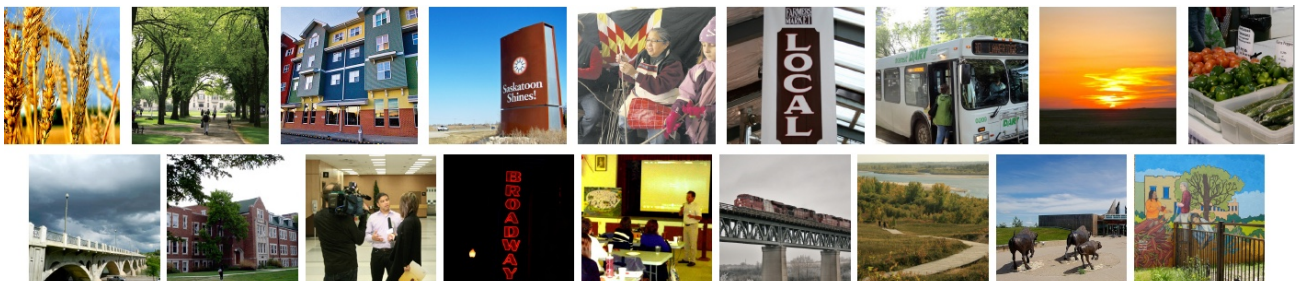




Prairie Hospice Society: Social Return on Investment Analysis Report

Anh Pham, Suresh S. Kalagnanam,
and Isobel M. Findlay



COMMUNITY-UNIVERSITY INSTITUTE FOR SOCIAL RESEARCH

Building Healthy, Sustainable Communities

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PRAIRIE HOSPICE SOCIETY: SOCIAL RETURN ON INVESTMENT ANALYSIS REPORT

ANH PHAM, SURESH S. KALAGNANAM,
AND ISOBEL M. FINDLAY



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We acknowledge with deep gratitude the Prairie Hospice Society staff who provided transportation and companionship to the interview participants and thank especially all the interview participants that took the time to share their experiences and stories with us. Their candour and commitment formed the foundation of the Prairie Hospice Society story and the development of the indicators and financial proxies to highlight the value of Prairie Hospice Society services.

EXECUTIVE SUMMARY

EVERYONE DESERVES TO DIE IN DIGNITY, TO RECEIVE THE RIGHT CARE in the right place. Increasingly, an educated population is demanding a say in what constitutes quality end-of-life care. If there are high emotional, physical, mental, psychological, and financial costs to dying, studies have demonstrated the cost-effectiveness of hospice palliative care. While it costs on average \$36,000 to die in a chronic care setting and up to 50% less in hospital-based palliative care, it costs \$16,000 to die at home. At a time when public and policy makers alike are concerned about the rising health costs of an aging population and the sustainability of the Canadian health-care system itself, it is especially important to document rigorously the potential costs and benefits of home-based hospice palliative supports that offer both quality of care and cost savings or cost avoidance, improving client and caregiver satisfaction, enhancing symptom control, reducing system pressures, and allowing for resources to be reallocated where most needed.

Prairie Hospice Society (PHS) is a non-profit community organization that is “committed to enhancing the quality of life of those facing advancing illness, death, and bereavement” and fulfilling its mission “to ensure access to quality end-of-life support in Saskatoon.” The organization helps individuals and caregivers cope with loss, uncertainty, and change through providing “client- and family-centred care to ... clients in the comfort of their own homes.” Volunteer training ensures “practical and emotional support through consistent relationship with individually matched clients.” The two major PHS programs are Hospice Without Walls — where clients are matched with a specific volunteer for regular visits — and Hospice Now to meet urgent and temporary non-medical supports, respite, and household-related services to clients, especially transportation. A third program, Bereavement Support, provides support to caregivers of deceased clients. PHS organizational sustainability is at the heart of its ability to continue to meet palliative needs in a continuous, caring, compassionate, and consistent way.

Against this background, this social return on investment (SROI) analysis includes qualitative, quantitative, and monetary summaries of information about the organization and its outcomes to capture impacts not typically valued in traditional metrics or measures of success. It is an important tool to assess the outcomes of organizational efforts, to communicate their successes and impacts, to manage their risks, and to support evidence-based decision making and optimal use of resources. In

situations where the focus is often on the cost of services delivered, SROI — credible, comparable, and broadly accepted — can highlight diverse values the delivery of those services represents for communities.

A review of existing PHS client and volunteer surveys, referral statistics, volunteer training evaluation, annual reports, and budget complemented 46 stakeholder interviews with board members, staff, volunteers, health-care providers, donors/funders, and clients and family members to value inputs, outputs, and outcomes of PHS. The feedback from clients and caregivers accessing the PHS services gives a deep understanding of the impact that PHS has made throughout the years. The following themes (and powerful testimony) emerged.

Enjoying Accessible, Compassionate Supportive Services

The services were accessible, representing no financial burden or other barrier to the client or family: “The one thing I can credit PHS for without hesitation is organization and ability to be accessible.” A volunteer’s therapeutic touch was so meaningful to a family member’s mother that it was a powerful means of reducing loneliness and discomfort:

Her ability to connect with [my mother] and her way of advising, explaining and certainly meeting the objective of eliminating some of that loneliness and quietness and discomfort around her illness. That is hugely valuable. That cannot be replaced....

For someone that is kind, caring, and could make that connection with her and visit with her in her familiar surroundings was a huge advantage.

Enjoying Voice and Choice, Dignity and Control

Voice and choice, as the literature suggests, prove powerful means of dying with dignity and maintaining control over one’s life and decision making. PHS services support families and clients that wish to die in the comfort of their homes. One family member explained:

We had many family and friends trying to convince us of the palliative care in the hospital, but we were so happy as a family to have him at home. We could visit him on our terms, and it meant the world to us and we would never let anyone take that away from us. Staying home with him until the end was just our decision from day one and PHS supported us and gave us some idea of what to expect.

Improving Pain and Symptom Management

In addition to offering choice and control, volunteer companionship has been able to relieve many people of the pain of loneliness and isolation and improve pain and symptom management:

A lot of our clients, what we’ve noticed that when they are in pain, a lot of the pain

isn't physical. It is pain of loneliness or pain because they want to see somebody. So, if they have a continuous visitor from PHS that they can rely on, it provides healing.

While the 2020 COVID pandemic has added to fears of hospital visits, acute care, or long-term care options, volunteer support via at least weekly contacts has continued to help clients manage.

Securing Peace of Mind

Confidentiality and knowledge of what to expect of end-of-life care and how to navigate the health-care system and community supports were assured:

The most valuable thing for my dad was building that friendship that would not judge his illness and there was no pressure. They were kind and became a friend. He grew to trust through that relationship. Especially on the end-of-life journey this is challenging for them to expect. In terms of our family, it was the combination of having someone that was a companion, friend to my father as well as the opportunity for PHS to identify some of the extra needs. Things like supplements and coming to check up on him regularly gave peace of mind to the family.

Filling a Medical System Gap and Helping Navigate the Health-Care System

The continuity of care, companionship, resources, and assistance in navigating the health-care system supports and supplements the medical system. The PHS staff and volunteers become “part of the family and is truly a family-centred care service”:

I can't imagine what it would be like to go through this without PHS because they filled in this huge gap and I can't even describe how big that gap is. No matter how strong of a network of friends you have, there is ... a lack of understanding on the process of death and dying. Everyone is trying to be helpful, but they don't have an understanding of what is happening to the family. Without PHS, I don't know if we would have been able to keep my husband at home.

Enjoying Relationships with Well-Trained / Well-Matched Volunteers

Many mentioned the quality of PHS volunteers, many of whom had worked in the health-care field or had been caregivers receiving PHS services.

A volunteer is someone that is outside the family and friend circle, someone with no baggage and clients report being able to talk to their volunteers about their feelings that they feel they can't directly share with family members. It's a friend who understands.

Securing Reliable and Emotionally Supportive Transportation

Transportation is a service that provides more than just the convenience of getting a client to and from an appointment or grocery store: it relieves a lot of stress and improves health:

It certainly was less stressful for me and my daughter. She didn't have to worry about how she was going to get to an appointment. It wasn't a second worry anymore. You had to worry about your chemo and then worry about a ride. That is an extra stress and it affects your health.

Benefitting from Care for the Family, Respite and Bereavement Services

Caregiver burnout is one reason that the Client Patient Access Service (CPAS) connects PHS to provide respite, emotional support, and comfort to the family:

What PHS allowed us to do was to continue on with our day-to-day lives and that's what my father wanted. He did not want to be a burden and he always felt guilty when we went out of our way to help him. We have work, families, children, and other obligations, responsibilities. PHS lightened that load and gave us the ability for our family to accomplish our day-to-day activities. They made it easier for us to have some normalcy knowing that we were going to lose a big part of our family.

Functioning Without PHS Services

Without PHS services, other options, according to all stakeholders, heavily depended on the individual, but some would have to manage their terminal illness on their own, rely more heavily on family, friends, and faith communities, hire more private services, or rely on or overuse medical services or long-term care. As many as half would have to turn to acute care options.

Impact Map

An impact map highlights intended changes, inputs, outputs, and outcomes of PHS services. Financial proxies are created for outcomes to aid in calculating the impact of the organization, taking into account what would or could have happened, the contribution of others, and the length of time the outcomes last.

Calculation of the SROI Ratio

The calculation below divides the discounted value of outcomes by the total investment. This SROI range assumes an extremely conservative measure of impact and also takes into account other alternative proxies and values. Below are the lower and upper range of the SROI ratio.

Lower Range

$$\text{SROI ratio} = \frac{\text{present value}}{\text{value of inputs}}$$

$$\text{SROI ratio} = \frac{\$926,555}{\$267,440}$$

$$\text{SROI ratio} = 3.46$$

Upper Range

$$\text{SROI ratio} = \frac{\text{present value}}{\text{value of inputs}}$$

$$\text{SROI ratio} = \frac{\$3,122,886.31}{\$267,440}$$

$$\text{SROI ratio} = 11.68$$

With these considerations and discounts, the social value range of PHS is 3.46 – 11.68. In other words, for every dollar PHS spends in providing the services to clients, there is a \$3.46 to \$11.68 social return on their investment.

INTRODUCTION

EVERYONE DESERVES TO DIE IN DIGNITY, TO RECEIVE THE RIGHT CARE in the right place. Increasingly, an educated population is demanding a say in what constitutes quality end-of-life care, a delicate process at a difficult time emotionally, physically, mentally, spiritually, and financially for the clients and their families facing the final stages of a terminal illness. If there are high emotional and other costs to dying, studies have demonstrated the cost-effectiveness of hospice palliative care defined by the Canadian Hospice Palliative Care Association (CHPCA) (2012) as a “combination of active and compassionate therapies intended to comfort and support persons and families who are living with, or dying from, a progressive life-limiting illness, or are bereaved” (p. 9). While it costs on average \$36,000 to die in a chronic care setting and up to 50% less in hospital-based palliative care, it costs \$16,000 to die at home (Canadian Hospice Palliative Care Association [CHPCA], 2012). At a time when public and policy makers alike are concerned about the rising health costs of an aging population and the sustainability of the Canadian health-care system itself, it is especially important to document rigorously the potential costs and benefits of home-based hospice palliative supports that offer both quality of care and cost savings or cost avoidance, improving client and caregiver satisfaction, enhancing symptom control, reducing system pressures, and allowing for resources to be reallocated where most needed (CHPCA, 2012).

Prairie Hospice Society (PHS) is a non-profit community organization that is “committed to enhancing the quality of life of those facing advancing illness, death, and bereavement” and fulfilling its mission “to ensure access to quality end-of-life support in Saskatoon.” The organization works to help individuals and caregivers cope with loss, uncertainty, and change through providing “compassionate non-medical client- and family-centred care to ... clients in the comfort of their own homes.” Volunteer training ensures “practical and emotional support through consistent relationship with individually matched clients” (PHS, 2020). The two major PHS programs are Hospice Without Walls — where clients are matched with a specific volunteer for regular visits — and Hospice Now, which is intended to meet urgent and temporary non-medical supports, respite, and household-related services to clients, especially transportation. Most Hospice Now clients are served through driving clients to appointments or providing respite to caregivers. A third program, Bereavement Support, was developed in 2019 to provide support to caregivers of deceased clients. About 20% of

PHS clients are those living alone, don't have family in the city, are estranged from their families or friends, or their community is unsure of what to do and have withdrawn from the person with a terminal illness. PHS provides a service that addresses a population with many physical and emotional barriers and rapidly changing care needs. Like all community-based organizations, PHS faces ongoing funding needs and challenges since its establishment in 2013, although it is important to note that the 2018–2019 annual report continues to register a healthy financial picture. Still, funding and organizational sustainability is at the heart of PHS ability to continue to meet the needs of the palliative community in a continuous, caring, compassionate, and consistent way.

Report Purpose

Against this background, this social return on investment (SROI) analysis builds on findings from previous Community-University Institute for Social Research (CUISR) reports on SROI and the use of financial proxies (Kalagnanam, Berthe & Findlay, 2019; Waikar, Kalagnanam & Findlay, 2013) to determine monetary values associated with social, environmental, and other impacts of the services provided by PHS. The SROI includes a combination of qualitative, quantitative, and monetary summaries of information about the organization and its outcomes. Information provided through this SROI can guide future decision-making and reflect the needs of diverse PHS stakeholders and communities in Saskatchewan.

The SROI methodology is a principles-based approach that assigns monetary value to social, environmental, and other impacts that are not typically valued in traditional metrics or measures of success. It gives organizations, institutions, and communities an important tool to assess the outcomes of their efforts, to communicate their successes and impacts, to manage their risks, and to support evidence-based decision making and optimal use of resources. In situations where the focus is often on the cost of services delivered by institutions or organizations, SROI can highlight diverse values the delivery of those services represents for communities. To the extent possible, SROI uses financial proxies to calculate social and other impacts. As such the SROI methodology represents a credible, comparable, and broadly accepted social impact measurement approach that can be valuable for the organization's sustainable growth. Decision makers recognize the value of people and communities, but it is difficult to translate these values into language that is understood and usable. Unfortunately, this may lead to undervaluing and subsequently underinvesting in social and other resources.

This report includes a literature review and elaborates on the methodology before explaining the findings and conclusions of the SROI analysis of PHS.

LITERATURE REVIEW

OUT OF THE 270,000 CANADIANS WHO DIE EACH YEAR, 90% DIE OF CHRONIC illness, such as cancer, heart disease, organ failure, dementia or frailty (Statistics Canada, 2018). According to the population projections published by Statistics Canada (2019), the Canadian population is undergoing major changes that are likely to have serious, long-lasting effects on society. The aging of baby-boomers “will have many repercussions as this cohort reaches the ages that generally separate working life from retirement.” Statistics Canada (2019) projects that by 2026 the number of deaths will increase to 330,000 and to 425,000 by 2036 — adding to the challenges of a health system facing increased costs of care (30% of the Medicare budget in the US, for instance) for the last year of life; a Saskatchewan study reported an increase in health-care system costs from \$1,373 12 months before death to \$7,030 for the last 30 days, but significantly lower costs for palliative care patients even in the last 30 days (CHPCA, 2012; Hollander, 2009). The challenges to the health system are exacerbated by other demographic trends including smaller family size and family members living in widely dispersed regions (Health Canada, 2018).

