



SASI™

Self-Assessment
for Systems
Integration Tool

A product of the
National Chronic
Care Consortium

Conducting an Internal Assessment on Systems Integration: Experiences with the NCCC SASI™ Tool

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Objectives

- ◆ To present the NCCC SASI tool and describe the internal self-assessment process healthcare organizations can use to measure and improve systems integration for chronic care populations
- ◆ To share learnings from the NCCC John A. Hartford Foundation grant



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About the NCCC

- ◆ The NCCC is a nonprofit, mission-driven membership organization. Our mission is to develop **real-world** solutions in chronic illness care.
- ◆ NCCC members are healthcare networks offering a continuum of primary, acute, and long-term care services.
- ◆ NCCC members share a vision of integrated care for a chronic care population.

For more information visit the NCCC Web site at www.ncccconline.org



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Product Development

SASI™ development was funded by The John A. Hartford Foundation and supported by member dues. The Member Task Force and NCCC staff developed the product and defined the content and format of the tool. Members and nonmembers tested the tool and applied it to their systems development efforts.

- ◆ Tool development—January 1994 to August 1995
- ◆ Client and caregiver focus groups—September 1994
- ◆ Beta testing at five sites—January and February 1995
- ◆ Field testing—October 1995 to May 1996
- ◆ Implementation at five project sites—June 1996 to June 1998
- ◆ Tool revision—2001

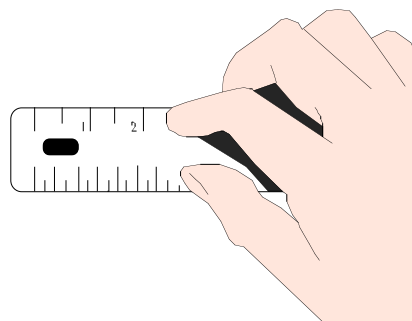


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Why Use SASI™?

- ◆ To guide strategic planning
- ◆ To enhance communication



- ◆ To periodically assess progress
- ◆ To promote systems thinking
- ◆ To support CQI

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NCCC Members Identified These Reasons for Self-Assessment

- ◆ To improve overall systems development
- ◆ To promote or advance affiliations/mergers with new provider partners
- ◆ To develop or improve services for chronic populations
- ◆ To refocus or redesign senior services

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The Process for Using SASI™

- ◆ What is the purpose?
- ◆ Who will be involved?
- ◆ What process/structure will be used?
- ◆ What timeframe will be set?
- ◆ How will this be connected to other efforts?
- ◆ Who will set/define priorities?
- ◆ How will results be measured?



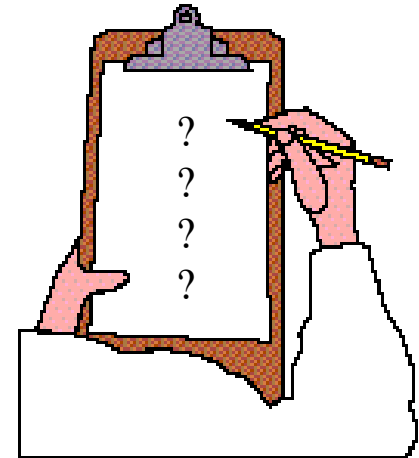
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A Leadership Team Must Answer These Key Questions

- ◆ What is the population of interest?
- ◆ What services are needed to keep that population healthy?
- ◆ What services do we have, and how are they structured/organized? What more do we need?
- ◆ How will we define our network or “system of care”?



