Better at Home Program Evaluation

Summary of Evaluation Findings and Recommendations

September, 2014

Foreword

United Way of the Lower Mainland has been working with and investing in seniors since 2006. Over the years, United Way's work has strengthened and grown social services; mobilized communities and built capacity; and influenced systems and policies. UWLM's work has contributed significantly to understanding how to support the well-being of seniors in the region.

United Way's leadership in seniors' work resulted in a partnership with the provincial government to develop, pilot, and now manage the seniors' program Better at Home.

Today, United Way invests $12.75 million in support of seniors, a mix of philanthropic dollars and government funds.

The Better at Home program provides seniors with non-medical home supports to help them live longer in their own homes while remaining socially connected to other people in their communities.

Better at Home was launched in 2012 and as of June 30, 2014, almost 5,000 seniors from across BC were enrolled in the program. The Better at Home approach to helping seniors receive non-medical home supports is unique and builds upon our CASI[1] experience. As with CASI, we undertook an initial program evaluation for Better at Home to gain early insights into program developments and improvements. The evaluation was conducted by external consultants and involved the first 16 Better at Home programs that were funded in January and April of 2013.

United Way thanks the many people that helped shape the initial evaluation, including members of the Better at Home provincial advisory committee, local Better at Home program staff, former CASI project staff, evaluation and research experts, and others. We want to especially thank the people at the Ministry of Health for their ongoing trust and support since the early CASI days in 2009.

This document presents a summary of the evaluation results (the full report of 238 pages is available upon request at: info@betterathome.ca). As with our CASI evaluation work, we are pleased to contribute this information to the growing body of knowledge in this field to help inform best practices and sustainable solutions in meeting the non-medical support needs of seniors. Over the coming months United Way is engaging key Better at Home stakeholders in these evaluation findings and the 'considerations for future' in order to ensure that Better at Home fully benefits from the findings and the important perspectives of its many stakeholders. A short report with the findings of the engagement process is expected in the Spring of 2015.

[1] Better at Home evolved from the promising results of the Community Action for Seniors Independence (CASI) project. Based on a shared commitment to support seniors' independence, United Way and the Government of BC partnered on CASI, a three-year pilot that was established in 2009, to test community-based models for providing non-medical support services to seniors in five BC communities. CASI was developed in response to a 2006 recommendation of the BC Premier's Council on Aging and Seniors' Issues that government help older people stay independent by providing a broader array of home support services.

Finally, and most importantly, we owe sincere thanks to everyone who took part in this evaluation – your support and valuable perspectives for this work are instrumental in helping us manage an effective Better at Home program for BC seniors.

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EXECUTIVE SUMMARY

United Way of the Lower Mainland's Better at Home program, launched in 2012, provides simple non-medical support services to seniors in BC. Funded by the BC Government, the program's goals are to help seniors live longer in their own homes while remaining socially connected to their community. Services are delivered by local organizations through volunteers, staff, and contractors and the type of services available are based on community needs.

Better at Home has been implemented in stages. At the time of this report, 60 organizations had been funded, of which 50 were providing Better at Home services.

This evaluation, conducted by Chomik Consulting & Research Ltd[2], occurred during the early stages of implementation of Better at Home and centers on the first 16 Better at Home programs. Quantitative and qualitative methodologies were used to engage with seven groups of Better at Home stakeholders across the 16 communities. These groups comprised program staff—lead agency executive directors and local program coordinators; seniors accessing the services; service providers; community developers; community stakeholders; and provincial program leaders. Using the information gathered from stakeholders, this evaluation examines and reports on the context, implementation, and impact of Better at Home to support operational planning and further development.

Context: The evaluation showed that a number of conditions in the broader environment influenced the operations and advancement of Better at Home. The most influential of these, across all stakeholder groups, was the existing economic climate in BC. This impacts not only Better at Home, but groups and organizations (e.g. health authorities, non-profit seniors-related groups) that collaborate with Better at Home to deliver services. Although the economic climate is not under the direct influence or control of the program, this risk can be mitigated by linkage and integration among Better at Home and groups and organizations across the non-profit and health sectors, which has already occurred to some extent.

Implementation: Overall, the evaluation found that Better at Home was implemented as originally conceived and in large part adhered to the guiding principles. While start-up funding was considered sufficient, most stakeholder groups expressed concern that funding levels may not suffice as service requests increase over time. In addition to financial resources, technical support and materials provided by United Way were judged to be supportive and helpful.

Some Better at Home communities felt they did not have enough time to effectively establish and implement operational processes and procedures. The workload to manage and support Better at Home at the community level is significant, and sometimes results in staff working many extra hours. While the

[2] With the exception of the executive summary and the foreword, all information in this report is provided by Chomik Consulting & Research Ltd. The full report of 238 pages is available upon request at info@betterathome.ca.

current mix of service providers delivering Better at Home services appeared to be working well (volunteers, contractors, and paid staff), some concern remains with respect to volunteer recruitment, retention and contractor availability and compensation. Overall, service providers for Better at Home were well prepared to assume their responsibilities.

Seniors expressed a relatively high level of satisfaction with the Better at Home services and identified interest in a number of additional services, such as: meal preparation, assistance with heavier household tasks, mental health support, and assistance with home health issues. Although Better at Home impacted the general activities of daily living among seniors, it did not have as great an impact with respect to encouraging seniors to do more in their community or expanding their social activities. Some early success reaching isolated and vulnerable seniors[3] has been realized, however, a parallel sentiment - that more should be done - also exists. The current opportunities for sharing lessons learned and challenges experienced among Better at Home communities have been well-received.

Impact: This evaluation generated evidence to suggest that the key components of Better at Home are working well and have a positive impact on seniors and service providers. The program has increased awareness of seniors needs and increased the number of non-medical support services available for seniors. It has also enhanced collaboration between key community stakeholders. While it is too early to declare Better at Home as the preferred model for delivering non-medical supports to seniors; it is fair to say that the program is being delivered in support of this aim. The impact and legacy of Better at Home over the longer term links to requirements for program sustainability. Adequate and secure funding is at the heart of program sustainability and funding through government channels is central to the sustainability of Better at Home.

Based on the information gathered and analyzed as part of this evaluation, a number of considerations were suggested for Better at Home.

1. Remain attentive to fiscal constraints faced by other groups and organizations at the community level, and assess the impact on Better at Home services on an ongoing basis.
2. Encourage Better at Home communities to strengthen and build upon the non-profit and health sector in order to further embed non-medical supports for seniors across BC.
3. Ensure that representatives of potential lead organizations participating in the community engagement process fully understand the process.
4. Allow local Better at Home programs to draw upon additional time for the community engagement process to ensure meaningful consultation occur and diverse perspectives be heard.
5. Examine the current funding formula and adjust to align with the phase of implementation and the diverse needs of rural/remote communities.
6. Ensure that sufficient time is available to allow communities to properly plan for implementation of the Better at Home program at the local level.

[3] Within the context of Better at Home, 'vulnerable' refers to seniors that are experiencing one or more of the following: live alone, are on low income, are 85 years or older, belong to an ethno-cultural community that may not be prevalent or well supported in BC. Better at Home does not target seniors who are vulnerable due to mental health challenges or severe health issues given that Better at Home is not a medically focused program.

7. Identify and apply strategies aimed at connecting with isolated and vulnerable seniors in Better at Home communities.
8. Remain cognisant of community capacity and respond with tailored support; provide support on issues common to all Better at Home programs (e.g., risk management and insurance).
9. Regularly monitor satisfaction among service providers to ensure that they continue to view their contribution as beneficial, and thereby, reinforce current intentions to remain with the program.
10. Support local Better at Home programs to identify barriers and solve problems related to service provider recruitment and retention.
11. Continue current methods to prepare and train incoming service providers, such as orientations and job shadowing.
12. Ensure appropriate level of human resources to support the program at the local level.
13. Consider lead organizations' infrastructure and capacity, degree of existing network with other agencies, and reputation in the community as part of the selection process for future Better at Home programs.
14. Continue with the sliding fee scale. Consider incorporating an additional category to the scale.
15. Consider increased marketing, targeted to the intended audience (e.g. vulnerable seniors), but be mindful of the increase in demand for service.
16. Direct greater effort at strategies that encourage community and social engagement of seniors at the local level.
17. Consider engaging with other groups and sectors to explore additional service needs for seniors and potentially work together to address those needs.
18. Continue and potentially augment or expand current learning mechanisms.
19. Continue to track the experience and outcomes of Better at Home so that it can continue to contribute to knowledge and theory-building in this field.
20. A strong evaluation framework and process should be developed and implemented to capture key learnings, challenges and opportunities, and movement on key indicators over time.
21. Continue efforts to secure government commitment, both in terms of philosophical support for the program, as well as adequate and ongoing funding for the future.

PART A: INTRODUCTION

1.0 Background

United Way of the Lower Mainland's Better at Home program, launched in 2012, provides non-medical support services to seniors in BC. The program's goals are to help seniors live longer in their own homes while remaining socially connected to other people in their communities. Funded by the BC Government, Better at Home is a key deliverable of the Ministry of Health's *Improving Care for B.C. Seniors: An Action Plan, February 2012*. The program is managed by United Way and implemented through non-profit agencies that primarily rely on volunteers to provide seniors with relatively simple services, such as yard work, friendly visits, light housekeeping, modest home repairs, grocery shopping, snow removal, and transportation to appointments.

Better at Home evolved from the promising results of the Community Action for Seniors Independence (CASI) project. Based on a shared commitment to support seniors' independence, United Way and the Government of BC partnered on CASI, a three-year pilot that was established in 2009, to test community-based models for providing non-medical support services to seniors in five BC communities. CASI was developed in response to a 2006 recommendation of the BC Premier's Council on Aging and Seniors' Issues that government help older people stay independent by providing a broader array of home support services[4].

