CONCENTRIC

Implementation Guide
Part 1

Definitions & Acronyms

Concept/Term	Full meaning or Definition
Care Plan	A consensus-driven dynamic plan that represents all of a patient's and care team members' prioritized concerns, goals, and planned interventions. It serves as a blueprint shared by all care team members, including the patient, to guide the patient's care and mostly to ensure or enable longitudinal coordination of care.
CONCENTRIC	**CON**necting and **C**oordinating an **E**nhanced **N**etwork for **TR**ansitions **I**n **C**are
Goal	A defined outcome or condition to be achieved in the process of patient care. Includes patient defined goals (e.g., longevity, function, comfort) and clinician specific goals to achieve desired and agreed upon outcomes.
Impact	An impact is a positive or negative, direct or indirect, intended or unintended change produced by an intervention
Implementation strategies	Methods or techniques used to enhance the adoption, implementation, and sustainability of an intervention [they address barriers, leverage facilitators and ensure fit with context]
Intervention	A single or combination of activities, strategies or programs designed to address a specific health issue or outcome
Logic model	A visual representation of how an intervention is intended to work
Peer	An individual who shares similar characteristics, experiences, or conditions as a person with SCI i.e. someone who has lived through or has first-hand experience of SCI and can offer unique insights, support, education and guidance based on their personal experience to others (PwSCI) undergoing similar experiences
PwSCI	Person(s) with spinal cord injury
SCI	Spinal Cord Injury
TiC	Transitions in Care - the complex set of actions designed to ensure the coordination and continuity of services as people experience changes in their health status, care needs, health care providers or settings.
Healing	Healing refers to all the mechanisms (i.e. interventions, supports, adaptations) that help with recovery
Recovery	Recovery refers to full inclusion in a meaningful life as defined by the concerned individual

Introduction to CONCENTRIC Model

Goal

To improve outcomes and experiences for persons with spinal cord injury (PwSCI) and SCI partners involved in their care, ensuring PwSCI receive person-centred, comprehensive, continuous and accessible care

Focal Transition Phase

Transition from Inpatient Rehabilitation to Community

Key Thematic Areas

1. Person-centred Care Planning
2. Communication and Collaboration
3. Focus on Healing and Recovery
4. Peer Support and Education
5. Resource Accessibility

Task Division for Next Step

Partners

Steering Committee

1. Provide guiding questions to partners in the North & South
2. Participate in meetings exclusively as facilitators i.e. not involved in decision-making or discussions to determine implementation activities.

North & South Partners

1. Go through the 5 themes and included recommendations
2. Start with Theme 1 to build the foundation
3. Co-determine sequence for Themes 2 to 5
4. Determine appropriate activities to implement recommendations

Change Champions

1. Participate in meetings and in determining appropriate activities to implement relevant recommendations.
2. See Change Champion Guide for further task breakdown or additional information

Introduction

Person-centred Care Planning

Communication and Collaboration

Focus on Healing and Recovery

Peer Support and Education

Resource Accessibility

All CONCENTRIC'S recommendations

Key Thematic Areas

16 prioritized recommendations grouped by five thematic areas

Model Process Summary

Working Group Meetings with SCI Partners

Generation of 35 Recommendations

Partners Prioritized Recommendations

Top 17 Recommendations Selected

Duplicated Recommendations Removed

16 Recommendations Reorganized

5 Thematic Areas & 16 Recommendations

Objective & Core Components Created

Note

Use the tabs on the left to jump to a desired focus area to view additional information such as main objective, core components and recommendations.

Alternatively, click the next button on the bottom right corner to navigate this guide

Introduction

Person-centred Care Planning

Click or hover on

Recommendations 1, 2, 3, 4

Communication and Collaboration

Focus on Healing and Recovery

Peer Support and Education

Resource Accessibility

Objective

Ensure PwSCI and relevant SCI partners are consistently engaged in the development of and have access to an updated person-centred multidisciplinary care plan across the care continuum.

Core Components

- Ensure care providers engage PwSCI and their family in developing and updating a person-centred multidisciplinary care plan that includes relevant health information, goals, and available SCI resources (Rec. 2).
- Provide information on SCI resources that are tailored to the need of each PwSCI in the multidisciplinary care plan (Rec. 3).
- Ensure that care plans are accessible to PwSCI and all relevant partners as appropriate throughout the care continuum (e.g. easy to read, understand and obtain a copy of) (Rec. 1).
- Establish clear post-discharge follow-up arrangements for PwSCI with scheduled visits to SCI specialized clinics (e.g. Physiatry) at specific intervals (Rec. 4).

