Self-Assessment for Systems Integration Tool

The Self-Assessment for Systems Integration (SASI) 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 1995, and then 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 to population groups with chronic care needs across a full continuum of care. People with chronic care needs require ongoing, multidisciplinary, 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 harder "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 his/her family members involved in their care.

SASI Objectives

1. Clients are involved in their own care and are strongly supported in self-care management.
2. The needs of all 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 system-wide 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.