



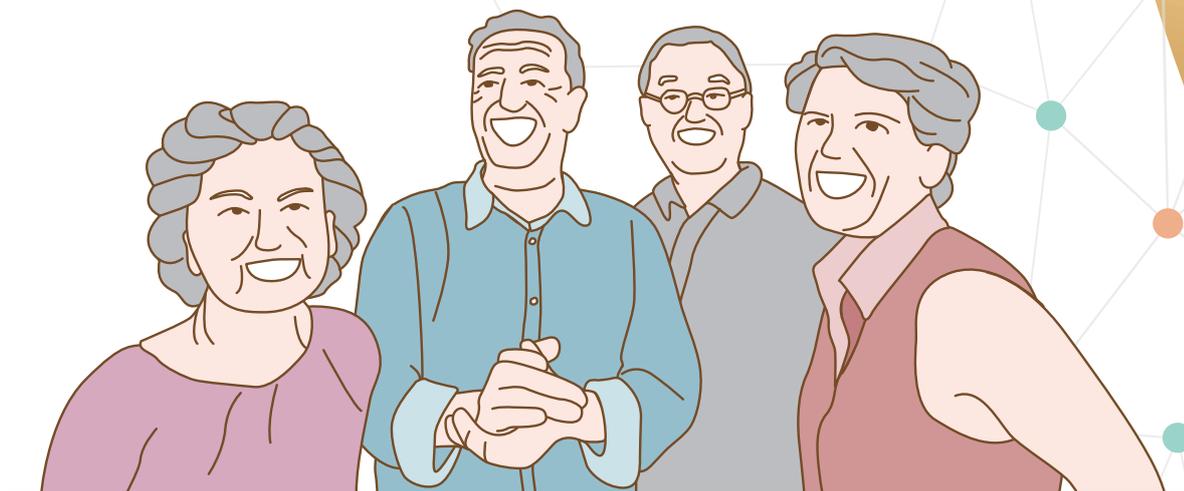
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椰子園老人養護之家

Holistic Reablement Care Model

Interdisciplinary Support Program
Social Return on Investment

Pingtung County Yeh Tzu Yuan
Private Senior Residential Care Facility



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Abstract

Founded in 1994, the Pingtung County Yeh Tzu Yuan Private Senior Residential Care Facility (hereafter “YTY”) serves older adults in the Kaohsiung–Pingtung area who cannot manage daily living and those who are bereaved, solitary, or otherwise in need of support. Guided by the mission to “advance older-adult welfare, promote respect for older adults, ensure stable daily living, safeguard health, and foster social harmony,” YTY provides diversified and individualized professional services, including nursing, personal care, social work, rehabilitation, and nutrition, and actively contributes to long-term care policy development. In 2016, YTY introduced the Self-Reliance & Life Reablement concept and advanced an innovative Holistic Self-Reliance Care model. The model was first piloted in community services; subsequent experience showed it could be implemented more fully within a residential setting, where Yeh Tzu Yuan Senior Residential Care Facility (hereafter “YTY Residential Care Facility”) now delivers the model through an interdisciplinary team. In parallel, YTY aligns with the Sustainable Development Goals (SDG 1, SDG 3, SDG 17), centering on strengthening older adults’ self-reliant living and quality of life as part of sustainable care.

Through meeting with Impact Express CO., LTD., YTY learned that Social Return on Investment (SROI) quantifies social benefits and therefore adopted this approach to assess the social impact of the Holistic Self-Reliance Care model. SROI enables YTY to present, with concrete data, how social inputs translate into outcomes so external audiences can clearly understand YTY’s contribution to long-term care in the Kaohsiung–Pingtung region. It also serves as a basis to review and optimize current services and to replicate the model, thereby expanding and deepening social value. This analysis compiles input costs, outcome data, and stakeholder feedback to quantify the social impact created by the Holistic Self-Reliance Care model implemented at the YTY Residential Care Facility.

This project is an evaluation-type SROI; covering 1 January 2024 to 31 December 2024 (one year). The Holistic Self-Reliance Interdisciplinary Care Support Program implemented in the residential facility generated an SROI of 4.57; sensitivity analysis ranged 3.46–5.08, indicating stable and high social value creation. From stakeholder consultations and feedback, the key outcomes are as follows:

- Older adults: positive body–mind–spirit changes, including improved physical health, reduced depression and negative thoughts, increased life motivation, and enhanced interpersonal relationships.

- Family members: reduced caregiving burden and improved family relationships due to appropriate care for their loved ones.
- Care professionals: enhanced professional skills, gained a sense of accomplishment, cultivated empathy, and heightened risk awareness through participation in the model.
- Organization (YTY Residential Care Facility): expanded external resource linkages, strengthened team cohesion, and innovation in service-model development—demonstrating YTY’s overall contribution to sustainable long-term care.

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Chapter 1: Introduction

1.1 Project Overview

Since 1993, Taiwan has entered the early stage of population ageing. Family caregiving capacity has gradually weakened, and the traditional, family-centred elder-care model has come under strain. In Pingtung at that time, medical and care resources were relatively scarce; many older adults living with disability or dementia struggled because families could not shoulder ongoing care pressures. Most residential facilities focused on basic custodial care, making it difficult to safeguard older adults' physical, psychological, social, and spiritual well-being or maintain functional capacity. In response, local community leaders founded the Pingtung County Yeh Tzu Yuan Private Senior Residential Care Facility (hereafter “YTY”) in 1994, with a mission to advance older-adult welfare, promote respect for older adults, ensure stable daily living, safeguard health, and foster social harmony,” providing a living environment in the Kaohsiung–Pingtung region that combines dignity, safety, and care. The model was first piloted in community-based services, but YTY subsequently found it could be implemented more fully in the residential setting where processes and resources can be integrated end-to-end; it is therefore operationalised through an interdisciplinary team at YTY’s residential care facility (hereafter “YTY Residential Care Facility”), which is also the focus of this evaluation.

As long-term care policy advanced and population ageing accelerated, YTY progressively developed diversified services integrating medical care, caregiving, and psychosocial support. In 2016, it introduced the concept of “reablement support and life restoration” and developed a distinctive Holistic Reablement care model. This model promotes functional restoration and life participation across four dimensions—physical, psychological, social, and spiritual—through an interdisciplinary team (registered nurses, care attendants, social workers, physical therapists, occupational therapists, nutritionists) working together to help older adults regain self-care ability and motivation for daily life. Unlike traditional “doing-for-you” custodial care, YTY’s Holistic Reablement model focuses on enabling older adults to live well, live longer, and live with dignity, putting into practice at the point of care the ideas of accompanied reablement and supporting autonomy.

According to Taiwan’s Ministry of Health and Welfare (hereafter “MOHW”) surveys from 2020 to 2023, dementia prevalence among those aged 65+ reached 7.99%, higher in women (9.36%) than men (6.35%). In Pingtung County, the number of people

with disabilities increased from about 20,000 (2.5%) in 2022 to 26,000 (3.3%) in 2026, underscoring the mounting dual challenges of ageing and disability. Over the same period, the number of long-term care institutions in Taiwan declined from 1,099 (2017) to 1,051 (2024); caregiving manpower remains in short supply, with over one-third reliant on migrant workers. Most facilities can only sustain basic care and lack models that actively promote functional recovery. By centring its services on Holistic Independence, and operationalising reablement with interdisciplinary collaboration, YTY addresses this service gap and has become a benchmark innovator in long-term care in the Pingtung region.

1.2 Scope and Objectives

1.2.1 Evaluation Target

This Social Return on Investment (hereafter “SROI”) analysis takes as its primary evaluation subject the Holistic Reablement care model implemented at the YTY Residential Care Facility. As the facility’s core programme, it combines 23 hours of daily living care with 1 hour of professional reablement (the 23+1 model) and is delivered through an interdisciplinary team to help older adults restore self-care ability, enhance quality of life, and maintain physical and mental health. The service primarily targets residents of the YTY Residential Care Facility—older adults living with disability, dementia, or partial decline in activities of daily living—most of whom are aged 65+ and come from Pingtung and the wider Kaohsiung–Pingtung region. Prior to admission, some residents held resistant or distrustful views toward institutional care, worrying that “once you enter a nursing home, you can never return home.” After experiencing YTY’s Holistic Independence approach, however, residents gradually found that reablement training, self-care practice, and group interaction led to marked improvements in both physical and psychological well-being. Families likewise shifted from initial anxiety and doubt to trust and recognition, realising that the YTY Residential Care Facility differs from typical “doing-for-you” custodial institutions and instead provides a reablement-centred environment that supports independent living. For this evaluative SROI, to align stakeholders’ starting points of change within the evaluation period, the quantitative outcome analysis for older adults is restricted to residents first admitted to YTY Residential Care Facility between 1 January and 31 December 2024 (n=33) who received the Holistic Reablement/23+1 model; the “family members” stakeholder group refers to the primary family members of this 2024 admission cohort.

The Holistic Independence model not only focuses on individual residents’ physical function training and psychological adjustment; it also emphasises rebuilding family and caregiving relationships. Through sustained interdisciplinary interventions, including nursing, care attendants, social work, physical therapy, occupational therapy, and

nutrition, the programme provides an integrated model of care. Internally, the facility also continues to strengthen staff education and team collaboration aligned with Holistic Independence to ensure ongoing improvements in service quality and professional capability.

The above stakeholders and service activities constitute the analytical scope of this study; where the quantitative outcome analysis for older adults (and corresponding family members) is conducted on the 2024 admission cohort, while other stakeholder analyses reflect the programme's operation during 2024.

1.2.2 Evaluation Period

The Holistic Reablement Care Model implemented by YTY Residential Care Facility has been in place for nearly ten years, continuously helping older adults with disability and dementia to restore daily functioning and autonomy, with considerable accumulated social benefits; however, in the early phase, many resources were not yet in place, and professional staff were still grasping new concepts and adapting to the new service model, so service items were not yet fully developed, and if one were to evaluate the SROI for the entire period, the final value might be biased. Moreover, data collection in the initial period was relatively difficult, and the nature of services also differed. Therefore, based on these factors and after discussions with YTY, the research team selected the most recent year—2024 when the model was relatively stable and the data were most complete—as the evaluation period. To align the “start point of change” across beneficiaries, the older-adult and family-member analysis in this evaluative SROI is restricted to residents newly admitted during 2024 (n=33), with baseline defined at admission and outcomes assessed within 2024. Organisation-level and care-professional outcomes continue to reflect full-year (1 January–31 December 2024) operations.

1.2.3 Evaluation Purpose

At present, records and explanations of the performance for the various long-term care services at YTY Residential Care Facility, most are reported qualitatively—via service performance Key Performance Indicators (KPIs), outcome reports, and photos; that is, the notable benefits for individual cases are shared or described in writing; although the data have been digitized and systematised, it remains difficult to see the concrete inputs, outputs, and outcomes of stakeholders in the project? It is also hard to understand the final income-and-expenditure position of each programme and its subsequent benefits. In addition, if the numerical evidence presented for programme results could be clearer and more persuasive, it would be easier to grasp future resource allocation and thereby promote efficiency gains.

In view of this, to understand whether the above Holistic Reablement Care Model generates greater social benefits, the YTY Residential Care Facility commissioned us to conduct an SROI evaluation to quantify and present the social value and impact created, on the one hand to evaluate the effectiveness of each service as a basis for subsequent improvements, and at the same time to provide a reference for future applications for international certification, thereby increasing opportunities to collaborate with future and potential counterparts. Most importantly, YTY aims to achieve this through exchanges and collaboration, diversified capacity-building courses, consultancy services, growth-partner support, and learning from domestic and international social-welfare practice. In addition, the facility seeks to optimise the quantified case-service model, replicate it successfully, and innovate services, thereby achieving the institution's goal of sustainable development.

1.2.4 Evaluation items

This SROI evaluation concerns the Holistic Reablement Care Model implemented by the YTY Residential Care Facility. Since 2016, the facility has introduced the concept of reablement support and developed an integrated care model centred on “reablement and independence,” combining whole-person care across body, mind, social, and spiritual dimensions to help older adults restore daily functioning, improve quality of life, and regain initiative and dignity in family and social relationships. At the outset, the research team and YTY Residential Care Facility originally planned to include the entire YTY within the evaluation scope, covering units such as community-integrated services, the day-care centre, and the cooperative. However, interviews with other units showed that although the Holistic Reablement concept has been promoted across different service sites, only in the residential facility is implementation the most complete and institutionalised; its activity framework, service processes, and tracking data are stable and quantifiable, best reflecting the core value and actual effectiveness of the Holistic Reablement Care Model. Therefore, after discussions with YTY management, this evaluation ultimately focuses on the residential facility's Holistic Reablement Care Model as the primary scope for the SROI analysis.

Within the residential facility, the Holistic Reablement Care Model—Interdisciplinary Support Program is centred on Holistic Reablement and primarily includes “23 hours of daily living care and 1 hour of professional reablement (the 23+1 model),” physiotherapy and occupational-therapy training, and various spiritual and leisure activities. Services are delivered through an interdisciplinary team (nursing, social work, physiotherapy, occupational therapy, nutrition, and spiritual care) collaborating to provide reablement training and psychosocial support targeting older adults' physical function, emotional state, life motivation, and interpersonal interaction. In addition to

daily care and professional courses, the services also include two supporting activities: “outdoor activities” and “staff training and development.” The former is intended to promote older adults’ social participation and psychological rehabilitation, enabling them to rebuild confidence in daily life through outings and community interaction; the latter continuously strengthens caregivers’ professional capabilities and service consistency—through interdisciplinary training and courses on the Holistic Reablement concept— to ensure that the quality of Holistic Reablement Care Model services is maintained and enhanced.

This evaluation aims—through systematic data collection and stakeholder engagement—to quantify and analyse the social impact of the residential Holistic Reablement Care Model across older adults, families, professional service staff, and the organisational level, and to explore how the model creates sustainable and replicable social value in practice.

Chapter 2: Research Methodology

2.1 SROI Analysis Framework

This study adopts the Social Return on Investment (SROI) analysis, a tool framework commonly used by non-profit organizations worldwide as a performance evaluation method. It not only allows external observers to clearly understand the social impact generated by the project, but also serves as a reference for internal performance evaluation. It applies to non-profit organizations, social enterprises, for-profit corporations, and the government sector. SROI analysis can be divided into two types: predictive and evaluative. Predictive SROI is for future projects, forecasting the social impact created by the outcomes to enable users to allocate resources effectively and maximize social investment. Evaluative SROI is a retrospective method that evaluates the social impact generated by ongoing projects to allow users to understand the effectiveness and serve as the basis for adjusting the plan. In 2012, the UK government assisted Social Value UK and Social Value International in publishing the "Guide to Social Return on Investment," which is used to measure the changes in the interests of stakeholders affected by intervention activities and calculate the impact and social value brought about by the changes and present the results in monetary value. More importantly, SROI is not just a number. Through further analysis, it could serve as a basis for decision-making, improving the effectiveness of social welfare management as a whole.

2.1.1 Explanation of SROI Analysis Framework and Execution Methodology

When conducting an SROI analysis, it is necessary to follow the six significant steps, as shown in Figure 2-1:

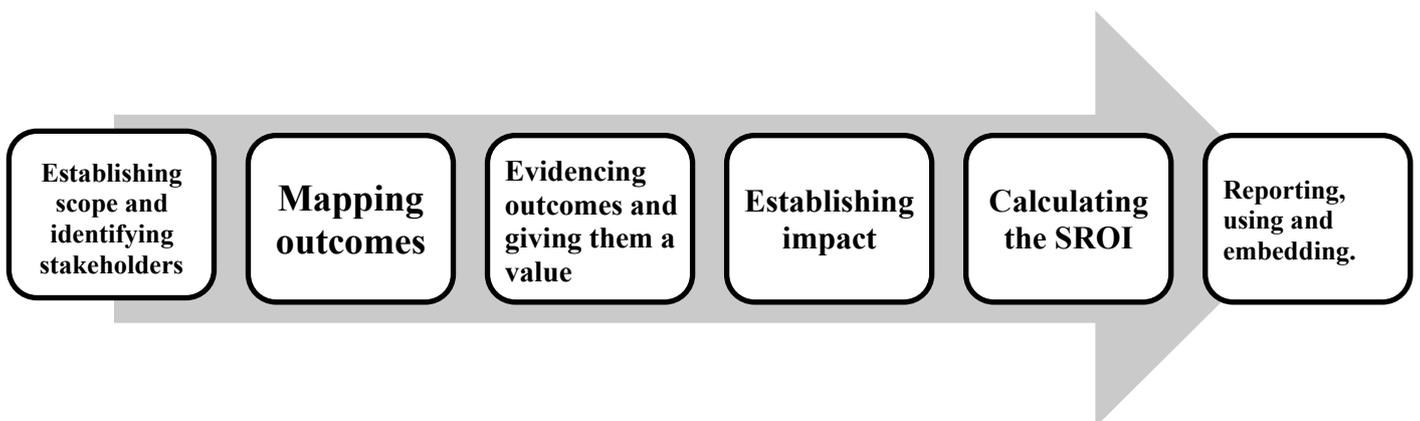


Figure 2-1: Steps of Operating SROI

(1) Step 1: Establishing scope and identifying stakeholders

This step involves determining the scope of SROI analysis and identifying the direct, indirect, and diffuse stakeholders and how they participate. Therefore, before conducting the analysis, it is necessary to understand the project's background and assume the expected and unexpected changes brought about by the project to confirm the feasibility of SROI analysis.

(2) Step 2: Mapping outcomes

This step mainly measures the relationship between stakeholders' input, output, and outcomes. Standard methods to understand this relationship include surveys, focus groups, interviews, questionnaires, and volunteer evaluations. Clearly describe the output directly caused by the input and the impact of the crucial changes that finally occur. Through stakeholder feedback, outline the causal relationship between input, output, and outcomes in a chain of events, and draw a chain of events. This step is the core of SROI.

(3) Step 3: Evidencing outcomes and giving them a value

Grasping the "outcomes" and measuring them through "indicators," confirming the outcomes' occurrence, then evaluating their value in monetary terms. Quantifying and pricing qualitative and narrative outcomes, setting indicators, and collecting relevant data to prove that results have occurred. Abstract narrative outcomes are monetized by using financial proxy variables in the impact map. Typical considerations for converting results into monetary value include the following examples:

- Traditional economic value (e.g., how many employment opportunities can be created)
- Financial alternative value (e.g., reducing the medical costs of potential risks)

(4) Step 4: Establishing Impact

This step involves sensitivity analysis, using four different analysis factors (Deadweight, Displacement, Attribution, and Drop-off) as measurement standards to avoid overestimating or bias results and increase the credibility of the analysis.

- Deadweight: Indicators of outcomes that would have occurred regardless of the intervention.
- Displacement: The extent to which results are replaced by other results.
- Attribution: The number of results that come from the contributions of other organizations or individuals.
- Drop-off: The gradual decline in effectiveness over time.

(5) Step 5: Calculate the SROI

Based on the data collected in the first four steps, the positive and negative effects are added and discounted to determine the full benefits. The SROI value is calculated by dividing the total benefits by the total investment.

(6) Step 6: Reporting, using and embedding

To effectively use SROI analysis as a management reference, researchers should present the report and discuss with stakeholders whether the analysis is appropriate. This step is crucial but often overlooked.

2.2 SROI Analysis Principles

SROI was developed from Social Accounting and cost-benefit analysis. In an SROI analysis, judgments and assumptions must be made throughout the entire process based on the available information. To ensure that SROI does not become a mere numerical game or a promotional tool, the SROI Guide requires users to adhere to the following eight principles when analyzing and reporting calculations:

- (1). **Involve Stakeholders:** Stakeholders can experience the changes brought about by intervention activities and are the best candidates for describing those changes. Identifying the stakeholders of a project and inviting them to participate in the SROI analysis process enables a better understanding of the people affected by the intervention activity, the value brought by the intervention, and the measurement methods used to quantify that value.
- (2). **Understand What Changes:** Value is created by different stakeholders and enjoyed by various stakeholders. Changes include expected or unexpected changes, as well as positive or negative changes. Corresponding change theories are needed to explain how these changes occur. These changes are the results of intervention behavior contributed by stakeholders and can be classified as social, economic, or environmental outcomes. We need to measure these outcomes to demonstrate that the intervention has brought about changes.
- (3). **Value the Things That Matter:** We can use equivalents to value outcomes, allowing outcomes that cannot participate in market transactions but are generated by non-profit organizations or government intervention activities to be presented.
- (4). **Only Include What is Material:** Information on decisions and outcomes impacting stakeholders' experiences should be analyzed and listed as essential materials. For

determining which information is important, reference should be made to institutional policies, peer organizations, social norms, and short-term financial impacts. Therefore, external audits are crucial to ensure that all vital information has been included in the analysis.

- (5). **Do Not Overclaim:** Use trends and existing data to help analyze the changes caused by intervention behaviors and compare them with other factors to eliminate unnecessary elements. Consider the contributions made by other individuals or organizations to match the contributions of the outcomes.

- (6). **Be Transparent:** Record and explain each decision related to stakeholders, outcomes, indicators, and benchmarks, including information sources and collection methods, considerations of different factors, and communication with stakeholders. In SROI analysis, we will analyze how these factors affect outcomes, and the more transparent and open the decision-making process is, the more credible the SROI analysis results will be.

- (7). **Verify the Results:** Although SROI analysis provides an opportunity to understand the value created by intervention behaviors comprehensively, it inevitably includes some subjective analysis. Appropriate independent audits can help stakeholders examine the work of SROI analysts to see if the decisions they made during the SROI analysis are reasonable.

- (8). **Be responsive:** Describe how the organization manages its influence and how it can actively amplify the various goals, strategies, and methods of influence based on stakeholder feedback. It can be divided into three aspects:
 - Operational : Improving the implementation of existing activities to increase social value.
 - Tactical : Choosing activities that can best achieve impact goals.
 - Strategic : Setting influence goals based on stakeholder needs and social goals.

Chapter 3: Scope of Research and Stakeholder Identification

3.1 Stakeholder Identification

3.1.1 Stakeholder Survey

During the initial research and assessment phase, the research team and the YTY Residential Care Facility co-hosted an SROI workshop. Participants included stakeholder representatives, primarily service providers, as well as core team members from across YTY's units. Through close information exchange during the workshop and review of follow-up materials, the team gathered oral data and documentation to clarify potential stakeholders and the roles they play within the service program.

This study referred to two methods to identify stakeholders. The first step was to use the IRIS+ indicators developed by the Global Impact Investing Network (GIIN) to identify stakeholders. GIIN, a non-profit organization established in 2009 with 330 members in nearly 50 countries/regions, is committed to accelerating the development of the impact investing industry. The organization gathers impact investors, uses innovative methods, provides guidance and support for good practices, and establishes evidence-based for the industry. In GIIN's Impact Measurement and Management (IMM) system, IRIS+ is a recognized system for measuring, managing, and optimizing impact, allowing investors to set impact goals based on impact categories and themes (according to the IRIS+ theme classification) or SDGs.

The second step was differentiating stakeholders based on their contact with the service program. Stakeholders were classified as implementers, direct beneficiaries, and indirect beneficiaries. The following is a detailed explanation:

According to IRIS+, stakeholders can be classified into Planet, Suppliers, Employees, Distributors, Clients, Microenterprises, Small and Medium Enterprises, and Others. The YTY Residential Care Facility provides various activities such as connecting resources, courses, and external collaborations, so the research team analyzed stakeholders mainly in the categories of clients, suppliers, employees, and partner organizations. As the YTY Residential Care Facility has contacted many partner organizations, the research team included those with close and sustained collaborations in the analysis.

