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Ontario Health Teams: Negotiating Social Work Values in an Emerging Integrated Care System

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Ontario Health Teams: Negotiating Social Work Values in an Emerging Integrated Care System

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Abstract

Ontario Health Teams (OHTs) represent Ontario's most recent shift towards integrated care. OHTs are underpinned by a common value framework, the "Quintuple Aim." The present study investigates how the Quintuple Aim enables and constrains the work of value-driven professionals, in this case social workers, working within the OHT system. An institutional ethnography was conducted at a Community Health Centre in a metropolitan OHT. Data was collected during six in-depth interviews with both social workers and management staff. Thematic analyses were performed from which four themes emerged: 1) participants' commitment to health equity, 2) issues with provincial leadership & neoliberalism within OHTs, 3) social workers' disengagement from OHTs, and 4) an on-going need for service integration. Findings suggest misalignment between the values espoused in the Quintuple Aim and providers' testimonies, most notably in the domains of health equity and provider experiences. Findings are interpreted through a critical neo-liberal lens and particular attention is paid to how performance evaluation targets constitute an unspoken set of values within OHTs. Implications are discussed for social work practice and integrated care practices within OHTs.

Contents

Introduction

Ontario has recently undergone a massive transition in how it funds and delivers health care services with the advent of Ontario Health Teams (OHTs). OHTs are regional interdisciplinary collectives of health and social service providers (e.g., hospitals, physicians, social workers, long-term care homes, etc.) which were first announced in 2019 (Ontario Ministry of Health and Long-Term Care [OMHLTC], 2019). After a tumultuous first few years of implementation and pandemic-related challenges, there are currently 58 OHTs covering the entire province of Ontario (Ontario Health, 2024). OHTs were designed to incentivize health care organizations and private practitioners within defined geographic localities to integrate their services. The OHT model employs two primary incentives to bolster service integration, namely, a collective governance structure and a single envelope funding package (OMLTC, 2019). Service providers who join their local OHT become "partners" that share clinical and fiscal accountability for the populations they serve (OMLTC, 2019). While OHTs remain answerable to a government agency (i.e., Ontario Health) and the Ministries of Health and Long-Term Care, they are in fact self-directed entities run by local health organizations and providers.

Integrated care is a central feature of the OHT model and is encapsulated in its "Quintuple Aim" framework (i.e., better patient experiences, better patient outcomes, better provider experiences, better cost effectiveness, and better health equity). Notably, OHTs were founded on an earlier version of this framework, the "Quadruple Aim," which was recently updated to include a fifth dimension, health equity (Nundy et al., 2022; OMHLTC, 2019). Ontario Health tasks OHTs with pursuing these interconnected and sometimes conflicting values within their respective geographic regions. The Quintuple Aims are intended to be synergistic and serve as five equally important domains of organizational attainment. However, beneath the surface, apparent tensions exist between these values. Cost effectiveness and patient outcomes

may be diametrically opposed in certain circumstances (e.g., limited imaging capacity due to cost concerns), as might patient and provider experiences (e.g., higher provider case loads increase patient access to care). These apparent tensions raise questions as to how value conflicts are navigated within OHTs and the general applicability of the Quintuple Aim framework for Ontario's newest integrated care contexts. The present study investigates a subdomain of these questions, namely, how social workers as value-driven providers working with OHTs encounter the Quintuple Aim framework, and whether a gap exists between the professed and realized aims of OHTs.

Intgrated Care in Ontario

Integrated care systems are health care structures that prioritize interdisciplinary and coordinated health approaches. They typically share common elements, including group practice settings, interdisciplinary teams, system coordination/integration efforts, a population health approach, an emphasis on patient-centered perspectives, and in some cases alternative payment structures or collective governance models. In recent decades, the World Health Organization has repeatedly emphasized the importance of integrated care for meeting its goals of universal health coverage, sustainable health service delivery, and a patient-centered approach to care (World Health Assembly, 2016). This emphasis aligns with mounting scholarly consensus on the cost efficiency of integrated care and its capacity for transformative health systems change (Busse & Stahl, 2014; Peckham et al., 2022; Shi et al., 2015). In addition to new service modalities, integrated care represents a shift in values. Implicit in the integrated care framework is an appreciation of the social determinants of health and the overlapping complexities that produce illness or promote health. Integrated care also insists on interdisciplinary collaboration as a site of shared knowledge production and complimentary care responses. Social work is one of six

crucial primary care domains relevant to integrated care (Ashcroft, Bobbette, et al., 2024), and its importance to primary care has been well-established in the wider integrated care literature (Ashcroft, Adamson, et al., 2024; Feryn et al., 2024; Fraser et al., 2018; Milano et al., 2022). Social work is uniquely implicated in the integrated care value system due to its professional commitments to both social justice advocacy and rectifying intersectional factors of exclusion (Canadian Association of Social Workers, 2023).

In a North American context, integrated care values are often conceptualized in a "Triple," "Quadruple," or "Quintuple Aim" framework. Originally posited by Berwick and colleagues (2008) as the Triple Aim, the authors argued for a three-pronged approach to health care evaluation in the United States, namely, improved patient experiences, improved population health outcomes, and improved per capita cost efficiency. Notably, the advancement here is the idea that improved patient experiences do not require increased per capita expenditure, rather, there is monetary value added through service integration (Berwick et al., 2008). The Triple Aim was subsequently broadened to include improved provider experiences (Quadruple Aim), and later, improved health equity (Quintuple Aim) (Nundy et al., 2022). Presently, Ontario has adopted the Quintuple Aim as a set of guiding principles for its OHTs.

Ontario's turn towards integrated care represents a new chapter for a health care system that has been described as "siloed" and "fragmented" (Aggarwal & Williams, 2019). In Ontario's conventional model, family physicians typically own and operate private practices, working within their own "silos" of care, unattached to other health care practitioners. These private practices tend to operate during daytime working hours leaving pronounced gaps in primary care during off-hours, especially in rural regions (Aggarwal & Williams, 2019). This inaccessibility is particularly troubling since family physicians have historically been patients' gateway to health

care in Ontario by providing preliminary assessments and determining care pathways through their referrals. Inadequate access to primary care is detrimental to both patients and the health care system since it reduces the likelihood of effective early screening/prevention measures and increases the likelihood that patients seek primary care in more expensive hospital settings.

For decades Ontario has attempted to overhaul its conventional primary care structure with limited success (Aggarwal & Williams, 2019). Importantly, OHTs break from previous provincial reform efforts by combining service delivery and funding agencies into unified organizational structures (Sibbald et al., 2021). There are currently 58 OHTs, each with their own governance structures and each receiving a single envelope of provincial funding to be shared amongst their partners (Ontario Health, 2024). OHTs serve geographically distinct regions of the province and vary substantially in the size and demographics of their catchment populations. Crucially, the OHT model hinges on local service provider integration. By combining local service providers under a single funding envelope, OHTs create financial ties that incentivize providers to integrate their services and find cost efficiencies. The upshot is that closer interprofessional ties are expected to lead to less service duplication, more thorough care coordination, more targeted service provision, and more opportunities for interdisciplinary innovation (OMHLTC, 2019). To achieve more targeted and locally-relevant service provision, OHTs are said to have substantial latitude in setting their own care priorities to meet the needs of their specific communities (OMHLTC, 2019).

Inasmuch as OHTs represent a philosophical shift for health care in Ontario they simultaneously represent tangible financial changes. Historically, conventional primary care in Ontario involved a fee-for-service arrangement with family doctors which compensated physicians based on the number of patients they served in a given pay period (Aggarwal &

Williams, 2019). While lucrative for physicians, researchers argue that this practice incentivizes quantity over quality of service provided (Adida et al., 2017; Powell-Jackson et al., 2015; Shi et al., 2015) and limits pathways for care coordination leading to more siloed primary care practices (Aggarwal & Williams, 2019). Importantly, OHTs aim to change this. As part of their funding envelope, OHTs receive annual, prospective capitation (per rostered patient) payments to cover the bulk of the services they provide (OMHLTC, 2019). Additionally, OHTs receive some "bundled payments" which are activity-based funds that cover a package of services for specific conditions. For instance, an OHT would receive a bundled payment to cover all the costs associated with a patient's hip replacement (i.e., diagnostics, surgery, hospital bed stay, rehabilitation, etc.). This is a marked change from previous fee-for-service arrangements where providers are guaranteed a set fee for each procedure performed. However, it is worth noting that while these changes affect primary care providers working within OHTs, family doctors are not required to join an OHT, thus many continue to practice independently and receive fee-for-service payments.

As with any system transformation of its magnitude the rollout of OHTs was not without controversy. Interviews with key OHT stakeholders revealed a perception that the process was rushed (Sibbald et al., 2021) and lacked a clear roadmap or vision for the future (Indar et al., 2023). One rationale for the limited guidance stakeholders perceived is that Ontario Health intended to promote local solutions to local problems by allowing providers and patients the autonomy necessary to design new systems suited to their specific needs. However, many providers reported that they found the increased administrative burden of OHT design to be overwhelming and beyond the scope of their expertise (Sibbald et al., 2021). A competing interpretation reflects a downloading of responsibility onto providers and away from the

Ministries of Health and Long-Term Care. If true, a lack of ministerial support for the design and implementation of OHTs may be indicative of a broader pattern of casting health care providers into a kind of middle management role. Under these circumstances Ontario Health would retain directorial control over OHT priorities but download the burden of administration and management onto health care providers. Notably, as financial vehicles, OHTs are constructed as "risk- and gain-sharing" arrangements between providers (OMHLTC, 2019). One such example of gain-sharing is a provision within the OHT framework that, at year end, allows OHTs to reinvest half of any unspent health care funds into equipment or initiatives of their choice within their region. While this may seem generous at first glance, this could also be understood as the ministries incentivizing providers to undercut their own budgets and the budgets of other organizations within their OHT. The potential neo-liberal influences at play within the OHT structure are discussed in greater detail in the *Theoretical & Methodological Considerations* section below.

OHT Literature Strengths & Gaps

Although OHT scholarship is in its infancy a sizable body of literature has sprung forth over the past few years. Current research on OHTs can broadly be divided into four domains: 1) early OHT formation, 2) program development/evaluation, 3) policy/comparative analyses, and 4) provider experiences. Throughout each of these research areas primary care remains a central topic of interest for scholars. This is unsurprising given Ontario's historical track record of chasing primary care reform and the emphasis that recent provincial guidelines place on primary care physicians (PCPs) as "cornerstones" of the OHT model (OMHLTC, 2019). The present section provides an overview of physician-led and primary care focused OHT research and attends to how certain values and epistemologies are reified while others are marginalized

through these endeavours. A second theme of interest within the literature is co-design, that is, a collaborative process involving patients, caregivers, and professionals in the design of health and social services. Co-design represents a key promise made by the province to its residents, that is, that the OHT model represents a patient-centered and responsive approach to community needs. From the outset, OHTs have been required to incorporate patient and family advocates (PFAs) in their governance structures (Sibbald et al., 2021), however, the extent to which PFAs or patients themselves feel this inclusion has been meaningful varies (Abelson et al., 2023; Sibbald et al., 2021). The early successes and challenges of co-design in OHTs are explored further in this section. Finally, the present section discusses gaps in the literature surrounding the role of social work in OHTs and touches on values conflicts within interdisciplinary organizations.

Primary care remains a core focus of OHTs and a hallmark of the model's success. PCPs are necessary collaborators in the OHT process considering the substantial clinical autonomy, capacity for leadership, and institutional knowledge they wield. They continue to play an important role in health system navigation, acting as gateways for patients to other health practitioners through their referrals. While Ontario residents in high-density regions of the province may have access to community health centres or other interdisciplinary clinics that provide internal/external referrals and systems navigation support, many rural residents continue to rely on their PCP or nurse practitioner as their sole non-emergency entry point into the health care system (Wilson et al., 2020). Hence, integrating PCPs into OHTs is crucial for ensuring universal access to care in Ontario. Simultaneously, integration provides an opportunity to re-task physicians away from health systems navigation roles and towards direct intervention. Notably, Ontario is experiencing an immediate shortage of PCPs and it is projected that as many as 20% of residents will not have access to a family doctor by 2026 (Ontario College of Family

Physicians, 2023). This trend is underpinned by a growing number of PCPs reducing both their working hours and number of services provided (Glazier, 2024) and was exacerbated by a wave of early retirements during the COVID-19 pandemic (Kiran et al., 2022; Walsh et al., 2024).

