



Team-based primary care: Learning how to evaluate the outcomes and implementation of team-based care

Summary Report
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Land Acknowledgement

We are grateful to have speakers and participants join this Best Brains Exchange virtually from regions across Turtle Island. We reflect on the lands we occupy and the Indigenous people who have stewarded these lands for hundreds of years.

We acknowledge that the topic of this BBE spans many territories, including those of the First Nations, Inuit, and Métis Peoples. We recognize that these lands are the traditional, unceded, or treaty territories of Indigenous communities who continue to contribute to the strength and vibrancy of this nation.

We encourage readers to learn about the lands they inhabit and to honor the histories, languages, and cultures of the Indigenous communities in your local area. Let this acknowledgment be a call to action to deepen our understanding of Indigenous histories and work towards reconciliation in meaningful ways.

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List of Abbreviations

BBE	Best Brains Exchange
CIHR	Canadian Institutes of Health Research
CPCRN	Canadian Primary Care Research Network
EMR	Electronic medical record
PCP	Primary care provider
PREMs	Patient-reported experience measures
PROMs	Patient-reported outcome measures
QI	Quality improvement
TBC	Team-based care

Executive Summary

On January 29 and 30, 2025, 66 pan-Canadian researchers, health system partners, decision-makers, and patients gathered virtually for discussion and information-sharing during a Best Brains Exchange (BBE). Participants joined from British Columbia, Alberta, Manitoba, Saskatchewan, Ontario, Quebec, Nova Scotia, New Brunswick, Prince Edward Island, Newfoundland, and the Northwest Territories.

This BBE engaged participants in open dialogue around the latest evidence and learnings to co-create a pan-Canadian common evaluation framework to assess the outcomes and implementation of team-based primary care. The aim of this exchange was to determine the core outcomes and domains by which to measure, evaluate, and monitor the implementation of team-based primary care in Canada.

The specific objectives of this BBE were to: 1) Determine the domains that ought to be used in evaluating the implementation and outcomes of team-based primary care; and 2) Discuss evaluation strategies to measure the impact and outcomes of team-based primary care, according to core principles, guidelines/standards, and equity considerations.

The BBE invited thought leaders to present on recent evidence concerning team-based primary care and actively engaged all participants in lively discussions to co-develop the evaluation framework. Participants were encouraged to prioritize the domains for evaluation, brainstorm pertinent outcomes, consider relevant data sources, and incorporate health equity considerations to ground the evaluation.

There was consistent and strong support for using a theory of change approach to guide measurement including logic models and the Donabedian framework. Ultimately, this knowledge exchange resulted in the identification of 16 domains for evaluation, organized as inputs, structures specific to team-based care, processes (activities) of teams, outputs (services delivered), and outcomes (classified as immediate, intermediate, and long-term).

In conclusion, this report summarizes the discussion, debate, and exchange of ideas from this two-day gathering. The drafted evaluation framework resulting from this BBE will undergo further refinement with interest holder consultation in March 2025.

Evaluation Framework Established by the BBE

The purpose of this Best Brains Exchange (BBE) was to co-create a pan-Canadian common evaluation framework for team-based primary care. Based on knowledge exchanged by field leaders and ideas generated during group discussions, attendees brainstormed the core outcomes and domains by which to measure, evaluate, and monitor the implementation of team-based care (TBC) in Canada. Many of the components of the framework aligned with findings from a recent evidence synthesis (commissioned as part of this BBE) to identify domains and measures used to evaluate team-based primary care.¹

The goal of this knowledge exchange was not to achieve formal consensus on the evaluative components but, rather, to engage experts in brainstorming the initial elements to include in a framework. This section summarizes and proposes the prioritized items from the BBE discussions to consider in developing the evaluation framework. There will be future opportunities to refine, adapt, and test the proposed evaluation framework.