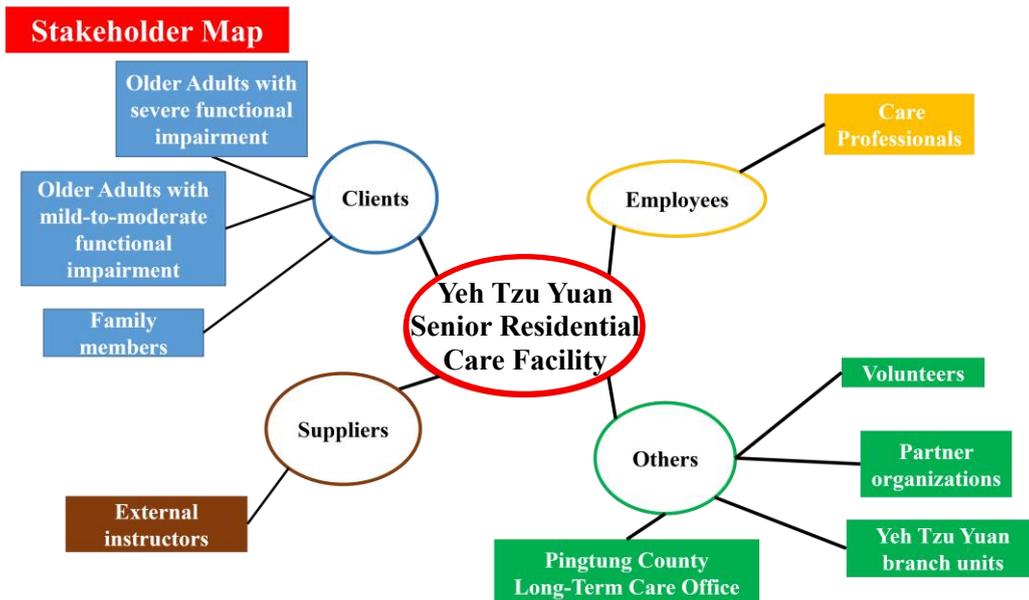


Figure 3-1: Potential stakeholders under each category based on IRIS+ Stakeholder classification

After an initial scan of stakeholders, we analysed their characteristics and confirmed that stakeholders of the YTY Residential Care Facility are primarily service users and service providers. Building on the stakeholder map in Figure 3-1, we examined the implementers, direct stakeholders, and indirect stakeholders of the service (see Figure 3-2) as follows:

- (1). **Implementers:** Operated by the YTY Residential Care Facility. For older adults living with disability and/or dementia, YTY delivers daily care and reablement training through an interdisciplinary team; it also offers various courses that provide psychological support and help restore prior levels of functioning.
- (2). **Direct stakeholders:** The primary beneficiaries and core users of resources and services are residents of the residential facility, typically older adults with disability, many also experiencing dementia. Following interviews and discussions with management, older adults were classified into two subgroups: older adults with severe functional impairment and older adults with mild-to-moderate functional impairment. The core service providers are a multidisciplinary team of care professionals whose capabilities span activities of daily living support, clinical care, psychosocial support, physical reablement, occupational activity design, and nutrition/dietary management. Through cross-disciplinary collaboration, this team integrates and delivers the Holistic Reablement service to provide comprehensive, individualised support. In addition, regular partner volunteers help lead residents in community-participation activities and other engagements that strengthen social connection.

(3). **Indirect stakeholders:** Other parties who benefit as a result of the programme’s implementation, with changes that arise indirectly through programme implementation rather than through direct service participation.. In this project, indirect stakeholders include family members who benefit when residents receive appropriate care, as well as external partner organisations (e.g., YTY branch units, partner organisations, and Pingtung County Long-Term Care Office) that provide instructors and support programme advancement.

Figure 3-2 presents the stakeholders of the Holistic Reablement Care Model mapped to the four IRIS+ categories and further distinguished as direct and indirect beneficiaries. Direct stakeholders (inner circle) include older adults (residents), care professionals, and external volunteers—roles that interact most directly with service users. Indirect stakeholders are counterparts who assist or collaborate in service delivery—such as suppliers, foundations, external instructors, and government agencies—as well as family members who benefit as residents improve.

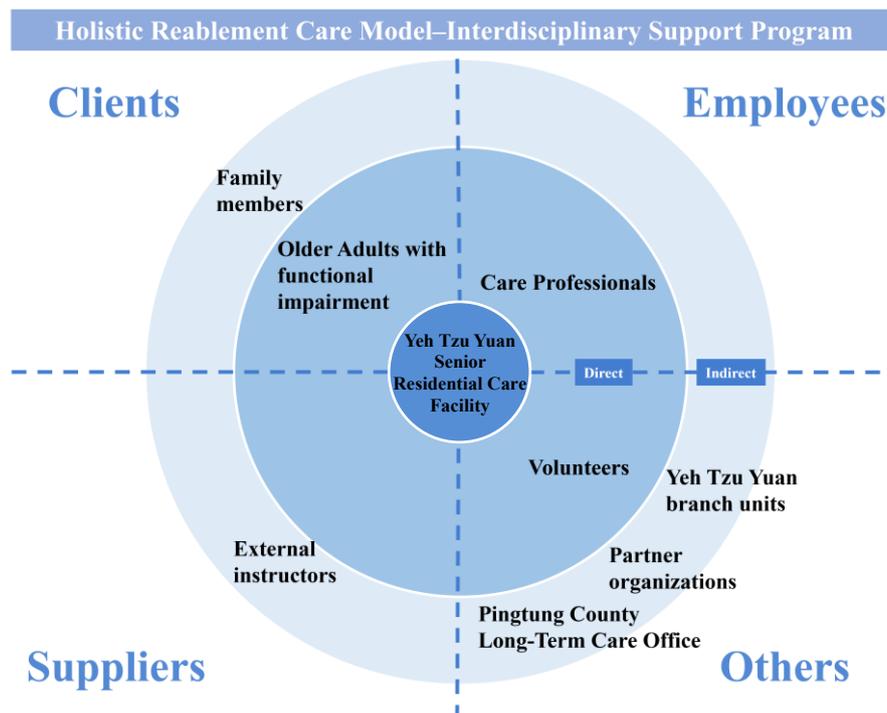


Figure 3-2: Potential stakeholders of Holistic Reablement Care Model—
Interdisciplinary Support Program based on IRIS+ categories

At different stages of engagement, the research team worked with the YTY Residential Care Facility to clarify scope and assess stakeholder relevance in a staged manner. At the inception meeting with management, we confirmed the purpose of this report and agreed that the evaluation would focus primarily on core stakeholders (rather than a fully extended scope that would also quantify suppliers, all partners, and public bodies). During the initial workshop (used to build shared understanding of SROI), we

nonetheless mapped a wider long-list of potential stakeholders and invited participants to verify whether any relevant parties were missing and whether the perceived influence levels reflected reality. Follow-up interviews were then used to refine our understanding of programme activities, exposure pathways, and stakeholder experiences of change; based on this evidence, we conducted a further relevance review to confirm which stakeholder groups should be taken forward into the impact map and quantitative analysis.

Table 3-1 summarises the resulting inclusion/exclusion decisions and the rationale for each stakeholder group. In this report, stakeholder relevance and significance are documented using the two criteria applied throughout: Relevant and Significant. “Relevant” indicates that there is a credible basis to expect or observe material change for the stakeholder and/or that the stakeholder materially influences programme delivery and outcomes. Relevance was assessed with reference to at least one of the following considerations: policy and regulatory priorities, stakeholder needs and evidenced experiences, peer practice/sector norms, broader societal norms, and short-term financial implications. “Significant” indicates that the real or potential impact (positive and/or negative) is sufficient to influence decisions and actions. These criteria guided stakeholder inclusion/exclusion; outcome-level materiality testing is then conducted subsequently within the selected stakeholder chains.

Within the stakeholder group of older adults, we further identified two subgroups based on functional impairment, using YTY’s routine baseline ADL assessment conducted at admission (intake) during 2024 as an objective and consistent classification criterion. Specifically, residents were classified into two subgroups based on their baseline ADL scores at admission in 2024. Following consultation with YTY’s interdisciplinary care professionals—who routinely use ADL assessment results in care planning and severity evaluation—we adopted an ADL score of 50 as the operational threshold for subgroup classification. Residents with $ADL > 50$ were classified as older adults with mild-to-moderate functional impairment, while residents with $ADL \leq 50$ were classified as older adults with severe functional impairment. This stratification aligns with YTY’s care planning practice and was also informed by qualitative interview evidence. Older adults with severe functional impairment more frequently described changes related to substantial improvements in functional capability and enhanced life motivation. In contrast, older adults with mild-to-moderate functional impairment tended to report improvements in physical health primarily in terms of functional maintenance and strengthening, alongside reductions in negative emotions. Based on these observed differences in the nature of experienced change, we adopted ADL-based stratification for subsequent outcome mapping and quantitative analysis.

For care professionals, we initially explored whether meaningful subgroups were required (e.g., by professional discipline/role) during both the interview phase and the survey design stage. Interview insights were reviewed across disciplines to identify any materially different outcome pathways, and quantitative results were checked for systematic differences in core outcome indicators by role. As no consistent or material divergence was observed that would justify separate modelling (and to avoid unnecessary fragmentation and instability due to smaller subgroup sizes), care professionals were treated as a single stakeholder group in the final impact map, with role-specific insights retained in the qualitative narrative rather than as separately quantified subgroups.

Table 3-1: Inclusion, Exclusion, and Categorization Results and Reasons for Stakeholders of Holistic Reablement Care Model - Interdisciplinary Support Program

Stakeholders		Inclusion or exclusion	Reasons
Category	Subgroup		
Older adults	Older adults with severe functional impairment	Inclusion	Older adults are the primary beneficiaries. They directly participate in the residential facility’s “23 hours of daily living care + 1 hour of professional reablement (23+1)” and a variety of social-participation activities. Based on ADL (Activities of Daily Living) assessments by social workers at admission (intake) during 2024, residents are grouped by functional status into severely disabled and mild-to-moderately disabled subgroups. An interdisciplinary team (care attendants, registered nurses, social workers, physical/occupational therapists, and nutritionists) provides individualized, person-centred support. For relevance, this stakeholder group aligns with policies and regulatory priorities, is tightly linked to project stakeholders (objectives and activities), is highly salient in the work of peers (sector practice), accords with societal norms (public concern for dignity and independence), and entails short-term financial impacts for the project if outcomes are not achieved. For significance, the intervention has a material effect on the scale, depth, and duration
	Older adults with mild-to-moderate functional impairment		

Stakeholders		Inclusion or exclusion	Reasons
Category	Subgroup		
			<p>of outcomes, with a direct causal connection to project goals.</p> <p>Triangulating provider and beneficiary/family interviews with admission baseline records shows that, While the two subgroups share largely the same service processes and activity design, their experienced change patterns differ. Older adults with severe functional impairment more frequently described (i) improvements in physical capability (i.e., observable progress in daily functioning) and (ii) enhanced life motivation. In contrast, those with mild-to-moderate impairment more often reported (i) maintaining physical function (i.e., slowing or preventing further decline) and (ii) reductions in negative emotions. To reflect these differences in effect and outcomes, both subgroups are modelled separately (with distinct parameters for attribution, counterfactual, and duration) and then weight-combined to ensure materiality in terms of relevance and significance.</p>

Stakeholders		Inclusion or exclusion	Reasons
Category	Subgroup		
Care professionals		Inclusion	<p>Care professionals are the project's core implementers, delivering the Holistic Reablement and 23+1 model through integrated, interdisciplinary care. The team spans daily living care, clinical nursing, reablement training, psychosocial support, and nutrition management to provide individualised, whole-person support. On relevance, this stakeholder group aligns with quality- and reablement-oriented long-term care policies, is tightly linked to project objectives, reflects sector practice, accords with societal expectations for dignified care, and has clear short-term financial implications for service efficiency if outcomes are not achieved. On significance, their engagement, skills development, and team culture materially affect the scale and depth of resident outcomes (functional recovery, emotional stabilisation, life motivation, social participation) and are directly linked to sustainable care capacity. At the same time, the intensity of caring for residents, especially during major health events or end-of-life stages—and the demands of adapting to the Holistic Reablement model may generate psychological pressure. Therefore, both positive and potential negative changes in staff experience are examined in this evaluation.</p> <p>Interviews and management discussions indicate that, despite varied specialties, learning pathways and changing mechanisms are broadly consistent and highly integrated across roles, making subgroup splits unnecessary. Accordingly, care professionals are included as a single stakeholder type in the model, with outcomes estimated and validated using common indicators and assumptions.</p>

Stakeholders		Inclusion or exclusion	Reasons
Category	Subgroup		
	Family members	Inclusion	<p>Family members are indirect beneficiaries whose quality of life and emotional load change as residents improve under the Holistic Reablement model. Interviews show post-admission stabilisation of older adults' health and mood, better family interaction, and reduced caregiver burden, anxiety, and conflicts—yielding near-term benefits in household time and spending.</p> <p>On relevance, this group aligns with policies on caregiver support, is tightly linked to core stakeholders, is recognised in the work of peers (family engagement in LTC), reflects societal norms for care quality, and carries short-term financial impacts if outcomes are not achieved. On significance, changes are material in scale, depth, and duration, and family feedback directly informs service optimisation. No meaningful heterogeneity was found to justify subgroups; therefore, family members are included as a single stakeholder group, with outcomes estimated via caregiver stress, family interaction/satisfaction, and work–life balance, and tested for sensitivity.</p>
	Yeh Tzu Yuan Senior Residential Care Facility	Inclusion	<p>The YTY Residential Care Facility is the initiator and operator of the Holistic Reablement and “23+1” model, delivering care/reablement, coordinating the interdisciplinary team, ensuring quality, and integrating external resources.</p> <p>In terms of materiality, its relevance is clear: the Facility's role aligns with long-term care policies, stakeholders' needs (residents and families), peers' quality practices, societal expectations for professional LTC, and it directly affects short-term staffing and budget decisions. Its significance is likewise evident: governance, processes, and capacity-building at the Facility</p>

Stakeholders		Inclusion or exclusion	Reasons
Category	Subgroup		
			have a causal and sustained influence on residents' functional gains, families' reduced caregiving burden, and staff development and cohesion, creating durable institutional value (e.g., improved quality and satisfaction, fewer incidents, stable occupancy). Interviews revealed no meaningful internal heterogeneity, so the Facility is treated as a single, core stakeholder in the SROI model.
External instructors		Exclusion	These are lecturers invited by YTY Residential Care Facility to deliver occasional classes. Potential outcomes include increased sense of achievement and additional income. However, interviews and discussions with management indicate that instructors vary by session and YTY is only one of many client sites, so YTY's influence on their behavior and decisions is minimal. Given low materiality and limited causal linkage, this stakeholder is excluded from the analysis.
Volunteers		Exclusion	Volunteers invited to assist with on-site activities may experience an increased sense of achievement. However, interviews show most volunteer at multiple institutions and YTY Residential Care Facility is only one service location; moreover, some volunteer-led activities involve residents who are not participating in the Holistic Reablement model, so the relevance to this evaluation is indirect. Given limited influence on volunteer behaviour/decisions and low materiality, this stakeholder is excluded.
Partner organisations	Yeh Tzu Yuan branch units	Exclusion	Includes the day-care centre, community service sites, the food bank, and the cooperative. Some units have introduced Holistic Independence concepts, but due to setting constraints they cannot offer the full spectrum of training and

Stakeholders		Inclusion or exclusion	Reasons
Category	Subgroup		
			reablement provided in the residential facility. As this SROI focuses on the fully implemented residential model, branch units are excluded.
	External partner organisations	Exclusion	Most partners in 2024 mainly provided course support and professional training. Interviews indicate YTY is just one of many partners; collaboration frequency and depth are limited and YTY's influence on their actions and decisions is minimal. Due to low materiality, they are excluded.
	Pingtung County Long-Term Care Office	Exclusion	Acts primarily as a policy-supporting body. While it does not directly deliver or receive the Holistic Reablement services, it has supported the programme's implementation and diffusion through enabling mechanisms—such as facilitating staff capacity-building at the early adoption stage, providing administrative coordination for county-wide dissemination (e.g., issuing official invitations for peer participation), and offering public resources (e.g., venues) to support results-sharing and cross-sector exchange. However, the Office does not experience material outcomes from the programme and has limited direct causal linkage to stakeholder outcome change; therefore, it is excluded from valuation.

From Table 3-1, the organisations that assist or collaborate with YTY Residential Care Facility are numerous and diverse. To keep this analysis focused and in line with SROI principles, we focused this evaluation on service recipients and frontline care professionals, rather than on assisting or collaborating organisations. Although these external partners do engage in substantive cooperation with YTY, most participate only in specific activities and therefore exert relatively limited influence on the programme's outcomes. Accordingly, external organisations were excluded from valuation, while their importance is duly acknowledged.

3.2 Stakeholders Engagement

At each stage, we examined how stakeholders engage with the Holistic Reablement Care Model at the YTY Residential Care Facility. We first held an initial workshop to familiarise stakeholders with SROI concepts and methods. Through stakeholder sharing, we documented how each group participates in services at the facility, and we conducted in-depth discussions with each implementation team to map activity flows. This clarified where change occurs during service delivery and the process linkages that form the outcome chain. After the first workshop, we conducted interviews with key stakeholders—led by interviewers formally trained in in-depth interviewing—and used the findings to construct a complete outcome chain and clarify inputs, outputs, changes, and outcomes. We then convened a second workshop to co-design the questionnaire with stakeholders and proceed to administration. The workshop and interview procedures are detailed below.

3.2.1 Confirming service process and understanding expected changes

- (1). **Workshop (I) and Interviews:** In the first workshop, the basic concept and steps of SROI were introduced, and five stakeholders participated. A detailed introduction was made on output, input, and outcomes, and stakeholder interview data was collected when the first workshop ended. After the workshop, we obtained preliminary views of stakeholders on input (including time cost), output, and outcomes, and the research team made deductions and analyses according to the content and structured the chain of events and preliminary SROI analysis.
- (2). **Progress discussion and follow-up interviews arrangement:** We discussed the interview arrangements with service providers of the YTY Residential Care Facility, confirming suitable stakeholder representatives to understand the service processes and ensure diversity was considered as the main pillar. We then arranged related interviews.
- (3). **Outputs and interviews (III):** Through the on-site physical workshop, reviewing and investigating the output data on the record sheet allowed us to show a detailed description of each stakeholder's experience. After understanding the output of each activity, cost and financial figures were confirmed with the manager of YTY Residential Care Facility, allowing us to comprehend the output data of each activity and conduct in-depth discussions for related reports.

- (4). **Chain of Events:** The research team conducted a report on the chain of events and stakeholders, exchanging views on the chain of events and outcomes. At the same time, further discussions were conducted on the content of the services, and a deeper understanding of stakeholder participation was achieved, confirming the challenges that may be encountered in subsequent investigations. This process contributed to the writing of the chain of events and outcomes, as well as to the subsequent design of the questionnaire.
- (5). **Workshop (II) and Interviews:** In the second workshop, we revisited with stakeholders the inputs, outputs, and outcomes identified earlier, explored whether any outcomes could be consolidated to confirm the final expected outcomes, and—on that basis—co-developed outcome indicators and financial proxies to measure results and capture stakeholder feedback.
- (6). **Design value game on financial proxy:** After completing the group discussion and interviews of the value game, the research team completed the preliminary financial proxy of the stakeholders. To ensure no problems were encountered with the sample, a questionnaire was conducted to ask stakeholders about the gifts they would buy for the holiday season, ranging from the lowest valued gifts to the highest valued gifts. This information provided more data for the research team to design the valuation method of the value game.
- (7). **Validation of questionnaire design:** After completing the questionnaire design, an online briefing was arranged for stakeholders to understand the questionnaire design. The goal was to verify and confirm the outcomes and indicators and ensure sufficient understanding of the questionnaire questions to verify the final outcomes. Detailed questionnaire content is provided in Appendix II Questionnaire for each stakeholder.

3.2.2 Stakeholder Interview and Survey

To ensure a comprehensive interview process and content, the research team conducted individual interviews with stakeholders. This approach allowed for the most authentic interview results, as stakeholders were not influenced by external factors. Table 3-2 below presents the sample period from 1 January to 31 December 2024, summarizing the number of subjects and interviewees for the Holistic Reablement Care Model—Interdisciplinary Support Program.

For qualitative interviews, we used purposive selection with support from YTY staff to ensure representation of key characteristics within each stakeholder group. For older

adults, interviewees were selected to cover both subgroups (older adults with mild-to-moderate functional impairment and older adults with severe functional impairment) as well as gender variation. For care professionals, interviewees were drawn from multiple disciplines to capture different professional perspectives within the interdisciplinary team.

For the quantitative survey, we adopted a broad distribution approach within the eligible older-adult stakeholder group defined for this evaluative SROI (older adults first admitted between 1 January and 31 December 2024, n=33). To support subgroup comparison, the survey administration followed the functional-impairment distribution of this eligible stakeholder group, which is approximately 2:1 (severe : mild-to-moderate) based on baseline ADL classification at admission. During survey administration, assisting staff were instructed to guide respondents to evaluate perceived change specifically within the 2024 participation period, using their condition at the time of admission in 2024 as the reference point. Where older adults were unable to reliably self-report due to cognitive or communication limitations, responses were completed with staff assistance based on professional observation and, where appropriate, corroborated with family input. If a condition had already been present prior to 2024 with no noticeable change during the evaluation period, a neutral score was recorded.

Table 3-2: Summary of the Number of Respondents and Samples of Stakeholders

Unit: Number of participants

Stakeholders			Research phase		Confirmation
Category	Subgroup	Population	Number of interviewees	Number of questionnaires	Number of interviewees
Yeh Tzu Yuan Senior Residential Care Facility		1	2	1	2
Care professionals		52	7	52	7
Older adults	Older adults with severe functional impairment	21	4	8	2
	Older adults with mild-to-moderate functional impairment	12		5	2
Family members		24	2	16	1
Partner organisations	External partner organisations	4	4	Excluded based on interviews	
	YTY Branch units				
Volunteers		1	1	Excluded based on interviews	
Pingtung County Long-Term Care Office		1	1	Excluded based on interviews	

The sample period for this evaluation is 1 January–31 December 2024. We consolidate, for each stakeholder group in the Holistic Reablement Care Model–Interdisciplinary Support Program, both (i) the total population size and (ii) the numbers interviewed or surveyed by questionnaire at each stage. Details follow.

(1) Interview Objectives:

To understand which activities stakeholders provide/participate in at the YTY Residential Care Facility, which services they provide/receive, and the process of

change after participation, including expected and unexpected outcomes.

(2) Core Interview Framework:

- a. **Preliminary Interview:** In-depth interviews necessitate the establishment of trust. Directly approaching the interviewee may result in insecurity. Therefore, the first half's goal is to build trust, which can enhance the authenticity of the interview content later.
- b. **Interview Techniques:** For overly abstract questions, the research team at National Sun Yat-sen University will supplement them with practical case examples to help interviewees describe their experiences more concretely.
- c. **Interview Mindset:** Establishing trust is crucial. Interviewers should approach interviewees with a caring attitude, making it easier to establish trust. It is recommended to first explain the reason for the interview, adopt a caring and empathetic approach, and establish common topics and frequencies.

(3) Interview Sample Size: The three core principles are theoretical sampling, theoretical saturation, and triangulation.

- a. **Theoretical Sampling:** The research question must be related to the interviewee and have a theoretical perspective (SROI). The interviewee must be related to the theory, which is completed when stakeholders are confirmed.
- b. **Theoretical Saturation:** Unlike quantitative reliability intervals, in qualitative research, each interviewee is interviewed individually. To understand data construction, it is necessary to determine whether new information has emerged from new interviews. If not, interviews will no longer be conducted. Based on actual experience, about 40 hours of interviews will be required. Since case studies are intended to explore uniqueness in-depth, repeat interviews may also be considered if the number of people is small.
- c. **Triangulation:** The authenticity and completeness of the interview content are ensured by verifying other information or content provided by previous interviewees and asking the current interviewee whether they agree.

(4) Interview Frequency: The research team will primarily follow the interviewee's schedule, and previous experience suggests that interviews will be conducted once every 1-2 weeks. If necessary, interviews can be conducted

more or less frequently.

(5) Timing and Content: Each interview will last approximately 50 minutes, including a 10-minute buffer for rest and organisation. The interviews will be conducted by 1-2 researchers and 1 care professional if necessary, with interviews being recorded to ensure data accuracy.

(6) Interview Questions :

- a. When did you come to the YTY Residential Care Facility and how long have you stayed?
- b. How did you first hear about it, and why did you decide to stay?
- c. What services do you receive here? How did staff communicate to earn your trust?
- d. After services/activities, what changes did you (or those around you) experience in thinking/behaviour/health/emotions/daily life/relationships? What concrete events evidenced these changes?
- e. How long did these changes last?
- f. If you had not come here, do you think the same changes would have occurred?
- g. Beyond this facility, have you received long-term care elsewhere? Did it help you obtain similar resources or outcomes?
- h. Did anything negative or unexpected occur to you or those around you because of this program?

3.2.3 Confirmation of Sampling Error

Questionnaires were administered to the primary stakeholder groups included in the SROI evaluation of the Holistic Reablement Care Model–Interdisciplinary Support Program, to measure both change processes and their monetary valuation. In sampling, we set a 95% confidence level and $\pm 5\%$ margin of error, then—using each stakeholder group’s population—computed required sample sizes by group. Random sampling inevitably entails sampling error; increasing sample size reduces it. Considering manpower, time, and feasibility, we retained the 95%/ $\pm 5\%$ standard and calculated targets accordingly. After cleaning returns and removing invalid responses, some groups’ actual completes differed from targets; we therefore computed realised sampling-error intervals, presented in the subsequent table.

