



SASI™
Self-Assessment
for Systems
Integration

Section 1: Guidelines and Indicators

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—For Describing Elements of Systems Improvement—

Introductory Note

This section is one part of the SASI™ tool created by the National Chronic Care Consortium. SASI™ refers to “Self-Assessment for Systems Integration.” This tool was developed under a two-year grant from The John A. Hartford Foundation by a multi-organizational task force comprising members of the National Chronic Care Consortium. It was first published in 1995 and slightly revised in 2001.

The tool was designed as an internal resource for provider systems to assist healthcare networks in planning, implementing, and measuring the success of their efforts to improve service delivery across a full continuum of care to population groups with chronic care needs. People with chronic care needs require ongoing, multidisciplinary, and coordinated care management, treatment, and services. The population of people with chronic care needs typically requires services from a spectrum of providers and thus offers a more difficult “test” of a healthcare network, in terms of coordination of care delivery, than a population with needs from only one service sector at one point in time.

The SASI tool allows for a critical self-assessment of a multi-organizational delivery network at a point in time. The tool uses the term “network” to refer to the entire set of facilities and services that make up the delivery system providing service to people with chronic conditions. “Client” refers to the patients, consumers, or residents receiving services and to the family members involved in their care.

This document walks through nine objectives of a chronic care network strategy in a format that presents:

- The desired objective
- Ways to conceptualize the objective
- Selected components of the objective
- Tasks that address the selected components

Page 3 lists the nine objectives; the body of the Guidelines and Indicators begins on page 4.

9 SASI Objectives

1. Clients are involved in their own care and are strongly supported in self-care management.
2. The needs of populations are identified; high-risk groups are targeted, though not to the exclusion of other groups.
3. A full array of effective and efficient services is provided.
4. Seamless care is provided across settings and over time.
5. Care management is focused on disability prevention and organized around defined populations (e.g., high-risk, condition-specific).
6. Information sharing systems allow providers in all settings to share meaningful information about clients, costs, and operations.
7. Financing systems promote systemwide management of cumulative costs, tied to care outcomes.
8. Management strategies and structures support cross-site, interdisciplinary efforts.
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.

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

Conceptualize

The client and his/her family:

- Play a central role in care and are seen by the network and providers within the network as the ultimate decision makers with regard to care plan development, identification of a set of services to be used, and key evaluators of the outcomes of care
- Understand the nature and underlying reasons for the client's disabilities and are aware of options for appropriate intervention strategies
- Are seen as "whole persons," with physical, social, and psychological needs and with circumstances that change over time—individual preferences and values are respected

Selected Components	Measure the degree to which:
<p>Education, self-help, and self-care services promote client involvement in all aspects of care.</p>	<p>The network of providers:</p> <ul style="list-style-type: none"> • Provides necessary education, self-help, and self-care services such as support groups and medication management • Services, education classes, and care training classes to assist clients and their families in understanding their condition(s) and the methods have been effective in addressing symptoms of these conditions • Provides financial or other incentives for clients to use these services • Measures and works to improve client and provider satisfaction with these services <p>Educational, public relations, and marketing materials:</p> <ul style="list-style-type: none"> • Assist clients in understanding their conditions and related network and non-network services • Are accurate, timely, tailored to key population groups, and culturally competent
<p>The philosophy, methods, and tools of care and care management promote client involvement in ongoing care.</p>	<p>Care management philosophy, methods, and tools:</p> <ul style="list-style-type: none"> • Recognize the client as the primary care manager • Promote client choice and educated participation • Promote individual self-determination and use of advance directives <p>Clients and family members are satisfied with their level of involvement in care planning, treatment, and health maintenance.</p>
<p>Personnel promote client involvement in all aspects of care, especially in care planning and implementation.</p>	<p>In partnership with clients and family members, network providers and personnel:</p> <ul style="list-style-type: none"> • Develop, implement, and monitor care plans • Consider both formal and informal supports • Assess functional ability • Access network and other community services • Promote client self-sufficiency in understanding their conditions and self-care

Objective 2: The needs of **populations** are identified; high-risk groups are targeted, though not to the exclusion of other groups.