Rapid population growth and aging[5] both contribute to the ongoing need for programs like CASI and Better at Home[6,7]. Research conducted by United Way in 2009 and other published literature demonstrate insufficient supports to help BC seniors live independently into their later years[8]. Although the province has increased the number of beds in assisted living and residential care facilities in an effort to keep pace with growing demand[9], limited bed availability in some areas has resulted in seniors spending unnecessary time in acute care beds while awaiting placement[10,11]. This is exacerbated when older people prematurely transition to assisted living or residential care facilities simply because they

[4] For more about the CASI pilot project evaluation see: www.uwlm.ca/sites/default/files/webfm/Our%20Work/Reports%20and%20Resources/Evaluation-of-CASI-November-2012.pdf
[5] B.C. Ministry of Health. Setting Priorities for the B.C. Health System, February 2014, p.14. http://www.health.gov.bc.ca/library/publications/year/2014/Setting-priorities-BC-Health-Feb14.pdf
[6] B.C. Ministry of Labour and Citizens' Services. Developing a system of non-medical home support for British Columbians: A Background Paper, p.2. http://www.cio.gov.bc.ca/local/cio/kis/pdfs/non_medical_home_support.pdf
[7] Chomik Consulting & Research Ltd. CASI Evaluation: Final Report on Project Findings Prepared for the United Way of the Lower Mainland, November 2012, p.2. http://www.uwlm.ca/sites/default/files/webfm/Our%20Work/Reports%20and%20Resources/Evaluation-of-CASI-November-2012.pdf
[8] Chomik Consulting & Research Ltd. CASI Evaluation: Final Report on Project Findings Prepared for the United Way of the Lower Mainland, November 2012, p.2. http://www.uwlm.ca/sites/default/files/webfm/Our%20Work/Reports%20and%20Resources/Evaluation-of-CASI-November-2012.pdf
[9] Government of B.C. Improving Care for B.C. Seniors: An Action Plan, February 2012, p.9. http://www.health.gov.bc.ca/library/publications/year/2012/seniors-action-plan.pdf
[10] Canadian Health Services Research Foundation. Exploring alternative level of care and the role of funding policies: An evolving evidence base for Canada, pp.23-24. http://www.cfhi-fcass.ca/Libraries/Commissioned_Research_Reports/0666-HC-Report-SUTHERLAND_final.sflb.ashx
[11] CIHI. Health Care in Canada, 2012: A Focus on Wait Times, p.63. https://secure.cihi.ca/free_products/HCIC2012-FullReport-ENweb.pdf

are no longer able to complete routine tasks of daily living on their own (e.g. driving, getting groceries, maintaining their homes and yards)[12].

While evidence calls for the provision of non-medical support services to seniors, differing policy viewpoints and controversies exist about *the best way* to deliver those services, particularly in an environment of constrained resources. Some suggest that non-medical support services for seniors be universal, fully funded by government, and delivered through paid workers in the health care system. Others emphasize the value in building on local community assets – non-profits, volunteers, businesses, and grass-roots efforts – to provide seniors with these services, while others argue for an integrated approach that draws on the strengths of both community assets and fully managed and funded government systems. While Better at Home is new, the kinds of services it offers have been delivered through various mechanisms and approaches in the past (e.g., provincial health authorities and their contractors, Veterans Affairs Canada, culturally affiliated groups, and community organizations). This history and complex social, political, and economic landscape provides the backdrop for Better at Home and this report[13].

1.1 The Better at Home Program

Better at Home provides simple supports to help seniors, especially those who are isolated and vulnerable[14], live in their own homes while remaining socially connected to other people in their communities. Better at Home is guided by a set of principles. First and foremost among them is that seniors – and by extension, their families and caregivers – be front and center in determining seniors' needs. Another key principle is that programs be community driven, thus local demographics and conditions play a role in shaping individual Better at Home programs. Other principles determine that Better at Home is prevention-oriented, evidence-informed; independence-focused; simple and understandable; based on need; integrated; and a non-governmental program.

To choose communities for Better at Home, United Way works with individuals who have relevant knowledge about the various regions in BC. Factors such as the concentration of seniors living in the area and seniors' vulnerability indicators are taken into consideration and potential locations are chosen. Community developers are brought in to engage local stakeholders, including seniors, to:

- map out existing assets for seniors
- help determine which non-medical support services from an eligible set or "basket" of services are most needed
- propose criteria for a lead organization to receive Better at Home funding from United Way and deliver the local program
- make a recommendation for the lead organization

The recommended lead organization then completes United Way's application process.

[12] British Columbia Medical Association May 2008 Report, Bridging the Islands: Re-Building BC's Home & Community Care System, Page 24. https://www.doctorsofbc.ca/files/HCC_paper.pdf, June 5, 2014.

[13] To learn more about Better at Home, visit www.betterathome.ca

[14] Within the context of Better at Home, 'vulnerable' refers to seniors that are experiencing one or more of the following: live alone, are on low income, are 85 years or older, belong to an ethno-cultural community that may not be prevalent or well supported in BC. Better at Home does not target seniors who are vulnerable due to mental health challenges or severe health issues given that Better at Home is not a medically focused program.

In the local program development phase the lead organization uses the results of their community's engagement process, especially regarding the priorities for services, for guidance. During this phase they determine the geographical boundaries for their service area, decide which services to offer, develop service delivery methods, seek out productive local partnerships, and set specific fees for services. Once this development work is complete, service delivery can begin.

Given the diversity of local conditions, it is fully expected that programs will differ from each other. However, Better at Home also ensures that key characteristics are consistent across all programs:

- Each program establishes a local advisory committee to provide guidance and help to ensure the program is integrated in the community and responding to local seniors' needs.

- Fees for services are guided by the Better at Home income-based sliding scale. Services are free for low-income seniors and subsidized for some. Seniors with an income above the BC average pay a full fee based on local market rates.

- All volunteers providing Better at Home services directly to seniors undergo a criminal record check.

- Local Better at Home program coordinators are expected to connect with staff from their local health unit, Community Response Network, and Division of Family Practice (where applicable), and other community resources to promote program awareness and integration.

- All programs submit regular reports to United Way to enable performance monitoring and accountability.

- United Way's provincial Better at Home staff provide all programs with ongoing support (e.g., through the application process, program development and implementation stages, and during ongoing operations) which includes one-on-one regular connection and guidance, resource materials, webinars, in-person training, and facilitated peer-to-peer dialogues. Learning is fundamental to Better at Home, thus local Better at Home staff are supported and expected to participate in the Better at Home community of practice.

At the time of this report, 60 lead organizations were receiving funding to deliver Better at Home programs across BC (several programs serve multiple communities). Initially, Better at Home was implemented in communities with 5,000 residents or more, however, several communities with less than 5,000 residents now have access to Better at Home. Better at Home has been implemented in stages, therefore, of the 60 funded, 50 were providing Better at Home services at the time of this report while the remainder were in earlier stages of development. As of June 30, 2014[15]:

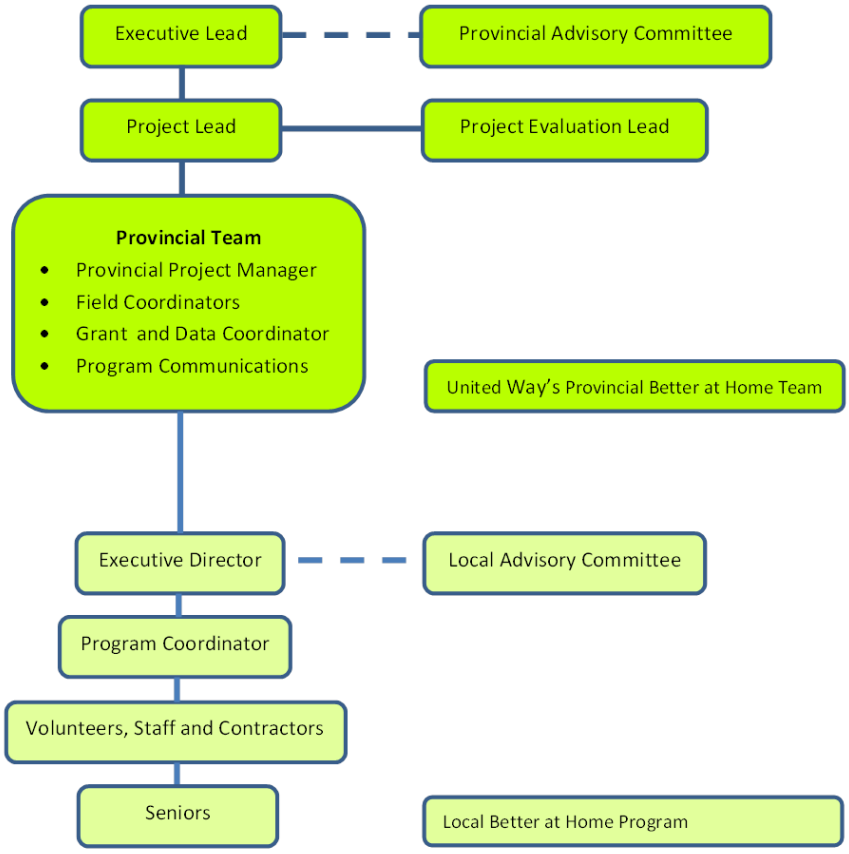
- 4,877 seniors were enrolled in Better at Home programs. Of these seniors:
    - 64% live alone.
    - 69% are women while 30% are men.

[15] Better at Home programs report data on a quarterly basis. The data in this section reflects the most current available at the time of this report and pertains to the 50 Better at Home programs that were offering Better at Home services as of June 30, 2014. The other Better at Home programs funded at that time were in development. Better at Home programs are expected to collect specified data regarding seniors attending their Better at Home program. In some instances, seniors choose not to disclose personal information. 'Unknown' data (where percentages do not equal 100%) in this section refers to data that seniors chose not to disclose or data that programs have yet to collect.

- 27% are in the 65-74 age range[16], 36% are in the 75-84 age range, and 24% are older than 85 years. The remaining 10% are 64 years or younger.
- 13% speak a language other than English as their primary language, while 85% speak English as their primary language.
- 78% self-report/identify or are described by local program personnel as being Caucasian, while 19% self-report/identify as not Caucasian, including, for example, Chinese, South Asian, First Nation Aboriginal, Metis Inuit[17].
- 81% qualify for full or partial subsidy to receive Better at Home services[18].