Despite many Canadians wishing to die at home, 60% die in hospitals (Statistics Canada, 2018), which represent 70% of the cost of terminal illness (CHPCA, 2012). The Canadian Institute for Health Information (2018) reports that out of the 75% of Canadians that would prefer to die at home, only 15% are able to access palliative home care services that result in patients being 2.5 times as likely to die at home and not use emergency or intensive care. Health Canada’s (2018) *Framework on Palliative Care in Canada* was designed to address issues of access and person-centred care and provide guiding principles, including respect for diversity and equitable access, to support the vision for palliative care in Canada. The Alberta Health Services (2014) *Palliative and End of Life Care: Alberta Provincial Framework* was similarly developed to address the express wishes of 86% of Albertans who would choose to die at home, while only 15% are enabled to do so. The evidence-based Alberta Framework aims to reach “a level of equity that provides choice, dignity, and care supports for patients and their families, clinicians, and care providers, under a patient-centred model” (p. 3). The framework based on four values — autonomy, self-actualization, dignity, and community (p. 8) — aims to reduce the burdens on individuals and families as well as the acute care system. Success measures include 14 system outcomes, including decreased use of emergency

department within 30, 60, and 90 days of death; decreased stays in or death in acute care; decreased interventions; and increased supports for patients and caregivers in setting of their choice. In addition to seven access measures, two policy, four education and resources, the framework has six patient outcomes (increased pain and symptom management, patient and family satisfaction, death in setting of choice, death at home, reduced adverse events and complaints) and four fiscal outcomes: decreased costs of care within last 90 days, funds raised, decreased costs to system in last year of life, and costs avoided (Alberta Health Services, 2014, p. 36)

Palliative care is an approach that aims to reduce suffering and to improve the quality of life for those living with a life-limiting illness (World Health Organization, 2020). Palliative care is holistic, addressing the physical, psychosocial, spiritual, and practical concerns of the person and their family, where an interprofessional team takes action in supporting the person's full range of concerns. It "places the person receiving care, and their family, at the centre of decision making. It places their values and wishes at the forefront of treatment considerations" (Health Canada, 2018, p. 4). In Saskatchewan, palliative care refers to an interdisciplinary service that provides active, compassionate care to the terminally ill at home, in hospital, or in other care facilities. According to Health Canada (2018), Saskatchewan had only four full-time palliative care physicians in the province, but general practitioners also provide palliative care services in consultation with palliative care physicians and experts. In 2018–2019, \$2.42 million was committed from the province to continue improvements and increase access to palliative care service throughout Saskatchewan. Together with federal funding of \$16.9 million, this investment "will work to increase the health system's capacity to provide palliative care services, such as pain/symptom management, and result in better support to people wishing to die at home, or in another facility of their choice, rather than in an acute care facility (Health Canada, 2018).

CHPCA (2012) makes the economic case for hospice palliative care. The cost of dying in Canada ranges from \$30,000 to \$40,000 for someone with a terminal illness, depending on both the cause and location of death. While most of the costs are paid by the health-care system, it is important to note that clients and their families experience out-of-pocket costs and share the caregiving role. Indeed, CHPCA (2012) highlights the burden on family caregivers who can carry more than two-thirds of the \$25,000 monthly cost of home-based palliative care in lost wages and leisure and out-of-pocket expenses. Reducing these costs to the health-care system could relieve pressure on health-care resources and reduce end-of-life care costs.

Hospice palliative care also proves to improve patient care with increased patient and caregiver satisfaction, better symptom control, and greater likelihood of the person dying in their preferred place (de Graaf, Zweers, Valkenburg, Uyttewaal, & Teunissen, 2016; CHPCA, 2012; Kleinpell, Vasilevskis, Fogg, & Ely, 2019). Early integration of palliative care, including palliative home care, is

associated with greater patient satisfaction, pain and symptom management, better emotional and psychological support, along with decreased hospitalization and interventions (Canadian Partnership against Cancer, 2017). A Canadian study led by Foreman, Kekewich, Landry, & Curran (2015) assessing the impact of palliative care consultations on resource use in the final 48 to 72 hours of life at an acute care hospital in Ontario found significant cost savings for medical imaging, laboratory, pharmaceutical, and other health costs. The earlier the consultation after admission, the greater was the cost saving to the health system.

Studies by Block, Casarett, Spence, Gozalo, Connor, & Teno (2010) examined the association between direct volunteer hours and quality of hospice care and found that there was a positive association between volunteer use in hospice settings and quality end-of-life care ratings by family members. Having hospice palliative care provided by volunteers in the community is both rewarding for clients, families, and the volunteers themselves and is a very cost-effective strategy for providing care. A study by Candy, France, Low, and Sampson (2015) similarly found that involving volunteers in the provision of palliative care significantly increased the client and family satisfaction ratings of care provided.

Studies in Canada and Europe offer some divergent data on the cost-effectiveness of home-based hospice palliative care. One Ontario study estimated a cost saving of \$9 million if 10% of end-of-life patients were transferred from acute care to home care, while a pilot study found increased costs (CHPCA, 2012). A comprehensive literature review on the cost effectiveness of palliative care internationally by Smith, Brick, O'Hara, & Normand (2014) found studies of variable quality but also statistically significant cost savings relative to comparator groups — adding to findings of care benefits in database systematic reviews of home palliative care by Gomes, Calanzani, Curiale, McCrone, & Higginson (2013), for example. Gomes et al. found that client, family, and health system burdens were all reduced although they concluded that more study is needed on cost-effectiveness. In the US, only one study failed to demonstrate cost savings while another reported \$2 in health-care savings for every \$1 spent on hospice palliative home care, which is also responsive to expressed wishes of patients. Voice, choice, and satisfaction remain important metrics. Hospice palliative home care may also relieve a long-term care crisis in Canada (CHPCA, 2012) — that has been magnified in the context of the 2020 COVID-19 pandemic.

METHODS

Ethics Approval

THIS STUDY WAS APPROVED ON JANUARY 23, 2020, BY THE UNIVERSITY of Saskatchewan Behavioural Research Ethics Board (Beh-REB #1685), which is constituted and operates in accordance with the current version of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS-2 2018). Research was conducted in adherence with all standards required under institutional Tri-Council behavioural ethics practices. Respondents were informed prior to their participation in the study of the purpose and design of the research, their right to withdraw at any time, and ability to provide input to the final document. Participants could opt in or out of having their contributions recorded and had the option to review transcripts in order to verify the ideas presented, introduce additional commentary, or correct any errors or omissions.

Important topics were probed deeply through in-depth face-to-face interviews at Preston Park II Residence (or telephone interviews where participants chose) with key informants representing diverse stakeholder groups (including clients and families, volunteers, board members, staff, health-care providers, and donors). If participants agreed, interviews were recorded and transcribed by the CUISR research assistant. Interviews lasted up to an hour and the findings identify inputs, outputs, and outcomes for each stakeholder group to develop indicators relevant to outcomes measurement and hence the financial proxies needed to calculate the social return. Existing data including PHS client/volunteer surveys, referral statistics, volunteer training evaluation, annual report, and budget were reviewed with the organization's permission.

Participant Recruitment

A variety of stakeholders broadly represented the people who contribute to and benefit from PHS so that the study could indicate the social value of the program. Altogether there were 46 participants in the study, which included 26 clients and family members, six volunteers, five health-care providers, four board members, four donors, and one staff member. To be eligible for the study, participants had to be 18 years of age or older; have direct experience of volunteering or working with PHS; or

be family members and clients that have used its services, government or other funders, or policy professionals. The criteria for participation excluded children and non-English speakers. The PHS team helped identify key stakeholders for this project and also helped with the recruitment process. An initial email from PHS with the study recruitment script was sent to appropriate potential participants who were invited to contact the researcher to confirm participation. The participants were then contacted via email or phone by the researcher to schedule an interview. There was no relationship between the researcher and participants and no compensation was offered. Consent, which was explained by the research assistant, was obtained in person at the time of the interview, or via telephone. The right to withdraw was indicated in the recruitment document and consent form. See Appendix A for the consent form.

Data Collection and Data Storage

Consent forms and participant contact information are stored in a locked office at Community-University Institute for Social Research (CUISR), University of Saskatchewan. Contact information has been coded and stored separately from the data collection. Participants were assigned a code number and the coding sheet is stored securely and separately from the data. Interviews were audio recorded and the digital recordings will be retained for five years. Transcriptions are de-identified. As a result of the relatively small sample of stakeholders at Prairie Hospice Society, collected information may reasonably be expected to identify an individual. Participants therefore had the opportunity to review the transcript and remove anything they felt uncomfortable with sharing.

Audio recordings and data are stored in locked files on a password protected computer. Files and recordings will be safely stored for up to five years after the project is completed. The files will then be destroyed when the data are no longer needed. Reports include no identifying information or names of research participants. The consent forms and contact master list will be kept separate from the research data.

Risks

There were no anticipated harms from participation, but questions could elicit feelings of distress, anxiety, or sadness due to talking about experiences volunteering, working, or using services with PHS. Since participating in the study was voluntary and participants were free to withdraw at any time without penalty and answer only those questions with which they were comfortable, it was assumed that they were open to discussing questions. If any signs of distress were evident, opportunities to stop participating were offered. If anyone expressed distress, they were free to withdraw from the study; we were also able to refer them to counselling services arranged through PHS.

Benefits

Participants often experience appreciation for the opportunity to be heard through a research study. Participants benefit directly by being able to tell their story and to help contribute to the sustainability of PHS. The research will also give the PHS comprehensive evaluative information that they can use to show funders their diverse values and social impacts and thus strengthen organizational sustainability.

Limitations

A limitation of this study method is related to the assumptions that are made about the change that has been made and the extent to which outcomes are attributed to the program activities. This limitation has been addressed through presenting alternative calculations to inflate or deflate the outcomes. Although changes cannot be fully attributed to the program activities, it assesses whether clients are experiencing changes. Another limitation of this study is the possibility of response bias (also known as survey bias), which is the tendency of individuals in self-reported data to respond to questions in ways that reflect well on their behaviours or provide responses that are socially acceptable (Furnham, 1986).

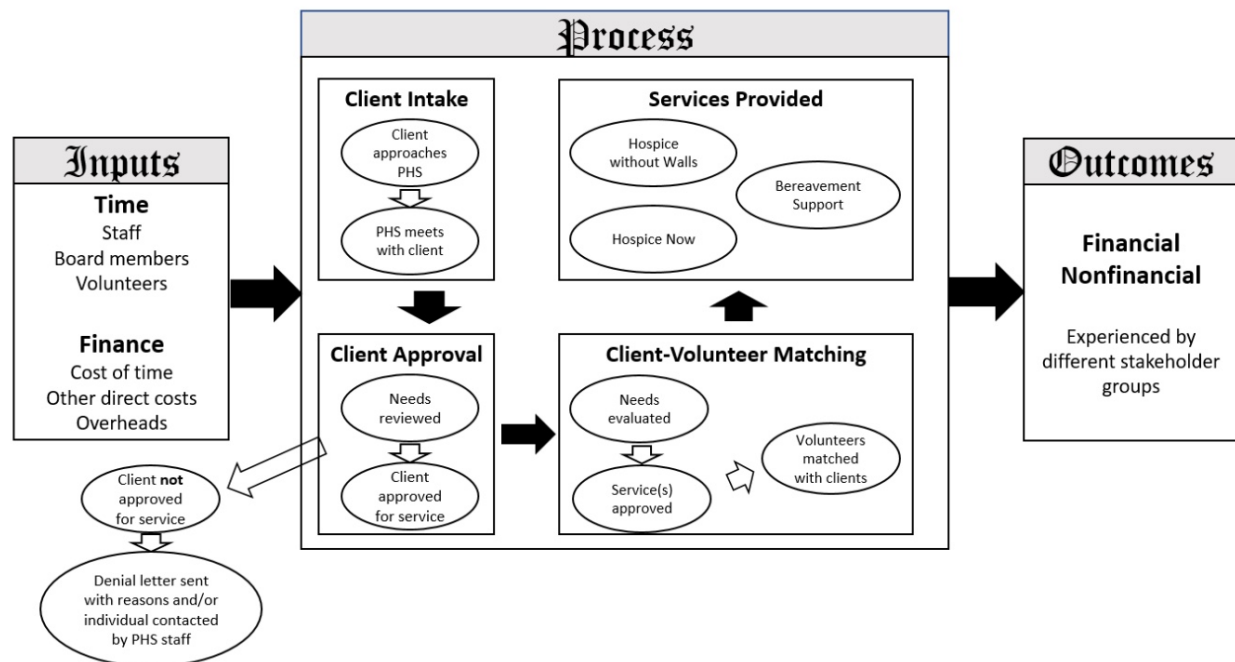
FINDINGS AND DISCUSSION

Stakeholder Analysis

PHS BOARD AND STAFF HELPED IDENTIFY STAKEHOLDERS. IDENTIFYING stakeholders assists in understanding the services provided (activities/changes), involvement of main stakeholders in the organization (inputs), quantitative number of activities (outputs), and discovering the outcomes for each group (see Figure 1, below, for the PHS Inputs, Process, and Outcomes).

- Clients — terminally ill clients who are accessing the PHS services that provide for their practical, emotional, and compassionate needs
- Family members and caregivers — those supporting clients who are terminally ill or are accessing respite services from PHS. Family members also receive bereavement support from PHS for up to a year after their loved one has passed away.
- Trained volunteers — providing compassionate and caring support to clients and their families through companionship, transportation, practical and emotional assistance, and support in navigating the health-care system.
- PHS board members — governance for the organization, fundraising, volunteering, and advocating for PHS.
- Staff volunteer coordinators — two volunteer coordinators who play a crucial role in meeting with potential clients, meeting volunteers, and making suitable matches between volunteers and clients.
- Donors (including fundraising committee members) — providing financial sources for PHS's operational budget.
- Palliative health-care team (Client Patient Access Service [CPAS], Palliative Nursing, Palliative Home Care) — those directly involved in referring clients to PHS, those providing care and having interactions with volunteers with PHS.
- Saskatoon Cancer Centre — Many clients are receiving medical care from the Cancer Centre and access PHS transportation or other services. The Cancer Centre refers clients to PHS.
- Medical Assistance in Death (MAID) Team — Clients requesting MAID can work together with the team to accomplish the client's end-of-life wishes at home. PHS takes a neutral stance and supports client's needs such as MAID.
- Saskatchewan Health Authority — trusting PHS and promoting their services to clients accessing palliative medical care services.