Given the growing importance of PCP integration for OHTs, a subset of the literature focuses on uncovering the factors that constrain and enable PCP integration. Family physicians cite lacking renumeration, limited ministerial direction, and power imbalances within OHTs as major constraints on their participation (Everall et al., 2022; Grady et al., 2021; Grady et al., 2023). As new and independent entities OHTs require substantial administrative and governance groundwork. While some large organizations, like hospitals and community health centres, are able to donate hours of labour from their salaried employees to shoulder this burden, independent physicians who join OHT governance structures are often doing so voluntarily and without renumeration (Grady et al., 2023). Conflicts in scheduling, with salaried staff preferring to meet during working hours and physicians unable to take time away from patients, constrain participation (Grady et al., 2023). PCPs also report hesitancy to commit their time and resources to OHTs during the early development phases (Everall et al., 2022). This is understandable for independent practitioners who were asked to volunteer their time or make substantial technological investments as a condition of OHT integration (e.g., converting their practice to a new electronic medical record-keeping software). Moreover, PCPs highlight power imbalances within the OHT structure which they claim privileges hospital and ministerial priorities over their own (Everall et al., 2022). Considering these constraints, independent PCPs claim they are poorly incentivized to participate in OHT governance structures. Low PCP participation rates limit the overall influence of PCPs within OHTs, constraining the scope of primary care considerations in these settings. PCPs argue for alternative power-sharing structures

(Embuldeniya et al., 2021), more after-hours and in-person meetings (Gordon et al., 2020; Grady et al., 2023), and renumeration for time spent on OHT administration, leadership, and planning (Everall et al., 2022; Grady et al., 2021; Grady et al., 2023).

Patient and PFA perspectives receive considerably less scholarly attention than their PCP counterparts. Nonetheless, the centrality of co-design to the OHT framework marks patient perspectives and engagement as vital topics for further study. In interviews with 16 PFAs and over 110 non-PFA OHT members, Sibbald and colleagues (2021) found that both groups perceived PFA participation in OHT governance as generally positive. While the authors found that PFA participation varied across OHTs, the most positive experiences of co-design occurred when PFAs felt their contributions were valued. Some OHTs signalled this value by offering trainings, renumeration, and voting rights to PFA members. Others struggled to cultivate perceptions of PFA value due to late involvement of PFAs in the OHT development process or an unwillingness to compensate or meaningfully integrate PFAs into decision-making structures. Importantly, the authors found that most non-PFA OHT members (i.e., practitioners, administrators) shared highly positive assessments of the value added by PFAs and co-design, while simultaneously many PFAs did not feel their contributions were being valued. This apparent discrepancy between professed and realized values within OHTs provides an interesting avenue for further study.

Co-design extends beyond the work of patient advocates. In its fullest realization, co-design involves broad patient engagement initiatives that capture the experiences of the patient, family, and caregiver populations. Typically, this is accomplished through feedback surveys that assess the effectiveness, accessibility, and comprehensiveness of care. Several such measures have been developed for use in OHTs with a prominent example being the Health System

Performance Network (HSPN) OHT Patient Experience Survey (Health Service Performance Network, n.d.). While thorough, this survey has provoked concerns among practitioners for its length and accessibility to patients (Slater et al., 2024). Striking a balance between accessibility and comprehensiveness of patient engagement measures continues to be a focus for researchers (Abelson et al., 2023; Slater et al., 2024). A further research gap exists around the application of patient, family, and caregiver working groups or interviews as regular evaluation methods for OHTs. However, as Slater and colleagues (2024) point out, OHTs must be mindful to not unduly burden patients as drivers of organizational change in the process of patient engagement. Relatedly, it is worth considering whether providers face a similar burden in regard to the unpaid administrative work expected of them within OHTs. Investigating how OHTs can balance these competing priorities while driving change is another area for further study.

A final relevant aspect of the OHT literature is the relative absence of social work considerations. At present, only a few OHT-specific investigations include social workers, and those that do tend to evaluate social work perspectives alongside other interdisciplinary professionals within the same team (Ashcroft, Bobbette, et al., 2024; Mehrfar et al., 2023; Sarakbi et al., 2024; Webber et al., 2024). Unlike their PCP counterparts, little consideration has been given to the factors that enable or constrain social work practice and integration with OHTs. This is despite the fact that social work is one of six crucial primary care domains (Ashcroft, Bobbette, et al., 2024), and its importance to primary care has been well-established in the wider integrated care literature (Ashcroft, Adamson, et al., 2024; Feryn et al., 2024; Fraser et al., 2018; Milano et al., 2022). Nonetheless, the daily activities of social workers and their manifest functions within integrated care teams remain understudied (Fraser et al., 2018; Milano et al., 2022). Further examination of social work perspectives in integrated care settings offers

possibilities for improving the quality and accessibility of mental health services as well as bridging interdisciplinary bodies of knowledge around health and mental health. The latter consideration remains an on-going struggle between medical professionals and mental health practitioners within OHTs (Sarakbi et al., 2024). Additionally, social workers occupy a unique place within the health care system due to their professional commitment to client advocacy (Canadian Association of Social Workers, 2023). Social work's emphasis on advocacy aligns closely with the professed co-design aims of OHTs. Hence, an investigation into how social work values are realized or challenged in OHT-based practice settings may offer new insights for co-design initiatives as well as uncover broader limitations for integrated care within the OHT framework.

Theoretical Considerations

Neoliberalism is an ideological and political project that values expanding the role of markets, individual responsibility, and capital accumulation (Garrett, 2019). Importantly, neoliberalism is as much an ideology as it is a set of interconnected and dominant discourses that aim to reshape how society is structured. These discourses are materialized and enacted through the promotion of defining neo-liberal values, such as market centrality and individual responsibility (Marthinsen, 2019). In this way, neoliberalism can be understood as a series of identity reformation projects that convince actors to take on its stated values and reconceptualize their own identities in ways that are compatible with capitalism. Through this process of value promotion and discursive dominance, neoliberalism also aims to "*remake* work and workscapes and alter the aims, aspirations and affiliations of a range of professional groups" (Garrett, 2019, emphasis in original). This is exceedingly relevant for social work and other helping professionals in the public and non-profit sectors which do not directly generate capital through

their daily work.

The influences of neoliberalism on social work and the health care sector in Canada are numerous. They include the marketization of health and social services, calls for governance reforms that emphasize hierarchical structures common in the private sector, and the proliferation of managerialism (Lawler & Bilson, 2013). Managerialism is a set of values which highlight the role and accountability of managers through an increased emphasis on efficient use of capital and greater fiscal awareness on the part of management (Lawler & Bilson, 2013; Marthinsen, 2019). Under managerialism, the success of a manager is judged by their ability to both control staff and attain assigned objectives, rather than their professional or technical capacities as senior professionals in their field (Lawler & Bilson, 2013). As such, managers are held individually responsible for their team's ability to meet service targets and reporting standards. This often places managers and frontline service providers in adversarial relationships where managers are tasked with extracting maximal value for money from providers, which shifts the traditional manager-provider dynamic from one of mentorship to subordination. Notably, managerialism is distinct from neoliberalism although both are underpinned by a similar set of values, including the centrality of financial considerations in relation to public service provision, and a hallmark emphasis on individual responsibility. Managerialism can be understood as one outgrowth of neo-liberal thought that is particularly applicable to health service organizations.

The OHT framework merges integrated care elements with neo-liberal and managerialist values. For instance, the Quintuple Aim mandates "improved cost efficiency" as a core focus for OHTs. While cost efficient social services are not inherently problematic, an emphasis on cost efficiency as a major outcome metric is concerning insofar as it incentivizes quantity over quality of care. Additionally, the OHTs shared governance structure, while lauded for its integrated care

capacity, also downloads administrative burdens and cost-cutting responsibility away from the Ministry of Health and onto health care providers. As a result, providers have been conscripted into more bureaucratic roles, requiring a shift in their aims, aspirations, and affiliations to meet the new demands of OHTs. Underpinning this shift is a conflict in values that plays out at the macro, mezzo, and micro levels. The present investigation is particularly interested in how social workers navigate their personal values as they conflict with their OHTs (micro) and how social work organizations support or exacerbate these struggles (mezzo).

A subgenre of institutional theory, namely institutional logic perspective (ILP), provides a complementary theoretical framework for analyzing values conflicts within organizational contexts. ILP understands organizations as sites of political struggle wherein values are negotiated and reified by organizational actors (Garrow & Hasenfeld, 2010). Importantly, ILP argues that values have symbolic and material significance for organizational actors by underpinning their meaning-making processes (Friedland & Alford, 1991, as cited by Garrow & Hasenfeld, 2010). Thus, what is at stake as values are being negotiated is how an organization's members make meaning of their work and interpret social relations. Ultimately, the values that become embedded within an organization determine how it constructs social problems and solutions (Garrow & Hasenfeld, 2010). Embedded values become an institution's "logics" once they are codified in its policies (Garrow & Hasenfeld, 2010). ILP offers insights into how organizational members adopt and resist institutional logics, as well as how institutional logics are amenable to change. It posits that institutional logics are dismantled when a plurality of alternative logics are available within an organization's "cultural schema," and simultaneously, when one or more entrepreneurial actors are able to convince their colleagues that an alternative logic is better than their current one (Garrow & Hasenfeld, 2010). ILP's emphasis on

entrepreneurial actors, or what I term *value champions*, as core determinants of organizational change highlights a potential role for social workers in resisting the neo-liberal discourses that resonate within their OHTs. ILP also invites an analysis of how social workers negotiate their personal and professional values within an organizational setting and how they make meaning of their function and social relationships within those contexts.

Research Questions

My research questions arise from both a critical understanding of neoliberalism and an appreciation of ILP as a value-driven framework of organizational change. My research seeks to answer the following questions: 1) how congruent are social workers' values with the *professed* and *realized* values of OHTs (e.g., Quintuple Aim), 2) how do social workers and managers negotiate values conflicts in an OHT/CHC setting, and how does this struggle contribute to organizational change, and 3) Where do social workers and management feel that OHTs are meeting or falling short of their integrated care promises?

Methods

Research Design

An institutional ethnography was conducted within a metropolitan Community Health Centre partnered in an Ontario Health Team. Institutional ethnography was chosen for this investigation because it is both grounded in participants' lived experiences and attentive to political (value) struggles within organizations. The goal of an institutional ethnography is to investigate how institutional facets embedded within participants' everyday activities shape their work, self-understanding, and relationships with others (Smith, 2005). This methodology assumes that political struggles among organizational actors are sites of institutional *coordination* (Smith, 2005). In other words, organizational actors reify or challenge work processes and organizational beliefs via their engagement with or resistance to them. The task of the ethnographer then is to uncover multiple individual perspectives, sites of conflict, and interrelations between actors within organizations to produce a unique understanding of how work is co-ordered and experienced. This methodology is congruent with ILP in its emphasis on how institutional logics coordinate work, and in turn, how actors inform institutional logics. Hence, institutional ethnography supports the present research questions by attending to how institutional values were experienced, reified, and resisted by study participants.

Participants

Recruitment was conducted using purposive sampling within an OHT-affiliated CHC. Members of the social work and management teams received an email inviting them to participate in the study. Prospective participants who responded to this email received a copy of the consent form and a detailed study description via email. Participants were then invited to select a time for a one-hour virtual interview with the Principal Investigator. A total of six participants completed the study: three social workers and three management staff. Participants

did not receive compensation for their contributions to the study.

Importantly, given the small size of the CHC participants were recruited from, confidentiality requirements place substantial limitations on the reporting of participants' demographic information. To protect confidentiality, standard declarations of participants' gender, race, age, and other identifying characteristics were withheld from this report. However, some contextual information is provided. At the time of the interviews, all three social workers were employed by the CHC in a direct service capacity and provided psychotherapy or counselling services as their primary function. Social worker participants had varied levels of social work experience, although none had been employed at this specific CHC for more than five years. Management participants' roles ranged from middle management to directorial staff. Each management participant had over a decade of experience employed in some capacity at the CHC, however, most entered their current managerial role within the past five years.

Data Collection

Participants completed a one-hour, in-depth interview with the Principal Investigator. Six in-depth interviews were conducted via Zoom during a three-week period in January 2025. A brief interview guide was used to both provide structure for interviews and allow digressions into participants' unique areas of interest and expertise (see *Appendix A*). Interviews touched on participants' familiarity with OHTs, their work activities, and their personal and organizational value systems. Prior to their interview date, participants were also asked to select an institutional text which they viewed as important to their work within the CHC or OHT (e.g., mission statement, CHC/OHT website segment, service brochure, etc.). Participants selected a single text or text segment which was then shared with the Principal Investigator prior to the interview date.

As part of their interview, participants answered questions about their text including their reason for selecting it and its importance to their practice.

Data Analysis

Interview data were initially transcribed using a transcription software, Transkriptor, and manually checked for accuracy. Transcripts were scrubbed of identifying information before being uploaded into MAXQDA for data analysis. Data were analyzed by the Principal Investigator using thematic analysis. Coding consisted of an iterative, inductive process which occurred in three rounds. First pass coding generated an initial codebook with 46 unique codes and subcodes. The initial codebook contained six broad thematic domains which were reviewed and condensed into a revised codebook with four themes. A second round of coding was conducted to assess the hypothesized themes' fit with the data. Second pass coding upheld the fit of all four themes and identified eight emerging subthemes. Finally, a third round of coding was conducted that focused on subtheme development. This final pass supported the fit of four themes and nine subthemes with the transcript data.

