

Social Return on Investment Report (SROI) – Taichung Veterans General Hospital



Activity: National Health Insurance Post-Acute Care (PAC) Program - Heart Failure

Type of Analysis: Forecast-type Social Return on Investment (SROI)

Date of Publication: January 2026

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1 Program Introduction

1.1 Program Background

This report analyzes the program “National Health Insurance Post-Acute Care (PAC) Program - Heart Failure”, with Taichung Veterans General Hospital (TCVGH) serving as the main implementing institution. TCVGH is responsible for case enrollment, care delivery, team integration, and performance reporting. This program aims to provide a six-month integrated care service for hospitalized patients aged 18 and above with a left ventricular ejection fraction (LVEF) \leq 40% and clinically stable conditions (NYHA Functional Class II~III) after discharge. The hospital also conducts a one-year follow-up period, which includes regular outpatient visits with specialists, remote monitoring, mobile app tracking, nutritional and rehabilitation guidance, and family caregiver support. The goal is to enhance patients’ self-care ability and overall quality of life, while reducing the risk of rehospitalization and acute deterioration.

Since 2014, Taichung Veterans General Hospital (TCVGH) has established a dedicated Heart Failure Department. In 2017, the hospital launched a Post-Acute Care (PAC) program for heart failure patients, forming a multidisciplinary team composed of cardiologists, nurses, dietitians, physical therapists, social workers, and case managers to provide integrated outpatient care services. As one of the first medical centers in Taiwan to adopt an integrated care model for heart failure, TCVGH demonstrated the program’s effectiveness during the 2018–2019 pilot period. The hospital successfully reduced the six-month hospital readmission rate from 50% to 1.5%, highlighting the significant social value and potential for broader dissemination of this care model.

This program aligns with the overall Post-Acute Care (PAC) policy direction promoted by the National Health Insurance Administration, Ministry of Health and Welfare (NHIA), emphasizing a continuum of care that transitions patients from the acute phase to post-acute recovery and eventually to chronic stabilization. The objective is to enhance medical efficiency, improve patient outcomes, and strengthen the long-term sustainability of the healthcare system. Taichung Veterans General Hospital intends to apply the Social Return on Investment (SROI) methodology to forecast and analyze the potential social impact and value creation resulting from the implementation of this program. The findings will serve as empirical evidence to support future policy refinement, system expansion, and outcome-based performance evaluation.

1.2 Social Return on Investment Analysis Method

“National Health Insurance Post-Acute Care (PAC) Program - Heart Failure” has established a comprehensive clinical monitoring framework. This includes functional improvement indicators such as ADL and the 6-minute walk test, as well as readmission and mortality rates. It has also built an integrated care process through cross-institutional collaboration. In addition, subjective tools such as the Minnesota Living with Heart Failure Questionnaire (MLHFQ) are used to assess quality of life. However, these indicators mainly reflect internal clinical performance and cannot fully capture the overall social benefits experienced by patients, families, caregivers, medical teams, and policy stakeholders. Social Return on Investment (SROI) helps fill this gap. By involving stakeholders, constructing theory of chain of events, translating outcomes, and estimating value, SROI makes otherwise “hard-to-measure” benefits tangible.

This program uses SROI analysis to reveal the following core social values:

- (1) Patients regain self-worth and social participation through stability and functional recovery.
- (2) Families experience improved quality of life and relationships due to reduced caregiving burden.
- (3) Medical teams enhance professional fulfillment and competency through collaborative care.
- (4) Evidence-based confirmation of social benefits enables the National Health Insurance Policy Division to advance policy development and scale implementation

Accordingly, this report uses a forecast-type SROI analysis. It combines clinical and non-clinical indicators to measure social value across patients, families, medical teams, and policy makers. This approach addresses the limitations of current tools and offers a solid, scalable, and communicable basis for public health policy.

This program applies a forecast-type Social Return on Investment (SROI) analysis to assess the impact and quantify the value generated by the “National Health Insurance Post-Acute Care Integrated Program — Heart Failure,” implemented at Taichung Veterans General Hospital (TCVGH). The forecast-type SROI is especially appropriate for policies and service programs that are still underway or not yet fully scaled. It programs potential future social value based on current outcomes and initial stakeholder feedback, providing an essential basis for ongoing investment, institutionalization, and policy refinement.

Patient enrollment in this program was conducted on a rolling basis, and the care process itself may extend across multiple calendar years. To ensure consistency, this report analyzes cases from the full year of 2022 as the foundation for model construction. The analysis adheres to the SROI Principles and Assurance Standards published by Social Value International (SVI). Key steps include identifying stakeholders, constructing chains of events, monetizing outcomes, adjusting for deadweight, attribution, drop-off, and displacement, and re-evaluating the expected duration of outcome. Finally, the analysis calculates the overall SROI ratio and supplements it with qualitative findings and risk assessments.

