



**SASI™**  
**Self-Assessment**  
**for Systems**  
**Integration**

# ***Section 3: Global Measures***

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## **Section 3: Global Measures**

### **—For A Quick Evaluation of Elements of Systems Improvement—**

#### **Introductory Note**

This Global Measures Section is a 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 of members of the National Chronic Care Consortium. It was first published in 1985 and slightly revised in 2001.

SASI™ 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 to population groups with chronic care needs across a full continuum of care. 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 will offer 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. The term “client” refers to the patient/consumer/resident receiving services and to the family member(s) involved in his or her care.

This Global Measures section should be used in conjunction with other SASI™ sections, particularly the Guidelines section (Section 1) and the Workbook (Section 2).

This document lists nine objectives of a network strategy. For each objective, certain measures are used to evaluate the progress or status of the network/organization to date. The measures are broad in scope, and only a few items are selected for review out of many components that could be selected to gauge progress. Close-ended questions that have a set range of options/responses (e.g., via a Likert scale) are often used in order to “force” the group to make a determination on level of progress in a particular area. These items can be tracked over time as one way of indicating progress. However, we strongly advise the organization to use the Workbook (Section 2) as well to conduct a more comprehensive review of progress.

The audience for this document is the set of 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 some executives. We encourage each organization to include consumers with chronic conditions on the “team” conducting the assessment.

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.

On page 3 you will find a list of the nine SASI Objectives; the body of the Global Measures section begins on page 4.

The NCCC gratefully acknowledges the financial support of NCCC members and The John A. Hartford Foundation to develop this tool. This document is copyright protected.

### 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.

### Global Measures: Client Involvement

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

1. Please indicate the **current status** of your organization's self-care management training and support services for chronic care clients. Check all that apply:

<input type="checkbox"/>	The network does not offer specialized self-care training/support to chronic care clients.	<input type="checkbox"/>	The network is planning to develop self-care training/support for chronic care clients.	<input type="checkbox"/>	The network has established at least some of these services, and at least 10% of chronic care clients are using them.	<input type="checkbox"/>	The network has established self-care training and support, and at least 50% of chronic care clients are using them.	<input type="checkbox"/>	The network has developed these services, and at least 75% of chronic care clients are using them.
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2. Does the network **provide any special training to practitioners** and teams about client involvement and self-care management skills/abilities/issues?

- Yes  No

2a. **If yes**, please briefly describe this training's purpose and content and indicate what percentage of direct-care providers *working with people with chronic conditions* have received this training.

**Description:**

Percentage of providers with training (circle one)	
5-15%	51-75%
16-25%	76-100%
26-50%	

3. Has the network **documented the effects of self-care training**, education, and self-care management support services on client satisfaction, care outcomes, self-care practices, and/or costs for people with chronic conditions in any way over the last two years?

- Yes  No

3a. **If yes**, please briefly describe what this documentation entails and the major results (use a one-page attachment if necessary).

## Global Measures: 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.

1. Please indicate the current status of your organization's understanding of the needs of high-risk and general service populations. Check all that apply:

<p>The network has not identified groups at high risk of adverse care and cost outcomes within its service population.</p> <input type="checkbox"/>	<p>The network is planning to identify populations at high risk of adverse care and cost outcomes and has created a good profile of its service population and their needs.</p> <input type="checkbox"/>	<p>The network has created a profile (e.g., demographic information, health status, healthcare use) of their service population and has identified at least one high-risk group within that population.</p> <input type="checkbox"/>	<p>The network has identified several high-risk population groups, documenting their characteristics, service needs, preferences, and use patterns.</p> <input type="checkbox"/>	<p>The network uses its profiles of general and high-risk population groups to plan services, monitor program effectiveness, and identify areas of additional need.</p> <input type="checkbox"/>
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- 1a. If the network has identified high-risk populations, please explain the specific types of risks the network is screening for (e.g., risk of high costs, risk of disability, risk of hospitalization, risk of nursing home placement, risk of functional decline).

