Health Promotion Perspectives
Papa, Health Promotion Perspectives 2026;16(3): 284-289
doi:10.34172/hpp.48259
https://hpp.tbzmed.ac.ir
TUOMS PRESS

Perspective

The Readiness Reading Matrix (RRM) for Evaluating Care Pathways in Italy: A Perspective

Roberto Papa*

Head of Quality, Risk Management and Health Technology Innovation Unit, Department of Staff, Aou Delle Marche, Ancona, Italy

ARTICLE INFO

Article History:
Received: August 10, 2026
Revised: September 4, 2026
Accepted: September 6, 2026
ePublished: November 5, 2026

Keywords:
Delivery of health care, Integrated, Health promotion, Patient participation, Public health, Quality indicators, Health care, Total quality management

***Corresponding Author:**
Roberto Papa, Email: Roberto.papa@ospedaliriuniti.marche.it

Abstract

Care pathways (CPs)—formally defined in Italy as Percorsi Diagnostico-Terapeutici Assistenziali (PDTA)—have long been a cornerstone of Italy's community-based healthcare reorganisation. Defined by the European Pathway Association as complex interventions for shared decision-making and the organisation of care for a defined patient group, CPs remain vulnerable to a systematic gap between potential and actual performance. This Perspective proposes the Readiness Reading Matrix (RRM), a logical framework intersecting Donabedian's structure-process-outcome triad with four readiness domains: interprofessional collaboration, lean standardisation, care continuity, and technological maturity, featuring patient co-design as a transversal axis. The RRM situates three previously disconnected international references—the Healthcare Readiness Index, the Telemedicine Readiness Inventory for Facilities, and the WHO's SARA tool—within a single conceptual architecture. This approach offers a systemic, rather than merely comparative, evaluation of health-system readiness. The framework is presented here as a reference architecture pending empirical validation, and is illustrated through an applied scenario.

Introduction

The introduction of care pathways (CPs), defined in Italy as Percorsi Diagnostico-Terapeutici Assistenziali (PDTA), is a central instrument of the community-based reorganisation set out in Italy's health planning documents.[1,2] The European Pathway Association defines CPs as complex interventions for shared decision-making and the organisation of care for a defined patient group over a defined period, characterised by explicit goals, multidisciplinary coordination and outcome monitoring.[3] Their formal existence, however, does not equate to integrated care: an organisation's actual capacity, its readiness, often remains disconnected from its regulatory formalisation. This gap between potential capacity (technology, guidelines) and actual capacity (operational integration, collaboration, delivered quality) is the focus that readiness addresses: a measure of a health system's preparedness to implement, sustain, and evolve a model of care.[4,5]

Current literature documents concrete instances of this misalignment: some organisations have advanced technology yet lack genuine multidisciplinarity, fragmenting care and contradicting the interprofessional nature of CPs;[3,5] others have strong collaborative capacity but inadequate monitoring, highlighting the need for systemic readiness evaluation.[6] Without data-driven assessment, identifying areas for improvement or justifying investment becomes impossible, the very need from which readiness indicators arise, though individually they remain measures lacking a unifying interpretive logic.

This gap is not solely a matter of operational efficiency. A CP lacking genuine readiness also limits the system's capacity to deliver, within the same pathway, secondary prevention and health promotion interventions such as therapeutic education, screening, and self-management support, which rely on the same continuity and coordination that readiness measures. Evaluating CP readiness may therefore serve as an indirect indicator of the health system's capacity to promote health, not merely to deliver care.

Existing literature offers guidance for defining these domains and their indicators. Interprofessional collaboration involves the active engagement of system stakeholders, assessed through indicators of staff perception and coordinated patient care.[7] Standardisation and guideline adherence draws on lean methods such as Value Stream Mapping to analyse workflows and identify waste, with validity resting on explicit indicators and precise resource estimation.[3,8,9] Continuity of care includes managing patient transitions across levels (e.g., hospital-to-community), measurable through integrated-care frameworks.[4] Technological readiness measures the capacity to leverage information to support the pathway,

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including telemedicine adoption and data-integration capability, requiring facility-specific assessment tools.[10,11]

These four domains, however, often remain siloed: the literature lists them without offering an integrated evaluative approach.

Managerial and Economic Aspects

Readiness indicators extend beyond the clinical domain, and are central to the managerial and economic sustainability of CPs:[3] they must be viewed as strategic management tools, not routine reporting exercises.

