NCCC Report

Using SASI to Advance Systems Integration: Findings Report

Findings from a grant project funded by The John A. Hartford Foundation
1996 to 1998

Written by
Deborah Paone

National Chronic Care Consortium

The National Chronic Care Consortium (NCCC) was awarded a two-year grant in 1996 from the John A. Hartford Foundation to:

- assist selected healthcare providers in implementing/using the NCCC's Self-Assessment for Systems Integration (SASI) tool
- examine the use and impact on system performance and client outcomes of SASI
- disseminate project learnings nationwide
- enhance the SASI tool and related resources based on new learnings

The main focus of the grant project was on the activities of three to five healthcare organizations, called SASI project sites, that agreed to use the Self-Assessment for Systems Integration tool over the course of 18 to 24 months in its efforts to integrated care for populations(s) with chronic conditions. The NCCC's task was to monitor the activities related to integration at these sites, provide technical assistance on the SASI tool, create a forum for facilitating shared learning, and obtain feedback on barriers and challenges to integration as well as on the SASI tool. This report summarizes the process, accomplishments, and challenges of this project.

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Executive Summary

Background

The National Chronic Care Consortium (NCCC) was awarded a two-year grant in 1996 from the John A. Hartford Foundation to:

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Project Successes

The project was successful in several ways:

- Five different types of healthcare provider organizations were chosen out of 12 interested applicants; the organizations selected represented a variety of types of organizations and market types.

- All five project sites maintained the effort over 18 to 24 months to use the SASI tool.

- Project sites made many advances in developing or improving services for older adults/chronic care population—though these efforts were not conducted as a result of the organization's assessment, the SASI tool contributed to shaping the efforts.

- All five organizations reported that the SASI tool helped frame the areas they should focus on, and that participating in the grant advanced their integration efforts. Though the task of integrating these healthcare organizations was complex and will be ongoing, these organizations made clear important advances activities and in internal capabilities that helped support integration goals.

- Key contacts from each site participated in monthly conference calls to share learning and provide updates.

- Project representatives and NCCC staff presented grant project activities and interim findings at several national and regional conferences; these presentations were described in subsequent proceedings or journal articles.

- Sites provided suggestions for modifications to the SASI tool to increase ease of use for other organizations.

Key Accomplishments

Synthesizing the developments of all the project sites within the time period, the following key accomplishments characterize the progress made:

- Enhanced understanding of integration concepts by key stakeholders

- Increased readiness for special Medicaid or Medicare products; launched new programs

- Developed or formalized affiliation/partnership agreements with an important chronic care partner

- Established system-wide leadership structures to monitor system integration

goals and accomplishments

- Developed or enhanced mid-level management teams to implement specific initiatives
- Launched disease-specific or continuity of care initiatives
- Improved infrastructure support for chronic disease management/chronic care service lines

Challenges

Major challenges reported by the key contacts at each site were similar:

- Time constraints due to changing or multiple priorities
- Lack of sufficient resources (staff and money) to accomplish objectives
- Internal reorganizations, creating confusion, mistrust, or fear
- Lack of systems awareness/thinking on the part of colleagues, partners
- Lack of infrastructure to support integration activities—very little extended system-wide
- Marketplace factors, particularly low managed care penetration

Characteristics of Effective Organizations

Characteristics of the organizations that seemed to contribute to efforts:

- Forward-thinking/acting CEOs or senior leaders
- One or two key staff who served as champions
- Partnership-friendly organizations
- Good team dynamics and culture of shared learning within the organization or the set of organizations making up the "team"

Findings Related to the SASI Tool and Process of Self-Assessment

- The process of self-assessment is new to many organizations.
- The composition of the team performing the assessment is important.
- In addition to staff representation from different sites of care and clinical disciplines, include representation from several key areas, i.e., Information Services, Finance, Human Resources, and Quality Improvement/Performance Measurement.
- A kick-off orientation/training jumps start the effort.
- Language is important—develop a common definition for key terms.
- The Workbook and Global Measures of the SASI tool were the most valuable sections.
- Scoring the tool, while not an exact science, can be helpful in synthesizing results for presentation to other groups.

Project Background

The National Chronic Care Consortium (NCCC) is a national alliance of leading-edge health networks, dedicated to transforming the delivery of services for people with chronic conditions. The NCCC examines issues of importance in healthcare and systems integration and works with its member organizations to serve as an operational laboratory to test methods and strategies to improve service delivery to this population.

SASI Tool Development

The NCCC designed its Self-Assessment for Systems Integration (SASI™) tool as an internal resource for provider systems—to assist these emerging healthcare networks with planning, implementing, and measuring chronic care integration across their full continuums of care. The tool allows for a critical self-assessment of a multi-organizational delivery "system" at a point in time. The SASI tool was developed under a multi-year grant from The John A. Hartford Foundation (January 1994 to May 1996), by a multi-organizational task force of NCCC members.

In 1994 this member task force worked to identify and outline the major indicators or elements of systems integration that are important in delivering effective and efficient care to a chronic care population. From that work, the staff and members created a draft tool. In 1995 the content and format of this draft tool were reviewed and refined through a beta testing process at five NCCC member sites. The tool was finalized by the end of 1995, and supportive materials for training and orientation on the tool were developed. The NCCC conducted a training session for more than 40 NCCC members in October of 1995.

The tool contains four sections:

1. The **Guidelines and Indicators** section expands on each of the nine objective statements, providing the healthcare organization using the tool to understand the nature and scope of each objective.
2. The **Workbook** section takes each objective and asks the healthcare organization to provide some detail about: What is the organization's status on this objective—how far has it progressed? What are some barriers to achieving this objective? What are the organization's short-term and long-term goals related to this objective—what action steps will be taken? Who will be accountable for moving ahead on the objective?
3. The **Global Measures** section contains a selection of quantitative and qualitative measures of progress pertaining to each objective in the form of questions that the healthcare organization must answer about itself. This provides a snapshot of the organization's progress at that point in time.
4. The **Resource Guide** section provides references to articles and other research pertaining to each objective.

SASI Objectives

The tool is centered around nine critical objectives of systems integration:

1. **Governance structures** support goal development and improve the ability of individual care providers to work together as a single system.
2. **Management strategies and structures** support cross-site, interdisciplinary integration efforts.
3. **Information technology systems** allow providers in all settings to share meaningful information about clients, costs and operations.
4. **Financing systems** promote system-wide management of cumulative costs, tied to care outcomes.

5. The needs of **high-risk populations** are identified.

6. A **full array** of effective and efficient services is provided.

7. Care management is focused on **disability prevention** and organized around **defined populations** (e.g., high risk, condition-specific).

8. **Seamless care** is provided across settings and over time.

9. **Clients are involved** in care management and self-care activities.

SASI Tool Testing

Six NCCC healthcare organizational members were involved in "field testing" the instrument in some way from October 1995 to May 1996, including: several hospital systems (vertically diversified), a staff-model health plan, and several long-term care systems with a continuum of services for older adults. Objectives of the organizations participating in the testing process related to their interest in creating a process and structure for moving systems integration forward and for measuring the level of integration across sites of care. Some of the test sites became involved in field testing primarily to develop or improve their services for the elderly across the continuum. The others sought to use SASI to improve overall systems integration and advance their affiliations/ mergers with new provider partners. Experiences of the six sites differed over the several months of testing. Three of the organizations moved ahead as expected, and three encountered roadblocks.

Benefits cited from the testing and early use experience with the SASI tool indicated that SASI:

- stimulated systems thinking;
- provided a framework for learning about the whole network;
- enhanced/supported a team process for working on issues of integration;
- provided the impetus to conduct an inventory of their full service array;
- helped to develop a common language among managers to discuss the issue of systems integration and create a common vision;
- provided a way to educate the Board and other audiences about systems integration;
- created a snapshot measurement of the degree of systems integration along nine key areas of focus; and
- helped to identify priority areas for future work.

Several key learnings emerged from these beginning efforts at systems integration using the SASI tool. Sites reported that an important factor in moving ahead was the caliber, commitment, and dedication of their own staff in their networks, particularly the staff involved in the committees or leadership groups working on SASI. Commitment and support from senior management was also important. Timing was important as well. Sites that had already identified and recognized the need to develop a structure and process for measuring their own progress toward integration, for communicating across sites of care, and/or for strategic planning around corporate objectives for the whole system, were able to make considerable progress in a shorter timeframe.