Ethical Considerations

The present study received approval from a research ethics committee within York University's School of Social Work. Project approval was also granted by the Executive Director of the Community Health Centre after a consultation process with their internal research division. Numerous measures were undertaken to ensure participants' informed consent, confidentiality, data protection, and researcher accountability. Participants were recruited through their organizational email addresses. Each member of the social work and management teams received a general template, blind carbon copy email inviting them to participate in the study. This was done to minimize multiple roles conflicts since the researcher was known to

participants as a placement student working within the CHC. Blind carbon copy emails were used to reduce the pressure participants may have felt to respond a direct message from an associate. This increased the likelihood that uninterested staff could simply ignore the participation request without feeling pressured to participate. Staff who expressed interest in the study received a copy of the informed consent form immediately and were allotted more than 48 hours to review the form before their interview date. At the start of each interview, the researcher reviewed the consent form with participants and offered an opportunity for questions and clarifications. Participants were reminded of their right to end the interview at any time, skip questions or sections of the interview, amend their transcript prior to data analysis, or remove their data from the final dataset.

All interviews were conducted as audio-only via the Zoom platform. Audio recordings were saved locally using Zoom's in-built recording function. Recording files were named with participants' initials and maintained on a local password-protected drive. Recordings were initially transcribed with software (i.e., Transkriptor) before they were manually reviewed for accuracy. During the transcript review process all identifying information was removed from the final transcripts. Final transcripts were maintained for data analysis. Initial recording files were then deleted to hedge against confidentiality threats posed by a data storage breach.

During the ethics approval process and consultation with the CHC, a request was made to the researcher to ensure that adequate knowledge dissemination occurred after project completion. Specifically, the CHC's principles of ethical research outlined that community-focused research must include reciprocal benefits. In alignment with this principle, the Principal Investigator prepared an executive summary of the research findings to be disseminated for staff within the CHC and offered to hold presentations with the social work and management teams.

Findings

Participant responses clustered around four major themes: 1) health equity as a core value; 2) issues with provincial leadership & neoliberalism; 3) social workers' disengagement from OHTs, and; 4) unmet needs for integration. Themes emerged based on their ability to capture patterns within participant responses and were subsequently narrowed to the research questions at hand. The present section provides evidence to substantiate the existence of the selected themes and closely attends to differences in perspective between social workers, management, and the stated aims of the relevant provincial ministries and OHT.

Health Equity as a Core Value

What Does Equitable Care Look Like?

Both social workers and management identified health equity as a central value in their practice. Health equity was the most commonly cited of the Quintuple Aims for both groups, particularly around access to care. One social worker summed up this sentiment well, they argued "the whole point of public, accessible services is to reduce any kind of limitation on care or as many limitations as we can on care," (Social Worker 2 [SW2]). As staff members at a CHC, participants were keenly aware of the barriers that many community members face when accessing care. Both staff and management spoke at length about their desire to reduce these barriers wherever possible and reiterated that health equity entailed equitable access to care.

Social workers were more likely than management to conceptualize health equity in terms of client-centered and holistic care modalities. This was most apparent in how social workers described their personal approach to practice, for instance one participant asked, "[How] do I put the client first? What is the client coming to me for? What do they need? And it's not my job to tell them what I think they need, it is for us to work through that together," (SW1). For this

social worker, an important dimension of client-centred care was self-determination. Their comments suggest that health equity requires more than just access to care, it requires care modalities which are rooted in client experiences and self-understanding. This perspective closely aligns with two core social work values, ‘Respecting the dignity and worth of all people,’ and ‘Promoting social justice,’ as outlined in the CASW Code of Ethics (CASW, 2023). Social worker participants described sharing in these values and emphasized their personal and professional responsibility towards health equity.

Management staff agreed with social workers on the importance of client-centered care (micro) but spoke more about organizational (mezzo) and structural (macro) barriers to health equity. This difference in perspectives between management and social worker participants is largely attributable to the distinct role and level of influence each group occupies within their CHC and OHT. As direct service professionals, social workers have limited influence over the strategic direction of their organization. This narrows the scope of possible social worker-driven health equity interventions within the workplace to the micro-level. Additionally, social workers are encouraged by their regulatory bodies and employers to pursue professional development as a means of improving their service quality and client outcomes. This professional development approach emphasizes micro-level health equity interventions, like client-centeredness, as sites of affectable change for social workers. In contrast, management staff have a moderate to high degree of influence over their organization’s strategic direction and do not provide direct service to clients. Thus, their roles are centered around mezzo-level considerations like resource allocation, organizational efficiency, and strategic planning. Management staff members’ emphasis on organizational and structural barriers to health equity reflects the scope of their role.

Accordingly, management staff offered suggestions for how their OHT could improve its

health equity pursuits, noting both a lack of evaluation criteria and a siloed approach to health equity at the OHT level. One manager recommended, "…Developing some policy and framework around what health equity looks like for us as an OHT and setting some clear sort of targets for ourselves to [meet] to ensure that we're advancing equity," (Management Staff 1 [M1]). In other words, without defined targets, health equity is more akin to a vague promise than a strategic objective. Interestingly, participants noted very rigid targets for other dimensions of the Quintuple Aim which had been set by the Ministry of Health and enforced by OHTs, particularly around patient outcomes and cost efficiency (see *Managerialism*). They argued that similar targets for health equity would be necessary before substantial progress could be made towards this aim at the OHT level.

Another management participant observed that the structure of their local OHT limits health equity possibilities. They stated, rather poignantly, "…One of the first things we did as OHT [was] form a Health Equity subcommittee… However, it's a committee on its own. And I don't believe in health equity committees personally. I think health equity needs to be embedded in everything," (M3). For this participant, health equity committees on OHTs represent a siloed approach that is more akin to health equity lip-service than enacting substantive change. In their call for equity to be "embedded in everything," the participant expands on social workers' understanding of health equity as a personal commitment to be made by both providers and organizations. Instead, Management Staff 3 highlights health equity as a possible organizational logic which could permeate the OHT fabric.

Provider Equity as Health Equity

Both social workers and management discussed health equity as extending beyond patients to include providers as well. Members of both groups raised concerns that providers'

needs regularly received less attention than patients' needs in health equity considerations. One social worker voiced this sentiment concisely, they stated, "A lot of it feels sometimes performative when we talk about using words like equity and equitable care, but that equity doesn't always feel like it goes back to the practitioners. It makes me question if we know what that word means anymore," (SW2). For participants, these two dimensions of the Quintuple Aim, provider experience and health equity, were clearly linked. Social workers highlighted particular equity concerns around high caseload demands and lacking hybrid work arrangements.

Management were similarly attuned to the lack of equity considerations afforded to providers and agreed that caseload targets (set by the province) were too high while compensation for health professionals in community settings remained too low. Targets were a frequent topic of conversation in discussions with both managers and social workers, particularly around the stress they place on providers. The tension between increasing patient access to care (i.e., more appointment availability) and provider experiences was evidenced by one management staff member, who stated:

> We work so hard to ensure that we are meeting our targets that sometimes a few things get lost in that… I think we do well in ensuring that our patients have a good experience. However, our providers may not fare as well as they try to [meet] their targets… We keep hearing more and more burnout. You know, I think we're pretty much failing in that category [because of] compensation differentials between community care providers and say, acute care in the hospital… I would say that we're absolute failures in that area. And it worries me that [this] will ultimately erode the kind of care that we're able to provide in a community setting. (M3)

Management staff members discussed feeling particularly restricted in what they could do to improve provider experiences, especially since caseload targets and funding decisions are made at the provincial level (see also *Provincial Priorities Supersede Local Priorities*). For Management Staff 3, provider compensation remained a glaring inequity. They claimed that hospital-based providers like nurses and social workers currently earn "$20,000 more" per year than community-based providers offering similar services (M3). They argued that one opportunity for OHTs to improve health equity for providers would be to harmonize provider compensation across organizations, eliminating the acute care/community care pay gap.

Resistance to Health Equity Performativity

The importance of health equity to both social workers and managers was cast in sharp relief when participants described their discomfort with health equity gestures that they felt were performative. When asked about a specific outreach initiative (a winter coat drive) conducted by their CHC in partnership with a local business, one social worker argued that the initiative did not go far enough to be touted as equitable, they stated:

> They're not reaching out to more people, only just a minority of those people you've reached. And then you make it sound like you're actually reaching majority of people. Winter is still ongoing. Winter hasn't ended. It should be a monthly basis thing that you give coats, not just once. Some people still need coats for their kids. When I saw that [promotional video for the winter coat drive], I'm just like, oh seriously, this is a promotional stunt. (SW3)

This participant expressed frustration with both the inadequacy of the initiative, and perhaps more specifically, the fact that corporate sponsors involved in the initiative were claiming valour for their health equity work through the promotional video.

Management also repudiated performative acts of health equity, although they tended to focus their critiques at the OHT and provincial levels. Speaking about their OHT partners, one management staff noted, “I think everyone has a health equity statement that's probably similar ours. However, I don't believe [in] statements really… [It’s fine to] keep talking the talk, but you have to walk the walk,” (M3). This participant’s concerns around health equity performativity were tied in part to limited community engagement efforts by their OHT partners. They understood community engagement as a central pillar of health equity which promotes health organizations’ accountability to their communities. However, the participant described perceiving disinterest from their partners on this front. They stated, “Unfortunately, I think that's what happens in that we are the so-called ‘community-based organization.’ So OK, [the local CHC] can handle that. They'll check off that box, right?” (M3). These comments draw attention to a values conflict within OHTs between those organizations and providers who are committed to substantive health equity changes, and those who are comfortable with simply checking off the equity box.

Issues with Provincial Leadership & Neoliberalism

Managerialism

Data-driven care targets were the most frequently cited dimension of managerialism that participants took issue with. To be clear, participants did not object having targets as an evaluation framework for health care, rather they emphasized that the current quantitative targets overlooked important dimensions of care provision. A management staff member described this distinction in detail:

> How many people do you see? How many [times] have you seen them? …Whereas I think when we're working with such complex communities such as ours that face so

> many systemic barriers, I don't think that gets captured well in targets. And I don't know if it gets captured well in the way we show our impact either. (M1)

Alluding to health equity, this participant questioned whether data-driven targets, such as client encounter quotas, are compatible with systemic change. They argue that such targets overlook the root causes of health disparities, thus missing a crucial component of the impact that CHC's intend to have for their communities. Despite the constraints imposed by data-driven targets participants still acknowledged their practical importance. "And part of me feels conflicted about that because I know ultimately that those numbers, and I hate using that word, but it's the truth… hold us accountable and it does reaffirm the funding," (SW1) noted one participant. The connection between accountability (i.e., meeting targets) and receiving funding was troubling for this participant because it shifted the defining objective of service delivery away from client-centered care. Their exact words were, "When we're focused on the quantity [of care], we're not always shedding light on the quality," (SW1).

Data-driven targets are not inherently emblematic of managerialism; they are simply an evaluation tool. However, such targets are commonplace within neo-liberal and managerialist organizations because they quantify success. Numerical outcome metrics (e.g., number of clients serviced) allow neo-liberal organizations to demonstrate progressive gains in cost efficiency which justify their funding and existence. Hence, setting and achieving data-driven targets are inherently important functions of neo-liberal service organizations. Managerialism becomes apparent when data-driven targets are used to download responsibility away from senior leadership and onto managers and individual practitioners. A fascinating example of this trend emerged during an interview with a management staff member. They described an on-going transition within their OHT related to data reporting. Historically, CHC data has been aggregated

at the team level (functional centres) before being reported upwards. This meant that funders knew how many clients an entire *team* of social workers encountered in a reporting period, but did not have insights into *individual* practitioner performance. “But now with the new OHT… you're no longer [reporting aggregate data] as a functional centre. You're your own identity,” (M2) the participant claimed. At the time of writing this change had not yet occurred, however the participant stated that the groundwork was being laid behind the scenes. This transition towards more individually-based accountability measures points to a pattern of managerialist strategies in place within this OHT.

Furthering this trend, OHTs themselves are structured as middle managers of sorts; OHT committee members act as go-betweens for their home organizations and Ontario Health. Management staff participants called particular attention to the uncompensated administrative burden that has been downloaded onto them since the formation of the OHTs. Each OHT is comprised of several committees and sub-committees which meet regularly, each requiring a substantial time investment from committee members to ensure progress is being made. In speaking about the burden OHT involvement placed on their organization, one management staff member noted:

> M3: Of course, it's not just my time because there are also staff members that are sort of doing this at the sides of their desks as well. As I say, I chose not to participate in any other committees at this time because it's just, you know, there's just not enough time... If I think of the cumulative time that our staff spend on just moving the OHT priorities along… there's at least a good day a week that we devote collectively to [the] OHT.