- 39,211 total services had been provided to seniors via Better at Home and of these, the most frequently used services were light housekeeping (42%), followed by transportation to appointments (19%), friendly visiting (15%), and grocery shopping (11%).
    - Of the 39,211 services, 19,605 (50%) services had been provided by volunteers.

Many stakeholders are involved in Better at Home (several of which were involved in this evaluation, as described below). The following diagram shows key entities and linkages that comprise the overall structure for Better at Home currently:



[16] Age at enrollment into the program.
[17] Ethnicity categories are based on the categories used by Census Canada.
[18] Better at Home services are delivered via a sliding scale. Full or partial subsidy is determined through an assessment of seniors' ability to pay for Better at Home services based on the senior's household income.

2.0 About this Evaluation

2.1 Purpose & Approach

This evaluation of Better at Home was conducted by Chomik Consulting & Research Ltd. It examines and reports on the context, implementation, and impact of Better at Home and is underpinned by the program's core goals to help seniors live longer in their own homes while remaining socially connected to other people in their communities. The purpose of this evaluation is to provide information to support operational planning and further development of Better at Home at both the provincial and community/program levels.

This evaluation occurred during the early stages of implementation of Better at Home and centers on sixteen Better at Home programs that received funding at two time periods:

- January 2013, which includes the following communities: Kamloops, Langley, New Westminster, Penticton and Sunshine Coast

- April 2013, which includes the following communities: Abbotsford, Esquimalt, North Shore, Oceanside, Port Hardy, Quesnel, South Surrey-White Rock, Surrey-Whalley, Tri-Cities, Vancouver West End and Williams Lake

Building on the CASI evaluation and lessons drawn from that effort, this evaluation was shaped through United Way's consultation with several key stakeholders, including the Better at Home provincial advisory committee, local Better at Home program staff, former CASI project staff, evaluation and research experts, and others.

A logic model approach was used for this evaluation. This approach provides a systematic way to examine relationships among the resources dedicated to a program, the activities that are undertaken, and the changes or results that are achieved. This approach ensures effective gathering and use of information, continuous learning about the program, and effective documentation of outcomes. The approach also provides for two forms of evaluation, both of which were applied to Better at Home: *formative evaluation* which examines the processes and core activities of a program and how it rolls out over time, and *summative evaluation* which centers on the program's aims and the results or outcomes it achieves. Emphasis was placed on a formative approach in order to generate early data and insights to support program improvements.

2.2 Evaluation Questions

Program evaluations typically aim to answer key questions that are important to the program's key stakeholders. This program evaluation focused on the context, implementation, and outcomes or impact of Better at Home through the following core questions (supporting evaluation questions were also addressed and are outlined in the full evaluation report – a 238 page document – that can be accessed upon request at: info@betterathome.ca):

Context: *How does the context that surrounds Better at Home influence its implementation and outcomes?*

Implementation: *What are the characteristic features of the implementation of Better at Home, and how has the implementation approach influenced program achievements?*

Outcomes/Impacts: *What is the impact of Better at Home on those involved in its mission, and how are things different today as a result of Better at Home?*

2.3 Data Sources & Collection and Reporting Methods

Seven groups of stakeholders participated in this evaluation, including:

- Executive directors – Leaders of Better at Home funded agencies
- Program coordinators – Individuals responsible for coordinating the program in local communities
- Seniors – Individuals or clients accessing Better at Home services
- Service providers – Volunteers, paid staff and paid contractors who deliver Better at Home services
- Community developers – Local contractors hired to lead Better at Home community engagement processes
- Community stakeholders – Individuals at the local level who were involved in the planning and implementation of a local Better at Home program
- Provincial program leadership – Stakeholders with a mandate or interest in seniors care, and those who provided program leadership, oversight and governance (representatives from United Way of the Lower Mainland, the Ministry of Health, and the Better at Home provincial advisory committee)

Both quantitative and qualitative methods were applied, which included:

- Telephone interviews with semi-structured questions were used to seek information from seniors accessing Better at Home services.
- Online surveys using semi-structured questions were used to seek information from service providers[19] and community stakeholders.
- Telephone interviews with open-ended questions were used to seek information from the community developers, local Better at Home program coordinators, executive directors of Better at Home lead organizations, and Better at Home provincial program leaders.

Throughout this document, the following terms are used to provide the reader with an understanding of how frequently a particular qualitative theme was cited:

- all = 100% of respondents
- most = 75-99% of respondents
- many = 50-74% of respondents
- some = 25 to 49% of respondents
- few = 2-24% of respondents
- 1 = 1 respondent
- none = 0% of the respondents

[19] For service providers who were not able to complete the survey online or did not wish to do so, a paper copy with a pre-addressed, postage paid envelope, was provided.

2.4 Limitations

While this evaluation was robust in design and execution, limitations related to evaluation design and data collection exist. With respect to timeframe, the evaluation was initiated once Better at Home communities had been operational for an eight-month period. However, the start of service delivery period varied across programs in each of the communities. For example, some programs were able to provide Better at Home services quickly if they had the infrastructure in place or had a history of running similar programs. At the time of interviewing therefore, some programs were further along in their implementation of Better at Home than others.

Another limitation pertains to the relationship between "dosage" (i.e., number of services that a senior has received through Better at Home) and impact on the senior. Some seniors had only one or two services which could have had a significant impact on their lives/well-being; whereas, other seniors may have had many services with less discernible impact, or vice-versa. Moreover, the window for interviewing seniors was three to eight months, meaning that some seniors may have been interviewed without time required to realize or comprehend any notable impact.

Some limitations are also associated with data collection. The identification of some evaluation participants (e.g., service providers and seniors) relied on the diligence of local Better at Home staff at the community level, and this varied across Better at Home programs. In addition, because some seniors were interviewed months after receiving their service(s), recall issues may have come into play. Recall challenges may have also been an issue given the fact that some of the seniors who participated in a telephone interview were very elderly and may have experienced memory problems.

PART B: SUMMARY of EVALUATION FINDINGS

This section presents a summary of the evaluation findings for each of the stakeholder groups that participated in this evaluation. The full evaluation report of 238 pages can be accessed upon request at: info@betterathome.ca.

1.0 Better at Home Seniors

A total of 310 telephone interviews (of a potential 474) were administered to Better at Home seniors resulting in a response rate of 65%. The majority of seniors interviewed were Caucasian females who spoke English as their primary language. Three-quarters of the seniors interviewed lived alone and were between the ages of 65 and 84. The annual household income level for most of the seniors was below $23,300. Many[20] of the seniors requested Better at Home services because they were experiencing a health issue (primarily chronic and a few acute) and required additional help to maintain their home. The length of time seniors had been receiving services varied from less than one month to over 12 months, with the majority of seniors receiving Better at Home services between 1-6 months.

The seniors received a range of Better at Home services, and according to Better at Home program records, the most frequently utilized services were light housekeeping and transportation, followed by yard work, friendly visits, grocery shopping, snow shoveling and minor home repairs. In addition to the services they were receiving through Better at Home, just under half of the seniors were receiving additional services outside of Better at Home, including: help from the health authority for bathing and medications, private hired housekeeping services, and assistance from family and friends.

Overall, the seniors were satisfied with the services they were receiving and satisfied with the service providers who were delivering the services. When asked about the benefits of Better at Home services and whether Better at Home had an impact on a number of quality of life indicators, most seniors believed the program is making life easier overall, helping them to remain living in their home, providing greater peace of mind, and helping them manage general activities of daily living. However, only a few seniors indicated that Better at Home is helping them to do more in their community, expand their social activities, or have more contact with people.

Just over half of the seniors paid for the services they were receiving, with the majority of these paying for their services in part (part subsidized by Better at Home). A significant number of the seniors indicated that the fee they were charged was affordable and that they were receiving value for their payment. Suggestions for changes to the program were offered by a few seniors, including: more advertising of the program in the community, more assistance with heavier housekeeping tasks, more hours of service per month, and improved communication with the local Better at Home office. Most of the seniors would recommend the program to others.

[20] The following terms apply throughout this report and are used to provide the reader with an understanding of how frequently a particular qualitative theme was cited: all = 100% of respondents, most = 75 to 99% of respondents, many = 50 to 74% of respondents, some = 25 to 49% of respondents, few = 2 to 24% of respondents, 1 = 1 respondent, and none = 0% of the respondents.

2.0 Better at Home Service Providers

A total of 95 service providers completed the Better at Home service provider survey[21]. Most completed the survey online while a few completed a paper copy which they returned by mail. The service provider respondents ranged in age from 18 years to over 75 years, were largely Caucasian, and most spoke English as their primary language. Some chose to become a service provider because they wanted to give back to their community, and others said they found the work meaningful and rewarding. A few service providers became involved with the Better at Home program because it was a paid job, or they wanted to gain experience working with seniors, or they hoped to earn practicum hours. The majority of service providers were volunteers, with a smaller number being contractors, and a few paid staff.

Overall, the service providers reported having a good relationship with the local Better at Home staff; most indicated that they were able to easily communicate with staff, they felt supported, and were pleased with how their time was scheduled. Most service providers also indicated that they had been adequately prepared to provide Better at Home services while a few reported they had not been adequately prepared to provide Better at Home services. Overall, the local Better at Home orientations were well received by service providers and helped to inform service providers about the Better at Home program, the roles and responsibilities of the various service provider positions, as well as relevant safety and security issues.

Some service providers were asked to provide additional time/assistance when they met with their senior clients (e.g., seniors asked them to spend more time doing housekeeping); and some service providers were asked to provide other types of services than they had been scheduled for (e.g., they came to provide housekeeping, but were also asked to assist with yard work). Some service providers observed that a senior needed help or services that were beyond what he/she was able to provide, including: meal preparation, mental health support (Alzheimer's), and assistance with banking.