The belief that "the chronic care population" was an important client group within these organizations' service areas and the feeling that service delivery to these groups could be improved.

SASI Grant Project Launched

In an effort to take the implementation of SASI a step further, and evaluate experiences of both NCCC member and nonmember organizations, the NCCC requested a second grant from The John A. Hartford Foundation and a two-year award

was granted in 1996. A core component of the grant would be the selection of four to five project sites that would be supported and monitored over the course of 18-20 months as they worked toward integrating their services and improving coordination of care, using the Self-Assessment for Systems Integration (SASI) tool. Project sites will share experiences and describe their approaches and strategies toward advancing systems integration.

Organizations participating in this grant project would receive NCCC technical assistance, facilitated orientation/training around use of the SASI tool, telephone and on-site consultation, and shared learning experiences via regular conference calls with the other project sites.

The NCCC developed criteria and an application process for interested healthcare organizations to apply for participation in this project and created reviewer panel of both NCCC senior staff and several external consultant experts to review applications and select the sites.

Criteria for and Characteristics of SASI Project Sites

- The system's/network's corporate objectives and goals should relate to population health management, and there should be a recognition of the need for systems integration.

- There should be an understanding of the importance of a chronic care population within the network's overall population and a description of the population and the marketplace. The drive to integrate care across settings should fit with the marketplace dynamics.

- The network's array of services, facilities, programs should be described. (Consider affiliates' or partners' services as well and describe how these programs work together to serve a common clientele.)

- The major goals for an internal systems self-assessment/planning process and for systems integration should be identified.

- The system/network should have a clear rationale for wanting to use the SASI tool as part of this larger effort towards systems integration.

- Key clinicians' involvement in this integration or self-assessment work should be articulated.
- There should be evidence of CEO support for participating in this two-year project. If there is Board support or involvement, these plans should be described.

- A key contact person should be identified—a person who has a corporate/system role and is designated by the CEO or other senior manager, and has the time, authority, and responsibility to move ahead.

- An internal committee structure should be established for looking at systems integration, and the connections with other management, governance and/or clinical/medical management groups should be specified. The SASI or integration committee should represent the continuum of settings and some elements of infrastructure. If already established, the charge and composition of this committee should be described.

- A timeframe (spanning 18 months) and a workplan should be sketched out and submitted. The expected priority areas of focus in this timeframe and how/when SASI or sections of the tool will be used should be described.

- There should be an understanding of NCCC's role and responsibilities in this project. For example, the NCCC will conduct on-site visits, interviews of key staff, information collection and analysis.

Project Site Selection

The NCCC received 12 applications from organizations that wanted to participate in this grant. The reviewer panel selected five healthcare provider organizations to participate in this grant—including long-term care systems, hospital systems, large and smaller organizations, alliances, and partnerships. These five organizations also represented different geographic markets with different market characteristics (from high managed care penetration to low penetration, from rural to urban). The panel deliberately chose this spectrum of organizations to learn if these differences seemed to affect the progress toward systems integration and the use of the SASI tool.

The organizations had certain characteristics in common as well: they were forward-thinking, had been involved in grant and pilot demonstrations before, and were committed to improving service to chronic care populations.

The five healthcare organizations selected were:

1. Atlanta Senior Care/Wesley Woods Geriatric Center, Atlanta, Georgia
2. Crozer-Keystone Health System, Chester, Pennsylvania
3. Fairview Hospital and Healthcare Services, Minneapolis, Minnesota
4. Loretto/Health Partnership for Seniors, Syracuse, New York
5. St. Vincent Hospital and Health Center, Billings, Montana

Reasons the sites stated for participating in this grant project included:

- to prepare for an anticipated managed care product focusing on older adults
- to improve overall systems integration
- to promote or advance an affiliation/merger with a provider partner(s)
- to improve services for chronic populations/seniors
- to redesign internal structure to support a population focus

Project Process

Over the course of the two-year grant, NCCC staff conducted two visits to each of the SASI Project sites. The first visit was primarily focused on providing an orientation to a group of people from that site on the SASI tool and how to use it, and to talk about general plans for moving ahead. These initial visits were helpful in kicking off the use of the SASI tool and in serving as a catalyst for moving ahead on some integration activities that had been started at that site. The initial visits were conducted between September 1996 and February 1997.

The final site visits were conducted between the period of September, 1997 and April, 1998. The format/structure for each site visit included: one-on-one interviews with executive leadership at each site, a group presentation and discussion around work to date, and observations to and from NCCC. In most project sites, the group presentation included a simple "integration status report" exercise that each group member was asked to complete individually. Each person rated their organization's progress on the SASI objectives, as of that point in time. The individual scores were then displayed and an average score computed. These visits were helpful to the sites in marking their progress and considering their accomplishments and struggles as a group.

Following each site visit, NCCC staff prepared a report recording the statements of key executives, obtained through one-on-one interviews. Excerpts from these interviews appear on pages 17 to 21.

In addition, the NCCC hosted monthly conference calls. Conference call discussions were a great way to keep in touch with each of the sites and to have the group of sites share learning across the country. Even though the type and marketplace of the organizations involved were quite different, it is remarkable that there were so many similar struggles and so much that could be shared to help each other. The site representatives bonded through these conference calls and came to rely on each other as resources. The structure of the calls included: a quick update from each site on key integration/chronic care activities, and then a 30-40 minute discussion on a selected topic. NCCC staff facilitated the calls and wrote brief summaries of the calls. Over the course of the two years, topics included:

- comparison of healthcare system performance measures
- SASI scoring options
- extended care pathway development
- primary care issues
- merging cultures/partnerships,
- conducting cost/benefit analysis of chronic disease programs
- issues in creating rural networks
- population-based planning
- creating a continuum approach to assessing client satisfaction
- risk screening/risk ID
- defining case management
- information systems issues
- staff training for integration

In addition to these monthly conference calls, a number of representatives from each site and NCCC staff met three times over the course of the grant period: on April 7, 1997, on September 20, 1997, and on April 26, 1998.

Project Sites Overviews

Atlanta Senior Care/ Wesley Woods Geriatric Center

Atlanta Senior Care (ASC) is an interdisciplinary alliance of medical care, community service, and educational organizations that began as a loosely structured collaboration between community-based service organizations, hospitals, nursing facilities, home healthcare, and other organizations focused on the needs of older adults in the Atlanta area. The organizations collectively anticipated growth in the Medicare HMO business in the Atlanta area and the growing interest by the state of Georgia to launch a Medicaid or dually eligible managed care pilot program for older adults, and ASC partners wished to be prepared to capitalize on these developments. The organizations differed in size and scope, but were supportive of a common mission. The alliance was established to "plan, provide, coordinate, and manage an array of health and community support services to maximize health and independence of seniors in the most appropriate setting given their needs," and to be leaders in the Atlanta metro area for the provision of specialized medical, social, and residential services for seniors by integrating care across the continuum.

The idea for the alliance began with the CEO of Wesley Woods Geriatric Center. Wesley Woods Geriatric Center at Emory University is a comprehensive residential/geriatric health system with a central campus of services and facilities located in Atlanta and other facilities and services in surrounding areas. Services include an acute geriatric medical center, outpatient clinics in primary and specialty care, skilled and intermediate care nursing facilities, senior housing with personal care services, and linkages with other nursing facilities and community-based services.

Wesley Woods provided early start-up management support and resources to get the alliance off the ground. Given the organizations' common interest, vision and mission, they came together formally in late 1995/early 1996 for discussions and informational meetings to determine if they could serve as a "virtual network" offering an array of services to older adults through a risk-based or capitated financing mechanism. Over two and a half years, ASC worked to create a structure for itself and determine how it would move ahead.

This project site included both the alliance, Atlanta Senior Care, and the organization Wesley Woods Geriatric Center; SASI would be used differently for each entity.

Project Goals

The major goals for Atlanta Senior Care to participate in the SASI process and this grant were to:

- inform and educate all member organizations and their leadership of the importance of system integration,
- provide a forum for discussion of programs, services, financing, and the population to be served,
- identify an effective organizational structure for Atlanta Senior Care to facilitate system integration, and
- produce at least one "product" (e.g., a capitated Medicaid program serving frail elderly) which would serve as a springboard to serving other populations through additional products.

