**Project: A GP for Me**

**Contract: Social Work Contract**

**Location:**

**Timeframe: 18 months – September 2014 to March 31 2016 (2448 hours)**

**Organization Summary:**

The Division of Family Practice is an innovation in health care in BC, designed to support and advocate for family physicians, increase primary health care capacity, and improve patient health outcomes. The \_\_\_\_\_\_\_ Division of Family Practice is a non-profit society managed by a Board of Directors. The Division serves members in \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**Contract Deliverables:**

Working with an interdisciplinary primary care team, the Social Work Contractor serves as the primary point of contact for physician and other health professionals for complex client access to appropriate services in a seamless and coordinated fashion.

Care coordination addresses interrelated medical, social, developmental, behavioral,

educational, and financial needs in order to achieve optimal health and wellness outcomes. The Social Worker works with the client’s family/caregiver(s), Family Physician and the primary care team to coordinate care and support clients and their families/caregivers through an integrated system.

The Social Work Contract requires expertise in the areas of depression and anxiety as well as self-management and patient advocacy and in navigating complex systems and communicating with a range of people, from family members to community services to doctors and specialists.

The contract requires that the contractor have the capacity, experience and skill to complete a range of deliverables, including, but not limited to:

1. Screen referrals and perform assessment of client’s needs to determine a treatment plan and eligibility for services in collaboration with primary physician and other health care professionals; and will need to
   * utilize a variety of interpersonal skills, engages with each client in order to facilitate the building of a therapeutic working relationship.
   * respond to risk indicators that identify a need for clinical or legal intervention to ensure safety and well-being of an individual or others;
2. Respond to issues and concerns and advocates on behalf of the client/family and/or caregiver to support their choices and needs while utilizing practices that align with current and recognized care management competencies. Identify problems and seek creative solutions or approaches that maximize client autonomy and choice.
3. Identify the need for, and ensure (or arrange) transition plans are in place for clients transferring between levels of care, including involvement in discharge planning and follow up after an admission to a hospital unit or emergency department.
4. Facilitate care conferencing to review client care plans, in collaboration with the interdisciplinary/intersectoral team, to determine timing and referral to services and interventions to improve client outcomes**.**
5. Participate in the development of a comprehensive shared community care plan in collaboration with the interdisciplinary team. The care plan indicates the most responsible clinician at any given time. This plan is to be shared with the client, family, primary care provider and referring clinics. Identify system barriers and potential solutions.
6. As part of an interdisciplinary/intersectoral team, establish effective working relationships and partnerships with other professionals, community members and agencies. Share knowledge and approaches with other team members, particularly the primary care Life Skills Work Contractor.
7. Maintain related records, document observations, interventions and outcomes on the Electronic Medical Record; collect required statistics for evaluation; prepare reports as required and in accordance with established standards and procedures.
8. Demonstrate working knowledge of clinical pathways appropriate to assigned clients.
9. Participate in, and contribute to the quality improvement activities and the evaluation of the A GP for Me initiative.
10. Maintain professional practice growth and knowledge to reflect current standards of practice

**Key Skills, Education and Experience**

* Baccalaureate degree in a related healthcare profession
* Three years recent related experience in a complex health care setting including experience with client coordination in a multidisciplinary environment, with a focus on facilitating integrated approaches to community health and well-being or
* An equivalent combination of education, training and experience
* Current valid BC Driver’s License, reliable vehicle with business use insurance
* Good working knowledge of clinic office routines, health system issues, primary care models, community health care resources, extended stakeholders
* An interest and understanding of the elderly population and the challenges of maintaining independence and wellness
* Good to strong capacity for technology, in particular with EMR systems
* Ability to work respectfully amongst many levels of hierarchy and administrations
* Experience as an independent contractor an asset
* Very independent work, must be self-motivated and accountable
* Familiarity with reporting processes
* Supportive, solutions-based, efficiency-minded attitude with a grassroots and patient- centered approach

**Core Ability and Capacity Requirements**

**Assessment and Treatment:** Demonstrated ability to complete initial and ongoing client assessments (clinical and diagnostic reasoning) through appropriate/prescribed technical, therapeutic, safety type interventions.

**Teaching:**  Ability to teach clients and others both one-on-one and in groups. Knowledge of and experience in self management support.

**Knowledge Integration:** Integrates best practice and current research evidence to support professional practice decisions and actions.

**Communication:** Demonstrated ability to communicate effectively with clients, families, the public, medical staff and members of the interdisciplinary team using verbal, written, computer communication means. Ability to effectively apply conflict resolution skills.

**Critical Thinking:** Demonstrated ability to integrate and evaluate pertinent data (from multiple sources) to problem-solve and make decisions effectively. Applies the problem solving process demonstrating critical thinking and decision making skills using a systems approach.

**Human Caring and Relationship Centered Practice:** Ability to promote client-focused care that demonstrates care for and with clients and significant others, sensitivity to diverse cultures and preferences, client advocacy and social justice concerns.

**Management:** Demonstrated ability to organize work, set objectives and establish priorities. Manages time and resources, implements activities to promote cooperation among the interdisciplinary team and collaborates across disciplines.

**Leadership:** Promotes staff morale, engagement and empowerment. Demonstrates creative planning for change and innovation, implementation of policies or other protocols, and ongoing professional development of self and others.

**Teamwork:** Demonstrated ability to foster teamwork and a commitment to excellence in the provision of client care.

**Equipment:**  Demonstrated computer skills including the use of Meditech and Windows based programs; knowledge of Electronic Medical Records is an asset. Demonstrated ability in the use of e-mail and word processing. Ability to operate other related equipment as required in the specific practice area.