A structured, multilevel evaluation framework, combining quantitative and qualitative indicators, gives health management a comprehensive view of organisational readiness,[6] supports resource allocation and process reorganisation, and may help leadership counter institutional pressure to preserve the status quo.[9] Economically, readiness indicators catalyse resource optimisation: lean adoption in hospitals has documented measurable waste reduction.[8,9] Because CPs are living documents, a readiness indicator system keeps this identification systematic rather than occasional, turning lean thinking into permanent monitoring infrastructure that supplies the data needed to update the CP as evidence evolves.[3,9]

The Central Role of the Patient

Active patient involvement is indispensable to an effective readiness indicator system:[7] integrating the patient into indicator design acknowledges that care quality is tied to the patient's perception of their own pathway.

This requires distinguishing two processes often treated as synonyms. Co-production describes the intrinsic bidirectional nature of any health service, where provider-recipient interaction shapes outcomes and quality.[12] Co-design is an intentional process derived from person-centred participatory design, aimed at understanding user experience to redesign services.[13,14]

Applied to CP readiness, we propose that co-design must precede co-production: patients should first help define the indicators themselves, determining which outcomes matter, how often to measure them, and which thresholds signal concern, before being involved in ongoing monitoring. This sequence is not explicit in the cited literature but is, in our view, a coherent implication: an indicator system built without this phase risks measuring what the organisation deems relevant rather than what patients experience as impactful. In Italy, this form of engagement is formally recognised in chronic-care guidelines, which stress rigorous structuring from the initial co-design phase.[7]

This sequence need not be strictly linear. An iterative model is equally plausible: an initial co-design phase generates provisional indicators, later refined as PROMs and PREMs data reveal blind spots the original design missed. Feasibility also varies by context: in emergency or intensive care, where patients cannot participate, co-design might instead draw on family members, patient advocates, or panels of past patients, with the transversal axis only partially satisfied. A concrete illustration: for interprofessional collaboration, a professional-only indicator typically tracks meeting frequency, whereas patients may instead prioritise whether their concerns were addressed at each transition, a related but distinct measure.

Co-design is nonetheless demanding. Patients on CPs are often elderly, unwell, or have limited health literacy, so meaningful participation requires accessible materials and sustained support, not a single consultation event. Without these, co-design risks tokenism or capture by the most articulate participants, a documented weakness of patient and public involvement;[15] reporting standards such as GRIPP2 make the process auditable,[16] and the costs of participatory work should not be underestimated.[17] Where patient preferences conflict with evidence-based guidance, co-design should shape which outcomes are measured, not which treatments are recommended. Its relevance also varies by domain: patients contribute most directly to care continuity and collaboration, less to technological maturity, where their input concerns usability rather than infrastructure.

Beyond co-design, patients must remain involved in ongoing monitoring of CP effectiveness. The literature supports integrating Patient-Reported Outcome Measures (PROMs) and Patient-Reported Experience Measures (PREMs) within CPs to capture patient-perceived experiences and outcomes.[18] Involving patients from co-design through to monitoring establishes a structured feedback loop across the readiness cycle.[7]

International Comparisons

Analyzing international models offers transferable strategies for the Italian context.

At international level, the Healthcare Readiness Index is a composite framework assessing health-system preparedness through both "Readiness Today" (current capacity) and "Readiness Tomorrow" (capacity for future adaptation),[6] evaluating robustness before an operational stress test.

The Telemedicine Readiness Inventory for Facilities (TRI-F) offers methodologies, still under validation, to assess whether community and primary care facilities are prepared, in infrastructure, staff culture, and processes, to adopt telemedicine platforms mandated by initiatives such as Italy's PNRR.[10,11]

The WHO's SARA tool, developed for a different context, monitors human-resource availability, infrastructure, and actual service-delivery capacity in low- and middle-income countries;[19] its distinction between formal availability and actual delivery capacity mirrors, at system level, the planning-performance gap this work identifies in individual CPs.

Disease-specific literature offers advanced models too: system-readiness frameworks applied to Alzheimer's disease pathways show that preventive assessment of system preparedness is a precondition for effective implementation of a modern diagnostic-therapeutic pathway.[4,5]

Table 1 compares the three frameworks against

criteria relevant to CP evaluation. Their scopes overlap only partially and none was designed for pathway-level assessment: the Healthcare Readiness Index operates at national level and lacks academic validation; SARA assumes resource scarcity that does not apply to Italian settings; TRI-F is domain-specific and still unvalidated. Applied simultaneously they can also conflict: a system rated favourably on aggregate national capacity may score poorly on facility-level digital readiness, with no shared logic to reconcile the two verdicts. This partial, non-communicating coverage motivates integration rather than selection.

