional complexity can be worked through in everyday practice rather than existing only as an abstract conflict between institutional logics. The present findings point to one way this can occur in interorganizational information sharing. Participants described concrete agreements, permissions, safeguards and implementation responsibilities that allowed organizations to act on both privacy and care-coordination responsibilities within particular arrangements. The evidence does not show that participants changed their underlying values or developed a new shared institutional logic. Rather, it shows how potentially competing responsibilities could become compatible within a defined information-sharing task.

This interpretation also places limits on the role of institutional theory in explaining the findings. Not every unresolved exchange reflected competing institutional expectations. Participants distinguished uncertainty about privacy requirements from fear and risk aversion, and they also described technical and resource constraints that could prevent sharing even when there was agreement that it should occur. Someone may hesitate because they do not understand how PHIPA or consent applies to a particular situation. A system may also lack the functionality needed to transmit information, or an organization may lack the staff or financial resources required to implement an interface. These problems should not automatically be interpreted as institutional conflict.

Institutional explanations are most useful when different understandings of responsible action lead participants toward different courses of action. Legal knowledge gaps, technical limitations and resource constraints require different explanations and different responses. Similarly, defining the purpose, recipients and safeguards of an exchange does not guarantee that sharing should proceed. A legal review may identify a legitimate restriction, and participants may differ in their interpretation of what is permitted. The study therefore does not suggest that greater agreement should override legal or professional requirements. Rather, it shows that the compatibility of privacy protection and care coordination becomes easier to examine when the analysis focuses on the terms of a specific information exchange instead of treating information sharing as a single organizational position.

Figure 1 summarizes this progression from the empirical findings to the analytical distinctions and theoretical interpretation developed in the study.

Figure 1. From reported information-sharing conditions to the theoretical interpretation



Information sharing depended on the specific task being performed

The findings also show that participation in an information-sharing arrangement was not all-or-nothing. An organization could be connected to a shared service and still be unable to complete every information-sharing task required for care. This distinction is important because describing organizations as connected can hide meaningful differences in what staff are actually able to do.

Wankah et al. (2022) describe agreements that support clinically relevant information sharing while also addressing privacy concerns and differences among information systems. The present findings add detail by showing that organizations could encounter different barriers at different points in the sharing process. In some cases, common agreements and technical preparation reduced the work required for local participation. In others, the technical mechanism had been developed but review remained unresolved. Participants also described situations in which staff could access information but could not contribute their own information through the same system. These examples distinguish the work required to establish participation from the functions available once access has been granted.

Shaw et al. (2017) similarly emphasize that integration depends on how work is organized across participating providers. The findings here show why the specific information task matters. Staff could sometimes view information from another provider but not add information of their own. In other cases, they could communicate through secure messaging but could not update a shared care record. These are different forms of participation, even though each may involve some level of connection between organizations.

Three analytical distinctions help explain these differences. **Availability** refers to whether the required information exists in a usable form and can reach the setting where it is needed. **Authorization** refers to whether the person or organization is permitted to receive or contribute that information within the applicable legal, organizational and contractual arrangements. **Operational capacity** refers to whether the necessary systems, staff and work processes are in place to complete the exchange. A specific information-sharing task may remain incomplete when any one of these conditions is missing.

These distinctions are not intended as a new general model of interoperability. Rather, they provide a way to describe the different conditions that participants associated with completing a particular information-sharing task. For example, a provider may be authorized to view information that is available through a shared service but still lack the technical functionality or workflow needed to contribute a care plan. Figure 2 summarizes these three conditions and shows how they apply to a specific exchange.

Figure 2. Conditions for completing an interorganizational information-sharing task

Availability	+	Authorization	+	Operational capacity
Is the required information available where it is needed?		Is the person or organization permitted to receive or contribute the information?		Can the systems, staff and work processes complete the exchange?
For example, the information may exist in an electronic medical record or another system that can be accessed.		For example, disclosure must be consistent with legal requirements, consent and organizational policies.		For example, the organization may need technical integration, trained staff and procedures to contribute information.

A sharing task may remain incomplete when any one of these conditions is absent.
For example, a provider may be authorized to view information that is available through ClinicalConnect while lacking the technical capability to contribute its own information.