Through the use of a forecast-type SROI model, Taichung Veterans General Hospital aims to empirically demonstrate the multifaceted value generated by the Post-Acute Care (PAC) program for patients, caregivers, medical teams, and policy-making bodies. This approach is intended to strengthen stakeholder communication, while also serving as a critical reference for future resource allocation under the National Health Insurance system and for the broader dissemination of integrated care models.

1.3 Analysis Period and Scope

The analysis covers the period from January 1, 2022 to December 31, 2022. This year was selected as the analysis period because it was the first full year after COVID-19 had become normalized. During this year, patient enrollment was sufficient, care pathways were complete, and data availability was high. Moreover, the majority of patients completed their primary medical care and remote follow-up within the same year, making it both representative and meaningful for forecasting. In addition, since patient enrollment for this program was conducted on a rolling basis, many patients’ actual care spanned across calendar years. Analyzing data from 2023 and beyond would be unfavorable for modeling and validation, as care

would be incomplete and indicators unstable. Therefore, this report focuses on data from 2022 as the sample basis for the forecast-type SROI model.

The geographical scope of this program primarily centers around Taichung Veterans General Hospital, located in Xitun District, Taichung City. The patient population predominantly comes from Taichung City, Nantou County, Changhua County, and Miaoli County. Both acute and post-acute care are provided within TCVGH, which operates a dedicated heart failure outpatient clinic offering integrated care services. Accordingly, the social value assessed in this report reflects the real-world context of the program, including patients' living environments, healthcare-seeking behaviors, and resource distribution across the aforementioned regions.

1.4 Purpose and Audience of the SROI Report

This report is produced from the “National Health Insurance Post-Acute Care (PAC) Program - Heart Failure” implemented by Taichung Veterans General Hospital. A forecast-type Social Return on Investment (SROI) analysis is applied to assess the multifaceted social value generated during the program's actual implementation. This includes improved patient health, better caregiver quality of life, stronger team effectiveness, and policy-level benefits. The report is structured in accordance with international social value standards (Social Value International), aiming to present non-financial impacts in concrete, monetized terms as a common language for policy and practice communication.

The report is intended for:

- (1) NHIA: As the policy authority, NHIA can use the findings of this report to review the effectiveness of the current integrated care practice. These findings can also serve as a basis for future expansion, institutionalization, or adjustments to the subsidy mechanism.
- (2) TCVGH internal decision-makers and care teams: This report can serve as a reference tool for cross-institutional review and forward-looking planning. It strengthens the perceived value of teamwork and helps internal stakeholders understand the implicit benefits brought by non-clinical indicators.
- (3) Collaborative Care Partners: By presenting the impact pathway and benefit dimensions revealed in this report, the program aims to enhance shared understanding among collaborative care members regarding the overall effectiveness of the initiative, thereby strengthening motivation for continued implementation.
- (4) Third-party verifiers and researchers: Developed through standardized methods and a logical model, this report provides a foundation for validation and communication. It also serves as an empirical case to support the future promotion of SROI analysis in healthcare sector.

Through this report, TCVGH hopes to deepen the healthcare system's understanding of the social benefits of integrated care. It also aims to help relevant institutions obtain more persuasive quantitative evidence and practical experience to support the implementation of value-based care policies.

2 Methodology

2.1 Introduction to SROI

This study adopts the Social Return on Investment (SROI) approach as the core evaluation methodology. SROI is a social impact assessment tool that emphasizes the comprehensive capture of social value, monetization of outcomes, and incorporation of stakeholder perspectives. Its primary goal is to measure the overall value created by a program, policy, or investment for society, and express the corresponding return in monetary terms relative to the resources invested.

2.1.1 SROI Evaluation Framework

SROI is based on an impact management logic and proceeds through the following six steps:

Step 1: Define scope and identify stakeholders – Clarify the scope of the program’s impact and its key beneficiaries.

Step 2: Develop a theory of change – Describe the logical relationships and change processes from inputs to outputs and outcomes.

Step 3: Measure outcomes and assign indicators – Design qualitative or quantitative indicators to verify that outcomes have occurred.

Step 4: Monetize outcomes – Use market value, proxy market methods, revealed preference, or well-being valuation to convert intangible outcomes into monetary terms.

Step 5: Adjust for impact factors – Account for deadweight, attribution, displacement, and drop-off to avoid overestimating impact.

Step 6: Calculate the SROI value – Calculate the SROI ratio by dividing the present value of benefits by the total investment, and verify robustness through sensitivity analysis.

2.1.2 Methodological Features

SROI is a mixed-methods evaluation approach that combines qualitative and quantitative techniques. It emphasizes a process that includes stakeholder engagement, outcome chain development, monetization of results, and adjustments for impact factors, in order to quantify non-financial outcomes—such as social, environmental, and economic impacts—and to assess the social value generated per unit of investment.

