Health Quality Alberta

Enablers for an Integrated People-centred Health System

Supporting the structural, cultural, and operational conditions for health quality

ENABLERS

Table of contents

Enabling an integrated people-centred health system

Jurisdictions around the world are envisioning an integrated and people-centred health system[i] that supports the health and well-being of people, communities, and the wider population. In such a system, collaboration thrives. Services are well coordinated, and people, organizations, communities, and governments co-create solutions.

An integrated people-centred health system is one that:

- Adopts a broad understanding of health — and acts on the **determinants of health**.[ii]
- Plans and sets priorities beyond a focus on medical treatment and improved clinical outcomes.
- Prioritizes the **wholistic** preferences, needs, and strengths of people and communities.
- Supports healthcare providers and recognizes the value of unpaid, informal caregivers.
- Sees people and communities as agents of change in achieving health and well-being and reducing health disparities.
- Sees social services as part of the health system to address more fully what matters to people and communities and thus builds partnerships among people, organizations, and communities within and across the health and social sectors.
- Designs for equitable access to health services and strives for equitable health outcomes.

While integrated people-centred care offers a compelling direction for transformation, realizing it requires deliberate shifts in how health systems are organized, governed, and experienced. A whole-system approach emphasizes the many enabling conditions and practices that need to be present to ensure a system is truly equipped to deliver integrated people-centred care.

A whole-system approach sees the improvement opportunities *within* sectors, situations, and care settings. And it also points to *the spaces between* them. That is, between government and healthcare service delivery, health and social sectors, provider roles and professional groups, providers and care receivers, and policy makers and communities.[7] It sees the spaces between all these system elements — and the accountabilities, roles, and relationships that shape and interconnect them — as rich, underdeveloped territory for collaboration and improvement.

[i] **Integrated people-centred care** is a catch-all term that refers to a type of health system, vision for health system transformation, improvement strategy, and a model of care delivery. It is described as a "fundamental design principle"[1] or "set of design principles"[2] because integrated people-centred care is understood as "so much more than the sum of a range of organizational processes acting at different levels."[1] In all forms, it is adopted for a similar reason: to shift thinking and practice in health system planning, decision-making, and care delivery — improving outcomes, quality, experience, and value. In doing so, it advances the Quintuple Aim: enhancing care experience, population health, and the work life of providers, while simultaneously reducing healthcare costs and advancing health equity.[3]

[ii] Some of the main determinants of health include income and social status, employment and working conditions, education and literacy, childhood experiences, physical environments, biology and genetics, gender, culture, race/racism and colonization.[4] Other determinants include access to health services and social supports, working in partnership,[5] positive coping skills, and healthy behaviours.

The **enablers** that are the focus of this resource are part of a Framework for an Integrated People-centred Health System. They are the conditions within structure, culture, and operations that support integration.