Domains to evaluate the implementation and outcomes of team-based primary care

There was consistent and strong support for using a theory of change approach to guide measurement including logic models and the Donabedian framework (**Figure 1**). Attendees frequently reflected on the relevance and suitability of structures, processes, and outcomes to organize domains and indicators, and highlight the interdependency of these components in the planning, implementation, delivery, and enhancement of TBC.²

At the broadest level, **structures** include the resources necessary to establish and sustain TBC models like adequate funding, health human resources, and electronic medical records (EMRs). **Processes** include the capacity of health providers within teams to deliver care, team functioning, and the roles of interprofessional providers in delivering care. Lastly, the **outcomes** of TBC can be categorized into immediate, intermediate, and long-term areas. The immediate outcomes include: (equitable and timely) access to health services, patient and provider experiences, and population health management. Intermediate outcomes include: coordination of care across team members, comprehensiveness of care, and workforce outcomes such as retention of staff. Long-term outcomes include: improved population health and value for money. Many participants noted the importance of measuring the structures and processes that underpin health care initiatives, policies, and investments and explicitly examining their causal relationships with outcomes. Health equity considerations are central and cross-cutting across domains.

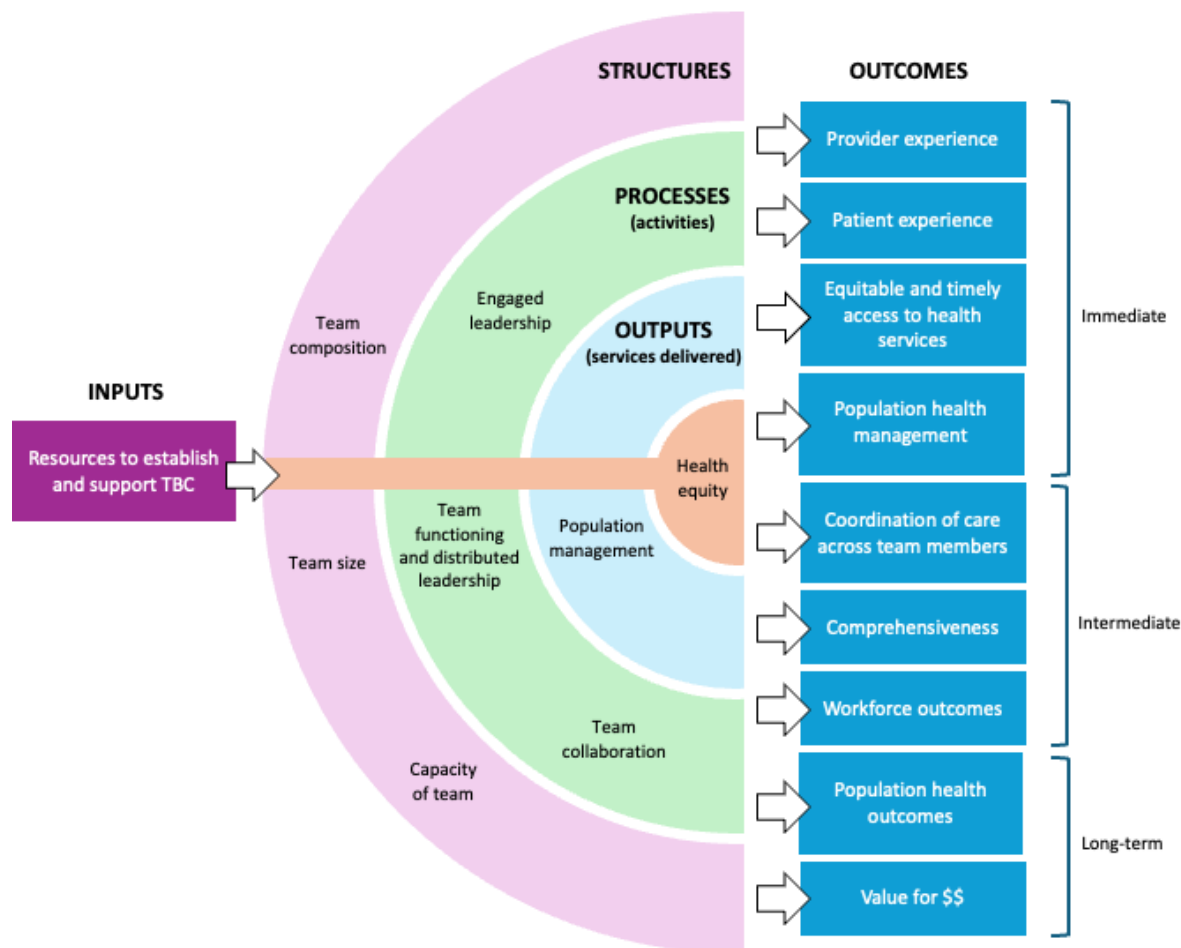


Figure 1. Domains to evaluate team-based care

Evaluation strategies to measure the impact and outcomes of team-based primary care

In line with the evaluative domains listed above, BBE attendees suggested measurement strategies to assess the impact and outcomes of team-based primary care. We organized these components as a results-based logic model to demonstrate links between resource inputs, activities performed, outputs or services delivered, and outcomes achieved. **Table 1** identifies the critical areas that require monitoring, evaluation, and reporting.