Conceptualize

The network:

- Emphasizes the need to identify populations at high risk of adverse care and cost outcomes for earlier intervention
- Recognizes the importance of studying the needs of specific population groups (e.g., Medicare/Medicaid dually eligible group, high-risk/frail seniors living alone)
- Uses scientific/sound methods for studying the needs of these population groups and/or those of the larger community (e.g., using sources such as health status appraisal/self-report, incidence and prevalence indicators or other health indicators census data, epidemiological studies, market research, focus groups, surveys, and input from formal and informal sources)
- Has a plan and menu of effective service options for intervening based on the needs of the population group
- Is accountable for collecting and updating community needs information, coordinating interventions systemwide, evaluating whether the network of providers is meeting its performance goals, and communicating this information to providers within the network

Selected Components	Determine the degree to which:
<p>The network develops a comprehensive picture of the needs and preferences of the community, enrolled population, or special population group of interest.</p>	<p>The network documents the population's basic characteristics (e.g., living arrangements, age, gender, ethnic group, economic status, health status, social support status, mental health status, language requirements, transportation requirements, cultural health customs, and accessibility and suitability of existing health and social services) and identifies primary, secondary, and tertiary prevention opportunities, as well as ongoing care needs.</p>
<p>The network identifies the subset of people within that group that are at high risk (e.g., by functional medical status) and that warrant closer targeting for services.</p> <p>The network identifies interventions for these risk groups that are likely to improve quality, decrease functional decline, improve satisfaction, reduce unnecessary or harmful care, and decrease costs of inefficiency or ineffectiveness.</p>	<p>The network identifies high-risk groups (e.g., through a process which includes the use of risk screens, risk stratification, and other risk identification methods) and documents the characteristics, service needs, preferences, and historical use patterns of these targeted high-risk groups.</p> <p>Network personnel research evidence about the range of effective options and client preferences for interventions and services for the high-risk groups, moderate-risk groups, and low-risk groups. The network responds by developing this range of service options and tracks efficacy of these interventions over time.</p> <p>The network:</p> <ul style="list-style-type: none"> • Targets high-risk populations, emphasizing self-care and prevention (see also objective 1 and 3). • Provides a flexible mix of services and documents that care is provided in the most appropriate setting.

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

Conceptualize

- The network understands the significance of providing a “full array of effective and efficient chronic care services.”
- The network:
 - Describes the services required by the target population group(s)
 - Identifies existing healthcare network and non-network resources that are linked through partnerships, affiliations, or ownership
 - Identifies the gaps in service and the ways these gaps will be filled over time

Selected Components	Determine the degree to which:
<p>The network offers a full array of services to its clients, either directly or indirectly.</p> <ul style="list-style-type: none"> • The network adjusts the service array based on: <ul style="list-style-type: none"> • Information about population changes • Service needs and preferences • Service efficiency and effectiveness • Available resources <p>The network assures convenient client access to the service array.</p>	<p>The network:</p> <ul style="list-style-type: none"> • Provides a full service array, including prevention, primary care, acute care, transitional care, rehabilitative care, long-term care, palliative care, self-care, and support services • Uses information on community enrollee population needs and high-risk groups to establish a comprehensive menu of network services (See objective 2)—network providers/personnel are aware of this menu of services, how the services can be accessed, what restrictions on use may exist, and how the service has been received by clients in the past • Develops partnership or affiliation agreements and linking mechanisms with other organizations to meet population needs—agreements specify how services link with each other • Avoids duplicating existing services • Accurately communicates the nature and key aspects of its health plans, prepaid products, and services to the community and its clients
<p>The network adjusts the service array based on:</p> <ul style="list-style-type: none"> • Information about population changes • Service needs and preferences • Service efficiency and effectiveness • Available resources <p>The network assures convenient client access to the service array.</p>	<p>The network:</p> <ul style="list-style-type: none"> • Provides a flexible mix of services and documents that care is provided in the most appropriate setting • Promotes functional independence through the use of affordable supportive services <p>The network regularly evaluates:</p> <ul style="list-style-type: none"> • Each service and program for its care-effectiveness and cost-effectiveness, making improvements as necessary • Customer preferences (e.g., clients, providers, and payers) using a variety of evaluation methods <p>Systems for intake/registration, information and referrals, and problem resolution are client-friendly, shared across settings, and documented for their effectiveness.</p> <p>Services are conveniently located, with transportation available.</p> <p>Services are scheduled in a timely manner, and referrals are appropriate.</p> <p>Physical environments are sensitive to persons with special needs and promote independence through adaptive devices, design, architecture, signage, and other technologies.</p>