Table 3-3: Calculation of Sampling Error

Stakeholders	Population	Sample	Recollected	Sampling error
Yeh Tzu Yuan Senior Residential Care Facility	1	1	1	-
Care professionals	52	46	40	7.52%
Older adults with severe functional impairment	21	20	8	27.93%
Older adults with mild-to-moderate functional impairment	12	12	5	34.96%
Family members	24	23	17	13.11%

Following a “data validity first” principle, the research team—supported by the facility’s staff—administered surveys. Some older adults had moderate to severe cognitive impairment, dementia, or Alzheimer’s disease. Even with basic communication ability, memory and comprehension limitations can hinder accurate recall of activities and self-change; forcing completion risks bias. For ethical and quality-control reasons, this cohort was included only when appropriate (e.g., with family consent and adequate real-time capacity), and where direct self-report was not feasible, responses were completed with staff assistance based on professional observation and communication with family members. In the qualitative interview stage, due to the same limitations, only one older adult with moderate-to-severe cognitive impairment was interviewed (with family consent), and the interview required additional support; the responses were subsequently cross-checked with family members and care professionals to confirm consistency. In the survey stage, 8 of the 30 older-adult questionnaires were completed for moderate-to-severe cognitive impairment cases through this staff-/family-informed assisted approach; however, because this process is time- and labour-intensive, this subgroup remains comparatively harder to reach and may be under-represented within the eligible older-adult stakeholder group (2024 admissions).

This introduces a risk of non-response/coverage and measurement bias, as the analysis may not fully reflect the lived experience and perceived change among older adults with moderate-to-severe cognitive impairment, and the direction of bias (over- or under-estimation) cannot be determined with confidence. To manage this risk, we (1) obtained family consent where needed, (2) used staff-assisted completion informed by professional observation and family communication, and (3) cross-checked key responses with care professionals and family members to improve consistency. All returned questionnaires underwent rigorous item-by-item review to support analytic reliability. In addition, this risk is addressed explicitly in the sensitivity analysis by testing conservative

scenarios, including adjustments to both the number of older adults achieving outcomes and the outcome values for this subgroup, to examine the potential effect on the overall SROI ratio. After quantitative analysis, we also conducted group or one-on-one validation interviews with older adults (and, when appropriate, primary caregivers) to verify key findings, add context, and check consistency.

3.2.4 Confirmation of SROI Results

Upon completing analysis and calculations, the research team presented the SROI results to all core stakeholder groups, including managers of YTY Residential Care Facility, care professionals, older adults, and family members, explained the analytical process, outcome logic, and stakeholder-specific impacts, and walked through the numeric results item by item for confirmation. In addition to these briefings, we conducted one-to-one validation interviews with representatives from each stakeholder group to review the theory of change, indicators, impact factors, financial proxies, and sensitivity results, and to record confirmations and suggested revisions. We also convened a cross-stakeholder results presentation session to share the findings, explain methods and assumptions, and facilitate discussion across groups. Verified outcomes aligned with stakeholders' lived experiences and feedback. In validation interviews with care professionals, we also gathered interpretation and comments from their professional perspectives. This process both fulfilled stakeholder participation and outcome validation requirements and ensured transparency of the evaluation: methods and impact findings were fully disclosed across stakeholders.

Chapter 4: Change Theory and Outcomes Mapping

4.1 Project Input

During the evaluation period (1 January–31 December 2024), the Holistic Reablement Care Model mobilised financial resources, personnel time, materials, and in-kind contributions, with total inputs of NT\$22,044,150 (including self-funded expenditures as well as in-kind donations and venue support). As this evaluative SROI quantifies outcomes for older adults who received the programme in 2024 (n=33), 2024 programme inputs were allocated in proportion to this group's share of the total older adults who received the programme during the year (33/70). This proportional allocation assumes comparable average resource intensity per participant across the 2024 cohort; any variation in individual care intensity is addressed within outcome modelling rather than input weighting. Itemised inputs by stakeholder are shown in Table 4-1 (data provided by YTY Residential Care Facility). The programme is fully self-funded (no programme subsidy is received). Funding consisted primarily of the facility's own expenditures, totalling NT\$21,196,445; the largest share was personnel costs for the interdisciplinary team. In addition, in-kind donations received in 2024 (supplies, assistive devices, electric beds) were recognised at fair value of NT\$793,217 and included as inputs. The Pingtung County Government also provided a public venue for the annual results-sharing exchange session, recognised as an in-kind contribution valued at NT\$5,950. The remainder reflects unpaid managerial time, valued using hourly rates supplied by management. Time costs for care professionals and fees for external lecturers engaged via partner organisations are already included within the facility's funding inputs; therefore, they are not counted again as separate inputs in this analysis. In accordance with SROI conventions, time inputs/ opportunity costs for primary beneficiaries—older adults and their family members—are not counted as separate inputs; resident fees paid to the facility are already reflected within the facility's expenditure line and are not double counted.

Table 4-1: Total resource invested in Holistic Reablement Care Model—
Interdisciplinary Support Program

Stakeholders	Input Subject	Input Items	Financial Value of Input
Yeh Tzu Yuan Senior Residential Care Facility	Personnel costs	Salaries and Wages, Overtime Pay, Employee Bonuses, Labor Pension Contributions (Employer) / Labor Pension Fund—Employer Contribution, Employee Self-Contributed Labor Pension (Voluntary), Employee Welfare Expenses, Staff Meals (Employee)	NT\$13,417,664
	Direct Care & Consumables	Resident Meals / Dietary Costs, Medical Supplies, Consumables	NT\$2,867,847
	General & Administrative Expenses	Miscellaneous Expenses, Postage and Telecommunications, Bank Service Charges / Processing Fees, Professional Service Fees, Other Expenses	NT\$1,107,244
	Utilities & Operating Costs	Utilities (Electricity/Water/Gas), Fuel Costs	NT\$467,689
	Insurances Expenses	Insurance Premiums	NT\$1,369,717
	Depreciation & Amortization	Depreciation, Depletion and Amortization	NT\$1,864,018
	Training & Education	Training Expenses	NT\$102,267
	In-kind Donations	Supplies, assistive devices, electric beds, etc.	NT\$793,217
Care professionals	Time Costs	1.Employee time is fully captured within the facility's expenditure on personnel. 2.Management contributes	NT\$48,538

Stakeholders	Input Subject	Input Items	Financial Value of Input
		~20 hours per month; valuation rate NT\$429 per hour.	
Older adults and family members	Residence Fee	Monthly accommodation and service fees by disability level (approx. NT\$28,000– NT\$37,000 per month).	Under the expense of the Yeh Tzu Yuan Senior Residential Care Facility, the cost would be excluded
External instructors	Labor Costs	Lecturer Fees	
Volunteers	Time Costs	Time inputs not directly attributable to the Holistic Reablement Care Model	NT\$0
Pingtung County Long- Term Care Office	In-kind Donations	Venue support	NT\$5,950
Partner organisations	Labor Costs	Lecturer Fees	Under the expense of the Yeh Tzu Yuan Senior Residential Care Facility, the cost would be excluded
Total Input			NT\$22,044,150

Note. All 2024 monetary amounts in this table have been proportionally allocated (33/70) to match the older-adult stakeholder group receiving the programme in 2024 (n=33).

4.2 Project Output

The services at the YTY Residential Care Facility span the physical, psychological, spiritual, and social dimensions of older adults' lives. Table 4-2 summarises the core activities and outputs of the Holistic Reablement Care Model—Interdisciplinary Support Program. By extending the Holistic Reablement approach from community settings into the residential care environment, YTY has moved beyond a purely custodial care model toward a more active, person-centred approach. Through interdisciplinary teamwork and daily-living reablement, residents strengthen self-care abilities, regain confidence and dignity, and experience a warm, supportive care setting. In parallel, diverse spiritual and leisure activities, outdoor participation, and community linkages promote health and social participation, while connecting families, communities, and caregivers to co-create a people-centred, inclusive care network.

Table 4-2: Description of Holistic Reablement Care Model—Interdisciplinary Support Program Activities

Activity Name	Activity Content
<p>Holistic Reablement Caring</p>	<p>Centred on the Holistic Reablement philosophy, an integrated care approach designs body–mind–social–spiritual reablement activities to strengthen residents’ self-care and life participation. Content includes activities of daily living (ADL) training (e.g., dressing, eating, personal hygiene), cognitive/mental activation (art, singing), emotion expression and support groups, social-interaction practice, and spiritual care with life-story sharing. The interdisciplinary team sets individualised plans based on assessment findings, encouraging residents to regain autonomy within their abilities. Through cyclical activities and continuous observation, residents progressively improve ADL independence, self-efficacy, and quality of life.</p>
<p>Outdoor Activities</p>	<ol style="list-style-type: none"> 1. Use outings (shopping, visits) as positive reinforcement to sustain participation in Holistic Reablement and ongoing daily-living training. 2. During shopping trips, residents choose items, calculate prices, and handle payment/change to stimulate cognition and delay decline. 3. Engage with the public during outings to enhance interpersonal interaction, lift mood, and maintain social functioning.
<p>Staff Training & Development</p>	<ol style="list-style-type: none"> 1. Provide structured in-service courses on Holistic Reablement concepts and practice. 2. Increase staff sense of achievement and improve residents’ ADL independence—thereby supporting dignified, autonomous living—through a practical “Reablement Care Skills Competition.” 3. Encourage staff to submit and share reablement case studies (presentations/publications) to strengthen knowledge transfer and team learning.

Table 4-3: Description of Holistic Reablement Care Model—Interdisciplinary Support Program Outputs

Activity Name	Stakeholders	Outputs	Documents
Holistic Reablement Caring	Older adults with severe functional impairment Older adults with mild-to-moderate functional impairment	<ul style="list-style-type: none"> ●23+1 round-the-clock care: 23 hours of daily-living care + 1 hour of professional reablement per day ●Physiotherapy (PT) reablement training: 3–5 sessions/week, 20–30 min/session ●Occupational therapy (OT): 2–4 sessions/week, 20–30 min/session ●Arts & leisure activities: 2 sessions/week, 50–60 min/session ●Spiritual & psychosocial support: 1 session/week, 60 min/session ●Culture, entertainment & daily-life activities: band performance every other week (1 hr); “shop activity” twice weekly (1 hr) 	<ul style="list-style-type: none"> ●Individualised Service Plan (ISP), twice/year per resident ●ISP progress records, ≥12 entries/year per resident ●Interdisciplinary meeting minutes (one set per meeting) ●Service records (one per service episode) ●Activity reports (one per session)
	Care professionals	<ul style="list-style-type: none"> ●Interdisciplinary practice time (Care professionals): ●Interdisciplinary meetings: ~6 hours/week (per care professional) ●PT clinical time: 5–6 hours/day (per therapist) 	
	Yeh Tzu Yuan Senior Residential Care Facility	<ul style="list-style-type: none"> ●OT clinical time: 4–6 hours/day (per therapist) ●Care attendants: 1–1.5 hours/day (per staff) devoted to reablement-focused tasks 	
Outdoor Activities	Older adults with severe functional impairment	<ul style="list-style-type: none"> ● “Self-Reliance Rewards Fair” (annual) ●Senior Welfare Games (annual) ●Festival/holiday events (on each 	<ul style="list-style-type: none"> ●Outing/participation reports with photos (one per event) ●Service records (one

Activity Name	Stakeholders	Outputs	Documents
	Older adults with mild-to-moderate functional impairment	holiday) ●Community participation (group/individual): Mon–Fri, 3–4 hrs/session/week	per activity)
	Care professionals		
	Family members		
	Yeh Tzu Yuan Senior Residential Care Facility		
Staff Training & Development	Care professionals	●Holistic Reablement model courses: 4 courses/year, 12 hrs/course ●Discipline-specific continuing education: ~20 hrs/year per staff member	●Holistic Reablement training records (one per session) ●Certificates of completion
	Yeh Tzu Yuan Senior Residential Care Facility	●Project showcase: internal showcase once/year; external peer conferences twice/year ●Reablement case submissions: 2–3 cases/year	●Course feedback & practice-application assessments (6–10 per session)

4.3 Chain of Events

The chain of events primarily serves to confirm the stakeholders involved, understand the program's implementation process, and clarify the perceived change associated with participation in the programme. The chain of events may be modified according to the understanding of the program. Usually, after interviewing the frontline implementers and participants, the chain of events will be revised again, and some unexpected outcomes will be obtained.

By mapping the chain of events, the research team presents the causal relationships across the change process and further infers the ultimate expected outcomes. In this project, explanations are organised by stakeholder type—older adults (sub-grouped into those with severe and mild-to-moderate functional impairment), care professionals, the

YTY Residential Care Facility, and family members. This section illustrates the outcomes for older adults; outcome descriptions for the remaining stakeholders are provided in Appendix I . The chain of outcomes is provided in Appendix III .

Table 4-4 presents the outcomes and change processes observed among older adults after receiving services. As the programme’s primary beneficiaries, older adults experience not only care and physical function training but also spiritual and leisure activities and outdoor participation. Consequently, beyond improvements in physical health, there are notable positive changes in emotional well-being, interpersonal relationships, and motivation for daily life.

Table 4-4: Summary of Outcomes for Older adults (sub-grouped into those with severe and mild-to-moderate functional impairment)

Outcomes	Chain of Events	Summary of Stakeholder Feedback
Improved physical health	<p>1. Receive assessment on physical, psychological, and social-interaction status by YTY staff→Receive care, training, and group activities→Find the training helpful and begin to trust staff→Do rehabilitation earnestly; become willing to do things by oneself→Gains in ADLs, mobility, and strength; fewer injuries→Improved physical health</p> <p>2. Receive care from care professionals→Staff listen to what I want to say and teach health knowledge→After trusting staff, follow guidance (medication, medical visits, routines) →Develop regular habits, seek care when unwell, eat with nutrition in mind→Improved physical health</p>	<p>Older adult: “Before coming to YTY, I was in a car accident and became paraplegic. After training here, I actually started to stand up—slowly but surely.”</p> <p>Older adult: “I used to be tube-fed and had to wear diapers. With the therapists’ training, I can now eat normally—by myself—and I no longer need diapers.”</p>
Reduced depression &	<p>1. Outdoor activities (shopping & seasonal events) led by designated staff →Go to places outside the</p>	<p>Older adult: “Joining outdoor activities and doing simple shopping tasks got me interacting more. I feel</p>

Outcomes	Chain of Events	Summary of Stakeholder Feedback
<p>negative thoughts</p>	<p>facility and meet people→Do shopping (choose items, calculate & make change) and exercise →Increase social interaction →Shift from preferring solitude to choosing group activities and interacting → Attend spiritual/psychosocial sessions and sharing circles → Gradually understand others' pain/challenges and learn empathy → Fewer outbursts or depressive moods → Fewer negative emotions → Reduced depression & negative thoughts</p> <p>2. Outdoor activities (shopping & seasonal events) led by designated staff → Attend festive/holiday activities → Celebrates Lunar New Year with everyone at YTY in a joyful atmosphere →Feels the festive atmosphere → Being occupied reduces overthinking → Reduced depressive or negative thoughts → Reduced depression & negative thoughts</p>	<p>calmer now and have fewer negative thoughts.”</p> <p>Older adult: “Festive activities (like Lunar New Year) made me feel less lonely. Staying busy helped me stop overthinking and feel less down.”</p>
<p>Increased life motivation</p>	<p>1. Receive services→ Accept companionship and social support → Feel carers' empathy and sincerity; feel listened to and build trust → Become more open-minded and become willing to try new things → Join life-review/life-story book making; share on stage and be recognized → Share one's life experiences → Rediscover interests and life goals</p>	<p>Older adult: “When I shared my life stories and worked on my life storybook, I rediscovered what I used to enjoy and regained my enthusiasm for life. If my body continues to improve, I want to go home and exercise with my friends.”</p> <p>Care professional: “To boost engagement and motivation, we offer small rewards during training—like</p>

Outcomes	Chain of Events	Summary of Stakeholder Feedback
	<p>→ Regain passion for life → Want to live each day well → Expressed renewed aspirations for independent living or greater autonomy → Increased life motivation</p> <p>2. Receive assessment on physical, psychological, and social-interaction status by YTY staff → Receive care, training, and group activities → Find the training helpful and begin to trust staff → Do rehabilitation earnestly; become willing to do things by oneself → Praise/rewards from staff for rehab; if functional goals met, eligible for care-fee discounts → Extrinsic motivation rises; set personal goals → Increased life motivation</p>	<p>drinks, snacks, a special meal, or even caring fee discounts. Some residents work hard to hit goals because it helps ease their family’s financial burden.”</p>
<p>Enhanced social relationships</p>	<p>1. Receive services → Accept emotional companionship and social support → Feel carers’ empathy and sincerity; feel listened to and build trust → Become more open-minded and become willing to try new things → Join life-review/life-story book making; share on stage and be recognized → Remember more past events/people; fewer memory lapses → Fewer interpersonal issues caused by repeated questioning → Fewer interpersonal conflicts related to dementia symptoms → Fewer temper outbursts when talking</p>	<p>Older adult: “ When I started joining the life-story book sessions and sharing my experiences, and I also went to the outdoor shopping activities where I had to choose items, calculate, and make change—it gave me more chances to use my brain. Little by little I felt more confident to talk with others, I repeat myself less, and there’s less friction when speaking with family or friends. Now I also chat more with people here and I’ve made new friends.”</p> <p>Family member: “My mother rarely smiled and didn’t like interacting with people. Since moving to YTY, every</p>

Outcomes	Chain of Events	Summary of Stakeholder Feedback
	<p>with family → Relationships with family improve → Enhanced social relationships</p> <p>2. Receive services → Accept companionship and social support → Feel carers' empathy and sincerity; feel listened to and build trust → Become more open-minded and become willing to try new things → Join life-review/life-story book making; share on stage and be recognized → Remember more past events/people; fewer memory lapses → Fewer interpersonal issues caused by repeated questioning → Fewer interpersonal conflicts related to dementia symptoms → More positive interpersonal interactions → Make new friends → Enhanced social relationships</p>	<p>visit I find her laughing and chatting with other residents or exercising together. That's the biggest change I've seen."</p>

Chapter 5: Outcome Verification and Establishment of Financial Proxies

5.1 Indicators

SROI necessitates the establishment of one or more metrics for each outcome to demonstrate its occurrence and to verify its extent and whether the impact is crucial or significant to the stakeholders. In this evaluation, indicators were developed based on stakeholder interviews and YTY’s internal monitoring practice, and were refined through workshops and follow-up validation discussions. Table 5-1 presents the indicators for all stakeholder groups.

Most outcomes were measured using multiple questionnaire-based indicators. These indicators serve two analytical purposes. First, individual indicator scores reflect the relative magnitude (depth) of perceived change at the individual level. Second, outcome achievement at the individual level is determined through a predefined pass rule, which informs the scale (number of beneficiaries) included in subsequent monetisation. This distinction between depth (indicator score) and scale (outcome pass rate) underpins the quantitative SROI calculation. As described in Section 3.2 (Survey Administration), respondents were instructed—through assisting staff where necessary—to evaluate perceived change specifically within the 2024 participation period, using their condition at admission in 2024 as the reference point. Where no noticeable change occurred during 2024, a neutral score was recorded.

Indicators were measured using a 5-point Likert agreement scale, interpreted as follows: 1 = Disagree (negative), 2 = Neutral/Unsure, and 3–5 = Agree (with higher values indicating stronger perceived change). An agreement-based Likert format was adopted following consultation with questionnaire design specialists. Rather than asking respondents to rate change magnitude directly on a numeric 1–5 interval scale, the agreement format reduces variability arising from differing interpretations of numeric intervals (e.g., what constitutes a “3” versus a “4” in absolute magnitude). This approach aligns with common social research practice and enhances interpretability for older respondents. The mid-point (score = 2) was defined as “neutral / no noticeable change” rather than the conventional 3-point midpoint. As this is a retrospective evaluation focused on change within a defined participation period, the scale was structured to distinguish clearly between (i) negative change (1), (ii) no observable change (2), and (iii) varying degrees of positive change (3–5). This configuration allows greater differentiation within the positive-change range while maintaining clarity and reducing

cognitive burden. Although a 7- or 9-point scale could theoretically capture finer gradations, a 5-point format was selected to balance sensitivity with response feasibility and to minimise respondent fatigue among older participants.

Table 5-1: Indicators of Stakeholders

Stakeholders	Outcomes	Indicators	Indicators Score	Quantity	
Older adults with severe functional impairment	Improved physical health	Total ADL score (Activities of Daily Living total score)	19.52 (ADL score delta)	15	
	Reduced depression & negative thoughts	Fewer outbursts or depressive mood	4.88	21	
		Accepts one's physical condition	5.00		
		Fewer negative thoughts	4.75		
	Increased life motivation	Desire to live each day well	5.00	21	
		Follows care staff's advice—adheres to rehab and eats well	5.00		
		Begins setting life goals	4.88		
		Wants to return home	4.50		
	Enhanced social relationships	Make new friends	4.63	21	
		Family relationships improve after receiving proper care	4.38		
		Willing to initiate conversations	5.00		
		Willing to join activities and interact with others	4.50		
	Older adults with mild-to-moderate functional impairment	Improved physical health	Total ADL score (Activities of Daily Living total score)	5.00 (ADL score delta)	5
Reduced depression & negative thoughts		Fewer outbursts or depressive mood	4.80	12	
		Accepts one's physical condition	4.80		
		Fewer negative thoughts	4.60		
Increased life motivation		Desire to live each day well	4.80	12	
		Follows care staff's advice—adheres to rehab and eats well	4.80		
		Begins setting life goals	5.00		
		Wants to return home	4.20		
			Makes new friends	4.60	12

Stakeholders	Outcomes	Indicators	Indicators Score	Quantity
	Enhanced social relationships	Family relationships improve after receiving proper care	4.60	
		Willing to initiate conversations	5.00	
		Willing to join activities and interact with others	4.40	
Care professionals	Enhanced professional skills	Communication skills improved	4.28	43
		Greater interdisciplinary collaboration ability	4.23	
		Team communication & task coordination improved	4.10	
		Enhanced problem-recognition ability	4.10	
		Improved diet & nutrition management ability	3.43	
		Improved physical-therapy competencies (training residents' mobility)	3.63	
		Improved occupational-therapy competencies (training residents' ADLs)	3.63	
		Improved course planning ability	3.50	
		Improved project management (planning, proposal writing, execution)	3.38	
	Increased sense of accomplishment	Seeing changes in service users	4.60	48
		Feeling the value of one's work	4.43	
		Achieving goals and receiving recognition from significant others	4.30	
		Seeing improved relationships between residents and family members	4.38	
	Enhanced empathy	Can empathise with older adults' lived experience and better interpret why they express certain needs or preferences	4.33	46
		Applies expertise to help friends/family in similar situations	4.33	
		I would describe myself as "soft-hearted"	3.73	
	Heightened risk awareness	Has applied work-learned content at home to prevent or improve situations	4.05	42
		Has detected risks and helped older relatives seek medical care/resources	3.98	
		Believes "I have a responsibility to observe and prevent care risks for older family members"	4.33	

Stakeholders	Outcomes	Indicators	Indicators Score	Quantity
	Increased mental stress	Feeling of helplessness when a resident's condition worsens or at end-of-life	2.88	18
		Stress from learning and adapting to the new care model	2.63	
		Stress from team re-forming when colleagues resign	3.18	
Family members	Improved family relationships	Older adult shows fewer negative emotions; relationship improves	4.41	23
		Chat with the older adult and share what happened at YTY	4.35	
		Participate in activities together with the older adult	4.29	
		As the older adult's condition improves, family relationships improves	4.35	
	Reduced caregiving burden	Less worry about incidents with the older adult	4.94	24
		More able to focus on one's own work and life	4.82	
		More at ease about the older adult returning home	3.29	
Reduced financial burden	Whether there is any fee discounts		7	
Yeh Tzu Yuan Senior Residential Care Facility	Expanded service models	Communication time cost with partner organisations saved		1
		Growth in donations and commissioned revenue		
		Growth in operating revenue related to the Holistic Reablement Care Model—Interdisciplinary Support Program		
	Strengthened team cohesion	Interdisciplinary meeting time (hours/week) attended by supervisors		1

In processing the questionnaire results, we adopted a conservative, non-overstating principle. For outcomes measured by multiple Likert-scale indicator items, an outcome is considered achieved at the individual level only when (i) at least one indicator item scores ≥ 4 , and (ii) none of the indicator items scores 1 (which would signal a negative direction for that outcome).

We acknowledge that using an agreement-based Likert scale to approximate change magnitude entails a measurement risk, as some respondents may not fully equate degree

of agreement with degree of change. In addition, as no formal pre-test baseline survey was administered, indicator scores reflect perceived relative change rather than precisely measured absolute change. To address these limitations, conservative outcome-pass criteria are applied, and sensitivity analysis is conducted on outcome scale (number of beneficiaries achieving the outcome) to test the robustness of results under alternative scenarios.

Exception—Older adults’ “Improved physical health”: this outcome is assessed using YTY’s objective Total ADL score rather than Likert items. We compute $\Delta\text{ADL} = \text{ADL}_{\text{end}} - \text{ADL}_{\text{start}}$ (baseline vs end-of-2024 assessment). Any positive ΔADL ($\Delta\text{ADL} > 0$) is treated as achieving the outcome, and ΔADL is also used as the indicator score to reflect the magnitude of change.