The service providers enjoyed delivering services to the seniors, and most indicated that service provision was rewarding and beneficial to them personally. They also believed that the provision of Better at Home services was beneficial for the seniors. They indicated that the services helped seniors to live longer in their homes, and to a lesser degree, stay more connected to people and their community.

When asked to suggest ways to improve the Better at Home program, service providers recommended: increased paid work hours for the program coordinator and program administration; greater awareness of the program among the community members; provision of outings for groups of seniors; and increased funding so that more seniors could participate in the program. Most service providers indicated that they would continue as a service provider with Better at Home going forward, while a few were not sure and did not comment as to why.

3.0 Better at Home Community Developers

A total of 12 telephone interviews (of a potential 15) were conducted with Better at Home community developers. Community developers who were interviewed answered questions that pertained to: their

[21] This was out of a potential 341 known service providers and an undetermined number of service providers employed by contracting companies. In some Better at Home programs, service providers are managed by contracting companies (not the Better at Home coordinator); thus, it was not possible to determine the total number of contractors, and therefore not possible to determine the overall response rate to the service provider survey.

role in the community engagement process; relevant resources; implementation, inclusion, integration; impacts; and thoughts about the Better at Home program moving forward.

When questioned regarding the quality of support and resources provided by United Way's provincial Better at Home staff, most community developers reported that staff were supportive and approachable and described traits of provincial staff such as accessible, helpful, and responsive. On the other hand, a few community developers commented that they had difficulty communicating with provincial staff and that program staff were inflexible with regard to the community engagement implementation process. There were a few reports of inconsistent and unclear instructions though these appeared to be most prevalent in the communities that began their work earliest in the process. Those who had access to other communities' *"resources… in terms of templates"* did not report the same concerns. Furthermore, one community developer who worked in more than one community noted improvements in these challenges over time.

Many community developers reported that the budget for the community engagement process was reasonably adequate though a few indicated that the funding was limited with respect to salary levels, and material and travel costs. Many community developers commented that many of the material and human resources utilized during the engagement process were provided through means other than the Better at Home funding. Community developers stressed the integral role of community partnerships in providing the necessary resources to make the engagement process successful, including: advice, staff and volunteer hours, meeting space, and connections to other stakeholders.

A number of factors were identified as helping or hindering the Better at Home community engagement process. Helpful factors included: community partnerships and participation, personal knowledge and experience, clear directions, and support from Better at Home provincial program staff. Major challenges included: community resistance to the program or process, communication issues with the provincial office, reaching vulnerable and isolated seniors, and a tight timeline to complete community engagement. With respect to involving vulnerable seniors, many community developers acknowledged the difficulty in connecting with them directly. While many community developers wished they could have better engaged this population, some noted that they were not sure how to go about it, and others indicated that time pressures (shortage) hindered their ability to build trusting relationships.

Partnerships with staff and community organizations were highlighted throughout the data as integral to the community engagement process. These included: partnerships among seniors; between seniors and service providers; between service providers; and between community developers, organizational partners, and seniors. Partnerships helped to integrate Better at Home with existing community assets, provided resources, and increased community capacity to provide services to isolated and vulnerable seniors. While many partnerships were established or strengthened during the community engagement process, community developers had difficulty engaging some groups, such as: First Nations communities and Aboriginal groups, faith-based communities, health authorities, and ethno-cultural communities.

Overall, the community engagement process was believed to have positively impacted communities in a number of ways including: increased awareness of Better at Home and of seniors' needs, collaboration and capacity building, and excitement for positive change. Going forward, community developers pointed to a number of requirements for program success. First and foremost, sustainable and adequate funding and human resources will be necessary to ensure continued service delivery to seniors, many of whom are beginning to depend on the program services. Collaboration between community partners and coordinated service delivery will help to minimize costs and effectively provide the full Better at

Home basket of services. Finally, United Way will need to continue to support local Better at Home program coordinators through training and resources, and continue approaching program implementation with flexibility and consideration of individual community needs.

4.0 Local Better at Home Program Coordinators

All 17[22] (100%) local Better at Home program coordinators participated in a telephone interview to gather their perspectives about: their roles in Better at Home, relevant resources, implementation, integration, impacts, learnings, moving forward with the program, and model building.

Program coordinators were provided by United Way's provincial Better at Home staff with a range of training and tools to fulfill their roles in the Better at Home program. While there were a few challenges such as technological difficulties, respondents were generally satisfied with resources such as: the handbook, the HUB[23], orientation and meetings, templates, media training, and support from field coordinators and other local program coordinators. Examples of other kinds of training and/or orientation the local program coordinators would have liked to receive included: increased standardization of operating procedures and material, examples of how to conduct billing, and guidance in budgeting.

With respect to resources, staff support and technological resources and support were largely believed to be sufficient. United Way's provincial Better at Home staff were largely reported to be accessible, prompt, and helpful. A few program coordinators had issues using the Better at Home database[24], or receiving timely technological support to sort out database glitches.

While the number of service providers was considered sufficient by many program coordinators, some respondents reported insufficiencies due to difficulty finding paid staff or contractors at a reasonable rate or difficulty recruiting volunteers. Most program coordinators were utilizing a mix of paid/contract staff and volunteers to deliver services and felt that this was working well overall, though there were some challenges. These included: volunteer retention, partnership issues, and difficulty meeting demand for services. In addition, program coordinators reported several resources that supported the program beyond those provided by United Way. These included: material resources, such as office supplies and food donations; staff and volunteer time; financial donations; and intangible supports such as providing contacts. Finally, program coordinators reported some resources that were limited or lacking in the program, such as: funding, support from the private sector, staff time, volunteer training, and lead organization infrastructure.

Several factors were believed by program coordinators to help or challenge the implementation of Better at Home. Challenges included: lack of financial resources, volunteer recruitment, timing of program implementation, demand for services, insufficient program planning, and interpersonal difficulties in the lead organization. Program coordinators also named factors that helped program implementation, including: lead organization infrastructure and staff support, personal expertise,

[22] One of the 16 programs that participated in the evaluation had two part-time program coordinators, each of whom participated in an interview, resulting in a total of 17 interviews completed with local program coordinators.
[23] The Better at Home HUB is an online environment used by Better at Home stakeholders, particularly local Better at Home program coordinators and United Way's Better at Home staff, to support learning, information sharing, and to provide access to tools and resources. It is one of several learning and information sharing approaches being used within Better at Home.
[24] The Better at Home database is a tool provided by United Way that local programs may use to collect information pertaining to the program. In addition to enabling local programs to collected required reporting information, the database is also customizable in order to meet specific needs or interests of the local program and lead organization.

training and tools provided, organization reputation, level of community need, and help and support from the community. In addition, the program coordinators commented on customized features that were added to their local programs. These were highly varied, and included examples such as: helping with meals during a friendly visit, creating mutually beneficial partnerships, and providing a program-specific orientation for staff and volunteers.

The Better at Home sliding scale was reported to be a helpful tool for program coordinators. They appreciated that it was easy to use, removed subjectivity in awarding subsidies, increased the program reach to serve more seniors, and was easy for seniors to understand. One challenge was that the scale was sometimes perceived by program coordinators to be misused by clients who were able to achieve subsidies due to low income despite having significant assets that would have afforded payment.

Program coordinators reported a number of difficulties in delivering adequate and appropriate services. The main issues were: limited funding and human resources, high demand for services, requests for services outside the scope of Better at Home, and offering services that were not high in demand. In order to better reach seniors, program coordinators suggested the following: better advertising, greater outreach to isolated seniors and ethno-cultural communities, stronger partnerships, more staff with specific skill sets, increased funding, and expansion of the population served. Furthermore, there were a number of seniors' needs (outside of the scope of Better at Home) that were not currently being met adequately by community programs, such as: meal preparation, home and health care services, mental health supports, and affordable housing. To improve Better at Home and seniors' services going forward, it was suggested many of these gaps and challenges be addressed.

Partnerships with non-profit organizations, planning tables, government, advisory committees, service providers, and health care providers were reported to be integral in the implementation and future success of Better at Home. These partners provided guidance, support, client referrals, and community connections. While many Better at Home local program coordinators had established relationships with the health authority and health care providers, others were either planning to develop these relationships as their programs expanded or were finding them difficult to develop. Other suggestions for further partnerships included: organizations serving those with developmental disabilities, multicultural groups, First Nation communities, youth, advocacy groups, and service groups (fire, police, and paramedics).

Overall, the Better at Home program was believed by program coordinators to have a number of positive impacts on the lead organization as well as the clients and the local community. These included: identifying needs of seniors; raising awareness; reaching more isolated seniors and connecting them to the community; increased community collaboration; increased organizational credibility; integration of services within the lead organization; increased staff knowledge; and increased capacity to meet seniors' needs. Amongst the positive impacts, some challenges were also identified. Major difficulties included: learning the program coordinator role, managing the workload, maintaining emotional distance from clients, having to refuse services, volunteer recruitment, and partnership challenges.

Major lessons learned by local Better at Home program coordinators were related to program delivery, support, communication, and planning. Program coordinators stated that their experiences showed there is a strong need for the program in their communities, and further, that each community is unique in its needs. The further explained that the demand for services will continue to grow, and in order to meet the most needs, there must be some flexibility in implementation while operating within the program's capacity. Also, it is necessary to establish strong relationships with stakeholders, advisory

councils, and other program coordinators in order to ensure a support system is in place. Communicating clearly and openly with clients, contractors, staff, and partners will help to ensure the success of the program. Finally, another major lesson described by program coordinators was that allotting time for program planning prior to program implementation is imperative to optimal program implementation.

Going forward, program coordinators suggested it will be essential to secure sustainable funding and continue to generate community support for the program. They further suggested that the program is beginning to build a framework for a model of delivering non-medical supports to seniors as it is clearly making an impact and meeting needs in the community. Despite a steep learning curve, local Better at Home program staff, community members, and clients are gaining significant knowledge about seniors' needs, community resources, and the ways in which communities can come together to best support seniors to remain independent in their homes, and remain more connected to their communities.