Deriving evaluation and performance measures from a common conceptual model, in this case team-based primary care, improves the relevance of the (proxy) indicators and ensures that they adequately reflect organizational values. This results-based logic model on TBC serves as a bridge between Donabedian’s conceptual model of “structure, process and outcome” and the operational framework where there are indicators that can be collected in a number of ways, including through EMR and administrative data, patient and practice surveys and interviews, focus groups, direct observation, and document analyses. This TBC results-based logic model was developed through rigorous consultation with both subject matter experts and pertinent literature.

Table 1. Results-based logic model of team-based care

Domains		Draft Indicators	Potential data sources and metrics
Inputs	1. Resources to establish and support TBC	<ul style="list-style-type: none"> • What resources are in place to support the establishment and sustainment of teams? (e.g., funding of teams, health human resources, EMR system, provider remuneration, team training) • Clinical infrastructure (e.g. technology-telehealth, remote monitoring) • Commitment to the communities served (stated mission is to promote the health of the specific community the practice serves) 	<ul style="list-style-type: none"> • Document analysis of policy reports, strategic plans, funding announcements, or meeting minutes • Human resource data (e.g., FTEs)
Structures specific to TBC	2. Team composition: interprofessional health providers	<ul style="list-style-type: none"> • Does the team represent the needs of patients/communities they serve? • How accessible are providers to the communities/populations they serve? • Interprofessional and ethnic/cultural diversity • What are the skills and areas of expertise of team members? 	<ul style="list-style-type: none"> • EMR data • Administrative database studies • Neighbourhood-level information about population demographics (e.g., Statistics Canada) • Practice survey • CCHS and provincial surveys • Patient feedback via surveys, interviews, or focus groups
	3. Team size	<ul style="list-style-type: none"> • Where do providers deliver care? (e.g., Are providers co-located? Are they a virtual team?) • How many people/professionals and types of providers make up the team? 	<ul style="list-style-type: none"> • EMR data • Practice survey • Document analysis (e.g., funding agreements)
	4. Capacity of team	<ul style="list-style-type: none"> • What is the breath of health services and supports delivered by the team? • What are the skills and areas of expertise of team members? • Are providers working to their full scope of practice? • Are scopes of practice well understood by team members? 	<ul style="list-style-type: none"> • Patient feedback via surveys, interviews, or focus groups • Provider feedback via surveys, interviews, or focus groups