> DH: And [is] your community health centre budgeted in any way like excess hours or even forgiveness in terms of the targets that you're trying to meet to accommodate for those administrative hours?
>
> M3: I'm laughing. Not at all. (M3)

This participant highlighted that much of the core administrative function of OHTs is happening "at the sides of [staff members'] desks," meaning it is outside the scope of their job descriptions and not directly compensated. The participant later clarified that Ontario Health does provide some funding for OHT administration, however within their local OHT, those planning and administration staff are housed at the local hospital. They continued, "What happens is [the local hospital] because … they're the fund holder [they] also are the ones who hire and have the support of the OHT planners," (M3). Other OHT partners, such as the CHC, are thus required to make disproportionate sacrifices in time and resources to participate in the OHT. Prior to the advent of OHTs, these administrative burdens would have been taken on by separate funder agencies, namely, the Local Health Integration Networks (LHINs), and not service delivery organizations. Instead, OHTs, and by extension OHT partners' staff, are performing double duty; they are responsible for both service delivery and funder-level administration.

Provincial Priorities Supersede Local Priorities

OHTs were touted by the provincial government for their responsiveness to local priorities. However, management staff described a dissonance between this promise and the reality that OHT priorities continue to be set at the ministerial level. One management staff recalled, "When we first heard [about] Ontario Health Teams and their mandate… it was understood that this was an opportunity to really look at coordination and planning of health care services at a very local geographic level," (M1). Another participant contrasted those initial

promises with their own experience as an OHT member, they stated, “Okay, so the mandate of the OHT is this coordinated care and within a certain geographic population. [But] what we've noticed is that the ministry have made [all the funding decisions],” (M3). These comments suggest that OHTs have not been given the latitude required to reallocate funds within their partnerships towards local health priorities. This provides further evidence for the notion that OHTs are functionally middle managers who are not vested with the authority required to alter their service offerings in response to local needs. Without this authority, OHTs miss out on one of the most prominent benefits of local service integration, that being local leadership.

A telling example of provincial priorities superseding local needs within the OHT arose during an interview with a management staff member. They stated:

> [One of our mandated priorities is COPD] which is interesting for me because we have a very small number of folks with COPD in the community. However, according to hospital data there, that is one of the conditions that bring people to the hospital more often and it's a higher cost condition to manage. So as a result, it sort of rises to the top of the priority list because of the cost associated with caring for folks with COPD. But again, in our community [we] see a lot more people with hypertension… But that's not the priority within our community that was identified by the province... So things like that, [that’s] the tension I see is that there's really, you know, sort of decisions being made around cost economy, economics rather than the real needs of the community. (M3)

Notably, this participant located the cause of different local and ministerial priorities within differences in values. Specifically, they argued that ministerial priorities take cost effectiveness as their defining value, an approach which directly conflicts with the “real needs of the community.” This statement provides evidence for the claim that the Quintuple Aim framework

is not comprised of five equally important values, rather, an unstated hierarchy exists which may look different for different health actors (i.e., providers, management, organizations, ministries). Importantly, while value rankings differ between actors, this difference remains inconsequential if ministerial priorities take precedence over all others. The same participant described the inflexibility of ministerial values when their OHT advocated for slightly altering their priority areas in light of the COVID-19 pandemic. They stated:

> Some of us advocated to say can we pivot our priority a bit to addressing COVID and long-COVID and lung health… So including COPD, but widen it to include people who would now be suffering from this. …I don't think that was ever sort of acknowledged [by Ontario Health]. (M3)

If OHTs lack the authority to make even small adjustments to their service priorities, it is unclear how they can facilitate meaningful planning and coordination of services. This again fortifies the notion of OHTs as middle managers, and the OHT structure more broadly as a managerialist means of downloading responsibility onto service organizations without consummate authority.

Social Workers' Disengagement from OHTs

Limited Knowledge & Involvement

Social workers expressed a distant relationship with their OHT. Importantly, none of the social worker participants held positions on any OHT committees, nor did any other social workers employed at their CHC. Management mentioned that one OHT committee which centred on mental health and addictions was seeking involvement from social workers in the OHT, but it had not yet filled these positions. Social workers described the distance they felt as being rooted in a lack of knowledge about OHTs. One participant stated, "My local Ontario Health Team, to be honest with you, I'm not really so much involved with them… I really don't

know much about them. …I'm not [familiar] with their role exactly and I'm not part of them," (SW3). This social worker expressed such limited familiarity with their OHT that they did not consider themselves to be a part of it. Another participant questioned who was responsible for forging ties between providers and their OHT, they noted:

> [One] part is my own kind of having my blinders on of like what kind of work I want to be doing versus being a part of a team that I didn't necessarily sign up for as an individual… Which also means the converse, which is I'm not gaining any benefits from the fact that I happen to be, you know, a part of an organization (CHC) that's part of that team (OHT). And the other side of it is kind of, is it my responsibility or is it my organization's (CHC) responsibility to really kind of bridge that gap in the most seamless way possible? (SW2)

This participant highlighted that providers who are employed by health organizations, as opposed to private practitioners, do not get a choice as to whether or not they became part of an OHT. They argued that since their CHC elected to join the local OHT, their CHC should be responsible for informing providers about their OHT's function, stoking provider engagement, and soliciting buy-in to the OHT project more broadly.

Management staff acknowledged that not enough had been done to draw providers into their OHT. One manager stated:

> I don't think we've been able to introduce the OHT concept as well as we should to the rest of the staff other than the management team that's sort of more closely involved in committees. But I say that, I'm not making an excuse for that, [but] I don't see the value of pulling staff into something where I don't think that they can add anything externally, because they are doing a great job with the clients that we serve. (M3)

Social workers' involvement in their local OHT were deprioritized by management for two reasons. First, management did not see the value proposition behind provider involvement in OHTs; they doubted whether their staff's contributions would have an impact on OHT committees. Second, management wanted to focus providers' attention on service delivery, an area where they claimed providers excel. It is worth asking, however, whether high performance targets placed on providers disincentivized management from seeking provider involvement in OHTs, and disincentivized providers from adding OHT work to their demanding workload.

Disengagement from OHTs presents immediate problems for social workers and integrated care at large. Without seats on OHT committees, social workers have limited influence on their mezzo-level policy environment. This entails lost opportunities to incorporate social work knowledge within multi-organizational strategy and results in OHT-level expertise deficits for core priorities like health equity. For integrated care, social worker disengagement represents an epistemological loss as much as a cultural one. One of the many strengths of integrated care is its embrasure of multiple disciplinary perspectives and subsequently, its more holistic approach to care planning than conventional medicine. However, interdisciplinary collaboration exists on a continuum. At its best, interdisciplinary collaboration is a cultural feature of organizations infused into their institutional logics. This degree of interdisciplinary culture is only possible through robust interdisciplinary engagement at each level of organizational functioning. While social workers and other allied health disciplines are well represented at the direct service level, their cultural and epistemological presence are muted at the OHT-level due to lacking representation. This results in OHT policy agendas and organizational processes that are less responsive to social work priorities such as critical practice, social justice, client advocacy, and cultural/spiritual care considerations.

Value Misalignment & Distrust

Beyond a lack of knowledge or time constraints, social workers voiced a hesitancy to embrace their OHT which stemmed from a value misalignment between the Quintuple Aim framework and their own critical practice approaches. When speaking about the Quadruple Aim, the Quintuple Aim precursor which OHTs were founded on, one social worker described this value misalignment in detail. They stated:

> The research behind the Quadruple Aim… and how the Quadruple Aim is implemented in a very westernized like model of thinking… [it] can mean excluding certain mindsets, certain cultural, you know, aspects, certain frameworks for people. [And] if it is rooted in the very colonized, very white supremacy dialogue, then how can we implement health care for a very complex and diverse population? (SW1)

For this social worker, a critical dimension of the Quadruple Aim framework is clearly missing. They expressed skepticism about the Quadruple and Quintuple Aims because these frameworks do not interrogate their own Westernized, biomedical epistemologies, nor do they seek to name and challenge the structural forms of oppression that predicate health outcome disparities. Without these critical inclusions, the participant found it difficult to trust that the value framework was in the best interests of patients and providers.

Another social worker expanded on this skepticism, citing their distrust of the Progressive Conservative provincial government which designed and implemented OHTs. They stated, “And I think like the general skepticism that I have… [is] of the decisions being made and the kind of motivations that underlie them. It's hard to trust that [those decisions are] in anybody's best interests,” (SW2). Importantly, distrust, premised on a misalignment in values, presents a substantial barrier to provider involvement in OHTs.

Unmet Needs for Integration

Structural Integration

One of the core promises of OHTs is to provide better patient and provider experiences through integrating service provision across organizations. However, participants questioned whether this integration was happening to a meaningful extent. Areas of particular concern for further integration included system navigation and information sharing for patients and providers. One manager observed, “It sounds good, right? … [As a patient] I'm getting referred, all my information is going to the right place… [But] I don't know if that's actually always happening,” (M1). OHTs are intended to increase integration of services by drawing local organizations into more formalized relationships with one another. The same participant wondered if simply formalizing those relationships had much of an impact on service integration, “We've been working with organizations in the community before the OHT. …So, we've already developed relationships,” (M1). For this participant, limited service integration within their region was not the result of lacking interorganizational relationships, rather, it stemmed from poor structural integration.

Management and social workers agreed that deeper structural integration was necessary to reap the benefits of coordinated service provision and highlighted a pressing need for a common electronic medical recordkeeping (EMR) software across organizations. One manager poignantly noted:

> I haven't seen any change [in care integration] to be honest because we do not have the levers to make those changes ...within the broader system now between acute, hospital, community, mental health and addictions, there's no clear pathway and no clear, no common EMR for example, that we can message each other [on]. So, while the system is

> trying to arrange care around the [client], that client still has to go through [each] door and tell their story over and over again. …It hasn't gotten to that, you know, we haven't arrived. (M3)

This participant argued that without a common EMR across organizations, providers' ability to coordinate care with practitioners outside their home organization is severely limited. EMRs represent a vital structural component of any health care system. They log valuable patient information including clinical notes, prescriptions, medical history, allergies, and more, in a single accessible file. They also provide auxiliary functions for practitioners such as appointment scheduling, direct messaging between providers, and referral pathways. Practitioners using the same EMR can share access to a single, comprehensive patient file. They can view each others' notes, readily access a patient's medical history, process simplified referrals, or send pertinent care coordination correspondence through direct messages to other practitioners. Without a shared EMR, however, practitioners construct their own independent patient files. Their clinical notes are thus unavailable to other providers requiring patients to repeat themselves and relay information between their care providers. This is evidently frustrating for patients and providers. One social worker echoed this frustration, stating, "It becomes difficult with the OHT piece because, again, agency 'A' doesn't have access to my files," (SW2). Without a shared EMR at the OHT-level, this participant noticed that client hand-offs between practitioners were disjointed, and care plan coordination was greatly restricted.

Beyond a common EMR social workers also called for improved resource sharing databases and referral networks within OHTs. One participant provided a clear rationale for this addition:

> One of the biggest [challenges] as a practitioner is finding information sometimes, and there is no set database for finding the information you need. And things [are] constantly changing… sometimes you're referring someone somewhere and a waitlist is full and you're not aware of that. (SW1)

This participant described spending significant amounts of their administrative time searching for resources online, contacting co-workers with informal information requests, or reaching out to external organizations about their waitlist lengths. They argued that a shared referral platform with accurate waitlist information, as well as a resource sharing hub for mental health resources, would be welcomed steps towards care integration within OHTs.

Value Integration

Social worker participants argued that their disengagement from OHTs stemmed in part from a misalignment of values with both provincial policies and the Quintuple Aim. One social worker voiced similar value misalignment that they noticed across disciplines. They claimed:

> [The] Sunshine list tells you who's who at my agency makes over $100,000. And there's not a social worker on there. No, it's managers, it's some management and doctors, and those are people who are getting paid less than they would be in other, you know, private practices or whatever. But that financial piece is still there. And so, does that lead to a disconnect between why we're doing the work that we're doing to some degree? (SW2)

Touching on the differences in compensation between medical professionals and social workers, this participant draws attention to the motivations that drive providers to undertake care work. One assumption at play here is that if a provider's primary motivation is financial, then may be less likely to be able to provide the kind of care that this social worker values, namely critical,

client-centred and holistic care. Whether or not this assumption is true, the *perception* of value misalignment jeopardizes interprofessional collaboration by stoking distrust of other providers' motivations. Bridging these kinds of values gaps may be necessary for more robust interdisciplinary care coordination.

Interdisciplinary value conflicts are influenced by systemic factors beyond just compensation structures. One management staff member argued that post-secondary degree programs do not adequately prepare providers for an integrated care environment:

> Our education system actually fails when it comes to teaching healthcare professionals around integrated care. It's very much a siloed approach. …A lot of our physicians have told me that [they're] not taught to think about how to work with other professional groups, chiropodists, dietitians. …Helping professionals as they enter their field of study within this kind of an integrated environment [need] to really understand that, yes, I'm not the only provider in this person's care. (M3)

This participant highlighted how traditional discipline-specific education practices may limit interdisciplinary coordination by de-emphasizing the importance and the routine nature of multi-faceted care plans. Therefore, improved cross-disciplinary training for all health professionals would benefit Ontario's integrated care efforts by forming a more concrete interdisciplinary value foundation on which to build subsequent coordination efforts.