Introduction

Person-centred Care Planning

Communication and Collaboration

Click or hover on

Recommendations 5, 6, 7, 8

Focus on Healing and Recovery

Peer Support and Education

Resource Accessibility

Objective

Ensure PwSCI and relevant SCI partners in the community and hospital settings are connected and able to maintain 2-way communication as needed throughout the care continuum.

Core Components

- Develop clear communication processes, protocols or channels to facilitate communication, connection and collaboration between PwSCI, their family, community partners, and care team in SCI centres (Rec. 5).
- Promote ongoing two-way communication between SCI specialists and the community care team of PwSCI after discharge (Rec. 6).
- Identify and establish connection with relevant SCI partners across the care continuum, particularly those who will serve as main contacts for PwSCI at the community level (Rec. 7).
- Create opportunities or platform for SCI partners to collaborate, share knowledge and network with the goal of creating and maintaining a community of practice across the acute care, inpatient, outpatient and community settings (Rec. 8).

Introduction

Person-centred Care Planning

Communication and Collaboration

Focus on Healing and Recovery

Click or hover on

Recommendations 9, 10, 11

Peer Support and Education

Resource Accessibility

Objective

Make healing and recovery key pillars of the rehabilitation process for PwSCI as early as from Inpatient Rehabilitation.

- Healing refers to all the mechanisms (i.e. interventions, supports, adaptations) that help with recovery.
- Recovery refers to full inclusion in a meaningful life as defined by each individual.

Core Components

- Care providers and PwSCI to co-determine and agree on realistic recovery goals based on the prognosis and expectations of the PwSCI at every stage of the care continuum (Rec. 9).
- Embed and integrate healing and recovery programs/principles into standard rehabilitation protocols or therapy sessions, drawing from current evidence on SCI prognosis (Rec. 11).
- Create opportunities for SCI partners to learn, discuss and share current knowledge on SCI prognosis and the healing expectations of PwSCI (Rec. 11).
- Integrate current services focused on healing and recovery (e.g. adapted exercise programs, which foster neuro recovery, including adapted recreation and sports programs (Rec. 10)).

Introduction

Person-centred Care Planning

Communication and Collaboration

Focus on Healing and Recovery

Peer Support and Education

Click or hover on

Recommendations 12, 13, 14

Resource Accessibility

Objective

Improve SCI knowledge and self-management skills for PwSCI through peer support, education, and regular relevant knowledge updates.

Core Components

- Review and modify as appropriate existing peer support programs for improving self-management skills of PwSCI (Rec. 12).
- Provide training to peers on how to formally teach other peers on self-management, taking into account the variations in peer experiences (Rec. 12).
- Organize education days/series in collaboration with PwSCI and partners to provide updated knowledge about SCI and SCI care (Rec. 14)
- Provide education for partners, including PwSCI, on how to access SCI-specific resources throughout the care continuum (Rec. 13).

Introduction

Person-centred Care Planning

Communication and Collaboration

Focus on Healing and Recovery

Peer Support and Education

Resource Accessibility

Objective

Streamline ways for PwSCI and partners to identify and access appropriate resources (funding, supports, etc).

Core Components

- Create a centralized resource list relevant to PwSCI and other SCI partners especially those relevant to individuals in Alberta (Rec. 16).
- Simplify and/or provide suitable guides or templates on the application process for resources, particularly funding with relevant partners (Rec. 15).

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

Click or hover on Recommendations 15, 16

All Recommendations by Thematic Areas

Person-centred Care Planning

1) Ensure accessibility of multidisciplinary care plan post-discharge by patient and relevant partners across the care continuum
2) Co-develop and revise multidisciplinary care plan in a timely manner with PwSCI, their family and relevant partners
3) Provide PwSCI individualized information on SCI resources in multidisciplinary care plan in preferred accessible format
4) Establish and communicate to PwSCI clear arrangement for post-discharge follow-up before discharge e.g. SCI Physiatry clinic follow-up at a set interval and then yearly thereafter