2. Has the network evaluated the validity of the tools it uses for identifying high-risk populations?

- yes  
 no  
 don't know

### Global Measures: Service Array

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

1. Please indicate the type of services offered to clients with chronic care needs, either directly or through affiliations. Check all that apply:

Housing with supportive services	Primary care and prevention of disability due to chronic illness	Transitional care, post-acute care, and /or rehabilitation services	Acute care	Mental health services (acute or outpatient)	Nursing home care (skilled or non-skilled)	Home healthcare (skilled or non-skilled)	Other support services, including adult day care, transportation, etc. (list below)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Does the network have a **shared system for intake and registration** so that information about clients is appropriately shared across all relevant settings?

- yes       no       don't know

3. Are periodic (at least annual) **client satisfaction surveys** about system services conducted for clients with chronic conditions?

- yes       no       don't know

4. Does the network have **specific care and cost targets** for defined chronic care populations?

- yes       no       don't know

**If yes**, please complete the matrix below. (Use an attachment if necessary.) An example of how to fill out this matrix is provided below.

Targeted population	Current size of population	Capitated or risk contract?	Care targets	Cost targets

Targeted population	Current size of population	Capitated or risk contract?	Care targets	Cost targets
Dually Medicare/Medicaid eligible	800 people	Yes	X hospital days/thousand X % readmissions in less than 30 days X % limited in 1 or more ADLs X % satisfied with services in last year	\$X Per member per month

## Global Measures: Seamless Care

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

1. Please indicate the current status of your **organization's or network's management of transitions across settings**. “**Transitional issues**” refers to issues and concerns arising from a chronic care client's movement between different settings (e.g., transferring from hospital to home care, to a nursing home, to rehab). Check all that apply:

<input type="checkbox"/> The network has not addressed transitional issues in any formal way.	<input type="checkbox"/> The network is planning to address transitional issues in a formal way.	<input type="checkbox"/> The network has established at least some policies, protocols, and/or pathways that specifically address transitional issues.	<input type="checkbox"/> The network has established comprehensive formal protocols and/or pathways that specifically address transitional issues.	<input type="checkbox"/> The network is actively monitoring the effects of transitions—across all of its settings—on client satisfaction, care outcomes, and/or costs.
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2. Does the network **provide any special training to practitioners and teams** about transitional issues for people with chronic care needs?

yes       no       don't know

2a. **If yes**, please briefly describe the training's purpose and content below:

3. Has the network **documented the effects of transitions** on client satisfaction, care outcomes, and/or costs in any way over the last two years?

yes       no       don't know

3a. **If yes**, please briefly describe what this documentation entails and major results (use a one-page attachment if necessary).

## Global Measures: Care Management

### Objective 5: Care management is focused on disability prevention and organized around defined populations.

1. Please indicate the **current status** of your network’s care management systems, especially those tailored to people with chronic care needs. Check all that apply:

<input type="checkbox"/> The network does not have a formal care management program/service.	<input type="checkbox"/> The network is planning to develop specialized care management for chronic care clients or targeted subgroups.	<input type="checkbox"/> The network provides specialized care management for chronic care clients or targeted subgroups.	<input type="checkbox"/> The network uses interdisciplinary teams to provide specialized care management for chronic care clients/subgroups.	<input type="checkbox"/> Providers in the network serving people with chronic care needs regularly participate in the care management model/program designed for chronic care clients.
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2. Please indicate **whether and how** any of the following **specialized care management practices** are used in your network:

Care management practice	Used in your network?	To what populations/conditions does this practice apply?	In the last 2 years, has the network evaluated this practice on preferred <i>disability prevention</i> outcomes?	In the last 2 years, has the network evaluated the impact of this practice on <i>other care</i> outcomes?	In the last 2 years, has the network evaluated the impact of this practice on the <i>cost of care</i> ?
Interdisciplinary care teams using multidisciplinary assessments of need	<input type="checkbox"/> yes <input type="checkbox"/> no		<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
High-risk screening/risk identification	<input type="checkbox"/> yes <input type="checkbox"/> no		<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
Menu of available interventions tied to risk identification findings	<input type="checkbox"/> yes <input type="checkbox"/> no		<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
Extended care pathways or protocols across settings	<input type="checkbox"/> yes <input type="checkbox"/> no		<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no

## Global Measures: Information Systems

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

1. Please indicate the degree to which the following statements accurately reflect your **network's information system**. Check all that apply:

The information system (including collection and dissemination of information):	True	Mostly true	Mostly untrue	Untrue
• Uses consistent data item definitions and data collection standards across settings				
• Is able to track chronic care population outcomes over time and across settings				
• Is able to track chronic care population costs over time and across settings				

2. Does the network have a **core set of care and cost data** that are collected across service settings?

yes       no       don't know

2a. **If yes**, please indicate what items are contained in this set and over what settings this information is collected. (Use an attachment if necessary.)