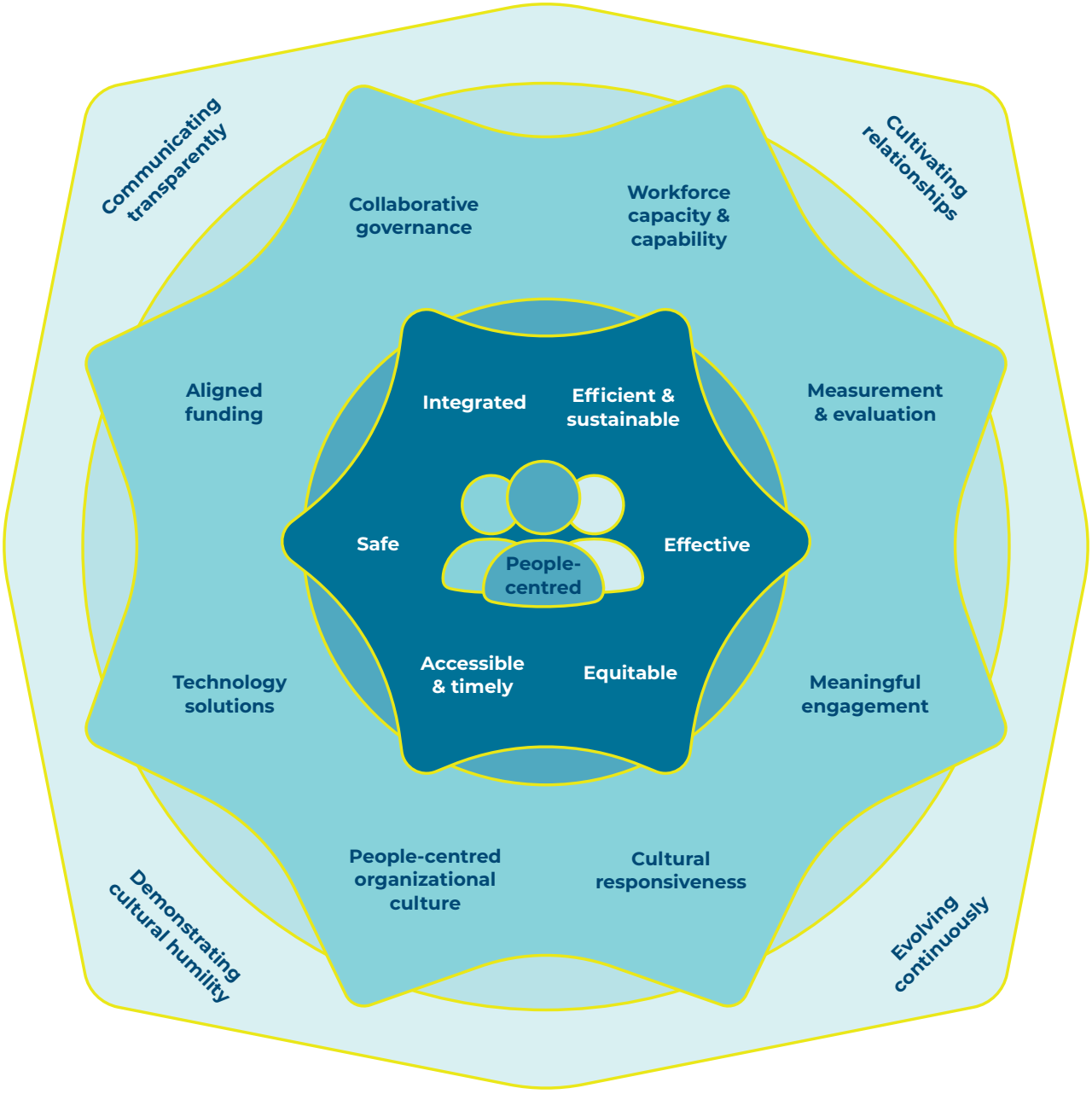
The framework also includes **quality dimensions** that describe what people should expect from an integrated people-centred health system and **shared responsibilities** that work within the enabling conditions of the system to shape how people work, collaborate, learn, and respond across roles and organizations.

As interrelated parts of the framework, the enablers, quality dimensions, and shared responsibilities provide an evidence-based model to move beyond disease-focused approaches toward systems and services organized around the full spectrum of people's and communities' needs.

Each part has its own role, but none works on its own. Their interdependence is what supports progress toward integrated people-centred care. This reflects a well-established understanding in health systems research that high-quality care is more than a clinical intervention. It is shaped by a complex, interconnected, and adaptive system of structures, practices, and contexts that influence people's experiences and outcomes.[9]

When used collectively and applied consistently, these interconnected parts — quality dimensions, enablers, and shared responsibilities — support coordinated action towards a more integrated people-centred health system.

The Framework for an Integrated People-centred Health System

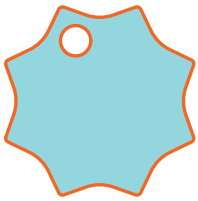


In developing this framework, input was sought from system partners across Alberta, patient advisors, and communities. Jurisdictional reviews were carried out to examine health system frameworks at regional, national, and international levels and definitions of person-centred care, quality, and safety.

Enablers

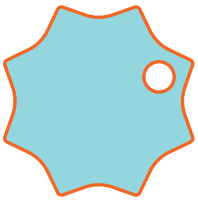
Enablers are the structural, cultural, and operational levers of change. They are the conditions needed for realizing health quality and creating an integrated people-centred system.

Enablers draw on leading thinking and practice in health system improvement and reflect areas that are widely recognized as shaping the quality of care and outcomes. They offer a shared way of understanding these conditions and can inform planning and improvement across different contexts.



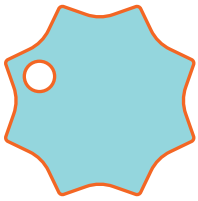
Collaborative governance

Through distributed leadership, people and organizations share accountability and work together to achieve goals.



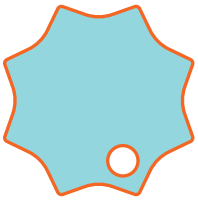
Measurement and evaluation

By design, information enables continuous improvement.



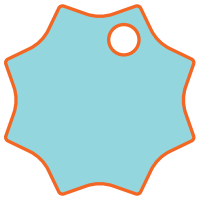
Aligned funding

Sustainable, innovative funding models promote multi-sectoral integration and deliver better value.