In January 1997, the Wesley Woods CEO hired a manager to be in charge of affiliated services and managed care activities for Wesley Woods, including the responsibility of providing support, guidance, and management expertise to Atlanta Senior Care. This individual provided ongoing support and day-to-day management for ASC activities and fostered the relationships with each of the organizations involved. In February, the NCCC staff provided an on-site orientation to the SASI tool and to some of the concepts and purpose behind

building an integrated delivery system. This highlighted the need for an approved system of governance and an overall business plan for ASC, as well as the need to examine current capabilities of sharing a core set of information (client specific, financial, etc.) across these organizations. The leaders from each organization of ASC worked over the next few months to formalize their management and governance structure. By April of 1997, they had created a comprehensive business plan for ASC and had signed Letters of Commitment incorporating a governance group and establishing Atlanta Senior Care as a limited liability corporation.

Leaders from several organizations making up the ASC also worked with representatives from the Georgia Medicaid office to put together a demonstration program targeting older adults living in the community who were frail and Medicaid eligible. The ASC worked on launching two products: their Medicaid demonstration program, called SOURCE, and a Medicare carve-out product.

At the same time, Wesley Woods and the Emory Health System were involved in merger discussions. The CEO of Wesley Woods was using the SASI tool to help identify major areas of focus for the new merged organization around chronic care populations.

How the Organization Used the SASI Tool

ASC used the SASI tool to:

- educate the leaders from ASC organizations on what systems integration means
- focus on the need for a management and governance structure for ASC
- underscore the need for shared objectives and shared risk to align incentives of partners

Wesley Woods used the SASI tool to:

- conduct an assessment on Wesley Woods' level of internal integration across sites of care
- identify key components of integration that would be important in moving ahead on the merger with Emory University

Major Barriers

Barriers for moving ahead included:

- cultural barriers—e.g. the medical orientation of some organizations versus the social orientation of others
- governance barriers—the need of each organization to have some level of input/control over ASC operations
- language barriers—e.g., every organization had a different definition and view of "case management"
- financial barriers—e.g., the level of investment possible by some of the smaller organizations was vastly different from the level of investment from larger organizations—the organizations had to debate what is equitable
- structural barriers—e.g., the incompatibility in information system hardware/software or the lack of information system capability

Major Catalysts

Factors which advanced progress included:

- senior administrator support for SASI and this process
- timely hiring of a skilled manager who took on the role of SASI facilitator and "diplomat" to the partner organizations, as well as day-to-day manager of the Medicaid SOURCE project
- market factors, which helped maintain partners interest in working together

Crozer-Keystone Health System

Crozer-Keystone Health System is a multi-organizational healthcare system, with services and facilities extending across the continuum of care, serving southeastern Pennsylvania. Facilities and services include: four acute care hospitals, many outpatient primary and specialty care services and clinics, two home healthcare agencies, two adult day care centers, four nursing facilities and two subacute care units (through an affiliation with Genesis Health Ventures), a comprehensive "healthplex" sports and fitness club, and several commercial, Medicaid, and Medicare managed care products offered through Health Plans of Pennsylvania—the health plan owned by Crozer-Keystone.

Crozer-Keystone used the SASI tool to enhance its efforts in creating a system-wide approach for managing specific diseases or conditions. This disease management initiative began in 1995 with an interest in developing a Congestive Heart Failure (CHF) program, called the Heart Success Program. Clinicians within Crozer-Keystone felt that care and cost outcomes could be improved by creating a different approach to managing the care of individuals with targeted chronic conditions such as CHF. With the leadership and project management skills of a cardiac nurse specialist and physician trained in geriatrics, Crozer created a clinician-driven interdisciplinary CHF disease management committee. Other potential diseases/ conditions were also identified (e.g., asthma, diabetes, frail elderly people), and Crozer created a Chronic Disease Management Steering Committee to guide these parallel efforts. The Committee is comprised of clinical and administrative leaders from many disciplines and sites of care within the system.

The Senior Vice President for Clinical Integration, a physician, provided the administrative authority and ongoing support for the work of this Committee and the development of these disease management programs.

Concurrently, Crozer had been selected by HCFA as a demonstration site to establish a Medicare Choice product for older adults through its health plan. Work was already underway to roll out this program to the community.

Following a SASI orientation/training visit by NCCC staff on October 30, 1996, the membership of the Disease Management Steering Committee was expanded to include key representatives from non-clinical disciplines, such as Finance and Information Services, consistent with the framework offered by the SASI tool.

In addition, Crozer formed a SASI Governance Group. The role of this group, comprised of 13 key senior administrators and executives representing all parts of the Crozer-Keystone system, was to take a "big picture" view of the entire system's integration efforts, focusing particularly on chronic populations. Members of this group were actively engaged in strategic planning and budgeting, trying to prepare for the increase in managed care penetration coming to their community. This group conducted an assessment of Crozer-Keystone Health System's capabilities according to the first four SASI objectives (Governance, Management, Information Systems, and Financing), using the *Workbook* and *Global Measures* sections of the tool.

The Medicare Choices demonstration pilot at Crozer's health plan (MedCare Plus) began enrolling patients in February 1997. Enrollment growth exceeded projections; however, early review of initial enrollees to this product raised concerns about adverse selection—there were several members enrolled in this product who experienced extensive healthcare needs soon after signing with the product. In addition, the number of enrollees/members of the product with a diagnosed chronic condition was high. Interest grew among health plan administrators in the disease management programs being piloted by Crozer.

The work of the Disease Management Steering Committee and of the SASI Governance Group, and the growing belief that disease management might help the health plan more effectively address the needs of the MedCare Plus enrollees, helped to highlight the need for an organizational structure and budget to support chronic disease management activities system-wide. Finding the necessary resources to get the disease management programs up and running was a struggle. As a result, they

created an Office of Disease Management (ODM), with a mission statement, goals, staff, budget, and reporting mechanism to senior management. While additional resources for launching new disease management programs will be continue to be needed, the existence of the ODM is evidence of Crozer's ongoing commitment to these special population subgroups.

Over the sixteen to eighteen months of observation, Crozer-Keystone Health System progressed on a number of fronts. In addition to the development of the organizational structure for an Office of Disease Management, there was growing awareness among senior administrators about the components of building an integrated system of care. The MedCare Plus product was launched, and the linkages between this health plan product and the activities of the delivery system were more closely forged. An affiliation with Genesis Health Ventures to offer long-term care and supportive services to older adults and others served by the Crozer system was established. Several specific chronic disease management programs were launched. Each chronic disease management program represents the efforts of an interdisciplinary group of people from Crozer, who have discussed, debated, and designed a preferred approach to the management of the disease of focus across the Crozer-Keystone system. The Congestive Heart Failure program, "Heart Success," completed Phase II of implementation and piloting, with extremely successful outcomes exhibited to date. The Chronic Frail Elderly program finalized the necessary care tracks and processes, and implemented a pilot program that has showed early positive results. Working groups for the Asthma and Diabetes programs formed and began meeting in August 1996, and pilots were launched in 1997 and 1998.

How the Organization Used the SASI Tool

Crozer-Keystone used the SASI tool and process to:

- educate senior administrators from Crozer on aspects of integration and realities of what that means
- gain support for disease management program development
- enhance disease management efforts by adding to composition of the Committees (e.g., finance manager)
- help forge linkages with the health plan around senior care issues

Major Barriers

The biggest barriers to moving systems integration forward at Crozer (particularly the kind of integration required for successful implementation of the chronic disease management program) were:

- the difficulty in convincing others that this population management approach would have financial benefits long-term (short-term cost concerns dominate at times)
- the difficulty in achieving consensus about what to do among different clinicians
- the need for much improved outcomes tracking, both clinical and financial outcomes— the lack of an integrated IS hampered efforts greatly
- the "turf issues" which can and did arise within/between disciplines
- the reality of many priorities within Crozer that could draw people away and reduce the effectiveness of the Committees working on the disease management programs

Major Barriers/Catalysts

Contributing factors that helped advance efforts at Crozer included:

- Project management, group facilitation, communication, and organizational skills of the project manager providing ongoing support and guidance for the disease management efforts
- Tangible support from senior administration and from key physicians for the development of these disease management programs.
- Involvement and interest of a number of key clinicians, e.g., geriatricians, endocrinologist, pulmonologist, and of other key areas, e.g., pharmacy, case management/social work, IS, finance.
- Developing the partnership with Genesis Health Ventures, e.g., this organization was able to contribute the skills of a geriatric nurse practitioner to the disease management efforts
- Grant money received from a pharmaceutical company that was helpful in implementing the asthma pilot.