Domains		Draft Indicators	Potential data sources and metrics
			<ul style="list-style-type: none"> Document analysis of professional competencies or scope of practice
Processes (activities) of teams	5. Engaged leadership (Leadership at all levels of the organization actively support TBC, create concrete measurable goals and objectives to clinical quality, addressing health inequities)	<ul style="list-style-type: none"> Concrete measurable goals and objectives about clinical quality, addressing health inequities Supports active quality improvement (QI) <ul style="list-style-type: none"> Improves practice quality through Plan-Do-Study-Act, peer coaching, audit/feedback, etc. Protected time for sustained QI efforts (e.g. focused team meetings, education materials) 	<ul style="list-style-type: none"> Document analysis (e.g., team goals and objectives, focus on QI and evaluation, leadership type and approach) Interviews, focus groups
	6. Team functioning and distributed leadership (Individuals with different skills and from different levels pool their expertise and resources, work together, and share in leading efforts to bring about change, improved team functioning)	<ul style="list-style-type: none"> What are the distinct and shared contributions and responsibilities of interdisciplinary health providers working with the team? Cultural humility 	<ul style="list-style-type: none"> EMR data Provider feedback via surveys, interviews, or focus groups
	7. Team collaboration	<ul style="list-style-type: none"> Communication amongst team: how often, format Team meetings: promotes teamwork, helps build relationships, clarifies roles, enables communication, problem solving, builds trust Team dynamics Community engagement 	<ul style="list-style-type: none"> Direct observation EMR Document analysis (of minutes, other meeting formats)
Outputs (services delivered)	8. Population management (practice	<ul style="list-style-type: none"> Review patient panel and team roles to assess meeting of patient/population needs 	<ul style="list-style-type: none"> Direct observation EMR

Domains		Draft Indicators	Potential data sources and metrics
	staff actively stratify the needs of patient panels and design team roles to match those needs, including panel management, health coaching and complex care management)	<ul style="list-style-type: none"> Engage patients in appropriate follow-up care (e.g., check registry, contact as appropriate, tie medication prescription renewal cycles to follow-up visits) Review health maintenance with EMR Provide information and skills to patients, supporting their engagement in self-management and/or behavior change Engage those who need it in complex care management where needs that are medically and psychologically complex are addressed Proactive patient outreach 	<ul style="list-style-type: none"> Interviews, focus groups
Outcomes	9. Provider experience (immediate)	<ul style="list-style-type: none"> Improved provider experience (e.g., joy from work) Work-life balance Sense of belonging (providers report psychological safety and being socially included and engaged within teams) 	<ul style="list-style-type: none"> Provider feedback via surveys, interviews, or focus groups
	10. Patient experience (immediate)	<ul style="list-style-type: none"> Patient-centred care Coordination of care 	<ul style="list-style-type: none"> Patient survey PREMs
	11. Equitable and timely access to health services (immediate)	<ul style="list-style-type: none"> How do teams impact timely access to primary care, attachment to a primary care provider [PCP], and continuity of care? How does TBC support or promote improved continuity of care? (e.g., same-day access to appointments, after-hours care) 	<ul style="list-style-type: none"> Administrative database studies EMR data Patient feedback via surveys, interviews, or focus groups
	12. Coordination of care across team members (intermediate)	<ul style="list-style-type: none"> Engagement of interprofessional team members Referrals outside team Referrals within team 	<ul style="list-style-type: none"> EMR data Provider survey Document analysis (e.g., team policies and procedures)
	13. Comprehensiveness (intermediate)	<ul style="list-style-type: none"> Preventive care, episodic care, behavioural change support, mental health support Addressing health and social inequities 	<ul style="list-style-type: none"> EMR data (research needs to help improve documentation)