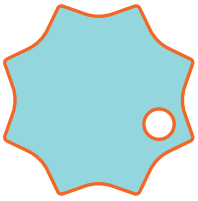
Cultural responsiveness

Capacity-building responds to diverse communities and contexts.



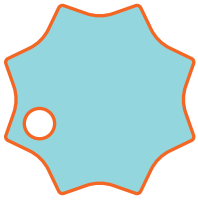
Workforce capacity and capability

Providers and staff can perform optimally.



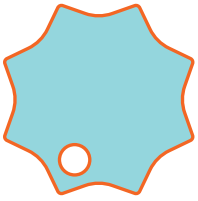
Meaningful engagement

People and communities have the knowledge and agency to co-create health solutions.



Technology solutions

Technologies enable new options for care delivery and facilitate the timely exchange of data across the system.



People-centred organizational culture

Interpersonal relationships thrive, and respect for people's potential is threaded throughout the organization.

Quality dimensions

The seven quality dimensions at the centre of the framework are interrelated. For example, quality depends on integration, and integration requires a people-centred approach. Each dimension interconnects with others in this way.

Taken together, the dimensions define what is meant by health quality and describe the care experiences, relationships with care providers, and health outcomes people should expect from an integrated people-centred system.

People-centred

Accessible and timely

Effective

Efficient and sustainable

Safe

Equitable

Integrated

Companion resources on the quality dimensions and shared responsibilities, as well as the full Framework for an Integrated People-centred Health System, are available at **hqa.ca/dimensions**.

Shared responsibilities

Shared responsibilities describe how people show up with and for one another across an integrated people-centred health system. They determine how the quality dimensions and enablers are lived in everyday practice.

From policy to leadership and care delivery, collective commitment and action to these responsibilities strengthen connection, reinforce shared purpose, and support integrated people-centred care. When practised consistently, shared responsibilities knit together the human parts of the system — people, interactions, communities, and networks — into a more cohesive whole.

Communicating transparently

Demonstrating cultural humility

Cultivating relationships

Evolving continuously

How the enablers can be used

The enablers guide the user in reflecting on the conditions needed to support integrated people-centred care. Thinking about each enabler creates awareness of the structural, cultural, and operational factors that influence quality and, when supplemented by measures and reflection, can reveal opportunities for system and quality improvement.

They are meant for people and organizations accountable for supporting health and well-being for individuals, communities, and the population:

- Policy, governance, and oversight
- Healthcare services, programs, and teams
- Quality improvement specialists
- Community health and social services
- General health and well-being sectors (e.g., recreation)

This includes a variety of roles: policymakers, leaders, administrators, professionals (e.g., physicians, nurses, social workers, community support workers), educators, researchers, improvement facilitators, caregivers, and patient partners.[iii]

The enablers can be applied at system, organizational, and care-delivery levels, informing policy, governance, planning, resource allocation, program design, and quality improvement efforts. They provide people, teams, and organizations with a common language for identifying strengths, gaps, and opportunities to strengthen the conditions that support integrated people-centred care.

Improvements can be realized in governance, planning, workforce development, organizational culture, engagement, resource allocation, and the overall capacity of the health system to support integrated people-centred care.

Ultimately, for the full potential of the enablers to be realized within an integrated people-centred health system, they need the support of people and organizations working together. While the enablers describe the conditions that help make high-quality experiences possible, the quality dimensions describe the experiences and outcomes people should expect from the health system, and shared responsibilities support how people work together to bring these conditions to life.

The enablers are defined in detail in the pages that follow. They are, by design, written to describe an ideal state. The definitions should be read as an answer to the question, 'What does each concept look like when fully realized?'

[iii] A person with lived experience with the health system working collaboratively with the system in a formal role.

ENABLERS

Definitions

- **Collaborative governance**
- **Aligned funding**
- **Workforce capacity and capability**
- **Technology solutions**
- **Measurement and evaluation**
- **Cultural responsiveness**
- **Meaningful engagement**
- **People-centred organizational culture**

DEFINITIONS

Collaborative governance

Through distributed leadership, people and organizations share accountability and work together to achieve goals.

Governance in an integrated people-centred health system is collaborative.[27] It recognizes that accountability for the health and well-being of people and communities is shared, because needs are diverse across those communities and individuals. Governance structures and the ways in which people participate in decision-making are designed to support full collaboration.

Clearly defined and assigned roles and accountabilities exist at all levels — policy, program planning, point of care — and across organizations and sectors. Each role is clear about its accountability, which supports collaboration.[6] Clarity is upheld by mutually reinforcing strategies. These include a shared vision, mandates, standards, and other ways that specify and monitor accountabilities (e.g., terms of reference, performance measurement).