Key features of the SROI methodology include:

- (1) Stakeholder-oriented – Through in-depth interviews, surveys, and workshops, stakeholders’ real experiences and perspectives are fully incorporated into identifying and verifying outcomes.
- (2) Rigorous theory of change – Through a logical chain of inputs, outputs, and short-, medium-, and long-term outcomes, the process of impact generation is systematically illustrated to avoid breaks or oversimplification in causal reasoning.
- (3) Adjustment of impact factors – Includes deadweight, attribution, displacement, and drop-off to ensure valuation reflects the program’s unique contribution without inflation.

- (4) Monetization of outcomes – Applies various approaches including cost-based methods, anchoring method and well-being valuation to convert non-financial outcomes into monetary terms.
- (5) Inclusion of long-term impact – Uses duration, annual drop-off, and discounting to project future social value and account for the time-related aspects of impact.

2.1.3 Relevance to the Heart Failure Care Program at TCVGH

The heart failure care program at TCVGH involves multiple stakeholders and has significant impacts across medical, psychological, family, and social domains. The application of SROI effectively captures the social value of this integrated healthcare service. Compared to traditional medical evaluations that focus only on clinical or financial metrics, SROI adopts a holistic perspective that includes improvements in patient health, emotional stability, caregiver stress relief, and the professional growth and cohesion of the care team, thereby forming a comprehensive framework for value assessment. By constructing the theory of change and monetizing outcomes, the approach makes previously unquantifiable social impacts concrete. Impact factor adjustments further ensure objectivity and credibility of the evaluation. In addition, the impact of the heart failure care program is long-term and cross-disciplinary in nature. The inclusion of duration, drop-off rate, and discount rate in the SROI methodology accurately captures the temporal dimension and changes in outcomes, providing policy makers such as the NHIA with robust and evidence-based insights. For TCVGH, SROI not only helps quantify the program's social value, but also supports value-based healthcare practice and enhances visibility in policy and public engagement, demonstrating the medical system's vital role in sustainable development and public health.

2.1.4 Types of SROI Analysis

SROI can be categorized into two types depending on the implementation stage, each suited to different decision-making needs and practical applications:

First, Evaluative SROI is applied to programs or activities that have already been implemented. Using retrospective methods, it evaluates the actual social, economic, and environmental impacts. This type of evaluation focuses on the collection of empirical data and the verification of existing outcomes. By drawing on actual data and stakeholder feedback, it concretely demonstrates the value created following the program's intervention.

Second, Forecast SROI is conducted during the planning or early implementation stages of a program to analyze the anticipated social value it may generate. Its purpose is not only to estimate the potential return on investment but also to help decision-makers optimize resource allocation, clarify the logic of the outcome chain, and identify key indicators that need to be observed and recorded, thereby enhancing the accuracy of future implementation and evaluation. Forecast evaluations also facilitate ongoing tracking of outcome changes during program implementation, laying the foundation for future evaluative SROI.

The SROI evaluation of the heart failure care program at Taichung Veterans General Hospital (TCVGH) is a forecast-type assessment. Since its pilot phase, the program has developed into a stable model and is expected to continue expanding in the future. Through forecast SROI, the anticipated future impacts of currently observed outcomes can be quantified. This approach also supports policymakers, such as the NHIA, in evaluating the feasibility of scaling and institutionalizing the

program. Moreover, it helps TCVGH and relevant agencies establish a more systematic framework for outcome monitoring, resource allocation, and impact verification as the program progresses—ensuring the sustainability and traceability of the social value being created..

2.1.5 Application and Practical Implications of the Eight Principles of SROI in the Heart Failure Care Program of Taichung Veterans General Hospital

1. Involve stakeholders

SROI emphasizes that all value creation originates from stakeholders. Their full participation is required to ensure the evaluation reflects their real experiences and areas of concern.

In this program, stakeholders include patients with heart failure, family members, various healthcare professionals, case managers, medical staff, and the NHIA. Through interviews, surveys, and workshops, their understanding of and perspectives on program changes were comprehensively collected and incorporated, establishing the social validity of the evaluation.

2. Understand what changes

SROI requires systematic understanding of what has changed—not just outputs (e.g., revisit rates, clinical control) but also “outcomes”—tangible changes in stakeholders’ lives, emotions, finances, and mental health.

This report established a detailed theory of change (or outcomes chain) to describe the logical relationships from inputs, activities, and outputs to final outcomes. These were verified both quantitatively and qualitatively through stakeholder feedback.

3. Value the things that matter

SROI focuses on “the "changes stakeholders care about most”. Even non-financial or emotional changes must be monetized to reflect their importance.

For the TCVGH program, in addition to hard indicators such as condition stabilization and reduced readmissions, intangible but important outcomes—such as emotional security, caregiving burden relief, strengthen self-efficacy & confidence, and vocational development etc. —were also included in the valuation to avoid the social values that truly matter to stakeholders were overlooked.