5.0 Executive Directors of Local Better at Home Lead Organizations

All 16 (100%) executive directors of local Better at Home lead organizations were interviewed in order to gather their perspectives about: their roles in Better at Home, resources, pre-program implementation, implementation, integration, impact, learnings, future of the program, and model building.

Executive directors generally believed that the United Way's provincial Better at Home staff were responsive, helpful, and flexible in the training and support they provided. Some executive directors also believed that they [executive directors] were provided with adequate resources and materials to carry out their roles, including the HUB, the handbook, and the initial orientation. On the other hand, some executive directors reported that little or no training was provided or that templates and material resources were inadequate or unhelpful. More concrete and clear resources and procedures were recommended in order to improve training in the future.

With respect to resources, most executive directors believed that the financial resources provided were adequate for the first year of the program, but those financial resources were only sufficient due to limited program implementation during that time. As such, funds were believed to be insufficient for future years of the program when services were fully developed. However, a few executive directors found that financial resources were not adequate to meet the need even with limited program implementation. Again, support provided by United Way's provincial Better at Home staff during implementation was believed to be sufficient by many executive directors, although a few respondents had issues with technological support or lack of clarity in directions.

The number and mix of service providers were reported by many executive directors to be adequate and appropriate; most communities were utilizing a mix of volunteer, paid staff, and contractors for services. However, some executive directors reported they were struggling to find an adequate supply of volunteers and/or contractors, with contractors being difficult to secure at reasonable rates and with adequate insurance coverage. Several paid and in-kind resources were utilized beyond Better at Home funds, including: staff hours from the lead organization and partners, volunteers, office supplies, facility space, gifts, donations, and grants. In order to more adequately support Better at Home, executive directors stated that the following resources were needed: increased funding for subsidies, program growth, and staff; more volunteers; material items; and templates and training resources.

Most executive directors reported that the community engagement process was community-driven and that it positively impacted the community in the following ways: it raised community awareness of, and thus engagement in, the program; it provided community input for growth and enhancement of seniors' services; it established a local advisory committee; and it generated community support for the lead organization. Conversely, other executive directors found challenges with the process such as an increase in conflict within the community and a lack of support from some organizations or the lead organization board members. A few executive directors believed the process was not community driven. Executive directors suggested that in the future, the process could be improved by: allowing for more time; encouraging more senior involvement; making the process more collaborative rather than competitive; and providing clearer instructions for the process and program expectations.

Executive directors identified a number of challenges in implementing their Better at Home programs, most commonly reporting: limited human and financial resources; difficulty recruiting and retaining volunteers; limited support for program start-up; and partnership challenges. Most frequently reported helpful factors for implementation were: adequate lead organization infrastructure; staff skills and expertise; adequate volunteers; pre-existing relationships with seniors and the community; healthy partnerships; and adequate planning and organization. Additionally, conditions in the broader environment influenced the implementation of Better at Home, such as: the proportion of low-income seniors; budget cuts in other organizations; concerns over sustainable program funding; and support and cooperation from the community and organizational partners.

According to many executive directors, the sliding scale fee model made Better at Home more accessible to seniors to some extent, as it allowed the program to reach seniors who would not otherwise be able to afford services. However, with a limited amount of funding for subsidies and a high demand for subsidies, some clients in need of services were being waitlisted. While a few executive directors believed the sliding scale did not pose administrative challenges, some commented that it added a heavy administrative workload or additional costs.

Many executive directors believed that services being provided were not completely adequate or appropriate as the demand for services was outweighing resources, and other services were needed beyond the scope of the Better at Home program. Suggestions for additional services and supports included: mental health and medical supports; meal preparation; companionship and recreation beyond friendly-visits; financial guidance; home care; and personal hygiene support. With respect to local Better at Home advisory committees, executive directors reported that they were most commonly providing information, guidance, and connections to the community.

Executive directors identified a number of partnerships that played a key role in the implementation of Better at Home in their communities. These included: non-profits, seniors centres, local government, volunteers, media, and seniors themselves. Most executive directors also reported relationships with the health authorities, and some had connections to local physicians, nurses, and medical clinics. A few other executive directors noted they were working on establishing relationships with health care. Further, a number of other groups were cited as important potential partners, including: First Nations, multicultural groups, seniors' centres and care facilities, Community Living, and schools.

Most executive directors reported that their organizations were positively impacted by the Better at Home program. Some of the positive impacts reported were: increased services for seniors; community awareness of the organization and services; increased ability to reach vulnerable seniors; increased awareness of seniors' needs; and stronger community partnerships. The most common aspects of the

program that were reported as rewarding were: connecting with seniors and meeting their needs; helping seniors to remain independent; being chosen as the lead organization; and successful program initiation and implementation. On the other hand, some executive directors reported negative impacts as follows: increased workload; difficulty meeting expectations; and negative sentiments towards Better at Home due to non-renewal of United Way funding for some programs in the community (other than Better at Home). The three most challenging aspects of the program were: increased workload, meeting community expectations, and not being able to provide services to all seniors in need.

The major lessons learned that were reported related to program planning and sustainability, staffing and workload, program promotion and delivery, and community support. Some executive directors commented on the importance of planning and time-management during program start-up. Hiring competent staff, having clear expectations around workload and time requirements, and having administrative support were all important lessons. It was also noted that understanding seniors' needs, setting boundaries, and being adaptable in program delivery were necessary components of success. Finally, building connections with the community and with other Better at Home programs helped implementation and avoided duplication of work.

Going forward, funding, meeting demand for services, recruiting and retaining volunteers, and managing safety concerns were identified by executive directors as major risks to Better at Home. Conversely, the requirement most frequently cited as necessary for continued success was sustainable funding. Most executive directors believed that Better at Home was becoming a model for delivering non-medical services, although it was noted that it was a model under development and that continued flexibility of the model will be required in its application if the model is to be successful. Finally, most executive directors stated that Better at Home was contributing to knowledge development, specifically in relation to seniors' unique needs, volunteer service provision, and methods of non-medical service delivery. However, as executive directors noted, it is still early in the process and development of the knowledge base will depend on how the evaluation information being gathered is utilized.

6.0 Better at Home Community Stakeholders

A total of 54 online surveys (of a potential 128) were completed by Better at Home community stakeholders, resulting in a response rate of 42%. Most community stakeholders were members of a Better at Home local advisory committee, representing a range of organizations including: non-profits with seniors as their focus, health authorities, and seniors representing seniors. Most community stakeholders were involved with the Better at Home program for at least seven months, and most indicated that they were familiar with the Better at Home program in their own community.

Community stakeholders had mixed opinions with respect to the level of resources (personnel/human, material, and financial) available to support the Better at Home program. Some community stakeholders indicated that resources were sufficient, some indicated they were not; and some community stakeholders indicated that additional resources (beyond those provided by Better at Home) were used to support implementation of the Better at Home program. These were largely in-kind resources, in the form of time – time contributed by volunteers, local advisory committee members, and unpaid staff time (program coordinators and program administration).

The majority of community stakeholders surveyed had participated in the community engagement process, and most believed that the process enabled diverse community perspectives to be shared/heard. A few highlighted difficulties with the community engagement process; indicating that it

created tension between those organizations interested in becoming the lead organization, and raised unrealistic expectations about Better at Home in the community. Some suggested that the funding would have been better spent if it went directly to the program, rather than the community engagement process.

Community stakeholders indicated certain features of lead organizations that helped the implementation of Better at Home. These included: the capacity of the lead organization, its state of readiness to undertake the role, and the history and reputation of the lead organization in the community. Additional helpful factors included the passion and commitment of the local Better at Home program coordinator, and effective collaboration among community organizations and groups. Conversely, a lack of funding for the program, heavy workload for the program coordinator, and limited availability of volunteers were seen as challenges to program implementation.

According to community stakeholders, Better at Home is collaborating effectively with a variety of community partners such as: other non-profit organizations with seniors as their focus, health authorities, Community Response Networks, private service providers, and municipal governments. Other partners that the Better at Home program may want to consider partnering with included: Work BC, the business community, and community volunteer services. Currently, no consensus exists among community stakeholders about the sufficiency of the number and mix of Better at Home services; and, some community stakeholders indicated a need for additional services including meal preparation and health-related services. Finally, some community stakeholders voiced concern that the number of seniors requiring services may be beyond the current capacity of local Better at Home programs.

Overall, community stakeholders found their experience with Better at Home rewarding; and, most agreed that the program is having a positive impact on seniors in terms of enabling them to remain in their homes longer, and to a lesser extent, stay connected to their communities. Greater awareness about the needs of seniors at the community level was identified as another outcome of Better at Home. Looking ahead, community stakeholders support increased and sustained funding for Better at Home; they believe too that continued collaboration will be important to ensure program sustainability over the longer term.

7.0 Better at Home Provincial Program Leadership

All 10 (100%) Better at Home provincial program leaders (which included representatives from United Way, the Ministry of Health, and the Better at Home provincial advisory committee) participated in a telephone interview to gather their perspectives about: resources, implementation, integration, impact, learnings, and looking ahead.

With respect to resources, most of the provincial program leaders believed that the financial resources provided to support Better at Home were sufficient to date; however, some questioned whether the current level of funding would be sufficient for future years, as the demand for services increases. Most program leaders believed that the resources dedicated to Better at Home were used effectively as evidenced by sound financial reporting and accountability practices.

Overall, the provincial program leaders believed that Better at Home was implemented as originally conceived. This position was supported by the fact that the program adhered to its guiding principles, adopted a community-based approach, and was built upon the CASI project - Better at Home's predecessor.

Some key activities or best practices that emerged as part of the implementation of Better at Home included: the use of volunteers to deliver services, community meetings to engage local service providers, use of existing non-profit organizations to lead local programs, and a commitment to continuous learning through various methods such as provincial meet-ups and the HUB. When asked to consider factors that supported program implementation, program leaders identified: effective leadership from United Way, alignment with the community development model, use of local advisory committees, trusting relationship between government and United Way, government funding, and political support for the program.

