**APPENDIX A**

**SERVICES**

1. The Consultant shall provide the following services:

**Contract Deliverables:**

Care coordination addresses interrelated medical, social, developmental, behavioral, educational, and financial needs in order to achieve optimal health and wellness outcomes. The Care Coordinator 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 contractor will have expertise in self-management and patient advocacy and will be adept at navigating complex systems and communicating with a range of people, from family members to doctors and specialists. It is the responsibility of the care coordinator to identify life and health goals with the individual and to coordinate services and community supports to work with the individual toward better health outcomes.

The Integrated Care Coordinator 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. The contract includes, but is not limited to:

1. Screen referrals and perform assessment of client’s needs and determines eligibility for services in collaboration with primary physician and other health care professionals; ensure timely access to appropriate services in a seamless and coordinated fashion. Assists with the resolution of physician, client, system, family and/or caregiver issues as needed.
2. Respond to issues and concerns and advocates on behalf of the client/family and/or caregiver to support their choices and needs; work across all sectors to identify problems and seek creative solutions or approaches that maximize client autonomy and wellness.
3. 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.
4. 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. Identifies system barriers and identifies potential solutions.
5. As part of the interdisciplinary/intersectoral team, establish effective working relationships and partnerships with other professionals, community members and agencies. Share knowledge and approaches with other team members.
6. Maintain related records, document observations, interventions and outcomes on the Electronic Medical Record; collect statistics; prepare reports as required and in accordance with established standards and procedures.
7. Demonstrate working knowledge of clinical pathways appropriate to assigned clients.
8. Contribute to the quality of program and practice by identifying needs, issues, and solutions by actively participating in interdisciplinary/intersectoral teams.
9. Maintain professional practice growth and knowledge to reflect current standards of practice by reviewing relevant literature, providing and attending education workshops and in-services, consulting and networking with other health professionals
10. Participate in, and contribute to the evaluation of the A GP for Me initiative.