Objective 4: Seamless care is provided across settings and over time.**Conceptualize****The network:**

- Emphasizes the need for seamless care across settings, between/among disciplines, and over time
- Has a strategy for continually improving transitions between settings and levels of care to minimize disruption in a client's course of care
- Understands the need to evaluate and support the role of informal caregivers in assuring continuity of care
- Has mapped out the linkages between all services

Selected Components	Determine the degree to which:
<p>Clinical care, care management, and service provision methods promote smooth transitions and continuity of care across settings and over time.</p>	<p>Care methods, care plans, and care pathways:</p> <ul style="list-style-type: none"> • Are based on a clear understanding of client/family goals and lifestyle preferences over the long term • Extend across all service settings, relating the goals and treatment in one setting to the goals and treatment in other settings • Describe and monitor specific reasons and procedures for transitions • Evaluate and support the role of informal caregivers in assuring continuity of care <p>Network personnel assist clients in obtaining resources across settings, including resources within and outside the network, to ensure that ongoing needs are met.</p>
<p>Practitioners and interdisciplinary teams promote smooth transitions and continuity of care across settings and over time.</p>	<p>Network personnel, practitioners, and teams:</p> <ul style="list-style-type: none"> • Have training and expertise related to cross-site coordination and communication • Follow network policies, procedures, and services related to transitions and continuity of care • Implement interdisciplinary plans • Are satisfied with the team process <p>The network supports pilot projects to test new methods for providing continuous care (e.g., where a primary caregiver or team follows the client across settings, where services are brought to the client's home).</p>
<p>The network evaluates and documents the continuity of care across settings and over time.</p>	<p>Smooth transitions and continuity of care are tracked, and, over time, improvement in transitions is shown to be associated with:</p> <ul style="list-style-type: none"> • Improvements in key clinical, functional, and cost indicators • Reductions in avoidable transitions and transfer trauma • Provisions of care in the least restrictive setting • Improved client satisfaction and capability for self-care activities

Objective 5: Care management is focused on **disability prevention** and organized around **defined populations** (e.g., high-risk, condition-specific).

Conceptualize

- The network understands the importance of condition- or population-specific care management, with an emphasis on preventing disability, providing care that responds to the unique concerns of persons with chronic illness, and effectively using resources.
- The network emphasizes an interdisciplinary approach to developing and implementing care management strategies.

Selected Components	Determine the degree to which:
<p>The network uses care management tools and processes that are responsive to the needs of high-risk groups and people with chronic conditions.</p>	<p>Care management methods:</p> <ul style="list-style-type: none"> • Include extended care pathways, condition guidelines, decision-support methods, and other protocols for primary physician offices • Promote care in the most appropriate setting and are focused on preventing disability or decline • Respond to variation in individual characteristics and needs (e.g., age, culture, health status) • Reflect the expertise and experience of an interdisciplinary group of providers • Can be applied to persons who have multiple chronic conditions and/or use multiple service settings
<p>Practitioners and care teams have the expertise and resources to treat people with specific chronic conditions and with multiple conditions and syndromes.</p>	<p>Practitioners and care teams:</p> <ul style="list-style-type: none"> • Understand the nature of disability progression • Work to prevent disability and/or slow its effects at every stage of the condition • Have the expertise and experience necessary to treat or refer persons who are at high risk or have one or more chronic conditions. • Use care management methods, information technology systems, training, literature reviews, and related resources to continuously improve their ability to treat people with chronic conditions
<p>Care and cost outcomes are improved over time.</p>	<p>Interventions focus on modifiable risks and support the goals of the client/family as well as those recommended by the providers.</p> <p>Client and cost outcomes are improved, as measured by:</p> <ul style="list-style-type: none"> • Appropriateness of service use • Reductions in the cumulative cost of treating a specific condition or target population group • Improvements in key functional and clinical indicators • Evidence that disability has been prevented or delayed

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

Conceptualize

- The network is working toward integrated information systems, a shared database or data repository, or other methods that allow meaningful, comprehensive information about clients, costs, and operations to be shared across settings, so that providers individually and collectively make care-effective and cost-effective decisions.