4. Only include what is material

SROI requires that only outcomes meeting “the principle of materiality” be included. Outcomes that are not directly related to the program or have minimal impact should be excluded.

Taichung Veterans General Hospital conducted interviews, expert assessments, and questionnaire surveys as part of its SROI evaluation. For each outcome, the analysis incorporated adjustments for deadweight, attribution, displacement, and drop-off factors to ensure that only the value genuinely created by the project was assessed, avoiding over-crediting the program for broader social changes.

5. **Do not over-claim**

Using the above impact adjustment factors, the program avoids “over-claimed” or “double-counting” results, especially when multiple stakeholders are involved or when outcomes evolve over time. Sensitivity analysis verifies the reasonableness of the valuation.

TCVGH plans to systematically disclose the source of each outcome, the calculation formulas, valuation basis, and stakeholder feedback in this evaluation report. The report also identifies potential sources of bias and includes sensitivity analysis results to ensure the credibility of the evaluation results.

6. **Be transparent**

SROI reports must fully disclose methodology, assumptions, data sources, and decision processes to allow external scrutiny.

This report details the origin, calculation formula, valuation basis, and stakeholder feedback for each outcome, while identifying potential bias and presenting sensitivity results to maintain credibility.

7. **Verify the result**

SROI evaluation emphasizes to strengthen evaluation reliability through the independent third-party assurance or internal review.

Although formal assurance has not yet been applied for during the evaluation stage of this project, a self-assessment and internal review have been conducted in accordance with the SROI assurance standards set by Social Value International. The possibility of seeking formal assurance in the future remains open to ensure the quality of the evaluation.

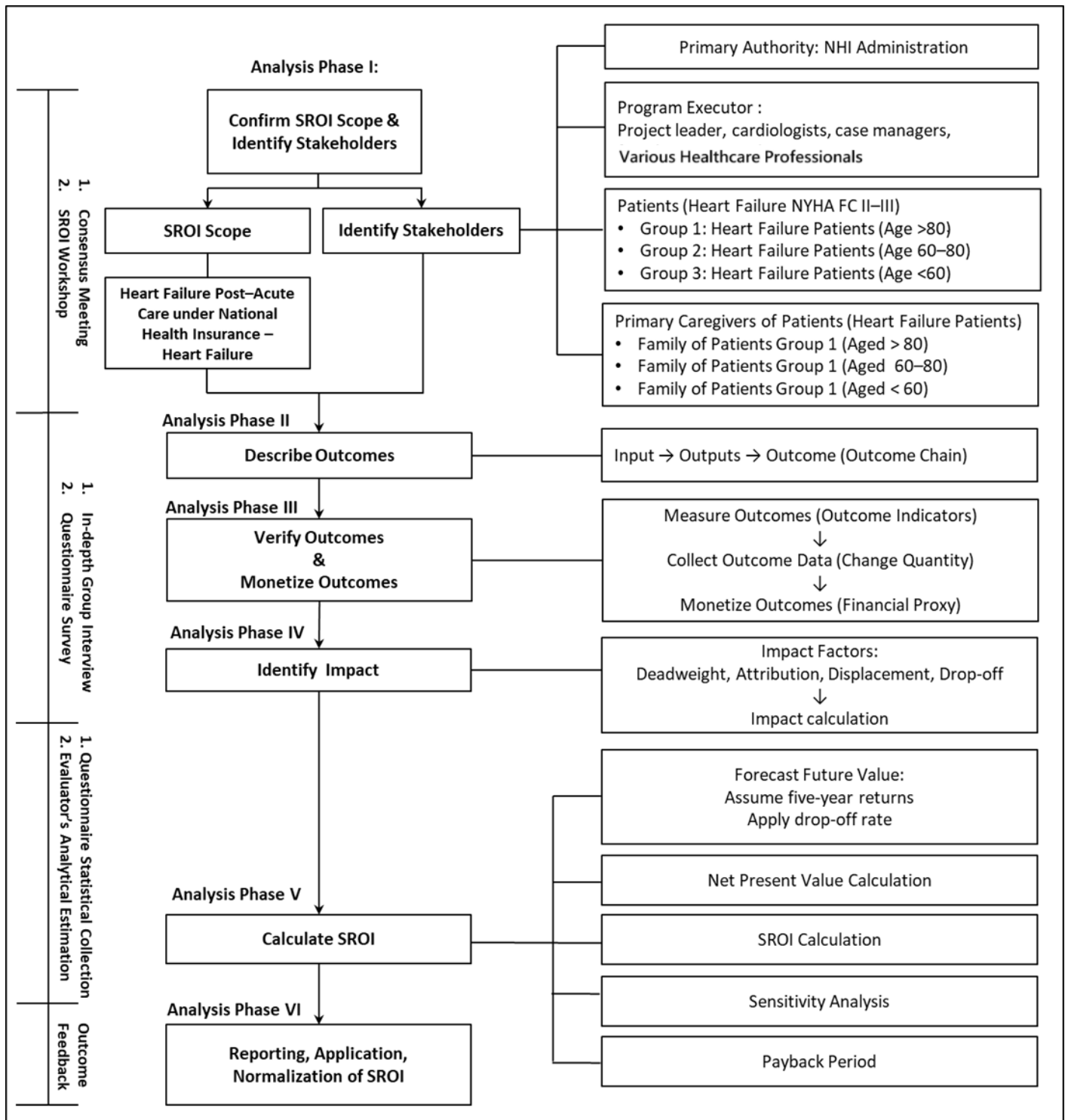
8. **Be responsive**

The goal of an SROI evaluation goes beyond valuation; it should serve as a foundation for organizational improvement and ongoing refinement.