Notably, some factors that supported implementation were also highlighted as factors that challenged implementation. Examples included the use of volunteers to deliver services, diversity of communities, limited program funding, complexity of the governance structure, and the perception that United Way places too much emphasis on administration costs. Conditions in the broader environment that impacted the implementation of Better at Home included: the overall economic environment in the province, limited financial position of some community organizations, and difficulty recruiting volunteers in some communities.

Most provincial program leaders believed that Better at Home had adhered to its guiding principles during program implementation; and many believed that Better at Home had applied a community-driven approach to implementing the program. Program leaders set forth a number of recommendations to improve Better at Home. Most frequently mentioned were: the integration of Better at Home services with the health care system, enhancing volunteer recruitment and training, and establishing ongoing funding to ensure program continuation. Additional ways to improve Better at Home included: adjusting the funding formula to better reflect local community size and needs, adapting the Better at Home model for application to rural and remote communities, and establishing relationships with the private sector/business as a potential source for long term funding.

Better at Home provincial program leaders identified a number of partnerships that played a key role in implementing Better at Home. These included: Ministry of Health, local community organizations, unions and labour, local United Way's, health authorities, Divisions of Family Practice, Community Response Networks, and seniors themselves. While many program leaders believed that Better at Home has integrated with existing provincial/regional/local assets or programs, they believed too that integration was only beginning (a work in progress). Integration occurred with, for example, Community Response Networks, Divisions of Family Practice, and a research entity (i.e., Michael Smith Foundation). A few program leaders were not aware of any integration between Better at Home and other existing programs or assets. When asked what other programs or assets Better at Home should partner with, program leaders suggested: Doctors of BC (formerly BCMA), Firefighters Union, First Nations, home care, BC housing, and municipal governments.

With respect to program impact, most provincial program leaders commented that it is too early to determine the extent to which Better at Home has moved toward achievement of its goals. While most believed that the program is on track to meet its goals, program leaders cautioned that any positive impact of Better at Home has been on a relatively small cohort of seniors to date. They questioned too whether Better at Home is actually servicing the people it targeted to serve. While many program

leaders believed that Better at Home has been effective or somewhat effective in reaching out to isolated and vulnerable seniors[25], others indicated that they did not know if this was the case.

When asked to comment on the top three achievements of Better at Home so far, provincial program leaders offered the following: successful engagement with local communities and First Nations, an established infrastructure to deliver non-medical supports to seniors, commitment to a strong learning environment, greater community awareness of seniors needs, effective internal and external communication practices, a provincial (versus pilot project) approach to Better at Home, volunteer recruitment, and capacity building at both the organizational and (non-profit) sector level. Some of the major lessons learned from Better at Home related to: the role of partnerships, the need for flexibility in program implementation, the importance of good communication practices and quality program personnel, the need to build on existing community resources, and the positive impact of political will and support.

Most Better at Home provincial program leaders believed that Better at Home is becoming a model for non-medical supports for seniors in BC, but a few believed it is too early to say. Similarly, program leaders believed that the program is making a contribution to knowledge with respect to providing non-medical supports to seniors, although some suggested that *"only time will really tell."* Looking ahead, the two most frequently reported risks facing Better at Home were (i) the uncertainty of sustained funding, and (ii) issues related to volunteers (especially recruitment and screening). Finally, secured funding, continuing volunteer recruitment and training, ongoing government commitment, and having a risk management plan in place were identified as requirements to sustain Better at Home into the future.

[25] Within the context of Better at Home, 'vulnerable' refers to seniors that are experiencing one or more of the following: live alone, are on low income, are 85 years or older, belong to an ethno-cultural community that may not be prevalent or well supported in BC. Better at Home does not target seniors who are vulnerable due to mental health challenges or severe health issues given that Better at Home is not a medically focused program.

PART C: DISCUSSION of EVALUATION FINDINGS

This section looks across all of the evaluation findings, compares and contrasts information gathered from the various stakeholder groups, and links the findings back to the core questions that framed this evaluation.

Context: *How does the context that surrounds Better at Home influence its implementation and outcomes?*

A response to this question considers evaluation findings regarding the broader environmental factors that influenced Better at Home. This evaluation showed that a number of conditions in the broader environment influenced the operations and advancement of Better at Home. The most influential factor that surfaced in this evaluation, across all stakeholder groups, was the existing economic climate in the province of BC, and related fiscal impacts within the non-profit sector.

At the program level, this evaluation uncovered an underlying concern within Better at Home communities about the lack of secured and ongoing funding to ensure the delivery of non-medical supports for seniors as part of Better at Home. Some trepidation existed among executive directors and program coordinators that Better at Home has created expectations among community groups and organizations, and community members, including seniors themselves, about the ability of the program to meet seniors' needs. Concerns rest upon the financial ability of Better at Home to support program coordinators and supporting staff, whose work load continues to increase; as well as the ability of the program to support or offer financial subsidies to those seniors who require it. All stakeholder groups believed funding uncertainty makes it difficult for Better at Home communities to continue their current course.

Moreover, executive directors and program coordinators believed uncertainty about fiscal security could yield negative impacts on the reputation of the lead organizations, as well as impact the trusting relationships which have been critical to the development of Better at Home and its ongoing implementation.

At an operational level, the broader economic climate has impacted the ability of Better at Home to recruit service providers (especially paid providers) across Better at Home communities. For example, some communities with economic prosperity experienced difficultly recruiting service providers at an affordable level, since they (the service providers) were accustomed to receiving higher levels of compensation, often in the private sector. In smaller communities, it was a matter of supply; these communities faced difficulty finding and hiring services providers, given the smaller "pool" of residents available to provide services in support of Better at Home.

The economic climate of the non-profit sector further sets the context for Better at Home. It was the view of executive directors and program coordinators that United Way's non-renewal of funding for some programs in the community (other than Better at Home) has led to apprehension at the community or local level. Some Better at Home communities feared that funding reductions in general

to other service organizations could lead to a greater demand for Better at Home services; and this, once again, could impact the ability of Better at Home to meet community and seniors' needs.

Moreover, some executive directors and program coordinators feared that funding cuts to community organizations could create an atmosphere of animosity between those programs that have been funded and those where fiscal capacity has been reduced. While articulated as part of this evaluation, the actual impact of funding reductions by the many different funders within the non-profit sector is difficult to assess, given that shifts in funding occur within the sector for various reasons and at various times, and given that they occurred as this Better at Home evaluation was underway.

Additionally, this evaluation revealed that the fiscal climate of health authorities could serve as a factor impacting Better at Home. Findings indicated that fiscal constraints, and a resultant reduction in some health authority services, could lead to an "off-loading of services" to Better at Home. To date however, there is no convincing evidence that service downloading has materialized to any significant degree. In fact, in some communities, the health authority and Better at Home are working together to refer clients to each other's services.

Many of the factors and conditions that characterize the broader context of Better at Home are not under the direct influence or control of the program. However, Better at Home can work to mitigate these risks by continuing to make a case for financial security, building on efforts to work collaboratively with other aspects of the non-profit sector (e.g., further service integration), and continuing to develop and reinforce partnerships within the non-profit sector. In addition, creating greater awareness about Better at Home and its positive impact on seniors, both provincially and at the community level, will help to stimulate and encourage community support and political will in favour of a secure, long lasting Better at Home program.

Implementation: *What are the characteristic features of the implementation of Better at Home, and how has the implementation approach influenced program achievements?*

Discussion related to the implementation of Better at Home rests on evaluation findings associated with program activities, inputs or resources that were dedicated to the program, deliverables, factors that facilitated and challenged implementation, and learnings to date. These topics are covered below.

Overall, this evaluation showed that Better at Home was implemented as originally conceived or planned. And in large part, program implementation adhered to the program's guiding principles which included: evidence-informed, consultative, responsive, bold and sustainable.

Activities that characterized the implementation of Better at Home were seen as central to the implementation process. Key among them were: the provision of resources early on; the implementation of a sliding fee scale, community engagement prior to program onset, provision of a basket of services by a mix of service providers (volunteers and paid staff/contractors), and the establishment of a local advisory committee. Of the key activities or practices that characterized program implementation, no particular activity/practice emerged that could be characterized as the "best" or "most valuable; rather, all core activities seemed to have a defining role in the implementation process.

While key activities were consistent across programs, each local Better at Home program approached implementation in a way that fit with the context of their own community as well as the needs of their lead organization and seniors. For example, some programs offered a variety of services (e.g. light housekeeping, transportation, friendly visits, snow shoveling, home repairs and grocery shopping), while others offered a few services (e.g. light housekeeping and transportation). And in some communities, the service providers largely constituted volunteers, while others used a mix of volunteers and paid staff/contractors. Still on this theme, some Better at Home programs provided ongoing volunteer training while others trained volunteers at program onset only.

Program implementation requires financial, material and human resources. This evaluation revealed mixed opinions regarding the sufficiency of financial resources, across the phases of program implementation. While some community developers found the level of resources dedicated to the community engagement process to be sufficient; others did not, and would have liked greater resources for salary and travel costs to support the process. In terms of program start-up, the level of financial resources appears to have been sufficient according to executive directors, program coordinators, and other community stakeholders. However, concerns were expressed by most stakeholder groups that funding levels may not suffice as requests for services increase over time; i.e., current funding levels would not be able to meet future demand for services. Levels of funding were also linked to the Better at Home sliding fee scale. This evaluation showed that the number of seniors who required some degree of subsidy for Better at Home services was relatively high; for example, in some communities there was a wait list for subsidized services. As such, Better at Home programs need to become adept at effectively managing the balance between subsidized and fully paid clients/services.

With respect to personnel or human resources, the technical support provided by United Way was judged by many at the local level as being supportive and helpful; particularly assistance provided by the field coordinators of the United Way's provincial Better at Home staff. However, a few Better at Home programs indicated that they would have liked a quicker response for support related to the operation of the program database; they reported waiting for technical assistance which held up program start-up.