Domains		Draft Indicators	Potential data sources and metrics
			of preventive care/ behavioural change) <ul style="list-style-type: none"> • Administrative data • Patient and provider survey
	14. Workforce outcomes (intermediate)	<ul style="list-style-type: none"> • Provider burnout • Productivity • Provider recruitment and retention 	<ul style="list-style-type: none"> • Human resource data (e.g., staff turnover, caseload) • Provider survey
	15. Population health outcomes (long-term)	<ul style="list-style-type: none"> • How does TBC impact health service utilization? (e.g., fewer emergency department visits, delayed admission to long-term care, preventable mortality) • Confidence in self-management of chronic conditions • What are the impacts of TBC on patient health? (e.g., disease prognosis, self-rated health outcomes, functional measures, medication use, health behaviours) 	<ul style="list-style-type: none"> • Administrative database studies (e.g., total costs of primary care per patient per year) • EMR data • PROMs
	16. Value for \$\$ (long-term)	<ul style="list-style-type: none"> • What are the costs and cost savings (value) of TBC? • Emergency department visits • Hospitalizations 	<ul style="list-style-type: none"> • Administrative data • EMR data • Total costs of primary care per patient per year • Total cost of healthcare

There were several considerations, challenges, and opportunities concerning the evaluation of team-based primary care exchanged throughout the BBE. The following is a summary:

Evaluation domains. Research, evaluation, and monitoring efforts need to adapt to the current fast pace of innovation and implementation. For example, rapid and living evidence syntheses can be used to help guide policy and implementation, implementation science and learning health system approaches can support agile implementation, and these efforts are best supported by data collection as close to real-time as possible so that rapid feedback loops can inform course correction and sharing of innovations and promising practices in a timely way.

Data sources and metrics. There was broad support for qualitative research approaches to understanding implementation in complex systems, including what is working and not working on the ground in different contexts, and for using mixed methods approaches to gain the greatest insights. EMR data can provide key insights into team roles and functions and who team members are seeing, and linked administrative data can provide system and population-level contexts and outcomes. Patient and provider surveys, interviews and focus groups can provide essential information about attachment, timely access, patient experience, team functioning, roles and responsibilities, scopes of practice, and development of capacity to care for additional patients. Provider experience measures such as well-being, burnout and workload were noted, as well as workforce outcomes including supply, recruitment and retention, productivity, and panel size. There was consistent endorsement of patient and provider reported experience and outcomes being among the highest priorities for measurement. Operationalizing and implementing these measures in ways that are feasible, not overly burdensome, and of value for decision-making in real time was felt to be critical.

Indicators. The quintuple aim of population health, patient experience, provider experience, value for money, and equity was widely endorsed as the most appropriate framework to guide measurement, performance and improvement. Many felt that equity needs to be incorporated into each of the other domains, with stratified analyses according to equity dimensions including age, sex, ethno-racial background, rurality, being Indigenous, and socioeconomic status, among other factors. Community participation and co-creation were seen to be key for equity, as was engagement with Indigenous communities, elders and knowledge keepers. Cost was raised as a major factor for decision-makers, who also felt that value for money and return on investment were important to measure. Cost alone was felt to provide limited information, as upfront costs alone do not capture the production of better health or the avoidance of downstream costs in other parts of the system.

Data issues. Infrastructure for data collection is routinely available in Canadian hospitals but is uneven and often minimal or absent in community settings like primary care. Building this infrastructure and enabling its use for rapid decision-making will be essential to the success of team-based primary care. This will require data collection and new decision support capacity in teams, networks and regions, along with managerial and leadership capabilities for learning and agile implementation. Numerous data gaps were identified, especially about the interprofessional workforce since many they are not remunerated in the same way as

physicians. That is, when items are billed to the provincial insurer, data are created that identifies activities such as types of visits and receipt of services. The majority of work completed by team members remains invisible. Lack of data on local community needs was flagged as a major gap, as was data to inform equitable implementation, given the propensity of well-educated and informed people to make preferential use of new services in contrast to those experiencing barriers to care. Mitigating the effects of the inverse care law, where those who need care the most get it the least, was seen as critical.

Further, provinces and territories vary greatly in the availability and accessibility of EMR data and linked administrative data, and concerns were raised about overly risk-averse privacy practices creating barriers to data access. Concerns were also raised about barriers to use of EMR data like vendor blocking and high fees, which still needs to be fully addressed.