For TCVGH, the evaluation results have already been used to inform improvements in medical service processes, optimize case management, support caregiver strategies, and guide policy dissemination. TCVGH also plans to establish a cyclical mechanism for regular evaluation and service improvement, aiming to institutionalize SROI and continuously enhance its value.

2.1.6 Research Framework Diagram

Figure 2.1.6-1 SROI Research Framework Diagram

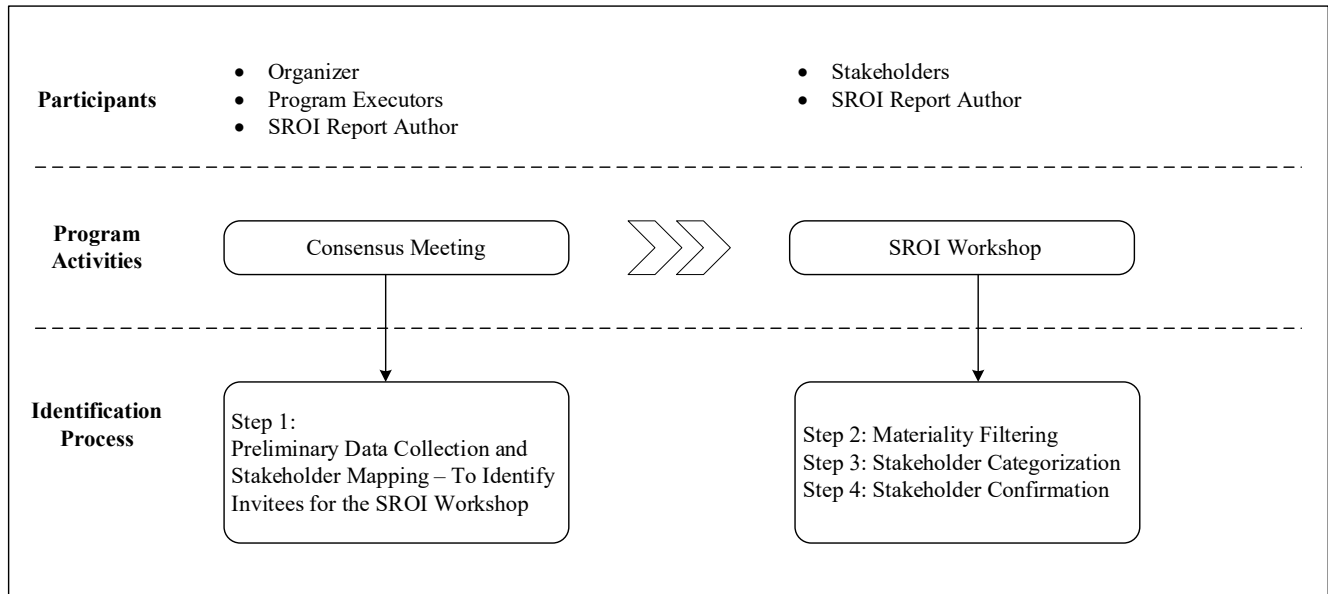


3 Stakeholder Identification and Engagement Process

3.1 Stakeholder Identification Process

Following the principles of Social Return on Investment (SROI), the program team collaborated with the SROI report author systematically identifies and includes stakeholders. The overall process is described as follows:

Figure 3.1-1 Stakeholder Identification Flowchart



This study adopted a multi-method and systematic approach to ensure that all stakeholders related to the PAC Heart Failure Program were appropriately identified. The following methods were used to develop the stakeholder list:

Consensus Meeting

Step 1: Preliminary Information Gathering and Stakeholder Inventory

Consensus meetings were conducted internally at TCVGH with program implementers and promoters—specifically the program implementation team, the case management group, and the SROI report author (Mrs. Hao Chen, Consultant, Cozeta Energy Service Co., Ltd.)—to preliminarily identify potential stakeholder groups. Patients and family members were not included at this stage. Drawing on clinical experience and the Post-Acute Care (PAC) pathway, the team mapped all individuals and organizations that interact with or are affected by the program, covering direct service recipients, care support roles, implementing units, and policy-driving entities. To help stakeholders identify other stakeholders within the consensus meetings, a concise structured facilitation was used: starting with care-pathway touchpoints to backtrack relevant interactors, then role nomination to surface units and individuals who might be affected or contribute, and finally open probes with cross-checks to fill gaps and reduce bias. Detailed materials are provided in Appendix C.