Figure 1. PHS Inputs, Process, and Outcomes



Data Sources

Record Review

A review of existing PHS records and evaluations was completed. Sources such as client surveys, volunteer surveys, referral statistics, volunteer training evaluation, annual reports, and the budget were analyzed to value inputs, outputs, and outcomes of PHS.

The client satisfaction surveys conducted in 2014, 2016, and 2017 all had excellent ratings for the overall quality of service of volunteers and staff. Altogether the highest rates of satisfaction of volunteers highlighted their courtesy, helpfulness, attentiveness, knowledge, respectfulness, flexibility, and ability to meet needs. There were two surveys conducted in 2015 and two in 2017 to understand satisfaction with the volunteer experience. The two 2017 surveys, involving 40 participants altogether, reported that 89% of the volunteers wanted to meet with other volunteers for support and networking. When asked why volunteers left the program, 27% had to leave because they moved, 16% found the work unsuitable, and 16% said their situation changed and could no longer volunteer. Sixty-six percent of volunteers reported 3–4 hours weekly was a manageable amount of hospice care and 21% found 1–2 hours more reasonable. Volunteer training course evaluations have been completed annually since 2014. In the most recent training course evaluation, 10 respondents rated as most helpful coverage of loss, grief and bereavement. The volunteers found the most informative information was about culture, diversity, and spirituality.

Statistical information included total number of 4,740 volunteer hours logged, an estimated 900 hours of time spent yearly doing board member tasks, 805 volunteer training hours, about 35 volunteers trained yearly, 355 rides given to clients, 39 hours of respite care, 42 family members receiving bereavement care. Avoidance costs and costs saved to the health-care system were discussed with the PHS team who concluded that PHS volunteers may have assisted in avoidance of both ER visits and inpatient hospital days. These conclusions were based on conversations and consultations with clients, families, volunteers and health-care providers. PHS volunteers may have assisted in avoidance of both ER visits and the hospital visits by 1) providing reassurance through spending time calming and relieving the anxiety of caregivers and clients who might otherwise have opted for a trip to the ER, and/or 2) aiding the family in getting resources to access more professional community help (e.g., when care needs change or become more serious the volunteer calls home care to request more assistance for the family, ask for reassessment of needs to gain more help, or request certain supplies such as catheters, dressings, etc. that the family may not have confidence to request themselves). It was estimated that approximately 20% of all their clients might have visited the ER if the volunteers were not able to provide support and resources. Also 20% of clients may have returned to hospital and been admitted for a stay or end-of-life care if a PHS volunteer had not assisted in mitigating problems to enable them to stay at home longer. It is difficult to assess how many days' costs were avoided for each client.

Interviews

The research assistant conducted stakeholder interviews with board members, staff, volunteers, health-care providers, donors/funders, and clients and family members. Forty-six in-depth interviews (Table 1) provided stories, knowledge of, and insight into the impacts and outcomes of PHS services. Interview guides for each stakeholder group are included in Appendix B.

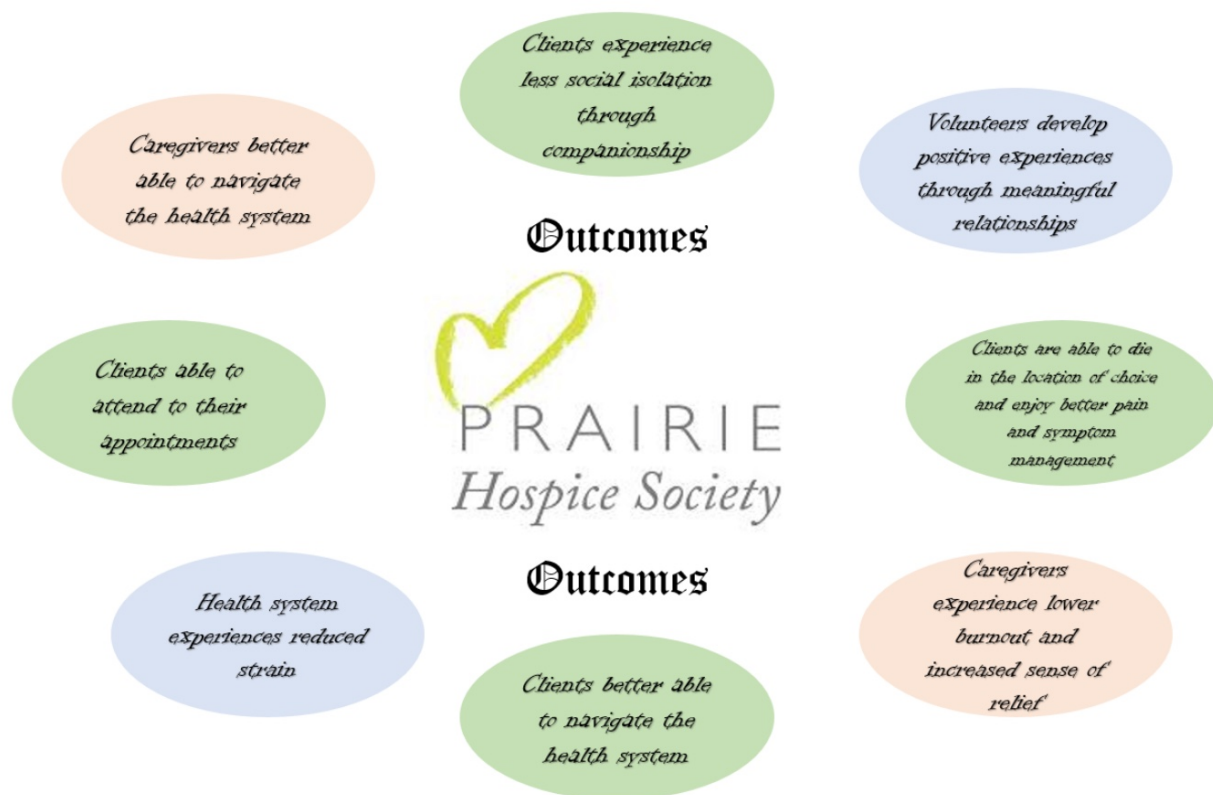
Table 1: Number of Stakeholder Interviews

Stakeholders	Number of Interviews
Client and family members	26
Volunteers	6
Health-care providers	5
Board members	4
Donors	4
Staff	1
Total	46

Qualitative Data Analysis

Interviews helped to determine the impacts of PHS services. Data from the interviews were analyzed and categorized for thematic analysis. Supervised by the co-principal investigators, the research assistant coded the transcriptions, which would identify data that were interesting and relevant to the SROI analysis. Codes were then sorted into themes used to understand the impacts of PHS. See Figure 2 for a summary of PHS Outcomes.

Figure 2. PHS Outcomes



Enjoying Accessible, Compassionate Supportive Services

The stakeholder perspectives on PHS services gave an understanding of the quality and impacts of the services to the community. The services were accessible, representing no financial burden or other barrier to the client or family, as confirmed by a family member:

The one thing I can credit PHS for without hesitation is organization and ability to be accessible. If someone reached out to call, they would always return the calls with whatever extra support or more information that we needed. What I found to be really important was to have to reschedule appointments. They were always diligent on getting back to us and very understanding and supportive.

Wait times for their services were very short and everyone reported having services within two weeks of meeting the PHS volunteer coordinators. It was mentioned multiple times that staff and volunteers were very friendly and compassionate people.

A family member mentioned that the volunteer's therapeutic touch was so meaningful to her mother while she was at home and in the hospital:

Her ability to connect with [my mother] and her way of advising, explaining and certainly meeting the objective of eliminating some of that loneliness and quietness and discomfort around her illness. That is hugely valuable. That cannot be replaced.

It was something that was very simple and it was a non-medical intervention, but [volunteer] visited her at the hospital and applied lotion to her hands, feet, and lower legs. It's not something I would think of personally, but for [volunteer] it was just that sense of being touched in a consoling, kind, and concerned way. [My mother] mentioned, "[Volunteer's name] even put lotion on my feet." Nothing was too much for her and the idea that if it provided some sort of relief or comfort it would be a priority to provide that for [my mother]. It was so amazing, and the details were so noticeable to [my mother]. Even though she was struggling she recognized that it changed the way she felt.

Enjoying Voice and Choice, Dignity and Control

If access and compassion are invaluable indicators of quality of care, voice and choice, as the literature suggests, prove powerful means of dying with dignity and maintaining control over one's life and decision making. PHS services support families and clients that wish to die in the comfort of their homes. One family member explained what the PHS services meant in that regard:

We had many family and friends trying to convince us of the palliative care in the hospital, but we were so happy as a family to have him at home. We could visit him on our terms, and it meant the world to us and we would never let anyone take that away from us. Staying home with him until the end was just our decision from day one and PHS supported us and gave us some idea of what to expect.

A caregiver stated that "[PHS] made it possible for me and my family to keep my husband at home to his end and this would have been his hope and desire. For us, it was incredibly empowering we had more strength to cope with the loss because of the way we were able to manage those last days."

Such was the impact of one volunteer on a client, according to his caregiver, that he could truly be himself:

He gained a friend who would understand his current journey, which is difficult for close family and friends to be there because they feel uncomfortable and don't know what to say or they are so devastated that they are not able to help with the normal everyday things in life. It gave him the opportunity to be himself and had the extra support and care.

Another caregiver spoke to the enormous benefits of her mother being able "to stay in the comfort of her home":

I'm sure it could be offered in some other way, but for [my mother] to stay in the comfort of her home where her life is unsettling enough. For someone that is kind, caring and could make that connection with her and visit with her in her familiar surroundings was a huge advantage.

It was mentioned multiple times that PHS allowed clients to stay independent of the health-care system longer and families were able to have peace of mind.

Improving Pain and Symptom Management

In addition to offering choice and control, volunteer companionship has been able to relieve many people of the pain of loneliness and isolation and improve pain and symptom management:

A lot of our clients, what we've noticed that when they are in pain, a lot of the pain isn't physical. It is pain of loneliness or pain because they want to see somebody. So, if they have a continuous visitor from PHS that they can rely on, it provides healing.

While the 2020 COVID pandemic has added to fears of hospital visits or acute care interventions, volunteer support has continued to help clients manage:

Probably half our people that are matched would normally be accessing acute care, whereas right now they are willingly staying at home (because of COVID-19) and using us as a medium to access help if they need it or use our skills to find out if there are other services we could help them with.

Securing Peace of Mind

Client and family members could count on confidentiality and information shared to help them understand what to expect in regard to end-of-life care, how to navigate the health-care system, and where to find other community supports and services. When asked about one of the most valuable services, two family members responded:

What I appreciated about PHS was the information given. No one wants to be questioning what's going on when they are already questioning why a family member has such a terrible disease. PHS was able to give two things: peace of mind and [help navigating] the medical system to keep us informed about next steps.

The most valuable thing for my dad was building that friendship that would not judge his illness and there was no pressure. They were kind and became a friend. He grew to trust through that relationship. Especially on the end-of-life journey this is challenging for them to expect. In terms of our family, it was the combination of having someone that was a companion, friend to my father as well as the opportunity for PHS to identify some of the extra needs. Things like supplements and coming to check up on him regularly gave peace of mind to the family.

A family member noted:

In a larger sense, PHS offering a service that is not available from any other medical service can be documented and the significance of how it provides support for a patient/client during a difficult time is critical within a family and not everyone has that available to them. For it to be there is hugely important, especially in a community where there is no hospice currently. Those are big shoes to fill but they are addressing some part of that so more flexibility in terms of visiting at home, which is an important aspect. The comfort of your own home and someone caring coming to visit.

Filling a Medical System Gap and Helping Navigate the Health-Care System

In addition to the peace of mind already mentioned, many mentioned that this service is an important support to the medical system, filling in a gap for palliative clients and their caregivers. The PHS continuity of care, companionship, resources, and assistance in navigating the health-care system support and supplement the efforts of the medical system. The PHS staff and volunteers become “part of the family and is truly a family-centred care service.” One family member and caregiver commented:

I can't imagine what it would be like to go through this without PHS because they filled in this huge gap and I can't even describe how big that gap is. No matter how strong of a network of friends you have, there is ... a lack of understanding on the process of death and dying. Everyone is trying to be helpful, but they don't have an understanding of what is happening to the family. Without PHS, I don't know if we would have been able to keep my husband at home. That would have been a huge disappointment to us and that would have been very sad if that would have happened.

Another respondent underlined benefits to the client and to the health system of companionship and continuity of care:

As far as other organizations, a lot of them benefit from us because we are picking up on things and passing on information, so it saves a step and a lot of time. With the health-care system, I think with us involved, it alleviates them from having to put their people in. I think we are keeping a lot of people out of hospital just because of companionship and continuity of care. Our volunteers see the same client, whereas with the health system it's always a different person providing care. The trouble with that is they won't pick up on stuff, because if you haven't met that person before you wouldn't know what is normal and what is abnormal. We save a lot that way.

Another situation describes how PHS services reduce burdens on the health-care system:

We had a fellow too that would go to the hospital regularly. I agree he probably had a little bit of pain. Sometimes you can manage a little bit of pain, but if you don't have any friends or anybody coming by, you don't have the will to stay at home and he was going to the hospital. Once he had a volunteer that checked in with him it was totally different, and he was happy to stay at home.

Volunteers give support to others working in the health-care system and they also help clients and families navigate the health-care system. One of the volunteer coordinators was able to shed light on resources provided to the clients and their families:

A lot of them don't know who to phone for what, but we cover that in our training with our volunteers. If the volunteers don't know the answer, they will phone us, and we can help them. Every day we get phone calls to help clients navigate the health-care system.

When asked about the most valuable service, a family member stated:

The other aspect for me and my husband was that [volunteer], who had a geriatric background, was very supportive of the changes we observed in [client] and a way of explaining, discussing, and even being a sounding board with the decision making. Not that she was the one that advised and told us what to do, but she was the person that heard our ideas and answered our questions. She was someone removed from the situation that provided that kind of information and support. Both of those are critically important to the end-of-life process.

Enjoying Relationships with Well-Trained / Well-Matched Volunteers

Many clients, family members, and health-care providers mentioned the quality of PHS volunteers. It was noted that they had intensive training in providing compassionate non-medical care to clients. Many have worked in the health-care field; some were former caregivers receiving PHS services for their loved one or have had some experience with caring for others. As one participant put it:

Every volunteer that I have had contact with was a solid 5/5. That must be a by-product of the training. Good quality and the people who are involved themselves are very conscientious and thoughtful about how sensitive some subjects are.

Clients and families reported that volunteers were very well matched with similar interests and backgrounds, which helped create very meaningful relationships and friendships that continued to grow throughout the client's journey. One client explained why her relationship with her volunteer was so meaningful and was so important to her:

I was afraid that other people would be terrified to be around other people with cancer, but when I got in contact with PHS and [name], my volunteer came in and sat down and she didn't care that I had cancer. We both grew up on farms, so we had other things to talk about other than the cancer, but the cancer didn't scare her and that was the main feeling as a person with cancer.