Fairview Hospital and Healthcare Services

Fairview Hospital and Healthcare Services is a large multi-organizational healthcare system with facilities and services throughout the state of Minnesota. Fairview has grown tremendously—from 8,000 employees to over 20,000 in just two years. Fairview now has eight acute care hospitals, including an academic medical center (the University hospital), 33 primary care clinics, seven home care agencies, 13 adult day care centers, 22 subsidized senior housing buildings, 24 nursing homes, and specialty services, such as an Alzheimer's unit, a Multiple Sclerosis Center, services for the deaf, geropsychiatric services, a community-based case management service, transportation services, retail pharmacies, rehabilitation services, and hospice.

Fairview had the longest history of any of the project sites in using the SASI tool. They used a draft version of the SASI tool in April 1995 to help craft the affiliation agreement and measure integration between Fairview and Ebenezer Society, (a long-term care and community-based services organization).

At that time the Fairview staff used a simple method to convert the qualitative reviews in SASI that were made for each objective into a quantitative score. Every person had one vote, using a scale from zero to four, with four being the most integrated or complete score. Each person voted once on each objective. The numbers were tallied and an average score was computed. This average was then shared with the group again to make sure that it seemed like a true consensus. The final score for each objective was recorded. Fairview used this same method of scoring when they made subsequent assessments using the SASI tool.

In late fall, 1995, they formed a joint committee of the two organizations, called the Chronic Care Systems Committee, to oversee implementation of the Fairview/ Ebenezer operations plan, use SASI to assess current integration and enhance progress around chronic care integration, and make recommendations to a senior level management committee regarding changing service mix, refocusing specific efforts, and guide future thinking around serving this population. Subgroups of the Chronic Care Systems Committee (CCSC) were formed around each SASI objective, and the *Global Measures* and *Workbook* sections of the tool were finished by fall, 1996. The SASI subgroups then came together as a full group to review the assessments and provide additional input and reaction. This was a valuable process, which resulted in greater awareness across the system about current initiatives. Some assessments were modified as a result of this group meeting. The Chronic Care Systems Committee used this information to create a set of recommendations that were presented to the senior management group in January of 1997.

Early in 1997, Fairview launched the development of nine clinical integration service lines, including a Chronic Care service line. The main focus of efforts during the grant period was on putting the administrative and medical leadership structure together for each service line. SASI continued to be used as an evaluative or framework tool for the chronic care service line.

The year 1997 was a year of transition for Fairview. Two significant mergers were conducted—the first with the University of Minnesota Medical Center, and the second with the Board of Social Ministry (a nursing home and senior housing system, with facilities primarily outside of the Twin Cities). Fairview more than doubled in size and greatly expanded its service area.

Major Barriers/Catalysts

During this grant period, a number of activities required significant internal energy and resources—especially the merger with the University of Minnesota. With its supertertiary capabilities and national patient base, the new Fairview University Medical Center presented new opportunities for chronic care integration, but also required attention in order to build the internal relationships and infrastructure between Fairview and the University of Minnesota. There was a lull in the use of SASI as the University staff came on board and as the clinical integration service lines were being developed. The timing of these activities was such that Fairview found itself focused much more on assimilating all the new staff, new organization, new cultures, than in conducting an evaluation of itself. Therefore this organization did not make as extensive use of the SASI tool in 1997 as it had in 1996.

Loretto/Health Partnership for Seniors

Loretto is system of services targeted to older adults, governed by a community-based Board. The mission of Loretto is to assist older adults and those with chronic conditions to enrich their lives and maintain wellness. The Loretto system includes a comprehensive array of housing options and community and residential based healthcare services. Loretto facilities and services are primarily located in Onondaga County of Central New York State. Services and facilities include: four independent living facilities, seven supportive living facilities, a PACE program, community residences for the developmentally disabled, three nursing care facilities, a diagnostic and treatment center, adult day medical care, transportation, respite care, home care, and case management.

In June 1996, Loretto and a local hospital, Community-General Hospital (CGH) signed a partnership agreement to link their respective systems of care into an integrated chronic care system. This was not a merger, but rather an agreement to work together. Community General Hospital is a 356-bed facility providing acute medical care, psychiatric services, subacute care, and skilled nursing care. Loretto also approached a local physician's group, Community Physicians Group, LLC, with 233 practicing physicians, to be a partner in improving care through increasing integration between the hospital, the long-term care services, and the physicians' services.

Loretto's main goals in participating in a self-assessment process were to:

- work with the Loretto and Community-General Boards to create a shared vision for a more integrated system of care
- develop key functional elements of the system, e.g., case management, financing, information services
- develop and implement methods to ensure customer feedback as the integrated system evolved.

The partnership of Loretto and CGH, called "Health Partnership for Seniors" wished to use the SASI tool as a framework for moving ahead. Following a training session conducted by the NCCC on September 3 and 4, 1996, a senior executive from Loretto presented the SASI tool to two committees of the developing alliance made up by these three organizations. This Leadership Committee and Operations Committee endorsed the use of the tool and their respective roles in performing a self-assessment of this organizational alliance. Loretto served as the lead in familiarizing CGH staff and others with the SASI tool.

In early 1997, the Operations Committee served as a SASI team and conducted a snapshot assessment of the multi-organizational alliance around the nine objectives of SASI using the *Global Measures* section of the tool. In February and March, this same committee divided into subgroups and completed the *Workbook* section of the tool, which helped to identify barriers and goals for the alliance for each SASI objective area (e.g., governance, management, information systems, financing, risk identification, service/program development, care management, transition planing, and client involvement). The Leadership Committee developed and reviewed a matrix of tasks. They reprioritzed tasks as necessary and established a six-month plan.

By mid 1997, the alliance was officially incorporated and a business plan for the alliance written. Unfortunately, the marketplace was in retrenchment. Several insurers in upstate New York dropped their involvement in Medicaid managed care, and backed off of Medicare-risk products that had been proposed. Therefore, the alliance found itself needing to retool their activities to fit with a fee-for-service dominated market that was unlikely to change in the near future. Loretto and CGH worked on certain key issues that would improve service to their common clientele, especially focusing on their intake, discharge, and transfer procedures. The two organizations also worked with the Boards to continue to educate on the components of integration.

Major Barriers/Catalysts

The major barrier to moving ahead has been the lack of marketplace interest in capitated, risk-based products. Fee-for-service payment still dominates, and the lack of managed care penetration greatly impedes efforts to create a coordinated, longitudinal, disability prevention approach to care.

The main factors advancing efforts included: staff leadership and CEO support, and the ability on the part of Loretto and CGH staff to build a partnership.

Saint Vincent Hospital and Health Center

Saint Vincent Hospital and Health Center is a Catholic, not-for-profit institution owned by the Sisters of Charity of Leavenworth/ Health Services Corporation. Saint Vincent Hospital and Health Center, located in Billings, Montana, is a 314-bed acute care facility, with a wide array of medical, rehabilitative, and subacute care services. Saint Vincent Hospital, through its Medical Group Practices Division also employs physicians to offer outpatient and ambulatory services. The hospital's service area extends 250 miles east and west. The population area served by Saint Vincent Hospital is approximately 460,000 people with over half of this population living in rural areas. Billings is a two-hospital town. Managed care penetration is still extremely low—less than 15 percent penetration. The state of Montana has one health plan, and that is one that the hospital developed in 1994 together with Montana Associated Physicians. The health plan, Yellowstone Community Health Plan, was selected in 1995 to participate in the HCFA-sponsored Medicare Choices demonstration.

Over several years, beginning in 1993, a team from Saint Vincent Hospital explored ways to improve healthcare delivery to the senior population and the chronically disabled in Billings and Yellowstone County. This team, called the Long Range Planning Committee found that current services were fragmented and often duplicated, and that there was a lack of focus on preventive services. Members of this committee began to develop a plan for creating an integrated network of service to seniors, both owned and non-owned services, and to include Yellowstone Health Plan in these efforts. This developing network was called the Community Healthcare Network.

Following a SASI orientation/training visit by NCCC staff in December of 1996, Saint Vincent put together a team of stakeholders, physicians, managers, administration, health plan representatives, and others to conduct an assessment using the SASI tool. The assessment highlighted the fact that home health care was a missing piece of Saint Vincent's continuum of services. Also, in several places within the system, staff were duplicating efforts—for example, in defining a case management model and risk screening method. In addition, certain areas were weak, i.e., information technology. The team chose the incoming Medicare Choices enrollees as the target population.