Governance models break down barriers between organizations and sectors and focus on cooperation not competition. Coalitions are built around a shared purpose. Multiple roles and perspectives, including patient partners and community, shape decisions across levels of government and health service delivery organizations.[28] People and organizations work together to navigate tensions between organizational mandates and the shared purpose.[29] Inclusive decision-making practices ensure diverse perspectives are considered. Conflict is resolved through constructive, respectful practices to maintain mutual trust and understanding.[iv]

Leadership is distributed, leveraging the effectiveness of people and groups working together.[30] It is a leadership approach that sees strength and influence from many different sources as necessary to creating change.[2]

An integrated people-centred health system owns its accountability to First Nations, Métis, and Inuit Peoples. It respects and upholds First Nations' Treaty Right to Health, Indigenous Peoples' own laws and protocols, the Truth and Reconciliation Commission of Canada Calls to Action, the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP), and the constitutional rights applicable to all Canadians.[11] This can be done when those in Indigenous, provincial, and federal governance roles collaborate and agree on Indigenous-led accountability mechanisms for improved healthcare.

[iv] Methods can include practices that are considered 'relational' and 'reflective', such as rapport-building and structured reflection in conversation.

DEFINITIONS

Aligned funding

Sustainable, innovative funding models promote multi-sectoral integration and deliver better value.

Sustainable, ethical funding decisions consider rising healthcare costs, limited financial and human resources, and other demands on the public treasury. Innovative funding models align care delivery with what matters to people and communities. This is done to deliver better value and to promote coordination and continuous care over time for complex, chronic health needs. Funding mechanisms[v] and accountabilities incent interdisciplinary team-based models and integrated care. Funding spans healthcare sectors, organizations, and providers, and crosses conventional bounds of health and social services.

Capacity and social infrastructure are increased to support the voluntary sector and community-based organizations in health service planning and delivery at the local level.[30] In an integrated people-centred health system, programs are sufficiently funded to ensure equitable access to quality care does not depend on a person's ability to pay.

[v] Some jurisdictions integrate health and social service budgets.

DEFINITIONS

Workforce capacity and capability

Providers and staff can perform optimally.

An engaged and productive workforce is equipped to function in a complex and dynamic system. Workforce **capacity** is well matched to the needs of communities and the population, both in number of staff and in how they are assigned.

Workforce **capability** includes providers and staff with the skills needed to help them deliver integrated people-centred care. They are equipped to respond to complex circumstances like chronic multimorbidity and persistent health inequalities. An education curriculum trains professionals to think and act inter-professionally and cooperatively. This helps build strong and trusting relationships among providers, across sectors, and with community partners.

Team-based care, creativity, continuous learning, and role flexibility is the norm. This amplifies the collective strengths of the team, manages complexity, and drives change. Individuals and teams are skilled in technology, project management, cultural responsiveness, change management, and leadership for a complex and adaptive system.

Together, workforce capacity and capability help providers find meaning and "joy in work"[32,33,34] and perform at their best to deliver integrated people-centred and safe care.[35] The work environment and work schedule enables balance in people's lives. It builds interdisciplinary teams and fosters communication. Staff participate in planning and decision-making.

DEFINITIONS

Technology solutions

Technologies enable new options for care delivery and facilitate the timely exchange of data across the system.

When equitably implemented and supported, technology and digital solutions offer innovative models of care delivery, especially with limited workforce capacity and in large geographic areas. Technologies enable timely, secure access and communication between care receivers, providers, and teams, and across sectors, to deliver coordinated, team-based care. They help patients be more engaged in their care, a key aspect of people-centredness. The health system identifies and addresses disparities in access, digital literacy, and comfort with technology across individuals and populations.

Various technologies support diagnosis, treatment, monitoring, and the scaling of sustainable alternative models of care delivery. This includes virtual care, telemonitoring, electronic health records, web- or mobile-based applications, wearable devices, machine learning, and artificial intelligence. Predictive models of care that use data and analytics to process real-time and historical data are leveraged to forecast individual and population health outcomes.

Technology supports wholistic care. Data sources and algorithms are free of biases that reinforce inequity.[36] Thoughtfully designed and managed artificial intelligence tools ensure the fullness of patient stories is documented accurately. Thus, patients' needs and values, not physical symptoms alone, inform care.

Different information systems, devices, and applications can 'talk to each other.' They can "access, exchange, integrate," and use data seamlessly within and across organizations and jurisdictions.[19,37] People's preferences, needs, goals, and strengths are the starting point for design and implementation.[36] Development includes co-design and early-stage testing to ensure technology meets the needs, preferences, and contexts of users (patients, clinicians, pharmacists, etc.).