Discussion

The provincial government introduced OHTs as a move towards more integrated care in Ontario, and in response to the shortcomings of previous health care reforms. Local Health Integration Networks (LHINs), the immediate predecessors of OHTs, were criticized for upholding a largely siloed approach to care, middling performance on key metrics (e.g., knee surgery wait times, readmissions, etc.), lacking EMR infrastructure, and a narrow focus on hospital and acute care providers (Dong et al., 2024). The present findings offer an opportunity to assess the extent to which OHTs have addressed these issues in the context of CHC-based social work practice. Social worker participants described a stark divide between internal (i.e., within CHC) and external (i.e., within OHT or beyond) care coordination for their clients. While internal communications were lubricated through the use of a shared EMR or face-to-face meetings with other care providers, external care coordination relied on faxes, emails, and frequently, clients themselves. Social workers recalled regularly asking their clients to relay case planning information, recommendations, or appointment summaries between themselves and external providers. Evidently, initial OHT promises of interconnected providers "So that patients don't have to repeat their health history over and over again," allowing for "Seamless transitions across different care providers and settings," have not yet been realized within OHTs (OMHLTC, 2019, p. 5). Participants stressed that a shared EMR within their OHT was a precondition for the level of provider connectedness promised by the government.

Much of the emerging OHT literature emphasizes factors that enable or constrain provider engagement, including relationship building, governance structures, and (lacking) provider incentives. This literature has overwhelmingly prioritized PCPs, and to a lesser extent nurse practitioners, as primary targets for OHT engagement due to their pivotal role in administering primary care and frequently siloed private practices (Everall et al., 2022; Grady et

al., 2021; Grady et al., 2023). PCPs most frequently cited barriers to OHT participation were poor renumeration, scheduling conflicts (i.e., time away from patients), and perceptions of power imbalances within OHT governance structures (Everall et al., 2022; Grady et al., 2023). Some PCPs were particularly concerned that local hospital and ministerial priorities dominated the discourse within their OHT and thus marginalized PCPs priorities (Everall et al., 2022). Management participants in the present study expressed some similar concerns. They too were disparaged by poor renumeration for their staff as well as substantial time commitments beyond the scope of their CHC roles. However, the leadership and strategic coordination opportunities embedded within OHTs incentivized CHC management's on-going engagement with their OHT. Importantly, for both PCPs and CHC management perceptions of their ability to lead within their OHT, or perhaps more fundamentally, to meaningfully influence its actions, moderated their willingness to engage, even in the face of other constraining factors.

To the writer's knowledge, the present study is the first to specifically address the factors affecting social workers' engagement in OHTs. A primary barrier to engagement for social worker participants was limited knowledge of their OHT including its purpose, structure, potential benefits, and recruitment possibilities. Lacking this foundational knowledge, social worker participants expressed feeling like they were not even part of an OHT. Social workers recognized their limited knowledge of OHTs as a potential barrier to engagement but questioned whose responsibility it was to "bridge that gap," (SW2). Management agreed with this social worker that they had not done enough to "introduce the OHT concept," (M3) to service providers within the CHC. However, management argued that they deprioritized service provider engagement due to a perception of limited value-added. As one manager put it, "I don't see the value of pulling staff into something where I don't think that they can add anything externally,"

(M3). Whether this limited value-added perception arose from an intimate knowledge of OHT bureaucracy and thus entailed doubts about the ability of individual actors to exert influence within OHTs, or whether it reflected a particular conceptualization of health professionals as service providers, the result was the same; managerial priorities disincentivized social worker engagement in their OHT.

Social workers also expressed intrinsic resistance related to value conflicts with OHTs. Social workers emphasized accessible, holistic, and client-centered approaches to care, values that did not always align with the Quintuple Aim. The most striking instances of misalignment emerged through participants' comments about value performativity. Social workers were particularly attentive to promises of improved health equity or provider experience that were either not being met or pursued only superficially. This tension between the Quintuple Aim professed by OHTs and the actions realized within their CHC/OHT contexts stuck with social workers and contributed to a distrust of OHTs and ministerial health priorities more broadly. Such fundamental value misalignment is concerning, not only in regard to social worker engagement with OHTs but as a serious risk for burnout (Reynolds, 2011). Burnout is a multidimensional construct that includes several clustered psychosomatic experiences, such as emotional exhaustion and depersonalization (Travis et al., 2016). Higher rates of social worker burnout entail meaningful consequences for quality of care and organizational functioning within OHTs. Social work counselling is premised on the emotionally laborious process of relationship building with clients. Social workers experiencing burnout may be too emotionally exhausted to engage in this process as fully as they otherwise would, leading to more distant therapeutic relationships and lower quality of care for clients. Social workers experiencing burnout are also more likely to become overwhelmed by workloads they could previously handle, creating further

problems for staff retention and staff engagement within service organizations. Given the centrality of social work values to practice, the tension between the Quintuple Aim and social workers' values raises questions about how OHTs reshape what social *work* looks like as well as the kinds of personal/professional values that enable a social worker to perform that work across their career.

Alongside social workers' professional values and the Quintuple Aim, a third set of competing values emerged from participants responses, that is, managerialism. Lawler and Bilson (2013) describe managerialism as a reconceptualization of managers' roles such that they emphasize efficient use of capital, greater fiscal awareness, and the ability to both control staff and attain assigned targets. Under managerialism, managers are held individually responsible for their team's ability to meet service targets and reporting standards. The influence of managerialism discourse was apparent at both the OHT and CHC levels. One of the promises made by the OHT framework is collective governance by local health service organizations, and more specifically, allowing organizations to collectively tailor their care priorities to meet local needs (OMHLTC, 2019). Participants were clear that this is not currently happening within their OHT. In the absence of basic strategic autonomy, OHTs are cast as middle managers. The result mirrors Lawler and Bilson's depiction of managerialism; OHTs targets are set from above and their success is measured on their ability to attain ministerial priorities and regulate their membership. Moreover, the financial structure of OHTs and their unified funding envelope incentivizes OHT partners to foreground financial considerations in their work within the OHT. For instance, OHT partners are incentivized to primarily attend to efficient capital expenditure and service target attainment as a means of safeguarding next year's budget, thus marginalizing other care-oriented priorities like access to care, health equity, and patient/provider experience.

The financial considerations and ministerial care priorities imposed by the OHT structure augment members' roles from health care leaders to middle managers. In other words, OHT committee members are cast as go-betweens for the Ministries of Health and Long-Term Care and their respective home organizations.

At the CHC-level the presence of managerialism values emerged through participants' depiction of service provision targets. For social workers, targets governed how many "encounters" (e.g., counselling session, client contacts, community events, etc.) each participant was required to attain within a given year. The team's manager was tasked with monitoring each social worker's progress and periodically intervening to support them in meeting their individual targets. Importantly, social workers' targets centered entirely on the frequency of service provision and ignored both service quality and client outcomes. Social workers described this singular focus on quantity of service provided as troubling and anti-thetical to the kind of comprehensive and holistic care they wanted to provide. As one social worker put it, "The work I do is measured in how many people show up… I could be the worst social worker in the world. But if people come through my door, then nothing bad is happening," (SW2). Evidently, a stark contrast exists between the participant's beliefs and the government's beliefs about what the "worst social worker in the world" looks like.

But where does the Quintuple Aim fit into this value conflict? If the Quintuple Aim is understood as having five equally important dimensions, it follows that Quintuple Aim adherents would pursue patient experience, provider experience and patient outcome considerations (quality of care) over cost efficiency ones (quantity of care) because the cumulative value of the first three aims would outweigh the latter one. Alternatively, the Quintuple Aim may not represent five distinct objectives inasmuch as one enmeshed one. This interpretation would imply

a middle ground response which attempts to pursue all five aims simultaneously (e.g., quantity and quality targets) without preferencing any one aim in particular. However, neither of these possibilities matches the reality of the narrow quantitative service provision targets attested to by participants.

Instead, service targets ran directly counter to certain dimensions of the Quintuple Aim, notably provider experience and health equity, without recourse for this malignment. One manager highlighted this trend succinctly, “I think there's always going to be that tension in this case between what [our] targets are and what needs to be done in order to ensure equitable, high-quality access to care,” (M1). The tension here is that the most efficient methods of service delivery cannot, by design, be the most equitable. This is because efficiency-seeking performance targets (e.g., client encounter quotas) construct clients equally, not equitably; each counselling session is only “worth” one encounter despite the contents of that session or the needs of the client. This equality in measurement obfuscates a diversity in practice. Client strengths and needs, provider experience and modality, client-provider fit, and individual positionalities all affect how social workers deliver their services, yet these factors are not captured in current performance targets. For instance, client ‘A’ may require extensive care planning, referrals to medical and social programs, and intensive counselling sessions, whereas client ‘B’ may need only cursory emotional support and psychoeducation. Given their high service quotas, social workers in OHTs may be required to underserve client ‘A’ because their care needs demand more time than has been allotted for counselling sessions. Alternatively, social workers caught between clients’ needs and their own quota may be compelled to sacrifice personal time to adequately serve their clients, thus increasing their risk of burnout.

The issue for OHTs is that efficiency-based performance targets do not serve all five of

the Quintuple Aims, and in fact, actively undermine three of them. Health equity is inherently inefficient and actively hindered by a cost efficiency focus. So too are patient and provider experience since they similarly value a degree of personalization over a one-size-fits-all approach. Insofar as OHTs rely on solely efficiency-based performance targets they cannot achieve a harmonious balance between the Quintuple Aims; cost efficiency will dominate the institutional logics of OHTs and OHT partner organizations. The unfortunate upshot of these efficiency-based, quantitative service targets is a reformulation of what care work looks like in health care organizations. Under the current paradigm, health care organizations, and by extension care providers, have one primary set of job responsibilities – meeting ministerial targets. Any other work, such as equity advocacy, professional development, or relationship building, is inherently secondary (or worse, extracurricular) to their primary function as provincially contracted service providers. This reality starkly contrasts the stated ideal of the Quintuple Aim.

In the public management literature, Dahler-Larson (2013) argues that performance indicators or targets are inherently political assertions of value which define interpretive frames and worldviews, the content of work, and professional identities. Thus, targets are not merely a product of a certain set of values but *constitutive* of one; they enact a set of values through their pursuit, reshaping organizations, procedures, and identities in the process. He offers three pathways by which performance targets constitute their environment: by shaping operating procedures which organize perceptions of a disordered reality (e.g., “good” social work means achieving a target number of client encounters); by providing a taxonomy, declaring what counts as an activity or outcome (e.g., how many minutes spent with a client equates to one encounter); and through the process of institutional ‘lock-in’ with performance targets, whereby incentives

and punishments become attached to target attainment (e.g., next year's funding, employment status, etc.) (Dahler-Larson, 2013, p. 976).

The concept of 'lock-in' invites parallels with the ILP notion of institutional logics. Garrow and Hasenfeld (2010) describe institutional logics as embedded values within an organization which have become codified into its policies. Once codified, institutional logics are ubiquitous, determining key meaning-making processes including social problem definition, organizational purpose, and professional identity. Despite their similarities, institutional logics differ substantially from target 'lock-in' in their respective theories of change. ILP proponents argue that institutional logics are dismantled when a plurality of alternative logics are available within an organization's "cultural schema," and when entrepreneurial actors can convince their colleagues that an alternative logic is better than their current one (Garrow & Hasenfeld, 2010). This perspective emphasizes the power of individual actors within organizations to act as value champions and to inform bottom-up organizational change. In contrast, performance target 'lock-in' is an entirely top-down phenomena. That is, insofar as performance targets are tied to punitive or financial outcomes, they retain their constitutive influence on organizational values and meaning-making processes. Under this framework individual actors cannot directly influence organizational values in the fashion that ILP suggests, however, they could indirectly assert their values by challenging performance target frameworks.

Recalling the tension participants experienced around performance targets, and the incongruous fit of narrow quantitative targets with the Quintuple Aim, I would argue that the Quintuple Aim is not the foremost value system embedded within participants' CHC or OHT. Instead, values aligned with neoliberalism and managerialism have become 'locked-in' to OHTs through financial and punitive incentive structures which formulate care around market-driven

ideals of customer service provision and corporate efficiency. To be clear, I am not arguing that the Quintuple Aim bears no influence on OHTs, rather it represents secondary or extracurricular functions of health care organizations within OHTs. Thus, each of the Quintuple Aims are only translated from theory into practice to the extent that they have specific performance targets associated with them. One management participant spoke to this distinction and noted a need to "…[Develop] policy and frameworks around what health equity looks like for us as an OHT and [set] some clear targets for ourselves to meet… to ensure that we're advancing equity," (M1). Interestingly, this participant described setting equity targets at the OHT-level instead of the ministerial level. This provides further evidence of a value hierarchy in OHTs wherein the most important (financial and service provision) targets are set provincially while less important values (health equity, provider/patient experience) are enacted discretionally at the local level. Targets are an accountability metric that in and of themselves are not inherently problematic. However, the ministerial use of narrow performance targets speaks to an unacknowledged framework of managerialist and neo-liberal values which are being enacted through OHTs, and which contradict OHTs professed Quintuple Aim.

