Enhanced Framework for Integrated People-Centred Care

A Behaviour Change Approach to Integrated Home Care, Primary Health Care and Community Services

Canadian Home Care Association

ABOUT THE CANADIAN HOME CARE ASSOCIATION

The Canadian Home Care Association (CHCA) is a national membership organization committed to fostering integrated, person-centred care in home and community settings. Representing a diverse membership of public and private organizations that fund, manage, and deliver services and products, the CHCA provides a unified voice to advance the integration of health care. Through advocacy, collaboration, and knowledge sharing, the CHCA champions a vision of a seamless, accessible, accountable, and evidence-informed health care system that prioritizes patients and their families while ensuring long-term sustainability.

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The Value of Integrated Care

Integrated care offers numerous benefits, including increased quality of life and satisfaction with care, enhanced service coordination, improved health outcomes, reduced duplication of services, and a more efficient healthcare system. In particular, integrating care within the community—by linking home care and community services with primary health care—is widely recognized as a crucial element of delivering quality care to individuals with complex chronic conditions, including seniors living with frailty.

The 2022 Commonwealth Fund Survey provides valuable insights into physician involvement in coordinating home care. In Canada, 54.3% of physicians reported frequently coordinating with home care and community services. While this figure indicates progress toward a more integrated approach, Canada still lags behind countries such as Germany (where 83.5% of physicians frequently coordinate with social services for home care needs), the United Kingdom (64.9%), and the Netherlands (64.3%). These countries exemplify strong integration between healthcare and social services, demonstrating a higher level of performance in this area compared to Canada.

Integrating home care and community services into the broader primary health care framework contributes to health system sustainability by promoting preventative care and optimizing resource utilization. Research indicates that effective integration improves the management of patient transitions from hospital to home, reducing the risk of complications and alleviating pressure on acute care facilities.

A Vision for Integrated Care

The Canadian Home Care Association (CHCA) envisions an integrated health and social care system where home and community care are essential components. The Enhanced Framework for Integrated People-Centred Care serves as a guidance document, focusing on integration through a lens grounded in home care, primary health care, and community services. By recognizing the essential role of home-based care, this Framework fosters a more cohesive and efficient healthcare system that supports individuals in environments where they feel most comfortable and secure—their homes and communities. The goal of the Enhanced Framework for Integrated People-Centred Care is to ensure that home and community care services are purposefully included in integrated care discussions and models across the country.

A Structural Blueprint Using the COM-B Model for Behavioural Change

The Framework is built on the COM-B model for behaviour change, which highlights three essential conditions for successful integration: Capabilities (skills and knowledge), Opportunities (operational processes and structures), and Motivation (incentives and beliefs). Recognizing that behaviour change is fundamental to successful integration, this behaviour-focused approach enhances stakeholder engagement, adaptability, and accountability, supporting the long-term success of integrated care models.

The Framework uses the World Health Organization's definition of Integration: "an approach to care that consciously adopts individuals', carers', families' and communities' perspectives as participants in, and beneficiaries of, trusted health systems that are organized around the comprehensive needs of people."

Alignment with Frameworks and Standards

The CHCA adapted integration frameworks from leading organizations, including the World Health Organization (WHO), the International Federation of Integrated Care (IFIC), and the Health Standards Organization (HSO). Additional insights were drawn from the College of Family Physicians of Canada's Patient's Medical Neighbourhood model and frameworks used across Canadian provinces. These sources shaped the review of integrated care through a home-based care lens.

Using the Enhanced Framework for Integrated People-Centred Care

This Framework offers a structured approach to developing integrated healthcare systems that prioritize patient-centered care, cultural responsiveness, and effective partnerships. It is designed for health and social care funders, policymakers, administrators, and providers and outlines three key pillars for successful integrated care: (1) Shared Governance, Accountability and Partnerships, (2) Community-Based Care, and (3) Engaged and Empowered People.

Each pillar within the Framework is accompanied by targeted strategies, such as integrating primary, home, and community care; aligning health workforce planning; promoting shared governance; and empowering community-driven health initiatives. Detailed enablers are provided through the COM-B model to guide actions that build skills (Capability), establish supportive systems (Opportunity), and cultivate shared values and goals (Motivation) to achieve successful integration.

- Policymakers can use the Framework to shape supportive policies and regulations.
- Healthcare providers and organizations can apply it to develop integrated care models that prioritize home and community care.
- Primary, home, and community care providers can better understand their roles within the integrated care system.