This evaluation also showed that local Better at Home program coordinators are experiencing a heavy workload, and that any program growth or expansion would require a commensurate level of financial support for the program coordinator function. It is important to point out too that many Better at Home programs received in-kind support to plan and deliver the program. In-kind support took the form of time and expertise from the local advisory committee, unpaid staff time (program coordinators and program administration), lead organization personnel time, volunteer time and facility space, grants and donations.

Similarly, materials provided by United Way to support local Better at Home programs were generally found to be helpful; in particular the HUB, and the provincial meet-up. However, a few Better at Home programs expressed a need for more standardization of operating procedures, such as insurance requirements for service providers and program forms. In addition, some community developers indicated that there was a lack of clarity from Better at Home leadership regarding information and processes related to the community engagement process. This seemed to be more prevalent in those Better at Home communities that began their work earliest in the process.

Two other inputs or resources that characterized the implementation of Better at Home include the sliding fee scale and the community engagement process. This evaluation shows that the application of the sliding fee scale helped Better at Home operations by providing a consistent framework for the fee

structure; and the tool was relatively easy to implement at the local level. In addition, the sliding fee tool removed subjectivity (e.g. decisions were based on fact), was easily understood by seniors, and helped to eliminate the stigma of accepting charity for some seniors. This evaluation showed that utilization of the sliding fee scale enabled a greater number of seniors to access Better at Home services. In fact, several of the Better at Home programs reported adding a 50% category to the scale to enable a greater number of clients to receive subsidies. While some concern surfaced among a few program coordinators that clients could abuse or misuse the sliding fee scale, there was no evidence to support this fear.

Generally, the Better at Home community engagement process was viewed as being community-driven with broad representation by community stakeholders. This evaluation showed that the engagement process led to an increased awareness of the needs of seniors and the program, provided an opportunity for community members to give input into the direction of Better at Home, and generated support for the lead organization. However, in a few Better at Home communities, the community engagement process was perceived to be less community-driven, and appeared to create conflict in the community. Some Better at Home communities would have liked more time for the community engagement process to unfold to ensure that all diverse perspectives across the community were effectively heard.

Turning to core services, this evaluation showed that the program was delivering a varying number and type of services across Better at Home communities. Some communities are offering all seven services[26]; others are offering a few services, but plan to add additional services as the program expands or there is an expressed need for such services. Program records indicated that the most frequently utilized services were housekeeping and transportation; followed by yard work, friendly visits, and grocery shopping. A smaller number of clients were utilizing snow shoveling or minor home repair services.

The current mix of service providers delivering services for Better at Home, either paid staff/contractors or volunteers, seemed to be working well for most Better at Home programs according to most stakeholder groups. By and large, housekeeping, yard work and minor home repair services were provided by paid staff/contractors; and volunteers provided friendly visiting, transportation, grocery shopping and snow shoveling services (although a few communities used contractors/paid staff provide to deliver transportation services). This evaluation showed that while the use of volunteers to deliver program services reduced program costs and encouraged community involvement, it also showed that at times, managing volunteers is not without challenges. Although the volunteers appeared to be committed to their work with Better at Home, sometimes personal commitments (e.g. travel, family etc.) interfered with their availability to provide Better at Home services.

While seniors expressed a relatively high level of satisfaction with Better at Home services, some indicated a desire for additional hours for services (e.g. housekeeping 4 times a month versus 1 time). There were also a number of services that seniors wished they could have received, but were not available. These included: prescription medication pick-up, changes to transportation service (less advance notice, drives in the evening), dog walking, affordable housing, mental health supports, meal preparation, health care services, and assistance with heavier housekeeping tasks such as oven and window cleaning and laundry.

[26] Services include housekeeping, transportation, yard work, friendly visits, grocery shopping, snow shovelling, and minor home repairs.

A number of influencing factors impacted Better at Home, both in a helpful and challenging way. Certainly, the capacity of the lead organization – in terms of available infrastructure, readiness to implement the program, sound reputation in the non-profit sector, and well-established networks in the Better at Home community – contributed to the successful implementation of Better at Home. Skilled, passionate and committed local Better at Home program coordinators also seemed to play an important role; as did local advisory committees, comprised of community stakeholders who understood the characteristics of the community and the needs of local seniors.

Program implementation at both a provincial and local level was further supported by effective collaboration and sound partnerships between the Better at Home program and other community groups, organizations and individuals. Key groups at play included: senior-related organizations, Community Response Networks, health authorities, local governments, media, Divisions of Family Practice, recreation and parks, local United Way offices, and seniors themselves. In consideration of other potential partners who could contribute to implementation, local Better at Home programs identified: First Nation communities, Aboriginal groups, senior care facilities, Community Living, schools, Work BC, business community, volunteer services, Doctors of BC, Firefighters Union and BC Housing. Besides partnerships, other factors that influenced the implementation of Better at Home in a positive manner were: adequate number of volunteers for service provision; leadership from United Way, in particular the field coordinators of the United Way's provincial Better at Home staff; and funding and political support for Better at Home.

Conversely, this evaluation uncovered a number of factors that challenged the implementation of Better at Home. Most were linked to funding. As noted earlier, funding uncertainty could negatively impact relationships with key stakeholders and question the reputation of lead organizations, putting pressure on any forward implementation. Also noted earlier, while the funding for program start-up was judged to be sufficient by most, concern was also expressed that as awareness of the Better at Home grows, and more seniors seek services, there would be insufficient funds to provide those services. This problem would be further compounded by an increased need for subsidized services. Finally, concern was expressed over funding requirements related to staff time (coordinator and program administration) to support program growth.

Training volunteers represented another challenge to program implementation according to executive directors and coordinators. While most Better at Home programs reported having an adequate supply of volunteers to deliver services, they contended that training and preparing volunteers for service delivery is both time and labor intensive. And, there are often hidden costs to using volunteers to deliver services. Moreover, volunteers are not always as reliable as paid staff, and they require significant support in the form of providing recognition and regular communication and contact. The recruitment of new volunteers also proved to be difficult in some Better at Home communities, especially smaller communities, where competition for volunteers runs high.

Finally, this evaluation showed that program implementation was challenged by efforts to reach isolated and vulnerable seniors. While it appeared that some success was achieved, reaching isolated seniors proved to be difficult for local Better at Home programs. It often required working through a third party, such as a neighbor or organization that had some direct association with these seniors. In addition, once identified, the needs of isolated seniors can be quite complex, requiring special care and consideration by the Better at Home program. At an operational level, other challenges to the implementation of local Better at Home programs included the following: nurturing and maintaining positive partnerships within the non-profit sector; meeting the needs and expectations of clients (e.g. clients requesting more

services hours, requests for services not provided by Better at Home); and client relations, in particular, managing emotional ties between service providers and seniors.

Several learnings emerged from this evaluation of Better at Home. Not surprisingly, lessons learned across all stakeholder groups aligned with the factors that helped and challenged implementation. They also linked to suggestions regarding ways to improve implementation of Better at Home, which included the following: dedicate more time for the community engagement process; allow additional time for program planning, as well as for developing protocols and operational procedures prior to the commencement of services; enhance the communication function between all aspects of the program and between the program and seniors; ensure adequate and ongoing funding along the implementation continuum; adjust the funding formula to better reflect local community size and needs (including rural and remote communities); and partner with a diverse group of community groups and organizations, including the private sector, which may be able to play a role in program funding.

In summary, this Better at Home evaluation highlighted a number of key features of implementation - the capacity of the lead organization, the skill level of local program coordinators, the role of partnerships, funding considerations, the volunteer /paid service provider mix, the engagement of sector groups and organizations, etc. Taken together, this package of features that defined and characterized the implementation of the Better at Home program sets the stage for the next link in the program chain – the achievement of program aims and outcomes.

Outcomes: *What is the impact of Better at Home on those involved in its mission, and how are things different today as a result of Better at Home?*

A response to this question considers evaluation findings that speak to the effects of Better at Home on those who are involved with it, including: individuals, organizations, communities, and systems. This question also contemplates the role of Better at Home as a model for the provision of non-medical supports for seniors, as well as the program's role in knowledge development in the field.

This evaluation of Better at Home demonstrated that the program is having a positive impact on seniors. According to the seniors, Better at Home is contributing to a number of key quality of life indicators such as: helping seniors to remain living in their homes longer; making life easier for seniors overall; providing greater peace of mind; and helping seniors to manage activities of daily living. At this point in time, there is limited indication that Better at Home is helping seniors to do more in their community, expand their social activities, or enjoy life more.

Better at Home appears to have positively affected service providers as well. Most service providers believed the program was beneficial and rewarding to them personally, and indicated that they enjoyed working with seniors and wanted to "give back in this way" to their community.

Executive directors from Better at Home lead organizations also reported positive impacts from the Better at Home experience. These included: enhanced capacity to meet the needs of seniors in their community; increased ability to reach vulnerable seniors and isolated groups; increased awareness of the needs of seniors among staff in the organization (and how to best address those needs); stronger and greater number of community partnerships; greater awareness of the services provided by the lead organization among community members; and a feeling of satisfaction of being able to meet the needs of seniors. Executive directors, along with local Better at Home program coordinators also helped to

inform the various factors and conditions that both challenged and helped the delivery of non-medical services for seniors at the ground or grass-roots level. On the other hand, some executive directors/lead organizations suggested that Better at Home resulted in negative effects such as: increased workload, difficulty meeting the needs and expectations of seniors (e.g., providing the number of services), and negative sentiment toward them (the lead organization) due to non-renewal of United Way funding for some programs in the community (other than Better at Home).

This evaluation showed that Better at Home had an impact on the community as a whole by increasing the number of non-medical support services available for seniors; and by enhancing collaboration between key community stakeholders, which increased the potential for greater service integration across the non-profit sector. Better at Home also contributed to building a network of volunteers – volunteers who felt rewarded and expressed a sense of belonging to their community. Finally, Better at Home helped to create greater awareness about seniors' needs across the community at large. However, and as noted above, concern was expressed at the community level regarding setting high expectations for services, and not being able to meet those expectations, should program funding become jeopardized.

