CONCEPT DESIGN
Working Group
REPORT
2022

CONnecting and **C**oordinating
an **E**nhanced **N**etwork for
TRansitions **I**n **C**are
(CONCENTRIC)

Executive Summary

Successful transitions in care (TiC) is strategic to achieving successful community reintegration for persons with life-long chronic conditions such as persons with spinal cord injury (SCI).

This report details the efforts of a broad range of SCI stakeholders across the province of Alberta who came together over a period of 9 months to brainstorm solutions to identified TiC gaps for persons with SCI in the province.

Guided by the U-Process framework, 36 individuals representing five different stakeholder groups participated in 9 sessions under the Concept Design Working Group (WG). The subsequent sections in this report provides insight to the sessions conducted, issues considered, challenges encountered, outputs produced and recommendations made for improving subsequent stakeholder engagement.

Working with the findings from Stage 1 of the project, the Concept Design WG achieved its goal to produce outputs for other working groups to develop further into a provincial SCI TiC model, called the CONCENTRIC model. These outputs include the ideal state for TiC and 15 main recommendations organized under 5 themes.

From evaluation of the working group and conversation during the sessions, providing sufficient time for stakeholder input, building trust between stakeholders and ensuring community participation does not overwhelm persons with SCI were emphasized.

In all, members of the WG expressed that it was a positive experience and successful collaboration.

Learning and working together to improve transitions in care, transform practices and reduce costs of care for persons with spinal cord injury

CONCENTRIC

For additional information visit:

www.concentricproject.com

A New Model for Spinal Cord Injury Care

VISION

Creating a community of SCI stakeholders committed to learning and working together to improve transitions in care for persons with spinal cord injury

MISSION

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

CONCENTRIC
Concept design working group report

Overview

Abbreviations

1) **WG** – Working Groups
2) **Government rep** – Government representatives
3) **SCI** – Spinal Cord Injury
4) **TiC** – Transitions in Care
5) **HCP** – Health Care Provider
6) **S-P-O** – Structures, Processes & Outcomes
7) **MDA WG** – Model Development & Actualization Working Group
8) **CIHR** - Canadian Institutes of Health Research

Sponsors & Supporters

Alberta Health Services
Canadian Institutes of Health Research / Instituts de recherche en santé du Canada
Friends of Glenrose
PRAXIS Spinal Cord Institute / Institut de la moelle épinière
Spinal Cord Injury Alberta / Lésions Médullaires Alberta
University of Alberta SCI Research Chair
The Alberta Paraplegic Foundation
Clinical Neuro Sciences Calgary Canada
FoMD
W21C

Why CONCENTRIC

Transitions in Care (TiC)

TiC is defined as “care transition, coordination and continuity during changes in health status, care needs, service providers or settings”. It may include informational, relational, and/or management continuity.

Challenge

TiC gaps resulting in Persons with SCI

- Been re-hospitalized 2.6 times more often, Spending 3.3 more days in hospital,
- 2.7 times more likely to have a physician contact and
- Requiring 30 times more hours of home care services in comparison to the rest of the population.

Geographical inequities

- Persons with SCI residing in the rural/remote areas are at a greater disadvantage in comparison to their counterparts in the urban areas where specialized centres are currently largely located

Further implication of TiC gaps

- Estimated cost of $1.5 to $3.0 million
- Unacceptable, unwanted and unpredictable cycle between secondary complications, adverse events, increased morbidity, hospital readmissions and emergency room visits
- Decreased patient and provider satisfaction

Solution

Develop an evidence-based, standardized and provincial TiC model that enables successful community re-integration and achieving a meaningful life for persons with SCI, particularly for those resident in rural or remote areas

01 **Stage 1**
Situational Analysis

Conduct situation analysis to identify the actual state of TiC from inpatient rehab to rural, remote or reserved communities in the province of Alberta.

02 **Stage 2**
SCI TiC Model Design

Using Stage 1 findings, brainstorm and co-develop a CONCENTRIC model that addresses identified challenges and leverages existing facilitators

03 **Stage 3**
Implementation & Evaluation of CONCENTRIC model

Implement, evaluate and make real time adjustments that improve effectiveness of the model derived in Stage 2

Project status summary

- CONCENTRIC is a 4-year CIHR funded provincial project that obtained approval in April 2019
- Due to Covid-19 challenges, a new end date of 2024 is set for the project
- Ethics approval to start operational activities and Stage 1 was obtained in January 2020.
- Pilgrimages working group responsible for data collection and analysis in Stage 1 was inaugurated in April 2020.
- Stage 1 analysis completed in March 2021 and Stage 2 officially started in June 2021
- Concept Design WG responsible for brainstorming solutions to identified challenges from Stage 1 findings inaugurated in June 2021 and completed their tasks in February 2022
- Other WGs involved in model design and actualization to be inaugurated in the coming months.

Phase Transition [Stage 1 to 2]

Subsequent to identifying barriers and facilitators to successful TiC, the next steps involve using them to **co-develop, implement and evaluate a model that addresses challenges while leveraging strengths**.