By adopting this Framework, stakeholders can work collaboratively to create a more responsive, inclusive, and sustainable healthcare system, ultimately improving outcomes for patients and their caregivers.

Coordinated health care involves aligning and organizing healthcare services to ensure patients receive appropriate care at the right time through effective communication and collaboration among providers. While it reduces fragmentation, services typically remain distinct and managed independently.

In contrast, **integrated health care** goes beyond coordination by merging healthcare and social services into a unified, cohesive system with interdisciplinary teams working under a shared vision. It not only aligns services but also transforms service delivery to provide holistic, person-centred care that addresses medical, supportive and social needs, creating a seamless and comprehensive care experience.

Framework at a Glance

The "Framework at a Glance" provides a concise overview of the foundational pillars, targeted strategies, and actionable enablers.

Shared Governance, Accountability and Partnerships

Goal: Foster partnerships and accountability through a shared vision for high-quality, integrated care.

Patient Outcome: *"My healthcare journey is well-coordinated, and my voice matters. My care team provides reliable care that respects my goals and preferences."*

Vision-Driven Partnerships

Unite providers, communities, and patients under a shared vision for integrated care and collaborative goals.

Capability: Educate stakeholders in planning and communication	**Opportunity:** Formalize partnerships and inclusive networks	**Motivation:** Recognition programs that foster cooperation

Accountability and Governance

Implement quality and safety standards with shared accountability to ensure equity and improvement.

Capability: Educate providers in evaluation, clinical governance, and compliance	**Opportunity:** Invest in interoperable systems and inclusive data-sharing agreements	**Motivation:** Use value-based frameworks to promote equity

Community-Based Care

Goal: Reshape health and social care delivery to prioritize proactive, patient-centred primary, home, and community care.

Patient Outcome: *"I can access care beyond hospitals—in my home, community, or physician's office. My care team respects my unique needs and goals, improving my life and honoring my identity"*

Connecting Primary, Home, and Community Care

Integrate home care, primary health care and community services for seamless, holistic care, especially for individuals with chronic conditions.

Capability: Build skills in chronic care, team-based care, and cultural competency	**Opportunity:** Establish inclusive processes and digital systems for integrated care	**Motivation:** Foster a team-based culture with shared goals and aligned incentives

Integrated Health Human Resource (HHR) Planning

Align workforce planning to meet diverse community needs, ensuring adaptability and cultural responsiveness.

Capability: Develop skills in teamwork, patient-centered care, and digital tools	**Opportunity:** Implement equitable task-sharing, fair workforce distribution, and career pathways	**Motivation:** Use retention programs to build resilience and reduce burnout.

Engaged and Empowered People

Goal: Involve patients, families, and communities in health management, fostering health literacy and resilience.

Patient Outcome: *"I am an active partner in my healthcare journey. Clear information and support from my care team make me feel confident, valued, and empowered"*

Strengths-Based Health and Wellness

Enable self-advocacy and informed decisions by providing accessible health information and support.

Capability: Create culturally inclusive health resources and promote self-advocacy	**Opportunity:** Enable shared decision-making, engage marginalize groups and embed mental wellness.	**Motivation:** Build patient-provider relationships and offer preventive education

Resilient Communities

Integrate health and social services to build sustainable, community-driven strategies.

Capability: Educate providers in a population health approach	**Opportunity:** Prioritize essential resources and local partnerships	**Motivation:** Inspire leadership with equity goals and community health recognition

Shared Governance, Accountability and Partnerships

This pillar emphasizes the importance of Vision-Driven Partnerships and Accountability in advancing integrated, community-based care. By aligning stakeholders—from healthcare providers to community organizations—around a shared vision, it fosters collaborative decision-making and mutual accountability. Through structured partnerships and regulatory frameworks, this approach builds trust, strengthens commitment, and ensures patient-centered, high-quality care across settings.

Accountability frameworks, paired with clinical governance, set clear performance standards, align oversight with strategic goals, and embed personal and collective accountability. Together, these strategies create a foundation for continuous improvement, efficient resource use, and equitable access, meeting the diverse needs of patients and communities.

A Patients' Perspective

My healthcare journey is well-coordinated, and my voice matters. All members of my healthcare team communicate openly and clearly, making sure I receive high-quality care that meets my goals and preferences. With trust and coordination, I receive reliable, responsive care that respects my goals and preferences.