They share the same intuition, a gap between formal availability and actual capacity, but express it through disconnected architectures difficult to apply to a single Italian CP; the following section proposes an architecture to integrate them.

Towards the Readiness Reading Matrix (RRM): A Logical Interpretative Framework

The original contribution of this Perspective is not to add another model to the existing three, but to present a logical structure—the Readiness Reading Matrix (RRM)—capable of interpreting them collectively and applying them systematically to the four CP readiness domains identified in the Introduction. The RRM intersects two axes that already exist, albeit separately, in the cited literature.

The first, vertical axis revisits Donabedian's classic structure-process-outcome triad:[20] structure describes available resources (technology, guidelines, formalised teams); process describes their actual operational use; outcome describes the resulting clinical or perceived result. Applied to readiness rather than quality, this operationalises the potential-performance distinction central to this article: potential corresponds to structure, while actual performance emerges only when structure, process, and outcome are aligned.

The second, horizontal axis corresponds to the four aforementioned readiness domains: interprofessional collaboration, lean standardisation, care continuity, and technological maturity. Patient co-design acts as a transversal axis rather than a fifth column; it conditions the quality of information gathered across all levels and domains, as co-designed indicators dictate what is practically measured as a process or recognised as an outcome.

Figure 1 visually summarises the RRM's architecture, while Table 2 operationalises it in detail, proposing an example indicator consistent with existing literature for each cell.

To operationalise the matrix, each cell is scored on a standardised 0–3 scale: 0 (absent, no evidence of the indicator), 1 (planned, formally intended but not yet in place), 2 (partially implemented, but inconsistently applied or unmonitored), and 3 (fully implemented, with routine data collection). For example, the Structure

Table 1. Critical comparison of the three international readiness frameworks

Criterion	Healthcare Readiness Index[6]	SARA[19]	TRI-F[10,11]
Conceptual coherence	Composite index; present/future capacity	Availability vs. actual delivery capacity	Facility-level digital readiness
Validation status	Policy think-tank product; not academically validated	WHO-standardised; applied across multiple countries	Psychometric validation still a preprint
Feasibility and cost	National-level data; not applicable to a single pathway	Extensive facility survey; resource-intensive	Facility questionnaire; moderate burden
Relevance to CP evaluation	Low: system level, not pathway level	Moderate: structure-process logic transferable	Partial: one domain only
Main limitation	No process or pathway granularity	Designed for resource-limited settings	No clinical-outcome indicators

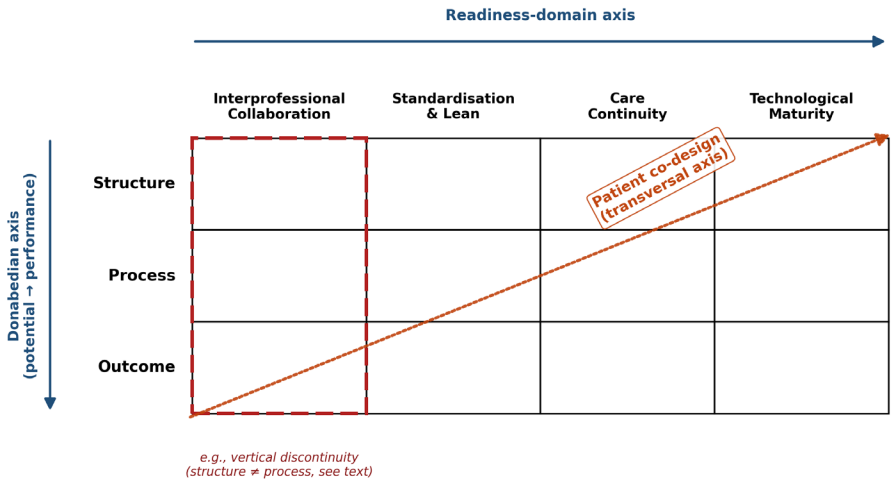


Figure 1. Schematic representation of the Readiness Reading Matrix (RRM). The vertical axis reproduces Donabedian's structure-process-outcome triad; the horizontal axis corresponds to the four readiness domains addressed in this Perspective (interprofessional collaboration, standardisation and lean, care continuity, technological maturity). Patient co-design runs as a transversal axis across all cells, conditioning the indicators generated at every level and domain. The dashed frame illustrates, by way of example, how a vertical discontinuity within a single domain (e.g., structure achieved, process still lagging) becomes visible only when cells are read row by row rather than aggregated into a single domain score