This interpretation is consistent with related work on interorganizational knowledge transfer and sociotechnical systems. Lim et al. (2015) show that information transfer depends on whether providers can obtain and use the knowledge required for care, while Sittig and Singh (2010) emphasize the interaction among technology, people, workflow and organizational conditions. The present findings add a more task-specific distinction. Having access to a system does not, by itself, demonstrate that an organization can participate fully in the information exchange. Managers therefore need to specify what information must move, in which direction, who must be able to act on it and what work must be completed before determining whether a shared service provides the required level of integration.

Costs and capacity explain some barriers better than institutional conflict

Not every barrier reflected uncertainty about appropriate conduct. The group discussion made this distinction more explicit by treating inadequate EMR integration as a barrier in its own right and by moving financial concerns out of a standalone barrier category. Participants also described investments already made in existing systems, implementation costs, staff shortages, slow transmission and poor image quality. Any of these can block sharing even when organizations agree that the exchange should occur. A missing interface may require technical work, and a staffing shortage may require resources. Neither problem necessarily requires a change in institutional expectations.

Feiock (2013) explains why the question of who pays can become difficult when autonomous organizations face different costs and benefits from collaboration. Provan and Kenis (2008) explain how organizations can coordinate common work while retaining separate authority. Together, these arguments help account for why participants treated funding as important without retaining it as an independent root cause. Common preparation may reduce repeated negotiation, yet each organization still needs the staff and money required for implementation. The available evidence is insufficient to determine whether a different governance structure would have organized or funded that work more effectively.

Kazlauskaitė et al. (2025) also show that sector and resource availability can affect information transfer in long-term care. In the present inquiry, participants provided stronger evidence for protective responsibility and coordination than for stewardship as a distinct institutional pattern. When an account concerns implementation costs or staff capacity without describing a conflict over appropriate conduct, a resource explanation is sufficient.

At the governance level, the central question is whether the organization has created the conditions that allow managers and clinicians to carry out appropriate information sharing in practice. Clear responsibilities, sufficient

resources, appropriate oversight and direct attention to the patient perspective can reduce situations in which technically possible exchanges remain difficult to implement or sustain.

Operational implications for managers

Managers should diagnose information-sharing problems at the level of the specific care task. The findings distinguish barriers related to authorization, technical integration, staff capacity and uncertainty about privacy requirements. These problems require different responses. Sittig and Singh's (2010) sociotechnical perspective similarly emphasizes that information exchange depends on the interaction of technology, people, workflow and organizational conditions. Managers should therefore identify what information must move, who needs it and what each participating provider must be able to do before deciding how to intervene.

The findings also suggest value in preparing common elements of information-sharing arrangements where organizations face similar requirements. Participants associated centrally prepared agreements and technical integration with easier local implementation. Wankah et al. (2022) likewise describe negotiated agreements as part of the managerial work required to support interorganizational information sharing. Common agreements, access procedures and training may therefore reduce repeated work, provided that managers still review the purpose, participants and responsibilities of each exchange.

Managers should also assess whether an information-sharing service supports the full care task. Participants described situations in which providers could view information but could not contribute through the same system. This distinction is consistent with research showing that effective information transfer depends on whether providers can obtain and use the information needed for care (Lim et al., 2015). Measures of implementation should therefore examine the functions that providers can perform, rather than access to the system alone.

Strategic implications for governors

Governors should ensure that responsibility for interorganizational information sharing is explicit in organizational priorities and accountability structures. Participants identified leadership, coordination and resource constraints as barriers to implementation. Research on network governance similarly shows that collaboration among autonomous organizations requires clear arrangements for coordinating shared work (Provan and Kenis, 2008). Governance oversight should therefore establish who is accountable for approving participation, supporting implementation and resolving problems that cross organizational boundaries.

Governors should also consider how the costs and capacity requirements of shared initiatives are distributed. Participants described differences in organizational resources and raised questions about who should pay for integration. Feiock (2013) explains that collaboration can be difficult when independent organizations face different costs and benefits from collective action. A partnership may therefore agree on the value of information sharing while some members remain unable to participate fully because of financial, technical or staffing constraints.

Finally, governance decisions should incorporate the patient perspective. Participants made timely patient access to personal health information more explicit during the group discussion, but patients were not recruited as a separate participant group. The study therefore identifies patient access as an issue requiring governance attention, while providing no direct evidence about patient priorities. Future decisions about shared information arrangements should include direct patient and caregiver input when organizations determine what information patients should be able to access and how that access should be provided.