If OHTs are understood as the most recent outgrowth of managerialism in Ontario's Health Sector, what is at stake for social workers is more than just value conflicts with their employer/colleagues or acute experiences of burnout; it is the reconceptualization of their professional identities within the current health care system. Throughout the present report, the terms "social work" and "service provider" have been used interchangeably. This is common practice both within the Health Sector and in common parlance. However, this "service provider" identity has not always been synonymous with social work. Health care "service providers" arose in unison with health care "consumers," (patients/clients), a trend tied to the rise of New Public

Management (NPM) in the 1980's and 1990's (Sześciło, 2016). NPM is closely related to neoliberalism and managerialism in that it emphasizes increased public sector accountability, cost efficiency, and exercising control over public sector professionals through the application of performance evaluation targets (Mullen, 2004). Most notably, NPM positions the government as a service broker tasked with purchasing social services for its denizens instead of providing for those needs directly. Consequently, social workers and other traditionally public sector employees (e.g., doctors, librarians, teachers, etc.) are cast as private contractors of sorts, "service providers," while the populations they serve are "consumers" that pay for services indirectly through tax contributions. This rise of the "service provider" identity has been particularly apparent in the Health Sector where there is an expanding private market of health and mental health services stoking competition with public and non-profit offerings.

The "service provider" identity undermines a prevailing professional understanding of social workers as advocates for social justice. This advocacy element of social work has been codified into the profession's Code of Ethics with "promoting social justice" listed as one of seven core principles of social work practice (Canadian Association of Social Workers, 2023). And yet, as "service providers," social workers are situated as micro-level professionals with duties to their immediate caseload and little responsiveness or accountability to mezzo- or macro-level injustices. Current performance targets within OHTs (i.e., client encounter quotas) reinforce this narrow, individualistic approach to social work; they do not evaluate social workers on their ability to affect systemic change or move towards social justice. The upshot is that social workers' identity as "service providers" is enacted through NPM values and accountability measures. This set of values has been pushed from top-down and permeates health care organizations in Ontario. Within the present sample, management participants upheld the

notion of social workers as "service providers" by focusing their labour on direct client-facing activities and downplaying their potential advocacy impact at the OHT-level. Social worker participants, to a lesser extent, also conceptualized themselves as "service providers" in that their primary responsibility in their capacities as social workers was to maximize service provision benefits for their individual clients. That is not to say that social workers were not cognizant of and willing to speak out against structural oppression. However, their work centered on meeting the needs of their caseload more than social justice advocacy within their CHC, OHT, or beyond. To the extent that social workers are positioned as "service providers" and are constrained by efficiency-based service provision targets, they are deeply limited in their ability to live up to their professional ideal of social justice within Ontario's Health Sector.

That being said, there are concrete steps available to policymakers and sector leaders which could improve value alignment and interdisciplinary service integration within the present OHT framework. Service provider engagement within OHTs remains a fruitful avenue for incorporating interdisciplinary perspectives into OHTs' institutional logics and identifying sites of collaboration or concern. This engagement may include increased service provider recruitment directly to OHT committees, or the creation of discipline-specific working groups within OHTs so that providers can amalgamate ideas and concerns before reporting them upwards. In any case, OHT leadership will need to press the Ministries of Health and Long-Term Care for more adequate renumeration for OHT work. Whether that remuneration is monetary (e.g., paid extracurricular meetings) or in-kind (e.g., performance target relaxation), further incentives are needed to compensate service organization staff for the added administrative and strategic planning burden they continue to bear.

Further work is also required to develop interdisciplinary value clarity. Presently, there

are several competing value frameworks at play within OHTs including the Quintuple Aim, managerialism, and discipline-specific codes of ethics. The present investigation has highlighted incongruencies between social work values and the first two of these frameworks, however, other allied health disciplines have their own codes of ethics with unique similarities and contradictions between themselves and the three aforementioned value frameworks. Accordingly, since value misalignment is a clear barrier to both OHT engagement and successful integrated care at large, OHT leaders could seek to articulate an interdisciplinary code of ethics within their OHT. In doing so, staff from across the OHT would be afforded the opportunity to forge a collective, overarching set of values that they could return to in their professional practice or leverage when advocating for organizational change. The creation of an interdisciplinary code of ethics should involve service providers from each discipline working within an OHT and afford opportunities for providers to negotiate their own personal and professional ethics with that of the collective. The end goal of this exercise would be to achieve greater clarity of values and purpose which could facilitate closer interdisciplinary collaboration and provide a more unified front from which to negotiate the Quintuple Aim within each OHT.

Limitations

The present study has two notable limitations. First, data were collected at one CHC within one metropolitan OHT. This raises questions about the generalizability of the present findings across social work settings (e.g., hospital, community, long-term care, etc.) and OHTs. For instance, given the diversity of governance structures across OHTs, it is possible that certain themes which emerged in the present sample (e.g., social worker disengagement from OHTs) are less prominent in other OHTs. Second, during their interviews, participants were not asked directly about experiences of neoliberalism, managerialism, or NPM (see *Appendix A*). This

decision was taken to reduce interviewer bias on participant responses and instead focus interviewees on the breadth of their workplace experiences and professional values. Consequently, an opportunity for participants to call attention to specific workplace experiences which they understand as manifestations of neoliberalism, managerialism, or NPM, was sacrificed for a more holistic portrayal of participants' work life.

Future Considerations

Further investigation is needed to address value negotiation within OHT governance structures, namely, by replicating similar ethnographic investigations with OHT partners from several provider organizations. Comparative analyses across multiple OHTs would be particularly beneficial for contextualizing the present findings. Moreover, other understudied primary care disciplines (e.g., Audiology, Dietitians, Occupational therapy, Physiotherapy, and Speech-language pathology) would benefit from similar discipline-specific or else interdisciplinary value negotiation investigations to assess their fit with the Quintuple Aim and OHTs. Performance targets emerged as a key area of concern for participants with direct influences on the manifestation of organizational values. Future research is needed to propose alternative evaluation frameworks which simultaneously support organizational efficiency while upholding critical perspectives in health service organizations.

Within the broader integrated care literature there is a continued need for critical perspectives. The Quintuple and Quadruple Aims are popular frameworks for health policymakers, yet there is limited research into their congruence with patient, provider, and management perspectives. Critical research is needed to assess both the fit of the Quintuple Aim with its purported stakeholders, as well as the framework's potential subversion by neoliberalism, managerialism, and NPM values.

Conclusion

The present study offers a preliminary ethnographic investigation of one primary care discipline, social work, within the integrated care contexts of OHTs. Social worker and management participants shared similar concerns about the implementation of the Quintuple Aim framework in OHTs, most notably in relation to provider experience and health equity. Participants' perceptions of value performativity demarcated clear sites of divergence between professed and realized values within OHTs. Through critical neo-liberal analysis of the present findings, a third, unspoken value system emerged. Managerialism and NPM values undermined both providers' professional values and the Quintuple Aim via the ministerial application of narrow quantitative performance targets. Performance targets were constitutive of a neo-liberal set of values within OHTs which aimed to reshape social workers' professional identity into "service providers" and patients/clients into "consumers." The application of performance targets within OHTs manifested practical and value-based constraints to social worker participation within their OHT, limiting opportunities for social justice advocacy in that policy arena. Given the constitutive effects of performance targets, social workers seeking value transformation within their workplace or OHT are perhaps best served by challenging existing performance evaluation frameworks within their workplaces to include more robust, holistic accounts of the impact they have with the communities they serve.

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Appendix

Appendix A – Interview Guide

Appendix B – Consent Form

Appendix C – Ethics Certificate

Appendix D – Thematic Analysis Matrix

Interview Guide

Introduction

Thank you for joining me for this interview today. Before we begin, I just wanted to remind you that your participation is completely voluntary. You do not have to answer any questions that make you feel uncomfortable, and you are welcome to end the interview at any time. Before we start, did you have any questions about confidentiality or your participation in the study today?

Demographic questions

1. How long have you been working at [current workplace] in your current role?
    a. Were you working at [current workplace] in a different role previously? For how long?
2. How long have you been practicing in your field?
3. Have you worked in any other Community Health Centres before this one?
4. Do you have a role on the [local OHT]? If so, what is your role and how long have you held it?
5. Do you currently, or have you previously, worked in another Ontario Health Team?

Integrated Care/OHT

1. How much do you know about or interact with your OHT?
2. **If you were at [workplace] before they joined the OHT**, what kind of changes have you noticed?
3. Do you notice any day-to-day impacts of being part of an OHT?
4. Tell me about your experiences as part of an integrated care team at [workplace].
    a. Where has being a part of that team worked for you?
    b. Where have you found it been challenging or frustrating?
5. If you had a magic wand, what would you change about how the CHC or the OHT function?

Values

1. How familiar are you with the Quadruple Aim framework?
2. Do you agree with the Quadruple Aim framework? What do you think it does well/poorly?
3. Do you feel that your organization is living up to the Quadruple Aim?
4. **For social workers** Do you feel that the Quadruple Aim compliments or conflicts with your professional Code of Ethics (e.g., CASW)? How so?

Text Discussion

1. Tell me about the text you brought in today, why is it important to you?
2. Are there specific parts of the text that you find most important?

3. How do you encounter this text in your daily practice?
    a. How does this text support you or your clients?
    b. How does this text restrict you or your clients?
4. Are there any recommendations you would give to your organization or other health and social service organizations based on how you experience this text?

Workplace Exploration

1. I'm curious about what your day-to-day activities look like at [workplace]. Could you tell me about what you look forward to on an average week?
2. What about things in your daily or weekly routine that are a concern for you, or that you don't look forward to?
3. What does your workplace support network look like?
    a. Do you feel that you have allies or people you can confide in, in the organization?
    b. Are there people that you wish were part of your support network who are not currently?
4. Where do you feel your workplace needs to improve?

Wrap-up

Did you have any final thoughts you wanted to share before we wrap-up today?

Just as a reminder, I am available after our interview if anything comes up for you that you want to discuss further. You can also email me to set up another time to talk, or if you prefer, pass along your thoughts in an email if that's easier.

With that said, thank you so much for taking the time today to participate in this study! The findings for this study will be ready around May of this year if you're interested in receiving a copy, let me know and I can reach out to you at the time.

Informed Consent Form

Date: January 7, 2025

Study Name: Ontario Health Teams: Negotiating Social Work Values

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Purpose of the Research: This project aims to understand social workers' experiences and the role of social work within Ontario Health Teams. Emphasis is placed on how social workers negotiate their personal and professional values within interdisciplinary care teams. Data from this research will be used for the Principal Investigator's major research paper in partial fulfilment of his MSW degree requirements and may be presented at conferences or submitted for academic publication.

What You Will Be Asked to Do in the Research: Participants in this study will be asked to complete a one-hour interview over Zoom. Ahead of the interview, participants will be asked to select one institutional text from their organization (e.g., policy, mission statement, section of the website) to bring to and discuss during the interview. During the interview, participants will be asked about their experiences at their current workplace, their personal and professional values, and the text they have selected.

Risks and Discomforts: There is a risk of emotional discomfort during interviews. Participants are reminded that they can end the interview at any time and that the researcher is available during or after interviews for debriefing.

Teleconferencing/videoconferencing technology has some privacy and security risks. It is possible that information could be intercepted by unauthorized people (hacked) or otherwise shared by accident. This risk can't be completely eliminated. We want to make you aware of this. If you are concerned about this, we would be happy to make alternative arrangements (where possible) for you to participate, perhaps via telephone. Please contact David Harding for further information. (dharding@yorku.ca)

Benefits of the Research and Benefits to You: Participants may benefit from discussing their workplace experiences in the context of the study. Participants may also gain new insights about their experiences or identify meaningful avenues for organizational change through their participation. Findings from this study will contribute to a research gap regarding the role of social work within Ontario Health Teams and integrated care settings more broadly. Future research in this area may lead to revised means of interdisciplinary collaboration or updated institutional/provincial policies that are more inclusive of social work perspectives.

Voluntary Participation and Withdrawal: Your participation in the study is completely voluntary and you may choose to stop participating at any time. Your decision not to volunteer, to stop participating, or to refuse to answer particular questions will not influence the nature of the ongoing relationship you may have with the researchers or study staff or the nature of your relationship with York University either now, or in the future. Prior to your interview with the researcher, you will receive a copy of the interview transcript and will be offered an opportunity to edit, revise, or redact any of your responses before they are submitted for data analysis.

Confidentiality: All information you supply during the research will be held in confidence and unless you specifically indicate your consent, your name will not appear in any report or publication of the research. Zoom interviews will be recorded for the purpose of transcription. Once interviews have been accurately transcribed, the original interview recording will be deleted. Your data will be safely stored on a password protected hard drive in a location that only research team members will have access to. All data will be stored confidentially by assigning each participant a number (i.e., Social Worker #1), and identifying information (e.g., specific names, places) will be removed from the data during transcription. The de-identified transcript data will be securely kept by the researcher until December 31st, 2026. Confidentiality will be provided to the fullest extent possible by law.