Many referred to their volunteers as their "best friend" and looked forward to the time they could spend together. In similar ways, volunteers stated that they were able to make new friends and still have relationships with a client's family after the passing of their loved one. Clients appreciate the flexibility of the volunteers as their needs changed and as the terminal illness progressed. Scheduling time with the volunteer for companionship, caregiver bereavement, and for rides to appointments was not difficult and worked well when schedules were exchanged. These volunteers provide continuity of care and consistency when the environment around a client or caregiver may be changing. Volunteers provide care in homes, long term care homes, in the hospital, palliative care unit, and check in with families after the client has passed away.

The companionship is important to clients in having someone in their life that they can trust and is outside the circle of their family and friends. This relationship with the volunteer doesn't carry past baggage and current clients have reported being able to talk to volunteers about their feelings:

A volunteer is someone that is outside the family and friend circle, someone with no baggage, and clients report being able to talk to their volunteers about their feelings that they feel they can't directly share with family members. It's a friend who understands.

Another caregiver stated, “My father-in-law is a reserved man and didn’t talk much about his feelings, but it was easier to talk to his volunteer because they are a neutral party. Being able to talk about his grief, anxiety about end of life, was beneficial.” Clients also appreciate the safety and security they feel with their volunteers. Some examples of family member appreciation follow:

Sometimes we talk about cancer and they listen. Very kind in that way.

It had a great impact on me because she came in and made herself welcome and she almost became a part of our family, it seemed. We so really, really liked her and our two children were overwhelmed at how much of a positive impact she made on their dad.

Securing Reliable and Emotionally Supportive Transportation

Transportation is a service that provides more than just the convenience of getting a client to and from an appointment or grocery store. Many clients and caregivers mentioned that the transportation provided by PHS relieved a lot of stress, and even brought health benefits:

It certainly was less stressful for me and my daughter. She didn’t have to worry about how she was going to get to an appointment. It wasn’t a second worry anymore. You had to worry about your chemo and then worry about a ride. That is an extra stress and it affects your health.

Taxis and other modes of transportation provided in the city don’t provide the same quality of service as the transportation services offered by PHS. A relationship is often created with the driver and clients mentioned that these drivers are their friends, giving them critical emotional support after a hard conversation with a health-care provider. Many enjoy the relationship, which makes them feel comfortable, safe, and secure and neither rushed nor financially burdened. It is a reliable service for many who need to go to the hospital or chemotherapy sessions once or even twice or more a week. One client testified to the impact on their own life and their family’s situation:

I can’t walk a full block without getting exhausted. I can’t go around to go shopping anymore. They [the family] can rely on PHS, trust them and know that I am safe. They are beautiful people. They have also been there for me, no matter what the weather is like and how nasty it is outside.

Hospice Now support allows clients and families to get a reliable person to give rides to and from appointments, taking away the burden of asking their family members or friends and paying for a taxi, private services, or even ambulance in emergency. Ultimately, it provides peace of mind for clients and their caregivers.

Benefitting from Care for the Family, Respite and Bereavement Services

Caregiver burnout is one reason that the Client Patient Access Service (CPAS) may make a request for PHS to reach out to the family. Caring for someone with a terminal illness can be difficult and PHS has been able to provide respite, emotional support, and comfort to the family.

One palliative care coordinator from CPAS mentioned:

We try to focus our referrals to people that don't have support around them. With that being said we still do make referrals to tough situations where we do identify caregivers are tapped out. We combine PHS services with home care respite which is only 8 hours a week. Think of a caregiver who still works and maybe they have kids that need to get places. We are only scratching the surface in what that family truly needs.

Time that the volunteer would spend with the family member then allows the caregiver to do something for themselves, run errands, work, or rest and sleep. Family members can have peace of mind knowing that their loved one is safe and they can take their mind off things for a short time:

What PHS allowed us to do was to continue on with our day-to-day lives and that's what my father wanted. He did not want to be a burden and he always felt guilty when we went out of our way to help him. We have work, families, children and other obligations, responsibilities. PHS lightened that load and gave us the ability for our family to accomplish our day-to-day activities. They made it easier for us to have some normalcy knowing that we were going to lose a big part of our family.

Asked about the impacts of the services on his family, a current client responded:

I have been undergoing cancer treatments since 2016 and up until this point my wife has been taking me whenever I had to go to treatments. She was using her vacation days and what happens is she would use them up and can't take a break. With a volunteer being able to step in and run me to get groceries, appointments or the doctor's is time that she doesn't have to take.

Emotional support to the families is crucial in such a difficult time. PHS is able to provide ongoing support to family members as they care for their loved one and continue with bereavement services as they are grieving the loss. Family members mentioned times when PHS volunteers or staff have reached out months after the death of their loved one and they appreciated and felt sustained by the ongoing care.

Functioning Without PHS Services

Without PHS services, other options, according to all stakeholders, heavily depended on the individual, but some would have to go without, manage their terminal illness on their own, rely

more heavily on family, friends, and faith communities, hire more private companionship and/or transportation services, or rely on or even overuse medical connections and services, including emergency and acute care or long-term care beds.

When asked what she would be doing without PHS services, a current client undergoing chemotherapy responded, “I would have to scramble for rides, that’s for sure. Or my daughter would have to take time off work and it’s not always easy finding someone. People work. Going by taxi is expensive, particularly if you had to go a few times a week.”

A caregiver mentioned in his interview, “It would be hard. I already had to pay for homecare, and I wasn’t working at the time. It would have been worse.” Another caregiver explained the situation that he was in at the time:

I was driving all the time, but I couldn’t be at work. My wife was mentally exhausted from caring for our son, and she had to take care of my daughter in the morning and my dad at the care home. If we didn’t have PHS, my wife would have to take a cab or get help from our community of friends to get to my son’s appointments. This is a time that people are mentally upset.... You can be driving, but your mind is somewhere else. In that case, when you have lost your focus on driving you may miss a light.... In that situation, whatever support the family can get is wonderful. It seems like nothing, but it’s so meaningful to get that support. Any mental support the family can get is awesome. It’s more than a quantity/cost; the mental impact is huge. With a family like ours with young kids, it was tough to manage everything.

Another caregiver stated, “We would have been left with the assistance that the health authority provides, which is good, but again is not geared towards the emotional element of caring for someone at home and the whole experience of death and dying.” Others’ situations suggested that they would have had to resort to costly alternatives: “We might have had to increase private services more because I was not well myself and I needed extra help too. It was hard for me to be a caregiver and look after the house. I suppose we would have had to hire more help or just trudge along.” Many, in other words, seem to be left with less than ideal, emotionally and financially draining situations without the services that PHS provides to the community.

When asked whether or not the client would be accessing the health-care system / acute care services more often without PHS service, one respondent mentioned:

Primarily, it would be fee-for-service, different nursing groups like Home Instead, Saskatoon Home Care, but everything else is cost. I have one client that is desperate for homecare, she has had respite from us and respite from the past. Unfortunately, our indoor respite right now is on hold until that we can safely say this virus has

moved out of the community for awhile. So, when we can't they are paying for it and they are paying a minimum of \$30/hr with a minimum of a 3-hour period. So, although these alternatives are accessible, you can get them, not everybody can afford them.

Considering Other Options and Their Accessibility

Clients mentioned that before hearing about PHS, spouses or family members would have to take time off work to take them to appointments or they would have to rely on a taxi or Uber. City transit isn't a viable option, especially for chemotherapy or radiation appointments because clients are so physically weak after the appointments that it would be very uncomfortable and difficult to manage. One client mentioned that access transit is another option, but they pick up so many people, you have to call far in advance, you wait a long time, and can't plan for a ride back from an appointment. The client mentioned that she had to get to appointments on time and it wasn't reliable enough.

Many clients are already accessing home care, as well as palliative nursing care, and PHS meets needs that are not readily found through other organizations. There is a volunteer program through home care for visitation and companionship, but the people are not matched, may not have similar interests, and clients may not get the same person every time so there isn't the same capacity to build a strong relationship.

Many mentioned that a physical hospice is currently being built at St. Paul's Hospital and will have 15 palliative beds. This is another option in the future but will not reach those that want to die at home or are unsure if their prognosis qualified for a hospice bed. PHS provides support to a large number of people in the communities and are accessible to the terminally ill community.

Making Suggestions for Improvement

Many study participants had little to suggest, saying PHS provided or is fulfilling their current needs right now. Others suggested expanding their services including more respite services, especially in the evening. Caregivers mentioned providing nighttime respite services as well since that is a costly private service. Clients and families understand the benefits and wish that there was more marketing, a better website, social media, and altogether increased awareness about PHS in the community. A client suggested having more volunteers to provide more assistance to the community as well as having some volunteers trained to help clients and caregivers navigate the palliative services and resources of other disciplines within the health-care system:

I would like to see a solid foundation for this organization to grow and the ability for them to promote what their services are so families know that going into the journey,

so they can plan a bit better from the outset. That takes financial consideration, people and resources. I can say the value of those services are more than a cheque being written. It is people helping people. It was priceless to me and my father.

Identifying Missing Services

Many participants did not have other suggestions for services they might have used or currently need that are not being provided. One client, for example, commented, “With PHS, there were no hoops. Services were clearly outlined and delivered as expected and I can’t think of anything that could have been done differently or there weren’t any services missing. I can’t think of anything that could have happened differently.”

It was mentioned a few times that meals, groceries, and general light housekeeping would be beneficial for clients that are not able to do some of these daily tasks on their own as a result of ambulatory restrictions or low energy levels. Still, it is important to note that some of these services are provided by volunteers who naturally integrate these services into their companionship time, just doing what friends do together, as it were. One family member noted, for example:

They did offer some light house cooking, meal prepping and some light household chores, but they really did shy against that and it was more transportation and companion visits. Where someone is in their home on their own, it would be very helpful if there was something like that available as well. That was important as well, my mom struggled to make herself a sandwich. Then again, we relied heavily on family for that.

Another family member wanted more bereavement and counselling services.

It was understood among all the stakeholders that this was a non-profit volunteer community service and PHS provides high quality service with the resources they have. Many stated that it might be difficult to expand without the appropriate funding.

Impact Map

An impact map based on stakeholder interviews and record reviews tells the story about the changes experienced by stakeholders as a result of an activity and then puts a value on that change. Specific sections of the impact map are explained below; the full impact map is available separately on the CUISR website at <https://cuivr.usask.ca>.

Intended/Unintended Changes, Inputs, and Outputs of Prairie Hospice Society

Intended and unintended changes specific to each stakeholder group emerged through interviews with stakeholders. The inputs defined are the investments or contributions made in order to make

the activities of the program or outcomes possible. The relevant monetized and non-monetized inputs are listed in Table 2 below. Outputs are the quantitative summary of the PHS activities for each stakeholder.

Table 2: Changes, Inputs, Value, and Outputs of Prairie Hospice Society

Stakeholders	Intended/Unintended Changes	Inputs	Value	Outputs
Clients	<p>Getting to appointments on time and ability to get rides for groceries and social activities.</p> <p>Reduced loneliness and improved physical and mental health.</p> <p>Improved pain and symptom management.</p> <p>Clients are able to die at home in chosen/desired location.</p>		\$0	<p>355 rides given to 40 clients.</p> <p>800 hours of transportation.</p> <p>Time spent with volunteers.</p> <p>129 companionship clients, 3,096 hours.</p> <p>Time spent with volunteers and staff.</p> <p>Clients are able to die in the comfort of their homes.</p>
Family Members	<p>Reduced caregiver burnout and better mental health.</p> <p>Time saved navigating the health-care system.</p> <p>Mental, spiritual and psychological support after losing a loved one.</p> <p>Follow up bereavement services.</p>		\$0	<p>39 caregivers receiving respite support. 140 hours spent providing respite to caregivers.</p> <p>39 caregivers receiving support navigating the health-care system.</p> <p>42 family members were given bereavement support.</p> <p>42 family members were given follow up bereavement support.</p>
Volunteers	<p>Satisfaction in contributing to the community. Providing a positive experience for clients, caregivers, and family members.</p>	<p>Time & commitment. Total 4,740 hours of volunteering. Driving clients to appointments. Training hours — 23 hours of volunteer training for 35 new volunteers.</p>	\$118,500	<p>4,740 of volunteer hours.</p>

Table 2 continued

Stakeholders	Intended/Unintended Changes	Inputs	Value	Outputs
Health-Care Providers	Reduced workload (or transferring work to other patients) in health-care system	Time referring clients to PHS.	\$0	Reduced use of health-care services (or utilizing the time saved to accommodate other patients to derive significant outcomes in terms of wait times, efficiency and effectiveness).
Board Members	Satisfaction in contributing to the community.	Time, commitment, skills, expertise and experiences.	\$22,500	11 board members meet 10x a year. Board members are on various committees for PHS. Total — 900 hours @ \$25.
Donors	Satisfaction in contributing to the community.	Financial sources for PHS.	\$0	
Staff	Satisfaction in contributing to the community.	Time, commitment, skills, expertise and experiences.	\$126,440	3 staff members (2 volunteer coordinators and 1 office assistant).
Total			\$267,440.00	

Outcomes, Indicators, Financial Proxies, and Values

Outcomes are the changes that stakeholders experience resulting from the inputs and activities of PHS. The outcomes have been considered for one year of the program. Indicators are specific, observable, and measurable characteristics that can be used to show changes a program is making toward achieving a specific outcome. Indicators help to identify financial proxies, which then assigns a monetary value to the specific stakeholder outcomes.