After discussing in consensus meeting, the preliminary list included the NHIA ; the TCVGH program leader (Director of the Heart Failure Division, Cardiovascular Center); cardiovascular center physicians; case managers; healthcare

professionals (rehabilitation physicians, palliative care physicians, nurse practitioners, ward nurses, pharmacists, physical therapists, dietitians, and social workers); pharmaceutical companies; enrolled heart failure patients; and primary caregivers (family members and hired caregivers).

This preliminary stakeholder list was then brought into the SROI workshop, where all major stakeholder groups (including patients and family caregivers) were engaged. Through the SROI workshop, the stakeholder list was collectively reviewed and refined, leading to the final confirmation of included and excluded stakeholders based on relevance and materiality.

SROI Workshop

Step 2: Materiality Filtering

Following the initial collection and mapping of stakeholder information, representatives of key stakeholder groups were invited to participate in an SROI workshop. In alignment with the SROI principles of “Involve Stakeholders” and “Materiality,” a materiality assessment was conducted for each stakeholder category. Through joint discussions, the team evaluated the actual level of involvement, the degree of impact experienced, and the potential value changes associated with each group. Based on this assessment, the final list of included and excluded stakeholders was determined to ensure the analysis remains representative, traceable, and methodologically sound.

To facilitate identification and confirmation of additional stakeholders during the workshop, we used a structured questionnaire to guide discussion (Appendix C). Participants first identified individuals or groups not yet included but observed to be affected by the program. We then described how these parties interact with the program (for example: participation in care, effects from care changes, provision of key inputs, availability of verifiable information, or relevance at the social level). Finally, we considered whether including them would improve the list’s coverage and analytical utility, applying a materiality screen. Roles with routine participation and no attributable change were noted as low materiality and not included in the primary analysis. Detailed information is provided in Table 3.1-1.

Based on the above assessment, the team applied the following criteria to determine whether to include stakeholders in this SROI analysis:

- (1) Whether significant changes occurred as a result of the program (impact)
- (2) Whether their perspective contributes to understanding the chain of outcomes, interpreting valuation results, and supporting the establishment of social value (relevance and weight scale)

The specific inclusion criteria are as follows:

- (1) Whether they directly participated in the care process or were substantially affected by changes in care
- (2) Whether they provided critical services or inputs that led to non-routine changes
- (3) Whether they could provide verifiable data or important perspectives on the outcomes
- (4) Whether they reflect the social-level value of the program’s impact

At the stakeholder identification stage, the team initially listed pharmaceutical companies and hired caregivers as potential subjects of analysis. However, after conducting interviews in SROI workshops, and following discussions in the stakeholder working group, it was determined that these parties only fulfilled their regular responsibilities. They did not experience

substantial differences in participation or value change as a result of participating in the program. Therefore, the following stakeholders were excluded from the final scope of analysis:

Item	Excluded Stakeholder	Reason for Exclusion
1	Pharmaceutical Companies	Although they supply the medications used in this program, their role is that of a routine supplier. They do not participate in the care plan design, process adjustments, or outcome tracking, nor do they incur additional inputs, risks, or benefits due to this program. Therefore, they do not meet the criterion of being “significantly affected” and are excluded according to SROI principles.
2	Hired Caregivers	Caregivers are mostly temporary assistants, and their care activities do not significantly change due to the program. Since the primary caregivers are still the family members, hired caregivers are not included in the scope of analysis.

Step 3: Stakeholder Categorization

(1) Program Executors

Beyond identifying stakeholders as a whole, the program further delineates subgroups within the medical execution team based on differences in professional roles, areas of contribution to patient care, and frequency of patient contact. This categorization recognizes that, while team members are all program executors who jointly provide treatment and specialized medical services (thus sharing broad commonalities), the substantive differences in the nature of their work within the program warrant subdivision into distinct subgroups to avoid overgeneralization and accurately reflect functional distinctions.

Following discussions and interviews conducted during the SROI workshop, it was observed that the program lead (Director of the Heart Failure Division, Cardiovascular Center) and most medical team members (such as cardiovascular center physicians, case managers, nurses, and rehabilitation and palliative care physicians) all actively participate in patient care and consultation. However, structural differences in professional role positioning, job content, and frequency of involvement justify grouping them into different subgroups for subsequent analyses.

Therefore, this report divides the medical professionals into three subgroups for valuation analysis:

Stakeholder Type	Stakeholder Subgroup	Reason for Being a Stakeholder Subgroup
Program Executors	Program Leader	The program leader is responsible for overall design, resource allocation, and cross-department coordination. Their level of involvement leans more toward decision-making and institutional promotion, and the changes they perceive are mainly reflected in their sense of control, organizational influence, and policy implementation effectiveness.
	Cardiovascular Center Physicians	The cardiovascular center physicians mainly play a decision-oriented role, responsible for disease diagnosis, formulating treatment strategies, and making clinical decisions for high-risk cases. Their participation is relatively concentrated during the treatment phase.