Vision-Driven Partnerships

Vision-driven partnerships are the foundation of effective integration in community-based care. This approach establishes a clear, cohesive vision that aligns diverse stakeholders across healthcare, social care, and community organizations.

How This Strategy Supports Effective Integration

Vision-Driven Partnerships are critical for advancing integrated care, ensuring that all stakeholders—patients, clinicians, policymakers, and community representatives—work toward shared goals.

- A shared understanding of integration and collaboration fosters mutual accountability, builds trust, and strengthens commitment among stakeholders.
- Collaborative leadership promotes adaptability, innovation, and resilience, enabling the adoption of new models to meet evolving needs.
- Partnerships that value clinical expertise and diverse perspectives reinforce purpose and commitment across the team.

Enablers for Successful Integration

The following actions, presented through the COM-B model, support integrated care by building strategic planning and collaboration skills, establishing structured partnerships and inclusive networks, and fostering mutual respect through vision-setting sessions and recognition programs.

COM-B Framework	ACTIONS
Capability Knowledge and skills	· Educate stakeholders in strategic planning and change management. · Develop abilities in communication and multidisciplinary collaboration so all stakeholders build the confidence to contribute. · Create an inclusive environment that respects each partner's unique experiences and contributions.
Opportunity Structures, resources and processes	· Establish formal partnership agreements that delineate roles, responsibilities, and shared goals. · Support the inclusion of all stakeholders through the creation of organized networks for primary care, home care, community groups and patients. · Create forums for continuous engagement that are supported through resources and technology to support inclusive decision-making.
Motivation Desires, plans and beliefs	· Host regular alignment and vision-setting sessions that reinforce the shared philosophy of integrated care. · Develop a recognition program with financial and non-financial incentives that reward integrated care goals. · Build a culture of mutual respect and trust that encourages cooperation.

Accountability and Governance

Accountability and clinical governance are essential for maintaining high standards of safety, quality, and consistency in integrated care. This strategy establishes regulatory and accountability frameworks that set transparent performance metrics, align clinical oversight with strategic goals, and promote a collaborative approach across all care levels, emphasizing both collective and personal accountability.

How This Strategy Supports Effective Integration

Accountability frameworks and clinical governance offer a structured approach to integration, ensuring care is delivered safely, efficiently, and with continuous improvement.

- Defined standards and reporting systems support transparent decision across care providers and settings.
- Integrating clinical expertise into strategic decisions ensures that all initiatives prioritize quality and safety.
- Clear accountability frameworks foster equal partnerships, outlining roles and encouraging shared and personal accountability.

Enablers for Successful Integration

The following actions, presented through the COM-B lens for behavioural change, are specific steps that support integrated care goals, such as strengthening clinical governance, promoting data sharing, enhancing accountability, and advancing health equity.

COM-B Framework	ACTIONS
Capability Knowledge and skills	· Educate partners and providers in methodologies for evaluating integrated performance metrics. · Develop skills in clinical governance and regulatory compliance reinforcing team and personal accountability.
Opportunity Structures, resources and processes	· Invest in interoperable information systems that facilitate data sharing, transparency, and coordination between providers. · Establish formal agreements promoting data sharing and inclusion of underrepresented community health inputs. · Encourage the adoption of clinical governance as a core component of integrated care through accreditation standards audits.
Motivation Desires, plans and beliefs	· Adopt value-based accountability frameworks (e.g., Quadruple Aim) to align success metrics with integrated care goals. · Build a culture where health equity is central to teamwork, mutual accountability, and personal responsibility. · Establish recognition systems celebrating team and individual contributions to integrated care goals.

Community-Based Care

This pillar involves reshaping healthcare delivery to be proactive, inclusive, and based in the community, prioritizing patient-centred approaches that extend beyond institutional settings. A core of this pillar is shifting attitudes and understanding that care can and should be delivered in environments where individuals feel most comfortable and connected. It emphasizes a flexible, inclusive, and responsive model of care that meets diverse needs, acknowledging the importance of cultural, social, and individual factors in care delivery.

By connecting primary, home, and community care, and enhancing workforce capacity through equitable and inclusive practices, this strategy ensures care is continuous, accessible, and comprehensive. It prioritizes personalized, collaborative, and interdisciplinary approaches, addressing the unique needs of diverse populations, while promoting equitable access to services. Embracing a equity, diversity and inclusion lens ensures that care is provided in ways that respect each individual's identity, cultural background, and specific health challenges, ultimately improving health outcomes and reinforcing the belief that care is most effective when delivered where individuals feel secure and valued.