Although this evaluation uncovered some optimism with respect to model building, it is too early to be definitive about Better at Home becoming a model for non-medical supports for seniors in BC. It is the case however, that many of the program's defining features – creation of a local advisory committee, community-driven approach to implementation, creation of safety and security training and protocols[27] – are contributing to the successful implementation of Better at Home and achievement of its outcomes. As such, Better at Home is contributing to knowledge about the delivery of non-medical supports to seniors; and should continue to do so as the program matures and more fully integrates over time.

The impact and legacy of Better at Home over the longer term links to requirements for program sustainability. Certainly, an ongoing Better at Home program requires adequate and secure funding in line with continued government commitment. Other factors to support sustainability include: maintenance of partnerships and community support, volunteer commitment, risk management planning, and flexibility in program planning and implementation.

This Better at Home evaluation has yielded rich findings with respect to context, implementation, and outcomes of the program. It has also shed light on other areas of inquiry that could be pursued in the future. This includes questions related to: integration, social connectedness, lead organization selection and support, vulnerable seniors, and issues related to volunteer and paid service providers. Future research could also consider trend analysis such as how seniors needs and use of Better at Home services change over time.

[27] For example, training for Better at Home services providers and local program staff that relates to safety and security topics, and required criminal record checks for volunteers that provide Better at Home services to seniors.

PART D: CONSIDERATIONS for the FUTURE

Based on the information gathered and analyzed as part of this evaluation of Better at Home, a number of recommendations or considerations for the future can be suggested. Like the section above, future considerations are organized by the key program areas or domains examined through this evaluation, including context, implementation, and outcomes/impacts:

Future Considerations Related to Context:

1. The economic climate within which Better at Home operates impacts not only Better at Home, but groups and organizations (e.g. health authorities, non-profit seniors related groups) that collaborate with Better at Home to deliver services. *Better at Home needs to remain attentive with respect to the fiscal constraints faced by other groups and organizations at the community level, and assess how this will impact the delivery of Better at Home services on an ongoing basis.*

2. This evaluation suggested that linkage and integration between Better at Home and groups and organizations across the non-profit and health sectors has occurred to some extent. *Better at Home communities should be encouraged in their efforts to strengthen and build upon these linkages in order to further embed non-medical supports for seniors across Better at Home communities in BC.*

Future Considerations Related to Implementation:

3. Overall, the community engagement process that characterized Better at Home was well-designed and well-implemented; and, it achieved the goal of creating a community-driven approach to program implementation. However, in some instances the engagement process led to tension between potential lead organizations. *As more Better at Home programs come on board, special care should be taken to ensure that representatives of potential lead organizations participating in the community engagement process fully understand how the process works and believe it to be open and fair to all involved.*

4. This evaluation showed that the amount of time allowed for community engagement was not sufficient for some communities who would have preferred more time to build relationships and gather broader points of view. *Local Better at Home programs should be able to draw upon additional time for the community engagement process to ensure that meaningful consultation occurs and that diverse perspectives be heard.* This will lead to a stronger community foundation for Better at Home overall.

5. While the level of funding provided for Better at Home appeared to be sufficient for program start-up, it may not be sufficient as the program continues to mature over time. *The current funding formula for Better at Home should be examined and adjusted to align with fiscal requirements along the implementation chain (from early to later implementation). Additional*

consideration should be given to examine the sufficiency of funding to meet the diverse needs of rural/remote communities as contrasted to those in urban settings.

6. This evaluation suggested that some Better at Home communities felt rushed into service delivery; they did not have enough time to effectively establish and implement operational processes and procedures. *Ensure that sufficient time is available to allow communities to properly plan for implementation of the Better at Home program at the local level.*

7. While some early success reaching isolated and vulnerable seniors[28] has been realized, a parallel sentiment - that more should be done - also exists. *Efforts should be directed at identifying and applying strategies aimed at connecting with isolated and vulnerable seniors in Better at Home communities. Since this is a shared aim across Better at Home programs, the identification and servicing of isolated and vulnerable seniors could be highlighted as a topic for discussion (problem solving) at upcoming Better at Home provincial meetings and/or conference calls.*

8. The level of support required by local communities from United Way's provincial Better at Home staff varied by community (e.g. material & technical support). At the same time, all local Better at Home programs share similar requirements to support program implementation. *United Way's provincial Better at Home staff needs to remain cognisant of community capacity, and respond to each community with a tailored, commensurate level of support; they also need to develop and provide advice and support on global issues that are common to all Better at Home programs (e.g., risk management and insurance requirements).*

9. Service providers across Better at Home communities have strongly indicated that they plan to continue to provide services on behalf of Better at Home. They believed that Better at Home is beneficial to them personally (e.g., an opportunity to give back to the community) and to seniors too (e.g., enable them to remain in their homes). S*atisfaction among service providers should be monitored on a regular basis to ensure that they are continuing to view their contribution to Better at Home as beneficial, and thereby, reinforce current intentions to remain with the program.*

10. While the current mix of service providers delivering Better at Home services appeared to be working well (volunteers, contractors, and paid staff), some concern remains with respect to volunteer recruitment and retention and contractor availability and compensation. *Human resource planning for Better at Home needs to account for these factors. With support from United Way's provincial Better at Home staff, local Better at Home programs need to work to identify barriers and solve problems related to service provider recruitment and retention in a way that fits with the capacity and context of their own community. This will support human resource sustainability in the near and longer term.*

11. This evaluation demonstrated that overall, service providers for Better at Home were well-prepared to assume their responsibilities. *Therefore, current methods to prepare and train incoming service providers, such as orientations and job shadowing, should remain an ongoing component of the Better at Home program.*

[28] Within the context of Better at Home, 'vulnerable' refers to seniors that are experiencing one or more of the following: live alone, are on low income, are 85 years or older, belong to an ethno-cultural community that may not be prevalent or well supported in BC. Better at Home does not target seniors who are vulnerable due to mental health challenges or severe health issues given that Better at Home is not a medically focused program.

12. The workload to manage and support Better at Home at the community level is significant. Local Better at Home program coordinators and other administrative staff sometimes contribute extra time in unpaid hours. This trend could increase as the demand for Better at Home services increases. *Provisions must be made to ensure that the appropriate level of human resources is in place to support the program at the local level. This requires regular assessment of human resource requirements and appropriate alignment of personnel contribution (time) with financial compensation or reimbursement.*

13. Local lead organizations played an important role in the implementation of Better at Home; and this evaluation showed that key characteristics of lead organizations matter. These include: lead organizations' infrastructure and capacity, degree of existing network with other agencies, and reputation in the community. *Any identification of lead organizations for future Better at Home programs should consider these key features as part of the selection process so that the potential for the successful implementation of Better at Home is optimized.*

14. At an operational level, this evaluation showed that the Better at Home sliding fee scale was well-received, that it is easy to use, and that it has effectively guided the fee assessment process. Some Better at Home communities added a 50% category to the scale which enabled a greater number of seniors to participate in the program. *Continue with the sliding fee scale as a way to establish costs for Better at Home services. Consideration should be given to incorporating an additional category to the scale across Better at Home; recognizing that this action would put pressure on Better at Home budgets (more subsidies), and would also add to the workload of Better at Home administrative personnel.*

15. Sentiment existed across several stakeholder groups that participated in this evaluation for increased advertising and marketing of Better at Home. While greater awareness of the program is important to ensure that seniors and community agencies are aware of the program, any additional marketing needs to be weighed against the resultant increase in demand for services. *Those in charge of advertising and marketing of Better at Home should be mindful of this effect. As well, advertising and marketing of Better at Home should be targeted and delivered in a way that gets the message(s) to the intended audience(s) (e.g. isolated and vulnerable seniors).*

16. This evaluation showed that while Better at Home impacted the general activities of daily living among seniors, it did not have as great an impact with respect to encouraging seniors to do more in their community or expand their social activities. *If these outcomes remain important to Better at Home, greater effort should be directed at identifying and implementing strategies that encourage community and social engagement of seniors at the local level.*

17. Better at Home seniors identified a number of services, beyond those offered by Better at Home, that they would be interested in receiving. These included: meal preparation, assistance with heavier household tasks, mental health support, and assistance with home health issues. *While it may not be the role of Better at Home to respond to all requests for additional services, this provides an opportunity for the Better at Home leadership to engage with other groups and sectors to explore additional service needs for seniors (and related implications), and potentially work together to address those needs.* This would also support further service integration across the health and non-profit sectors.

18. Currently, Better at Home provides a few key opportunities for sharing lessons learned and challenges experienced among Better at Home communities. The HUB and provincial meetings are two examples, and both have been well-received by Better at Home personnel. *These learning mechanisms should be continued and could be augmented or expanded to maximize opportunities for information sharing and knowledge development related to the implementation of Better at Home*.

Future Considerations Related to Impact:

19. This evaluation generated evidence to suggest that the key components of Better at Home are working well. While it is too early to declare Better at Home as the preferred model for delivering non-medical supports to seniors; it is fair to say that the program is being delivered in support of this aim. *Efforts should continue to track the experience and outcomes of Better at Home so that it can continue to contribute to knowledge and theory-building in this field.*

20. Better at Home requires thoughtful and rigorous evaluation. As Better at Home continues to be implemented across the province, strategies should be in place to support planning and evaluation at the community and provincial level. This includes effective ways to capture key data elements that will allow for the ongoing assessment of the progress and impact of Better at Home, as well as the ability to adjust course if required along the way. In addition to supporting program improvements, evaluation provides data/information to generate questions for future research, as well as information to rationalize the continuation of Better at Home over the longer term. *As such, a strong evaluation framework and process should be developed and implemented to capture key learnings, challenges and opportunities, and movement on key indicators over time.*

21. Adequate and sustained funding is at the heart of program sustainability. Funding through government channels is central to the sustainability of Better at Home. *It is therefore recommended that efforts to secure government commitment continue both in terms of philosophical support for the program, as well as adequate and ongoing funding for Better at Home in the months and years ahead.*