Key Takeaways from the BBE

Beyond the core outcomes and domains prioritized during this BBE, the knowledge exchange resulted in tailored messaging about team-based primary care for pertinent audiences: clinicians, educators, researchers, and decision-makers (**Table 2**).

Table 2. Key takeaways from the BBE

		Key takeaways
Audience	Clinicians	<ul style="list-style-type: none"> • Ensure teams are attentive and responsive to the population and community served. Over time, consider patients’ evolving needs, gaps, and opportunities to enhance care. • When establishing and expanding teams, ensure interprofessional and ethnic/cultural diversity among providers. • Engage with research and evaluation opportunities to participate in the collection and/or analysis of data to improve TBC. When results are available, facilitate and act on feedback to course correct and share innovations. • Identify opportunities to embed standardized data collection in clinical notes/documentation to enable comprehensive data analysis for evaluation purposes. • Work to dispel interprofessional hierarchies by promoting interdisciplinary collaboration, communication, and to ensure providers are working to their full practice scope.
	Educators	<ul style="list-style-type: none"> • Train and encourage providers to collaboratively work as part of interdisciplinary teams, including how to work collaboratively with other professions and how to organize care within teams. • Educate providers about the professional competencies and practice scope of other disciplines. • Use insights from evaluations (as part of the learning health system approach) and research to strengthen TBC.

		Key takeaways
Audience	Researchers	<ul style="list-style-type: none"> • Develop, test, and refine the methods, approaches, domains, and measures to evaluate TBC. • Adapt and tailor the evaluation framework resulting from this BBE based on the needs, priorities, and goals of your team. • Where possible, collect and analyze both qualitative and quantitative data to overcome data challenges. • Incorporate patient and provider experiences into future evaluations. • Generate evidence to understand the impacts of implementing TBC models in different settings across Canada. Use evidence to directly inform funders and decision-makers (e.g., through publications, policy briefs). • Consider a range of outcomes for TBC including but not limited to those prioritized in this report (including workforce outcomes, patient experience, provider experience, cost/value, prognosis, health service use, and equity considerations). • Develop an approach to identify teams within administrative data sources and EMRs to understand individual and collective contributions of interdisciplinary providers.
	Decision-makers	<ul style="list-style-type: none"> • Agree on a core set of domains and indicators important for evaluating TBC. • Invest in implementation of teams in order to increase access and attachment to TBC with a focus on equity. Adequate resources, incentives, and remuneration are key enablers. • If teams are to expand access to care for their communities, changes in roles, task shifting, first contact availability for all team members, expanded roles for clerical and medical office assistant staff, and innovative digital solutions are needed. These major organizational changes require new supports, resources, training, leadership, governance arrangements, managerial capacities, and payment structures. • Encourage health system partners to apply and adapt the framework generated from this BBC to evaluate TBC. • Assess evidence and knowledge translation products resulting from evaluations of TBC to inform future investments. • Consider regional and population differences that will impact how different teams are structured and supported. Tailor team-based supports accordingly. • Rather than thinking about the <u>costs</u> of TBC, consider the <u>value</u> (or cost savings) of teams (e.g., addition of team members within primary care reduces downstream costs).

Implementation of TBC is needed. There was fruitful discussion around the theme of *change management and supports* since implementation of TBC is ongoing. Implementation science and learning health system approaches can support agile implementation, and these efforts are

best supported by data collection as close to real-time as possible so that rapid feedback loops can inform course correction and sharing of innovations and promising practices in a timely way.

If teams are to expand access to care for their communities, changes in roles, task shifting, first contact availability for all team members, expanded roles for clerical and medical office assistant staff, and innovative digital solutions will be needed. These kinds of major organizational changes require investment in new supports, resources, training, leadership, governance arrangements, managerial capacities, and payment structures. Fee-for-service reimbursement was noted several times as a barrier to TBC. Also required is a change in culture that flattens hierarchies to allow everyone to contribute to their full scope in a collaborative and supportive environment focused on the needs of patients and communities. Top-down physician power dynamics were identified as a potential challenge to equitable TBC and a memorable quote was “we want to sit in a circle, not on a ladder”. Trust is a key prerequisite for teams to function effectively, as well as a commitment to collaboration and psychological safety. Practice facilitation was identified as a key resource to support change and innovation, along with peer mentorship, learning communities, and other approaches for learning and sharing.

