

In a Primary Care Network (PCN), a group of family doctors and Alberta Health Services coordinate health services for patients. The Highland PCN includes the communities of Airdrie, Beiseker, Carstairs, Crossfield, Didsbury, and surrounding areas. The Highland PCN encompasses 23 clinics, 74 physician members and serves over 70,000 patients. Several health care professionals work closely with physicians to support patient care.

As a member of the PCN's Health Management Team, the Social Worker is responsible for assessment, intervention, and consultation services for patients, and ensures that social work clinical practice is evidence-based and meets professional standards of practice. This position involves provision of patient and family care, group facilitation and education, consultation and collaboration with health care teams, and other referral and community groups. This role works in partnership with a Registered Nurse and includes seeing patients for a variety of reasons including mood and anxiety concerns, occupational problems, financial concerns, sleep disturbances, bereavement, chronic pain, and/or adjustment disorder.

Accountabilities and Responsibilities

Assessment, Intervention, Education and Advocacy

- Assists patients and their families/support network, achieve their optimal physical, emotional, mental, spiritual health and well-being
- Detects and addresses a broad spectrum of behavioural health needs with the aim of early identification, quick resolution, long-term prevention, and wellness for as many patients as possible. This is accomplished through education, brief interventions, and referral to community resources and/or group psycho-educational programs
- Provide support and advocacy to clients and families for issues related to health and financial needs.
- Conducts risk assessments, as indicated
- Coordinates services, including referral, and care with the medical home team and others involved in the circle of care to ensure the patient's needs are met in a timely manner. Patients requiring more speciality level care will be identified and referred to the appropriate resource
- Provides support and advocacy to patients and families for issues related to health and instrumental needs
- Provides family physician with same day feedback on patient encounters
- Acquires and maintains a comprehensive understanding of community services and referral processes
- Supports a comprehensive, proactive service delivery model within participating clinics, to ensure patients are assessed and screened according to current best practice guidelines
- Works in a flexible, responsive manner to provide services in a variety of practice environments within the medical home
- Works collaboratively within the PCN to enhance the delivery of primary care services
- Assist with financial concerns (i.e., social assistance, AISH, Senior's benefits, etc.)
- Assist with injury and disability benefits where client or family members are not able to themselves
- Assist with guardianship, personal directive, trusteeship, and enduring power of attorney

Team Responsibilities

- Supports the implementation of strategies for improving the quality and provision of care for the practice population
- Promotes programs and services that support patient care

- Ensures the maintenance of up to date and accurate records in the Electronic Medical Record (EMR) to optimize patient care and adhere to the practice policy
- Participates in data collection and evaluation as required
- Offers training support for team members and assist in their professional development
- Initiates and maintain positive community partnerships
- Acquires and maintains expertise in the management of chronic/complex mental health conditions and mental health treatment modalities (e.g., behavioural health, cognitive behavioural, solution focused) consistent with relevant guidelines and best practices

Qualifications and Experience

- Current unrestricted registration with ACSW
- Authorization to perform psychosocial intervention or the willingness to obtain
- Minimum of a bachelor's degree in Social Work
- 5 or more years of experience, preferably in a primary care setting
- Experience working with patients experiencing mental health and/or chronic conditions
- Addictions and/or behavior change training or experience is an asset
- Experience in rural health preferred
- Experience with Electronic Medical Records (EMRs)
- Ability to flex time as required (evenings and weekends)
- Valid driver's license and own vehicle as travel is required
- Fully vaccinated against Covid-19

Abilities, Knowledge, and Skills

- The ability to prioritize time, workload, and patients to ensure efficient, effective care provided in a rapid and evolving environment
- Leadership, problem solving, conflict resolution and critical thinking skills
- Excellent written and verbal communication skills
- Experience in working in a collaborative, consultative manner within an interprofessional team
- Knowledge of medications
- Maintains up-to-date resources of patient education materials and resources for commonly seen problems
- Sound judgement, self-directed, flexible, and displays initiative in a new and evolving role

Apply

Please submit your resume and cover letter, **stating salary expectations and job posting number**, in confidence to recruitment@hpcn.ca.

Please note that only candidates who are selected for an interview will be contacted. We thank all other candidates for their interest.