A Patients' Perspective

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I can access the care I need in settings beyond hospitals, in my home or physician's office, or in my community. My care is provided by skilled healthcare professionals who work together and see me as a whole person, recognizing my unique needs and goals. This approach improves both my life and the lives of those who support me, while honouring my cultural and personal identity.

Home Care, Primary Health Care and Community Services

Integrated home care, primary health care and community services ensures comprehensive care tailored to the needs of individuals, particularly those with chronic and complex conditions. This approach focuses on providing holistic, accessible care within the home and community, aiming to prevent hospitalizations, improve health outcomes, and reduce costs.

How This Strategy Supports Effective Integration

Integrated home care, primary health care and community services strengthens the foundations of integrated care models by:

- Making care more readily available to vulnerable populations, such as frail seniors and those with chronic complex conditions.
- Addressing the physical, mental, social, and cultural dimensions of health and well-being.
- Building interconnectedness between health and social care providers.
- Preventing duplication and ensuring care is delivered by the right provider in the right setting.

Enablers for Successful Integration

The following actions, presented through the COM-B model, support integrated care by building competencies in chronic care management and cultural respect, creating inclusive processes and resource-sharing systems, and fostering team-based accountability with clinical oversight.

COM-B Framework	ACTIONS
Capability Knowledge and skills	· Build competencies in managing chronic and complex conditions, team-based care, and shared decision-making. · Enhance cultural competencies to ensure respect for diverse cultural, social, and personal preferences. · Increase proficiency in using digital tools and technology systems.
Opportunity Structures, resources and processes	· Create a formal process to capture the and incorporate the perspectives of primary care providers. · Design integrated resource-sharing facilitated through effective navigation and partnerships. · Prioritize investment in integrated information communication technology systems.
Motivation Desires, plans and beliefs	· Foster a team-based culture with shared goals and accountability. · Create and align incentives for achieving positive health outcomes collaboratively. · Embed clinical oversight into planning and accountability.

Integrated Health Human Resource Planning

Integrated Health Human Resource (HHR) Planning is a strategic, coordinated approach to workforce management in healthcare that aligns recruitment, training, deployment, and retention efforts with the goals of delivering effective, patient-centered, and sustainable care across diverse settings. This strategy ensures that healthcare providers are strategically distributed across care settings.

How This Strategy Supports Effective Integration

An integrated workforce planning strategy leverages multiple approaches to enable integrated care:

- Adaptive Workforce Clusters deploy multidisciplinary healthcare teams flexibly across primary, home, and specialized care settings.
- Skills-Mix Frameworks match the right provider to the right task, integrating regulated and non-regulated providers.
- Digital Interoperability Training Hubs centralize digital training, equipping providers with essential skills to use digital systems efficiently.
- Community-Engaged Workforce Development Alliances bring together healthcare organizations, educational institutions, and community groups to develop a culturally competent workforce.

Enablers for Successful Integration

The following actions, structured through the COM-B model, support integrated care by building skills in multidisciplinary teamwork, adaptability, and cultural competence; creating equitable task-sharing and retention policies; and fostering long-term commitment, resilience, and job satisfaction.

COM-B Framework	ACTIONS
Capability Knowledge and skills	· Build competencies in multidisciplinary teamwork, patient-centered care, and digital interoperability. · Regularly evaluate and address skill gaps through targeted upskilling. · Establish structured mentorship and knowledge-sharing initiatives to transfer skills and enhance cultural competence.
Opportunity Structures, resources and processes	· Create task-sharing policies that promote adaptable role design across regulated and non-regulated providers. · Develop policies for fair distribution of healthcare providers, especially in underserved areas, to support Adaptive Workforce Clusters.
Motivation Desires, plans and beliefs	· Implement Longitudinal Retention Incentive Programs (LRIPs) that recognize long-term service and excellence. · Cultivate leadership within healthcare teams to inspire commitment and foster a collaborative, adaptable team-based culture. · Provide mental health and resilience resources to reduce burnout and increase job satisfaction.