5.1.1 Delta change analysis

To provide an additional reference for the relative strength of outcomes at the group level, we conducted a delta analysis based on each indicator’s distance from the predefined effectiveness threshold. For indicators measured on the five-point Likert agreement scale, the effectiveness threshold is set at 4 (“Agree”). Group-level delta values are calculated as (mean score – 4). A positive delta indicates that the group average exceeds the effectiveness threshold, while a negative delta indicates that the average level of agreement does not reach the threshold.

It is important to note that this delta does not represent a pre–post difference, as no formal baseline survey was administered. Rather, it reflects the group’s relative distance from the predefined outcome benchmark within the 2024 participation period. Accordingly, delta values are interpreted comparatively across outcomes and stakeholder groups, and not as precise estimates of absolute change magnitude.

For older adults’ “Improved physical health,” the indicator is the objective Total ADL score. Delta is calculated as $\Delta\text{ADL} = \text{ADL}_{\text{end}} - \text{ADL}_{\text{start}}$. As the achievement threshold for this outcome is $\Delta\text{ADL} > 0$, the reported delta corresponds directly to ΔADL (i.e., distance from a zero-change threshold).

Table 5-2: the ‘delta’ change between baseline and status for relevant outcomes

Delta change analysis										
Stakeholder Feedback										
Stakeholders	Outcomes	Indicator 1	Indicator 2	Indicator 3	Indicator 4	Indicator 5	Indicator 6	Indicator 7	Indicator 8	Indicator 9
Older adults with severe functional impairment	Improved physical health(ADL score delta)	19.52	-	-	-	-	-	-	-	-
	Reduced depression & negative thoughts	0.88	1.00	0.75	-	-	-	-	-	-
	Increased life motivation	1.00	1.00	0.88	0.50	-	-	-	-	-
	Enhanced social relationships	0.63	0.38	1.00	0.50	-	-	-	-	-
Older adults with mild-to-moderate functional impairment	Improved physical health(ADL score delta)	5.00	-	-	-	-	-	-	-	-
	Reduced depression & negative thoughts	0.80	0.80	0.60	-	-	-	-	-	-
	Increased life motivation	0.80	0.80	1.00	0.20	-	-	-	-	-
	Enhanced social relationships	0.60	0.60	1.00	0.40	-	-	-	-	-
Care professionals	Enhanced professional skills	0.28	0.23	0.10	0.10	-0.58	-0.38	-0.38	-0.50	-0.63
	Increased sense of accomplishment	0.60	0.43	0.30	0.38	-	-	-	-	-
	Enhanced empathy	0.33	0.33	-0.28	-	-	-	-	-	-
	Heightened risk awareness	0.05	-0.02	0.33	-	-	-	-	-	-
	Increased mental stress	-1.13	-1.38	-0.83	-	-	-	-	-	-
Family members	Improved family relationships	0.41	0.35	0.29	0.35	-	-	-	-	-
	Reduced caregiving burden	0.94	0.82	-0.71	-	-	-	-	-	-
	Reduced financial burden	-	-	-	-	-	-	-	-	-

5.1.1.1 Delta analysis for older adults (sub-grouped into those with severe and mild-to-moderate functional impairment)

For the first outcome, “Improved physical health,” measured using Total ADL score, both subgroups demonstrate positive functional change during the 2024 participation period. The severe group records a larger ADL delta (+19.52) compared with the mild-to-moderate group (+5). Interview evidence suggests that the nature of improvement differs by functional level: for older adults with severe impairment, gains often involve meaningful recovery in daily functioning—such as progressing from full dependence to partial participation or regaining basic self-care abilities—whereas for those with mild-to-moderate impairment, improvements more commonly relate to maintaining or strengthening existing functions, including balance, mobility, and sustained independence. These qualitative accounts align with the observed ADL deltas and indicate that physical improvement manifests at different functional levels across the two subgroups.

For “Reduced depression & negative thoughts,” both subgroups score above the effectiveness threshold across indicators. Interviews indicated that some residents initially expressed pessimism or emotional resistance upon admission. Over time, through accompaniment and structured activities, residents reported greater emotional stabilisation.

For “Increased life motivation,” indicator means remain above the effectiveness threshold across both subgroups. Interview accounts describe residents becoming more willing to participate in routines, rehabilitation, and life-review activities. Items such as “Desire to live each day well” and “Begins setting life goals” record strong endorsement in both groups. The item “Wants to return home” shows positive agreement in both subgroups (severe 4.50; mild-to-moderate 4.20), though with some variation consistent with differing living expectations.

For “Enhanced social relationships,” both subgroups exceed the effectiveness threshold across indicators. Residents described greater willingness to initiate conversations and participate in group activities. Differences between subgroups are modest. While family-related interaction items show slightly lower endorsement in the severe subgroup, overall scores remain above the benchmark.

5.1.1.2 Delta analysis for care professionals

For care professionals, delta results show variation across outcomes. As for “Enhanced professional skills,” the most salient deltas appear on “Communication skills improved” and “Greater interdisciplinary collaboration ability,” suggesting that the interdisciplinary model most directly strengthens day-to-day coordination and teamwork. Other items such as team coordination and problem recognition remain above the threshold, while indicators related to diet management, therapy-specific competencies, and project management fall below it—consistent with interview feedback that staff most clearly perceive change in communication and collaborative practice rather than in expanded technical roles.

The outcome “Increased sense of accomplishment” also shows high value—especially on “Seeing changes in service users” and “Feeling the value of one’s work.” When interviewing with care professionals, they emphasised that witnessing residents’ progress reinforces professional identity and affirms the meaning of long-term care work.

As for the outcome, “Heightened risk awareness” shows notable change. The largest delta appears on “Has detected risks and helped older relatives seek medical care/resources,” indicating that YTY’s skills training and resource linkages have been internalised as everyday competencies and even extended to family settings. This reflects both sharper professional problem detection and stronger identification with one’s professional role.

For “Enhanced empathy,” YTY’s “constraint experience” course enables staff to viscerally feel elders’ physical and psychological discomfort, leading to greater compassion in care. Several colleagues noted that, while they understand and assist residents, they still frame this as professional duty rather than an extension of personal emotion; thus, the outcome chiefly captures professional empathy rather than personality shift.

Finally, for the negative outcome “Increased mental stress,” the highest source is “Stress from team re-forming when colleagues resign” (3.18), as turnover requires rebuilding trust, redistributing roles, and adjusting communication patterns. This is

followed by “Feeling of helplessness when a resident’s condition worsens or at end-of-life” (2.88). While emotional strain is present, ongoing training and supervision help staff balance professional boundaries and process grief constructively. Stress related to learning and adapting to the Holistic Reablement model is comparatively lowest (2.63), suggesting that current stress patterns are more closely associated with changes in team composition than with the care model itself.

5.1.1.3 Delta analysis for family members

For family members, the indicator delta of “Reduced caregiving burden” shows the strongest change. After an older adult move into the YTY Residential Care Facility, families most immediately experience a marked drop in caregiving pressure, as they no longer need to worry constantly about emergencies while working or going out and can re-centre on their own lives. Indicator results show very strong endorsement for both “Less worry about incidents with the older adult” (4.94) and “More able to focus on one’s own work and life” (4.82). By contrast, “More at ease about the older adult returning home” remains comparatively lower (3.29), reflecting continued reliance on institutional care.

The outcome “Improved family relationships” also shows consistent improvement, with all four indicators exceeding the effectiveness threshold: “Older adult shows fewer negative emotions; relationship improves” (4.41), “Chat with the older adult and share what happened at YTY” (4.35), “Participate in activities together with the older adult” (4.29), and “As the older adult’s condition improves, family relationships improves” (4.35). These results suggest that alongside stabilised health and mood, families perceive more frequent and smoother interaction.

5.2 Duration

Duration refers to the period during which outcomes can be observed and measured, as each outcome has different durations. In this evaluation, duration is determined based on stakeholders’ subjective expectations together with objective judgement derived from the programme scope and stakeholder exposure. As the Holistic Reablement Care Model includes diverse and comprehensive activities, different stakeholder groups derive different outcomes, and their expected durations vary with personal characteristics, family context, and work roles. In the questionnaire, only respondents who report having experienced a specific outcome further assess its duration; we summarise these duration estimates using a simple average method, as presented in Table 5-3.

Table 5-3: Duration of each stakeholder

Stakeholders	Outcomes	Duration (Year)
Older adults with severe functional impairment	Improved physical health	5
	Reduced depression & negative thoughts	5
	Increased life motivation	4
	Enhanced social relationships	4
Older adults with mild-to-moderate functional impairment	Improved physical health	5
	Reduced depression & negative thoughts	5
	Increased life motivation	4
	Enhanced social relationships	5
Care professionals	Enhanced professional skills	4
	Increased sense of accomplishment	4
	Enhanced empathy	4
	Heightened risk awareness	5
	Increased mental stress	1
Yeh Tzu Yuan Senior Residential Care Facility	Expanded service models	1
	Strengthened team cohesion	1
Family members	Improved family relationships	4
	Reduced caregiving burden	4
	Reduced financial burden	1

From Table 5-3, most outcome durations fall between 4 and 5 years. This is consistent with YTY’s emphasis on reablement and independence-building rather than purely custodial care, which can support sustained self-care and psychosocial effects beyond the service period. Stakeholder interviews also suggest that benefits may continue after activities end, indicating medium- to long-term efficacy in the service design. However, for care professionals, the longer reported durations may carry a risk that some perceived effects reflect accumulated learning and practice developed prior to 2024, rather than being attributable solely to the 2024 evaluation period. This risk does not apply in the same way to older adults and family members, as the survey for these stakeholder groups was administered to the eligible 2024 admission group receiving the programme. To manage uncertainty and avoid overestimation, we explicitly test shorter and more conservative duration scenarios in the sensitivity analysis (including scenarios that reduce care-professional durations), and the results remain robust.

5.3 Materiality

The research team discussed the questionnaire threshold results with stakeholders, adhering to the principle of not exaggerating, to confirm their rationality and correctness. Based on internal data, questionnaire distributions, stakeholder validation, and professional consultation, we confirmed that the outcomes taken forward are correct, complete, and appropriate for inclusion in the final calculation.

Relevance of outcomes has been established in earlier sections (see Table 3-1) and reconfirmed through stakeholder interviews and validation discussions. All outcomes presented in this section therefore meet the relevance criterion, meaning they are credibly linked to stakeholders’ lived experience and to the programme’s theory of change. The materiality test conducted here focuses on confirming their significance.

All materiality-related questionnaire items used a consistent 5-point agreement scale (1 = Disagree, 2 = Neutral/Unsure, 3–5 = Agree), including items designed to capture potential negative outcomes. For the materiality test in this report, an outcome is considered to pass the significance threshold when it meets both criteria:

- (i) The outcome indicators meet the predefined effectiveness threshold (as described in Section 5.1).
- (ii) The average importance score reported by stakeholders is ≥ 4.0 .

Figure 5-1 illustrates the process of determining the materiality of outcomes.

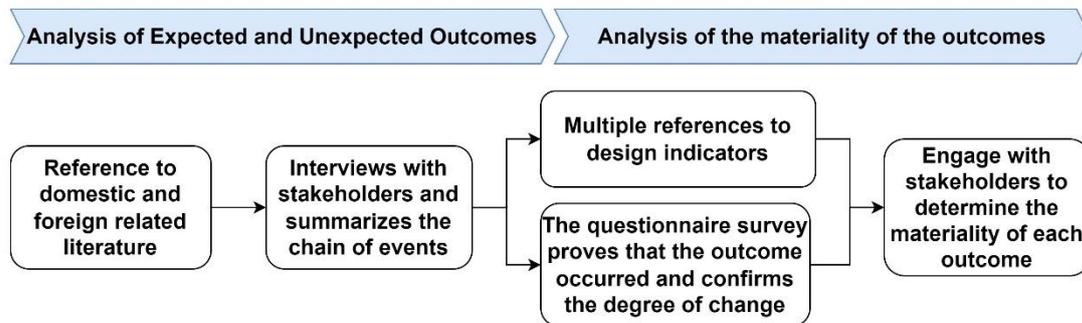


Figure 5-1: The Process of Determining the Materiality of Outcomes

Determining the materiality of Outcomes

Table 5-4 summarizes whether each outcome meets the materiality criteria for each stakeholder group. In SROI, materiality is assessed based on two principles: “Relevant” and “Significant.” Relevant refers to whether the outcome is meaningfully connected to the stakeholder and the programme’s change pathway; Significant refers to whether the magnitude and importance of the outcome are sufficient to influence stakeholders’ decisions or actions.

The outcomes in this report originate from stakeholders and have been confirmed through interviews and questionnaires as both relevant and significant. Table 5-4 presents the materiality results for older adults (sub-grouped into those with severe and mild-to-moderate functional impairment), care professionals, the YTY Residential Care Facility, and family members following their participation in the program.

Table 5-4: Summary of Determining the Materiality of Outcomes

Stakeholders	Outcomes	Relevant	Quantity (%)	Importance
Older adults with severe functional impairment	Improved physical health	✓	71%	5.00
	Reduced depression & negative thoughts	✓	100%	5.00
	Increased life motivation	✓	100%	4.88
	Enhanced social relationships	✓	100%	4.63
Older adults with mild-to-moderate functional impairment	Improved physical health	✓	42%	5.00
	Reduced depression & negative thoughts	✓	100%	4.60
	Increased life motivation	✓	100%	5.00
	Enhanced social relationships	✓	91%	4.40
Care professionals	Enhanced professional skills	✓	83%	4.36
	Increased sense of accomplishment	✓	92%	4.32
	Enhanced empathy	✓	89%	4.49
	Heightened risk awareness	✓	81%	4.56
	Increased mental stress	✓	48%	4.10
Yeh Tzu Yuan Senior Residential Care Facility	Expanded service models	✓	100%	5.00
	Strengthened team cohesion	✓	100%	5.00
Family members	Improved family relationships	✓	96%	4.56
	Reduced caregiving burden	✓	100%	4.82
	Reduced financial burden	✓	15%	4.20

5.4 Outcome Verification

To ensure that the outcomes are final and significant, and to avoid the risk of double counting, outcome verification is conducted. After determining the final outcomes, the chain of events and various values are revisited and discussed to guarantee that the stakeholders' results are accurate and credible.

Table 5-5: Inclusion or exclusion of outcomes

Stakeholders	Outcomes	Inclusion or Exclusion	Description
Older adults with severe functional impairment	Improved physical health	Inclusion	Based on the quantitative indicator thresholds and stakeholder validation, older adults with severe functional impairment demonstrate consistent and meaningful change across all identified outcomes. “Improved physical health” is evidenced by gains in ADL independence, improved mobility and strength, more stable routines, and better health management. As far as emotions and attitudes are concerned, “Reduced depression & negative thoughts” is reflected in fewer emotional outbursts, greater acceptance of one’s condition, and fewer negative thoughts; “Increased life motivation” is demonstrated through a stronger desire to live each day well and the rediscovery of personal interests and meaning in life, as residents reconnect with their identity through daily routines and reflective activities. In terms of interpersonal relationships, “Enhanced social relationships” is reflected in initiating conversations, forming friendships, joining activities, and improved family interaction. All four outcomes meet the criteria of relevance and significance based on
	Reduced depression & negative thoughts	Inclusion	
	Increased life motivation	Inclusion	

Stakeholders	Outcomes	Inclusion or Exclusion	Description
	Enhanced social relationships	Inclusion	stakeholder experience and indicator performance; therefore, they are included in the next stage. As these outcomes may reinforce one another, potential overlap risk is acknowledged and addressed in the sensitivity analysis.
Older adults with mild-to-moderate functional impairment	Improved physical health	Inclusion	Older adults with mild-to-moderate functional impairment also demonstrate meaningful outcomes, though with different pathway. Improved physical health is evidenced by positive change in Total ADL scores during the 2024 participation period. “Reduced depression & negative thoughts” is reflected in more stable mood, fewer negative thoughts, and greater acceptance through active participation in structured activities. “Increased life motivation” is shown in a stronger desire to live each day well and renewed engagement in daily routines and outdoor activities. “Enhanced social relationships” is reflected in forming friendships, initiating conversations, and improved family interaction. Potential overlap across outcomes is disclosed and examined in sensitivity analysis.
	Reduced depression & negative thoughts	Inclusion	
	Increased life motivation	Inclusion	
	Enhanced social relationships	Inclusion	
Care professionals	Enhanced professional skills	Inclusion	Interviews and survey results indicate that the YTY Residential Care Facility’s Holistic Reablement model, delivered through interdisciplinary teamwork, distinguishes it from typical long-term care settings. Through integrated training, such as combining classes, hands-on practice, and experiential

Stakeholders	Outcomes	Inclusion or Exclusion	Description
	Increased sense of accomplishment	Inclusion	<p>learning, care professionals strengthen communication, interdisciplinary collaboration, team coordination, and problem-recognition abilities, which together constitute “Enhanced professional skills.”</p> <p>“Enhanced empathy” is reflected in deeper understanding of residents’ life experiences through daily person-centred care and life-story work, as well as through constraint experience that fosters appreciation of residents’ vulnerability. “Increased sense of accomplishment” is demonstrated in staff recognition of residents’ improvements and affirmation received from residents and their family. “Heightened risk awareness” is reflected in improved detection of care risks and proactive responses in both work and daily contexts. In terms of working pressure, “Increased mental stress” is observed during team restructuring when colleagues leave, as well as in situations involving resident deterioration, end-of-life stages, and adaptation to new care approaches.</p> <p>All five outcomes meet the criteria of relevance and significance based on stakeholder experience and indicator performance and are therefore included in the outcome valuation stage.</p>
	Enhanced empathy	Inclusion	
	Heightened risk awareness	Inclusion	
	Increased mental stress	Inclusion	

Stakeholders	Outcomes	Inclusion or Exclusion	Description
Yeh Tzu Yuan Senior Residential Care Facility	Expanded service models	Inclusion	<p>Management interviews indicate that implementation of the Holistic Reablement model has progressively formalised and systematised service delivery within the organisation. “Expanded service models” is reflected in the organisation’s strengthened ability to structure and diversify services, institutionalise interdisciplinary processes, and increase external recognition, including interest from other long-term care organisations in adopting related techniques and equipment.</p> <p>At the same time, “Strengthened team cohesion” is reflected in a more stable and shared working culture within the organisation, as reablement goals become embedded in daily practice and organisational routines become more consistent. Management accounts describe clearer alignment of direction and stronger collective commitment to the organisational mission, supporting sustained and standardised service delivery.</p> <p>Both outcomes meet the criteria of relevance and significance based on organisational experience and verified operational changes and are therefore included in the outcome valuation stage.</p>
	Strengthened team cohesion	Inclusion	
Family members	Improved family relationships	Inclusion	<p>Family interviews and survey results indicate change across three outcomes. “Improved family relationships” is reflected in smoother interaction and more positive communication between residents and family members.</p>

Stakeholders	Outcomes	Inclusion or Exclusion	Description
	Reduced caregiving burden	Inclusion	<p>“Reduced caregiving burden” is demonstrated through less worry about incidents and greater ability to focus on work and daily life. “Reduced financial burden” applies to families who received care-fee discounts linked to residents’ functional improvement.</p> <p>All three outcomes meet the criteria of relevance and significance and are therefore included in the outcome valuation stage.</p>
	Reduced financial burden	Inclusion	

5.5 Financial Proxy

In this stage, in addition to determining the number of people affected by the key outcomes, the duration of the outcomes, and the evaluation indicators for the project outcomes based on the "Pricing Key Outcomes" principle, financial proxy variables need to be established for the monetization of the outcomes. Wu (2017) suggests that during the monetization process, researchers often refer to official statistics or internal organizational data. If there are outcomes that cannot be quantified, the Contingent Valuation Method (CVM) can be used to establish financial proxy variables by evaluating the willingness of individuals to pay or compensate for hypothetical goods. Alternatively, the Revealed Preference method can be used to determine prices through the prices of related market-traded goods.

In this evaluation case, the financial proxy variables are based on stakeholders’ feedback. For each outcome, seven to eight items with varying degrees are listed, and an open-ended option is reserved, allowing stakeholders to answer according to their situation and best represent the value of each outcome. The reasonableness of the report content is then confirmed through further discussions with stakeholders.

5.5.1 Process for Determining Financial Proxy

(1). Step 1: Determine the Evaluation Method

The research team analyzes the financial valuation methods provided in the certified SROI reports and literature, including monetized and non-monetized valuation methods. Monetized methods include cost-benefit analysis, revealed preference, and welfare valuation methods, while non-monetized methods include the weighting and scoring methods.

(2). Step 2: Elimination of Evaluation Methods

During the interview stage, the team discusses with stakeholders the valuation method to be used for each outcome. Given the challenges in implementing the travel cost method in the revealed preference method, simplifying the journey description is easier for stakeholders to understand but presents challenges in clearly defining transportation modes, travel times, and travel environments. In the hedonic pricing method of revealed preference, it is also difficult to describe the costs incurred to achieve social outcomes.

(3). Step 3: Decision to Adopt the Value Game, Unit Cost Approach, and Direct Financial Measurement

We adopt three complementary valuation approaches in this SROI: the Value Game (Stated Preference method), the Unit Cost Approach, and Direct Financial Measurement based on audited financial records.

For individual-level psychosocial and experiential outcomes, we use the Value Game as a stated preference method. Although SROI studies often apply Contingent Valuation or Choice Experiments, interviews and surveys indicate that YTY Residential Care Facility primarily serves older adults with disability or dementia, whose comprehension and expressive capacity may be limited. Their perception of “value” can be influenced by wording and abstract price elicitation. After multiple discussions, we therefore adopted the Value Game, which asks stakeholders to rank or select concrete, recognisable items, activities, or experiences. This enables relative value judgments that are closer to lived perception and cognitively more accessible; For outcomes that can be reasonably represented through observable resource inputs (e.g., staff time saved and supervision hours spent on the meeting to enhance cohesion), we apply the Unit Cost Approach, estimating monetary value by multiplying standardised unit costs (such as hourly wage rates) by measurable quantities. This method provides a transparent and operational proxy where valuation

can be grounded in identifiable resource use; For outcomes that involve realised financial changes—such as growth in commissioned revenue, operating revenue attributable to the 2024 cohort, or reductions in care fees experienced by family members—we apply Direct Financial Measurement. Valuation is based on audited financial statements or documented fee adjustments, with appropriate boundary alignment to the defined stakeholder scope. Rather than estimating avoided or hypothetical costs, this approach reflects actual monetary changes recorded during the evaluation period.

Together, these three approaches balance perceived stakeholder value with objective, resource-based and accounting-based quantification. By matching valuation methods to outcome characteristics, the analysis strengthens methodological appropriateness and enhances the robustness and credibility of the overall SROI calculation.

(4). Step 4: Financial Proxy Collection

Once the appropriate valuation method is confirmed, the research team reviews relevant literature and prior project experience, and conducts small-group interviews to identify stakeholders' candidate financial proxies and value rankings (see Table 5-6). For outcomes valued using the Value Game method, the questionnaire also includes open-ended items so stakeholders can nominate items they personally see as representative, ensuring the proxy set adequately reflects perceived value and improves accuracy and inclusiveness.

To ensure stakeholders anchor their judgment to “value” (perceived worth of the outcome) rather than “price,” the formal questionnaire presented only item/activity names and descriptions, without displaying any prices or price ranges. Supporting staff were instructed to emphasise that respondents should select the option that would bring a similar level of perceived experience/worth as the outcome (i.e., “equivalent value”), not the option that seems more expensive. Staff also provided a brief neutral example to illustrate the “equal value” concept and, after the respondent made a selection, confirmed the respondent's understanding of what their chosen option represented in relation to the outcome. In addition, a follow-up open-ended question allowed respondents to enter an amount in NTD if they had a concrete monetary anchor, which supports reasonableness checking and triangulation.

For outcomes valued using the Unit Cost Approach, measurable quantities (e.g., hours saved or supervision time) are identified and multiplied by standardised unit costs.

For outcomes valued through Direct Financial Measurement (including organisation-level revenue growth and family members’ reduced financial burden), relevant financial records and documented fee adjustments are reviewed in consultation with management to determine realised monetary changes within the defined evaluation boundary.

(5). Step 5: Financial Proxy Pricing

After internal deliberation, prices are determined based on different price ranges. Using the market items selected by stakeholders, we identify prices of comparable items available in the market and use these as the basis for reasonable valuation. For transparency in reporting and to support consistent pricing, the research team assigns internal price bands to the proxy items during analysis; these bands are used for valuation and documentation only and were not shown to respondents during the Value Game elicitation.