Stage 1 activities

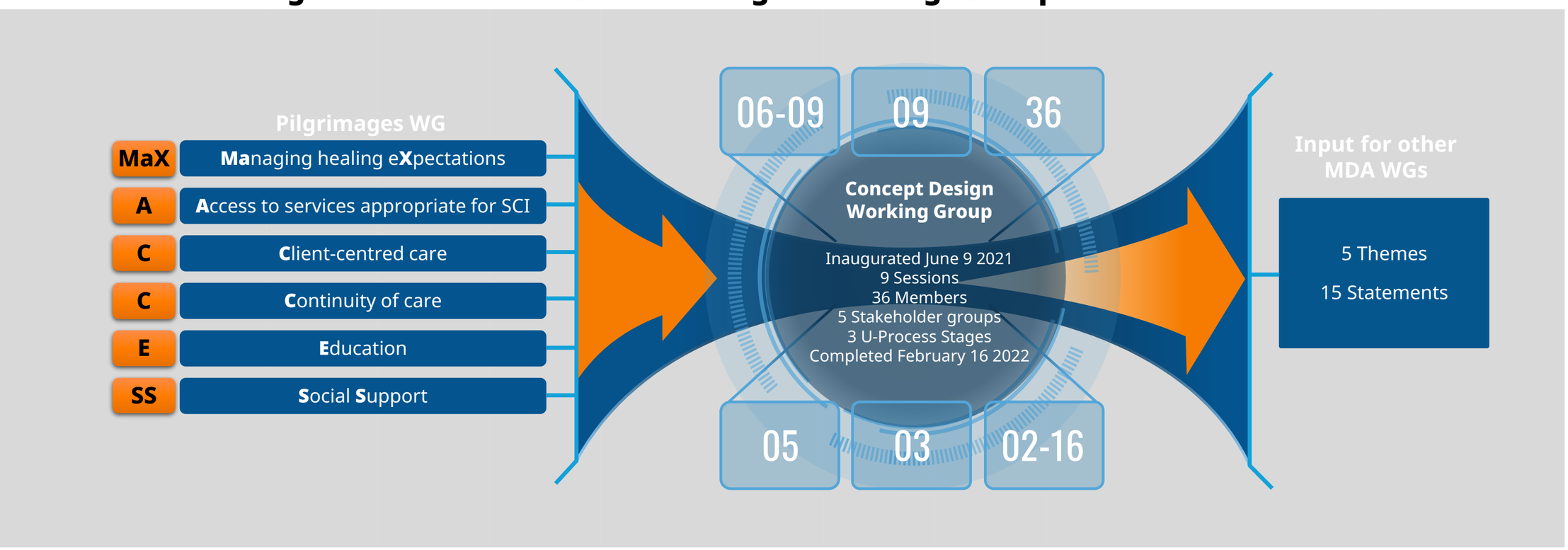
Three complementary activities undertaken to achieve the goal of Stage 1 include;

- Semi-structured activities to obtain the experience and perspective of persons with SCI and SCI care providers on TiC
- Pathway mapping to model the care pathway from inpatient rehab to community and for rehospitalization in Alberta.
- Thick description of services and resources available within the province produced by conducting document and webpage analysis and informal interview with care providers

Stage 1 outcome

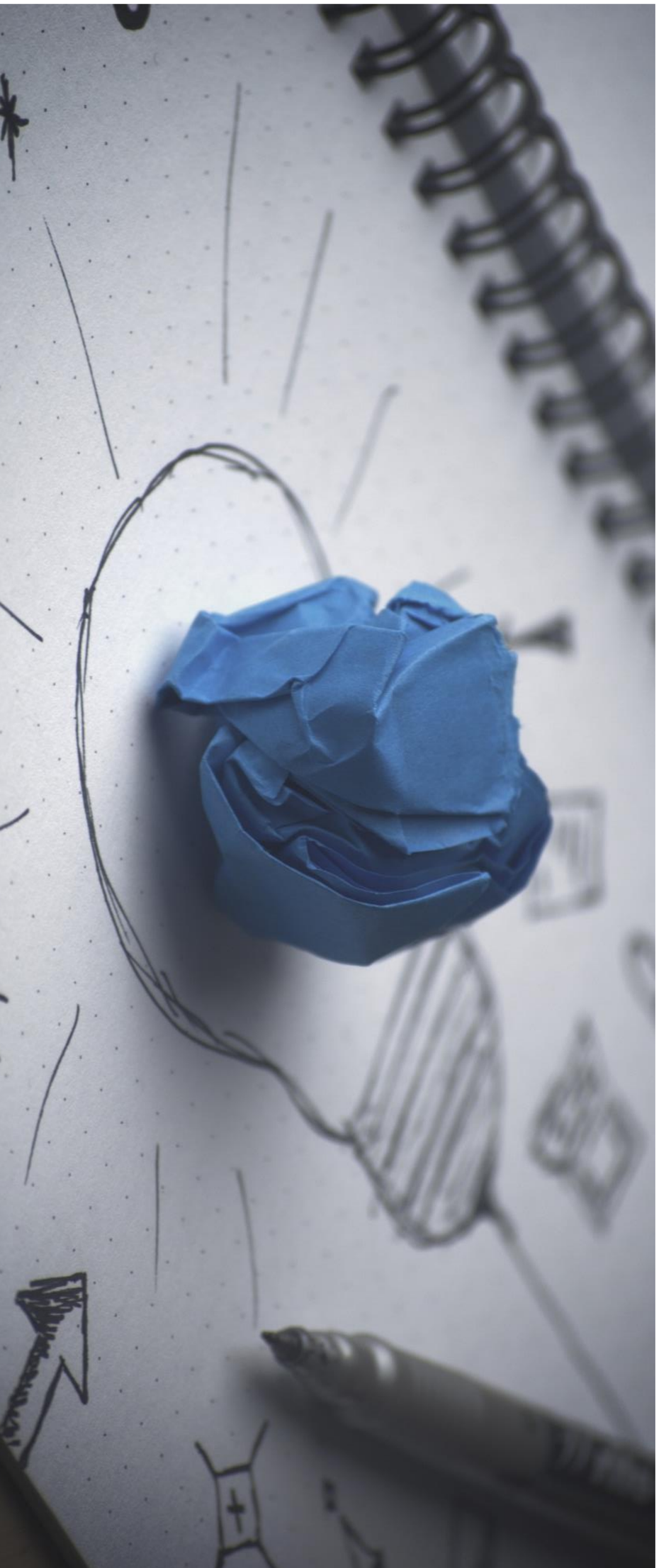
Analysis of Stage 1 data resulted in six (6) themes with the acronym **Max ACCESS** *(see image below)*

Overview of generation and utilization of Stage 1 and Stage 2 output



** WG – Working Group*
** SCI – Spinal Cord Injury*
** MDA WG – Model Development and Actualization Working Group*

Concept Design Working Group



Goal

To obtain input of SCI stakeholders and generate recommendations enriched by multi-stakeholder perspective

Tasks

1. Familiarize with and utilize Stage 1 findings to identify and propose the ideal state strategic to successful TiC
2. Identify the structure, processes and outcomes critical to achieving the ideal TiC state

Leadership – Co-Chairs

- Person with lived experience of SCI & a community partner
- Community partner

Membership composition

- Person with lived experience of SCI
- Community partner
- Government representative
- SCI Researchers
- Health care provider

A total of **44 SCI stakeholders participated** in the working group in different capacities either as full-time members (39), collaborators (3) or speakers/case givers (5)

Guided by the U-Process theory with 3 main phases (i.e. co-sensing, co-presencing & co-creation), **a total of 9 sessions** were held between June 2021 and February 2022

Evaluation of the WG which included planned activities, accomplishments and experience participating in the WG was conducted in March 2022