Engaged and Empowered People

This pillar focuses on actively involving patients, families, and communities in integrated healthcare by fostering strengths-based health literacy and resilient, self-directed communities. By equipping individuals with the skills and confidence to navigate health and social care, and by building supportive, community-centered networks, this pillar promotes proactive health management and overall well-being.

Emphasizing inclusivity and cultural responsiveness, it ensures that care models are adaptable and relevant to the unique needs of diverse populations. By empowering communities, this approach strengthens local accountability, supports preventive health practices, and builds sustainable, integrated care systems that enhance quality, equity, and accessibility for all community members.

A Patients' Perspective

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I am an active partner in my healthcare journey. I have access to clear, personalized information that guides my decisions and helps me manage my health. With support from my care team and community, I feel confident, valued, and empowered.

Strengths-Based Health and Wellness

Strengths-based health and wellness is a strategy within integrated care systems that enhances individuals' and communities' ability to access, understand, and use information for informed decision-making. This strategy leverages inherent capabilities and resources, building on existing strengths rather than focusing solely on deficiencies. It encompasses health literacy (the capacity to understand health information) and health system understanding (knowledge of how to navigate and engage with the health and social care system), empowering individuals to take active roles in managing their health.

How this Strategy Supports Effective Integration

This strategy supports whole-person care, holistic well-being, and personal accountability, aligning with the goals of integrated care.

- Empowers individuals to advocate for themselves and communicate with providers.
- Empowers families and caregivers with the knowledge and confidence to actively participate in care delivery, coordination, and effective advocacy for care recipients.
- Encourages prevention and health promotion, reducing chronic disease incidence and supporting wellness, with tailored resources that address varying health needs across populations.
- Builds on local strengths to support wellness initiatives, reflecting the diversity within communities.

Enablers for Successful Integration

The following actions, organized through the COM-B model for behavioral change, support integrated care goals by promoting inclusive health literacy, empowering self-advocacy, and building culturally responsive care practices.

COM-B Framework	ACTIONS
Capability Knowledge and skills	· Develop inclusive resources and tools that enhance health and health system literacy. · Provide education on roles and responsibilities in care that is accessible to all, supporting self-advocacy and personal accountability.
Opportunity Structures, resources and processes	· Create inclusive forums for shared decision-making where patients, caregivers and providers can share experiences and learn from one another. · Promote community-wide wellness initiatives that engage marginalized groups. · Embed mental health promotion, early intervention, and resilience-building strategies into all aspects of care delivery.
Motivation Desires, plans and beliefs	· Cultivate patient-provider relationships that recognize and respect diverse backgrounds. · Educate on preventive health with materials and programs that adapt to diverse cultural norms, lifestyles, and accessibility needs.

Resilient Communities through a Population Health Approach

Resilient communities and population health are interdependent strategies that aim to improve health outcomes by addressing both immediate healthcare needs and broader social determinants of health. Resilient communities foster strong, coordinated networks among healthcare providers, social services, community organizations, and other stakeholders, promoting overall well-being and long-term sustainability. A population health approach expands this by focusing on the health outcomes of entire communities, considering the impact of social, economic, and environmental factors.

How this Strategy Supports Effective Integration

This combined strategy reinforces the integration of healthcare and social services, creating adaptable networks that can respond to crises and support individuals with complex health conditions.

- Stronger local accountability for managing diverse health needs, supporting communities in tailoring health strategies that align with their social, cultural, and environmental realities.
- Efficient resource allocation by utilizing local strengths and adaptive community networks.
- Improved crisis response and management for vulnerable populations enabling quicker mobilization and support.

Enablers for Successful Integration

The following actions, structured through the COM-B model for behavioral change, support integrated care goals by fostering cultural competency, enhancing access to community resources, and building resilient, inclusive community networks.

COM-B Framework	ACTIONS
Capability Knowledge and skills	· Enhance healthcare providers' skills in understanding the social determinants of health and prevention strategies. · Apply clinical guidelines that incorporate population health metrics and adapt interventions.
Opportunity Structures, resources and processes	· Consider access to essential resources like housing, education, and nutrition in the planning and delivery processes. · Promote culturally relevant community-based services through strategies such as social prescribing. · Build partnerships with local organizations, including cultural groups, businesses, and faith-based communities.
Motivation Desires, plans and beliefs	· Nurture leadership that emphasizes equitable population health goals. · Implement reward systems that recognize achievements in population health outcomes, focusing on culturally responsive care rather than volume-based service delivery.

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