Table 2. Readiness Reading Matrix (RRM): detailed indicators per cell (structure-process-outcome matrix by domain)

	Interprofessional Collaboration	Standardisation and Lean	Care Continuity	Technological Maturity
Structure	Formal constitution of the multidisciplinary team; documented roles and responsibilities[7]	Availability of updated guidelines and protocols[3]	Structured hospital-community communication channels[2,4]	Available telemedicine platforms; data interoperability[10,11]
Process	Frequency and quality of team meetings; coordinated patient care[5,7]	Value Stream Mapping application; actual CP adherence[8,9]	Documented patient transition across care levels[4]	Real adoption rate and clinical use of platforms[10,11]
Outcome	Staff- and patient-perceived collaboration[7,18]	Documented waste reduction and reduced unwarranted variation[8,9]	Avoidable readmissions; patient-perceived continuity[4,18]	Improved access; reduced waiting times[6,10]

and Interprofessional Collaboration cell scores 3 when a multidisciplinary team is formally constituted with defined roles and a documented meeting schedule, 2 when it exists but meetings are irregular, 1 when planned but not constituted, and 0 when absent; the same logic applies to the remaining eleven cells. Data sources vary by cell and typically include administrative records, meeting logs, staff or patient surveys, and documentary review; a cell is left unscored, rather than imputed, when no reliable source exists, since an unscored cell is itself diagnostic. Interpretation follows a simple rule: a discontinuity of two or more points between adjacent levels within a domain flags a specific, actionable gap, whereas uniformly low or high scores indicate, respectively, a genuine absence of readiness or a domain requiring no immediate intervention.

The RRM's diagnostic value lies in identifying vertical discontinuities rather than relying on aggregate domain scores. An organisation with advanced technological structure but a weak collaborative process—as described at the beginning of this work—is readiness-positive at the structural level but readiness-negative at the process level. This critical issue would be masked by an aggregate score but becomes immediately apparent when examining the "Interprofessional Collaboration" column row by row, as illustrated in Figure 1.

To make this diagnostic logic tangible, consider a hypothetical scenario, with scores assigned for illustration only, involving a type 2 diabetes CP in a mid-sized Italian organisation. At the structural level, the organisation has invested in the National Telemedicine Platform and possesses updated regional guidelines; thus, the matrix's first row would score 3 in the Standardisation and Technological Maturity columns. At the process level, however, multidisciplinary meetings between general practitioners, diabetologists, and community nurses remain rare and unstructured, scoring 1 in the second row of the Interprofessional Collaboration column. Under an aggregate scoring system, the structural strengths might offset this process weakness, yielding an acceptable overall score. Evaluated through the RRM, the structure-process discontinuity in interprofessional collaboration emerges as a specific, actionable criticality. This points toward targeted interventions—such as establishing a monthly multidisciplinary board—rather than redundant technological investments. While this scenario is illustrative and requires validation with real data, it demonstrates how the matrix orients diagnosis toward actionable interventions rather than mere scoring.

Applying the three international references individually to this scenario illustrates the gap the RRM addresses. The Healthcare Readiness Index, oriented toward aggregate capacity, would register the technological investment as a positive signal; SARA, focused on structural resources, would confirm that a multidisciplinary team formally exists, without capturing whether it meets regularly; TRI-F, scoped to technological maturity, would score platform availability highly but would not examine collaboration at all. All three, in isolation, support the same inference: the pathway needs no corrective action, or at most further technological consolidation. The RRM's cell-by-cell reading leads to the opposite conclusion, isolating a deficit that composite readings absorb into an otherwise satisfactory profile and redirecting the intervention from technology, already adequate, toward coordination. The difference is not one of precision but of direction: the same evidence, read through different architectures, yields opposite operational priorities.