2 video animations of the TiC ideal state, **6 themes and 15 statements** indicating key domains for successful TiC and **2 scientific posters** for ISCOS 2022 conference were generated

Concept Design Working Group (continued)

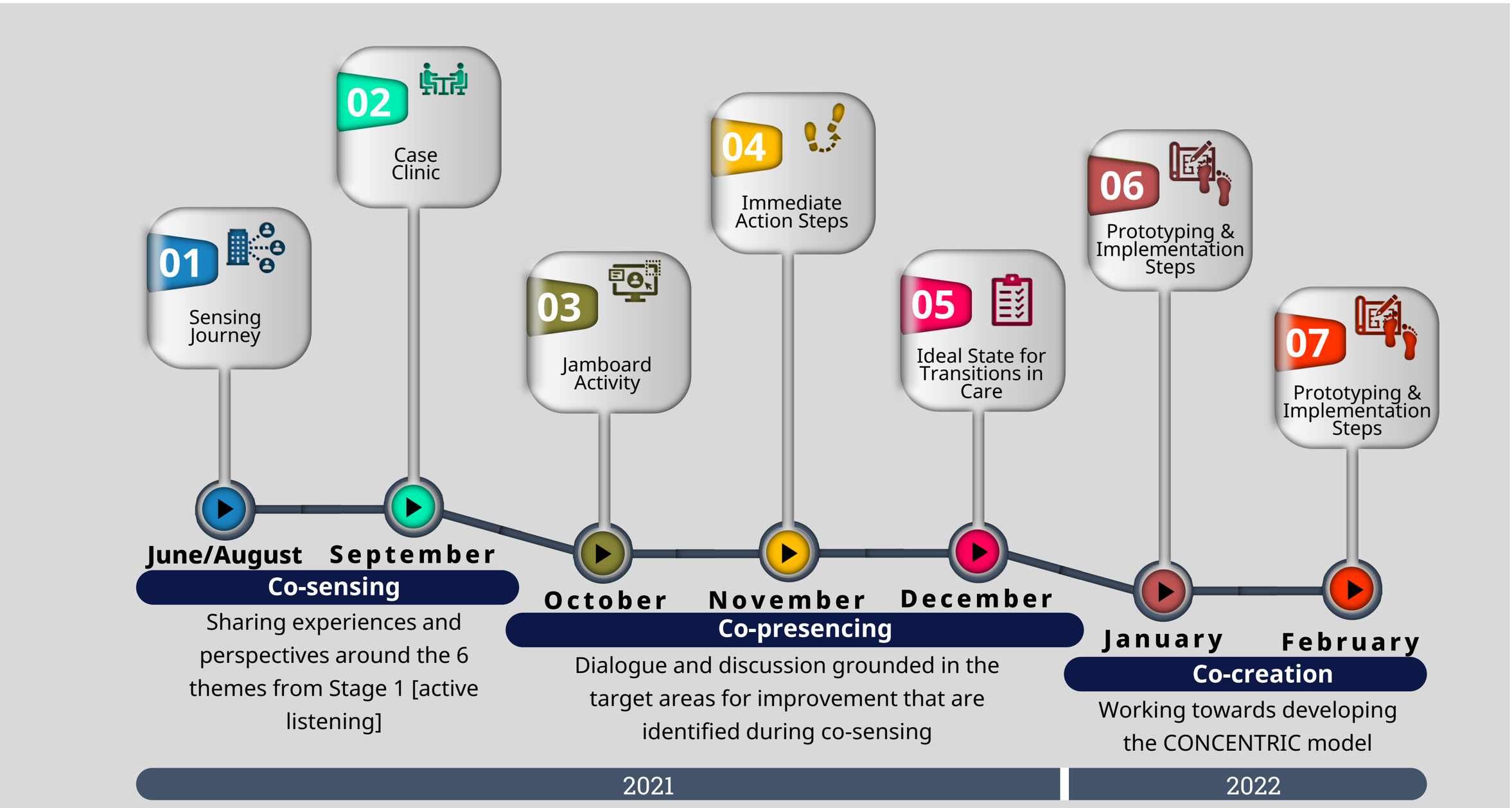
Guiding Theory

U-Process Theory or Theory U

The U-process theory hopes to draw attention to feedback gaps that occur between parts of a system and the entire system. These gaps are viewed as responsible for emergence of silos or institutional bubbles which often result in inefficient or failed systems.

To address system failure, the theory emphasizes and prescribes methods or tools that facilitates a shift of focus to the collective while still acknowledging the significance of the parts or individual.

The figure below breaks down the **3 phases of the U-process as adopted in guiding the activities of the Concept Design WG.**



**See the next pages for further explanation and breakdown of each U-process phase*

Additional information on the U-process theory;

1) *https://www.u-school.org/*
2) *Scharmer, C. O. (2009). Theory U: leading from the future as it emerges: the social technology of presencing. Berrett-Koehler*

Introductory Sessions

JUNE 9 SESSION

Tasks

1. Highlight represented stakeholders, organizations or institutions
2. Debrief on issues driving the project
3. Provide project update
4. Set expectations and terms of reference for the Concept Design WG
5. Co-determine way forward

Main ask

Request for nomination for Co-Chairs

Main conclusion

- Maintain a large group and form smaller groups as needed when there is a need to focus on a specific topic