Selected Components	Determine the degree to which:
<p>The network has a plan for sharing information and related policies and processes for accomplishing this plan.</p>	<p>The information sharing plan:</p> <ul style="list-style-type: none"> Is part of the network's overall strategic plan and is re-evaluated on an ongoing basis Defines the purpose and objectives of the information sharing system and the types and specification of technology (e.g., hardware, software, operating systems, and linkages) needed to assure accessibility across settings Reflects the input of staff from all network settings in terms of what information is shared and in what format Addresses data/client confidentiality issues and responds to HIPPA requirements
<p>Information technology systems are being developed/ refined to be compatible across settings. Adequate support is provided for implementation of the systems.</p>	<p>Information technology systems used by providers in the network:</p> <ul style="list-style-type: none"> Are linked where possible and use compatible platforms across settings or are accessed through the Internet in a safeguarded site Use consistent data item definitions and data collection standards across settings, periodically documenting the quality and accuracy of the data abstraction and entry processes Adhere to current industry standards Are increasingly able to track care outcomes and cumulative costs over time and across settings for aggregate populations, for specific target groups (e.g., by chronic conditions), and at an individual level <p>Practitioners and staff within the network:</p> <ul style="list-style-type: none"> Are satisfied that the information systems support their decision making in real-time Use the information technology system(s) to document decisions related to improving client outcomes, service effectiveness, and service efficiency
<p>Each provider within the network has the ability to access meaningful information on clients, costs, and operations.</p>	<p>Practitioners and staff:</p> <ul style="list-style-type: none"> Have access to a common client/patient information database or Internet site containing a core set of client and cost data (e.g., clinical, demographic, financial, use, and care) that is collected over time and across service settings—information is safeguarded Correctly use the information systems, having adequate training and experience to do so Correctly follow data confidentiality policies, including HIPPA requirements Receive periodic reports that link care, cost, and outcome data Review the value of the core data set and information policies and reports at least annually

Objective 7: Financing systems promote systemwide management of cumulative costs, tied to care outcomes.

Conceptualize

The network:

- Has a strategy for using financial incentives to encourage the achievement of cumulative client outcome and cost goals.
- Is developing a strategy for pooling financing for the entire continuum of care, with an understanding of the sources of funds to be pooled and the scope of services to be provided to the defined population.

Selected Components	Determine the degree to which:
<p>Financing mechanisms and budgeting and payment methods contain structures and incentives for integrating chronic care delivery.</p>	<p>The network and its providers:</p> <ul style="list-style-type: none"> • Are funded or are working toward funding for the full continuum of care • Have established collective care and cost goals for a given population • Manage risk to reduce exposure to catastrophic costs • Use updated systems to document and manage the cumulative cost of care for a condition/client over time and across settings, relating care and cost outcomes • Use market forces to promote better care delivery methods that improve longitudinal care outcomes <p>Payment systems:</p> <ul style="list-style-type: none"> • Join funding streams when possible • Align financial incentives across settings and services within the network, basing reimbursement on a provider’s ability to meet setting-specific and networkwide care and cost goals • Promote self-care, preventive care, and care in the most appropriate setting <p>Client cost sharing arrangements promote self-care, preventive care, and care in the most appropriate setting.</p>
<p>The network and its plan and provider partners are increasingly operating services under a joint agreement with shared risk.</p>	<p>Payer/provider contracts support:</p> <ul style="list-style-type: none"> • A level of risk sharing among providers commensurate with their level of investment and ability to accept financial risk • A “systems” approach to care that does not put one entity at undue risk over another • An actuarially-sound payment structure that adequately reflects the cost of serving persons with chronic illness (e.g., adjusting rates based on predicted variation in health status, case mix, and utilization) <p>An increasing number of clients are served under a shared risk arrangement.</p> <p>The network’s product design and marketing strategies are aligned with the network’s delivery model.</p>

Objective 8: Management strategies and structures support cross-site, interdisciplinary efforts.