Communication and Collaboration

5) Establish process(es) that allows a PwSCI and family to connect, communicate and engage with partners in the community and SCI centres in a collaborative way
6) Ensure ongoing 2-way communication between SCI specialists at the SCI centres and relevant community healthcare practitioner/team
7) Identify relevant partners across the care continuum including healthcare practitioner/team who becomes the main contact for PwSCI at the community level
8) Create a community of practice involving community, acute, inpatient and outpatient partners

Focus on Healing and Recovery

9) Co-develop realistic goals for recovery between PwSCI and clinicians at each phase of rehabilitation
10) Support PwSCI to connect and participate in adapted recreation and sports/physical activity programs
11) Make neuro recovery and functional restoration a key aspect of rehabilitation across the care continuum with the understanding of the current knowledge on prognosis and expectations of PwSCI

Peer Support and Education

12) Use peer support programs to improve skills for self-management and provide update on current SCI knowledge
13) Educate and support SCI partners (PwSCI, family & care team) on how best to access SCI resources as early as during inpatient rehab and throughout the care continuum.
14) Co-develop education and associated materials with PwSCI and relevant partners e.g. education series and SCI Education Days

Resource Accessibility

15) Make navigation and application for funding and resources easier for PwSCI
16) Connect with key partners to leverage existing resources and create a centralized list

Objective

Ensure PwSCI and relevant SCI partners are consistently engaged in the development of and have access to an updated person-centred multidisciplinary care plan across the care continuum.

Core Components

Recommendations

1) Ensure accessibility of multidisciplinary care plan post-discharge by patient and relevant partners across the care continuum
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Core Components

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Objective

Make healing and recovery key pillars of the rehabilitation process for PwSCI as early as from Inpatient Rehabilitation.

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Core Components

Recommendations

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Objective

Improve SCI knowledge and self-management skills for PwSCI through peer support, education, and regular relevant knowledge updates.

Core Components

- Review
- Provide
- Organiz
- Provide

Recommendations

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13) Educate and support SCI partners (PwSCI, family & care team) on how best to access SCI resources as early as during inpatient rehab and throughout the care continuum.

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Objective

Streamline ways for PwSCI and partners to identify and access appropriate resources (funding, supports, etc).

Core Components

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Recommendations

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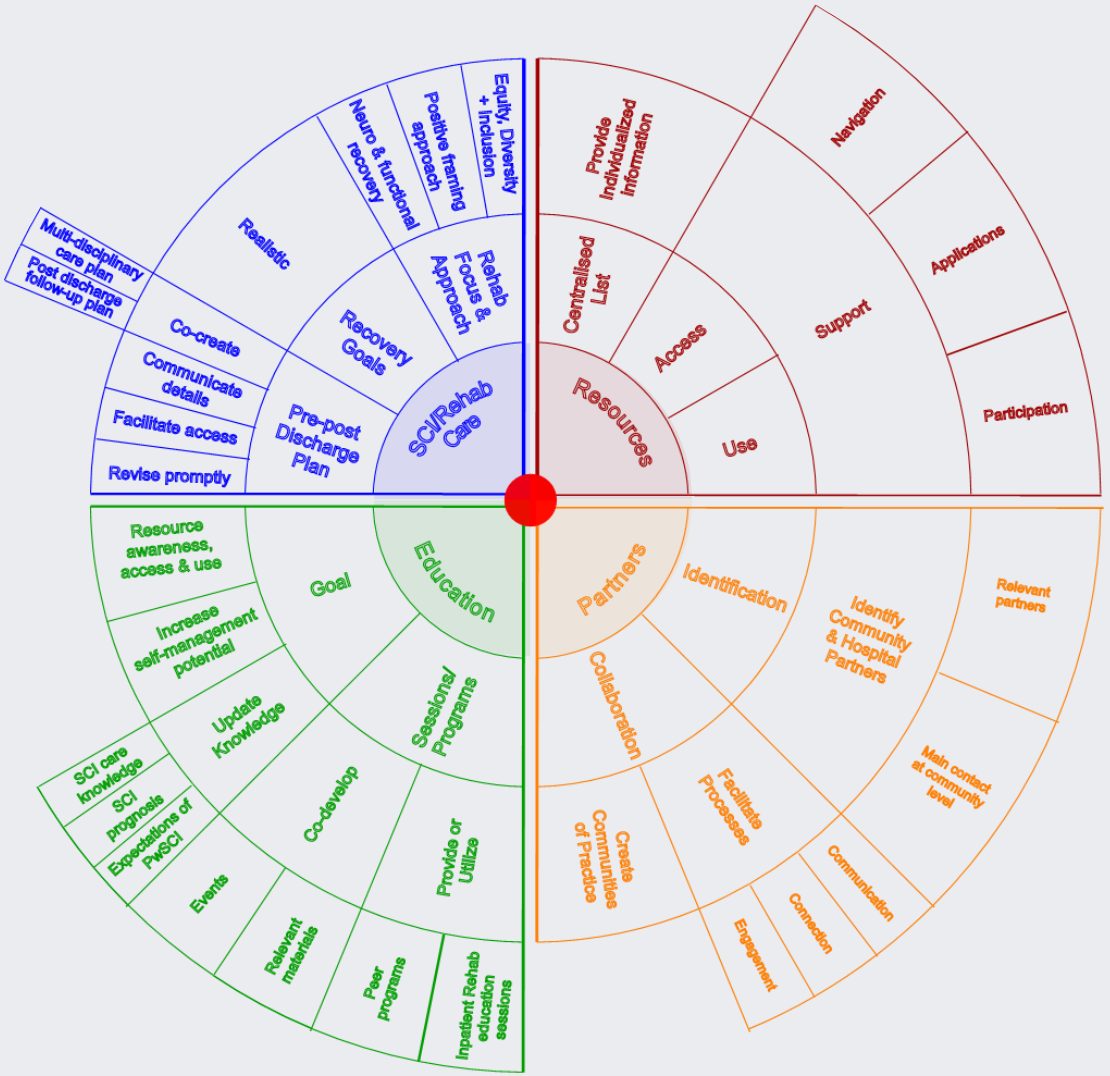
Recommendations At a Glance