JUNE 25 SESSION

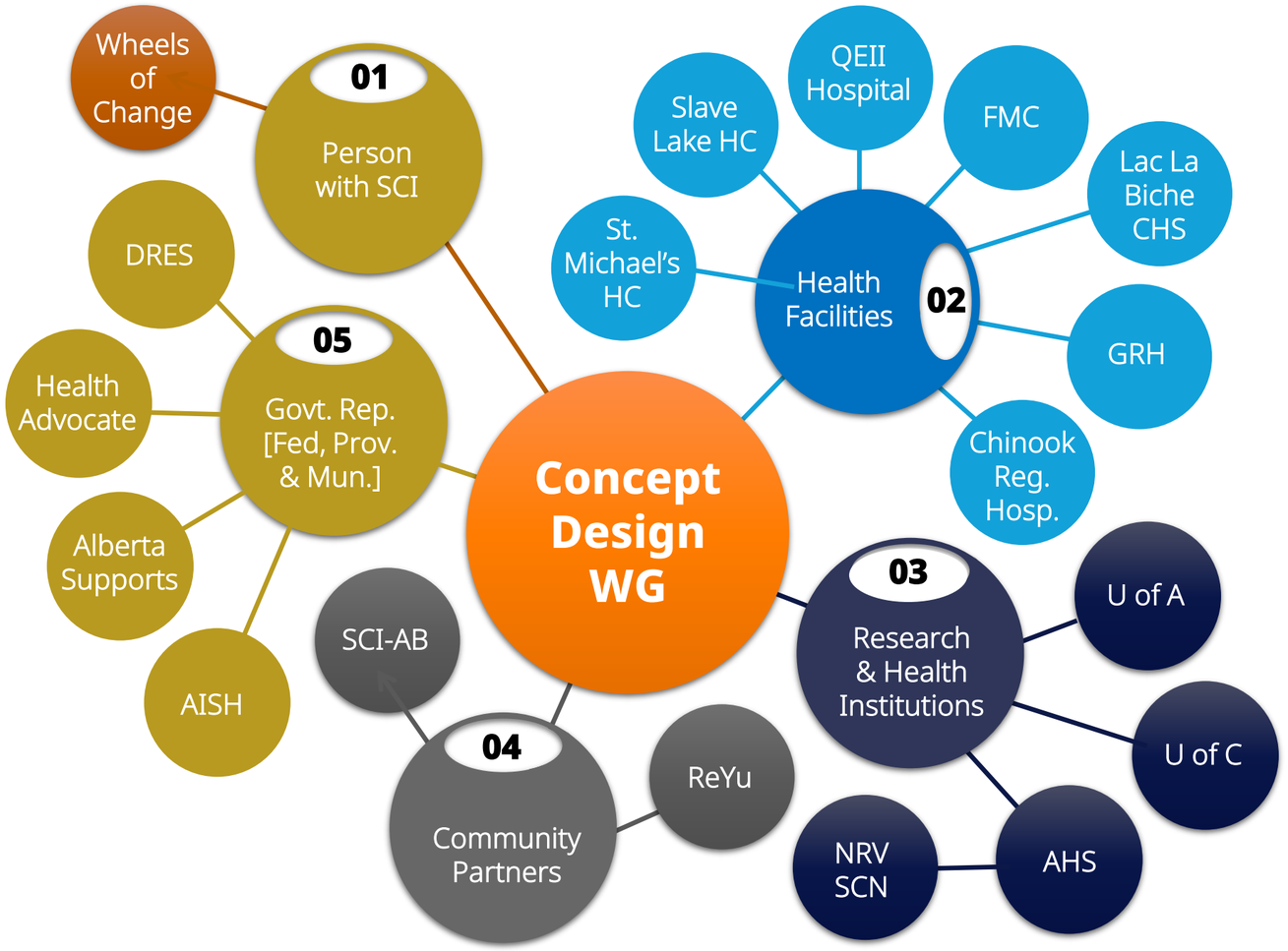
Tasks

1. Getting well-acquainted with one another and how each fits into the TiC process
2. To examine and fill gaps in existing TiC pathway maps
3. Introduce members to the U-Process
4. Co-determine meeting frequency

Conclusions

- View services/programs that are currently missing as ideal state and propose ways to integrate them into the existing TiC pathway
- Use “person-centred” instead of “patient-centred” care

Represented Stakeholders



Abbreviations

AHS	Alberta Health Services
AISH	Assured Income for the Severely Handicapped
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
Mun.	Municipal
NRV SCN	Neurosciences,. Rehabilitation and Vision Strategic Clinical Network
Prov.	Provincial
QEII Hospital	Queen Elizabeth II Hospital
ReYu	ReYu Paralysis Recovery Centre
SCI-AB	Spinal Cord Injury Alberta
Slave Lake HC	Slave Lake Healthcare Centre
St. Michael's HC	St. Michael's Health Centre
U of A	University of Alberta
U of C	University of Calgary

Co-sensing phase

Co-sensing involves helping members to understand their individual mental models/ perspectives with the purpose of aiding everyone to **open up themselves, uncover reality, and see the system they are a part of**.

Stage 1 output used for Co-sensing activities

6 themes and 8 associated statements (Max ACCESS)

Statement 1
Set personalized care plans for persons with SCI that ensures their successful adaptation to the realities of their injury and the attainment of their highest functional recovery potential, harmonizing the functional recovery expectations from individuals and their healthcare teams.

Statement 2
Service providers involved in the care of persons with SCI identify and bring to their attention existing services, programs and resources that are close to where they live

Statement 3
Service providers facilitate access to services, programs or resources that are suitable for persons with SCI

Statement 4
Using client-centred principles, service providers engage with persons with SCI and their family to determine and address their care needs

Statement 5
Service providers create a clear, standardized care pathway across rural and urban settings that allows for building connections, improving current relationships and facilitating the prompt sharing of updated client data within and across teams, facilities, services or programs

Statement 6
Using the most appropriate format that would allow subsequent retrieval and use, provide training on SCI knowledge and management skills to persons with SCI and the different individuals involved in their care

Statement 7
Facilitate achieving knowledge that addresses potential impediments to care or community re-integration

Statement 8
Connect persons with SCI and their caregivers to support networks that enable them to successfully address financial, physical, geographical, social and psychological challenges that they encounter

Co-sensing phase (continued)

Co-sensing activities

AUGUST 4 SESSION

Tasks

1. Introduction of Co-Chairs
   - Person with lived experience of SCI & a community partner
   - Community partner
2. Introducing & conducting sensing journey activity
3. Introduction of speakers

Session outcome

- 58 statements reflecting problems or challenges across the 6 themes from Stage 1 findings were highlighted
- 61 statements describing potential solutions or recommendations were prescribed

SEPTEMBER 1 SESSION

Tasks

1. Introduction of timeline for working group
2. Introducing & conducting case clinic activity
3. Introduction of case givers
4. Generative dialogue – reflection on how insight provided by case givers offer new perspectives on the existing state of TiC

Session outcome

- Knowledge of the similarities and differences in the perspective of person with SCI and their care providers within the healthcare system and in the community regarding their TiC experience and the future they envision

Sensing Journey

To listen to and understand various assumptions and perspectives on themes identified as strategic to a focal concern [i.e. findings from analysis of Stage 1 interview data].

