

CONCENTRIC MODEL IMPLEMENTATION GUIDE

PART 1

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CONnecting and **CO**ordinating an **EN**hanced **NE**twork for **TR**ansitions in **C**are:
A New Model for Spinal Cord Injury Care in Alberta



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MISSION & VISION

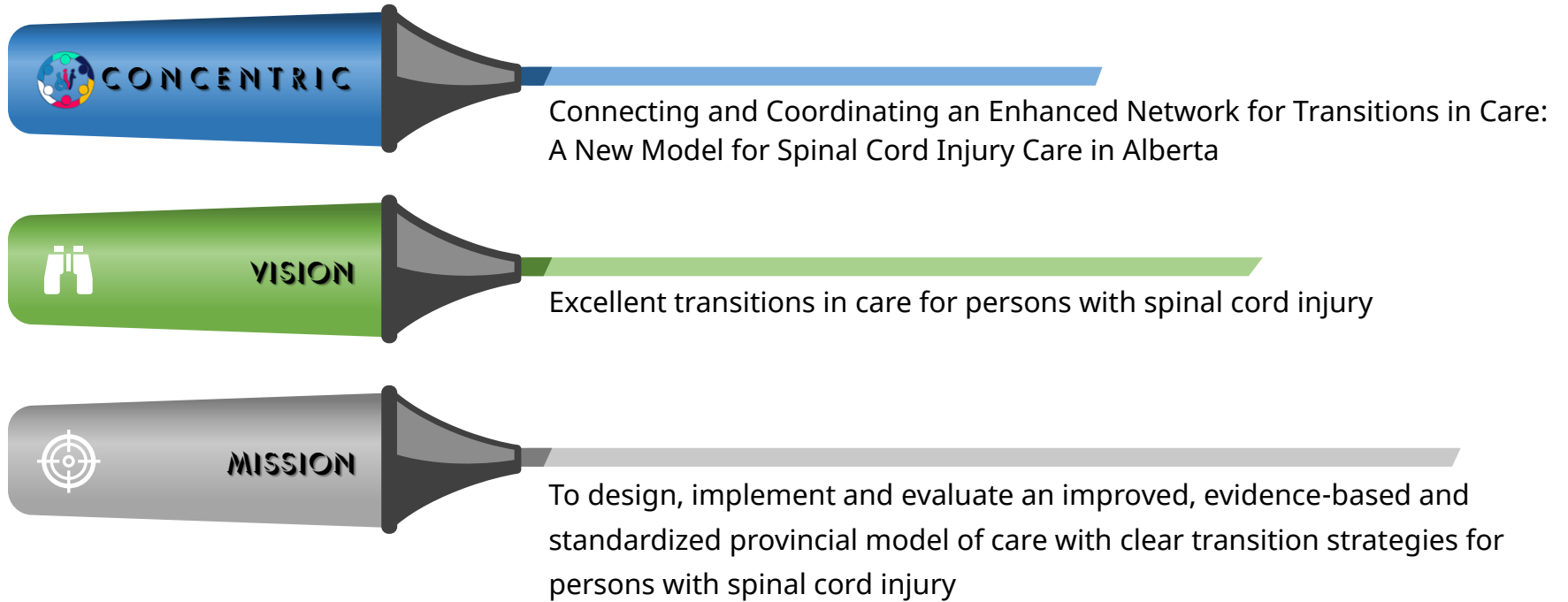


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ABBREVIATIONS AND DEFINITIONS

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	CONnecting and Coordinating an Enhanced Network for TRansitions In Care
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

I. INTRODUCTION

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 the community

Key Thematic Areas:

Recommendations from Stage 2 were prioritized by our partners and collaborators resulting in 16 highly prioritized recommendations (see [Appendix A](#) for full list) under 5 thematic areas.

1. Person-centred Care Planning (Recommendations 1, 2, 3, 4)
2. Communication and Collaboration (Recommendations 5, 6, 7, 8)
3. Focus on Healing and Recovery (Recommendations 9, 10, 11)
4. Peer Support and Education (Recommendations 12, 13, 14)
5. Resource Accessibility (Recommendations 15, 16)

Task Division for Next Step

Steering Committee

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

North & South Partners

- a) Go through 5 themes and included recommendations
- b) Start with Theme 1 to build the foundation
- c) Co-determine sequence for Themes 2 to 5
- d) Determine appropriate activities to implement recommendations

Change Champion

- a) Participate in meetings and in determining appropriate activities to implement relevant recommendations.
- b) See Change Champion Guide for further task breakdown or additional information

II. THEMATIC AREAS BREAKDOWN

1. Person-centred Care Planning (Recommendations 1, 2, 3, 4)

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).

Recommendations

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

2. Communication and Collaboration (Recommendations 5, 6, 7, 8)

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).

Recommendations

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

3. Focus on Healing and Recovery (Recommendations 9, 10, 11)

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)).

Recommendations

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

4. Peer Support and Education (Recommendations 12, 13, 14)

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).

Recommendations

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

5. Resource Accessibility (Recommendations 15, 16)

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](#)).

Recommendations

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

III. APPENDIX

A. All Prioritized Recommendations

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.
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
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
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
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, especially those specific to Alberta.

B. Recommendation–Transition Stage Breakdown

	Person-centred Care Plan (1, 2, 3, 4)	Communication and Collaboration (5,6,7,8)	Focus on Healing and Recovery (9, 10, 11)	Peer Support and Education (12,13,14)	Resource Accessibility (15,16)
Across Care Continuum	Ensure accessibility of multidisciplinary care plan post-discharge by patient and relevant partners across the care continuum	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	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	Co-develop education and associated materials with PwSCI and relevant partners e.g education series and SCI Education Days	Connect with key partners to leverage existing resources and create a centralized list, especially those specific to Alberta
	Co-develop and revise multidisciplinary care plan in a timely manner with PwSCI, their family and relevant partners	Create a community of practice involving community, acute, inpatient and outpatient partners	Co-develop realistic goals for recovery between PwSCI and clinicians at each phase of rehabilitation		
On/During Admission		Identify relevant partners across the care continuum including healthcare practitioner/team who becomes the main contact for PwSCI at the community level		Use peer support programs to improve skills for self-management and provide update on current SCI knowledge	Make navigation and application for funding and resources easier for PwSCI
				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.	
	Provide PwSCI individualized information on SCI resources in multidisciplinary care plan in preferred accessible format				
Preparing for Discharge/ At Discharge	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				
Post Discharge		Ensure ongoing 2-way communication between SCI specialists at the SCI centres and relevant community healthcare practitioner/team	Support PwSCI to connect and participate in adapted recreation and sports/physical activity programs		