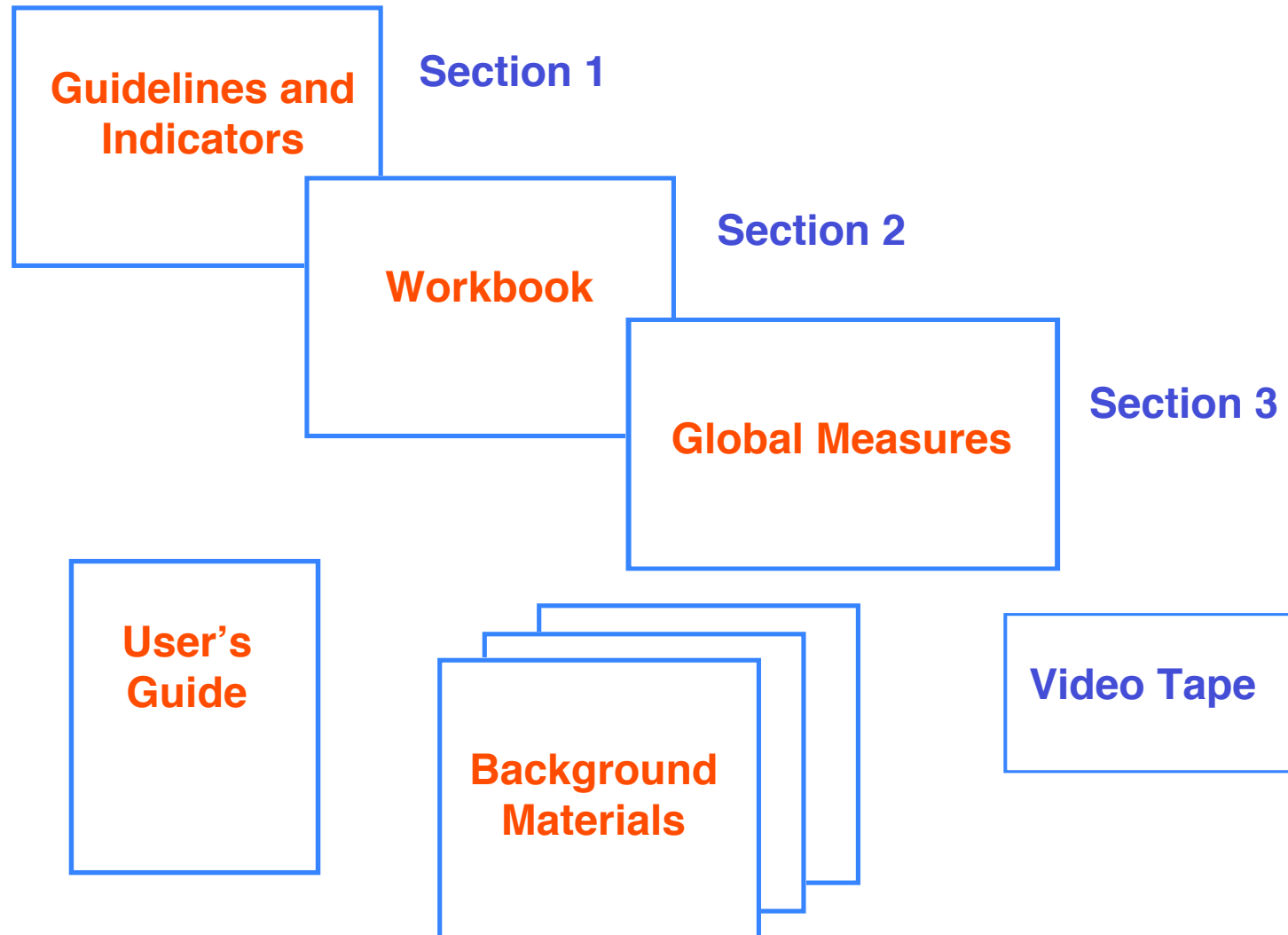


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SASI “Tool Kit”





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SASI Content: 3 Sections

1. **Guidelines and Indicators: greater depth for each objective**
 - ◆ Concepts and components
 - ◆ Strategies for implementation



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SASI Content: 3 Sections

2. Workbook: open-ended questions

- ◆ Status/progress?
- ◆ Barriers?
- ◆ Goals/next steps?
- ◆ Accountability?