Speakers/Hosts [each assigned a specific theme]

- Person with lived experience of SCI & community partner
- Physiatrist
- Outpatient Clinic Nurse

Discussion points

Speakers talk about

- the role they play in the system,
- the issues/challenges they are confronted with,
- the systemic barriers sustaining identified challenges,
- what a better system should look like and
- the initiative/change with greatest impact potential

Case Clinic

To access the wisdom and experience of peers with firsthand experience of a focal concern. The goal is to enable members address identified challenges in a better and more innovative way

Case Givers

- Person with lived experience of SCI
- Community partner
- Family Doctor

Discussion points

Speakers talk about

- the key challenge faced in term of transitions for persons with SCI from inpatient rehab into community
- how other stakeholders might view the situation
- the future they are trying to create
- where they need input or help

Co-presencing phase

This phase involves letting go of everything that is not essential from the past and present and **connecting and surrendering to the best or highest possible future** that wants to or ought to emerge

Pre-session Webinar

Members invited to **webinar on scoping review on Spinal Cord Injury models of care delivery** adopted across the world

Activity I Questions

- Where would you situate yourself in the current transition in care map?
- What changes should be made in your current role that will ensure successful transition in care (from inpatient rehab to community) for people with SCI?
- Based on your experience of other stakeholders, what would you like to see happen, change or improve in the way we currently transition people with SCI from inpatient rehab to community?
- What would you need [human, financial, structural etc.] to ensure that your expectations in the previous question will become a reality?
- Which individuals would you bring onboard as core partners to implement the new system of transition in care for people with SCI?
- Specific to this project, which stakeholders from Slave Lake and Lethbridge would you need to bring on board?

Activity II Questions

How do we achieve the ideal state for

- While in inpatient rehab
- In preparation for discharge

Activity III Questions

How do we achieve the ideal state for

- Across all transition points
- When back at home and in the community

OCTOBER 6 SESSION

Goal – To envision what the future state should be and require

Task – To co-determine the ideal state **[Activity I]**

Outcome/Output

❶ Ideal state
- for inpatient rehab
- when preparing to leave in-patient rehab
- when back home and in the community
- across all transition points or the care continuum

❷ Video animation of the ideal states

Scan/Click Scan/Click

NOVEMBER 3 SESSION

&

DECEMBER 1 SESSION

Goal – To familiarize with co-developed ideal transitions in care states

Task – To discuss further the ideal states created from October session and improve them **[Activity II & III]**

Outcome – 5 Themes, 15 Statements

Co-presencing phase (continued)

15 statements organized under five themes were identified as actions strategic to improve TiC for persons with SCI

Co-presencing sessions output

01

1. Regularly update the inventory or list of resources (i.e. community services/programs and supports, contacts) for SCI
2. Make available a list of updated resources to persons with SCI, their family and care team
3. Advocate for and support persons with SCI and their family to access and utilize appropriate resources

Resources

02

4. Determine individualized follow-up plans after inpatient rehab with persons with SCI
5. Include a well-defined process and resource list for patient and family members to address their questions and concerns
6. Gather and provide appropriate pre-selection and pre-screening information for Persons with SCI to increase their chances of success with government funding applications or alternative sources of funding
7. Care providers and persons with SCI collaborate to create an individualized care plan that is shared and utilized across care settings
8. Provide early and ongoing guidance, support and coordination in the inpatient rehabilitation and community settings to increase access to new and emerging therapies that may promote healing/recovery after SCI

Person-centred approach driven by the Person with SCI

03

9. Organize meetings regarding care plan with persons with SCI and their hospital and community care teams before discharge from hospital
10. Form regional SCI partnerships to improve communication, connection and harmonization of practices between inpatient rehab and community teams
11. Develop clearly defined roles, expectations and accountability within the regional SCI partnerships

Connectedness

04

12. Provide training to persons with SCI on patient rights (e.g. building skills such as confidence in asking questions, requesting for alternative options from care team, and self-advocacy.
13. Educate persons with SCI on how to use and navigate the healthcare system.
14. Support care teams to utilize a teach-back approach when providing training for persons with SCI.

Empowerment

05

15. Create the opportunity for persons with SCI to choose transitional housing to improve their community reintegration (i.e. provision of temporary housing with supportive services to facilitate transition back into the community)

Innovative transition between inpatient rehab and community re-integration

✶Alternative way of grouping the statements have been suggested and would be presented at the general meeting scheduled for October 19, 2022. The proposed themes, excluding Theme 5 above, include;

- *Resources [Statements 1, 2, 3, 5, 6];*
- *Individualized care plan & follow-up [Statements 4, 7, 9];*
- *Promotion of healing & recovery [Statement 8];*
- *Regional partnership [Statements 10, 11];*
- *Empowerment [Statements 12, 13, 14]*

Co-creation phase

This phase has two parts; **prototyping the new future that wants to emerge** and incorporating, in an iterative manner, feedback from stakeholders to improve the prototype before it is piloted.

JANUARY 13 2022

SCI Transitions in Care Feasibility Survey 2022

The broader SCI community were engaged in completing a feasibility survey to obtain their input in determining which of the 15 Statements generated from the Co-presencing sessions can be achieved in the short-term (<1 year), medium-term (1 - 3 years) or long-term (> 3 years)

JANUARY 26 SESSION

&

FEBRUARY 16 SESSION

Task

1. Review the Feasibility survey response
2. Apply Donabedian model to the 15 Statements to identify elements strategic to achieving the ideal/future state that is envisioned

Output

Identified structures, processes and outcomes (S-P-O) organized into four logic models

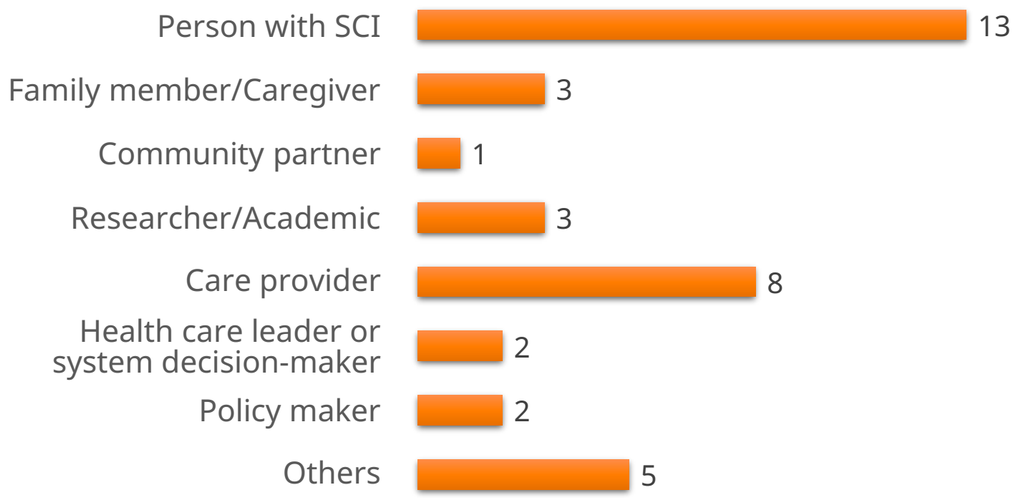
Session Conclusions

- Some items would require more time to achieve than what the feasibility survey reflected
- Statements are interconnected and some therefore can't be achieved without implementing the other