DEFINITIONS

Technology solutions cont.

Technologies enable new options for care delivery and facilitate the timely exchange of data across the system.

Industry collaborates with universities and government to foster innovation in development and procurement. They test and evaluate — with users — the effectiveness, technical integration, and impact. Planning for adoption and integration with existing systems is part of phase-one development to reduce the burden associated with change in the work environment. Learning about successful technology solutions from other jurisdictions and health systems is encouraged.[38]

Interoperability occurs when capacity is addressed in key ways. Interconnectivity is established for systems, devices, and applications to exchange data. Format and rules are defined for data exchange. Standardized definitions and coding vocabularies are created to ensure shared meaning for users. Data sovereignty is upheld, including Indigenous data governance principles, and data-related inequities are addressed. Governance, policy, legal, and organizational functions support shared consent, trust, and integrated end-user processes and workflows.[19,37] Cyberthreats, funding needs, and regulatory barriers are managed.

DEFINITIONS

Measurement & evaluation

By design, information enables continuous improvement.

An inclusive approach monitors, measures, researches, and evaluates data and information to support continuous improvement. Information is available about people's care experiences, perceptions of health and well-being, health circumstances and outcomes (e.g., symptoms, treatment effects, function, etc.). The social determinants of people's health, such as education and income, are considered.

Healthcare performance indicators, patient-reported outcomes or experience measures, and population health measures are included. The latter provides information about the many factors that influence individual and collective health. All sources of data and information are used and assessed at individual, community, and population levels. This is done to examine whether people are receiving integrated people-centred care, if care-delivery models have shifted towards integrated people-centred care, and if an enabling environment has been created.

Equitable, people-centred health measurement practices are used. Such practices avoid measurement bias that overlooks or misrepresents the experiences of equity-deserving groups and perpetuates health inequities.[39] Context-based, people-centred approaches reflect the diversity of people and their experiences. Inclusive qualitive methods are adopted, such as conversations and interviews. These make it easier for people to share their diverse perspectives of their health and healthcare experiences. By closing gaps in data and information, health inequities in needs, experiences, and outcomes can be addressed.

Within a trusting relationship, participants in measurement activities understand why their experiences are being measured and how their information will be used to support change and improvement. Learnings are shared across organizations and sectors to build a wholistic picture of how a system is performing.

DEFINITIONS

Measurement & evaluation cont.

By design, information enables continuous improvement.

Progress towards integrated people-centred care is understood as a journey. When defining what success will look like, and when it can be expected, many perspectives are considered (e.g., care receiver, provider, community, etc.). Everyone understands some of the benefits will only be realized in the medium to long term.

Evaluation planning is proactive and embedded into program planning and implementation. Appropriate measures and tools are developed to evaluate the effectiveness of changes made. The quality of engagement is also measured to assess people's experience of being engaged, the impact of engagement, and how well engagement as an organizational responsibility is being carried out.[40]

Implementation science is used to explore how, why, and which types of interventions (e.g., policies, programs, specific practices) work in particular contexts. This supports reaching targeted populations and the spread and scale of effective interventions.[41] Further, implementation science offers insights into how implementation is (or is not) happening, and ways to revise — from different perspectives — strategies to achieving quality.

DEFINITIONS

Cultural responsiveness

Capacity-building responds to diverse communities and contexts.

The health system has the capacity to respond appropriately to the preferences, needs, strengths, experiences, and contexts of diverse communities. Services are respectful of, and relevant to, communities' health beliefs, health practices, languages, and histories.[42] Cultural responsiveness "is what is needed to transform systems," inspiring action across individual, organizational, and system levels.[43]

At the individual level, cultural responsiveness shapes how providers act and internalize what they learn from education, training, and listening to others' experiences. It enables them to experience and demonstrate cultural humility. They are able to see the "differences in power and privilege and the historical and contemporary inequalities that emerge in and from social and therapeutic relationships."[43]

At system and organizational levels, the cultural and historical factors that have influenced health system development and organization are acknowledged.[43] This awareness leads to reform of high-level strategic governance structures and policies, so that cultural responsiveness is established as the norm across the health system. These efforts are vital to delivering culturally safe care and addressing inequitable experiences and outcomes for Indigenous Peoples and other communities facing systemic barriers.[25,44]

DEFINITIONS

Meaningful engagement

People and communities have the knowledge and agency to co-create health solutions.

The strengths and capacity of people to make informed decisions about their health and healthcare is recognized and supported. Communities are engaged in creating and sustaining their own health and well-being, with the goal to "unlock community and individual resources for action on health."[6] People find it easy to get clear and relevant information from providers to self-manage their health needs and participate in care decisions.