Table 5-6: Financial Proxy for each stakeholder

Stakeholders	Outcomes	Financial Proxy
Yeh Tzu Yuan Senior Residential Care Facility	Expanded service models	<ol style="list-style-type: none"> Partner organisations: time saved per new partner contact × manager hourly wage. In 2024 there were 11 new partners; and 40 minutes saved per partner; total NT\$3,146. Government and public resources: donations changed little; commissioned revenue increased from NT\$24,284,038 (2023) to NT\$31,762,254 (2024), an increase of NT\$7,478,216. Growth in operating revenue related to the Holistic Reablement Care Model— Interdisciplinary Support Program: operating revenue increased from NT\$37,744,448 (2023) to NT\$43,389,355 (2024) (total increase NT\$5,644,907); after excluding the portion attributable to residents outside the 2024 newly admitted reablement cohort, the eligible increase applied in this evaluation is NT\$2,661,170.
	Strengthened team cohesion	Interdisciplinary meeting hours (6 hrs/week × 52 weeks) × 2 supervisors × supervisor hourly wage (NT\$429) = NT\$267,696.

Stakeholders	Outcomes	Financial Proxy
<p>Older adults with severe functional impairment/ Older adults with mild-to-moderate functional impairment</p>	Improved physical health	<p>Value game item list</p> <ul style="list-style-type: none"> • Large-capacity upright freezer (\leq NT\$100,000) • Branded leather L-shaped sofa (NT\$100,001–150,000) <ul style="list-style-type: none"> • Premium mattress (NT\$150,001–200,000) • Sony 85-inch 4K TV (NT\$200,001–250,000) • High-end home-theatre karaoke set (NT\$250,001–300,000) • Premium marble bathtub (NT\$300,001–350,000) <ul style="list-style-type: none"> • 11-day luxury trip to Dubai and the Maldives (NT\$350,001–400,000)
	Reduced depression & negative thoughts	
	Increased life motivation	
	Enhanced social relationships	
<p>Care professionals</p>	Enhanced professional skills	<p>Value game item list</p> <ul style="list-style-type: none"> • Apple iPhone 16 (\leq NT\$50,000) • MacBook laptop (NT\$50,001–75,000) • New GOGORO electric scooter (NT\$75,001–100,000) • Branded leather L-shaped sofa (NT\$100,001–125,000) • Premium refrigerator (NT\$125,001–150,000) • Six-month premium essential-oil full-body spa membership (NT\$150,001–175,000) • 12-day Mediterranean cruise (NT\$175,001–200,000) • Branded high-end massage chair (NT\$200,001–250,000)
	Increased sense of accomplishment	
	Enhanced empathy	
	Heightened risk awareness	
	Increased mental stress	
<p>Family members</p>	<p>Improved family relationships</p>	<p>Value game item list</p> <ul style="list-style-type: none"> • Designer luxury handbag (\leq NT\$75,000) • New GOGORO electric scooter (NT\$75,001–100,000) • Branded leather L-shaped sofa (NT\$100,001–

Stakeholders	Outcomes	Financial Proxy
	Reduced caregiving burden	125,000) • Premium refrigerator (NT\$125,001–150,000) • Six-month premium essential-oil full-body spa membership (NT\$150,001–175,000) • 12-day Mediterranean cruise (NT\$175,001–200,000) • Branded high-end massage chair (NT\$200,001–250,000)
	Reduced financial burden	Fee discounts provided by YTY in 2024: total NT\$252,000.

Note: Any price ranges shown in Table 5-5 are for analysis/reporting transparency only; the questionnaire displayed item names/descriptions without prices.

Using the Value Game Method for Financial Proxy: A Case Study of older adults.

The survey asked participants, "Please think about whether the following items represent the value of "Increased life motivation" to you based on your inner thoughts." In the questionnaire, only the item names/descriptions were presented (no prices or price ranges were shown). The questionnaire included seven options: :

- a. Large-capacity upright freezer
- b. Branded leather L-shaped sofa
- c. Premium mattress
- d. Sony 85-inch 4K TV
- e. High-end home-theatre karaoke set
- f. Premium marble bathtub
- g. 11-day luxury trip to Dubai and the Maldives

To obtain more accurate financial proxies for measuring social value, participants were asked the following question after selecting one of the above gifts: "Based on the item you have chosen, what do you think is a reasonable financial value (in NTD)?"

(6). Step 6: Pretest and Revision of Questionnaire

After completing the initial questionnaire, the research team appended a first-round list of financial proxies at the end and conducted a small pretest with stakeholders to confirm comprehensibility of both the items and the Value Game

valuation approach. Based on pretest feedback, wording and valuation scenarios were refined to better reflect stakeholder experience. For formal administration, internal staff at the YTY Residential Care Facility assisted with distribution and collection so that respondents could complete the survey in a familiar setting. To ensure consistency, the team recorded an instructional video explaining the procedure and item interpretations for staff who supported administration; when older adults had questions during completion, internal staff could reference the video to provide neutral clarification. Throughout the process, the principle of neutrality was observed to avoid leading or suggesting responses and to safeguard data reliability and validity.

(7). Step 7: Identification and Correction of Invalid Samples

After the survey was distributed, the research team reviewed stakeholder entries for the financial proxies. If a stakeholder selected the highest price band but entered a subjective amount far below that band due to limited experience or difficulty evaluating outcomes, the case valuation for that outcome was excluded to uphold the principle of not exaggerating outcome value. If a stakeholder selected the highest price band but did not enter a subjective amount in the follow-up question, the team recorded the lowest price among the three like-for-like financial proxies identified within that band. If the subjective amount entered was slightly higher than the chosen band, the highest of the three identified proxies was used; if the subjective amount was lower than the chosen band, the lowest proxy was used. If no subjective amount was entered at all, the average of the three identified proxies was used. If the subjective amount fell within the chosen band, that amount was taken as the value of the stakeholder's outcome. These rules were applied to produce reasonable valuations while carefully observing the principle of not overstating results.

5.5.2 Financial Proxy Valuation Results

The following describes the valuation approaches adopted. Most outcomes were valued using the Value Game method, while selected resource-based outcomes were measured using the Unit Cost Approach. For certain organisation-level and financial outcomes where actual monetary changes were directly observable (e.g., revenue growth or fee reductions), the value was derived from documented financial records within the defined evaluation boundary.

(1) Value Game: Activities or courses that can generate similar outcomes in the market and have identical properties to the project output are used as financial proxies. Only the names are listed without prices, and stakeholders are asked to fill in activities or courses they believe can achieve the same level.

(2) Unit Cost Approach: For outcomes that can be directly linked to measurable resource inputs (e.g., staff time or supervision hours), financial value is calculated by multiplying the quantity of input used by an appropriate unit cost. This approach anchors valuation in observable and verifiable cost structures.

Table 5-7: Market Value of Financial Proxies

Stakeholders	Outcomes	Valuation Method	Outcome number of people	Outcome Weighting	Average Financial Proxy Value
Older adults with severe functional impairment	Improved physical health	Value Game	15	5.000	NT\$342,142.86
	Reduced depression & negative thoughts	Value Game	21	5.000	NT\$312,500.00
	Increased life motivation	Value Game	21	4.875	NT\$356,250.00
	Enhanced social relationships	Value Game	21	4.625	NT\$311,250.00
Older adults with mild-to-moderate functional impairment	Improved physical health	Value Game	5	5.000	NT\$360,000.00
	Reduced depression & negative thoughts	Value Game	12	4.600	NT\$352,000.00
	Increased life motivation	Value Game	12	5.000	NT\$342,000.00
	Enhanced social relationships	Value Game	12	4.400	NT\$330,000.00
Care professionals	Enhanced professional skills	Value Game	43	4.364	NT\$153,787.85
	Increased sense of accomplishment	Value Game	48	4.324	NT\$141,378.38
	Enhanced empathy	Value Game	46	4.486	NT\$178,285.49
	Heightened risk awareness	Value Game	42	4.563	NT\$154,562.22
	Increased mental stress	Value Game	25	4.100	-NT\$98,157.84
Yeh Tzu Yuan Senior	Expanded service models	Unit Cost Approach	1	5.000	NT\$10,142,532.00

Stakeholders	Outcomes	Valuation Method	Outcome number of people	Outcome Weighting	Average Financial Proxy Value
Residential Care Facility		and Direct Financial Measurement			
	Strengthened team cohesion	Unit Cost Approach	1	5.000	NT\$267,696.00
Family members	Improved family relationships	Value Game	23	4.563	NT\$135,749.88
	Reduced caregiving burden	Value Game	24	4.824	NT\$136,117.59
	Reduced financial burden	Direct Financial Measurement	7	4.200	NT\$36,000.00

Although Outcome Weighting (importance ratings) and Average Financial Proxy Values would generally be expected to move in the same direction, Table 5-7 shows they do not always change proportionally. This may arise from several interpretive risks: (i) Outcome Weighting reflects respondents' relative prioritisation of outcomes, while the Value Game proxy expresses an "equivalent value" through market-anchored items and individual reference points; (ii) importance ratings may cluster at the high end (ceiling effects), limiting their ability to discriminate across outcomes; and (iii) some outcomes are inherently harder to match to a single comparable item or activity, which can increase variability in proxy responses. To manage these risks, the Value Game was administered with clear guidance to select items representing an equivalent level of perceived value (rather than price), comprehension was confirmed during completion, and open-ended value entries and predefined validity rules were used to identify and handle inconsistent responses. Any residual uncertainty linked to the potential misalignment between importance ratings and proxy values is disclosed and will be further explored through sensitivity analysis scenarios (e.g., conservative adjustments to proxy values and/or outcome counts), with a fuller discussion consolidated in the Risk section.

In the subsequent interpretation of results, relative differences in monetary valuation are used as the primary basis for comparing outcome value, as financial proxies provide a continuous measure of expressed value and are directly applied in the SROI calculation, while importance ratings serve primarily as a materiality screening reference rather than as a weighting factor in the monetisation stage.

5.6 Impact Factors

According to the SROI guidance, four major impact factors should be considered: counterfactual, displacement, attribution, and drop-off. In this evaluation, impact factors are calculated from questionnaire responses (using average scores for each outcome), except displacement, which is set separately based on admission records for the organisation-level outcome where substitution is plausible.

In addition to stakeholder-reported estimates, we conducted a brief evidence scan to sense-check the plausibility of counterfactual and attribution adjustments. Long-term care research indicates that older adults' functional and psychosocial outcomes can follow heterogeneous trajectories over time, meaning some degree of stability or improvement may occur even under usual care or through other supports (Kruse et al., 2013; McCusker et al., 2016). In practice, this may include older adults achieving similar benefits through other channels such as community-based activities (e.g., exercise groups or social interaction at community centres) even without entering YTY. For attribution, observed changes may also be influenced by concurrent activities and supports, for example, participation in non-program activities (e.g., volunteer-led singing, musical instruments, or other recreational sessions) in addition to the Holistic Reablement Care Model.

For family members, caregiver burden and family dynamics may shift due to broader contextual changes (e.g., institutional placement and changes in daily care arrangements), and may also be affected by pre-existing relationship foundations and external supports such as public subsidies (Yeh et al., 2002). For care professionals, professional development and empathy-related outcomes are influenced by multiple factors including workplace learning conditions, organisational context, and exposure to training beyond any one intervention (van Lierop et al., 2022; Nembhard et al., 2023; Paulus & Meinken, 2022). Patient-safety and risk-awareness competencies are likewise shaped by education and organisational practices, and may be influenced by other training programmes or system-level requirements (Agbar et al., 2023; Amaral et al., 2023). These sources do not replace the questionnaire-based estimation approach used in this study; rather, they provide external support for including counterfactual and attribution factors and inform conservative sensitivity testing where uncertainty remains. These considerations help interpret the stakeholder-specific impact factor patterns reported in Sections 5.5.1–5.5.3.

- Counterfactual factors: the proportion of an outcome that would have occurred regardless of the intervention.
- Attribution factors: the share of observed change attributable to other programmes or external factors; removing these yields the project's contribution ratio.

- Drop-off factors: the year-on-year decline in outcome effects after activities end; present benefits and future annual benefits differ as effects decay.
- Displacement factors: effects that shift outcomes or burdens onto other programmes or stakeholders, i.e., achieving results while causing negative externalities elsewhere. The SROI guide illustrates this by adding streetlights in Area A that lower crime there but shift crime to Area B. The guide also notes that not every project exhibits displacement.
- Contribution: the project's effective attributable impact after accounting for counterfactual, attribution, and displacement. Calculated as $(1 - \text{counterfactual}) \times (1 - \text{attribution}) \times (1 - \text{displacement})$, it estimates the portion of the outcome clearly attributable to this project, reflecting the true benefit share excluding external factors.

For this study, these adjustment factors were evaluated per outcome by stakeholders via questionnaire; responses were averaged for calculation. Table 5-8 consolidates the impact factors across all stakeholders. Analyses by stakeholder will be as follows.

Displacement factor estimation

Displacement is assessed only where there is a credible mechanism that benefits are being shifted away from other providers or stakeholders rather than created as additional value. For individual-level outcomes for older adults, family members, and care professionals, the outcomes reflect changes in health, wellbeing, relationships, and professional capability attributable to service exposure; they do not represent a transfer of the same “benefit” from another stakeholder group, nor did stakeholder discussions identify a plausible pathway by which these outcomes would systematically worsen outcomes elsewhere. Therefore, displacement is set to 0 for these outcomes (and is treated as a scenario test only where relevant in sensitivity analysis). By contrast, displacement is relevant for the organisation-level outcome Expanded service models, because part of the increase in operating (accommodation) revenue may reflect residents transferring from other residential care facilities in the local market (i.e., a market-share substitution effect). In this evaluation, the total value of Expanded service models is NT\$10,142,532, of which the operating-revenue component attributable to the eligible 2024 newly admitted cohort is NT\$2,661,170. Admission records show that 5 of the 33 newly admitted older adults in 2024 transferred from other facilities. We therefore estimate potentially displaced value as $\text{NT\$}2,661,170 \times (5/33) = \text{NT\$}403,208$, and express displacement as a proportion of the total outcome value: Displacement factor = $403,208 / 10,142,532 = 3.98\%$ ($\approx 4.0\%$), applied to the impact calculation for Expanded service models.

5.6.1 Impact factors analysis for older adults (including two subgroups):

From the older-adult impact factor results (Figures 5-2 and 5-3), most outcomes for both older adults with severe functional impairment and those with mild-to-moderate functional impairment show contribution rates above 50%, indicating that the Holistic Reablement Care Model has clear and substantive effects on older adults' physical and psychosocial development. Contribution is consistently strong for "Improved physical health" in both groups (64%), suggesting robust and relatively irreplaceable effects in reablement-related functioning. Interviews echoed this: "If I hadn't come to Yeh Tzu Yuan, I might have remained bedridden, life meaningless, temper worsening," reflecting a strong reliance on service effects. Overall, drop-off remains notable across outcomes, indicating that some benefits depend on continued support; for the severely disabled, "Increased life motivation" shows a relatively high drop-off (38%), implying that motivation is more contingent on ongoing care, companionship, and daily encouragement.

Among outcomes, "Improved physical health" shows a stable pattern in both subgroups (counterfactual 20%, attribution 20%, contribution 64%). While persistence differs by subgroup (drop-off 30% for the severely disabled versus 20% for the mild-to-moderate group), the results still imply that functional gains are meaningful and that follow-up linkage to community rehabilitation resources after discharge may help sustain improvements, especially for more dependent residents.

In the psychological domain, the two subgroups show a clearer divergence in impact-factor patterns. For "Reduced depression & negative thoughts," older adults with mild-to-moderate functional impairment have higher counterfactual and attribution than those with severe functional impairment (both 28% vs 20%), implying that—relative to the severe group—emotional stabilisation among the mild-to-moderate group is more likely to be influenced by prior experiences, concurrent activities, and individual disposition, and therefore shows lower project contribution (52% vs 64%). By contrast, for "Increased life motivation," the pattern is reversed: the mild-to-moderate group reports a slightly lower counterfactual than the severe group (20% vs 23%), resulting in a marginally higher contribution for motivation in the mild-to-moderate group (64% vs 62%). This suggests that, for residents with better baseline function, the programme's routines of participation, goal-setting, and identity-building activities (e.g., life-story work and sharing life experiences with care staff and peers) are more consistently perceived as driving renewed purpose and daily engagement.

Differences are even more pronounced in drop-off. For "Reduced depression & negative thoughts," drop-off is lower for the severe group (20%) than for the mild-to-moderate group (28%), indicating that once emotional outbursts and negative thinking are reduced through sustained support, the improvement tends to remain relatively stable

even after leaving the facility, whereas for the mild-to-moderate group the effect is somewhat more sensitive to post-discharge context—yet still shows a moderate level of decay. For “Increased life motivation,” the severe group shows substantially higher drop-off (38% vs 20%). Discussions with care professionals and management suggest this is closely related to functional limitations: after discharge, older adults with severe impairment often face greater barriers to going out and maintaining the social circle and shared activities that helped sustain motivation inside the facility (e.g., continuing hobbies rediscovered through life-story sharing and receiving affirmation from others). In contrast, older adults with mild-to-moderate impairment are more able to maintain activity participation and life goals through community access and everyday routines, leading to stronger persistence of motivation over time.

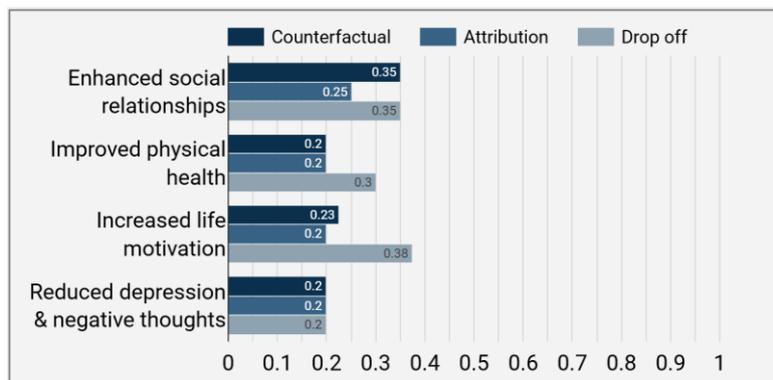


Figure 5-2: Impact Factors for Older adults with mild-to-moderate functional impairment (Bar chart)

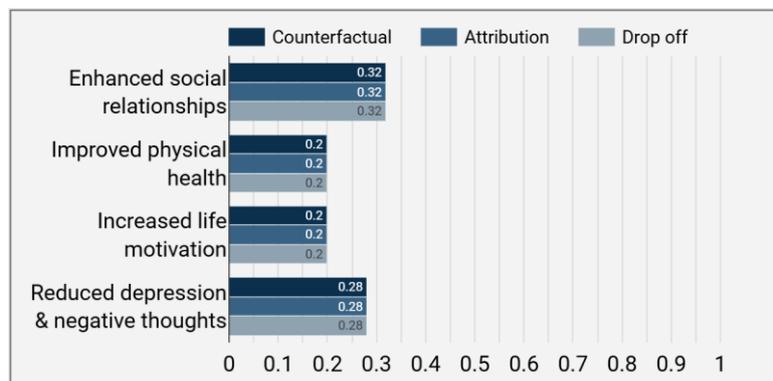


Figure 5-3: Impact Factors for Older adults with severe functional impairment (Bar chart)

Lastly, “Enhanced social relationships” shows the lowest contribution in both groups (49% for the severely disabled; 46% for the mild-to-moderate group). This is reasonable, since social outcomes are more strongly shaped by personality, pre-existing family dynamics, visit frequency, and prior social networks in addition to programme exposure. The comparatively higher counterfactual/attribution and higher drop-off (32–35%) also suggest that social gains are more context-dependent and may require sustained facilitation to maintain.

5.6.2 Impact factors analysis for care professionals:

From the impact factor results (Figure 5-4), contribution rates for positive outcomes range between 38% and 48%, indicating that a substantial proportion of observed professional development is attributable to the Holistic Reablement Care Model. “Heightened risk awareness” shows the highest contribution (48%), with comparatively lower counterfactual and attribution factors, suggesting relatively strong irreplaceability. This capability is closely linked to YTY Residential Care Facility’s interdisciplinary collaboration mechanisms and structured risk-management training, which differ from more routine care setting

As for “Enhanced professional skills” and “Increased sense of accomplishment” both show contribution levels above 40%. The higher drop-off for professional skills (44%) suggests that the persistence of skill application may depend on continued exposure to a reablement-oriented organisational context. “Enhanced empathy” shows comparatively lower contribution (38%) and higher counterfactual, which is reasonable given that empathy may also be shaped by individual disposition and prior experience. Interviews indicate that empathy is particularly strengthened through the constraint experience course, deepening understanding of residents’ discomfort within the professional context.

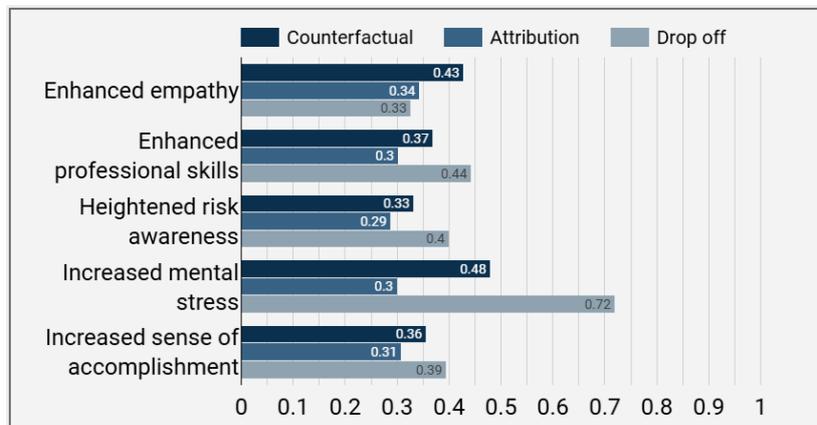


Figure 5-4: Impact Factors for Care professionals (Bar chart)

For the negative outcome “Increased mental stress,” contribution is 37%, with relatively high counterfactual (48%) and especially high drop-off (72%). The elevated counterfactual suggests that psychological pressure—such as feelings of helplessness when residents’ conditions deteriorate or stress from team restructuring after staff turnover—would likely arise in other care settings as well and is not unique to YTY’s care model. The high drop-off indicates that such stress is situational rather than structurally persistent. Interview feedback further notes that supervisors and senior colleagues provide guidance when staff experience pressure, and the organisation offers

stress-adjustment courses open to both residents and staff, equipping personnel with coping strategies. As a result, while psychological stress may arise at specific moments, it is less likely to remain prolonged over time.

5.6.3 Impact factors analysis for family members

From the impact factors results (Figure 5-5), the value of “Reduced financial burden” is calculated directly from fee reductions on care fees provided by YTY Residential Care Facility; therefore, there is no external benefit, the duration is limited to the current year, and drop-off is set at 100%. In the family-member impact factors chart, the largest differences appear in the counterfactual factors. This indicates that, while improved elder health does support repair and better quality of family interaction, changes in “Improved family relationships” are not wholly attributable to health gains and are also shaped by internal communication, family support, and pre-existing relationship foundations. Attribution shows a similar pattern; differences are smaller but still suggest that family outcomes are partly driven by other support systems and living conditions.

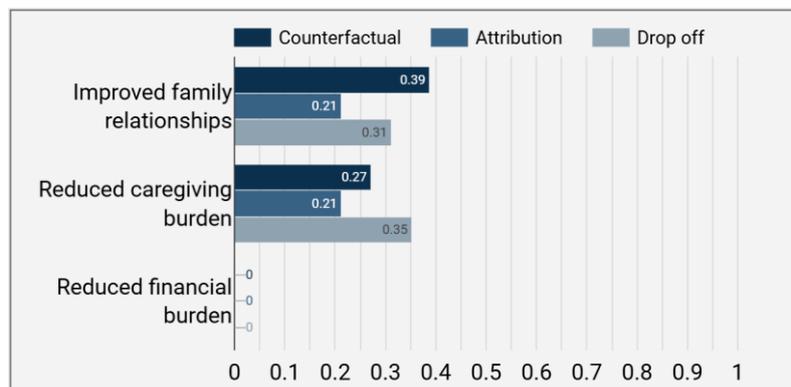


Figure 5-5: Impact Factors for Family members (Bar chart)

Regarding drop-off, most values for families are higher than those for older adults, indicating greater dependence on YTY Residential Care Facility’s services. In particular, for “Reduced caregiving burden,” families commonly reported that without facility’s support, pressure and burden would rebound quickly, which means persistence is highly contingent on ongoing services and organisational backing. Overall, family outcomes show marked change but relatively limited persistence and stability, highlighting the institution’s critical role in family support within the long-term care system.