Goal

To develop the first prototype of CONCENTRIC model that reflects the ideal or future state that is envisioned to emerge for subsequent working groups to leverage

Survey respondent breakdown [37 responses]



Survey response summary

	Statement Number(s)	Total Number
Less than 1 year	1, 2, 3, 4, 6, 7, 9, 12, 13, 14	10
Between 1-3 years	8, 10, 11	3
Greater than 3 years	15	1
Inconclusive	5	1

Donabedian model

This model focuses on quality of care and makes the assumption that it can be inferred from information classified under three categories;

- ***Structure*** [setting in which care occurs],
- ***Process*** [what is actually done in giving and receiving care]
- ***Outcome*** [the effects of care on the health status of patients and populations]

Process summary

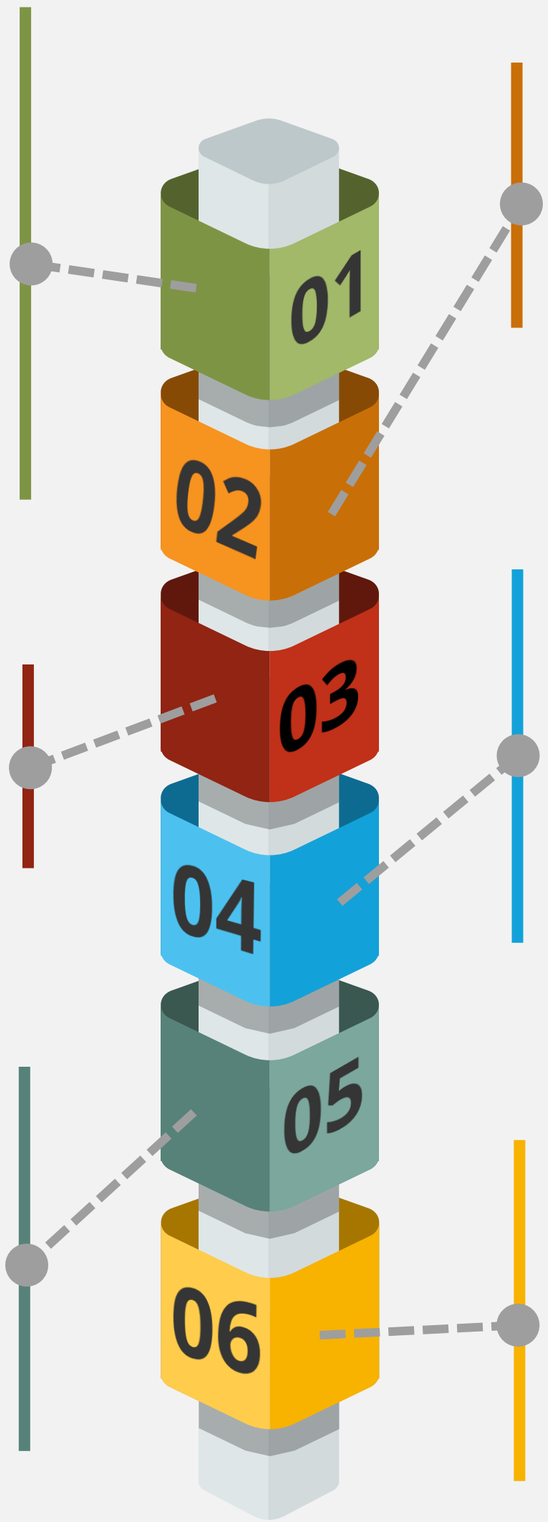
Stakeholder engagement process

Identify, recruit & engage stakeholders

- General meeting held and emails sent out to wider SCI community for potential stakeholders [both referral and self-nominations accepted]
- Working group created and engagement parameters decided

Acquaint stakeholders with issue of concern

Stakeholders were presented findings from evidence generation phase to familiarize with and discuss identified challenges



Derive ideal state

Brainstorming session held to determine ideal TiC state

Animate and rank ideal state

- Aid stakeholders in visualizing how solutions generated for achieving ideal state would work
- Engage larger community to rank feasibility of solutions in the short, medium and long-term