Communities and individuals co-produce health services and healthy environments. They contribute to health policy by partnering meaningfully across sectors and roles. Deliberate efforts are made to include people and communities who have been excluded or underrepresented in decision-making. Supportive environments help people feel safe to contribute and share experiences, fostering mutual trust and belonging.

The health system mobilizes community resources using asset-based, community development approaches to build models of care delivery based on local strengths and goals. These efforts are foundational to an integrated people-centred health system; they bring forward lived experience, context, and strengths, leading to responsive and equitable policies, strategies, programs, and care decisions.

DEFINITIONS

People-centred organizational culture

Interpersonal relationships thrive, and respect for people's potential is threaded throughout the organization.

Organizational culture reflects the values, beliefs, attitudes, and behaviours embedded in care settings and workplaces that shape how people and teams interact and how work is done. In essence, it is 'how things are typically done.'

People-centred organizational culture recognizes the potential of people individually and collectively. It sees and cares for providers (and all staff) as people, so the focus is *doing with* people rather than *doing to*.[45] Everyone, including unofficial leaders, contributes through their influence and strengths to act on the things they can change.

Ethical practice is expected and supported. Healthy interpersonal relationships are reinforced through mutual trust and open communication. Individuals recognize and respect the expertise of colleagues. They demonstrate compassion, curiosity, inclusivity, creativity, and flexibility in how they work with others. Learning is prioritized over judgment.

These conditions enable an environment where change can happen, and new ways of working can emerge. Monitoring and strengthening organizational culture supports progress across all dimensions of quality by highlighting how people can interact, collaborate, and improve care together.

As a people-centred organizational culture is sustained, shared beliefs, attitudes, and behaviours may spread beyond individual workplaces. This can influence how people work across organizational boundaries to lead change between services, professional groups, and organizations. Ultimately, such a culture is "about relationships and how mutual understanding of (the) needs and aspirations of people across all levels builds trust, commitment, and capacity to make things better for all."[46]

References

1. Goodwin, N. (2013). Understanding integrated care: A complex process, a fundamental principle. *International Journal of Integrated Care, 13*, e011. DOI: 10.5334%2Fijic.1144

2. Health Standards Organization. (2021). HSO *Integrated People-Centred Health Systems standard.* **https://healthstandards.org/integratedcare/**

3. Nundy, S., Cooper L., & Mate, K. (2022). The quintuple aim for health care improvement: A new imperative to advance health equity. *Journal of the American Medical Association, 327*(6), 521—522. DOI:10.1001/jama.2021.25181

4. Government of Canada. (n.d.). *Social determinants of health and health inequalities.* **https://www.canada.ca/en/public-health/services/health-promotion/population-health/what-determines-health.html**

5. Syme, S. (2004). Social determinants of health: The community as an empowered partner. *Preventing Chronic Disease, 1*(1), A02. Retrieved on March 12, 2026, from: **http://www.cdc.gov/pcd/issues/2004/jan/03_0001.html**

6. World Health Organization. (2016, April 15). Framework on integrated, people-centred health services. Retrieved on March 26, 2024, from: **https://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_39-en.pdf?ua=1&ua=1**

7. Health Quality Ontario. (2015). **Quality Matters: Realizing Excellent Care for All.**

8. Agency for Healthcare Research and Quality. (2017). The CAHPS ambulatory care improvement guide. Practical strategies for improving patient experience. Retrieved on March 12, 2026, from: **https://www.ahrq.gov/cahps/quality-improvement/improvement-guide/4-approach-qi-process/index.html**

9. Barasa, E., Cloete, K., & Gilson, L. (2017). From bouncing back, to nurturing emergence: Reframing the concept of resilience in health systems strengthening. *Health Policy and Planning, 32*(suppl 3), iii91-iii94. DOI: 10.1093/heapol/czx118.

10. Government of Canada. (n.d.). Visions for distinctions-based Indigenous health legislation: executive summary. Retrieved March 26, 2024, from: **https://www.sac-isc.gc.ca/eng/1667579335081/1667579367781**

11. Indigenous Primary Health Care Advisory Panel. (2023, April). Honouring our roots: growing together towards a culturally safe, wholistic primary health care system for Indigenous peoples - Indigenous Primary Health Care Advisory Panel final report. Retrieved March 20, 2024, from: **https://open.alberta.ca/publications/maps-indigenous-primary-health-care-advisory-panel-final-report**

12. Tatum, B. (2000). The complexity of identity: “Who am I?.” In Adams, M., Blumenfeld, W., Hackman, H., Zuniga, X., Peters, M. (Eds.), Readings for diversity and social justice: An anthology on racism, sexism, anti-semitism, heterosexism, classism and ableism (pp. 9-14). Routledge.