Table 3: Outcomes, Indicators, Financial Proxies, and Values of Prairie Hospice Society

Stakeholders	Outcomes	Indicator	Quantity	Financial Proxy	Value
Clients	Clients are able to attend their appointments and miss appointments less frequently. Reduced financial cost for transportation services.	Clients report having to find transportation services before they used PHS or if PHS volunteers were not available.	710 per year	Average cost of taxi ride in Saskatoon. Cost of using taxi services to get to appointments.	\$25.50 for \$18,105
	Companionship and counselling during transportation.	Clients report having to find transportation services before they used PHS or if PHS volunteers were not available.	800 per year	Cost of companionship during transportation.	\$28.00 for \$22,400
	Reduced social isolation.	Number of companionship clients.	65 per year	Annual cost of adult leisure centre membership.	\$600.00 for \$39,000
	Companionship	Number of companionship hours.	1,548 per year	Cost of private companionship visits.	\$28.00 for \$43,344
	Improved pain and symptom management.	Cost savings to the health-care system due to better pain and symptom management at home.			
	Increased sense of control and dignity.	Cost savings to the health-care system when clients dies at home.			
Family Members	Decreased caregiver burnout. Increased ability for caregiver to cope with circumstances.	Caregivers reporting reduced stress.	140 per year	Cost for private respite care services.	\$32.00 for \$4,480
	Time saved navigating the health-care system.	Family members report saving time navigating the health-care system having support from the PHS volunteers.	936 per year	Cost saved navigating the health-care system. Decreased loss in caregiver wages.	\$25.00 for \$23,400

Table 3 continued

Family Members (con't)	Increased sense of relief from having bereavement support from PHS staff and volunteers.	Family member reports feeling supported after the death of their loved one.	42 per year	Cost of counselling services.	\$120.00 for \$5,040
	Increased psychological health from having bereavement support from PHS staff and volunteers.	Family members feel continually supported after the death of their loved one.	42 per year	Cost of follow-up bereavement services.	\$55.00 for \$2,310
Volunteers	Volunteers create meaningful relationships with clients and caregivers.	Volunteers report having new friendships.	2,370 per year	Average Saskatchewan Health Authority wage.	\$32.78 for \$77,688.60
	Volunteers generate a positive experience for themselves.	Volunteers are satisfied about contributing to the community.			
Health-Care Providers	Decreased health-care burnout and usage of health-care system.	Number of hospital outpatients reduced.	167 per year	Cost of a hospital visit and hospital overhead.	\$482.65 for \$80,602.55
	Decreased cost to health-care system.	Number of visits to a physician reduced.	167 per year	Average cost of a counselling visit by a physician for 30 minutes.	\$150.00 for \$25,050
	Decreased number of ER visits.	Number of ER visits reduced.	33 per year	Minimum cost of road ambulance and an ER visit.	\$1,134.09 for \$37,424.97
	Decreased number of inpatient admissions.	Number of inpatient admissions reduced.	2 per year	Average cost of a standard hospital stay. Average stay in Palliative Care is estimated to be 4 weeks.	\$203,364 for \$406,728
	Improved pain and symptom management.	Cost savings to the health-care system due to better pain and symptom management at home.	84 per year	Average cost of pharmaceuticals for patients during last 72 hours of life.	\$323.97 for \$27,213.48
	Clients are able to die at a desired/chosen place.	Cost savings to the health-care system when client dies at home.	21 per year	Difference in the cost of dying in the hospital versus dying at home.	\$20,000 for \$420,000

Table 3 continued

Board Members	Board members satisfaction with volunteering for PHS.	Board members report being satisfied with volunteering for PHS.	225 per year	Simple assumption of average board member's wage.	\$50.00 for \$11,250
Donors	Satisfaction in donating to PHS.	Donor report being satisfied with donating to PHS.			
Staff	Job satisfaction for staff.	Staff report being satisfied with working for PHS.	3 per year		
Total Gross Impact					\$1,244,036.60

To clarify the quantities and values, brief descriptions are provided. There were 355 rides given excluding transportation for companionship clients. The quantity of rides was doubled to calculate a taxi ride to and from a location. An average taxi rate in Saskatoon was used for the financial proxy value. Transportation costs include taxi and companionship fees. Rides given to clients are often the same people, relationships are built, and emotional support is offered during the rides. The cost for an average taxi ride in Saskatoon is \$25.50 and companionship services are \$28.00 per hour. Transportation hours and companionship hours have been counted separately. The number of companionship clients is 129 and if half of these clients experienced reduced social isolation the cost savings of these clients is equivalent to purchasing an adult Leisure Centre card. The 39 caregivers received 140 hours of respite services from PHS. The calculation assumes that volunteers had spent 1548 hours of companionship visiting.

PHS reported volunteers spending 104 hours providing respite in the year. Family members saved time navigating the health-care system. It was estimated that 2 hours were saved each month for 39 caregivers, that 936 hours (2 hours per month) were saved for the caregivers costed at a \$25.00/hour wage. For 42 families receiving PHS bereavement services, the cost saving was calculated to be one bereavement support service for each family member. If half of the volunteer hours were spent working instead of volunteering to receive the same outcomes of creating meaningful relationships with others, this volunteering time could be valued at an average Saskatchewan Health Authority wage.

PHS services allow the health-care system to avoid costs. If each client was able to avoid one outpatient visit and one physician counselling visit hundreds can be avoided. The cost of an outpatient hospital visit is \$269.19 and the cost of the overall average for hospital overhead is \$213.46.

The number of ER visits was calculated using 20% of 167 clients served, which is 33. The ER costs include road ambulance using the lower range of \$245 and an ER dispatch cost of \$889.09, according to the Saskatchewan EMS, could have been saved. If 1% of these clients were able to die at home instead of being admitted to the Palliative Care Unit, a massive cost to the health-care system could be avoided. The average cost of a standard hospital stay is \$7263.00. Based on hospital data, we are able to look at the number of days that palliative care patients spent in hospital during their last month of life. According to Health Canada (2018), more than half of palliative care patients (54.9%) in Ontario spent five days or longer in hospital during their last 30 days of life. About a quarter (25.8%) of palliative care patients spent half or more of their last month of life in the hospital (Health Canada, 2018). Overall the average inpatient hospitalization costs are \$203, 364. We calculated it for 1% of PHS clients. It was estimated that these palliative clients stayed in hospital for an average of 4 weeks.

According to PHS, 900 hours of volunteering is spent on being a board member. For 25% of the hours spent at PHS, a board member could be working on another board or working another job to have a similar outcome. We made conservative estimations of average board compensation and quantities of change, and the value of financial proxies, to prevent an overvaluation of the impacts.

Impact (Deadweight, Attribution, and Drop-Off)

To calculate the impact, it is important to take into account what would or could have happened, the contribution of others and the length of time the outcomes last. These considerations are called deadweight, attribution, and drop-off (see Table 4).

Deadweight measures the amount of the outcome that would have happened even if the activity did not take place. The deadweight was given lower percentages of 5% and 10% for services that are not provided through the other organizations and the health-care system. These are services that may not have happened otherwise because they are unique services that PHS provides and are not accessible in the community. Since PHS volunteers could have developed meaningful relationships and could have created positive experiences for themselves with another organization, they were assigned a 15% deadweight.

Attribution is an assessment of how much the outcome was caused by other people or organizations. It brings awareness to what other activities could have contributed to the observed changes. Regarding care for the clients, it was mentioned by multiple stakeholder groups that home care was often involved, as well as family caregivers and other paid services, in addition to the services provided by PHS. Certain outcomes are more specifically provided to clients that are not attributed to other services in the community. The attribution percentages were low in companionship, since clients are matched to volunteers having similar interests and both clients and volunteers mentioned

that they created deep friendships through the companionship services. Family members mentioned that it wasn't the same as paid companionship services or health-care staff, because there is a different person every time in those cases and the connection wasn't always there. Time saved navigating the health-care system was helpful to family members and clients, since PHS volunteers are trained specifically to give resources and direct family members and clients, which saves time for both the client and the health-care system. The attribution for this was at 5% since there are not readily available people that are as highly educated about the health-care system and other community resources and that can deliver assistance in such a personal way. Outcomes with higher attribution percentages included decreased health-care burnout and decreased cost to the health-care system.

Drop-off estimations take into consideration how long the outcomes last. The drop-off percentages are 0% for all outcomes since the SROI is not calculated for more than a year.

Table 4: Deadweight, Attribution, and Drop-Off

Outcomes	Deadweight	Attribution	Drop-Off
Clients are able to attend their appointments and miss appointments less frequently. Reduced financial cost for transportation services.	5%	10%	0%
Companionship and counselling during transportation	5%	10%	0%
Reduced social isolation	5%	10%	0%
Companionship	5%	5%	0%
Improved pain and symptom management	N/A	N/A	N/A
Increased sense of control and dignity	N/A	N/A	N/A
Decreased caregiver burnout. Increased ability for caregiver to cope with circumstances.	5%	10%	0%
Time saved navigating the health-care system	10%	5%	0%
Increased sense of relief from having bereavement support from PHS staff and volunteers	10%	10%	0%
Increased psychological health from having bereavement support from PHS staff and volunteers	5%	10%	0%
Volunteers create meaningful relationships with clients and caregivers. Volunteers generate a positive experience for themselves.	15%	10%	0%

Table 4 continued

Decreased health-care burnout and usage of health-care system	10%	20%	0%
Decreased cost to health-care system	10%	20%	0%
Decreased number of ER visits	10%	20%	0%
Decreased number of inpatient admissions	10%	20%	0%
Improved pain and symptom management	5%	10%	0%
Clients are able to die at a desired/chosen place.	10%	20%	0%
Board members satisfaction with volunteering for PHS	15%	10%	0%
Satisfaction in donating to PHS	N/A	N/A	N/A
Job satisfaction for staff	N/A	N/A	N/A

Impact

The impact calculation takes into consideration the number of times the impact happened multiplied by the financial proxies minus the deadweight, attribution and drop-off. The calculations of impact for PHS are listed in Table 5 below.

Table 5: Impact Calculations

Outcomes	Quantity	Value	Deadweight	Attribution	Drop-Off	Impact
Clients are able to attend their appointments and miss appointments less frequently. Reduced financial cost for transportation services.	710	\$25.50	5%	10%	0%	\$15,479.78
Companionship and counselling during transportation.	800	\$28.00	5%	10%	0%	\$19,152.00
Reduced social isolation.	65	\$600.00	5%	10%	0%	\$33,345.00
Companionship	1,548	\$28.00	5%	5%	0%	\$39,117.96
Improved pain and symptom management.	N/A	N/A	N/A	N/A	N/A	N/A

Increased sense of control and dignity.	N/A	N/A	N/A	N/A	N/A	N/A
Decreased caregiver burnout. Increased ability for caregiver to cope with circumstances.	140	\$32.00	5%	10%	0%	\$3,830.40
Time saved navigating the health-care system.	936	\$25.00	10%	5%	0%	\$20,007.00
Increased sense of relief from having bereavement support from PHS staff and volunteers.	42	\$120.00	10%	10%	0%	\$4,082.40
Increased psychological health from having bereavement support from PHS staff and volunteers.	42	\$55.00	5%	10%	0%	\$1,975.05
Volunteers create meaningful relationships with clients and caregivers. Volunteers generate a positive experience for themselves.	2370	\$32.78	15%	10%	0%	\$59,431.78
Decreased health-care burnout and usage of health-care system.	167	\$482.65	10%	20%	0%	\$58,033.84
Decreased cost to health-care system.	167	\$150.00	10%	20%	0%	\$18,036.00
Decreased number of ER visits.	33	\$1,134.09	10%	20%	0%	\$26,945.98
Decreased number of inpatient admissions.	2	\$203,364	10%	20%	0%	\$292,844.16
Improved pain and symptom management.	84	\$323.97	5%	10%	0%	\$23,267.53
Clients are able to die at a desired/chosen place.	21	\$20,000.00	10%	20%	0%	\$302,400.00
Board members satisfaction with volunteering for PHS.	225	\$50.00	15%	10%	0%	\$8,606.25
Satisfaction in donating to PHS.	N/A	N/A	N/A	N/A	N/A	N/A
Job satisfaction for staff.	3	N/A	N/A	N/A	N/A	N/A
Total Net Impact						\$926,555.11

Calculation of the SROI Ratio

The calculation below divides the discounted value of outcomes by the total investment. This SROI range assumes an extremely conservative measure of impact and also takes into account other alternative proxies and values. Below are the lower and upper range of the SROI ratio.

Lower Range

$$\text{SROI ratio} = \frac{\text{present value}}{\text{value of inputs}}$$

$$\text{SROI ratio} = \frac{\$926,555}{\$267,440}$$

$$\text{SROI ratio} = 3.46$$

Upper Range

$$\text{SROI ratio} = \frac{\text{present value}}{\text{value of inputs}}$$

$$\text{SROI ratio} = \frac{\$3,122,886.31}{\$267,440}$$

$$\text{SROI ratio} = 11.68$$

With these considerations and discounts, the social value range of PHS is 3.46 – 11.68. In other words, for every dollar PHS spends in providing the services to clients, there is a \$3.46 to \$11.68 social return on their investment.

Alternative Calculations

Alternative calculations can be considered for the impact map. The alternative options included cost of Access Transit services, higher cost savings in ambulance rides, increased board member impact, increased counselling costs for clients and increased number of inpatient hospitalizations avoided.

The cost of Access Transit is the same as the conventional transit fees which are \$3 for one ride or \$913 for an adult yearly pass. For a senior yearly pass, it costs \$313. For anyone that is not able to take the conventional buses, access transit is available for those with physical and cognitive disabilities. Access Transit rides have to be booked seven days in advance; it is a shared ride service and the trips are rarely from one point to another. The calculation for the taxi was used for the social value calculation because most clients spoke about using taxis for alternative transportation options.

Adult Yearly Transit Pass

Social Value = 3.52

Senior Yearly Transit Pass

Social Value = 3.45

According to the Government of Saskatchewan (2019), the cost of a basic road ambulance in Saskatoon ranges from \$245 to \$325 for residents of Saskatchewan with a valid health card. PHS services are saving 20% of clients from using an ambulance because they do not have a volunteer there to help manage their health concerns, anxiety and stress with having a terminal illness. With this increase in cost savings using the upper range of ambulance costs being \$325 the social impact ratio would be 3.47.

Increased Cost of Road Ambulance

Social Value = 3.47

Board members at PHS are all volunteers that are highly skilled and trained people. The value of the board members and their input is important. If half the hours of board members were spent working on another board, the social value for 450 hours at an assumed wage of \$50.00 would be 3.50.

Increased Board Member Impact

Social Value = 3.50

If every client had used consistent counselling from physicians or a counselling specialist, the increased saving would be 12 visits a year, or once a month counselling services. Since many volunteers are currently working or retired professionals, the quality of their counselling is high. Visits are made for up to 4 hours a week for companionship; the cost savings increases the social value to 3.95 for every dollar that is spent in providing the PHS services. \

Increased Cost of Counselling

Social Value = 3.95

The largest cost savings outcomes are the reduced number of outpatients, reduced number of visits to the physician, reduced number of ER visits, decreased number of inpatient hospitalizations, improved pain and symptom management, and clients being able to die in the community or at home. The original calculations are very conservative. This alternative calculation describes the cost savings if the number of PHS clients were doubled in all the categories described above. When 10% or 17 clients are able to stay home instead of going to the hospital, the social value of PHS is 5.62.

Increased Cost Saving to Health-Care System

Social Value = 5.62

If 10% of the 167 clients are able to avoid being admitted as an inpatient because of the support of PHS in the community, the social value would increase to 11.68. This is still a conservative measure that assumes the cost savings for only 17 clients.

Reduced number of inpatient admissions

Social Value = 11.68

CONCLUSION

PHS SERVICES HAVE AND CONTINUE TO MAKE AN IMPACT ON THE LIVES of those living with a terminal illness and the family members caring for their loved ones. An SROI analysis helps highlight valuable impacts. In the case of PHS services, the SROI analysis underlines value for clients, family and other caregivers, reducing burdens and enhancing quality of life, reducing pressures on the health-care system and contributing to cost reductions and avoidance for the system and broader community. Adding to the literature on the cost effectiveness of palliative home care, the SROI analysis based on the most conservative of assumptions demonstrates the following range of SROI ratio or social value: from 3.46 to 11.68. In other words, for every dollar invested, the return on investment is between \$3.46 and \$11.68. The literature is clear that the social value is estimated to increase in the context of an aging Canadian population and a trend to smaller and dispersed families adding challenge and cost to the health-care system.