During the spring and summer of 1997, Saint Vincent restructured several key areas within their system, bringing geriatric services, inpatient and outpatient rehabilitation therapy, case management services, and several related areas all under one Continuing Care Division. With this structure as a foundation, the system worked to revamp case management services, designing tools and methods that would serve a frail, community-based older population (in preparation for the Medicare Choices product). In addition, St. Vincent established a geriatric medicine clinic that could serve as the primary care provider to enrollees, as one of their choices within the health plan product. The clinic would be staffed by allied health professionals—nurse practitioner, physician assistant, and nurses—and would offer an extensive case management service, especially for high risk clients. By fall of 1997, the health plan Medicare Choices product had more than 1000 enrollees, including many who had chosen the geriatric medicine clinic as their primary care provider.

Major Barriers/Catalysts

The significant internal changes, as Saint Vincent's added other hospitals and expanded its geographic region of focus and as it restructured several departments, were barriers in that they caused a fair amount of upheaval and staff stress. With staff leaving and others coming on and others changing roles, this affected the ability of the SASI teams to move ahead. Also, the phase of marketplace—still acute care oriented and fee-for-service dominated—was a hindrance, at times to those who were trying to change mindset of other providers to encourage a more long-term perspective on needs and coordination across settings and over time. Money and time served as constraints as well. One of the major barriers also served as a catalyst. The internal changes, once they were worked through, did bring key expertise and operations together. The Continuing Care Division is much stronger and more able to move ahead than it would have been otherwise. Other factors that were very important in advancing integration efforts were: the top notch staff leading the effort, and the strong CEO support.

The Self-Assessment Process

As described, all five project sites maintained an effort over 18-24 months to use the SASI tool as part of their work to integrate care across settings and service—despite the fact that none of the organizations received any financial assistance for doing so. The process used by the sites to conduct the self-assessment included:

- a review by the champion/key contact person of the whole tool
- an orientation/training session conducted on-site by NCCC staff, supplemented by additional sessions conducted by the key contact person (the "champion") from the site
- the creation of a "SASI" team, often with sub-groups identified, and a process outlined for conducting the assessment
- group meetings and discussions, where the assessment was conducted
- a group review of results, often with modifications
- a reporting of results to others, including senior managers
- identification of next steps, which often included modifying current initiatives to make them more comprehensive, and to involve additional key disciplines/perspectives

Within the first year, each project site had put together a team and used the SASI tool worksheets to conduct a self-assessment across their system on the 9 key objectives. The worksheets and measurement results were provided to NCCC. Common themes and issues emerged from the assessments. Barriers to achieving the goals outlined in the tool often included lack of understanding on what integration means, or inability to think "system" versus department or facility, as well as time and money constraints. Strategies for moving ahead often included education/training, further development of a system-wide infrastructure, and better evaluation methods to measure results. The table below and on the next page provides highlights for each objective.

Highlights from SASI Project Sites' Self-Assessment on Barriers and Strategies by Nine SASI Objectives

SASI Area	Barriers	Strategies
Governance	• Need for systems thinking on the Board • Size, composition, structure of the Board • Lack of awareness of chronic care/chronic populations	• Board education • Change size, composition, and structure • Establish accountability within the Board for special populations, e.g., a committee of the Board
Management	• Time, money constraints • "People issues," e.g. lack of understanding of a continuum approach • Lack of information systems to support chronic care • No ROI criteria or measures that take into account important indicators for chronic care	• Dedicate office of chronic disease, establish line of authority • Orientation for key staff chronic care and continuum • Develop IS workplans that include tracking chronic populations • Set management goals that take into account chronic care and measure activities against them

Highlights from SASI Project Sites' Self-Assessment on Barriers and Strategies by Nine SASI Objectives

SASI Area	Barriers	Strategies
Information Systems	• Costs of IS upgrades and hardware • No agreement on what information is needed nor standards for sharing • Lack of knowledge or expertise in establishing IS across settings • No operational plan to guide IS • Staff/practitioners not prepared to interpret data	• Define CCN information needs more clearly; create a data set group across the network specifically for chronic care • Review current systems and their interface ability • Create an infrastructure for IS planning that fits into overall network IS plan • Training/education on data analysis and interpretation
Financing	• Missing links in services funded • Some providers have few capitated lives • Do not have good cross-network cost or actuarial data upon which to base rates • No performance data to serve as a balance to cost focus • Discord between revenue and delivery side	• Secure more capitated contracts allowing for greater flexibility in service provision • Analyzing existing cost data across services and tie data together • Establish performance indicators, track outcomes of pilot chronic disease programs • Establish guiding principles and open dialogue between contracting and delivery
Population Profiling/ High Risk	• IS inadequate for population profiling • Lack of system or process for soliciting client and family input on needs, preferences • Low or no enrollment—can't justify expense for risk ID	• Seek better information sources, e.g. employers, health plans • Create focus groups of patients, families, community • Work toward greater enrollment groups
Full Service Array	• Contracts not based on risk sharing between providers; no financial incentives • No consistent vision for preventive services • Lack of feedback to/from community agencies regarding services consumers need and the availability/quality of existing services.	• Obtain more risk-based contracts with other providers • Conduct pilots around disease groups with preventive efforts tracked • Create feedback mechanisms with community agencies
Care Management/ Disability Prevention	• The network's coordination infrastructure is immature, weak • Lack of support for care management tools already developed • Lack of core competencies across the network to apply tools; knowledge base varies by practitioner • No major pressures financially to managed care differently (yet) • Network is not directed to outcome-based practice	• Continue disease management pilots that help demonstrate effectiveness of integrated care management methods and tools • Integrate human resources and technology across the whole network (minimum level of competency) • Work toward more integrated financial systems that promote disability prevention • Create population "teams" to develop and implement plans toward reorienting to outcomes-based practice
Seamless Care	• No integrated IS to support seamless care • Organizational infrastructure does not support an integrated approach • Limited number of practitioners with expertise to work in teams, to coordinate care • Professional turf issues over roles and responsibility for transitions	• Work toward IS or data sharing across sites • Employ and support practitioners with skills and expertise in this area • Establish clear guidelines for responsibility for transfer and patient education
Client Involvement	• No consistent way to promote client involvement • Lack of training to think/work with patients in this way • Unclear delineation of roles and responsibilities	• Develop a co-management care delivery approach with patients • Have clients on care pathway teams • Establish system for accountability and shared decision-making

Project Site Interviews

As a part of her coordination and documentation of this project, Deborah Paone conducted interviews with senior executives at each of the project sites.

The following pages contain excerpts from these interviews. In some cases, the answers may be compilations of responses given by different executives at the organizations.

Atlanta Senior Care/ Wesley Woods Geriatric Center

Q: If I say the words "system integration" or "network integration" —what do these words mean to you and your organization?

A: To survive, organizations have to connect to other services along the continuum. Inevitably, managed care will come to town—hospitals have to learn the importance of long-term care services, organizations have to learn how to manage people in their home. Systems thinking goes beyond the boundaries of the institution, beyond traditional roles. In a truly integrated system, the set of organizations work together efficiently to provide everything a person needs to work toward their health/social goals.

Q: Looking back over the last 18-20 months, how has your thinking about system integration evolved?

A: In integration activities with other organizations who may have different language, culture, approach, etc. the client is the common denominator—this is so *important.* Infrastructure pieces have to be aligned with integration goals to make it work. Culture is also very important.

Q: What are the methods or strategies that you've employed that have been most successful in moving your organization ahead?

A: One method that works is to bring integration down to the client level to make it real. Almost everyone wants to do better for their patients. The SASI tool identifies all the important aspects of integration; the framework it presents is not a formula, though, it is a way of life. People need to begin thinking and seeing this way. Without a governance and management structure, you probably don't get integration—these key stakeholders have to be on board. CEO leadership also is important.

Q: How has the work with the SASI tool fit into your integration or managed care efforts?

A: It is helping us as a blueprint for the important aspects to think about and talk about, either internally or with our partner organizations.

Q: Has the SASI tool had any impact on your organization or on key people or activities within your organization? Describe this impact, if any.

A: Through my work with SASI and the NCCC I've begun to think differently about what business we're in—we are here for the older person, we are part of a bigger "system" of care. The infrastructure pieces have to be aligned with this. The culture of the organization must support this.