Educational supports for encouraging TBC are needed. TBC is new for many clinicians with most not trained in team environments and lacking awareness of the scope and capabilities of other professionals, how to work collaboratively with other professions, and how to organize care delivered by teams. Some professionals were not trained in or oriented to primary care.

Evaluation of TBC is critical. Using an organizing framework and what to measure about TBC had some consensus among participants.

Organizing framework. There was consistent and strong support for using a theory of change approach to guide an evaluation framework, including logic models and the Donabedian framework. For example, team composition and roles are key structural issues, team functioning and decision-making are key processes, and these structure and processes need to be aligned with the outcome of meeting community needs. Many noted the importance of measuring the structures and processes that underpin health care initiatives, policies, and investments and explicitly examining their causal relationships with outcomes.

Outcomes of TBC could be organized around the quintuple aim. Population health, patient experience, provider experience, value for money, and equity was widely endorsed to guide measurement, performance and improvement. Many felt that equity needs to be incorporated into each of the domains, with stratified analyses according to equity dimensions including age, sex, ethno-racial background, rurality, being Indigenous, and socioeconomic status, among other factors. Community participation and co-creation are key for equity, as was engagement with Indigenous communities, elders and knowledge keepers. Cost was raised as a major factor for decision-makers, who also felt that value for money and return on investment were important to measure. Notably, cost alone provides limited information, as upfront costs alone do not capture the production of better health or the avoidance of downstream costs.

What and how to measure. Research, evaluation, and monitoring efforts need to adapt to the current fast pace of innovation and implementation. For example, rapid and living evidence syntheses can be used to help guide policy and implementation. There was broad support for qualitative research approaches to understanding implementation in complex systems, including what is working and not working on the ground in different contexts, and for using mixed methods approaches to gain the greatest insights. EMR data can provide key insights into team roles and functions and who team members are seeing, and linked administrative data can provide system and population-level contexts and outcomes. Patient and provider surveys, interviews and focus groups can provide essential information about attachment, timely access, patient experience, team functioning, roles and responsibilities, scopes of practice, and development of capacity to care for additional patients. Provider experience measures such as well-being, burnout and workload were noted, as well as workforce outcomes including supply, recruitment and retention, productivity, and panel size. There was consistent endorsement of patient and provider reported experience and outcomes being among the highest priorities for measurement. Operationalizing and implementing these measures in ways that are feasible, not overly burdensome, and of value for decision-making in real time was felt to be critical.

Building the infrastructure for EMR and patient/provider surveys that can be linked to administrative data and enabling its use for rapid decision-making will be essential to the success of team-based primary care. Both data collection and its use will require new decision support capacity in teams, networks and regions, along with managerial and leadership capabilities for learning and agile implementation.

Numerous data gaps were identified, especially about the interprofessional workforce since they are not remunerated through billing provincial/territorial health plans and therefore their patient encounters are not tracked. Lack of data on local community needs was flagged as a major gap, as was data to inform equitable implementation, given the propensity of well-educated and informed people to make preferential use of new services in contrast to those experiencing barriers to care. Mitigating the effects of the inverse care law, where those who most need care receive it the least, was seen as critical.

Provinces and territories vary greatly in the availability and accessibility of EMR data, patient and provider surveys and linked administrative data, and concerns were raised about overly risk adverse privacy practices creating barriers to data access. Concerns were also raised about barriers to use EMR data like vendor blocking, high fees, and lack of interoperability, which remain to be fully addressed. Developing an evaluation framework for TBC in Canada is a high priority given recent investments in health care transformation and the expansion of teams.

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