Some of the impacts are harder to quantify and monetize than others. What price can we put on peace of mind, on a husband and father being enabled to be himself, a family feeling empowered, clients and family feeling appreciated and finding a friend to understand what they are going through, to have their burdens relieved and to be able to act and interact on their own terms? How can we do justice to the value of dying with dignity in the place of one's choosing, having voice and choice and maintaining control over one's life? Hence the importance of the qualitative data to complement the financial proxies and ratio calculations so that we do some justice to the full range of social and health impacts.

The PHS data and the interviews that complemented them tell powerful stories of the profound impacts of PHS services. They confirm the literature on the importance of volunteers who bring no baggage and offer no judgments to the task of end-of-life care. They confirm too the value of the continuity of care the volunteers provide, which makes them especially sensitive to changing client needs, picking up on what might be missed by different health-care providers who do not see the client so consistently. The interview testimonials confirm too how PHS services importantly support and supplement the health-care system, filling critical gaps in service, while helping improve pain and symptom management and securing high levels of both client and caregiver satisfaction.

The impact of PHS services is well described by a family member:

This province is known for people helping people. PHS should be applauded for its kind work in the background, while they may not be known or seen by everybody on the front lines. The people that they are impacting appreciate it and especially when their service didn't leave us when my father did. It's an ongoing appreciation for what they did.

REFERENCES

- Alberta Health Services. (2014). *Palliative and End of Life Care: Alberta Provincial Framework*. Retrieved from <http://albertahealthservices.ca/assets/info/seniors/if-sen-provincial-palliative-end-of-life-care-framework.pdf>
- Block, E.M., Casarett, D.J., Spence, C., Gozalo, P., Connor, S.R., & Teno, J.M. (2010). Got volunteers? Association of hospice use of volunteers with bereaved family members' overall rating of the quality of end-of-life care. *Journal of Pain Symptom Management*, 39(3), 502–506. doi: 10.1016/j.jpainsymman.2009.11.310.
- Canadian Hospice Palliative Care Association (CHPCA). (2012). Cost-effectiveness of palliative care: A review of the literature. The Way Forward initiative: An Integrated Palliative Approach to Care. Retrieved from <http://www.hpcintegration.ca/media/36290/TWF-Economics-report-Eng-final-webmar7.pdf>
- Canadian Institute for Health Information. (2018). *Access to palliative care in Canada*. Retrieved from <https://www.cihi.ca/en/access-data-and-reports/access-to-palliative-care-in-canada>
- Canadian Partnership against Cancer. (2017). *Palliative and end-of-life care*. Retrieved from <https://s22457.pcdn.co/wp-content/uploads/2019/01/Palliative-and-end-of-life-care-report-2017-EN.pdf>
- Candy, B., France, R., Low, J., & Sampson, L. (2015). Does involving volunteers in the provision of palliative care make a difference to patient and family wellbeing? A systematic review of quantitative and qualitative evidence. *International Journal of Nursing Studies*, 52(3), 756–768. <https://doi.org/10.1016/j.ijnurst.2014.08.007>
- de Graaf, E., Zweers, D., Valkenburg, A., Uyttewaal, A., & Teunissen, S. (2016). Hospice assist at home: Does the integration of hospice care in primary health care support patients to die in their preferred location — A retrospective cross-sectional evaluation study. *Palliative medicine*, 30(6), 580–586. <https://doi.org/10.1177/0269216315626353>
- Foreman, T., Kekewich, M., Landry, J., & Curran, D. (2015). Impact of palliative care consultations on resource utilization in the final 48 to 72 hours of life at an acute care hospital in Ontario, Canada. *Journal of Palliative Care*, 31(2), 69–75.

- Furnham, A. (1986). Response bias, social desirability and dissimulation. *Personality and Individual Differences*, 7(3), 385–400. doi:10.1016/0191-8869(86)90014-0
- Gomes, B., Calanzani, N., Curiale, V., McCrone, P., & Higginson, I.J. (2013). Effectiveness and cost-effectiveness of home palliative care services for adults with advanced illness and their caregivers. *Cochrane Database of Systematic Reviews*, 6, 1–279
doi: 10.1002/14651858.CD007760.pub2
- Health Canada. (2018). Framework on palliative care in Canada. Retrieved from <https://www.canada.ca/en/health-canada/services/health-care-system/reports-publications/palliative-care/framework-palliative-care-canada.html#p1.1>
- Hollander, M.J. (2009). Costs of end-of-life care: Findings from the province of Saskatchewan. *Health Care Quarterly*, 12(3), 50–58. doi: 10.12927/hcq.2013.20878
- Kalagnanam, S.S., Berthe, A., & Findlay, I.M. (2019). *Social return on investment financial proxies and the Saskatoon Poverty Elimination Strategy*. Community-University Institute for Social Research.
- Kleinpell, R., Vasilevskis, E., Fogg, L., & Ely, E. (2019). Exploring the association of hospice care on patient experience and outcomes of care. *BMJ Supportive & Palliative Care*, 9(1), E13. Retrieved from <https://spcare.bmj.com/content/9/1/e13.full>
- Prairie Hospice Society. (2020). Prairie Hospice Society: Welcome. Retrieved from <https://www.prairiehospice.org/>
- Smith, S., Brick, A., O'Hara, S., & Normand, C. (2014). Evidence on the cost and cost-effectiveness of palliative care: A literature review. *Palliative Medicine*, 28(2), 130–150.
doi: 10.1177/0269216313493466
- Statistics Canada. (2018). Deaths, by place of death (hospital or non-hospital). Retrieved from <https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1310071501>
- Statistics Canada. (2019). *Population projections for Canada (2018 to 2068), provinces and territories (2018 to 2043)*. Retrieved from <https://www150.statcan.gc.ca/n1/pub/91-520-x/91-520-x2019001-eng.htm>
- Waikar, R., Kalagnanam, S.S., & Findlay, I.M. (2013). *Financial proxies for social return on investment analyses in Saskatchewan. A research report*. Community-University Institute for Social Research.
- World Health Organization. (2020). *WHO definition of palliative care*. Retrieved from <https://www.who.int/cancer/palliative/definition/en/>

APPENDIX A: CONSENT FORM



Interview

Participant Consent Form

Project Title

Prairie Hospice Society: Social Return on Investment Analysis Report

Researchers

Co-Principal Investigator: Dr. Isobel M. Findlay, Professor Emerita, Management and Marketing, Edwards School of Business, University of Saskatchewan, (306) 966-2120, findlay@edwards.usask.ca

Co-Principal Investigator: Dr. Suresh Kalagnanam, Associate Professor, Department of Accounting, Edwards School of Business, University of Saskatchewan, (306) 966-8404, kalagnanam@edwards.usask.ca

Research Assistant: Anh Pham, MPH, University of Saskatchewan, (306) 966-2120, anh.pham@usask.ca

Purpose and Objectives of the Research

This research study builds on findings from the 2013 and 2019 CUISR reports on Social Return On Investment to report on monetary values associated with social, environmental, and other impacts of the services of Prairie Hospice Society. The study will help guide decision making, and to reflect the needs of diverse Prairie Hospice Society stakeholders and communities in Saskatchewan.

The project will use a social return on investment (SROI) methodology, which is a principles-based approach that assigns monetary value to social, environmental, and other impacts that are

typically not valued in traditional metrics or measures of success. It gives organizations, institutions, and communities an important tool to assess the outcomes of their efforts, to communicate their successes and impacts, to manage their risks, and to support evidence-based decision making and optimal use of resources. In situations where the focus is often on the costs of services delivered by institutions or organizations, SROI will highlight diverse values that the service delivery represent for communities. This SROI analysis will use financial proxies to calculate Prairie Hospice Society's social impacts.

Procedures

Interviews will be used to collect study data. An interview guide has been developed by the CUISR research team. Data collection will occur in Saskatoon at Preston Park II Retirement Residence or by telephone if participants choose. The interviews will include up to 70 participants and will last up to an hour. If participants agree, interviews will be audio recorded for transcription purposes. Interviews will be recorded and transcribed by the CUISR research assistant. You may choose to review, add or delete before approving the transcript. The participants will receive their transcript and have a deadline of two weeks to respond and return the transcript with any revisions. A reminder email will be sent to participants after one week, if there is no response by the deadline it will be assumed that participants accept the transcript as sent to them. Please feel free to ask any questions regarding study procedures and goals or your role.

Funded by

This study is funded by Prairie Hospice Society.

Potential Risks

There are no anticipated harms from participation, but questions may elicit discomfort or distress as a result of talking about experiences volunteering or having family members utilizing the hospice care services. This minimal risk is addressed by your voluntary participation and ability to choose not to answer any questions you feel uncomfortable answering. You also have the right to withdraw from the study for any reason without penalty. Should you feel any distress, we can refer you to counseling services that are provided by Prairie Hospice Society.

Potential Benefits

Participants often experience appreciation for the opportunity to be heard through a research study. Participants benefit directly by being able to tell their story and also to enhance understanding of the value of the services of Prairie Hospice Society. The research will give the Prairie Hospice Society a comprehensive evaluation to show funders and other stakeholders their values and social impacts.

Confidentiality

The data from this research project will be published as a final report submitted to Prairie Hospice Society and available on the CUISR website. The data may also be presented at conferences and in an academic paper. The data will be presented in aggregate form, so that it will not be possible to identify individuals. All personal data will be removed before the responses and interventions are analyzed and reported. This means that any direct quotes, opinions, or expressions will be presented without revealing names. Confidentiality will be further protected by allowing only the research team access to the recordings of the interviews and by storing the signed consent forms separately from transcriptions. The only case where confidentiality will be waived is when the participant has agreed to have their contributions acknowledged.

You have the right to withdraw from the study. Your data will be deleted if you request it. Identifying factors (such as names, specific locations) will be removed and individuals will be given pseudonyms where necessary. The researchers will undertake all necessary steps to safeguard the confidentiality of the interviewee by following confidentiality protocols expressed above.

If you agree, the interview will be audio recorded for transcription purposes. You may request that the recording be turned off at any time and without giving any reason.

After the interview and prior to the data being included in the final report, you will have the opportunity to review the transcript if you choose to and to add, alter, or delete information you contributed from the transcript as you see fit.

Storage of Data

Data will be securely stored at CUISR for a period of five years after publication at which time it will be destroyed. Electronic files and recordings will be kept in CUISR password protected computer files. Hardcopy data will be stored in locked filing cabinets in a locked CUISR office and, as mentioned above, transcripts will be stored separately from signed consent forms.

Right to Withdraw

Your participation is voluntary and you can answer only those questions that you are comfortable with. You may withdraw from the research project for any reason, at any time (before data are aggregated for the report) without explanation or penalty of any sort. Whether you choose to participate or not will have no effect on your access to services or how you will be treated. The deadline to withdraw from the study is one month after your participation.

Follow-Up

To obtain results from the study, please contact CUISR by phone (306-966-2120) or by email (cuisr.research@usask.ca) or visit our website <https://cuisr.usask.ca>.

Questions or Concerns

Contact the researchers using the information at the top of page 1.

This research project has been approved on ethical grounds by the University of Saskatchewan Research Ethics Board. Any questions regarding your rights as a participant may be addressed to that committee through the Research Ethics Office ethics.office@usask.ca (306) 966-2975. Out-of-town participants may call toll free (888) 966-2975.

Consent

SIGNED CONSENT

Your signature below indicates that you have read and understand the description provided; I have had an opportunity to ask questions and my/our questions have been answered. I consent to participate in the research project. A copy of this Consent Form has been given to me for my records.

_____	_____	_____
Name of Participant	Signature	Date
_____	_____	_____
Researcher's Signature		Date

A copy of this consent will be left with you, and a copy will be taken by the researcher.

ORAL CONSENT

Oral Consent: I read and explained the consent form to the participant before receiving the participant's consent, and the participant had knowledge of its contents and appeared to understand it.

____ Check the right to remain confidential in contributing to this research (name will not appear in the publications)

____ Check the right to being acknowledged for your knowledge (meaning your name will appear in the publications)

____ Check if you would like to have the opportunity to review the transcript.

_____	_____	_____
Name of Participant	Signature	Date

APPENDIX B: INTERVIEW QUESTIONS¹



Interview Guide — Health Professionals

Project Title

Prairie Hospice Society: Social Return on Investment Analysis Report

Researchers

Co-Principal Investigator: Dr. Isobel M. Findlay, Professor Emerita, Management and Marketing, Edwards School of Business, University of Saskatchewan, (306) 966-2120, findlay@edwards.usask.ca

Co-Principal Investigator: Dr. Suresh Kalagnanam, Associate Professor, Department of Accounting, Edwards School of Business, University of Saskatchewan, (306) 966-8404, kalagnanam@edwards.usask.ca

Research Assistant: Anh Pham, MPH, University of Saskatchewan, (306) 966-2120, anh.pham@usask.ca

Questions

How many clients have been referred to Prairie Hospice Society through the Saskatchewan Health Authority, Cancer Clinic, Nursing Homes, or other community organizations?

Have you directly referred or have had experiences with clients utilizing Prairie Hospice Society services?

If Prairie Hospice Society did not exist, what other health services would be used instead?

1. For ethics purposes, each guide listed in these pages is required to have the logos, the project title, and list of personnel at the top. For the purposes of this report, to avoid repetition, we have provided it only on the first page of the appendix and identified individual interview groups with appropriate headings.

How accessible are the alternatives?

What do you believe are the impacts of Prairie Hospice Society services for clients?
(Prompt for client impact)

What are the strengths of the services provided by Prairie Hospice Society?

What are some suggestions for improvement of the services provided by Prairie Hospice Society?

Are there any barriers to referring clients to Prairie Hospice Society?

What do you believe are the most valuable services that Prairie Hospice Society offers?

Any other comments/ information important for us to understand Prairie Hospice Society impacts
(on individuals, families, communities, health or other systems, etc.)?

Interview Guide — Volunteers

Questions

How many volunteer services have you provided to clients?

Can you describe examples of the different services? (prompt if necessary, about range of services)

How do you think the services made a difference in the lives of client and family/supports?

Without those services, what alternatives would clients and family/supports have had?

How accessible are the alternatives?

Why have you chosen to volunteer with Prairie Hospice Society?

How many hours of training does each volunteer receive?

If you have had a client assignment, did the training provide you with what you needed to
provide services?

How many clients have you had? How many volunteer hours have you provided?

What training aspects were the most helpful in providing service to your clients?

What additional training or supports would you suggest providing for volunteers?

What are some things you believe Prairie Hospice Society is doing well?

What have been the benefits to you of volunteering at Prairie Hospice Society?

Any other comments/ information important for us to understand Prairie Hospice Society impacts?