Stakeholder Type	Stakeholder Subgroup	Reason for Being a Stakeholder Subgroup
Program Executors	Case Managers	Case managers are care coordinators who participate throughout the entire disease course. They are intensively responsible for case tracking, referral arrangements, family communication, and integrating medical team resources, making them the most deeply involved role in the practical operations of the program.
	Various Healthcare Professionals	Various Healthcare Professionals (including rehabilitation physicians, palliative care physicians, nurse practitioners, ward nurses, pharmacists, physical therapists, dietitians, social workers) are all part of the program execution team. However, their timing of participation, professional tasks, and depth of interaction with patients vary. Their perceived changes are usually related to professional contributions and a sense of value recognition within interprofessional collaboration.

(2) Patients (Heart Failure Patients)

In accordance with the SROI principle that “where different subgroups may experience different types or degrees of change, they should be analyzed separately,” this stakeholder category was segmented based on clinical observations and interview findings. It was noted that patients of different age groups may exhibit variations in health outcomes, recovery levels, daily living needs, care dependency, and emotional responses. In some cases, they may experience distinct outcome chains, while in others, the same outcome chain may apply but with different levels of change. Therefore, the patients (heart failure patients) were divided into three age-based groups: over 80, 60~80, and under 60.

Stakeholder Type	Stakeholder Subgroup	Reason for Being a Stakeholder Subgroup
Patients	Patients age over 80	Often accompanied by multiple chronic diseases and frailty, highly dependent on care stability and medical support.
	Patients age 60~80	The main enrollment group of the program. They retain some recovery potential. They value independence and the ability to return to family life, and seek a balance between regaining health and restoring their social roles.
	Patients under age 60	Often still capable of working and under economic pressure. They have clear expectations for rapid recovery and returning to work, focusing on restoring their economic function and social participation.

(3) Primary Caregivers (Family)

In this program, the primary caregivers were categorized into three groups based on the age of the patients they cared for: “caregivers of patients age over 80”, “caregivers of patients aged 60–80”, and “caregivers of patients age under 60”. This classification primarily reflects the fact that patients in different age groups exhibit varying degrees of functional decline, comorbid chronic conditions, and levels of care dependence. These differences result in substantial variations for caregivers in terms of time commitment, perceived burden, and impact on daily life. To avoid averaging out the differing outcome changes, this analysis divided caregivers into the above subgroups, based on interviews and case management records, to more accurately capture the social value changes experienced by caregivers. This approach aligns with the SROI principle that “outcome differences must be individually assessed”.

Stakeholder Type	Stakeholder Subgroup	Reason for Being a Stakeholder Subgroup
Primary Caregivers (Family)	Patients age over 80	Older patients are often disabled or have multiple chronic diseases. Caregivers need to provide long-term care, assist with daily activities and medical decisions, and experience greater life disruption and psychological stress. Therefore, their outcomes are analyzed separately.
	Patients age 60–80	This subgroup of caregivers is mostly children or spouses who, despite having physical strength and caregiving experience, often have to juggle work and family. Their stress is reflected in emotional well-being and quality of life, so they are analyzed as an independent group.
	Patients age under 60	Caregivers in this group are often younger children or relatives. Although the intensity of care may not be the highest, they experience more role conflict and greater impact on future planning, warranting a distinct perspective to assess their contribution and outcomes.

Step 4: Confirmation of Stakeholders

After completing the preliminary data collection and stakeholder inventory, this report further applied the principles of materiality — namely, “whether they were affected by the program” and “whether they could contribute analytical data” — to screen and exclude certain parties. Group interviews were conducted to capture stakeholders’ perspectives on the program and the nature of their participation.

Finally, to avoid conflating heterogeneous groups, stakeholders were appropriately grouped and subdivided based on their frequency of interaction with patients, their role positioning, and differences in outcomes. Drawing on interview findings, program documents, and clinical workflows, the final list of stakeholders included 4 main categories (11 subgroups) as the basis for constructing the chains of outcomes and estimating social value in subsequent analysis. This process ensured that all included stakeholders were representative and had sufficient data, while excluding those who merely performed routine tasks and did not experience significant changes (such as pharmaceutical companies, hired caregivers), thereby maintaining the focus and credibility of the report’s analysis.