Scope and limitations

This study examines how members of one regional Privacy and Security Working Group understood barriers to sharing personal health information across organizations. Participants were selected because they were familiar with privacy and security practices in their organizations. The study therefore provides insight into how these

knowledgeable organizational participants understood specific sharing arrangements. It was not intended to estimate how frequently particular barriers occurred across the Ontario Health Team or to compare sectors. Patients were also not recruited as a separate participant group, so findings concerning patient access reflect participants' views rather than patients' own experiences.

The original analysis drew on 18 questionnaire responses, a 60-minute group session attended by 22 people, the retained Zoom transcript and study records produced during the inquiry. The group discussion was used to clarify and refine the preliminary findings rather than to produce ranked priorities or formal consensus.

The findings are based on participants' descriptions of information-sharing arrangements. The study did not independently assess the legal, technical or organizational circumstances of each example. The analysis therefore supports conclusions about how participants understood the conditions that helped or constrained sharing, rather than conclusions about the legal correctness or effectiveness of particular arrangements. The theory-informed analysis interpreted these accounts through institutional concepts while retaining financial, technical and operational explanations where they better fit the evidence.

Further research

Future research should examine specific information-sharing arrangements as they are developed and put into use. Following an initiative from initial proposal through legal review, agreement development, technical implementation and routine operation would allow researchers to identify where delays or disagreements arise and what resolves them. This type of longitudinal research could distinguish uncertainty about legal requirements from disagreements about organizational responsibility, technical limitations and resource constraints.

The findings also suggest value in comparing arrangements that rely on common preparation with those negotiated separately by participating organizations. Such comparisons should account for differences in the sensitivity of the information being shared, the organizations involved and the technical work required. Measures such as the time required to complete review, the functions available to participating providers and the extent of continued manual information transfer would provide stronger evidence about whether particular governance or implementation arrangements improve information sharing.

Further research should also include the people who use and receive information in routine care. This study drew on organizational participants with knowledge of privacy and security, while patients and caregivers were not recruited as a separate participant group. Including patients, caregivers, clinicians and information professionals would allow researchers to examine whether the same arrangement meets the needs of different users. It would also provide a stronger basis for examining the distinction identified in this study among information availability, authorization and operational capacity.

Conclusion

Participants described PHI sharing as a series of related activities that require organizations to decide what information should move, who should receive it, what each participant is permitted to do and whether the necessary systems and work processes are in place. The group discussion refined the original analysis by separating uncertainty about privacy requirements from fear and risk aversion, identifying EMR integration as a distinct barrier and giving greater attention to timely patient access to PHI.

The findings also show that privacy protection and coordinated information sharing were present together in arrangements that participants considered workable. These arrangements included defined permissions, access controls, agreements, training and technical connections. The relevant issue was therefore how organizations established the conditions for a particular exchange while meeting their responsibilities for protecting PHI.

The study contributes two related distinctions. First, institutional compatibility can be examined at the level of a specific information exchange by considering whether participants see the purpose, recipients, permissions and

responsibilities as acceptable and sufficiently defined. Second, participation in an information-sharing arrangement depends on more than access to a system. Availability, authorization and operational capacity describe different requirements for completing an information task. A provider may be able to view information while lacking the permission, technical functionality or work process needed to contribute information or use it in another part of care.

These distinctions provide a basis for examining why some information-sharing arrangements proceed while others remain incomplete. They also provide a clearer way to separate institutional concerns from legal, technical and resource constraints when organizations attempt to coordinate PHI sharing across organizational boundaries.

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Competing interests

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Author contribution

The author was responsible for study conceptualization, methodology, data collection, qualitative analysis, interpretation and preparation of the manuscript.

Data availability

Anonymized questionnaire responses and group-session materials are available from the corresponding author upon request, in accordance with participants' informed consent. Requests should be directed to kmcdermott@wlu.ca.

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ChatGPT, developed by OpenAI, was used during editing to help revise existing manuscript text to improve readability and make the narrative more concise. The AI aided in validating references and acted as a thought partner in theoretical positioning. The GPT-5.6 Sol model was used. The author takes full responsibility for the manuscript's content and conclusions.

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