Interview Guide — Prairie Hospice Society Board Members

Questions

- How many people are on the board for Prairie Hospice Society?
- How often do board members meet?
- What types of services are provided by the Prairie Hospice Society?
- What are the inputs that allow Prairie Hospice Society to provide services to clients?
- How are individuals, families, organizations and the health care system benefitting from these services?
- What do you value most about Prairie Hospice Society? Its greatest strengths?
- What are some areas of improvement for Prairie Hospice Society?
- How many clients have accessed Prairie Hospice Society services?
- Are there any barriers to providing services to clients?
- Without these services, what alternatives would clients or family/supports have?
- How accessible are the alternatives?
- What do you see for the future of Prairie Hospice Society?
- Any other comments/ information important for us to understand Prairie Hospice Society impacts (on individuals, families, communities, health or other systems)?

Interview Guide — Clients and Family/Supports

Questions

- What types of services have you accessed with Prairie Hospice Society? (Prompt with range of services)
- What are the most valuable services provided by Prairie Hospice Society?
- Are there any barriers to accessing the services provided by Prairie Hospice Society?
- What are the benefits of receiving those services from Prairie Hospice Society?
- What are some of the impacts you or family/supports have experienced through these services?

Without these services, what alternatives would you or family/supports have had?

How accessible are the alternatives?

How satisfied were you with the following aspects of their services?

1 = very dissatisfied

2 = dissatisfied

3 = neutral

4 = satisfied

5 = very satisfied

- Time it took to begin the services
- Helpfulness of the information provided
- The amount of volunteer time assigned to me
- The scheduling of the volunteer time
- Quality of interaction and services provided by Prairie Hospice Staff and volunteers
- Range of services provided
- Protection of my privacy and confidentiality by staff and volunteers

Overall, how satisfied are you with the quality of service provided by volunteers and staff?

1 = very dissatisfied

2 = dissatisfied

3 = neutral

4 = satisfied

5 = very satisfied

Do you have any suggestions for improvement for the services provided?

Are there any services missing?

Any other comments/ information important for us to understand Prairie Hospice Society impacts (on individuals, families, communities, health or other systems, etc.)?

Interview Guide — Donors/Funders

Questions

Why have you or your organization chosen to fund/donate to Prairie Hospice Society?

What do you believe are some of the impacts that Prairie Hospice is creating for its clients?

What are the benefits/impacts Prairie Hospice Society is creating for you/your organization?

Without Prairies Hospice Society services, what alternative services/supports are available?

How accessible are the alternatives?

What value does Prairie Hospice Society provide to the community of Saskatoon?

What would you like to know about the organization to continue to give funding in the future?

What would you like to see for the future of Prairie Hospice Society?

Any other comments/ information important for us to understand Prairie Hospice Society impacts
(on individuals, families, communities, health or other systems)?

Interview Guide — Staff

Questions

How many people are on the staff of Prairie Hospice Society?

What functions do they perform?

What types of services are provided by the Prairie Hospice Society?

What are the inputs that allow Prairie Hospice Society to provide services to clients?

How are individuals, families, organizations and the health care system benefitting from
these services?

What do you value most about Prairie Hospice Society? Its greatest strengths?

What are some areas of improvement for Prairie Hospice Society?

How many clients have accessed Prairie Hospice Society services?

Are there any barriers to providing services to clients?

Without these services, what alternatives would clients or family/supports have?

How accessible are the alternatives?

What do you see for the future of Prairie Hospice Society?

Any other comments/ information important for us to understand Prairie Hospice Society impacts
(on individuals, families, communities, health or other systems)?

LIST OF PUBLICATIONS —

Community-University Institute for Social Research

Allan, Nancy, & Michael Gertler. (2006). *Remaking the Links: Fair Trade for Local and Global Community Development*. Saskatoon: Community-University Institute for Social Research.

Amankwah, Dinah. (2003). *Integrative Wraparound (IWRAP) Process Training*. Saskatoon: Community-University Institute for Social Research.

Avis, Kyla, & Angela Bowen. (2004). *Postpartum Depression Support Program Evaluation*. Saskatoon: Community-University Institute for Social Research.

Banks, Christopher. (2003). *The Cost of Homophobia: Literature Review on the Human Impact of Homophobia on Canada*. Saskatoon: Community-University Institute for Social Research.

Banks, Christopher. (2004). *The Co\$t of Homophobia: Literature Review on the Economic Impact of Homophobia on Canada*. Saskatoon: Community-University Institute for Social Research.



Basualdo, Maria, & Chipso Kangayi. (2010). *Cypress Hills Abilities Centres, Inc: Exploring Alternatives. A Research Report*. Saskatoon: Centre for the Study of Co-operatives and Community-University Institute for Social Research.

Battiste, Marie, Isobel M. Findlay, Joe Garcea, Jania Chilima, & Ryan Jimmy. (2018). *Maximizing the Potential of Urban Aboriginal Students: A Study of Facilitators and Inhibitors within Postsecondary Learning Environments*. Saskatoon: Community-University Institute for Social Research and UAKN Prairie Regional Research Centre. http://uakn.org/wp-content/uploads/2016/10/NAFC-UAKN-PHASE-2-National-Report_Prairie-Region_Saskatchewan-Final-Report-.pdf

Berntson, Ron. (2003). *Peer Victimization Experiences in High School*. Saskatoon: Community-University Institute for Social Research.

Bidonde, Julia. (2006). *Experiencing the Saskatoon YWCA Crisis Shelter: Residents' Views*. Saskatoon: Community-University Institute for Social Research. Please contact Clara Bayliss at the YWCA at 244-7034, ext. 121 or at info@ywcaskatoon.com for copies of this report.



Bidonde, Julia, & Catherine Leviten-Reid. (2011). *"A Place to Learn, Work, and Heal": An Evaluation of Crocus Co-operative*. Saskatoon: Centre for the Study of Co-operatives and Community-University Institute for Social Research.



Bidonde, Julia, Mark Brown, Catherine Leviten-Reid, & Erin Nicolas. (2012). *Health in the Communities of Duck Lake and Beardsy's and Okemasis First Nation: An Exploratory Study*. Saskatoon: Centre for the Study of Co-operatives and Community-University Institute for Social Research.

Bowditch, Joanne. (2003). *Inventory of Hunger Programs in Saskatoon*. Saskatoon: Community-University Institute for Social Research.

Bowen, Angela. (2004). *Healthy Mother Healthy Baby: Program Logic Model and Evaluability Assessment*. Saskatoon: Community-University Institute for Social Research.



Brown, K., I. Findlay, & R. Dobrohoczki (2011). *Community Resilience, Adaptation, and Innovation: The Case of the Social Economy in LaRonge*. Saskatoon: Centre for the Study of Co-operatives and Community-University Institute for Social Research.

Brownlee, Marilyn, & Allison Cammer. (2004). *Assessing the Impact of the Good Food Box Program in Saskatoon*. Saskatoon: Community-University Institute for Social Research.

Brownlee, Marilyn, & N. Chopin. (2009) *Evaluation Report: Snapshot of Collaborative Processes*. Saskatoon: Saskatoon Regional Intersectoral Committee and Community-University Institute for Social Research. Saskatoon: Community-University Institute for Social Research.

Chambers-Richards, Tamara, Rawia Ahmed, & Isobel M. Findlay. (2014). *Parkinson Society Saskatchewan: Working Together to Meet Member Needs — A Research Report*. Saskatoon: Community-University Institute for Social Research.

Chopin, N., S. Hogg, S. McHenry, J. Popham, M. Stoops, S. Takahashi, & I.M. Findlay. (2012). *Fetal Alcohol Spectrum Disorder Awareness and prevention Strategies: Learning from the Reported Alcohol Knowledge and Behaviours of College-Age Youth — A Research Report*. Saskatoon: Community-University Institute for Social Research.

Chopin, Nichola, Bill Holden, Nazeem Muhajarine, & James Popham. (2010). *Ten Years of Quality of Life in Saskatoon: Summary of Research 2010 Iteration*. Saskatoon: Community-University Institute for Social Research.



Chopin, N., & I.M. Findlay. (2010). *Exploring Key Informants' Experiences with Self-Directed Funding: A Research Report*. Saskatoon: Community-University Institute for Social Research and Centre for the Study of Co-operatives.

Chopin, N., & S. Wormith. (2008) *Count of Saskatoon Homeless Population: Research Findings*. Saskatoon: Community-University Institute for Social Research.

CUISR. (2001). *Proceedings of the Prairie Urban Congress 2001*. With support from Canada Mortgage and Housing Corporation, City of Saskatoon, GE Capital Mortgage & Insurance Canada, Government of CANADA, Saskatchewan Housing Corporation, and Western Economic Diversification Canada. Saskatoon: Community-University Institute for Social Research.

CUISR. (2002). *Partnerships for a Healthy Sustainable Community: CUISR — Present and Future*. Saskatoon: Community-University Institute for Social Research.

CUISR. (2003). *"We Did It Together": Low-Income Mothers Working Towards a Healthier Community*. Saskatoon: Community-University Institute for Social Research.

CUISR. (2004). *Building Community Together: CUISR — Present and Future*. Saskatoon: Community-University Institute for Social Research.

CUISR. (2004). *CUISR at the Crossroads: Strategic Planning Session, June 23, 2004*. Saskatoon: Community-University Institute for Social Research.

CUISR. (2005). *Partnering to Build Capacity and Connections in the Community*. Saskatoon: Community-University Institute for Social Research.

CUISR. (2010). *2009 Saskatoon HIFIS Report on Homelessness*. Saskatoon: Community-University Institute for Social Research.

Daniel, Ben. (2006). *Evaluation of the YWCA Emergency Crisis Shelter: Staff and Stakeholder Perspectives*. Saskatoon: Community-University Institute for Social Research. Contact the YWCA at 244-7034, ext. 121 or at info@ywcaskatoon.com for copies of this report.



Diamantopoulos, Mitch, & April Bourgeois. (2014). *Worker Co-operative Development: Problems, Prospects, and Proposals*. Saskatoon: Centre for the Study of Co-operatives and Community-University Institute for Social Research



Diamantopoulos, Mitch, & Isobel M. Findlay. (2007). *Growing Pains: Social Enterprise in Saskatoon's Core Neighbourhoods*. Saskatoon: Centre for the Study of Co-operatives and Community-University Institute for Social Research



Dozar, Marsha, Don Gallant, Judy Hannah, Emily Hurd, Jason Newberry, Ken Pike, & Brian Salisbury. (2012). *Individualized Funding: A Framework for Effective Implementation*. Saskatoon: Centre for the Study of Co-operatives and Community-University Institute for Social Research.

Drechsler, Coralee. (2003). *Influencing Poverty Reduction Policy Through Research Evidence: Immigrant Women's Experience in Saskatoon*. Saskatoon: Community-University Institute for Social Research.

Dressler, Mary Pat (2004). *Aboriginal Women Share Their Stories in an Outreach Diabetes Education Program*. Saskatoon: Community-University Institute for Social Research.

Dunning, Heather. (2004). *A Mixed Method Approach to Quality of Life in Saskatoon*. Saskatoon: Community-University Institute for Social Research.

Dyck, Carmen. (2004). "Off Welfare ... Now What?" *A Literature Review on the Impact of Provincial Welfare to Work Training Programs in Saskatchewan*. Saskatoon: Community-University Institute for Social Research.

Dyck, Carmen G. (2005). "Off Welfare ... Now What?" *Phase II, Part 2: Analysis*. Saskatoon: Community-University Institute for Social Research.



Elliott, Patricia W. (2011). *Participatory Action Research: Challenges, Complications, and Opportunities*. Saskatoon: Centre for the Study of Co-operatives and Community-University Institute for Social Research.

Engler-Stringer, Rachel. (2006). *Collective Kitchens in Three Canadian Cities: Impacts on the Lives of Participants*. Saskatoon: Community-University Institute for Social Research.

Engler-Stringer, R., & J. Harder. (2011). *Toward Implementation of the Saskatoon Food Charter: A Report*. Saskatoon: Community-University Institute for Social Research

Evitts, Trina, Nazeem Muhajarine, & Debbie Pushor. (2005). *Full-Time Kindergarten in Battlefords School Division #118 Community Schools*. Saskatoon: Community-University Institute for Social Research.

Fernandes, Neville. (2003). *Saskatchewan's Regional Economic Development Authorities: A Background Document*. Saskatoon: Community-University Institute for Social Research.

Fillingham, Jennifer. (2006). *SEN-CUISR — Environmental Charitable Organization Feasibility Study, Phase Two*. Saskatoon: Community-University Institute for Social Research.



Findlay, Isobel M., Julia Bidonde, Maria Basualdo, & Alyssa McMurtry. (2009). *South Bay Park Rangers Employment Project for Persons Living with a Disability: A Case Study in Individual Empowerment and Community Interdependence*. Saskatoon: Community-University Institute for Social Research and Centre for the Study of Co-operatives.



Findlay, Isobel M., & Anar Damji. (2013). *Self-Directed Funding: An Evaluation of Self-Managed Contracts in Saskatchewan*. Saskatoon: Community-University Institute for Social Research and Centre for the Study of Co-operatives.



Findlay, Isobel M., James Popham, Patrick Ince, & Sarah Takahashi. (2013). *Through the Eyes of Women: What a Co-operative Can Mean in Supporting Women during Confinement and Integration*. Saskatoon: Community-University Institute for Social Research and Centre for the Study of Co-operatives.

Findlay, Isobel M., Bill Holden, Giselle Patrick, & Stephen Wormith. (2013). *Saskatoon's Homeless Population 2012: A Research Report*. Saskatoon: Community-University Institute for Social Research. July 30. 70 pp.

Findlay, Isobel M., Joe Garcea, John Hansen, Rose Antsanen, Jethro Cheng, & Bill Holden. (2014). *Comparing the Lived Experience of Urban Aboriginal Peoples with Canadian Rights to Quality of Life*. Saskatoon: Community-University Institute for Social Research and UAKN Prairie Regional Research Centre.

Findlay, Isobel M., Jania Chilima, Tamara Chambers-Richards, Vincent Bruni-Bossio, Dana Carrière, & William Rowluck. (2016). *The Urban Aboriginal Service Delivery Landscape: hemes, Trends, Gaps and Prospects: Final Report*. Saskatoon: Community-University Institute for Social Research and UAKN Prairie Regional Research Centre.

Findlay, Isobel M., Sana Rachel Sunny, Sugandhi del Canto, Colleen Christopherson-Côté, & Lisa Erickson. (2017). *Impacting Community Strength and Sustainability: Community-Campus Engagement and Poverty Reduction at Station 20 West*. Saskatoon: Community-University Institute for Social Research.

Findlay, Isobel M., Jania Chilima, Bill Holden, & Abdrahmane Berthe. (2018). *2018 Point-in-Time Homelessness Count, Saskatoon, Saskatchewan*. Saskatoon: Community-University Institute for Social Research.



