Senior Outreach to Services (S.O.S.)
VIRGINIA DEPARTMENT FOR THE AGING
SERVICE STANDARD

<u>Definition</u>
Senior Outreach to Services (S.O.S.) is a model of service coordination that is designed to provide a mobile, brief intervention that links seniors to supports and services available in their community. Aggressive information and assistance/outreach services are used to reach seniors. A face-to-face interview is conducted with a senior to determine available services that can support him/her living in the community. The seniors are provided aid in accessing and implementing the needed supports and services. Program evaluation is conducted on a regular basis.

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

<u>Program Components</u>:
S.O.S. provider agencies must include the following elements in their programs:

- <u>Resource File</u>:
  S.O.S. service providers must maintain an accurate, up-to-date, and well-organized information system on the opportunities, services and resources available to seniors in the community, including detailed data on service providers.

- <u>Electronic Media</u>:
  The use of electronic media to receive and solicit information via the internet is encouraged in the S.O.S. program.

  Electronic screening tools and web-based systems, such as Virginia Easy Access, Virginia Navigator, BenefitsCheckUp.org and Social Security Administration on-line screening tools can be utilized to benefit the S.O.S. client.

<u>Outreach:</u>
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, senior centers, adult day care centers and other locations where seniors gather.

- Service provider information provided to individuals residing in single family homes and congregate housing and to seniors visiting the local Area Agency on Aging seeking services.

Screening/Assessment:
S.O.S. requires a face-to-face interview that informs older persons of available opportunities, services and resources. Screenings/assessments are conducted in the client's home, in community settings, or at the Area Agency on Aging with the older person and, if applicable, with the older person's permission, his or her caregiver.

- The S.O.S. referral form is to be completed in assessments conducted in the client's home and in community settings.

- Home visit and Area Agency on Aging assessments must utilize pages 1 and 4 of the Uniform Assessment Instrument (UAI) (Page 3 optional).

- Community and congregate setting assessments must utilize Page 1 of the UAI or the Quick Form. In the community setting, page 4 of the UAI is to be completed if warranted by the privacy of the setting.

Cost Sharing:
S.O.S. is not a cost sharing program.

Referral/Assistance:
The S.O.S. referral/assistance process includes:

- 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 resources; and, if necessary,

- Advocating with agencies on behalf of older persons.

Evaluation:
Program evaluation is an integral part of the S.O.S. model. The process includes, but is not limited to:

- Contacting individuals 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 part of the follow-up.

- Administering, yearly, an anonymous client satisfaction survey to at least 10% of the clients served in the S.O.S. program.

- Aggregating and analyzing information collected through monthly reports and the yearly client satisfaction survey.

Administrative Elements

A qualified service coordinator must administer the S.O.S. program. A qualified service 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 service coordinator's job application, or observable in the job or promotion interview.

Staff Qualifications:

- Knowledge: Service coordinators should have a knowledge of: aging and/or the impact of disabilities and illness on aging; how to conduct interviews; consumers' rights; person-centered practices; local human and health service delivery systems, including support services and public benefits eligibility requirements; effective oral, written, and interpersonal communication principles and techniques.

- Skills: Service coordinators should have skills in negotiating with consumers and service providers; identifying and documenting a consumer's needs and preferences; identifying services within the established services system to meet the consumer's needs and preferences; and coordinating the provision of services and supports by diverse public and private providers.

- Ability: Service coordinators should have the ability to demonstrate a positive regard for consumers and their families; be persistent and remain objective; work as a team member, maintaining 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 to communicate with different types of persons from diverse cultural backgrounds; and conduct interviews.

Individuals meeting all the above qualifications shall be considered a qualified S.O.S. service coordinator. However, it is preferred that the service coordinator will posses a minimum of an undergraduate degree in a human service field, or be a licensed nurse. In

addition, it is preferable that the service coordinator will have two years of satisfactory experience in the human services field working with older adults or individuals with disabilities.

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 Peer Place for each client receiving services. Service units can be reported on a daily basis, but not aggregated (summarized) beyond more than one calendar month. S.O.S. units of service include:

- Persons served (unduplicated);

- The number of referrals made to service providers, including referrals for area agency on aging services;

- Implementations: the number of services implemented and,

- Number of clients (unduplicated) with two or more deficiencies in Activities of Daily Living (ADLs)

Program Monthly Reports

- Aging Monthly Report (AMR) to VDA by the twelfth (12th) of the following month. This report must be updated and submitted even if no expenditures or units of service occurred.
- PeerPlace or AIM client level data transmitted to VDA by the last day of the following month.

Criminal Background Checks:
VDA requires that the agency and their contractors protect 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, techniques for conducting interviews, and procedures for conducting the allowable activities under this service.

- Service coordinators should receive a minimum of 8 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.

Client Records:
Service providers must maintain specific program records that include:

- S.O.S. Referral Form

- UAI – pages 1 and 4 for home visits and area agency on aging assessments; Page 3 is optional. Page 4 of the UAI will be used to determine ADL deficiencies as warranted by the client's condition and status.

- In community and congregate settings, the Quick Form may be used instead of Page 1 of the UAI. Page 4 is to be completed, if warranted by the privacy of the setting. For example, questions related to incontinence may be omitted.

- Consent to Exchange Information Form – signed by the client.

PeerPlace users must make sure that the required data is entered/scanned into that electronic record system.