Click on one of the four main areas of the chart for an expanded view



Recommendations At a Glance

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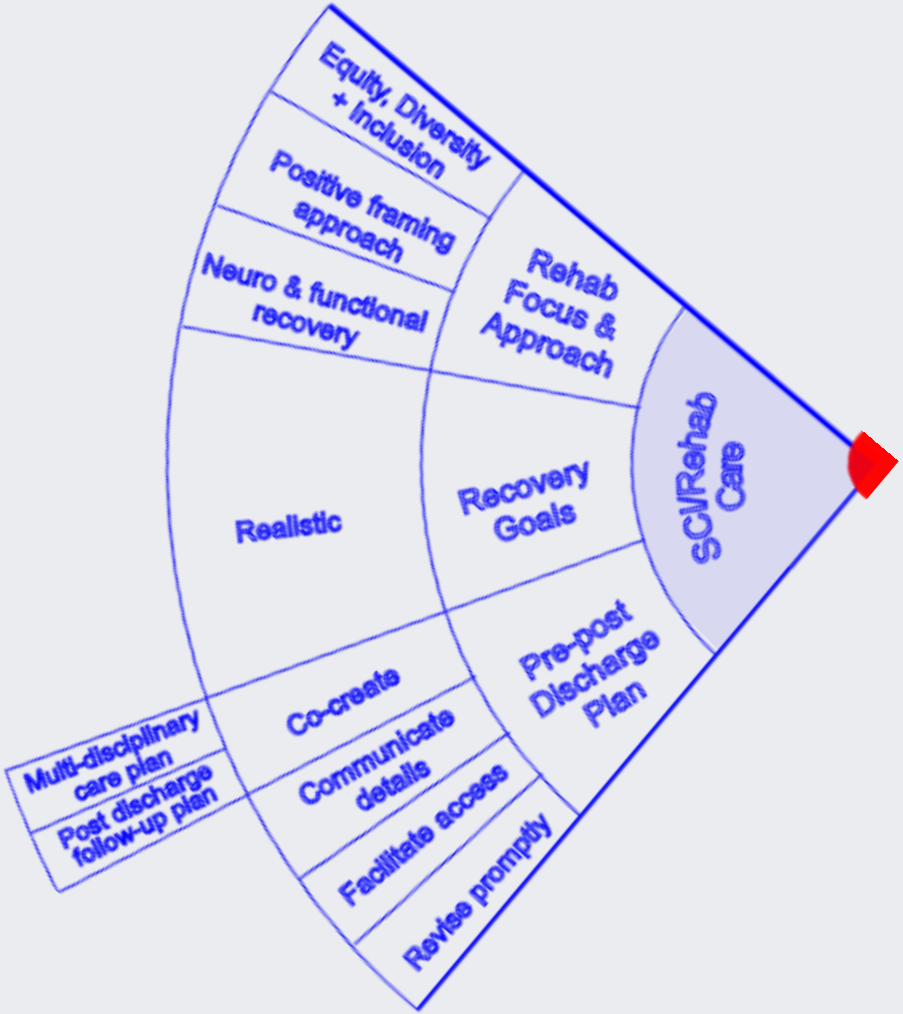