Table 5-8: Impact Factors

Stakeholders	Outcomes	Counterfactual factors	Displacement factors	Attribution factors	Drop-off factors	Contribution
Older adults with severe functional impairment	Improved physical health	20%	0%	20%	30%	64%
	Reduced depression & negative thoughts	20%	0%	20%	20%	64%
	Increased life motivation	23%	0%	20%	38%	62%
	Enhanced social relationships	35%	0%	25%	35%	49%
Older adults with mild-to-moderate functional impairment	Improved physical health	20%	0%	20%	20%	64%
	Reduced depression & negative thoughts	28%	0%	28%	28%	52%
	Increased life motivation	20%	0%	20%	20%	64%
	Enhanced social relationships	32%	0%	32%	32%	46%
Care professionals	Enhanced professional skills	37%	0%	30%	44%	44%
	Increased sense of accomplishment	36%	0%	31%	39%	45%
	Enhanced empathy	43%	0%	34%	33%	38%
	Heightened risk awareness	33%	0%	29%	40%	48%
	Increased mental stress	48%	0%	30%	72%	37%
Yeh Tzu Yuan Senior Residential Care Facility	Expanded service models	20%	4%	20%	100%	61%
	Strengthened team cohesion	10%	0%	30%	40%	63%
Family members	Improved family relationships	39%	0%	21%	31%	48%
	Reduced caregiving burden	27%	0%	21%	35%	57%
	Reduced financial burden	0%	0%	0%	0%	100%

Chapter 6: Impact Map

6.1 SROI analysis results

The aforementioned identified stakeholders' change processes and outcomes and found Indicator, Financial Proxy, and impact factors for measuring outcomes. Next, the value of outcomes for each stakeholder will be calculated.

The discount rate (2.00%) used in this report is based on the prevailing interest rate in Taiwan during the project period. In projects with a long period, it is more likely to be affected by external factors and follows the eight principles of SROI. We also conducted a sensitivity analysis in this analysis to ensure its rationality. Finally, the SROI calculation method is the total present value of outcomes divided by the total input value, and the social return on investment (SROI) of this assessment case is 4.57.

Table 6-1: SROI calculation

Total social value	\$ 100,823,370.40
Total input	\$ 22,044,150
SROI	\$ 4.57

SROI Value Map																Calculating Social Return								
Stage 1 Who and how many?		At what cost?		Stage 2 What changes?		Stage 3 How much?		Stage 3 How long?			Stage 3 How valuable?			Stage 4 How much caused by the				Still material?						
Stakeholders	Inputs	Outputs	Outcomes		Indicator and source	Quantity (scale)	Duration of outcomes	Outcomes start	Express the relative importance (value) of the outcome			Counterfactual %	Displacement %	Attribution %	Drop off %	Impact calculation	Discount rate		2.0%					
			Outcome description	Weighting					Valuation approach (monetary)	Monetary valuation	0.00						2.0%							
Older adults with severe functional impairment	21	\$ -	Holistic Reablement Caring Outdoor Activities Staff Training & Development	Improved physical health	15	5	Period after	5.00	Value Game	\$ 342,142.86	20%	0%	20%	30%	3,284,571	0.00	3,284,571.43	2,299,200.00	1,609,440.00	1,126,608.00	788,625.60			
				Reduced depression & negative thoughts	21	5	Period after	5.00	Value Game	\$ 312,500.00	20%	0%	20%	20%	4,200,000	0.00	4,200,000.00	3,360,000.00	2,688,000.00	2,150,400.00	1,720,320.00			
				Increased life motivation	21	4	Period after	4.88	Value Game	\$ 356,250.00	23%	0%	20%	38%	4,638,375	0.00	4,638,375.00	2,898,984.38	1,811,865.23	1,132,415.77	0.00			
				Enhanced social relationships	21	4	Period after	4.63	Value Game	\$ 311,250.00	35%	0%	25%	35%	3,186,422	0.00	3,186,421.88	2,071,174.22	1,346,263.24	875,071.11	0.00			
Older adults with mild-to-moderate functional impairment	12	\$ -	Holistic Reablement Caring Outdoor Activities Staff Training & Development	Improved physical health	5	5	Period after	5.00	Value Game	\$ 360,000.00	20%	0%	20%	20%	1,152,000	0.00	1,152,000.00	921,600.00	737,280.00	589,824.00	471,859.20			
				Reduced depression & negative thoughts	12	5	Period after	4.60	Value Game	\$ 352,000.00	28%	0%	28%	28%	2,189,722	0.00	2,189,721.60	1,576,599.55	1,135,151.68	817,309.21	588,462.63			
				Increased life motivation	12	4	Period after	5.00	Value Game	\$ 342,000.00	20%	0%	20%	20%	2,626,560	0.00	2,626,560.00	2,101,248.00	1,680,998.40	1,344,798.72	0.00			
				Enhanced social relationships	12	5	Period after	4.40	Value Game	\$ 330,000.00	32%	0%	32%	32%	1,831,104	0.00	1,831,104.00	1,245,150.72	846,702.49	575,757.69	391,515.23			
Care professionals	52	\$ 48,538	Holistic Reablement Caring Outdoor Activities Staff Training & Development	Enhanced professional skills	43	4	Period after	4.36	Value Game	\$ 153,787.85	37%	0%	30%	44%	2,905,051	0.00	2,905,050.92	1,619,786.09	903,153.52	503,576.55	0.00			
				Increased sense of accomplishment	48	4	Period after	4.32	Value Game	\$ 141,378.38	36%	0%	31%	39%	3,020,214	0.00	3,020,213.77	1,828,453.73	1,106,955.76	670,156.99	0.00			
				Enhanced empathy	46	4	Period after	4.49	Value Game	\$ 178,285.49	43%	0%	34%	33%	3,079,609	0.00	3,079,609.23	2,076,536.47	1,400,178.85	944,120.57	0.00			
				Heightened risk awareness	42	5	Period after	4.56	Value Game	\$ 154,562.22	33%	0%	29%	40%	3,093,152	0.00	3,093,152.25	1,855,891.35	1,113,534.81	668,120.89	400,872.53			
				Increased mental stress	25	1	Period after	4.10	Value Game	\$ -98,157.84	48%	0%	30%	72%	-897,921	0.00	-897,921.17	0.00	0.00	0.00	0.00			
Yeh Tzu Yuan Senior Residential Care Facility	1	\$ 21,995,612	Holistic Reablement Caring Outdoor Activities Staff Training & Development	Expanded service models	1	1	Period after	5.00	Direct Financial Measurement & Unit Cost Approach	\$ 10,142,532.00	20%	4%	20%	100%	6,233,167	0.00	6,233,167.36	0.00	0.00	0.00	0.00			
				Strengthened team cohesion	1	1	Period after	5.00	Unit Cost Approach	\$ 267,696.00	10%	0%	30%	40%	168,648	0.00	168,648.48	0.00	0.00	0.00	0.00			
Family members	24	\$ -	Holistic Reablement Caring Outdoor Activities Staff Training & Development	Improved family relationships	23	4	Period after	4.56	Value Game	\$ 135,749.88	39%	0%	21%	31%	1,505,996	0.00	1,505,996.39	1,035,372.52	711,818.60	489,375.29	0.00			
				Reduced caregiving burden	24	4	Period after	4.82	Value Game	\$ 136,117.59	27%	0%	21%	35%	1,878,253	0.00	1,878,253.26	1,215,340.30	786,396.64	508,844.87	0.00			
				Reduced financial burden	7	1	Period of activity	4.20	Direct Financial Measurement	\$ 36,000.00	0%	0%	0%	0%	252,000	252,000.00	0.00	0.00	0.00	0.00	0.00			
		\$ 22,044,150														Total		44,346,924	252,000	44,094,924	26,105,337	17,877,739	12,396,380	4,361,655.19
																Present value of each		252,000	43,230,318	25,091,635	16,846,593	11,452,339	3,950,485.49	
																Total Present Value							100,823,370.40	
																Net Present Value (PV)							78,779,220.40	
																Social Return (Value)							4.57	

Figure 6-1: SROI Value Map

If categorized by stakeholders, the results and details are as follows. Table 6-2 shows the discounted social value created by each stakeholder group, and the total is added up.

Table 6-2: Stakeholder Social Value Calculation

Stakeholders	Outcomes	Social Value
Older adults with severe functional impairment	Improved physical health	NT\$8,701,792.74
	Reduced depression & negative thoughts	NT\$13,424,920.63
	Increased life motivation	NT\$10,087,377.96
	Enhanced social relationships	NT\$7,191,735.38
Older adults with mild-to-moderate functional impairment	Improved physical health	NT\$3,682,263.94
	Reduced depression & negative thoughts	NT\$6,019,899.04
	Increased life motivation	NT\$7,421,141.29
	Enhanced social relationships	NT\$4,676,385.19
Care professionals	Enhanced professional skills	NT\$5,721,265.59
	Increased sense of accomplishment	NT\$6,380,677.14
	Enhanced empathy	NT\$7,206,768.04
	Heightened risk awareness	NT\$6,845,958.79
	Increased mental stress	-NT\$880,314.88
Yeh Tzu Yuan Senior Residential Care Facility	Expanded service models	NT\$6,110,948.39
	Strengthened team cohesion	NT\$165,341.65
Family members	Improved family relationships	NT\$3,594,504.48
	Reduced caregiving burden	NT\$4,220,705.04
	Reduced financial burden	NT\$252,000.00

6.2 Sensitivity analysis

In order to ensure the objectivity and verifiability of the research results, the SROI guide requires sensitivity analysis and related information disclosure in each analysis report. Therefore, in order to pursue rigor and comply with the eight principles of SROI, sensitivity analysis was performed on various indicators. The main analysis items include interest rate, quantity of outcome, financial multipliers, factor adjustment, outcome value, and costs.

Table 6-3: Sensitivity Analysis Table

Adjustment items	Explanation of adjustment items	Adjustment value	Adjusted SROI
Interest rate	To observe the impact of interest rates on SROI, the annual interest rate is adjusted to 1% and 3%.	1.00%	4.67
		3.00%	4.48
Quantity of outcome	Outcome numbers for individual-level stakeholder groups are estimated from questionnaire samples. As realised sample sizes fell short of required levels, estimated numbers may over- or underestimate true values in the eligible population. Additionally, because outcome achievement is determined by using indicator thresholds derived from self-reported Likert responses, there is a risk that some respondents may not have fully distinguished agreement from magnitude of change, despite guidance focusing on change during the 2024 participation period. This may lead to potential over- or under-identification of outcomes. Therefore, for all non-organisation stakeholder groups, we test three scenarios: (i) upper- and (ii) lower-bound scenarios adjusting numbers using each group's realised sampling-error rate (95% level), and (iii) an additional conservative scenario reducing outcome numbers to reflect possible misclassification arising from uncertainty in interpreting change-based indicator items. Organisation-level outcomes remain unchanged as they are record-based.	Numbers achieved \times (1 + group sampling error), capped at population	4.84
		Numbers achieved \times (1 – group sampling error), floored at 0.	3.60
		Quantity of outcome determined by indicators \times 0.9	4.20

Adjustment items	Explanation of adjustment items	Adjustment value	Adjusted SROI
Drop-off factors multiplier	Sensitivity analysis was conducted by magnifying and diminishing the drop-off factors, when the factors was multiplied by 0.8 and 1.2 times. The results are as follows.	0.8 times	5.04
		1.2 times	4.16
Counterfactual factors multiplier	Sensitivity analysis was conducted by magnifying and diminishing the counterfactual factors, when the factors was multiplied by 0.8 and 1.2 times. The results are as follows.	0.8 times	4.94
		1.2 times	4.21
Attribution factors multiplier	Sensitivity analysis was conducted by magnifying and diminishing the attribution factors, when the factors was multiplied by 0.8 and 1.2 times. The results are as follows.	0.8 times	4.87
		1.2 times	4.27
Displacement factors	Displacement is applied only to “Expanded service models” because part of the accommodation revenue increase may reflect residents transferring from other facilities (market substitution). We test 15% as a commonly used conservative benchmark in SROI when market evidence is limited, and 33% as an extreme upper-bound stress test assuming equal substitution across three nearby residential care facilities (including YTY).	15%	4.54
		33%	4.49
Increase or decrease in duration	Outcome durations are based on stakeholder judgement and therefore may be overestimated. This risk is particularly relevant for care professionals, as capability gains and workplace learning	-1 terms	4.12

Adjustment items		Explanation of adjustment items	Adjustment value	Adjusted SROI
		effects may partly reflect accumulated experience from before 2024 rather than being fully attributable to the 2024 evaluation period. To avoid overstating long-term value, we test shorter duration scenarios in the sensitivity analysis.	-2 terms	3.46
Financial proxy indicator multiplier	Cost multiplier	Total inputs were allocated to the eligible 2024 newly admitted older-adult group using a proportional scaling approach. Because some inputs are shared or fixed and cannot be precisely attributed to the 33 older adults, the estimated inputs may be over- or under-stated. We therefore test $\pm 10\%$ input scenarios.	0.9 times	5.08
			1.1 times	4.16
	Average value multiplier	Some older adults with moderate-to-severe cognitive impairment required staff-/family-informed assistance in questionnaire completion, so monetised outcome values may have measurement uncertainty with an indeterminate direction of bias; we therefore test both upside and downside scenarios for older adults ($\pm 10\%$). In addition, care-professional outcomes cannot be cleanly bounded to the newly admitted cohort in 2024 and may include accumulated effects from prior years; thus, the downside scenario also applies a conservative 20% reduction to care-professional outcome values.	Older adults' outcome values \times 1.10	4.85
			Older adults' outcome values \times 0.90 AND Care professionals' outcome values \times 0.80	4.07
SROI multiplier		Sensitivity analysis is conducted by increasing or decreasing the SROI multiple by 10%, and the multiple is adjusted to 0.9 or 1.1 times. The results are as follows.	0.9 times	4.12
			1.1 times	5.03

From Table 6-3, we ranked sensitivity parameters separately for downside (largest decreases) and upside (largest increases) to highlight where the result is most vulnerable and where improvement leverage is greatest.

Largest downside movements (risk exposure; biggest drops from 4.57):

- (1) Duration -2 years: 3.46 (-1.11)
 - (2) Quantity of outcomes (lower-bound; sampling-error adjustment): 3.60 (-0.97)
 - (3) Average value downside (older adults -10% & care professionals -20%): 4.07 (-0.50)
 - (4) SROI multiplier 0.9: 4.12 (-0.45)
 - (5) Duration -1 year: 4.12 (-0.45)
 - (6) Inputs $+10\%$: 4.16 (-0.41)
 - (7) Drop-off $\times 1.2$: 4.16 (-0.41)
 - (8) Quantity of outcome determined by indicators $\times 0.9$: 4.20 (-0.37)
- (Other parameters produce smaller downside shifts, including counterfactual/attribution multipliers, interest rate, and displacement stress tests.)

Downside risk (largest SROI decreases). The strongest downside sensitivity comes from shorter outcome duration, indicating a material risk that persistence may be overestimated—particularly for care professionals, where capability gains can reflect accumulated learning beyond the 2024 cohort boundary, and for older adults, where sustaining gains after leaving the facility depends on post-discharge conditions and supports. The second-largest downside driver is outcome quantity, where realised sample sizes—especially for older-adult subgroups and families—create wider sampling error, meaning the observed achievement rates may over- or under-estimate true outcome incidence in the eligible population. This highlights the importance of strengthening follow-up measurement coverage and/or repeating measurement cycles to narrow uncertainty.

Largest upside movements (largest increases from 4.57):

- (1) Inputs -10% : 5.08 ($+0.51$)
- (2) Drop-off $\times 0.8$: 5.04 ($+0.47$)
- (3) SROI multiplier 1.1: 5.03 ($+0.46$)
- (4) Counterfactual $\times 0.8$: 4.94 ($+0.37$)
- (5) Attribution $\times 0.8$: 4.87 ($+0.30$)
- (6) Older adults' outcome values $+10\%$: 4.85 ($+0.28$)
- (7) Quantity of outcomes (upper-bound; sampling-error adjustment): 4.84 ($+0.27$)
- (8) Interest rate 1% : 4.67 ($+0.10$)

Upside opportunity (largest SROI increases). The largest upside swing is from lower inputs (costs), reflecting that inputs were allocated to the eligible 2024 cohort using a

proportional method; if costs are better attributed (e.g., separating fixed/shared costs from marginal costs for the 33 admissions), the SROI could increase materially—while the same issue also implies a potential overstatement risk if costs are not well bounded. The next-largest upside comes from reducing drop-off, consistent with the downside ranking: improving outcome persistence (through discharge transition arrangements, community linkage, and family engagement) is both the most important risk area and the largest practical lever for increasing programme impact. Other parameters (interest rate, displacement, and—comparatively—counterfactual/attribution multipliers) show smaller effects and therefore are secondary priorities for risk control and performance improvement.

6.3 Risk Management

To support transparency in line with SVI Principle 6, this section consolidates the key risks, limitations, and sources of uncertainty identified throughout the evaluation. Risks were disclosed and managed iteratively across the process—during scoping, stakeholder engagement, instrument design, data collection, validation, and modelling. At each stage, the research team discussed evaluation choices, assumptions, and control measures with relevant stakeholder groups (e.g., management, care professionals, older adults, and family members) to confirm feasibility, minimise bias, and avoid overstating results. Where uncertainty could materially affect results, it is reflected through explicit modelling choices and sensitivity scenarios.

Risk identification and mitigation were embedded in the evaluation workflow rather than treated as a one-off exercise. During workshops and interviews, stakeholders were invited to review the theory of change, confirm outcome definitions and boundaries, highlight potential unintended effects, and flag practical constraints affecting measurement. During survey administration and data processing, additional checks were applied to support data validity (including staff support protocols where needed, item-by-item review, and post-analysis validation discussions). In modelling, conservative decision rules were applied (e.g., non-overstating principles, exclusion of invalid valuations, and explicit treatment of uncertain parameters).

Table 6-4 summarises the main risks and limitations identified in this SROI, their plausible direction of influence on results, and the mitigation approach applied. For transparency, each item is managed using the same procedures already set out in earlier sections of this report (e.g., stakeholder validation, data-quality checks, clear boundary setting to avoid overlap, and sensitivity testing where uncertainty remains).

Table 6-4: Risk Management Table

Risk name	Brief description	Risk management approach
Indicator interpretation risk	Although respondents were instructed to evaluate change during the 2024 participation period, some may not have fully distinguished between agreement with a statement and the magnitude of change. As indicators were based on self-reported Likert responses rather than direct baseline–endline comparison, misclassification of outcome achievement may occur.	Provide standardised administration guidance emphasising change during 2024; apply conservative outcome pass rules; and test robustness through three sensitivity scenarios, including an additional conservative scenario that downward-adjusts outcome numbers to reflect potential misclassification.
Sampling shortfall / sampling error	For some stakeholder groups, realised responses fell short of target sample sizes; achieved outcome numbers may over- or under-estimate true values in the eligible population.	Test upper- and lower-bound scenarios by adjusting achieved outcome numbers using each stakeholder group’s realised sampling error (95% level). Organisation-level outcomes are not adjusted because they are record-based.
Cognitive-impairment coverage & measurement bias	Older adults with moderate-to-severe cognitive impairment are harder to interview/survey, creating potential coverage/non-response and measurement uncertainty with an indeterminate direction of bias.	Use ethically appropriate staff-/family-informed assisted completion with family consent where needed and cross-check key responses with family members and care professionals; test uncertainty via sensitivity scenarios on older-adult outcome values ($\pm 10\%$) and outcome numbers (sampling-error bounds).
Boundary alignment risk (care professionals)	Older adults/family members are bounded to the 2024 newly admitted cohort, but care professionals cannot be segmented on the same boundary; staff outcomes may partly reflect effects not specific to the eligible 2024 cohort.	Disclose boundary differences; apply sensitivity scenarios for care professionals on outcome values (0.8), durations (shorter), and outcome numbers (sampling-error bounds), alongside impact-factor multiplier tests.
Outcome overlap / double counting risk	Some outcomes may share mechanisms (e.g., psychosocial outcomes; professional skills vs empathy), creating potential overlap in valuation.	Define outcomes and chains of events with clear boundaries; avoid overlapping proxies; where uncertainty remains, reflect it through conservative sensitivity scenarios (e.g., value adjustments).

Risk name	Brief description	Risk management approach
Financial-proxy risk (Value Game)	Value Game results depend on respondents understanding “value equivalence” rather than stating market prices; inconsistent interpretation may affect proxy selection and amounts.	Present item options without prices to reduce price-anchoring; include an open-ended amount question for stated willingness-to-pay/valuation; standardise administration with neutral instructions, pretest, and apply validity rules for inconsistent entries.
Self-reported impact-factor uncertainty (counterfactual / attribution / drop-off)	Impact factors are primarily derived from questionnaire judgments and may be influenced by recall, framing, or interpretation.	Validate reasonableness through stakeholder review and triangulation where applicable; test robustness using factor multipliers (0.8/1.2) in sensitivity analysis.
Duration overestimation	Outcome durations are based on stakeholder judgement and may be overstated, particularly for care professionals where effects may reflect accumulated experience prior to 2024.	Test shorter duration scenarios (e.g., -1 year and -2 years) in sensitivity analysis and disclose uncertainty in interpretation.
Input allocation uncertainty (proportional scaling)	Total inputs are allocated to the eligible 2024 newly admitted older-adult cohort using proportional scaling; some inputs are shared/fixed and cannot be precisely attributed, creating potential over- or under-estimation.	Test $\pm 10\%$ input scenarios (0.9/1.1) in sensitivity analysis; maintain clear input boundaries to avoid double counting.
Displacement (market substitution) for “Expanded service models”	Part of the accommodation-revenue increase may reflect residents transferring from other facilities (market-share substitution) rather than net new value.	Estimate displacement using admission records; stress-test alternative displacement rates (15% and 33%) in sensitivity analysis.

Chapter 7: Conclusion and Recommendations

7.1 Conclusion

This report presents the impact evaluation process and results for the Holistic Reablement Care Model–Interdisciplinary Support Program at the YTY Residential Care Facility, following the six steps of the Social Return on Investment (SROI) method: defining scope and stakeholders, mapping outcomes, evidencing and valuing outcomes, establishing impact, calculating value, and disclosing and applying impact. The evaluation focuses on impacts generated during 1 January–31 December 2024, with the eligible older-adult stakeholder group defined as residents first admitted and receiving the Holistic Reablement programme within 2024 (n=33). This boundary alignment strengthens comparability across the theory of change, outcome evidence, and impact modelling, and supports a clearer interpretation of programme effects within the evaluation period.

Across the evaluation workflow, stakeholder engagement was embedded through workshops, interviews, survey co-design, and results validation. Outputs were consolidated using activity records and programme documentation, while outcome chains were constructed through iterative qualitative inquiry to capture both expected and unexpected changes. To support robust quantification, outcome verification, duration, impact factors, and financial proxies were assessed through a structured questionnaire approach, with additional validation discussions conducted with stakeholder representatives to confirm the plausibility of assumptions and interpretation of results. In the valuation and modelling steps, conservative rules were applied to avoid double counting and over-claiming, and where uncertainty could materially affect results, it was addressed through explicit parameter setting and sensitivity scenarios.

Based on the final impact map and monetised outcome valuation, the evaluation-type SROI ratio for the 2024 programme is 4.57. Sensitivity testing indicates a reasonable range of 3.46–5.08, showing that the overall conclusion remains robust under plausible alternative assumptions. Variations with higher sensitivity are associated mainly with assumptions that affect the persistence and scaling of benefits (e.g., duration, input allocation, and drop-off), whereas changes to financial and impact-factor parameters generally remain within a stable range.

Taken together, the results indicate that the Holistic Reablement model generates substantial and multi-dimensional social value for key stakeholder groups. Through this

analysis, benefits across different dimensions were identified and evidenced in detail, as described below:

7.1.1 Basic Analysis of Social Value Calculation Results

Figure 7-1 shows the distribution of social value calculated via Social Return on Investment (SROI) for the YTY Residential Care Facility, highlighting differences across stakeholder groups. The largest shares accrue to older adults with severe functional impairment and those with mild-to-moderate functional impairment, who are both the primary beneficiaries and the larger cohorts.

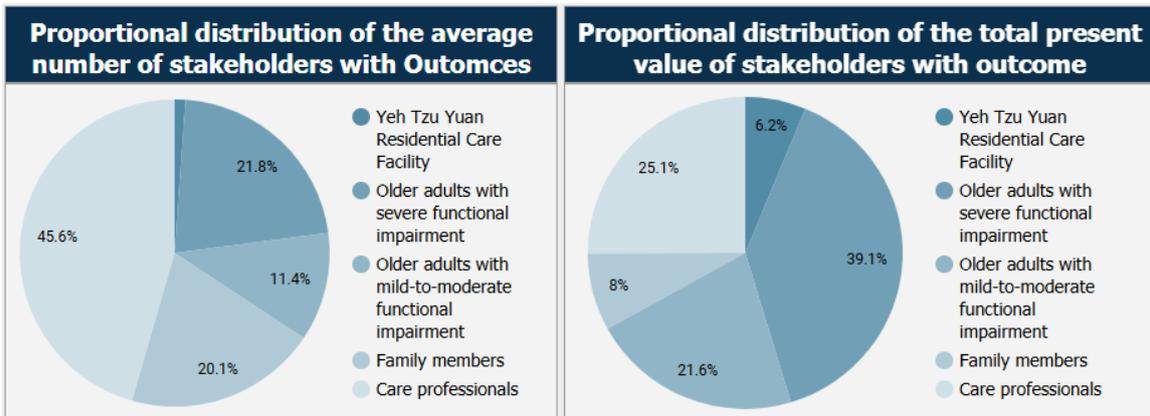


Figure 7-1: The social value allocation for Yeh Tzu Yuan Senior Residential Care Facility

Service recipients typically generate the greatest social benefits because services improve their welfare, increase skills and knowledge, and strengthen capacity for social and economic participation. For example, Holistic Reablement training helps older adults regain elements of independent daily living and physical mobility; social-participation activities increase interpersonal interaction, reduce negative emotions, and even restore hope, thereby shortening the prolonged trajectory—common in Taiwan—from being bedridden to end of life. In aggregate, services at the YTY Residential Care Facility deliver significant social benefits for older adults living with disability and dementia, catalysing broader social change.