The data collected in this research project may be used – in de-identified form - by members of the research team in subsequent research investigations exploring similar lines of inquiry. Such projects will still undergo ethics review by the HPRC, our institutional REB. Any secondary use of anonymized data by the research team will be treated with the same degree of confidentiality and anonymity as in the original research project.

Please note that it is the expectation that participants agree not to make any unauthorized recordings of the content of a meeting / data collection session.

Questions About the Research? If you have questions about the research in general or about your role in the study, please feel free to contact David Harding by e-mail (dharding@yorku.ca). You can also reach out to Anne O'Connell, Graduate Program Director, Social Work, York University (aoconnel@yorku.ca). This research has received ethics review and approval by a delegated ethics review committee within the York School of Social Work and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines. If you have any questions about this process, or about your rights as a participant in the study, please contact the Manager, Research Ethics in the Office of Research Ethics, York University (e-mail ore@yorku.ca). This office oversees the ethical conduct of research studies and is not part of the study team. Everything that you discuss will be kept confidential.

Legal Rights and Signatures:

I _____ consent to participate in Ontario Health Teams: Negotiating Social Work Values conducted by David Harding. I have understood the nature of this project and wish to participate. I am not waiving any of my legal rights by signing this form. My signature below indicates my consent.

Signature _____ Date
Participant

Signature _____ Date
Principal Investigator

Additional consent

1. **Audio recording**

☐ I consent to the audio-recording of my interview(s).

2. **Consent to use of quotes**

☐ I consent to the use of quotations in any final reports/ publications of the research

PANEL ON
RESEARCH ETHICS

Navigating the ethics of human research

TCPS 2: CORE 2022

Certificate of Completion

This document certifies that

David Harding

successfully completed the Course on Research Ethics based on the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS 2: CORE 2022)

Certificate # 0000534734

27 October, 2024

Thematic Analysis Matrix

Theme	Sub-Theme	Talking Points	Quote	Px	Notes
Health Equity as a Core Value	**What Does Equitable Care Look Like?**	Access to Care, Population health, holistic care, combatting personal biases, health equity must be infused in all health work	I think one of the biggest challenges that we're facing is just, you know, is, is lack of equity in our community, you know, like in and incredible health disparities that are are being faced by, you know, community members. And so, you know, I, I think that the, and I'm speaking a little bit more about this earlier around sort of like the tension around the undocumented. I think that's a huge piece of right. It's it is very, I don't want to say it's unique to our community because it's not. But we have a huge number of undocumented and, you know, I, I think until we figure out a solution to care for them and, and more, you know, better and, and have coordinate and, and truly integrated care for them, this they, it's going to, you know, cost the system a massive amount of money, right?	M1	Undocumented residents have additional barriers to health care access that are felt acutely at the CHC level, and which have the potential to cost OHTs significant amounts of money in reactive versus proactive care.
			the whole point of public accessible services is to reduce any kind of limitation on care or as many limitations as we can on care. And if I can do as much as I can to, to treat, um, the person for all they are and all they bring, um, and, do everything I can to combat, you know, my own internal biases. (SW2) 00:17:48 DH The Canadian Association of Social Workers, the CASW or they OASW Code of Ethics do you follow those? 00:17:53 SW3 I always do because one of the aspects that I usually like to do is inclusiveness and also to be able to provide a safe uh surrounding for the clients whereby I don't use my power over -- use my power to support my clients and also to make them feel comfortable enough to be able to talk to me and to take away my biases and shelve it. So that's how I incorporate those code of ethics and values into my practice. (SW3)	SW2 & SW 3	Common idea of addressing personla biases and stigma as health equity work. Personal responsibility to provide holistic care.
			And so how do I put the client first? What is the client coming to me for? What do they need? And it's not my job to tell them what I think they need, it is for us to work through that together and they the client. I come from a very client-centred, -focused, strengths-based approach, trauma informed and very social work perspective, which can sometimes conflict as we've talked about with with evidence based practice, especially in the scientific field of of things.	SW1	Client-based and holistic perspectives are not always rooted in Western, evidence-based epistemologies. "It's not my job to tell them what they need" but to come to that decision with clients
			I think the problem I end up having is how much emphasis we have on clients that are outside of [our CHC] where their doctor is not a part of our system and, and should they have access to our care? Absolutely. Um, but it's a question of like the buck stops there on a lot of things and, and so it feels like inequitable care because of that.	SW2	Current OHT system as inequitable based on access to care concerns
			You know, as an OHT, you know, developing some policy and framework around what Health Equity looks like for us as an OHT and setting some, some clear sort of targets for ourselves to, to meet them and to ensure that we're, we are advancing equity.	M1	What can be done at the OHT level to improve health equity?
			...One of the first things we did as OHT, we did form a Health Equity subcommittee, I believe, which I was part of early on. And so we, you know, we continue to sort of introduce, well, the problem is we have a Health Equity committee. However, it's a committee on its own. And I don't believe in Health Equity committees personally. I think Health Equity needs to be embedded in everything.	M3	Health equity can't be siloed off into a committe
	Provider Equity as Health Equity	Recurring theme particularly for MGMT. Includes pay rates, burnout concerns, demands of data-driven care	a lot of it feels sometimes performative when we talk about using words like equity and equitable care, but that equity doesn't always feel like it goes back to the, to the practitioners. Um, it makes me question if we know what that word means anymore, right?	SW2	Our definition of halth equity is warped, it doesn't include providers
			And we're talking about how like Health Equity and equity overall, like right, yes, but all staff should have equal opportunity to do like professional development, to better themselves, to try to, you know, climb the ladder, right? ...But I do find sometimes that there are like challenges or barriers for some of the staff not to do their, their professional development...And then when they apply for certain positions, they're denied it because they're not qualified for it. But but how can you like it's a vicious cycle because you want to get qualified for it, but they're not you're not getting the opportunity to do [that].	M2	Advancement opportunities are limited for some staff, especially those lower on the corporate ladder
			We work so hard to ensure that we are meeting our targets that sometimes a few things get get lost in, in the, in the, in that. So for example, you know, we when we think of patient experience, I think we do well in, in ensuring that our patients have a good experience. However, our providers may not fare as well as they try to meet those needs, meet their targets and deal with, you know, all of the fallout of what's going on in the world right now. You know, and especially, you know, we, we keep hearing more and more burnout. You know, I think we're pretty much failing in that, in that category because of, you know, in the community setting anyway, because of compensation differentials between community care providers and say, acute care in the hospital. So for example, a nurse makes about $20,000 more in a hospital, probably a social worker as well. So we tend to, we tend to, you know, we, we, we really are, I would say that we're, we're absolute failure in that area. And, and it's, and it worries me that it would erode, this will ultimately erode the, the kind of care that we're able to provide in a community setting.	M3	TWOFOLD: provider experience as less than patient expereince. ALSO inequitable payment strcuture of health landscape.
			But I think what's important is each practitioner finding their own groove and what they can take home. Because that's also my self-care is being able to stay rooted in who I am through my practice and not adhering to, 00:37:53 SW1 um, you know, some of the rules and standards that are there that might change and conflict with who I am.	SW1	Resistence to rules and procedures that conflict with personal and professional values as a means of protecting from burnout and stying true to your practice ethics

	Resistence to Health Equity Performativity	Both groups frustrated with this. MGMT discussed partners (in OHT) not upholding promises. SWs discussed internal/systemic shortcomings	I think everyone has a Health Equity statement that's probably similar ours. However, I don't believe statements really, you know, it's a, it's like walking the walk talk. You know, keep talking the talk, but you have to walk the walk. And not because folks do not want, I mean, these are statements you can't really argue with. Of course, everyone will say that we do this. However, what, what I think might be missing at times is that real understanding of of those equity needs of certain groups because we have to do it throughout the organization.	M3	"Walking the talk" is not happening
			And I'm wondering how much of that community outreach and involvement and knowledge you see your partners within the OHT doing or are partners looking towards you to be that link? 00:52:15 M3 Unfortunately, unfortunately, I think that's what happens in that we are the so-called community based organization. So OK, [our CHC] can handle that. They'll check off that box, right? So, and you know, and I don't know, I'm, I feel that hospitals perhaps the thinking is they're not meant to be, you know, community facing, which is wrong	M3	Their CHC is being looked at to "check off" the health equity requirements within their OHT, particularly around community engagement. Despite the fact that health equity is the responsibility of all OHT partners.
			It sounds like some frustration that you're feeling there too, like that the that they're, they're claiming that they're doing this great job, but they're not living up to that promise of Health Equity. 00:16:16 SW3 No, they're not. They're not reaching out to more people, only just a minority of those people you've reached. And then you make it sounds like you're actually reaching majority of people. Winter is still ongoing. Winter hasn't ended. It should be a monthly basis thing that you give coats, not just once. Some people still need coats for their kids. When I saw that {promotional video for the winter coat drive}, I'm just like, oh seriously, this is a promotional stunt.	SW3	Winter coat drive
			and then bringing in that fifth piece [health equity] feels a little... again based off of who is pushing it as, as the direct funding source, feels more more performative.	SW2	Distrust of the Ministry funders to understand what health equity looks like and means
Issues with Provincial Leadership & Neoliberalism	**Managerialism**	Data-driven targets, Individualization of responsibility (unpaid admin burden)	It's like how many people do you see? How many, you know, times have you seen them? Right. Like that's that's it. Yeah. Whereas I think when we're working with such complex communities such as ours that face so many systemic barriers, I don't think that that gets captured well in, in, in targets. And I don't, I don't know if it gets captured well in the way we show our impact either, right.	M1	Data-driven targets. Quantitative data, on government detrmined metrics, is currently the only way that impact is being assessed
			But I think it's a problem we have in general with, you know, like for example, right now you're doing qualitative research, right? You are researching the quality of the interaction between the Ontario health teams and and and agencies and the work I do is measured in how many people show up, how many people show up again and how many people show up to groups. And like, I could be the worst social worker in the world. But if people come through my door, then nothing is nothing bad is happening. Yeah, right. So, So the way that we also measure these things and the way that we get funding as this again, step, you know, once removed a public health care system where the onus isn't on Ontario Health to tell me I'm doing a bad job, but to tell, you know, my agency to tell me I'm doing not enough work, not whether or not it's good or bad. And so that whole human piece, the qualitative piece should be a bigger part of of especially of all health care work, I think in general. But in mental health care, in mental health work, I think maybe more explicitly because people can really talk about how they feel better or how they, these like little things that can't really demonstrate, that aren't as demonstrable from day-to-day can affect somebody.	SW2	Closely ties the quantitative nature of data-driven targets to the managerialism strategy of using agencies to police their providers into doing more work "whether its good or bad"
			one of the things we do that I believe other CHC's do as well is we do extended demographics where we collect clients' information. And part of me feels conflicted about that because I know ultimately that those numbers and I hate using that word, but it's the truth. Those numbers, the statistics, the data, it goes back to CHC's because it does hold us accountable and it does reaffirm like the funding, because we have to show that we're getting funding for a reason. ...So that information is there for a reason, but part of it is how that information is also used by stakeholders and in other ways, right? And there's always, you know, in, in, in the, in a neoliberal, very capitalist focused society, information is, is used in a lot of different ways. ...And part of it is when we're focused on the numbers were not when we're focused on the quantity, we're not always shedding light on the quality.	SW1	Data collection as both necessary accountability to funders and neoliberal tool for cost efficiency. Data collection is necessary for meeting the needs of the community -- but how is it being used? Some distrust here as well.
			Yeah, and of course, it's not just my time because they're also staff members that are sort of doing this at the sides of their desks as well. As I say, I chose not to participate in any other committees at this time because it's just, you know, there's just not enough time... ,If I think of the cumulative time that our staff spend on just moving the OHT priorities along, I would say, you know, there's at least a good day a week that we, we devote collectively to, to OHT. 00:09:32 DH And is -- are you specifically or is your community health centre budgeted in any way like excess hours or even forgiveness in terms of the targets that you're trying to meet to accommodate for those administrative hours? 00:09:47 M3 I'm laughing. Not at all.	M3	Substantial administrative burden of OHTs goies uncompensated for most OHT partners. This is not the case for the fund holder -- the local hospital. CONTEXT: OHT committee membership also takes provider's time away from their targets -- puts them on the back foot for meeting government priorities (see JF 00:09:09)