Q: What would you recommend to other organizations considering using the SASI tool and process? Would you enhance the tool or process in any way?

A: The SASI tool is flexible enough to be used by many different types of organizations. It gives a framework for the important things to think about/act upon. It doesn't dictate a solution. As with many things, though, implementation is key—once the SASI assessment is done, the organization must move ahead to perform activities that address the deficits uncovered. Otherwise, the assessment has gone to waste. You need a champion and top administrative support to make it happen.

Crozer-Keystone Health System

Q: If I say the words "system integration" or "network integration" —what do these words mean to you and your organization?

A: It means that all the pieces of the system work together; that applications, such as information systems, other infrastructure pieces, are focused on overall goals, not only one piece of the system. It means that there is a level of commitment to overall goals that forces compliance, if parts of the system are unwilling (at first) to make changes for the good of the whole. It means continuum of care—even though that term is overused. It means seamless care for a population.

Q: Looking back over the last 18-20 months, how has your thinking about system integration evolved?

A: The last year or so of activities have confirmed my opinion that one needs to have senior management involved to keep commitments—a group that has the authority to act, make decisions. When we got involved in SASI and this grant, we had already made strides toward creating an integrated system. For example, we already had one board, and we had already combined IS across the system to report to one person at the network level—same for Finance, and the management of our acute hospitals. We had the leaders assembled.

System integration is now higher up on the corporate radar screen, as is disease management. There are more identified champions than there were. Our ability to manage chronic disease is extremely important. Also there is more consistency of the message across the system—In a recent presentation by different individuals from different parts of the system, there was amazing consistency, very complementary activities—it was good to observe this.

Q: How has the work with the SASI tool fit into your integration or managed care efforts?

A: The tool was easier to use for us, because we had already developed a sense of a system. The tool gave us a framework to bring the pieces together. It gave a focus to our efforts, and helped us prioritize activities by seeing where we had gaps and where we wanted to go. It was an assessment, exactly as it is described. Out of this work comes a list of possible initiatives.

The tool and process helps everybody stay on the same page and is consistent with good planning. Our health plan is a laboratory to test out the population management approach that is in SASI. The value of the tool in the way we have used it (at two levels: senior management and then with specific clinical disease initiatives) provides an important opportunity to get very high level people within the organization involved.

Q: Has the SASI tool had any impact on your organization or on key people or activities within your organization? Describe this impact, if any.

A: Yes, it clearly had an impact—even for people who weren't involved in specific efforts. This thinking/framework percolated throughout the organization. Now we are more ready to use the Disease Management Office as a resource to identify key issues. Also, we have a plan Task Force; we are creating action lists and becoming more organized about priorities, but we could use SASI for the health plan itself.

Q: What do you feel are the greatest challenges in moving ahead?

A: Getting buy-in from the physicians and case managers for the disease management programs. Also, we need a financial methodology that shows that disease management programs, when assessed on a longer term horizon for evaluation, make sense. How do we get the buy-in for programs with upfront costs otherwise?

Fairview Hospital and Healthcare Services

Q: If I say the words "system integration" or "network integration"—what do these words mean to you and your organization?

A: The words mean integration from a customer's perspective; the endpoint is improved satisfaction. It means how the customer perceives us—for them things like a reduced price, services that are easy to use, and care that is consistently good—these are the things they are interested in.

There is a difference between what is in the "system" (which I see as a wholly owned multi-organizational company) and the "network" (which can include other, non-owned organizations as key partners/affiliates.

Q: What is your long-term vision for this healthcare delivery system?

A: To have the system be affordable, reliable, comprehensive, produce good results, and be easy to use.

Q: Looking back over the last 18-20 months, how has your thinking about system integration evolved?

A: Systems integration is very difficult. There is a loss of identity—we sense our borders eroding as we move from a facility orientation to a systems orientation—it is hard for staff and others for whom the past orientation has been familiar, comfortable and rational.

Q: What are the methods or strategies that you've employed that have been most successful in moving your organization ahead?

A: CEO and executive leadership has been important. Having physicians be part of the process, especially in the service line development—this is critical. Integrate around define subgroups and then you can measure success more concretely. Our outcomes from the MS center have been phenomenal.

Q: How has the work with the SASI tool fit into your integration or managed care efforts?

A: The systems integration agenda and the chronic care agenda are compatible . . . if not the same. The reason for system integration is better care; the reason for coordination across the continuum for chronic populations is better care. I see SASI as a systems integration tool which can be applied to a chronic care population. The work with SASI has been key to creating a baseline for our chronic care service line. SASI helped us provide strategic direction and measure our progress toward clinical integration. We have used the SASI model many times to describe integration to people and show how things fit together.

Q: Has the SASI tool had any impact on your organization or on key people or activities within your organization? Describe this impact, if any.

A: Yes. SASI has been helpful in organizing the Chronic Care Systems Committee (active in '96 and '97). Several people have gained additional awareness about what integration means through SASI.

Q: Please discuss other key issues that you think are important with regard to system integration and/or chronic care populations.

A: Don't try to achieve system integration from the middle of the organization to push it up (or down). Make sure that it is a top priority at the senior management level/Board level. The necessary transitions that will occur over time are threatening, cumbersome and chaotic. Senior management needs to be on board, expect some element of chaos, be willing to work through this change process, and show a constancy of purpose at critical stages in the evolution to the integrated system.

Loretto/Health Partnership for Seniors

Q: If I say the words "system integration" or "network integration"—what do these words mean to you and your organization?

A: It means 'continuum,' 'seamlessness,' for the client/customer; ease of movement from one place to another; breaking down walls; developing partner organizations. There is internal integration and external integration. Integration activities have to be maintained at two levels—this has been a challenge. We need these concepts to trickle down to individual sites, facilities.

Q: Looking back over the last 18-20 months, how has your thinking about system integration evolved?

A: Our thinking about systems integration has changed—more things can be shared than we thought could happen. We were more exclusive a year and a half ago, but we did not need to be as exclusive (e.g., in working with just one hospital) as we thought.

Last year was an eye-opener for us; we formed new relationships and began to understand what those partnerships would mean. We have moved up a tremendous learning curve over the last 18 months. The number of access points are so many and so varied. There are many opportunities for improving continuity. We see a need for better outcome measures—ones we could have confidence in.

Q: Has the SASI tool had any impact on your organization or on key people or activities within your organization? Describe this impact, if any.

A: SASI was the springboard for our discussions; it provided the framework for those discussions. The SASI tool brought the groups together and helped form the relationships and set targets for what we wanted to do. The SASI meeting(s) were helpful to us in understanding our common goals—new and interesting ideas emerged about how to accomplish some of the objectives in SASI, e.g., to develop pathways, etc.

The impact on our organizations included a change or evolution of our culture—we became immersed in the NCCC vision; we pushed ourselves and our partners to try harder. A real positive, a turning point, was the Board education that we did with the assistance of a couple of well-schooled Crozer-Keystone staff leaders, and people like Connie Evashwick, and attendance at the NCCC National Conference—these things all reinforced the message and brought it home to us.

The SASI tool gave us a chance to understand what an integrated system will look like, what it will be.

Q: What are the methods or strategies that you've employed that have been most successful in moving your organization ahead?

A: The SASI meetings; bringing in the outside experts I've mentioned; networking with the other SASI sites and NCCC members; our face-to-face SASI meetings where our partners attended and our conference calls—these things have been very helpful. Focusing on common goals. Finding areas where we could make a difference in the short-term

When we went through objectives seven, eight, and nine—these related to care management and disability prevention and "seamlessness" of care—we learned a lot; we identified many potential areas for blending our work together. We're now planning to do a 10-person study where we follow these individuals through settings and services and learn from their care experiences.

Q: What would you recommend to other organizations considering using this tool?

A: Connect up with others who are leaders—the networking and support is valuable. Remember that SASI is a process as much as a tool.

Saint Vincent Hospital and Health Center

Q: If I say the words "system integration" or "network integration" —what do these words mean to you and your organization?

A: Coordinated care through affiliation contracts between and among service providers for efficient cost effective healthcare.

A grouping of healthcare providers working together for a defined community.

Providers are connected for the patient's best interest. Before we link, we have to learn to meld our visions. Providers have to want to connect to make it all happen.

Q: What is your long-term vision for this healthcare delivery system?