Garcea, Joe, & Neil Hibbert. (2014). *International Students in Saskatchewan: Policies, Programs, and Perspectives*. Saskatoon: Community-University Institute for Social Research and Centre for the Study of Co-operatives.

Gauley, Marg. (2006). *Evaluation of Respectful Conflict Resolution and Peer Mediation Program*. Saskatoon: Community-University Institute for Social Research.

Gold, Jenny. (2004). *Profile of an Inter-Sectoral Issue: Children Not in School*. Saskatoon: Community-University Institute for Social Research.

Gress, Cara Spence, Isobel M. Findlay, Bill Holden, Stephen Wormith, Pamela Brotzel, Sana Rachel Sunny, & Hanna Holden. (2015). *2015 Point-in-Time Homelessness Count: Saskatoon, Saskatchewan*. Saskatoon: Community-University Institute for Social Research.

Grosso, Paula. (2003). *Uprooting Poverty and Planting Seeds for Social Change: The Roots of Poverty Project*. Saskatoon: Community-University Institute for Social Research.

Grosso, Paula, & Jodi Crewe. (2004). *Project Greenhorn: Community Gardening*. Saskatoon: Community-University Institute for Social Research.

Harlingten, Leora. (2004). *Saskatoon Charging and Disposition Patterns Under Section 213 of the Criminal Code of Canada*. Saskatoon: Community-University Institute for Social Research.



Heit, Jason. (2012). *Mapping Social Capital in a Network of Community Development Organizations: The South West Centre for Entrepreneurial Development Organizational Network*. Saskatoon: Centre for the Study of Co-operatives and Community-University Institute for Social Research.

Henry, Carol J., Carol Vandale, Susan Whiting, Flo Woods, Shawna Berenbaum, & Adrian Blunt. (2006). *Breakfast/Snack Programs in Saskatchewan Elementary Schools: Evaluating Benefits, Barriers, and Essential Skills*. Saskatoon: Community-University Institute for Social Research.



Hurd, E., & L. Clarke. (2014). *Awareness of and Support for the Social Economy in Saskatoon: Opinion Leader Views*. Saskatoon: Centre for the Study of Co-operatives and Community-University Institute for Social Research.



Hurd, Emily. (2012). *Community Conversations about the Good Food Junction Co-operative*. Saskatoon: Centre for the Study of Co-operatives and Community-University Institute for Social Research.

Jackson, Maureen. (2004). *Closer to Home: Child and Family Poverty in Saskatoon*. Saskatoon: Community-University Institute for Social Research.

Janzen, Bonnie. (2003). *An Evaluation of the Federation of Canadian Municipalities Quality of Life Reporting System*. Saskatoon: Community-University Institute for Social Research.

Jimmy, Ryan, & Isobel M. Findlay. (2015). *YXE Connects 2015: A Research Report*. Saskatoon: Community-University Institute for Social Research.

Jonker, Peter, Colleen Whitedeer, & Diane McDonald. (2005). *Building Capacity of Fond du Lac Entrepreneurs to Establish and Operate Local Tourism Business: Assessment and Proposed Training*. Saskatoon: Community-University Institute for Social Research.

Kachur, Brittany. (2014). *Urban First Nations, Inuit, and Metis Diabetes Prevention Project: Fresh Food Market Evaluation*. Saskatoon: Community-University Institute for Social Research.

- Kalagnanam, Suresh S., Abdrahmane Berthe, & Isobel M. Findlay. (2019). *Social Return on Investment Financial Proxies and the Saskatoon Poverty Elimination Strategy*. Saskatoon: Community-University Institute for Social Research.
- Kelsey, Melissa V. (2004). *Determining Saskatoon's Value Profile*. Saskatoon: Community-University Institute for Social Research.
- Klimosko, Kris, Marjorie Delbaere, & Isobel M. Findlay. (2015). *Engaging Provincial Stakeholders: A Strategic Communication Plan for Department of Pediatrics*. Saskatoon: Community-University Institute for Social Research.
- Klymyshyn, Sherry, & Lee Everts. (2007). *Evaluation of Saskatoon Community Clinic Group Program for "At Risk" Elderly*. Saskatoon: Community-University Institute for Social Research.
- Kynoch, Bev. (2003). *The Brightwater Environmental and Science Project: Respecting Traditional Ecological Knowledge — The Soul of a Tribal People*. Saskatoon: Community-University Institute for Social Research.
- Li, Song. (2004). *Direct Care Personnel Recruitment, Retention and Orientation*. Saskatoon: Community-University Institute for Social Research.
- Lisoway, Amanda. (2004). *211 Saskatchewan Situational Analysis*. Saskatoon: Community-University Institute for Social Research.
-  Lynch, Karen, & Isobel M. Findlay. (2007). *A New Vision for Saskatchewan: Changing Lives and Systems through Individualized Funding for People with Intellectual Disabilities — A Research Report*. Saskatoon: Centre for the Study of Co-operatives and Community-University Institute for Social Research.
-  Lynch, Karen, Cara Spence, & Isobel M. Findlay. (2007). *Urban Aboriginal Strategy Funding Database: A Research Report*. Saskatoon: Centre for the Study of Co-operatives and Community-University Institute for Social Research.
- MacDermott, Wendy. (2003). *Child Poverty in Canada, Saskatchewan, and Saskatoon: A Literature Review and the Voices of the People*. Saskatoon: Community-University Institute for Social Research.
- MacDermott, Wendy. (2004). *Youth ... on the Brink of Success. Youth Addictions Project*. Saskatoon: Crime Prevention — Community Mobilization and Community-University Institute for Social Research.
- MacDermott, Wendy. (2004). *Common Functional Assessment and Disability-Related Agencies and Departments in Saskatoon*. Saskatoon: Community-University Institute for Social Research.
- MacDermott, Wendy. (2004). *Evaluation of the Activities of the Working Group to Stop the Sexual Exploitation of Children*. Saskatoon: Community-University Institute for Social Research.
- McDowell, Megan, & Isobel M. Findlay. (2014). *Healthy Seniors on the 'Net: Assessing the Saskatoon Public Library's Computer Project*. Saskatoon: Community-University Institute for Social Research.

- McRae, Stacy, & Keith Walker. (2007). *An Evaluation of Family to Family Ties: A Review of Family Mentorship in Action*. Saskatoon: Community-University Institute for Social Research.
- Moneo, Cameron, Maria Basualdo, Isobel M. Findlay, & Wendy MacDermott. (2008). *Broadway Theatre Membership Assessment. A Research Report*. Saskatoon: Community-University Institute for Social Research.
- Muhajarine, Nazeem, Stacey McHenry, Jethro Cheng, James Popham, & Fleur MacQueen-Smith. (2013). *Phase One Evaluation: Improving Outcomes for Children with FASD in Foster Care: Final Report*. Saskatoon: Community-University Institute for Social Research and Saskatchewan Population Health and Evaluation Research Unit.
- Muhajarine, Nazeem, Maureen Horn, Jody Glacken, Trina Evitts, Debbie Pushor, & Brian Keegan. (2007). *Full Time Kindergarten in Saskatchewan, Part One: An Evaluation Framework for Saskatchewan Full-Time Kindergarten Programs*. Saskatoon: Community-University Institute for Social Research.
- Muhajarine, Nazeem, Trina Evitts, Maureen Horn, Jody Glacken, & Debbie Pushor. (2007). *Full-Time Kindergarten in Saskatchewan, Part Two: An Evaluation of Full-Time Kindergarten Programs in Three School Divisions*. Saskatoon: Community-University Institute for Social Research.
- Ofosuhene, Maxwell. (2003). *Saskatchewan River Basin-Wide Survey of Residents' Attitudes Towards Water Resources and the Environment*. Saskatoon: Community-University Institute for Social Research.
- Olfert, Sandi. (2003). *Quality of Life Leisure Indicators*. Saskatoon: Community-University Institute for Social Research.
-  Pattison, Dwayne, & Isobel M. Findlay. (2010). *Self-Determination in Action: The Entrepreneurship of the Northern Saskatchewan Trapper's Association Co-operative*. Saskatoon: Community-University Institute for Social Research and Centre for the Study of Co-operatives.
- Pham, Anh, Suresh S. Kalagnanam, & Isobel M. Findlay. (2020). *Prairie Hospice Society: Social Return on Investment Analysis Report*. Saskatoon: Community-University Institute for Social Research.
- Prokop, Shelley Thomas. (2009). *Program Evaluation of the Saskatoon Community Clinic: Strengthening the Circle Program*. Saskatoon: Community-University Institute for Social Research.
- Propp, A.J. (Jim). (2005). *Preschool: As Essential As Food. An Effectiveness Review of the Saskatoon Preschool Foundation Tuition Subsidy Program*. Saskatoon: Community-University Institute for Social Research.
- Quaife, Terra, Laurissa Fauchoux, David Mykota, & Isobel M. Findlay. (2014). *Program Evaluation of Crisis Management Services*. Saskatoon: Community-University Institute for Social Research.
- Quinlan, Elizabeth, Ally Clarke, & Natasha Miller. (2013). *Coordinating and Enhancing Care and Advocacy for Sexual Assault Survivors: New Collaborations and New Approaches*. Saskatoon: Community-University Institute for Social Research.

- Radloff, Karla. (2006). *Community Resilience, Community Economic Development, and Saskatchewan Economic Developers*. Saskatoon: Community-University Institute for Social Research.
- Reed, Maureen. (2003). *Situating Indicators of Social Well-Being in Rural Saskatchewan Communities*. Saskatoon: Community-University Institute for Social Research.
- Roberts, Claire. (2006). *Refugee Women and Their Postpartum Experiences*. Saskatoon: Community-University Institute for Social Research.
- Ruby, Tabassum. (2004). *Immigrant Muslim Women and the Hijab: Sites of Struggle in Crafting and Negotiating Identities in Canada*. Saskatoon: Community-University Institute for Social Research.
- Sanderson, K. (2005). *Partnering to Build Capacity and Connections in the Community*. Saskatoon: Community-University Institute for Social Research.
- Sanderson, Kim, Michael Gertler, Diane Martz, & Ramesh Mahabir. (2005). *Farmers' Markets in North America: A Literature Review*. Saskatoon: Community-University Institute for Social Research.
- Schmidt, Heather, Cynthia Chataway, Patrick Derocher, Jeff McCallum, & Yolanda McCallum. (2006). *Understanding the Strengths of the Indigenous Communities: Flying Dust First Nation Focus Group Report*. Saskatoon: Community-University Institute for Social Research.
- Schwark, Tyler, Rahul Waikar, Suresh S. Kalagnanam, & Isobel M. Findlay. (2014). *Saskatchewan Summer Literacy: An Evaluation of Summer Reading Programming in Saskatchewan Public Libraries*. Saskatoon: Community-University Institute for Social Research.
- Seguin, Maureen. (2006). *Alberta Mentoring Partnerships: Overview and Recommendations to Saskatoon Mentoring Agencies*. Saskatoon: Community-University Institute for Social Research.
- Sinclair, Raven, & Sherri Pooyak (2007). *Aboriginal Mentoring in Saskatoon: A Cultural Perspective*. Saskatoon: Indigenous Peoples' Health Research Centre in collaboration with Big Brothers Big Sisters of Saskatoon and the Community-University Institute for Social Research.
- Sivajohanathan, Duvaraga, Isobel M. Findlay, & Renata Andres, 2014. *Parent Resources for Information, Development, and Education: Pre-Service Evaluation — A Research Report*. Saskatoon: Community-University Institute for Social Research.
- Soles, Kama. (2003). *Affordable, Accessible Housing Needs Assessment at the North Saskatchewan Independent Living Centre*. Saskatoon: Community-University Institute for Social Research.
-  Spence, Cara, & Isobel M. Findlay. (2007). *Evaluation of Saskatoon Urban Aboriginal Strategy: A Research Report*. Saskatoon: Community-University Institute for Social Research.
- Stadnyk, Nadia, Nazeem Muhajarine, & Tammy J. Butler. (2005). *The Impact of KidsFirst Saskatoon Home Visiting Program in Families' Lives*. Saskatoon: Community-University Institute for Social Research.
- Sun, Yinshe. (2005). *Development of Neighbourhood Quality of Life Indicators*. Saskatoon: Community-University Institute for Social Research.

- Tannis, Derek. (2005). *Mentoring in Saskatoon: Toward a Meaningful Partnership*. Saskatoon: Community-University Institute for Social Research.
- Townsend, Lynne. (2004). *READ Saskatoon: Literacy Health Benefits Research*. Saskatoon: Community-University Institute for Social Research.
- Tupone, Juliano. (2003). *The Core Neighbourhood Youth Co-op: A Review and Long-Term Strategy*. Saskatoon: Community-University Institute for Social Research.
- Umereweneza, Patience, Isobel M. Findlay, Marie Lovrod, Crystal Giesbrecht, Manuela Valle-Castro, Natalya Mason, Jaqueline Anaquod, & Renée Hoffart. (2019). *Sexual Violence in Saskatchewan: A Survey Report*. Saskatoon: Community-University Institute for Social Research.
- Patience Umereweneza, Marie Lovrod, Isobel M. Findlay, Crystal Giesbrecht, Manuela Valle-Castro, Natalya Mason, Jaqueline Anaquod, & Renee Hoffart. (2020). *Sexual Violence in Saskatchewan: Voices, Stories, Insights, and Actions from the Front Lines*. Saskatoon: Community-University Institute for Social Research.
- Victor, Janice. (2011). *Report to the Saskatoon Regional Intersectoral Committee: The Middle Ring Evaluation*. Saskatoon: Community-University Institute for Social Research.
- Wāhpāsiw, Omeasoo, Isobel M. Findlay, & Lisa Erickson. (2015). *Exploring the Potential for a University of Saskatchewan Research Shop: A Compliance Report*. Saskatoon: Community-University Institute for Social Research.
- Waikar, Rahul, Suresh Kalagnanam, & Isobel M. Findlay. (2013). *Financial Proxies for Social Return on Investment Analyses in Saskatchewan: A Research Report*. Saskatoon: Community-University Institute for Social Research.
- Williams, Alison, with Sylvia Abonyi, Heather Dunning, Tracey Carr, Bill Holden, Ron Labonte, Nazeem Muhajarine, & Jim Randall. (2001). *Achieving a Healthy, Sustainable Community: Quality of Life in Saskatoon, Saskatchewan. Research Summary*. Saskatoon: Community-University Institute for Social Research.
- Wohlgemuth, Nicole R. (2004). *School Fees in Saskatoon*. Saskatoon: Community-University Institute for Social Research.
- Woods, Florence. (2003). *Access to Food in Saskatoon's Core Neighborhood*. Saskatoon: Community-University Institute for Social Research.
- Wright, Judith, & Nazeem Muhajarine. (2003). *Respiratory Illness in Saskatoon Infants: The Impact of Housing and Neighbourhood Characteristics*. Saskatoon: Community-University Institute for Social Research.



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