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SASI Content: 3 Sections

3. Global Measures: snapshot of progress through mix of quantitative and qualitative measures



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SASI Content: 9 Objectives

1. **Clients** are involved in their own care and are strongly supported in self-care management.



- ◆ Clients are partners in care management and health maintenance.
- ◆ The network empowers clients, families, and practitioners.
- ◆ Consistent, supportive information and education is provided throughout the course of service delivery.

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SASI Content: 9 Objectives

2. The needs of populations are identified; **high-risk groups** are targeted, though not to the exclusion of other groups.
 - ♦ Population characteristics are documented; a profile of chronic care clients is developed.
 - ♦ Risk groups are identified; resources are appropriately targeted, with high-risk groups emphasized.





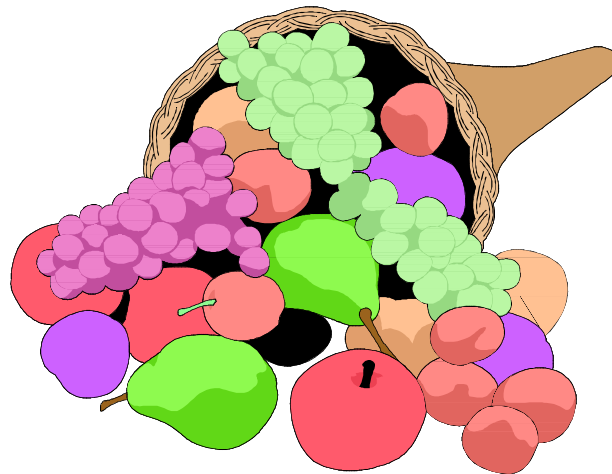
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SASI Content: 9 Objectives

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



The array:

- ◆ Includes health, LTC, and community support services
- ◆ Includes other services based on client needs and preferences
- ◆ Is routinely evaluated for efficiency and effectiveness



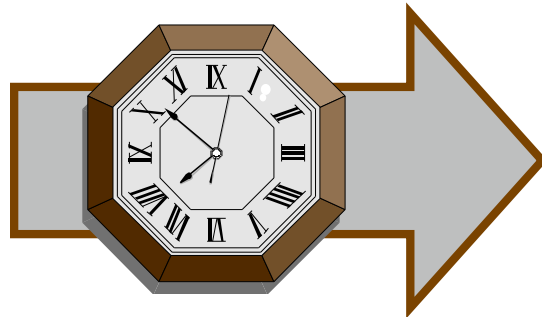
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SASI Content: 9 Objectives

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



- ◆ A particular focus on transitions between settings, services, and levels of care
- ◆ Care management tools and interdisciplinary teams



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SASI Content: 9 Objectives

5. Care management is focused on **disability prevention** and organized around **defined populations**.

- ◆ Disability prevention at all stages
- ◆ A systemwide care management model
- ◆ Modifiable risks for defined population groups





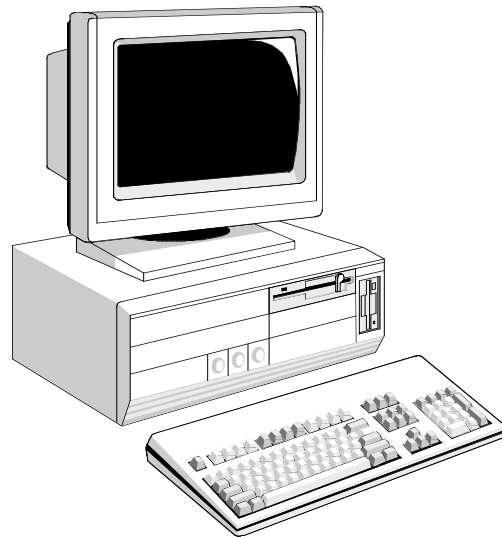
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SASI Content: 9 Objectives

6. **Information sharing systems** allow providers in all settings to share meaningful information about clients, costs, and operations.



- ◆ The IS plan reflects an understanding of the information needs for effective chronic care management over time.
- ◆ IS can track care and cost outcomes across settings.