A: I see our system becoming regionalized; the hospital, health plan, long-term care services—will all come together, resulting in high quality, cost-effective healthcare for people served. Patients and families will evaluate a team of providers as working together for seamless flow of care.

Q: Looking back over the last 18-20 months, how has your thinking about system integration evolved?

A: More than ever, I see the need for coordinated services across the continuum and the need for collaboration among service providers. Patients are the focus and reason for healthcare services, so changes need to be made to serve their best interests.

Integration is necessary, but it is a long process. No one entity can accomplish mush on its own—it is a group effort.

We were thinking about the system in a small way prior to this effort—we have moved out of the acute care box and are now realizing the system is much larger. Also that we don't and shouldn't do everything—we are moving more toward developing partnerships.

Q: What are the methods or strategies that you've employed that have been most successful in moving your organization ahead?

A: Restructuring of our network—bringing all stakeholders under one governance; dividing up accountability among and between team leaders so everyone feels a part of the strategies. Getting buy-in at all levels of the organization. Having the right person lead many of our efforts. Having common goals. Understanding of the importance of continued education.

Q: How has the work with the SASI tool fit into your integration or managed care efforts?

A: The SASI tool helped us to look a little deeper at ourselves and our activities. It increased the level of cross-site communication—there were things going on at different levels or parts of our organization that the other didn't know about. SASI helped shine a light on this and that helped us to do something about coordinating our efforts.

Q: Has the SASI tool had any impact on your organization or on key people or activities within your organization? Describe this impact, if any.

A: It prompted restructuring efforts so there was less turfism and more collaboration among providers. We've had a realization that systems are bigger than one part plus one part plus one part.

Q: What would you recommend to other organizations considering using the SASI tool and process?

A: Start at the top (the Board, the senior administrators, etc.) with emphasis on education, purpose of the tool, methodology, and the many ways the tool can be used to further integration efforts. Get buy-in at as many levels as possible. The organization using this tool has to be committed to moving ahead on integration efforts, and needs to devote resources to that effort. A person who oversees the process and commitment from the top levels of management are also necessary.

Project Site Accomplishments

Specific key accomplishments of each site are highlighted below:

Atlanta Senior Care/ Wesley Woods

- Wesley Woods CEO hired an experienced administrator/manager to provide structure and ongoing management for Atlanta Senior Care in January, 1997.
- In 1997 several organizations from within ASC launched a pilot Medicaid program for frail elders, called SOURCE, working with the State of Georgia.
- A governance structure and an overall business plan for ASC was put together.
- Atlanta Senior Care was incorporated as a limited liability corporation (LLC).
- Wesley Woods entered into negotiations with their long-standing acute care partner, Emory University which resulted in an asset merger.
- Wesley Woods used the SASI tool for their internal efforts to improve integration over their long-term care campus.

Crozer-Keystone Health System

- Formed a senior management level "SASI Governance Group," focusing on system-wide issues
- Created an Office of Disease Management, with a mission statement, goals, staff, budget, and reporting mechanism to senior management.
- Established several multidisciplinary steering committees to create a condition-specific disease management program for diabetes, the "frail elderly," and asthma. These committees were enhanced with representation from the finance and information system areas within Crozer-Keystone.
- Pilot tested and implemented several disease management programs, with early positive results.
- Rolled out Crozer-Keystone's health plan's Medicare Choices product to the community.

Fairview Hospital and Healthcare Services

- Formed, in 1995, a Chronic Care Systems Committee to oversee implementation of an affiliation between Fairview and Ebenezer Society and to use SASI to assess current service to chronic care populations served by Fairview. This Committee completed its assessment in 1996 and made recommendations to senior management in 1997.
- Conducted an asset merger with the University of Minnesota hospitals and clinics.
- The Ebenezer Society conducted an asset merger with The Board of Social Ministry—a large organization with nursing homes and other long-term care services in many regions of the state of Minnesota.
- In early 1997, launched the development of 9 clinical integration service lines, including a chronic care service line. This continues to be a major effort to redefine clinical care and service delivery across the Fairview/University set of services and facilities.
- In 1996 and 97, formed "functional integration teams" around several key components of the Fairview system, e.g., laboratory services and pharmacy. These teams reviewed current operations and

made recommendations which have resulted in management and infrastructure changes in these support services—working to tie facilities and services together system-wide.

Loretto/Health Partnership for Seniors

- Provided Board training to increase understanding of systems integration components/issues
- Improved continuity of care between Loretto and Community General Hospital;
- Provided information to patients and families on the alliance;
- Provided some joint patient education programs;
- Formed a limited liability corporation with an acute care partner—Community General Hospital, and began exploring joint program development with another acute care partner to better serve common clients/patients;
- Increased communication between the 2 organizations, set up channels of communication; increased organizations' ability to solve problems;
- Stopped patient dumping by increasing the awareness and understanding of intake and discharge staff about levels of care and service capabilities and by establishing regular communication and increasing access to decision-makers in a timely way;
- Created several tools (e.g., the assessment tool and triggers, the hospital transfer form);
- Worked on joint marketing efforts for programs serving similar clientele;
- Wrote several joint grant proposals;
- Worked with physicians that the two organizations both had on staff, focusing on things like lab and X-ray;
- Set up the Loretto CARES info system data base to connect to the hospital emergency room;
- Established same day admission procedures for home health;
- Began working on developing pathways across the system
- Increased planning efforts for a roll-out of a PACE program targeting frail older people.

Saint Vincent Hospital and Health Center

- While Saint Vincent continued to respond to a larger system reorganization process, they completed an internal reorganization to bring senior services, rehabilitation, and community services/case management under one management structure.
- Yellowstone Community Health Plan (owned by St. Vincent) rolled out their Medicare Choices product for older adults.
- Worked with local officials to acquire a home care agency.
- Developed, through a partnership with a local nursing home, assisted living units for seniors.
- Established a new seniors primary care clinic, staffed by a physician assistant, nurses and case managers, with oversight by a well-respected physician. This proved to be a successful clinic, attracting many seniors to the Medicare Choices product and to Saint Vincent.
- Saint Vincent developed and staffed a case management model/service that provides good assessment, care planning, service provision, follow-up, and monitoring, especially for frail older adults.

Project Site Challenges

The key contacts at each site reported ongoing challenges in advancing integration, including:

- Changing organizational structures—four out of the five organizations experienced significant organizational change in the form of mergers and acquisitions or extensive internal reorganization

- Multiple internal priorities—these organizations had many "irons in the fire;" this contributed to the time pressures and competition for resources that every site reported facing during this time period

- Internal resistance to change on the part of colleagues or on the part of certain key stakeholders/partner organizations. This was attributed to lack of understanding about what integration really means or a lack of a common vision for how to best serve the community/clientele. This was also experienced as defensiveness by others to protect their turf, possibly due to fear in their own ability to respond to required changes.

- Marketplace factors—low managed care penetration, for example, served as a barrier for one site in that it was not there to "force the issue;" showing that system-wide integration was an immediate important objective to work toward

- The self-assessment process was new to many people—it was hard for staff to make the mental shift required to think beyond a single facility or services to thinking about the whole system as one unit.

- After the assessment, organizations were not sure how to proceed—there seemed to be so many ideas or areas for improvement, and a lack of time, money, or sufficient authority to pursue all of them

Findings

Characteristics of Effective Organizations

Several characteristics emerged that seemed to contribute toward integration efforts:

- Forward-thinking and acting CEOs or senior leaders
- One or two key staff who served as champions of integration to improve care for clients/patients—these champions had the clear support of senior management and had authority to make changes
- Partnership-friendly organizations that were willing to put in time and effort to build relationships with other organizations—every organization extended itself in working with other non-owned organizations. Three of the five organizations spent considerable time in working with partners who were actually part of their "SASI team."
- Good team dynamics and a culture of shared learning within the organization or the set of organizations making up the "team"—enough team players were on the groups to pull others along.

Organizations that made the most progress in this timeframe also had:

- Visible physician leadership in integration efforts focusing on a chronic care population
- A tangible initiative that was being implemented with a clearly defined target group (a chronic care population identified and being "enrolled" in a program) that the CEO identified as important

Knowledge Gained About the Self-Assessment Process

The process of self-assessment is new to many organizations—healthcare professionals are more familiar and comfortable with an accreditation or certification process where an outside agency comes in to evaluate certain aspects of the organization, and ensure that specific requirements are being met. Self-assessment, however, relies on the judgment and abilities of internal staff. A new thought process and different skills are required.