3. In what percentage of network service settings are **electronic medical and other client records available to providers in real-time**?

none  
 fewer than 10%  
 10 to 24%  
 25 to 49%  
 50 to 74%  
 75 to 100%  
 don't know

## Global Measures: Financing Systems

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

1. Please indicate the **current status** of your organization's movement **toward risk contracts**. Check all that apply:

<p>The network does not serve any clients through risk contracts. <input type="checkbox"/></p>	<p>The network is developing contracts to serve clients through risk contracts. <input type="checkbox"/></p>	<p>The network is providing care to about 5–10% of its chronic care clients through risk contracts. <input type="checkbox"/></p>	<p>The network is providing care to about 20–30% of its chronic care clients through risk contracts. <input type="checkbox"/></p>	<p>The network is providing care to more than half of its chronic care clients through risk contracts. <input type="checkbox"/></p>
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2. Do the network's internal budgeting/financing systems provide incentives for **providers to work across settings in meeting common network care and cost goals**?

yes       no       don't know

- 2a. **If yes**, please describe these incentives and their use. (Use an attachment if necessary.)

3. Do **payment systems provide incentives** for providers to serve persons with chronic illness?

yes       no       don't know

- 3a. **If yes**, please explain. (Use an attachment if necessary.)

## Global Measures: Management Strategies

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

1. Please indicate the current status of your organization's network management and leadership. Check all that apply:

<input type="checkbox"/> No overall networkwide management structure or leadership team exists.	<input type="checkbox"/> The network has a management team made up of administrators, directors, and clinical leaders from some service settings.	<input type="checkbox"/> The network has a management team made up of key personnel from all service settings.	<input type="checkbox"/> The network management team has developed a strategic plan around chronic care population needs.	<input type="checkbox"/> The network management team is implementing an operations plan to ensure the network meets chronic care population needs.
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2. If network leadership/management teams exist, please list the titles of people on the team(s) and what settings they serve in as administrators/managers or clinical leaders. (Use an attachment if necessary.)

3. Does the network have an operational plan for how sites of care are to work together around chronic care populations? (If so, please describe briefly on separate attachment.)

yes       no       don't know

- 3a. If yes, how is client input collected and reflected in the network's work plan(s)? (Use an attachment if necessary.)

4. What percentage of service settings within the network are under a common accounting, strategic planning, budgeting, and fiscal reporting cycle?

none  
 fewer than 10%  
 10 to 24%  
 25 to 49%  
 50 to 74%  
 75 to 100%  
 don't know

## Global Measures: 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.

1. Please indicate the **current status of your network's governance structure(s) related to chronic care populations**. Check all that apply:

<input type="checkbox"/> Each organization in the network has its own governance system—there is no networkwide structure.	<input type="checkbox"/> A networkwide governance structure (e.g., board) has been established.	<input type="checkbox"/> The networkwide governing body is planning to create a committee to examine chronic care issues and population needs.	<input type="checkbox"/> The networkwide governing body has established a chronic care committee of the board. That committee is developing a vision statement and strategic plan around chronic care populations for the network.	<input type="checkbox"/> The chronic care committee of the network board has worked with management to develop specific outcomes for the network to monitor related to chronic care populations.
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2. Does the healthcare network have a strategic plan for improving chronic care service delivery systemwide? (If so, please attach.)

yes       no       don't know

- 2a. **If yes**, how is client input collected and reflected in strategic plan? (Use an attachment if necessary.)

3. Does the network regularly **measure** its progress toward systemwide outcomes for chronic care populations?

yes       no       don't know

- 3a. **If yes**, please describe the methods, tools, and processes used to do so. (Use an attachment if necessary.)