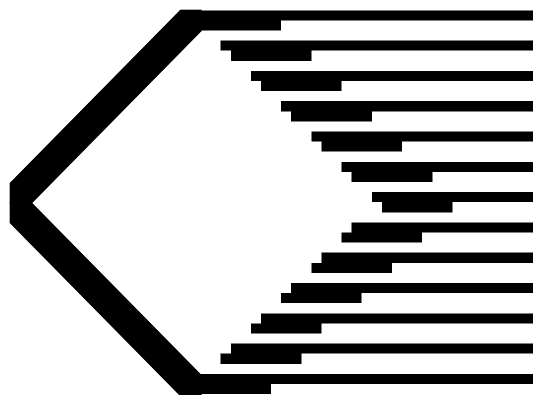

SASI™
Self-Assessment for Systems Integration

Section 2: Workbook

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Section 2: Workbook

—For Planning the Work of Systems Improvement—

Introductory Note

This workbook is a part of the SASI™ tool created by the National Chronic Care Consortium. SASI™ refers to “Self-Assessment for Systems Integration.” The NCCC designed this tool as an internal resource for provider systems to assist emerging healthcare networks with planning, implementing, and measuring their integration efforts across their full continuums of care in order to improve service delivery to population groups with chronic care needs. This population typically requires services from a spectrum of providers and it offers a more difficult “test” of a provider network. The 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. This Workbook should be used in conjunction with other SASI sections, particularly the section on guidelines.

This document lists nine objectives of a chronic care network strategy in a format that allows users to make notes about the progress their organization is making in achieving these objectives. For each objective, the workbook allows users to note responses to four questions:

- What **progress** has our network made in this area?
- What are the major **barriers** to progress in this area?
- What **steps** will our network take to improve this indicator in the next year? In the next two years? In five years?
- **Who** will be responsible for overseeing progress?

The audience for this document is the individuals conducting the organizational or network self-assessment. This typically will include managers from various settings and programs, clinicians involved in systems improvement and program development, experts from various disciplines, and network executives. Many different topics are covered. Certain sections will be especially relevant to different professionals, e.g., to clinicians, administrators, directors of finance, customer service managers, or experts in information systems, strategic planning, quality improvement, human resources, or health education. Whenever possible, the expertise of these various professionals should be sought out to ensure an accurate picture of the organization/network strengths.

Page 3 contains a list of the nine SASI Objectives; the body of the Workbook begins on page 4.

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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.

Workbook: Client Involvement

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

NCCC Indicator	**Status:** What progress has our network made in this area?	**Barriers:** What are the major barriers to progress in this area?	**Goals:** What steps will our network take to improve this indicator in the next year? In the next 2 years? In 5 years?	**Accountability:** Who will be responsible for overseeing progress?
The approach to care is **client-driven.** Education, self-help, and self-care **services promote client involvement** in all aspects of care.				
The **philosophy, methods, and tools of care and care management** promote client involvement in ongoing care. Clients are seen as “whole persons,” and care reflects this.				
Personnel promote client involvement in all aspects of care, especially in care planning and implementation.				

Workbook: Population Needs and High-Risk Groups

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

NCCC Indicator	**Status:** What progress has our network made in this area?	**Barriers:** What are the major barriers to progress in this area?	**Goals:** What steps will our network take to improve this indicator in the next year? In the next 2 years? In 5 years?	**Accountability:** Who will be responsible for overseeing progress?
The network develops a **comprehensive picture** of the needs and preferences of the **entire community**, enrolled population, or special population group of interest.				
The network **identifies the subset** of people within that group **that are at high risk** (e.g., by functional or medical status or living situation) and that warrant closer targeting for services.				
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.				

Workbook: Service Array

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

NCCC Indicator	**Status:** What progress has our network made in this area?	**Barriers:** What are the major barriers to progress in this area?	**Goals:** What steps will our network take to improve this indicator in the next year? In the next 2 years? In 5 years?	**Accountability:** Who will be responsible for overseeing progress?
The network offers **a full array of services** to its clients, either directly or indirectly.				
The network **adjusts*** the service array based on: • Information about population changes • Service needs and preferences • Service efficiency and effectiveness • Available resources * *There is a review at least annually.*				
The network assures **convenient client access** to the service array.				

Workbook: Seamless Care

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

NCCC Indicator	**Status:** What progress has our network made in this area?	**Barriers:** What are the major barriers to progress in this area?	**Goals:** What steps will our network take to improve this indicator in the next year? In the next 2 years? In 5 years?	**Accountability:** Who will be responsible for overseeing progress?
Clinical care, care management, and service provision methods **promote smooth transitions** and continuity of care across settings and over time.				
Practitioners and interdisciplinary teams promote smooth transitions and continuity of care across settings and over time.				
The **network evaluates and documents** continuity of care across settings and over time.				

Workbook: Care Management

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

NCCC Indicator	Status: What progress has our network made in this area?	Barriers: What are the major barriers to progress in this area?	Goals: What steps will our network take to improve this indicator in the next year? In the next 2 years? In 5 years?	Accountability: Who will be responsible for overseeing progress?
The network uses care management **tools and processes** that are responsive to the needs of high-risk groups and people with chronic conditions.				
Practitioners and care teams have the expertise and resources to treat people with specific chronic conditions and with multiple conditions and syndromes.				
Care and cost **outcomes are improved over time.**				

Workbook: Information Systems

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

NCCC Indicator	**Status:** What progress has our network made in this area?	**Barriers:** What are the major barriers to progress in this area?	**Goals:** What steps will our network take to improve this indicator in the next year? In the next 2 years? In 5 years?	**Accountability:** Who will be responsible for overseeing progress?
The network has a **plan for sharing information** and related policies and processes for accomplishing this plan.				
Information technology systems are in place and allow for sharing across settings.				
Each provider within the network has the **ability and training to access meaningful information** on clients, costs, and operations.				

Workbook: Financing Systems

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

NCCC Indicator	Status: What progress has our network made in this area?	Barriers: What are the major barriers to progress in this area?	Goals: What steps will our network take to improve this indicator in the next year? In the next 2 years? In 5 years?	Accountability: Who will be responsible for overseeing progress?
Financing mechanisms and budgeting and payment methods contain structures and incentives for integrating and coordinating chronic care across settings.				
The network and its plan and provider partners are increasingly operating services under a **joint contract arrangement with shared risk.**				

Workbook: Management Strategies

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

NCCC Indicator	**Status:** What progress has our network made in this area?	**Barriers:** What are the major barriers to progress in this area?	**Goals:** What steps will our network take to improve this indicator in the next year? In the next 2 years? In 5 years?	**Accountability:** Who will be responsible for overseeing progress?
Management staff and leadership teams develop **workplans** and spearhead chronic care service improvement.				
The network evaluates its **progress** toward **specific** chronic care **objectives** that are systemwide.				
Simplified administrative procedures support network strategies across management settings.				

Workbook: Governance

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.

NCCC Indicator	**Status:** What progress has our network made in this area?	**Barriers:** What are the major barriers to progress in this area?	**Goals:** What steps will our network take to improve this indicator in the next year? In the next 2 years? In 5 years?	**Accountability:** Who will be responsible for overseeing progress?
The healthcare network establishes a **"Chronic Care Strategy Committee"** or similar steering committee of the board.				
The committee oversees the development of a chronic care **mission and vision statement** and a **strategic plan**.				
The committee **monitors** and **holds leadership accountable** for progress toward goals.				