Findings regarding the self-assessment process included:

- The composition of the team performing the assessment was important. The most effective teams had different settings/facilities represented (e.g., hospital, home care, nursing home care, physician office or primary care clinic, community-based services), and different disciplines and technical expertise (e.g., physician, nurse, social worker, and experts from Information Services, Finance, Strategic Planning and Quality Improvement).
- Team members had to be high up enough in the organization to be able to effect operational changes but not so high as to be removed from day-to-day issues.
- A kick off orientation/training was important—key contact representatives reported it was helpful to have NCCC staff do this session on-site. Also, a 12-minute videotape was used in orientation; this *Mrs. Dorothy Peterson* videotape traces the progress of a 72-year old woman through the healthcare system and set of post-acute services following her stroke. The video was extremely valuable in gaining the attention and support from clinical staff and in centering focus on the main reason to integrate, i.e., to improve care to the client across a complete set of services so that needs are met from the patient's perspective.
- The NCCC conducted monthly conference calls around key topic areas; these calls helped structure and enhance shared learning across the five sites. During those calls, each site provided a brief update on recent activities, and then participants would discuss one critical component of integration.

Knowledge Gained About the Self-Assessment Process

The project sites made several comments or recommendations about the SASI tool and process:

- The Workbook and Global Measures sections of the tool were most useful. Sites preferred completing the workbook section first (with one worksheet for each objective) and then the Global Measures.
- The SASI tool has many pieces and this, at times, made it seem like a daunting task to use it. The language, words and style did not always match that of the organization—so organizations "translated" sections of the tool to match their own language and culture.
- A few case studies, illustrating how to move ahead on a particular objective following the self-assessment process, would be helpful.
- The tool process should require that a person from Information Services, Finance, Human Resources, and Quality Improvement/Performance Measurement be involved in the self-assessment process and part of the SASI team. Much of what comes out of a self-assessment such as this can result in activities being proposed that will affect these areas or that require the buy-in and expertise from these areas.

Advice from Project Sites

Project participants offered advice to other organizations using the SASI tool:

- Identify a "champion of the cause" for system-wide coordination and integration for a defined population
- Make sure that at least one person is familiar with the SASI tool and has sketched out a process that will be used to conduct the assessment.
- Conduct a kickoff training and orientation session. Help people understand that the assessment is for the entire set of services/facilities/programs that deliver care to the defined population group in order to maximize care and cost goals. This is a system self-assessment, not a single facility assessment.
- Tie the self-assessment process to identified corporate strategic directives/goals, so that the assessment is seen as a way to accomplish these goals—not an exercise that is apart from these goals. Involvement and interest will be higher if self-assessment is perceived as helping to accomplish "something we had to do anyway," rather than an "add-on."
- Complete the two "measurement" sections of the SASI tool at the same time (the Workbook and Global Measures).
- Select a scoring system to use to translate the group's assessment of progress for each objective into a number or percentage. SASI includes several options for scoring the objectives—select one and stay with that method for comparison across time periods.
- When discussing the organization's progress pertaining to a specific objective, have one person serve as a recorder to write down the major points of discussion and give a flavor for how the organization is reaching the goals of the stated objective. This descriptive information will help bring to life the measurement results/scores given.
- Remember that the assessment process yields a set of measures that characterize where the organization is at a point in time—the measurement should only be a starting point. The organization must have a process for addressing the issues and ideas raised in the course of conducting the assessment. In other words, the organization must act on the information in some way. Project site representatives say that "measurement is good, but action is everything."

Project sites also offered advice on who should be involved in the SASI process:

- Senior management should be actively supporting this effort. This process involves a group of key people within the organization conducting an assessment of where the organization is in integrated care. The self-assessment process , the issues that arise from discussions about the organization's progress, and the ideas for moving ahead—all of these things can be threatening to some and exciting to others and can generate varied opinions about what to do next. This energy can lose focus and/or staff can feel that they are swimming in "uncharted waters" if senior management is not kept informed and is visibly in support of the process to assess and plan for next steps.

- Clinical leadership should be involved throughout the process. Physicians and other clinicians may be especially interested in discussions on SASI objectives relating to high risk identification, care management/ disability prevention, seamless care, and client involvement. If possible and practical, the organization conducting this assessment may wish to have physicians/other clinicians lead the discussions on these objectives.
- To assure a comprehensive assessment, the group of people that perform the assessment should represent a variety of sites of care. All sites of care that are used and are important to the target population, defined upfront in the assessment process, should be represented in some way on the assessment group.
- Information system technology and infrastructure is important for communicating, planning, and measuring progress. Lack of the necessary IS infrastructure or IS input was often cited by these project sites as holding back progress on integration around a defined goal. If possible, it would be important to have a key staff person from IS on the group—especially for SASI the objective on information systems technology.
- Have someone with a finance background involved in the SASI assessment. For example, Crozer-Keystone had a disease management steering committee with a person from Finance involved—this person was able to prepare a cost-benefit analysis of a disease management program that was being proposed as an important tool for managing frail elderly people enrolled in the health plan's Medicare risk product.
- It is also a good idea to involve decision-makers from certain key areas at critical points in the self-assessment process, e.g., Human Resources, Strategic Planning, and Quality Improvement. These individuals should be involved at the beginning of the process and near the end of the process, when a report is being prepared on findings. The SASI assessment process examines issues that are important to these disciplines, e.g., staff training, compensation and performance evaluation, strategic and operational planning, quality improvement and system performance measures.

NCCC Staff Conclusions

After two years working on this project, NCCC staff had the following conclusions:

- The SASI tool and process and the shared learning activities that promote cross-site learning did enhance these organizations' progress toward integration. The grant involvement seemed especially to support a key contact person (a "champion") who valued the ability to keep in close touch with others trying to do similar things at their institutions.
- CEO support seemed to be the most important factor to effecting change and examining progress toward integration system-wide. However, this was not enough; the CEO needed "doers" within the organization to make things happen. Interestingly, the champions/ "doers" were not selected—they emerged as natural leaders.
- The most effective champion was the person who was personally and passionately committed to improving care for people with chronic conditions. In addition, these champions were good communicators; they worked effectively in groups, they understood how to marshal support from other key stakeholders, they had excellent facilitation skills that enhanced the team process, and they kept their CEO or senior manager well-informed.
- Self-assessment was a difficult concept for some of the staff from these organizations to grasp. It is different from accreditation—organizations should prepare their staff for how a self-assessment process differs from other, more familiar certification or accreditation processes, and illustrate in clear terms how results will be used.
- With regard to moving ahead after the assessment was completed, the actual initiative chosen was not as important as the willingness to act. In fact, many of the key initiatives that progressed had already been planned or started before this project began. What was important was that the original initiative changed to take a broader view of "system" and the teams that worked on the initiative were enhanced as a result of the self-assessment. This helped round out the effort, and, importantly, increased the number of people/departments that were aware of the initiative, which increased buy-in.

Acknowledgements

The National Chronic Care Consortium (NCCC) is a mission-driven organization of leading-edge health networks dedicated to transforming the delivery of chronic care services.

The NCCC's mission is to serve as an operational laboratory for enabling innovative health networks to establish prototype systems for better serving persons with chronic conditions.

Using SASI to Advance Systems Integration: Findings Report

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For more information on the NCCC's complete vision of integrated chronic care across a continuum, please contact:

National Chronic Care Consortium
8100 26th Avenue South
Suite 120
Bloomington, MN 55425
Phone (612) 858-8999
Fax (612) 858-8982
www.nccconline.org

Mrs. Peterson Videotape

"Mrs. Peterson: A Case Study"

... a tragic case study of a woman who could be alive today if not for the fragmented and poorly coordinated healthcare system she encountered ...

The urgent need for an integrated network of care is illustrated in this 12-minute videotape detailing the tragic events leading to the death of an 72-year-old woman, Mrs. Dorothy Peterson. This videotape detailing Mrs. Peterson's experience—and how it could have been different—provides opportunities and challenges to rethink strategies for healthcare delivery. John Oliver, CEO of Georgetown and District Memorial Hospital, reports that he has used it to stimulate departmental discussion and to bring different groups together to focus on the needs of clients.

We recommend this tape for any organization that is considering a focus on client experiences in healthcare networks and is working toward developing a more integrated continuum of care.

"Mrs. Peterson: A Case Study" can be ordered from Terra Nova Films; call 800-779-8491.