

SENIOR OUTREACH TO SERVICES (S.O.S.)

Definition

Senior Outreach To Services (S.O.S.) is designed to be a mobile, brief intervention, and service linking form of care coordination. S.O.S. will provide an aggressive information and assistance/outreach service to seniors living in the community. The objective of S.O.S. is to link as many eligible seniors as possible with existing services. To promote independent living, S.O.S. will assist seniors with paperwork, make calls on their behalf, follow up with the senior and the service provider, bring resource/ education programming to congregate housing sites and regularly meet with seniors on their home territory. S.O.S. will utilize the evaluation tools developed by Virginia Commonwealth University during the development phase of the S.O.S. model to provide data in support of community needs assessment and community planning activities.

Eligible Population

Individuals are eligible for S.O.S. if they are 60 years of age or older and living in the community.

Service Delivery Elements

Agencies providing S.O.S. must perform all of the following components:

Resource File: The utilization of accurate, up-to-date, and well-organized information systems on opportunities, services and resources available in the community, including detailed data on service providers.

Electronic Media: The process of receiving and soliciting information via the Internet and email. The use of electronic screening tools and web-based systems such as SeniorNavigator.com, BenefitsCheckUp.org, and SSA online screening tools are encouraged.

Outreach: Outreach is the proactive seeking of older persons who may be in need of S.O.S. assistance. Strategies for outreach include, but are not limited to:

- Resource/educational programming provided to congregate housing residents
- Home visits to individuals residing in single family homes and congregate housing

Information: The process of informing an older person of available opportunities, services, and resources.

Screening/Assessment: Screening/assessment, using the S.O.S. Intake/Referral Form is conducted with the older person and, if applicable and with the older person's permission, his or her caregiver(s). The interview is conducted in the person's residence or in a private portion of a congregate housing community room. Cost sharing does not apply to this service.

Referral/Assistance: The process of initiating an arrangement between the older person or caregiver and the service provider; advising older persons and their caregivers; providing information to older persons to link them with the opportunities, services, and resources available to meet their needs; assisting the person or caregiver to contact the appropriate community resource; and if necessary, advocating with agencies on behalf of older persons.

Follow-Up: The process of contacting individuals and the organizations to which they were referred to determine the outcome of the referral. Determining the quality and effectiveness of the referral and the service provided to the person referred. Additional assistance to the individual in locating or using needed services may be a part of the follow-up. Follow-up is an integral part of the S.O.S. model and must be completed whenever possible.

Planning and Evaluation: The process of aggregating and analyzing information collected through the use of the service utilizing evaluation instruments developed and tested by Virginia Commonwealth University.

Administrative elements

A qualified Care Coordinator must possess a combination of relevant work experience in human services or health care and relevant education that indicates the individual possesses the following knowledge, skills, and abilities at entry level. These must be documented on the Care Coordinator's job application, or observable in the job or promotion interview.

Staff Qualification:

- Knowledge: Care Coordinators should have a knowledge of aging and/or the impact of disabilities and illness on aging; conducting client interviews; local human service delivery systems, including support services and public benefits eligibility requirements; effective oral, written, and interpersonal communication principals and techniques.
- Skills: Care Coordinators should have skills in negotiating with consumers and service providers; identifying and documenting a consumer's needs for services within the established services system to meet the consumer's needs; coordinating the provision of services by diverse public and private providers.
- Ability: Care Coordinators should have the ability to demonstrate a positive regard for consumers and their families; be persistent and remain objective; maintain effective inter- and intra-agency working relationships; work independently, performing position duties under general supervision; communicate effectively, verbally and in writing; develop a rapport and communicate with different types of persons from diverse backgrounds, and interview.

Individuals meeting all the above qualifications shall be considered a qualified Care Coordinator; however, it is preferred that the Care Coordinator will possess a minimum of an undergraduate degree in a human service field, or be a licensed nurse. In addition it is preferable that the Care Coordinator will have two years of satisfactory experience in the human services field working with the aged or disabled.

* It is acceptable for administrative staff to coordinate the Resource/Educational program component of S.O.S.

Units of Service:

Units of service must be reported in GETCARE for each client receiving services. Service units can be reported on a daily basis, but not aggregated (summarized) more than beyond one calendar month

- Persons served (unduplicated)
- Referrals: the number of referrals made to service providers, including referrals for area agency on aging services.

Optional Units of Service (Reported on AMR)

- Implementations: the number of services implemented.
- Group Presentations: the number of presentations made to groups of seniors.

Program Reports:

- Aging Monthly Reports (AMR) to VDA by the twelfth (12th) of the following month. If the area agency on aging provides this service, this report must be updated and submitted even if no expenditures or units of service occurred.
- GETCARE client level data transmitted to VDA by the last day of the following month.

Quality Assurance:

Criminal Background Checks:

- VDA strongly recommends that the agency and their contractors protect their vulnerable older clients by conducting criminal background checks for staff providing any service where they go to or into a client's home.

Staff Training:

- Staff should receive orientation on agency policies and procedures, client rights, community characteristics and resources, and procedures for conducting the allowable activities under this service.
- Care Coordinators should receive a minimum of 10 hours of in-service training per year based on the need for professional growth and upgrading of knowledge, skills, and abilities.

Supervision/Case Review:

Consultation, supervision and case review shall be available to all staff providing the service.

Program Evaluation:

The agency should conduct regular systematic analysis of the persons served and the impact of the service utilizing the Virginia Commonwealth University evaluation tools.

Client Record:

Service providers must maintain specific program records that include:

- S.O.S. Intake/Referral Form (which incorporates the Virginia Service – Quick Form in its entirety).
- Consent to Exchange Information Form.
- Progress Notes or contact logs to document case activity.