The RRM repositions the three references as partial readings of the same matrix: the Healthcare Readiness Index's "Today/Tomorrow" distinction is the temporal projection of the process-outcome axis;[6] SARA's formal-versus-actual distinction mirrors the structure-process separation;[19] TRI-F occupies the technological-maturity column alone.[10,11] Integrating them preserves their specificities while revealing which readiness areas remain unaddressed by each isolated model. Concretely, a pathway that is structurally advanced but operationally uncoordinated, invisible to any composite score, becomes a specific, addressable finding once read through the matrix rather than through any single framework.

To our knowledge, this integration has not previously been attempted, most plausibly because the three references originated in professional communities that rarely communicate: a policy think tank,[6] the psychometric tradition of digital-health assessment,[11] and WHO administrative monitoring.[19] Each validated its tool internally, without cross-comparison. Because CP readiness is a hybrid construct spanning clinical, organisational, technological, and experiential elements, it exposes this disciplinary silo: no single framework can fully describe it, which is why none of the developing groups identified the gap.

Implementation Considerations

Applying the RRM raises practical questions the framework does not settle. Responsibility would most naturally sit with the quality and risk management function, which already holds the data sources and the mandate to act; the exercise

is intended to be light, drawing on existing data rather than new instruments, with rater training focused on calibrating the descriptors against a shared reference pathway. Clinical resistance is likelier where the matrix is perceived as an audit rather than a diagnostic aid; framing discontinuities as signals of where support is needed, and involving clinicians in indicator co-design, mitigates this. The RRM adds no parallel monitoring layer: it reorganises data that existing CP monitoring requirements already generate. A phased pathway is advisable: a pilot on one high-prevalence CP, refinement of descriptors and thresholds, then wider extension.

Limitations

This Perspective presents the following limitations. First, the matrix has not yet been applied to real-world data; the scenario discussed serves a purely explanatory purpose and does not constitute empirical validation. An empirical application of the RRM to a high-prevalence pathway—the type 2 diabetes CP—is currently underway. This will provide the first test of the matrix's discriminant capacity using real data, benchmarking it against aggregate assessment tools.

A validation protocol is defined as follows. The sample will comprise 5–10 type 2 diabetes CPs from diverse settings; two trained raters, blinded to each other's scores, will independently rate each pathway on the twelve matrix cells using administrative records, meeting logs, and routinely collected outcomes. Inter-rater reliability will be assessed via the intraclass correlation coefficient (threshold > 0.75). Discriminant validity will be tested by comparing the RRM's cell-level diagnosis against composite scores from the Healthcare Readiness Index, SARA, and TRI-F, to establish whether the RRM detects discontinuities that aggregate scoring conceals.

Second, the indicators proposed in Table 2 are illustrative rather than exhaustive. Their assignment to a specific level (structure, process, or outcome) is occasionally conventional rather than definitive; for instance, a technology platform's adoption rate could be interpreted as either a process indicator or an intermediate outcome, depending on the chosen evaluation design.

Third, two references used to contextualise the international frameworks have not undergone full peer review: the Healthcare Readiness Index[6] is a policy think-tank product rather than an academically validated instrument, and the psychometric validation of the TRI-F[11] is currently a preprint. Both were retained as the most detailed sources available on their respective instruments, though this should be considered when interpreting the correspondences proposed above.

Finally, the assertion that co-design should precede co-production is a theoretical inference of this work. While consistent with established conceptual distinctions in the literature,[12,13,14] it has not yet been empirically verified within this specific application domain.

Conclusion

Readiness is not a static attribute of CPs but a dynamic evaluation process, interpretable through an explicit logical architecture. The RRM, intersecting the structure-process-outcome triad with four readiness domains and patient indicator co-design, does not replace existing international models but offers an integrated evaluative lens capable of pinpointing not just whether a health system is ready, but where exactly the chain between planning and performance breaks down. Because this chain also shapes a CP's capacity to deliver prevention and health promotion alongside clinical care, the ongoing empirical application of the RRM to the type 2 diabetes CP will provide a crucial real-world test. This validation is a necessary, though insufficient, step toward genuinely integrated, patient-centred, sustainable care pathways in Italy.

Acknowledgements

Not applicable.

Competing Interests

The author is Head of the Quality, Risk Management and Health Technology Innovation Unit at AOU delle Marche. This work reflects a personal theoretical position, developed as an individual scientific contribution, and does not represent an official position of the affiliated institution. There are no commercial or financial conflicts of interest regarding the publication of this article.

Ethical Approval

Not applicable.

Funding

This research received no specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

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