Recommendations At a Glance

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Recommendations At a Glance

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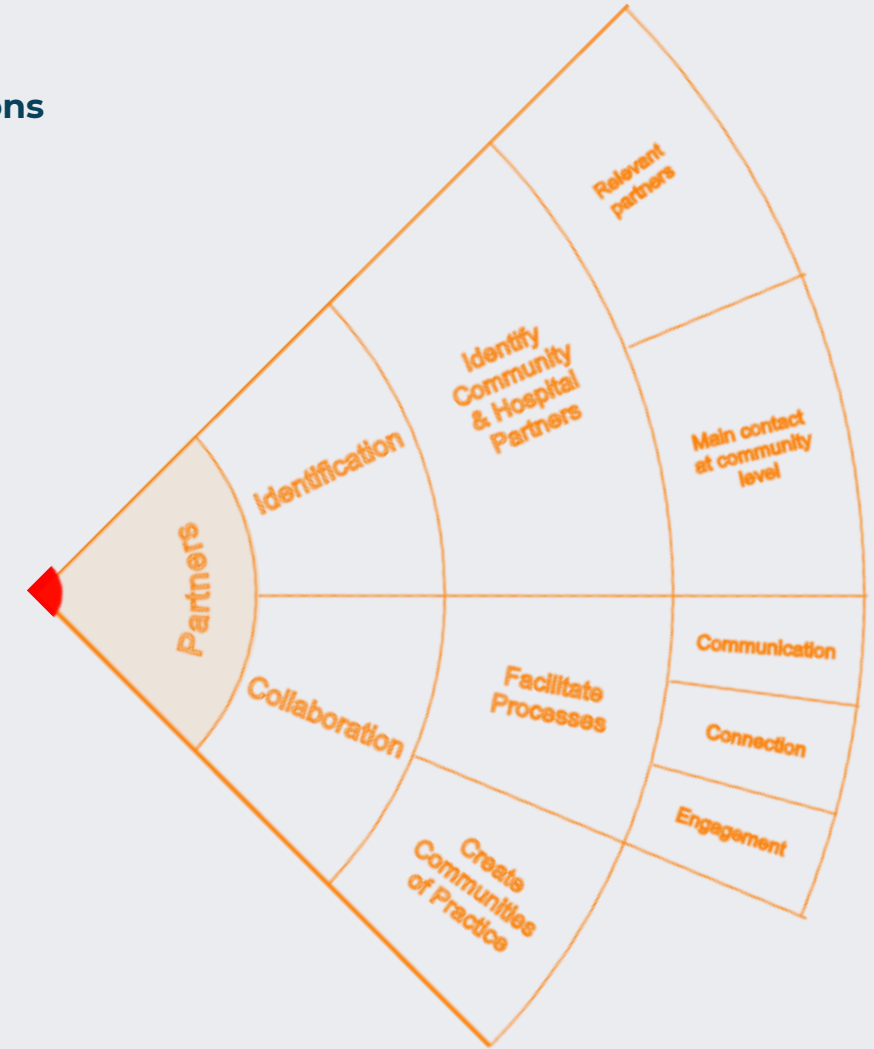

Recommendations At a Glance

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CONCENTRIC

Project title:

CONnecting and **C**oordinating an **E**nhanced **N**etwork for **TR**ansitions **I**n **C**are: A New Model for Spinal Cord Injury in Alberta

Main objective

To design, implement and evaluate an improved, evidence-based and standardized provincial model of care with clear transition strategies for persons with spinal cord injury

Scope

Transition from Inpatient Rehab to Community

Stages

Stage 1 – Situation Analysis

To understand the transitions in care experience of persons with SCI & SCI stakeholders