			But now with the new OHT, especially the ones in [our municipality] that that we're being part of, you're no longer [going to be reporting as] a functional centre. You're [being reported as] your own identity, which means the social worker, if you're one of eight, they are just going to look at that, that social worker's data [individually] like you know what I mean? 00:15:58 DH Yeah, interesting. So when you send off the reports to the OHT, they can see breakdowns by practitioner. 00:16:04 M2 Yes, they can see, yeah, breakdowns by practitioner and that's, I think that's what they're aiming towards. And when they're collecting data right versus clumping them all together in a functional centre	M2	Individualizing responsibility -- moving away from aggregate data reporting to individual practitioner
	Provincial Priorities Supersede Local Priorities	Province is setting targets for OHTs. OHTs do not get to establish local priorities or metrics. COPD example.	Right, right. And in terms of those funders that you're that you're talking to are does the OHT make decisions in terms of allocating any funding or are those decisions made at the ministry level? 00:29:40 M3 It's made at the ministry level so far it has been made there. OK, so the mandate of the OHT is this coordinated care and within a certain geographic population. So, but what, what I, what we've noticed is that the ministry have made [all the funding decisions], and it's based on evidence and data that they have around, you know, what, what, what are some of the challenges and healthcare usage data	M3	Admission of ministry setting the funding priorities for OHTs -- directly contravening the stated aims of OHTs
			So for example, there are community, the priorities are mental health and addictions, the healthcare priorities things COPD, which is interesting for for me because we have a very small number of folks with COPD in the community. However, according to hospital data there, that is one of the conditions that bring people to the hospital more often and they it's a higher cost addition to manage. So as a result, it sort of rises to the top of the priority list because of the cost associated with caring for folks with COPD. But again, in our community, what we see more of, we see a lot more people with hypertension, for example, because even, and that is, you know, research shows that folks from certain ethnic, cultural and ethnic groups, such as the black population, the Asian population, they have a higher prevalence of, of hypertension. But that's not the priority within our community that was identified by the province... So, so things like that, that that's sort of the, the, you know, the, the tension I see is that there's really, you know, sort of decisions being made around cost economy, economics rather than the real needs of the community.	M3	COPD vs hypertension priorities example. Cost efficiency as most important care outcome on provincial level
			I think the only thing that probably concerns staff and then ultimately it concerns me is, is the targets, right? Like like it would, it would be nice to see what their like the reasoning behind all these target numbers and stuff, right? And I guess they do have some type of data like demographic data and and that, but sometimes these targets are so like they're just impossible to to obtain	M2	Rationale behind targets is opaque. Targets are seemingly impossible to attain
			However, you know, but also in our funding that we receive, I don't think there is time allotted and thought, you know, sort of put into the time it takes for professionals to consult with each other. So it's, you know, the way we measure our performance is "OK, you've got 7 hours in their day and you need to see seven clients in that day." Not thinking about the the time it takes to consult maybe with your colleague that you know, may need to offer some kind of input into the care and all you know and not to mention all the documentation that needs to happen for that care. -- And, you know, and I spend lots of time and, you know, talking to our funders around lowering targets or changing targets because this is the way it is on the ground, especially when you're dealing with populations like we serve who do have multiple complexities to their care.	M3	Integration of services requires time set aside for coordination. That must be recognized within funding models
			the strategic plan process included consultation with staff, our board, clients, community members and partners, right? So it's, it's informed by, you know, expertise and experience from people that are important to our CHC, right? It's not like it's just coming from, you know, our leadership team. It, it comes from many voices. So all of that is part of the development strategic plan. And it, it basically provides us with like our, our priorities at a high level	M1	Stakeholders set local CHC priorities. This is an importat feature of keeping the organization (CHC) accountable to its community
Social Workers' Disengagement from OHTs	**Limited Knowledge & Involvement**	SW's received little orientation to their OHT. MGMT do not believe it is a priority to involve SW's. SW's do not want to take time away from their clients for OHTs.	I don't think we've been able to introduce the OHT concept as well as we should to the rest of the staff other than the management team that sort of more closely involved in committees. But I say that I'm not making an excuse for that because I don't see the value of pulling staff into something where I don't think that they can add anything externally because they are doing a great job with the clients that we serve. And I'd rather, you know, sort of help them help our staff to, you know, for example, if clients need something, we the, the value of the OHT is now we have some relationships that I could easily make a phone call to the hospital or, you know, the right person at the hospital, the right person at another organization to ensure that that pathway is there for our clients. So, but I don't know how much we can invest in having staff think too much about this OHT	M3	Rationale for limited staff orientation to and involvement in OHTs
			what are the impacts of being part of an OHT for the CHC that you're with? Do you see it have that tangible change daily activities or in the day-to-day when you're not attending committee meetings or you know, Co chairing? Do you see a difference within the community health centre? 00:11:45 M1 To be honest, I would, I would, and again, I'm not a provider, but I, I would say in general, I would say not really, no. The reason being at the end of the day, you know, like we're, we're seeing clients, you know, like our, our, our goal is we need to, you know, make sure people are getting served. And, and so you know, that that has not changed, right, since being part of an OHT	M1	Limited value proposition from the perspective of management to have providers involved in OHTs. Providers roles andexpertise are constructed as client-facing.

			So one part is my own kind of having my blinders on of like what kind of work I want to be doing versus being a part of a team that I didn't necessarily sign up for as an individual. And so my own piece of it is if I don't have to worry about them, then it's not going to disrupt what I'm doing or influence that in a way that I don't necessarily want to. Which also means the converse, which is I'm not gaining any benefits from the fact that I happen to be, you know, a part of an organization that's part of that team. And the other side of it is kind of, is it my responsibility or is it my organization's responsibility to really kind of make that gap, bridge that gap in the most seamless way possible? Sorry. And continue to, you know, really emphasize the fact that these are resources or collaborations that are there and yeah, and, and make it obvious. So a bit of it is, is, yeah, obfuscating responsibility. And the other piece of it is, is not wanting to change kind of how I I know what I'm doing, so to speak.	SW2	Concern that OHT involvement means changing one's workflow as a provider. Concerns also raised about who's responsibility it is to inform providers about the OHT and its potential benefits
			My local Ontario health teams, to be honest with you, I'm not really so much involved with them, so I really don't know much about them. All I know is like association of my community health centre. so I'm not, I'm not really familiar with their role exactly and I'm not part of them	SW3	Lack of familiarity with OHTs led social workers to feel so disengaged from OHTs as to not view themselves as being a part of one. "My CHC is associated… I'm not part of them"
	Value Misaligment & Distrust	Poor value proposition for SWs. They do not believe they can have an impact. The distrust the governement that brought about OHTs	Yeah, I guess. I guess like to put it like really bluntly, I feel like I haven't been sold on on the idea of what a collaboration would look like [within an OHT].	SW2	Limited perceived value of OHTs.
			the research behind the quadruple aim and the mindset of, and how the quadruple aim is implemented in a very westernized like model of, of thinking or westernized framework of thinking. Sorry. So, you know, we are a world of many people and even on Ontario we have amazing populations and it's, it's amazing to see how we, you know, how we are as a community and who were made-up of and with the quadruple aim, the implementation of it can mean excluding certain mindsets, certain cultural, you know, aspects, certain frameworks for people. And it can be root-- If it is rooted in the the very colonized, very white supremacy dialogue, then how can we implement health care for a very complex and diverse population	SW1	The Quapdruple Aim is a Western framework that excludes alternate understandings of care. This SW is resistant to engage with the OHT structure because it is premised on a framework that the SW views as incompatible with the population they serve
			And I think like the general skepticism that I have and, and I imagine many people both as, as social workers with many people in community health and just community organizations have of our current political climate in the province of the decisions being made and the kind of motivations that that underlie them. Um, it's hard to trust that they're in anybody's best interests of, of people who are going to be affected either on the, on, as workers on the ground or the people we, we, we work with.	SW2	Overall distrust that the health system shares social workers' values of holisitc client-centered care. This distrust underpins disengagement from the health policy space, including OHTs
Unmet Need for Integration	**Structural Integration**	Information sharing, referrals, EMR. "Lack of power" to make this happen at OHT level; change must come from above.	Yeah, and, and I would say that, you know, the, you know, one of the things too is that, you know, it, it sounds good, right? Like it sounds like yes, absolutely. You know, like, you know, I'm getting referred, all my information is going to the right place, you know, this and that. But I, I don't know if it's, I don't, I don't know if that's actually always happening. Because I think one of the things that we've sort of identified is, is that, you know, we've been working with organizations in the community before the OHT. Do you know what I mean? Like everyone's been there, [local hospital] has been there. You know, other home care has been there. So we've already developed relationships, like relationships were in existence, right? So I think, you know, the opportunity to be in an OHT, you know, allows us to maybe maybe perhaps formalize some of those relationships a little bit better. It, you know, sort of pushes us to provide, you know, maybe a different structure around the way we're, we're working together. But I, I don't know if it's necessarily changed the, the relationships between organizations	M1	Integration of services is a promise of OHTs that providers and OHT partners agree with -- but nothing is substanitally new enough about OHTs to make this happen. The relationships between organizations already existed in some cases.
			But what I find is that for us to do this as a system between primary care, acute care in the hospital, specialist care, community care, it's very disjointed and I haven't seen any change to be honest because we have we do not have the levers to make those changes ...within the broader system now between acute hospital, community mental health and addictions, there's no clear pathway and no clear, no common EMR for example, that we can message each other. So while the system is trying to arrange care around the patient or the client, that client still has to go through sort of, you know, each door and tell their story over and over again to the wherever door they they [reach], which is expensive. It hasn't gotten to that, you know, We haven't arrived.	M3	Lack the power required to integrate on a structural level. The benefits of integration are unattainable without shared EMR. Local OHT partners lack the power to make that structural integration happen
			That becomes like almost a dead end of like I'm throwing things out to the wind for, for, you know, best of luck. If it's a housing issue, if it's, if it's an escalation in psychiatry and, and it's not something their family doctor can do, again, it's kind of like, or if they're family doctors not on site. I don't have the resources to say, let me get us a consult from, from somebody from, from a psych MD who can tell me if this is outside of my capacity or not or, or I need that external support. And so those limitations, which it would be cool and, and, and again, I think that that's, going back to the, the, the health teams piece, if we had those resources as part of the health team, right? Some, some of them are like I think, some of the agencies do deal with housing, but not with the psych piece that like I want more of the health pieces to be accessible. I want to be able to like quickly message an oncologist if I need to or like, yeah, a psychiatrist if I need to. But again, those integrations are formal but not but there's no infrastructure.	SW2	Referral and support pathways for providers within OHTs are still murky and truncated. Especially if certain service providers are not partnered within your OHT
			And it becomes difficult with the OHT piece because like, again, like agency A doesn't have access to my files. Um, and like whether or not they should, like, so if you're gonna fold all these things in, it should be seamless. Meaning the client should have part of their consent to work with me, should be consent to work with these other agencies. And maybe it's a matter of like selective consent when, when they, when they join.	SW2	Need for broader EMR, revisiting consent procedures for this new OHT-wide shared care approach
			But also one of the biggest things is, is, is as a practitioner is finding information sometimes and there is no set database for finding the information you need sometimes. And things that are constantly changing and things that are constantly evolving or, you know, sometimes you're referring someone somewhere in a wait list is full and you're not aware of that.	SW1	Finding referral information and tracking waitlists/referral pathways is a disorganizaed process

	Value Integration	Integrated care is more successful when providers share values. Need for education, training team building around shared care model values	Are there tensions that you notice between disciplines? 00:26:16 M3 I think so. I think the, the tensions that that occur in, in my experience, and this is certainly just, you know, from my vantage point is I feel that, you know, our, our education system actually fails when it comes to teaching healthcare professionals around integrated care. It's very much a siloed approach. So as I mean, and I don't, I could be wrong, I haven't been educated in each of these systems, But you know, I do know that a lot of our physicians, you know, have told me that they don't, you know, they're not taught to, to think about, you know, how to work with other professional groups, you know, chiropodists, dietitians. They they teach their their subject matter and they're very well versed in it. But when it comes to partnering and really thinking about how to, you know, share care, I guess maybe even a shared care model is another piece that, you know, could be do better in, you know, sort of helping professionals as they enter their, their field of study within this kind of a integrated environment to really understand that, yes, I'm not the only provider in this person's care.	M3	Shared care education
			So, so I think with like, you know, people go into politics with specific kind of ideas, usually doesn't matter what they are, but like they have a certain set of like ideas around why they go into politics. And maybe they fall into health, right, as like an opportunity to to further their career in politics. With, with medicine specifically, there tends to be two distinct reasons why people go into medicine is that it's a stable financial job and and maybe along with that, like the the parental kind of idea of it being a good job -- and to help people. And sometimes those those two ideas go hand in hand and that's great when they do or that's fine when they do, I don't know. But when it comes to social work, I've rarely met a social worker who got into social work because it's a great paying career.	SW2	Perceived difference in values leads to potential mistrust of members of other disciplines and questions about their motivations
			you don't want staff to stigmatize people who have addictions, right? So you can train them as much as you can. You can have them do as many like workshops and activities and stuff. But what it comes down to is, is, is are they going to, are they gonna practice it right? Yeah. Sometimes it takes a while for them to change their views and, and how and how they, you know, they, they treat people with addictions and some, and some staff won't, some staff are still, you know, stigmatizing them	M2	Training is not always effective at addressing value gaps. This example is around stigma for addictions, but similar patterns could hold for other value-based trainings. For example, holistic care approaches which de-emphasize the centrality of evidence-based practice would face deep-seated personal resistance from members of many disciplines.