Deconstruct and model solutions

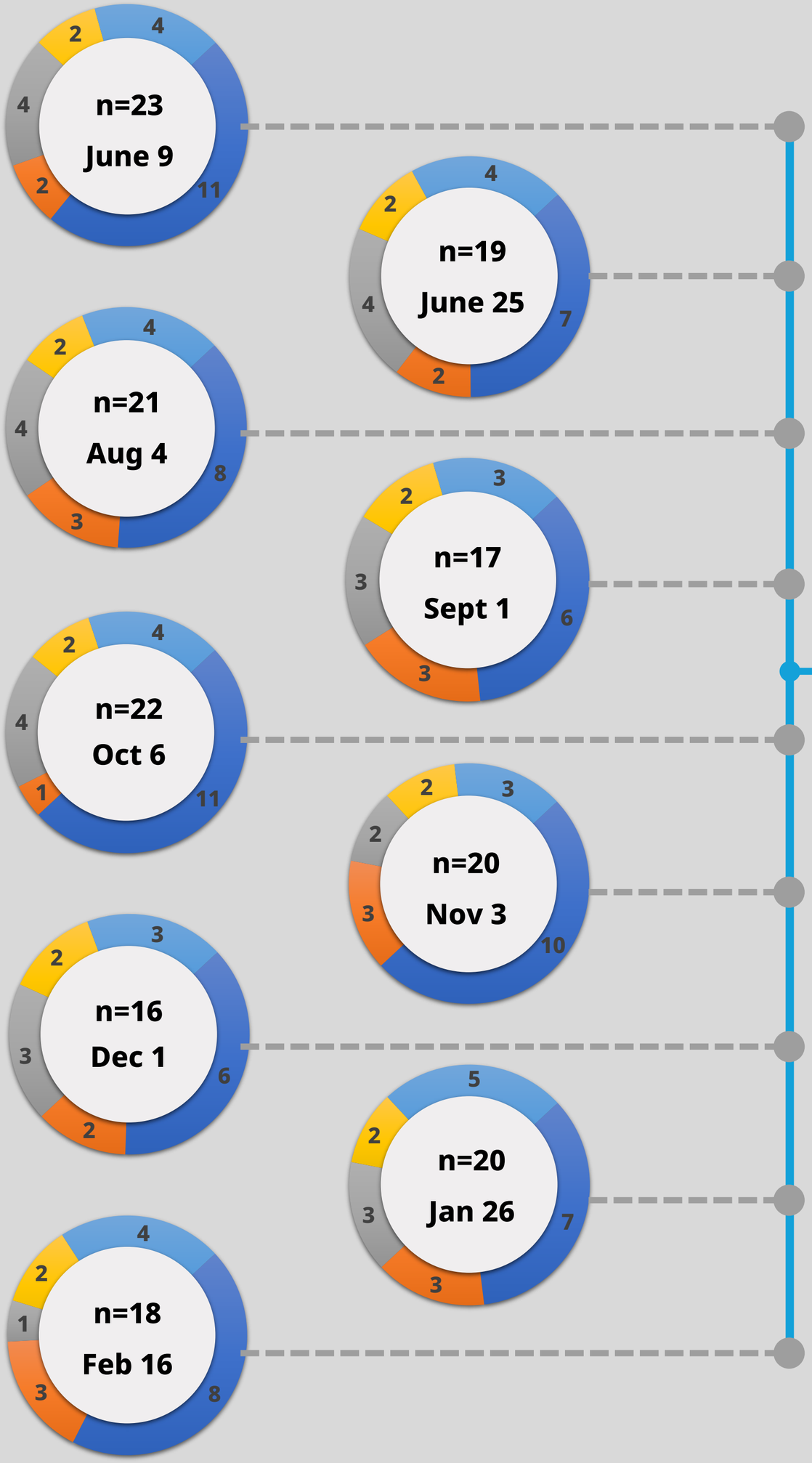
- Co-generate structure, processes and outcomes [S-P-O] for solutions
- Model S-P-O across transition points

Evaluate engagement process

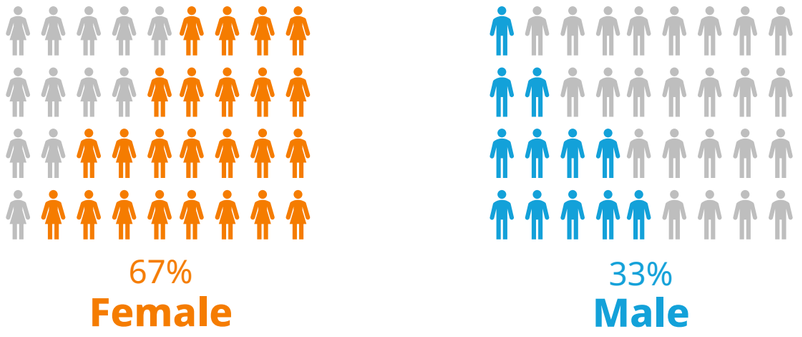
- Obtain stakeholder perception of engagement process via survey and informal interviews
- Analyse and provide feedback on responses

From Gill et al 2022 "*CONCENTRIC stakeholder engagement: Translating research into practice*" – Poster presentation at ISCOS 2022 Conference

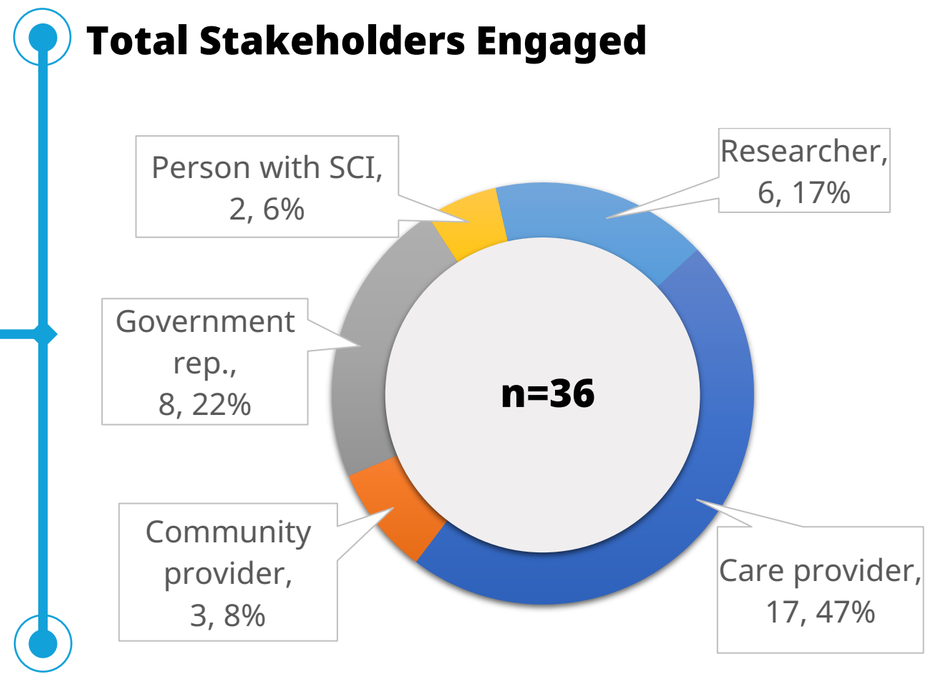
Attendance summary



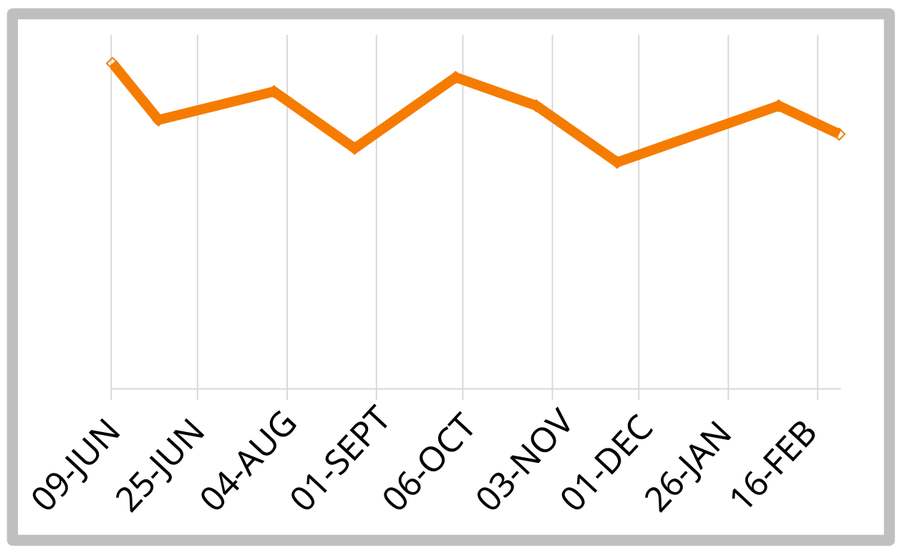
Total Stakeholders by Sex (n=36)