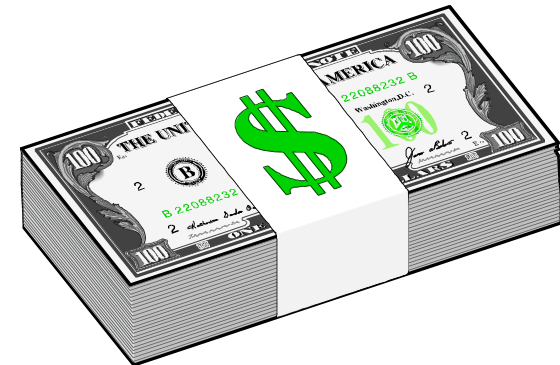
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SASI Content: 9 Objectives

7. **Financing systems** promote systemwide management of cumulative costs, tied to care outcomes.
- ◆ Risk contracts provide incentives to support integrated care across the continuum.
 - ◆ Care delivery, financial incentives, product design and marketing are developed in concert.





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SASI Content: 9 Objectives

8. Management strategies and structures

support cross-site, interdisciplinary integration efforts.



- ◆ Administrative and clinical teams are established, coordinated, and focused on networkwide goals.
- ◆ Budgeting, HR, etc. are considered as a network.



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SASI Content: 9 Objectives

9. **Network governance** supports and improves the ability of individual care providers to work together as a single system to improve outcomes and continuity of care delivery to people with chronic care needs across settings.

- ◆ Assure adequate resources for CCN
- ◆ Articulate mission, vision for the network
- ◆ Establish performance expectations





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Important Steps for Moving Ahead

- ◆ Focus on overall mission and remember the common client
- ◆ Formulate goals and define process for work effort
- ◆ Develop a leadership team with “champions of the cause”
- ◆ Develop a common language





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Important Steps for Moving Ahead

- ◆ Understand the services and facilities and how they work—add to the team if necessary
- ◆ Entertain a diversity of perspectives (but maintain a collaborative spirit)
- ◆ Define steps for moving ahead—make them concrete
- ◆ Educate and communicate
- ◆ Reassess periodically





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Selected Results of Project Sites

- ◆ Increased willingness to share information across sites
- ◆ Helped uncover strengths within certain organizations, e.g., pathway expertise, IS, and cost/care tracking
- ◆ Conducted an inventory of facilities and services across the network/system
- ◆ Assisted in RFP development for an information system—set a vision for what an information system should do



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Selected Results of Project Sites

- ◆ Assisted in coordination of research initiatives in geriatrics/aging
- ◆ Assisted in CON, systemwide capacity planning
- ◆ Unearthed difficulty in tracking patient experience and matching clinical and financial information across sites of care
- ◆ Identified need for a governance/management committee on integration across the network



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Selected Results of Project Sites

- ◆ Supported development of new Office of Disease Management at the system level
- ◆ Provided framework for discussion/action for a new multi-organizational affiliation
- ◆ Influenced the structure/direction of internal reorganization of a developing system



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Critical Success Factors

- ◆ A strategic vision for the future
- ◆ CEO/senior management support for a systems process that relies on internal expertise/knowledge
- ◆ Willingness to create action plans around key areas based on assessment activity
- ◆ A designated champion for facilitating the process—a trusted, “big picture” thinker who knows how to get things done





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Critical Success Factors

- ◆ The right people on a leadership group—broad-based, with various perspectives and authority to act
- ◆ Good communication across the network
- ◆ A demonstrated ability to move toward a collective vision of where the network should be headed





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Reminders

- ◆ SASI™ needs to **fit into an organization's natural process** of communicating, planning, and evaluating.
- ◆ As **organizations evolve** and new partnerships are formed, the reasons to use SASI™, the methods of use, and the people involved may **change**.
- ◆ SASI™ does not contain the answers—it **launches a process** and serves as a **catalyst** for system change.