Stage 2 – Model Development

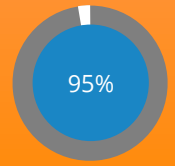
To build partnership with SCI stakeholders and co-develop CONCENTRIC model

Stage 3 – Model Implementation & Evaluation

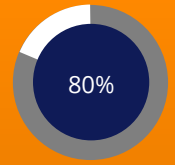
To co-develop activities to implement CONCENTRIC model recommendations and evaluate their impact

Project dashboard

Completion Rate:



Expected
(Since April 2019)



Actual
(Since ethics approval - Jan 2020)

Date recap

Official Start Date

April 2019

Official End Date

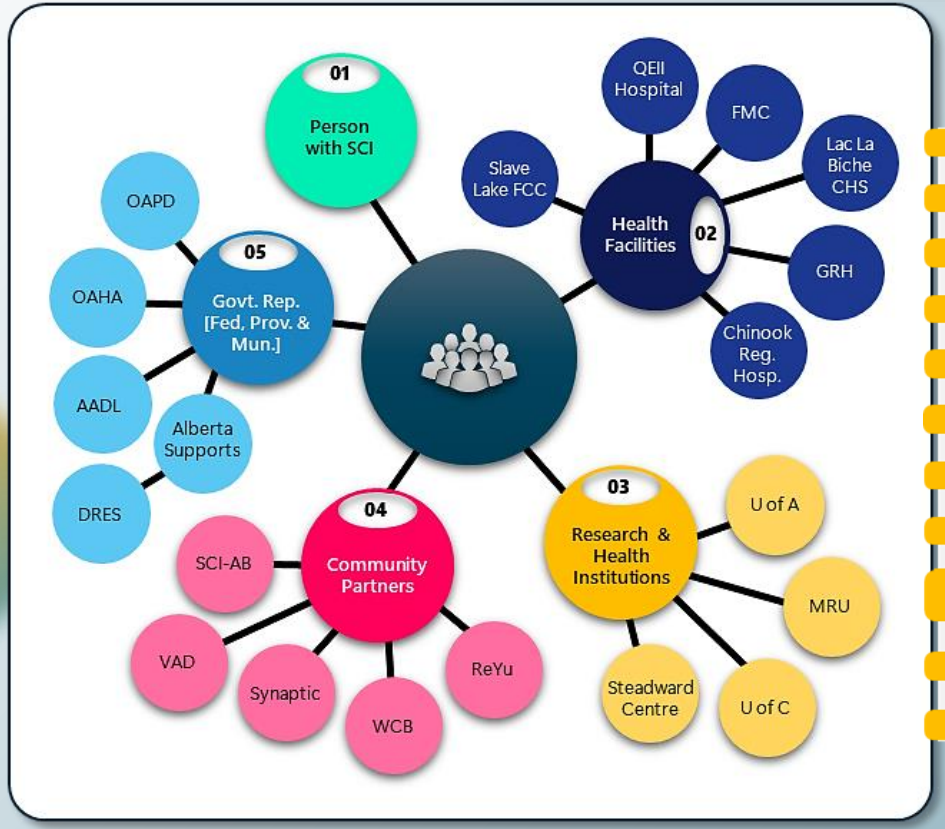
March 31, 2026

Current Stage

Stage 3

More info

Engaged Partners



Abbreviations

Chinook Reg. Hosp.	Chinook Regional Hospital
DRES	Disability Related Employment Supports
Fed.	Federal
FMC	Foothills Medical Centre
Govt. Rep.	Government Representative
GRH	Glenrose Rehabilitation Hospital
Lac La Biche CHS	Lac La Biche Community Health Services
MRU	Mount Royal University
Mun.	Municipal
OAPD	Office of Advocate for Persons with Disabilities
OAHA	Office of the Alberta Health Advocates
Prov.	Provincial
QEII Hospital	Queen Elizabeth II Hospital
ReYu	ReYu Paralysis Recovery Centre
SCI-AB	Spinal Cord Injury Alberta
Slave Lake FCC	Slave Lake Family Care Clinic
Synaptic	Synaptic Spinal Cord Injury and Neurological Rehabilitation Centre
U of A	University of Alberta
U of C	University of Calgary
VAD	Voice of Albertans with Disabilities
WCB	Workers' Compensation Board

Thanks for all your contributions...

CONCENTRIC

Other Project Information

*Opens in new window

Project Website

2023 Report

2022 Report

2021 Report