13. Eklund, et al. (2019). “Same same or different?” A review of reviews of person-centred and patient-centred care. *Patient Education and Counseling, 102*(1), 3-11. DOI: 10.1016/j.pec.2018.08.029.

14. Lines, L., Lepore, M., & Wiener, J. (2015). Patient-centred, person-centred, and person-directed care: They are Not the Same. *Medical Care*, 53(7), 561-563. DOI: 10.1097/MLR.0000000000000387.

15. Mitchell, P., Cribb, A., & Entwistle, V. (2023). A wide vocabulary for person-centred care. *Future Healthcare Journal, 10*(1), 82-84. DOI: 10.7861/fhj.2022-0096.

16. Orlove, B., et al. (2023). Placing diverse knowledge systems at the core of transformative climate research. *Ambio, 52*, 1431-1447. DOI: 10.1007/s13280-023-01857-w

17. Government of Alberta. (2024). *Alberta’s One Health Antimicrobial Resistance Framework for Action*. Retrieved March 13, 2026, from: **https://www.alberta.ca/one-health-antimicrobial-resistance-framework-for-action**

18. World Health Organization. (2017). Environmentally sustainable health systems: A strategic document. Retrieved March 26, 2024, from: **https://iris.who.int/bitstream/handle/10665/340375/WHO-EURO-2017-2241-41996-57723-eng.pdf?sequence=3**

19. Affleck, E., Murphy, T., Williamson, T., Price, R., Wolfaardt, U., Price, T., Layton, A., Hamilton, B., Dean, S., Frazer, C., Chapman, A., Shute, R., West., Denman, M., Golonka, R., & Lindeman, C. (2023). Interoperability Saves Lives. **www.albertavirtualcare.org**

20. First Nations Health Authority. (n.d.). #itstartswith me Creating a Climate for Change. Retrieved, March 26, 2024, from: FNHA-Creating-a-Climate-For-Change-Cultural-HumilityResource-Booklet.pdf

21. Hollnagel, Erik. (2012, May). Proactive approaches to safety management. *Health Foundation*. Retrieved on March 26, 2024, from: **https://www.health.org.uk/publications/proactive-approaches-to-safety-management**

22. NHS. (2019, July). The NHS Patient Safety Strategy. Safer culture, safer systems, safer patients. Retrieved on March 26, 2024, from: **https://www.england.nhs.uk/wp-content/uploads/2020/08/190708_Patient_Safety_Strategy_for_website_v4.pdf**

23. Ito, A., Sato, K., Yumoto, Y., Sasaki, M., & Ogata, Y. (2021). A concept analysis of psychological safety: Further understanding for application to health care. *Nursing Open*, *9*(1), 467-489. DOI: 10.1002/nop2.1086.

24. Whitehead, M. (1992). The concepts and principles of equity in health. *International Journal of Health Services, 22*(3), 429-445. DOI: 10.2190/986L-LHQ6-2VTE-YRRN

25. Kirmayer, L., & Jarvis, G. (2019). Culturally responsive services as a path to equity in mental healthcare. *Healthcare Papers, 18*(2), 11-23. DOI: 10.12927/hcpap.2019.25925

26. World Health Organization. (2020). *Community engagement A health promotion guide for universal health coverage in the hands of the people*. Retrieved on March 26, 2024, from: **https://iris.who.int/server/api/core/bitstreams/d0b65571-347a-4260-8ae0-a346ac882d72/content**

27. Gordon, D., McKay, S., Marchildon, Bhatia, R., & Shaw, J. (2020). Collaborative governance for integrated care: Insights from a policy stakeholder dialogue. *International Journal for Integrated Care, 20*(1), 3. DOI: https://doi.org/10.5334/ijic.4684

28. World Health Organization. (2023). *Social participation for universal health coverage.* Retrieved on March 26, 2024, from: **https://iris.who.int/bitstream/handle/10665/375276/9789240085923-eng.pdf?sequence=1**

29. Michgelsen, J., Glimmerveen, L., Pittens, C., & Minkman, M. Decision-making dilemmas within integrated care service networks: A systematic literature review. *International Journal for Integrated Care, 22*(4), 11. DOI: 10.5334/ijic.6458

30. World Health Organization. (2007). People-centred health care. A policy framework. Retrieved on March 26, 2024, from: **https://www.who.int/publications-detail-redirect/9789290613176**

31. Bodenheimer, T., & Sinsky, C. (2014). From Triple to Quadruple Aim: Care of the patient requires care of the provider. *Annals of Family Medicine, 12*(6), 573-576. DOI: 10.1370/afm.1713