According to Figure 7-2, the top three contributors to SROI are, in order: “Reduced depression & negative thoughts” (0.88), “Increased life motivation” (0.79), and “Improved physical health” (0.56). Together, they account for the major share of total social value, evidencing strong effects of YTY’s Holistic Reablement care model on physical, psychological, and spiritual reablement. In the first three years of adopting Holistic Reablement, YTY achieved functional gains, yet older adults’ responses were below expectation. This prompted their recognition that reablement’s core lies not only in physical recovery but even more in psychological and emotional rebuilding. The present SROI results confirm that strategic direction: while physical health is essential,

the most far-reaching change for older adults emerges from alleviating negative emotions and rekindling passion and motivation for life.

Additionally, “Enhanced Social Relationships” (0.54) reflects the social benefits created through YTY’s activity design and participation opportunities. Regular group-based and cognitively engaging activities encourage communication, stimulate thinking, and help reduce dementia-related risks, which in turn supports smoother interaction with peers and family members. Overall, the outcome profile reflects YTY’s holistic reablement approach and evidences a progressively integrated, person-centred long-term care model.

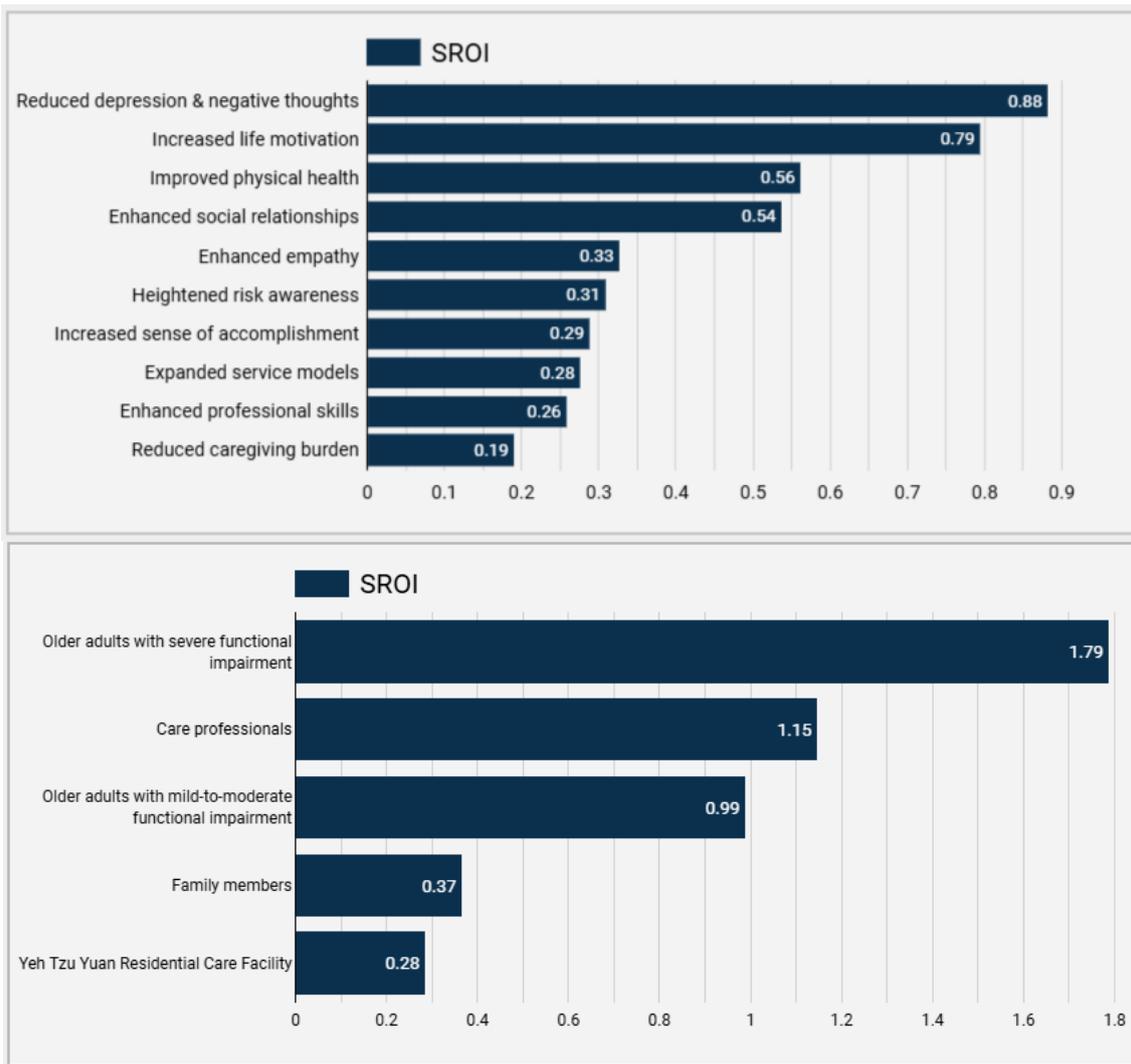


Figure 7-2: Bar chart of SROI ratio allocation

7.1.2 Severely disabled older adult: stabilising wellbeing and rebuilding daily function

Based on the SROI analysis, the largest social value for older adults with severe functional impairment is concentrated in “Reduced depression & negative thoughts” and “Increased life motivation”, with additional substantial value generated through “Improved physical health” and “Enhanced social relationships”. Before admission, many in this subgroup experienced significant dependence in daily living and fluctuating mood. Through the 23+1 Holistic Reablement model—delivered by an interdisciplinary team combining daily living care with structured reablement and psychosocial support—residents commonly reported clearer routines, greater confidence in daily functioning, and improved emotional steadiness. In interviews, several elders described tangible progress and renewed hope, such as, “I thought I’d be lying down for life, but now I can get up, walk, and feed myself.”

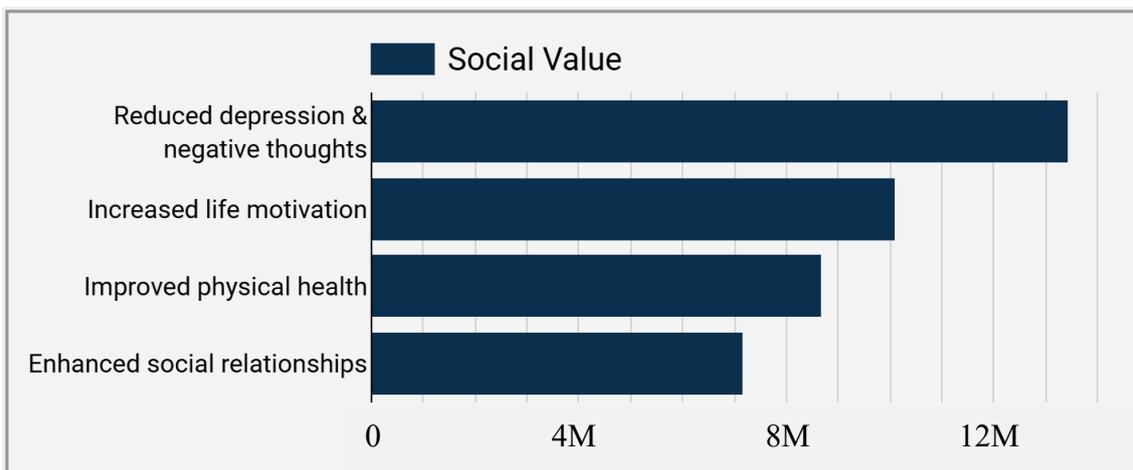


Figure 7-3: Social Value by Outcome — Older adults with Severe Functional Impairment (Bar Chart)

Notably, both subgroups show improvement in “Enhanced social relationships,” including greater willingness to initiate conversations and participate in activities, indicating strengthened interaction with peers and family members. Overall, the severe subgroup’s outcome profile reflects meaningful and multi-dimensional gains across emotional wellbeing, motivation, daily function, and social connection, demonstrating the programme’s strong contribution to quality of life among residents with higher care needs.

7.1.3 Mild-to-moderately disabled older adults: sustaining motivation and active participation

For older adults with mild-to-moderate functional impairment, the SROI results show that social value is led by “Increased life motivation” and “Reduced depression & negative thoughts”, followed by “Enhanced social relationships” and “Improved physical health”. Compared with the severe subgroup, residents in this group enter with stronger baseline capability (higher ADL baseline score) and clearer awareness of their condition, which supports more active engagement in reablement routines and group activities. Interviews indicate that programme features such as goal-setting, encouragement mechanisms, and opportunities for sharing and participation help residents sustain a forward-looking mindset; some residents also described taking on supportive roles (e.g., encouraging peers), reflecting strengthened initiative and purpose.

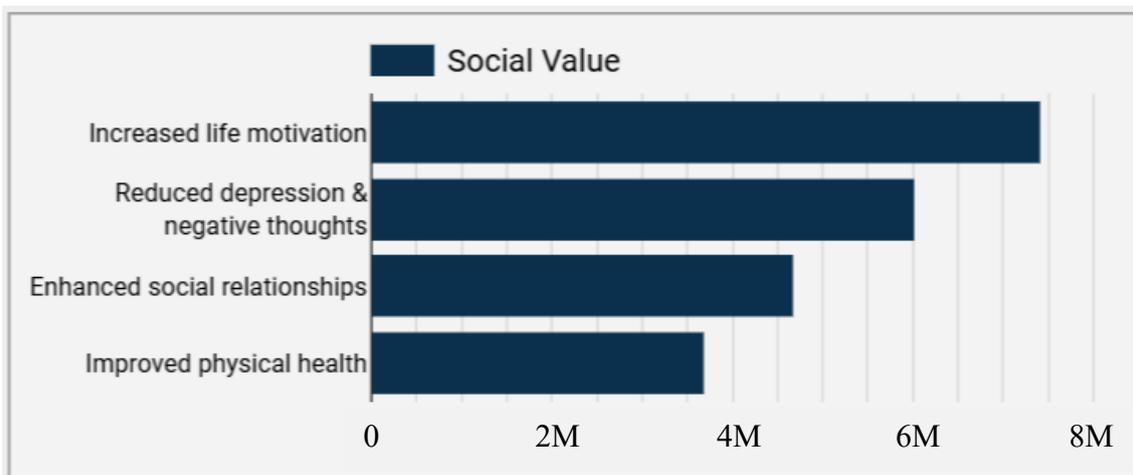


Figure 7-4: Social Value by Outcome — Older adults with Mild-to-Moderate Functional Impairment (Bar Chart)

Overall, the mild-to-moderate subgroup’s outcome pattern highlights sustained psychological activation and participation alongside continued improvements in social connection and daily functioning—showing that the Holistic Reablement model supports not only maintenance of capability, but also ongoing motivation and engagement in everyday life.

7.2 Recommendation for Project Improvement

7.2.1 Quantitative Data to Support Qualitative Decision-Making

Quantitative data can help verify qualitative findings or surface points to question. For example, survey results provide numerical views of attitudes and opinions that can be compared with qualitative data from interviews or focus groups to identify inconsistencies. In short, combining qualitative and quantitative data offers a fuller, more

nanced understanding and enables better-informed decisions. Social Return on Investment (SROI) analysis captures impact data in social-welfare services and supplies the evidence needed to underpin qualitative insights. In this assessment, services at the YTY Residential Care Facility show strong consistency between qualitative and quantitative results, confirming that the services deliver positive impacts for stakeholder groups.

Historically, the YTY Residential Care Facility already maintains comprehensive assessments of physical status, such as ADL. To improve measurement sensitivity, YTY can complement the ADL total score with the Functional Independence Measure (FIMTM), an 18-item instrument scored on a 7-point ordinal scale across motor and cognition domains. Compared with Barthel/ADL-style scoring, FIM provides a broader operational range and helps reduce ceiling effects, making it better suited for detecting smaller incremental changes over time (Australian Institute of Health and Welfare, 2026; Proding et al., 2017). Based on the outcome valuation and total present value analysis, psychosocial outcomes account for a significant proportion of total social value among older adults. Future evaluation mechanisms can therefore incorporate additional psychological-domain indicators. These can be tailored by subgroups to reflect differing priorities across functional levels, with corresponding adjustments in instrument selection and scoring to increase measurement sensitivity and managerial usefulness. In addition, because ADL item scoring can be relatively coarse in practice, the Facility may consider supplementing ADL with a finer-grained functional assessment tool (e.g., the Functional Independence Measure, FIM), which rates functional performance across 18 items on a 7-level scale and can help detect smaller but meaningful changes in independence over time.

7.2.2 Reduce dependence and extend reablement and psychosocial effects

SROI results (Figure 7-2) show high performance for “Reduced depression & negative thoughts” and “Increased life motivation” under the Holistic Reablement care model, evidencing strong psychosocial effects. However, impact factors analysis also reveals high drop-off after service, especially for older adults with severe functional impairment, indicating notable dependence on the institution. While in-residence outcomes are strong, post-discharge persistence needs strengthening. We propose three strategies—discharge/return-home transition, community extension, and ongoing emotional support—to sustain gains.

First, for transition, establish an individualised discharge-readiness protocol: pre-assess home environment and independence conditions, and deliver family co-learning so families understand and participate in reablement, thereby reducing adaptation challenges after the older adult returns home. Second, collaborate with day-care centres

and community organisations to create “community reablement partner hubs,” providing continued exercise guidance and emotional support within familiar settings. In addition, institutionalise life-review activities and pair them with peer-support and online groups so former residents can maintain social ties, encouragement, and the supportive interactions built during residence. Finally, include life motivation and emotional stability as tracked items in the Individual Service Plan (ISP), with scheduled follow-ups and data monitoring to maintain gains.

Overall, the aim is “independence without interruption upon exit,” integrating family participation, community linkages, and psychological support to reduce dependence and extend outcomes, thereby reinforcing the value of YTY Residential Care Facility’s reablement services.

7.2.3 Advance inter-professional capability and secure workforce continuity

This evaluation shows positive impacts on care professionals from the Holistic Reablement model. Through interdisciplinary teamwork and practice, care attendants, nurses, social workers, nutritionists, physiotherapist, occupational therapist, and administrators learn from one another and broaden perspectives, moving beyond routine, easily substitutable caring job. Such collaboration deepens knowledge and skills, heightens risk awareness and service agility, and increases achievement and professional identity. SROI results (Figure 7-2) highlight “Heightened risk awareness” and “Increased sense of accomplishment,” reflecting greater pride and meaning in work. By contrast, “Enhanced professional skills” generates comparatively lower outcome value and total present value than the other positive staff outcomes, suggesting an area where further strengthening may yield additional impact. While inter-professional capability is evident, gaps remain, especially in dietary and nutrition management (relative gaps for care attendants, nurses, and social workers). We also recommend reinforcing PT/OT fundamentals for care attendants and nurses, so frontline staff collaborate more proactively in reablement contexts.

Although “Increased mental stress” was not material, mitigation is crucial for sustaining workforce effectiveness. Beyond grief and helplessness when these older adults worsen or pass away, the largest stressor is turnover-driven adaptation: rebuilding team cohesion, restoring knowledge transfer, and coping with fluctuating interdisciplinary performance. Institutionalised training and knowledge management are therefore vital: normalise peer supervision and experience sharing (e.g., monthly cross-disciplinary case reviews combined with stress-adjustment workshops, embedded in existing case meetings), build a “backup team” mechanism via cross-training and external partnerships, and document core curricula and SOPs to create a standardised, transferable knowledge system that reduces reliance risk.

Overall, this strategy balances professional deepening with workforce sustainability. By relieving stress, stabilising operations, and supporting continuous learning, the Holistic Reablement model becomes not only a care concept but also a durable cultural cornerstone of the YTY Residential Care Facility.

7.2.4 Strengthen family participation to deepen care outcomes

Analysis of family members indicates that “Reduced caregiving burden” generates higher outcome value than “Improved family relationships.” Impact-factor patterns suggest that family-relationship outcomes carry a relatively higher counterfactual component, implying that such improvements are influenced not only by the programme but also by pre-existing family dynamics and broader contextual factors. By contrast, the programme demonstrates clearer attributable contribution in reducing caregiving burden; however, this outcome also exhibits relatively high drop-off, indicating dependence on continued institutional support.

To strengthen persistence and deepen relational impact, YTY may establish a family co-care participation mechanism that shifts families from passive supporters to active partners. Concise on-site family support sessions can emphasise the core principles of the Holistic Reablement model—avoiding over-assistance for the sake of efficiency (e.g., routine hand-feeding or prolonged wheelchair use) and instead using prompting and partial assistance to promote residents’ self-care capacity. In addition, structured “Family Days” integrating reablement and leisure activities can enhance emotional connection and foster more distinctive relational gains. Such approaches may help extend outcome durability, internalise reablement practices within families, and reduce over-reliance on institutional support after discharge.

7.2.5 Tiered psychological measurement design by functional subgroup

Subgroup analysis indicates that psychosocial outcomes account for a substantial proportion of total social value across both older-adult groups, although the internal structure of value differs between them.

For older adults with severe functional impairment, “Increased life motivation” generates the highest impact in the current-period calculation, reflecting strong attributable effects within 2024. However, when persistence is considered, “Reduced depression & negative thoughts” produces the highest total present value due to its longer duration and lower drop-off. This pattern suggests that while motivation can be effectively activated during residence, emotional stabilisation may be more sustainable over time. Accordingly, future ISP design for this subgroup should prioritise structured measurement of emotional stability—such as frequency of negative affect, acceptance of

physical condition, and emotional fluctuation—while tracking motivational activation through clearly separate indicators to avoid conceptual overlap.

For older adults with mild-to-moderate functional impairment, both impact and total present value are led by “Increased life motivation,” followed by “Reduced depression & negative thoughts.” Compared with the severe subgroup, psychological activation appears more persistent and less vulnerable to drop-off, indicating that maintaining goal engagement, participation intensity, and proactive behaviours is particularly central for this group. ISP psychological indicators may therefore focus more strongly on measurable goal attainment, participation frequency, and self-initiated engagement, while retaining emotional monitoring as a complementary axis.

Across both groups, “Improved physical health” shows relatively high per-person valuation but lower realised outcome counts, suggesting measurement-sensitivity constraints rather than lack of importance. Psychological measurement refinement should therefore be implemented alongside ongoing functional tracking, with clearly separated emotional-stability and life-motivation constructs to maintain analytical clarity.

By adopting a severity-tiered psychological measurement framework, emotion-centred for the severe subgroup and motivation-centred for the mild-to-moderate subgroup, the Holistic Reablement model can more precisely capture and sustain the dimensions of value most strongly evidenced in the SROI results, while avoiding conceptual overlap and potential double counting within psychosocial domains.

Appendix

Appendix I Summary of Outcomes for Holistic Reablement Care Model–Interdisciplinary Support Program

Appendix 1-1: Summary of Outcomes for Care professionals

Outcomes	Chain of Events	Extract of Stakeholder Feedback
Enhanced professional skills	<ol style="list-style-type: none"> 1. Launch inter-professional meetings and plan the ISP → Conduct reablement assessments for older adults and design training plans → Identify issues during training for different conditions → coordinate with inter-professional colleagues on how to train the older adult → Improve problem-awareness and inter-professional collaboration → Enhanced professional skills. 2. Launch inter-professional meetings and plan the ISP → Conduct reablement assessments and design training plans → Learn to embed training in daily routines or deliver it through activities → Strengthen OT/PT competencies → Enhanced professional skills. 3. In inter-professional meetings, each discipline shares assessments and perspectives → Through communication, understand other roles and learn each other’s strengths (e.g., social workers’ communication, dietitians’ nutrition management) → Build a common language for the team → Understand each person’s professional habits and best-fit roles → Better team communication → 	<ol style="list-style-type: none"> 1. Care professional: “At school we had lots of teaching materials and tools for training patients, but in a NPO like YTY we learn to teach with limited resources, using everyday movements to deliver reablement.” 2. Care professional: “With the inter-professional model, if each of us does our part well, division of labour reaches maximum effect. We also pick up skills from other fields, like how social workers talk with families, or how PTs design exercises for specific problems.”

Outcomes	Chain of Events	Extract of Stakeholder Feedback
	<p>improved team communication and division of labour → Enhanced professional skills.</p> <p>4. Communicate with family members to plan suitable care approaches → Gradually learn how to work with families → Better communication skills → Enhanced professional skills.</p> <p>5. Unfamiliar with the new long-term care model → Begin training and direct work with residents → Progressively understand Holistic Reablement through teamwork → Apply the knowledge and philosophy in daily care → Identify elders' pain points and accept them as they are → Residents begin to trust staff and follow guidance → Smoother guidance during training and increased willingness to “do it myself” → Learn how to communicate and secure engagement, including incentives and fee discounts → Better communication skills → Enhanced professional skills.</p> <p>6. Organise resident activities (exercise and social) → Invite external lecturers to lead sessions → Identify suitable lecturers for sustained collaboration → expand the lecturer pool → Stronger course-planning ability → Enhanced professional skills.</p> <p>7. Attend in-house professional courses → Continue learning Holistic Reablement concepts and integrate them into practice → Strengthen the link between theory and practice → Reinforce one's</p>	

Outcomes	Chain of Events	Extract of Stakeholder Feedback
	own specialty and inter-professional collaboration → Enhanced professional skills.	
Increased sense of accomplishment	<ol style="list-style-type: none"> 1. Communicate with families to design suitable care → Explain YTY’s care approach and reframe preconceptions about nursing homes → Align expectations and collaborate → Families see reablement succeed → they feel reassured about YTY → Families and residents express appreciation to staff → Increased sense of accomplishment. 2. Communicate with physicians about tube removal readiness → Implement the plan and adjust dynamically → resident successfully removes tubes → observe concrete change → Resident mood improves and optimism rises → Increased sense of accomplishment. 3. Invite families to join activities → Deepen mutual understanding and trust → Reablement succeeds → Arrange surprises from family, strengthening relationships → Observe better elder-family bonding → Stronger professional identity → Increased sense of accomplishment. 4. Present at internal showcases or external events → Once felt routine care lacked “professionalism” → During presentations, demonstrate expertise and results → Share confidently with peers outside → Increased sense of accomplishment. 	<p>Care professional: “YTY’s model differs from many nursing homes. It is not only repetitive custodial care; we train, run activities, and sometimes provide psychological support. Early on it was hard to adapt, but when residents succeed in reablement, their surprise, gratitude, and renewed hope make us proud of our profession.”</p>

Outcomes	Chain of Events	Extract of Stakeholder Feedback
Enhanced empathy	<p>1. Receive Holistic Reablement training → Through inter-professional work, deepen understanding of the model → Apply its knowledge and philosophy in care → Realise the job is more than easily replaceable routine tasks → Stronger identification with professional value → Aspire to use one’s expertise to help people in personal life as well → Enhanced empathy.</p> <p>2. Complete pre-service onboarding → learn YTY’s culture and working model → Mandatory “constraint experience” (restraints, diapering, forced feeding, blindfolding, and prolonged bed rest) to embody the feelings of neglected-care scenarios → Recognise elders’ circumstances and discomfort under such tools → By learning residents’ life histories during care, staff can better understand the underlying reasons behind residents’ expressed needs → Staff can empathise that residents’ needs may be shaped by their life experiences and personal traits → Enhanced empathy</p>	<p>YTY Director: “Every new staff member goes through a ‘shock’ session to experience restraints, so they grasp what it feels like for elders. Then they understand why we avoid these tools and prioritise reablement. Diapers are a good example—people think diapers solve incontinence, but after the experience they realise it is not that simple.”</p>
Heightened risk awareness	<p>1. Receive Holistic Reablement training → Through inter-professional work, internalise the model → Apply knowledge and philosophy in care → recognise the role goes beyond routine tasks → Professional knowledge becomes internalised → Detect issues in nearby elders earlier and know how to</p>	<p>Care professional: “YTY’s skills training and resource linkage have become everyday competencies. When elders around me show warning signs, I can spot them early</p>

Outcomes	Chain of Events	Extract of Stakeholder Feedback
	<p>prevent or respond when events occur → Heightened risk awareness.</p> <p>2. Learn the Holistic Reablement concept → Endorse the philosophy → Witness successful cases → Believe the same capabilities can be applied to one’s own older relatives → Feel responsible to observe and prevent care risks at home → Heightened risk awareness.</p>	<p>and help with medical referral or connect them to viable resources.”</p>