Total Stakeholders Engaged



Attendance trend line



Evaluation

Evaluation survey was sent out to members to obtain their **feedback on what worked well and what didn't** so as to make appropriate corrections and adjustments in subsequent working groups

Survey launch date
March 11 2022

Number of responses
14 respondents

Areas covered

- About the working group (WG)
- About planned activities of the WG
- About accomplishments

"The group activities were very successful. They were engaging, made you reflect and think deeply. The whole group was involved which is why so many excellent ideas have come out of this working group."

"Great process for respectful, collaborative work!"

"This has been an enjoyable group and purpose to be part of, with purposeful and meaningful discussions and follow-up."

"Overall it has been a very positive experience!"

Survey excerpts

Responses with strongly agree and agree only
I was able to reflect on my own practices and how they link to others in the group.
I was able to identify potential areas of improvement by listening and learning from others
Opinions/ideas/suggestions of members were respected, including mine
I was able to listen to others and identify my purpose in terms of improving transitions in care for people with SCI
Reflections during participation allowed me to learn more about myself and my role within the SCI world.
The WG had adequate diverse partners representing priority areas/settings & groups for model development and actualization (Stage 2 work).

Responses with at least one person disagreeing
Activities/Action plan for the WG were clearly described.
Timelines for achieving the deliverables and outcomes were appropriate.

Summary of "other comments" responses
A summary of progress - where we started, where we're at and what's to come
Effect of lag time in virtual meetings on hearing people from diverse background clearly
Improved understanding of differences between stakeholders, facilities or units
Need for more time
Need for more time for additional input
Regular update on where the group are in relation to the bigger picture

Meeting Chats

Conversation excerpts

These conversations always make me reexamine my biases as a HCP! Even the automatic language that we use can have real impact. I so appreciate this, thank you everyone!

Can you imagine how Albertans must feel trying to access services when professionals are having such a hard time trying to coordinate and work together. This really has to change

It is important to include as much community participation without the patient feeling overwhelmed.

I think that TRUST is critical - TRUST between the professionals, and TRUST between the professionals and community partners. When we have more trust among each other, we probably will be more willing to share and to work together

Suggested websites/resourcesposted in chatbox

1. https://www.alberta.ca/alberta-health-charter.aspx
2. https://peas.albertahealthservices.ca/
3. North American spinal cord injury consortium - https://nasciconsortium.org/
4. Here is an App designed by AHS that allows patients to record inpatient/clinical… https://www.albertahealthservices.ca/info/Page16144.aspx
5. https://myhealth.alberta.ca
6. https://www.albertahealthservices.ca/findhealth/Service.aspx?id=1080775&serviceAtFacilityID=1126573#contentStart
7. https://www.albertahealthservices.ca/y2a/y2a.aspx
8. This is from the Stoke Mandeville Spinal Injuries Unit in the UK… https://www.sralab.org/sites/default/files/2017-03/Adult%20NAC%20revised%20Jul%2008.pdf
9. https://wapps.sickkids.ca/myhealthpassport/
10. http://fcrc.albertahealthservices.ca/publications/journals/Family-Health-Journal.pdf
11. https://www.albertahealthservices.ca/assets/info/trt/if-trt-pediatric-transfer-plan.pdf
12. https://jooay.com/
13. https://scitcs.org/
14. This link describes an initiative in Grande Prairie to meet the needs of those who require permanent supportive housing due to mental health and addictions… https://engage.cityofgp.com/coordinatedcarecampus#:~:text=The%20Coordinated%20Care%20Campus%20is,government%2C%20and%20community%20service%20providers.&text=City%20departments%20such%20as%20Enforcement,to%20the%20Coordinated%20Care%20Campus
15. Take the time to review the following website. entering as a guest…https://helpseeker.org/ . This is an excellent hub, along with https://informalberta.ca/

Recommendations and Challenges

Several lessons were learnt and challenges faced. Below are recommendations drawn from the Poster presentation made by the working group's Co-Chairs at the ISCOS 2022 Conference and some challenges encountered.

Challenges

- Time insufficiency for proposed tasks
- Time conflicts – finding a time that is suitable for members who prefer to hold meetings during their working hours and those who may not be chanced to do so
- Difficulty engaging front-line workers due to Covid and Connect Care

Recommendations from Co-Chairs

Presentation Title
CONCENTRIC stakeholder engagement: Translating research into practice

Presentation date
September 15 – 18 2022

Conference
The 61st International Spinal Cord Society Annual Scientific Meeting (ISCoS 2022)

01 Updates
Regularly update engaged stakeholders on what is completed, what is pending and where things currently stand

02 Extended sessions or hours
Be prepared to extend meeting hours or sessions as required to complete the working group's tasks

03 Existing and new skills
Be open to learn new skills or knowledge or to improve existing ones

04 Effective communication & listening
Focus on listening to and assimilating what people actually say than merely just listening so as to respond what they are saying

05 Members' input
Adopt methods such as breakout sessions that would increase the chances of obtaining everyone's input

06 Missed sessions
Find ways to debrief members on sessions they missed without hindering the progress of subsequent sessions

07 Working group leadership
Maintain consistent communication between the working group leadership and project team to ensure project's success

08 Mission drift
Adopt methods such as weekly meetings with appropriate individuals that would help keep project on track and on time

Team

Thanks for the sacrifices made and all your contributions to the CONCENTRIC Project

- Adalberto Loyola-Sanchez
- Ashton Ulliac
- Ayan Ali
- Benveet Gill
- Benjamin Farnell
- Bonnie Lashewicz
- Braeden Kaupp
- Brooke Nowicki
- Catherine Douglas
- Chester Ho
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