32. Sikka, R., Morath, J., & Leape, L. (2015). The Quadruple Aim: Care, health, cost and meaning in work. *BMJ Quality Safety, 24*, 608-610. DOI: 10.1136/bmjqs-2015-004160

33. Stein, K., Amelung, V., Miller, R., & Goodwin, N. (2021). The Fourth Dimension of the Quadruple Aim: Empowering the workforce to become partners in healthcare. *International Journal of Integrated Care, 21*(2), 34, 1-4. DOI: 10.5334/ijic.5985

34. Gillian, J., Mills, T., Budworth, L., Johnson, J., & Lawton, R. (2021). The association between health care staff engagement and patient safety outcomes: A systematic review and meta-analysis. *Journal of Patient Safety, 17*(3), 207-216. DOI: 10.5334/ijic.5985

35. Wolf, A., Forsgren, E., Björkman, I., Edvardsson, Öhlén, J., & the University of Gothenburg Centre for Person-Centred Care. (2024). *Towards state of the science in person-centred care.* **https://gupea.ub.gu.se/server/api/core/bitstreams/095010b4-1f8f-41cc-b313-b6768033fef3/content**

36. Healthcare Information and Management Systems Society. (n.d.). Interoperability in Healthcare Resources. **https://www.himss.org/resources/interoperability-healthcare**

37. SCIROCCO. (n.d.). *SCIROCCO maturity model for integrated care.* **https://www.scirocco-project.eu/maturitymodel/**

38. Equitable People Centred Health Measurement. (n.d.). *EPHM methodology.* **https://www.healthyqol.com/methods.html**

39. Faculty of Health Sciences Public & Patient Engagement, McMaster University. (2020). *The public and patient engagement evaluation tool (PPEET).* YouTube. **https://www.youtube.com/watch?v=pNXnASRm2qg&t=8s**

40. World Health Organization. (2015). *WHO global strategy on people-centred and integrated health services. Interim report.* Retrieved March 13, 2026, from: **https://www.afro.who.int/sites/default/files/2017-07/who-global-strategy-on-pcihs-main-document_final.pdf**

41. Department of Health. (2009). *Cultural responsiveness framework guidelines for Victorian health services*. Melbourne, Victoria. Retrieved March 26, 2024, from: **https://content.health.vic.gov.au/sites/default/files/migrated/files/collections/policies-and-guidelines/c/cultural_responsiveness---pdf.pdf**

42. Indigenous Allied Health Australia. (2019). *Cultural responsiveness in action: an IAHA framework*. Retrieved March 26, 2024, from: **https://iaha.com.au/workforce-support/training-and-development/cultural-responsiveness-in-action-training/**

43. Wilson, S., Heaslip, V., & Jackson, D. (2017). Improving equity and cultural responsiveness with marginalized communities: Understanding competing worldviews. *Journal of Clinical Nursing, 27*, 3810-3819.

44. Cook, N. F., Brown, D., O'Donnell, D., McCance, T., Dickson, C., Tønnesen, S., Dunleavy, S., Lorber, M.,Falkenberg, H., Byrne, G., & McCormack, B. (2022). The person-centred curriculum framework: A universal curriculum framework for person-centred healthcare practitioner education. *International Practice Development Journal, 12*(4), 1-11. DOI: 10.19043/12Suppl.004

45. Accreditation Canada. (n.d.). *People-centred care program*. **https://accreditation.ca/assessment-programs/people-centred-care-program/**

46. Bindman, A. (2017). A Shared responsibility for developing a learning health system. *Journal of Nursing Care Quality, 32*(2), 95-98. DOI: 10.1097/NCQ.0000000000000255

47. Alizadeh, M., Azizi, N., Mahdavi, S., & Baghlani, F. (2025). Unveiling the shadows: Obstacles, consequences, and challenges of information opacity in healthcare systems. *Philosophy, Ethics, and Humanities in Medicine, 20*(6). DOI: 10.1186/s13010-025-00170-6

48. Gittell, J., Godfrey, M. & Thistlethwaite, J. (2013). Interprofessional collaborative practice and relational coordination: Improving healthcare through relationships. *Journal of Interprofessional Care, 27*(3), 210-213. DOI: 10.3109/13561820.2012.730564

49. Bishai, D., Saleh, B., Huda, M., Aly, E., Hafiz, M., Ardalan, A., & Mataria, A. (2024). Practical strategies to achieve resilient health systems: Results from a scoping review. *BMC Health Services Research, 24*(1), 297. DOI: 10.1186/s12913-024-10650-8