Conceptualize

- Network management and leadership teams create an implementation plan for effective systemwide chronic care service delivery and put it into operation.
- The network recognizes the magnitude of the effort and devotes sufficient resources to it.
- The network CEO visibly supports the chronic care strategic and operational plan and its implementation.

Selected Components	Determine the degree to which:
<p>Management staff and leadership teams develop workplans and spearhead chronic care service improvement.</p>	<p>The network dedicates qualified management staff and cross-site, interdisciplinary leadership teams to create and implement work plans.</p> <p>These teams:</p> <ul style="list-style-type: none"> • Understand the basic issues involved in chronic illness, the need for service delivery improvement, the key factors and steps in organizational change, and the role they play in helping to improve care outcomes across the network • Identify key objectives, initiatives, and tactics and help to implement them across service settings and disciplines • Report they have adequate time, authority, and resources to carry out the effort • Solicit client input on the work plans, objectives, key activities, and process for achieving network goals. <p>Practitioners and staff understand how the chronic care mission and plan relate to the overall network mission.</p>
<p>The network evaluates its progress toward specific chronic care objectives that are systemwide.</p>	<p>New or existing CQI teams and processes document progress toward specific objectives, such as: preventing or delaying disability and its effects; improving client functional and health status; improving client/family satisfaction and sense of well-being; and improving access, cost-effectiveness, efficiency, and “user-friendliness” of services.</p>
<p>Simplified administrative procedures support network strategies across management settings.</p>	<p>Providers and settings share a common budget cycle and have compatible accounting, bookkeeping, reporting, and claims processing structures.</p> <p>Human resource policies and salary/benefit structures across settings are coordinated (as necessary and feasible) to support cross-site efforts.</p>

Objective 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.

Conceptualize

- Each board within the network supports the work of the network as a whole in focusing on chronic care population groups and working to improve outcomes.
- The healthcare network board develops a structure within the existing framework of governance to focus on a systemwide strategy for improved care, for example, a chronic care “governance group” of some type (e.g., steering committee) is formed to develop the vision, mission, and strategic plan for the chronic care strategy, to support management during implementation, and to ensure accountability on these issues.
- The healthcare network recognizes that meaningful client involvement is critical in shaping a better care delivery system and that this begins at the governance level.

Selected Components	Determine the degree to which:
<p>The healthcare network establishes a steering committee of the board for examining issues around chronic care needs, e.g., a “Chronic Care Strategy Committee.”</p>	<p>Membership on the committee includes community representatives, potential clients, and people with expertise/background in various settings (e.g., acute care, community-based long-term care, nursing home care, housing).</p> <p>Other advisory structures support the work of the governance group (e.g., physician and client advisory councils or committees on integration).</p>
<p>The committee oversees the development of a chronic care mission and vision statement and a strategic plan.</p>	<p>The chronic care mission and vision:</p> <ul style="list-style-type: none"> • Reflect the input of leadership, staff, and clients • Reflect the healthcare network’s overall mission and goals • Support a networkwide approach for integrating chronic care services on behalf of a person with chronic care needs from multiple levels of care, settings, and disciplines <p>The chronic care strategic plan:</p> <ul style="list-style-type: none"> • Gives managers operational responsibilities and tactics for bringing services and programs together to improve continuity • Identifies outcomes, performance expectations, and timelines for chronic care integration • Reflects the input of leadership, staff, and clients <p>Affiliate organizations have chronic care strategic plans that support the overall network strategic plan.</p>
<p>The committee monitors and holds leadership accountable for progress toward goals.</p>	<p>The committee:</p> <ul style="list-style-type: none"> • Uses systemwide performance tools and measures to evaluate improvements in integration, care outcomes, client satisfaction, and financial performance • Reports back to the board on a regular basis with regard to progress on the chronic care strategy