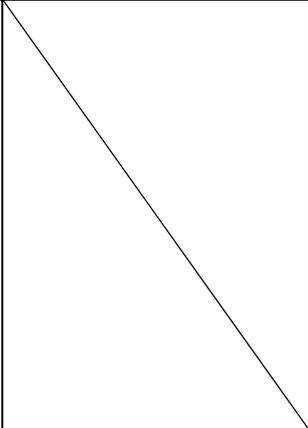
Appendix 1-2: Summary of Outcomes for YTY Residential Care Facility

Outcomes	Chain of Events	Extract of Stakeholder Feedback
<p>Expanded service models</p>	<p>1. Roll out the Holistic Self-Reliance care model → Committed to helping older adults regain function and enhance self-care ability → Partner external organizations; apply for grants; invite instructors → Build trust with government and partner organisations → Build a collaboration network → External organisations purchase YTY’s services and technical know-how/ Embed this service concept across other units of the organization → Expanded service models.</p>	<p>1. Director of YTY: “At the beginning this service model was really hard to push, but once we had successful reablement cases, government agencies and other LTC organisations began approaching us to collaborate and purchase our services and equipments.”</p> <p>2. Director: “Once there are some people seeing our performance, admissions rise and</p>

Outcomes	Chain of Events	Extract of Stakeholder Feedback
		<p>external resources flow in. Then we have more funding to expand services or strengthen care skills and training programmes.”</p>
<p>Strengthened team cohesion</p>	<ol style="list-style-type: none"> 1. Embed the Holistic Reablement concept within the organisation → Leadership champions the culture; all staff (incl. admin) learn and practice HSR → Staff recognise the value of their work → Care teams continually learn and implement HSR core principles → Interdisciplinary collaboration is institutionalized to deliver HSR → Recognize the importance of division of labor and collaboration, and learn to integrate others’ expertise into one’s own practice → Stronger sense of meaning at work → Strengthened team cohesion. 2. Embed the Holistic Reablement concept within the organisation → Leadership champions the culture; all staff (incl. admin) learn and practice HSR → Staff recognise the value of their work → Care teams continually learn and implement HSR core principles → Interdisciplinary collaboration is institutionalized to deliver HSR → Results and self-growth reinforce alignment with the organization → Build a healthy organizational culture → Strengthened team cohesion. 	<p>Care professional: “In here, the director tells us to give our all during work hours, then truly clock off. Do not stay to work overtime. If we need to attend courses, we can take official leave. This culture makes us more willing to learn and to contribute to the organisation.”</p>

Appendix 1-3: Summary of Outcomes for Family members

Outcomes	Chain of Events	Extract of Stakeholder Feedback
Improved family relationships	<p>Older adult is admitted to YTY →Health deterioration triggers irritability and negative thinking, increasing family conflict→ Family meets YTY staff to co-plan an ISP → Observe marked improvement in the older adult’s physical and mental status → With better health, older adults experience fewer negative emotions → Relationship with the older adult improves → Improved family relationships.</p>	<p>Family member: “When my father had the accident, he lost movement in his lower body. The atmosphere at home was gloomy and we often argued or stopped talking. Now he is receiving very good care here and we are amazed. We chat with him and join activities together; our relationship is gradually returning to how it was.”</p>
Reduced caregiving burden	<ol style="list-style-type: none"> 1. Older adult is admitted to YTY →Health deterioration triggers irritability and negative thinking, increasing family conflict →Family meets YTY staff to co-plan an ISP → See reablement at YTY exceed expectations and develop trust in YTY → Less worry about incidents (injury, outbursts, depression, etc.) → Reduced caregiving burden. 2. Older adult is admitted to YTY →Health deterioration triggers irritability and negative thinking, increasing family conflict→Family meets YTY staff to co-plan an ISP → See reablement at YTY exceed expectations and develop trust in YTY 	<p>Family member: “When my mother was home alone, I could hardly focus on work because I kept worrying she might fall or get hurt. With YTY’s care and training, I can concentrate much better on my job.”</p>

Outcomes	Chain of Events	Extract of Stakeholder Feedback
	<p>→Have more time to plan work, life and leisure → Focus better on one's own work and life → Reduced caregiving burden.</p>	
<p>Reduced financial burden</p>	<p>Older adult is admitted to YTY → The older adult is unwilling to enter a nursing home; family relations deteriorate with frequent arguments →Family meets YTY staff to co-plan an ISP → The older adult receives training and achieves successful reablement → Disability level improves and YTY grants care fee discounts → Reduced financial burden.</p>	

Appendix II Questionnaire for each stakeholder

Stakeholders	Question group	Questionnaire Content
Older adults with severe functional impairment / Older adults with mild-to-moderate functional impairment	Demographics	<ol style="list-style-type: none"> 1. What is your name? 2. What is your gender? 3. What is your age? 4. What was your level of functional impairment when you entered YTY Residential Care Facility?
	Outcome 1: “Improved physical health”	<p>Five-point Likert scale</p> <ol style="list-style-type: none"> 1. During your participation in the Holistic Reablement training in 2024, what was the change in your total ADL score? ADL score change = (most recent ADL total score in 2024) – (first ADL total score recorded after joining the programme in 2024): ___ points Note: If you are unsure, a care staff member may help you check the ADL records.
	Outcome 2: “Reduced depression & negative thoughts”	<p>Five-point Likert scale</p> <ol style="list-style-type: none"> 1. Do you agree that you lose your temper or feel depressed less often? 2. Do you agree that you accept your current health condition? 3. Do you agree that you have fewer negative thoughts?
	Outcome 3: “Increased life motivation”	<p>Five-point Likert scale</p> <ol style="list-style-type: none"> 1. Do you agree that you want to start living each day well? 2. Do you agree that you listen to care staff, work hard on rehabilitation, and eat properly? 3. Do you agree that you have started to set life goals? 4. Do you agree that you would like to return to your home?
	Outcome 4: “Enhanced social relationships”	<p>Five-point Likert scale</p> <ol style="list-style-type: none"> 1. Do you agree that you have made new friends? 2. Do you agree that after receiving appropriate care, your relationship with family has improved? 3. Do you agree that you are willing to initiate conversations with others? 4. Do you agree that you are willing to participate in various activities and interact with others?

Stakeholders	Question group	Questionnaire Content
Care professionals	Demographics	1. What is your name? 2. What is your gender? 3. What is your age? 4. What is your major in YTY Residential Care Facility? (care attendant, physiotherapist, occupational therapist, social worker, nurse, administrative staff, nutritionist)
	Outcome 1: “Enhanced professional skills”	Five-point Likert scale 1. Do you agree that your communication skills have improved? 2. Do you agree that your inter-professional collaboration has increased? 3. Do you agree that your team communication and division of labour have improved? 4. Do you agree that your problem-awareness ability has improved? 5. Do you agree that your dietary and nutrition management skills have improved? 6. Do you agree that your physiotherapy skills have improved (training older adults’ physical activity)? 7. Do you agree that your occupational therapy skills have improved (training older adults’ independent living skills)? 8. Do you agree that your course planning ability has improved? 9. Do you agree that your project management skills have improved (project planning, proposal writing, project execution)?
	Outcome 2: “Increased sense of accomplishment”	Five-point Likert scale 1. Do you agree that you have seen positive changes in clients? 2. Do you agree that you feel the value of your work? 3. Do you agree that after achieving goals you receive recognition from important others? 4. Do you agree that you have seen relationships improve between residents and their families?
	Outcome 3: “Enhanced empathy”	Five-point Likert scale 1. Do you agree that you can understand and empathise with older adults’ physical or psychological conditions?

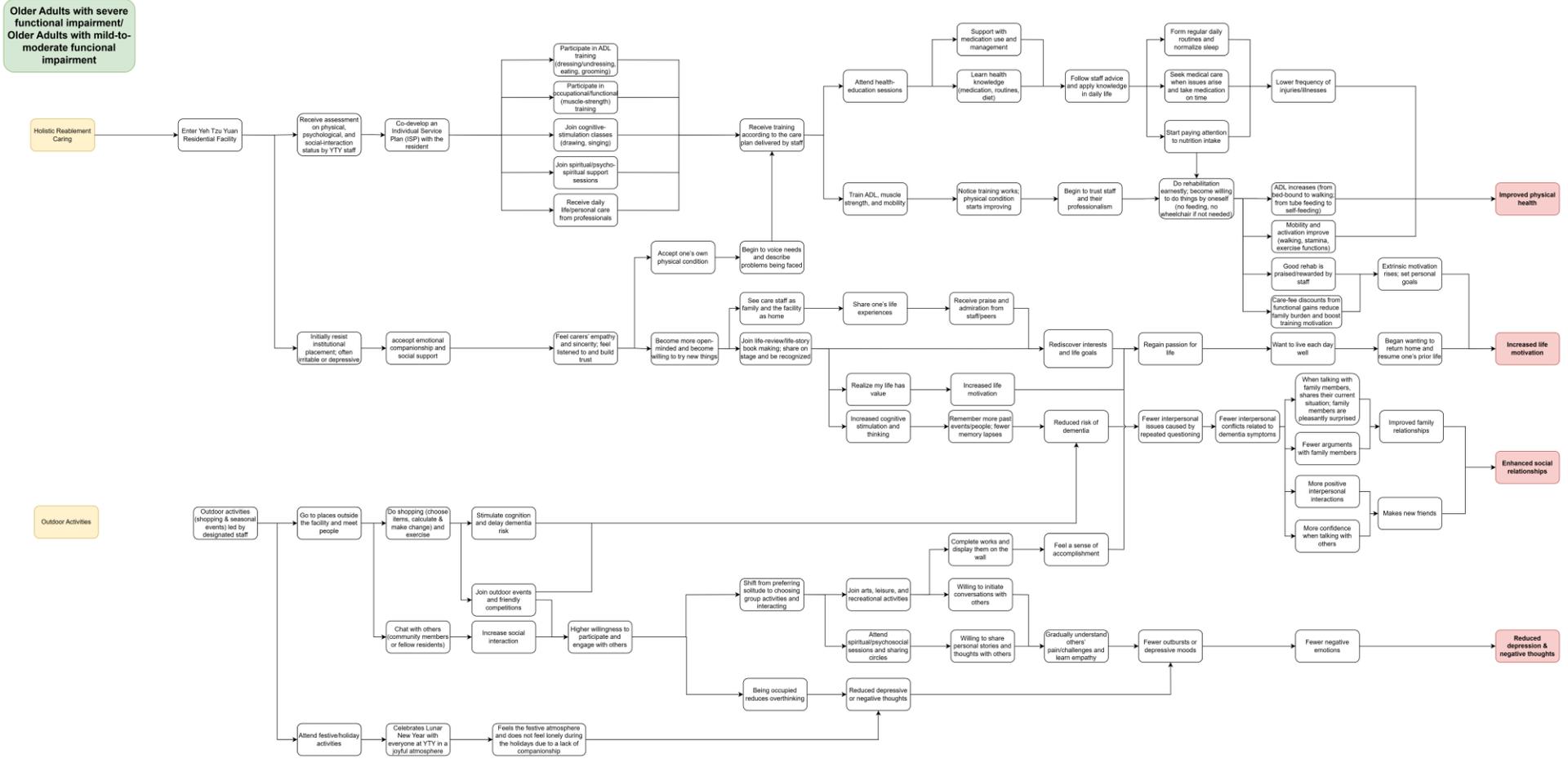
Stakeholders	Question group	Questionnaire Content
		2. Do you agree that when friends or relatives encounter situations similar to those of older adults at work, you use your professional knowledge or experience to help them? 3. Do you agree with the statement “I would describe myself as soft-hearted”?
	Outcome 4: “Heightened risk awareness”	Five-point Likert scale 1. Do you agree that you have applied what you learned at work to take preventive measures or improve situations in your family? 2. Do you agree that after detecting risks you have helped older relatives of friends or family seek medical care or resources? 3. Do you agree with the statement “I have a responsibility to observe and prevent care risks for older adults in my family”?
	Outcome 5: “Increased mental stress”	Five-point Likert scale 1. Do you agree that you have felt helplessness when a resident’s condition worsens or at end-of-life? 2. Do you agree that you have the stress from learning and adapting to the new care model? 3. Do you agree with you have stress from team re-forming when colleagues resign?
Family members	Demographics	1. What is your name? 2. What is your gender? 3. What is your age?
	Outcome 1: “Improved family relationships”	Five-point Likert scale 1. Do you agree that the older adult shows fewer negative emotions and that your relationship has improved? 2. Do you agree that you chat with the older adult and share what happened at YTY? 3. Do you agree that you participate in activities together with the older adult? 4. Do you agree that as the older adult’s physical and mental condition improves, family relationships improve?

Stakeholders	Question group	Questionnaire Content
	Outcome 2: “Reduced caregiving burden”	<p>Five-point Likert scale</p> <ol style="list-style-type: none"> 1. Do you agree that you worry less about unexpected situations with the older adult? 2. Do you agree that you can focus more on your own work and life? 3. Do you agree that you feel more at ease allowing the older adult to live at home?
Common Items (applies to all stakeholder groups’ questionnaire)	Materiality of Outcomes	<ol style="list-style-type: none"> 1. Do you agree that the “Outcome Name” you gained by participating in the program is important to you? [Importance] Five-point Likert scale. 2. For how long will the effects of the “Outcome Name” continue? [Duration] options: less than 1 year, 1 year, 2 years, 3 years, 4 years, 5 years.
	Impact factors	<ol style="list-style-type: none"> 1. Do you agree that one year after the program ends you would still maintain the “Outcome Name”? Example: because the older adult is no longer staying at YTY, although health improved, the family’s caregiving burden gradually increases. [Drop-off factors] Five-point Likert scale. 2. Do you agree that, without participating in the YTY program, you would NOT have gained the benefits of the “Outcome Name” during the same period? Example: if YTY had not provided this program, this outcome would be unlikely to occur within the same timeframe. [Counterfactual factors] Five-point Likert scale. 3. Do you agree that the benefits of the “Outcome Name” were produced by the YTY program rather than by participating in other organisations’ activities during the same period? [Attribution factors] Five-point Likert scale.
	Outcomes Valuation	<ol style="list-style-type: none"> 1. Please consider whether the following items represent the value that the “Outcome Name” brings to you. In other words, if you were given one of the items below, would you choose that item and give up the “Outcome Name” produced by the program? If you believe the outcome is priceless or of no value, select the highest

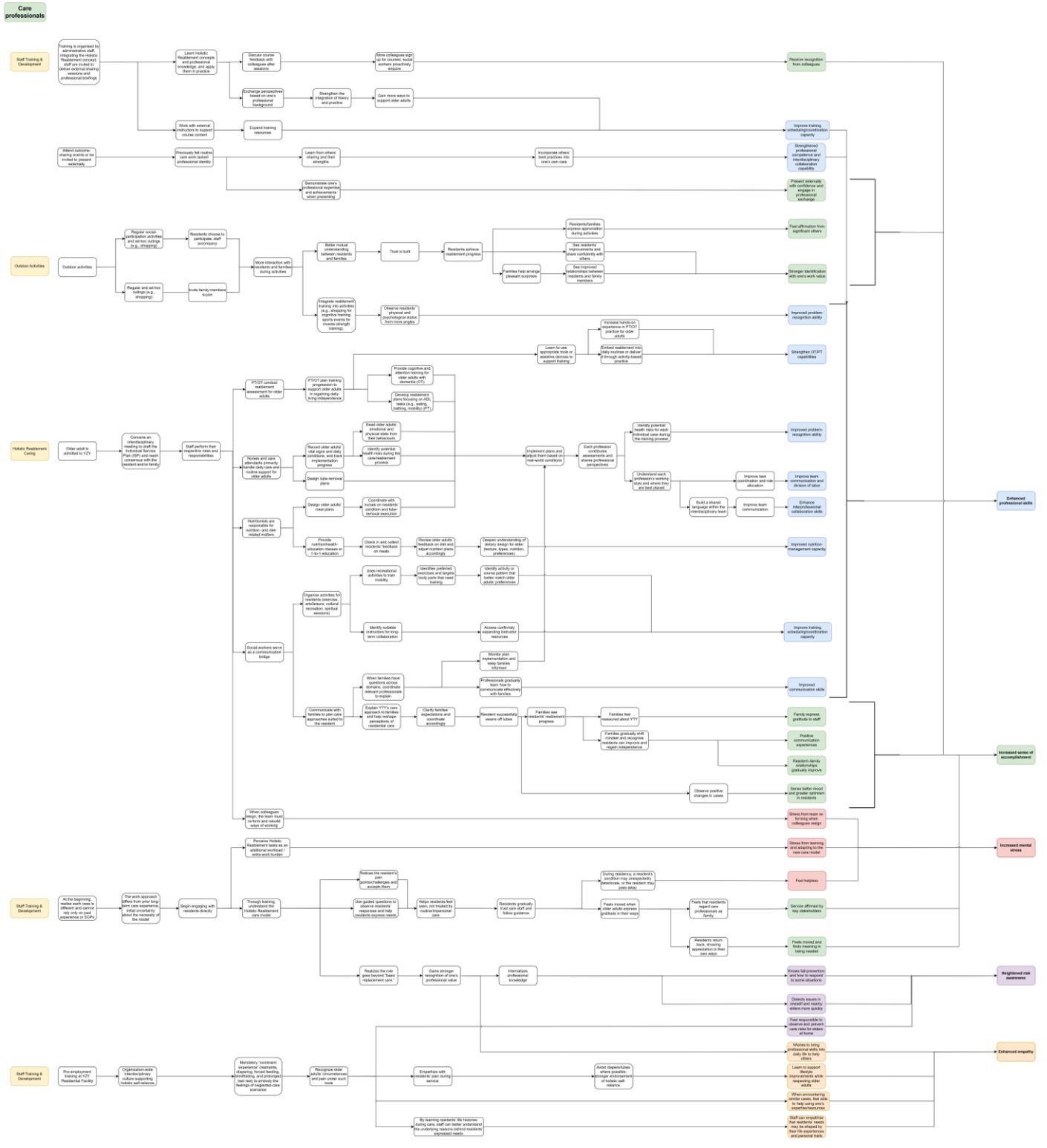
Stakeholders	Question group	Questionnaire Content
		<p>or lowest option accordingly. [Financial proxy] Use the Value Game item list for the relevant stakeholder.</p> <p>2. Following the last question, based on the item you selected, what do you consider reasonable specific financial value in NTD for the “Outcome Name”? [Valuation check] open numeric field, optional.</p>
	Other Outcome Confirmation	<p>8. Besides the outcomes listed above, what other benefits did you gain from this program? (open-ended)</p>

Appendix III Chain of Events

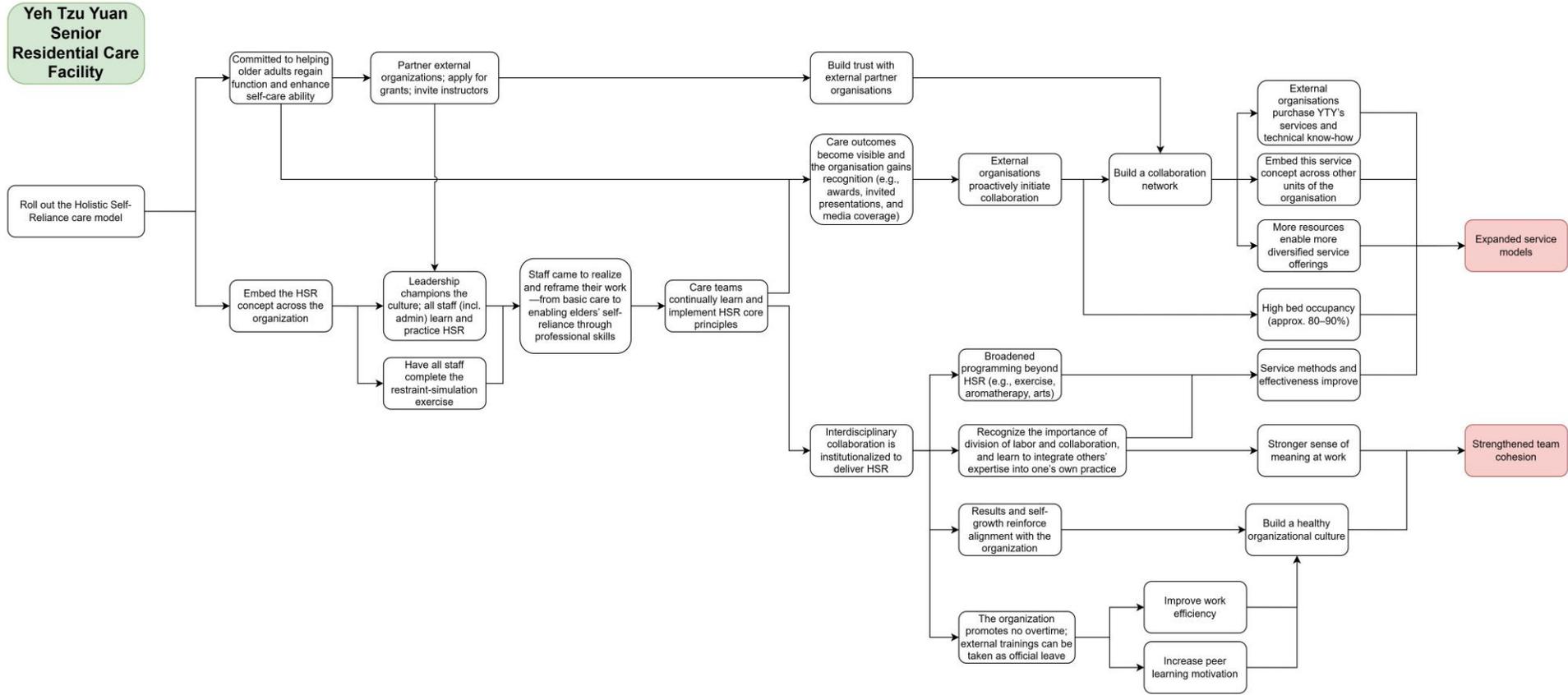
Chain of events of Older adults with severe functional impairment/
Older adults with mild-to-moderate functional impairment



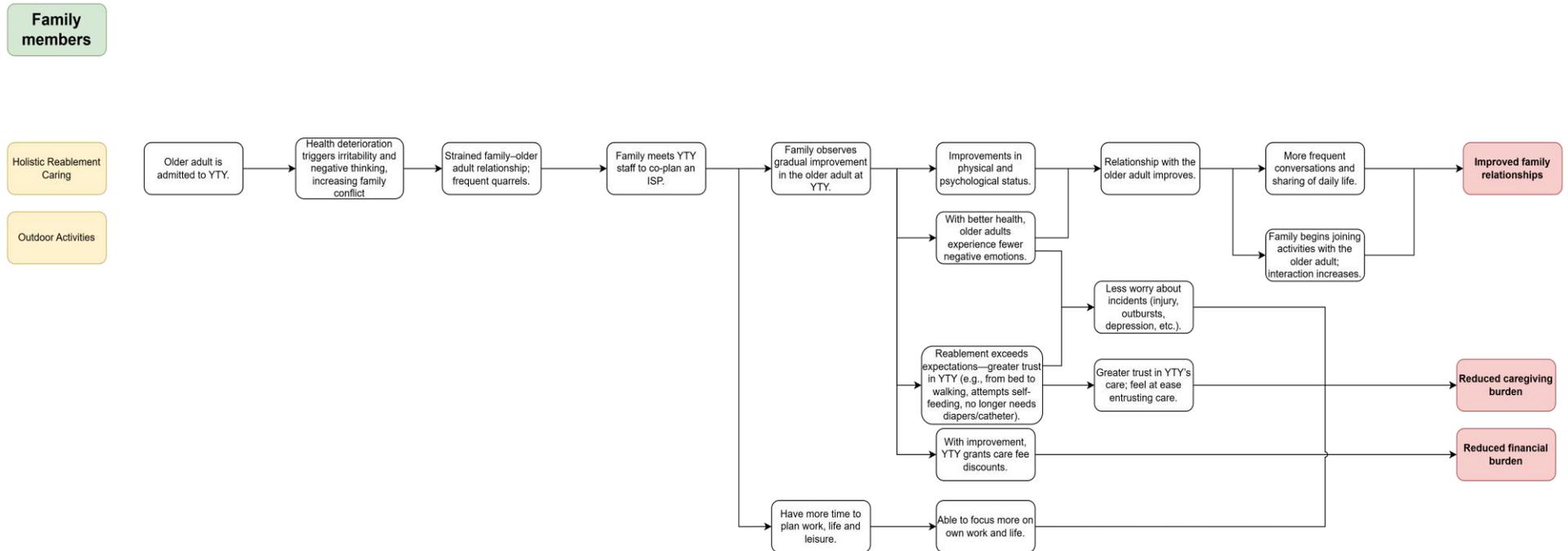
Chain of events of Care professionals



Chain of events of Yeh Tzu Yuan Senior Residential Care Facility



Chain of events of Family members



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