Table 3.1-1 Stakeholder Materiality Assessment and Confirmation Table

Stakeholder Type	Included Personnel (Subgroup)	Number of People	How They Participate in Activities		Stakeholder Inclusion	
			Description of Participation and Impact (Materiality)	Relevance	Included	Excluded
Organizer	National Health Insurance Administration (NHIA)	1	<p>Participation: Promotes the program, sets indicators, and monitors policy effectiveness</p> <p>Impact: Improves policy evaluation and adjustment basis through quantified outcomes</p>	Direct impact or affected	V	
Program Executors (TCVGH)	Program Leader	3	<p>Participation: Integrates resources, responsible for program execution and coordination</p> <p>Impact: Invests effort in integration and design, influencing work achievement and resource allocation</p>	Direct impact or affected	V	
	Cardiovascular Center Physicians	24	<p>Participation: Responsible for diagnosis, program enrollment, and follow-up management</p> <p>Impact: Witnesses program outcomes firsthand, enhancing decision-making confidence and sense of achievement</p>	Direct impact or affected	V	
	Case Managers	2	<p>Participation: Provides necessary professional care and life support</p> <p>Impact: Participates in evaluation and feedback mechanisms, experiences professional value and achievement</p>	Direct impact or affected	V	
	Various Healthcare Professionals	10	<p>Participation: Provides necessary professional care and life support</p> <p>Impact: Participates in interdisciplinary collaboration, reflecting teamwork experience and clinical benefits</p>	Direct impact or affected	V	

Stakeholder Type	Included Personnel (Subgroup)	Number of People	How They Participate in Activities		Stakeholder Inclusion	
			Description of Participation and Impact	Relevance	Included	Excluded
Patients (Heart Failure NYHA FC II~III)	Patient Group 1: Heart Failure Patient (age over 80)	42	Participation: Receives program care and medical arrangements Impact: Improved disease stability and self-reliance, enhanced quality of life	Direct impact or affected	V	
	Patient Group 2: Heart Failure Patient (age 60–80)	82	Participation: Receives program care and medical arrangements Impact: Improved disease stability and self-reliance, enhanced quality of life	Direct impact or affected	V	
	Patient Group 3: Heart Failure Patient (age under 60)	23	Participation: Receives program care and medical arrangements Impact: Improved disease stability and self-reliance, enhanced quality of life	Direct impact or affected	V	
Caregivers of Heart Failure Patients	Family of Patient Group 1 (age over 80)	38	Participation: Cooperates with medical care and provides daily assistance Impact: Reduced caregiving burden, improved family relationships, reduced psychological stress	Direct impact or affected	V	
	Family of Patient Group 2 (age 60–80)	69	Participation: Cooperates with medical care and provides daily assistance Impact: Reduced caregiving burden, improved family relationships, reduced psychological stress	Direct impact or affected	V	
	Family of Patient Group 3 (age under 60)	19	Participation: Cooperates with medical care and provides daily assistance Impact: Reduced caregiving burden, improved family relationships, reduced psychological stress	Direct impact or affected	V	
	Hired Caregivers	4	Participation: Cooperates with medical care and provides daily assistance Impact: Care activities not significantly affected by the program	Minimal interaction		V

Stakeholder Type	Included Personnel (Subgroup)	Number of People	How They Participate in Activities		Stakeholder Inclusion	
			Description of Participation and Impact	Relevance	Included	Excluded
Pharmaceutical Companies	Pharmaceutical Representatives	1	<p>Participation: Did not directly participate in service provision</p> <p>Impact: No behavioral or outcome changes due to the program</p>	Minimal interaction		V

3.2 Stakeholder Engagement Process

To adhere to the SROI principle of “Involve stakeholders”, this analysis was designed from the outset to include a multi-stage, cross-disciplinary participation process to ensure that the analysis reflects diverse perspectives and real experiences. The specific methods are as follows:

Phase 1: Stakeholder Identification and List Development

Together with the program’s lead unit (Cardiovascular Center), the team reviewed the relevant processes and affected parties to draft a preliminary stakeholder list. At this stage, input from both clinical and administrative departments was incorporated to ensure coverage of the three key aspects: program promotion, service provision, and service receipt.

Phase 2: Stakeholder Materiality Filtering

At the stakeholder materiality filtering stage, the team conducted on-site, group-based in-depth interviews, inviting stakeholders from diverse backgrounds (including the program team, clinical staff, patients, and their families). The purpose was to determine whether each party was affected by the program and whether they could provide valid data for analysis. The interviews focused on their actual roles and modes of participation in the program, their subjective feelings and experienced changes, the outcome indicators they considered important and verifiable, and their views on resource inputs and perceived value. Using these inputs, the team identified stakeholders who were representative and had sufficient data, while excluding roles that only performed routine tasks or did not exhibit significant changes, thereby ensuring the coverage and credibility of subsequent analyses.

Phase 3: Stakeholder Classification and Screening & Confirmation

Based on interview and data analysis results, the team first examined the differences and overlaps among stakeholders, then screened and grouped them according to two principles: (1) whether they experienced substantial change, and (2) whether they could provide valid information to support valuation. On this basis, the list of core stakeholders included in the analysis was established, and the final confirmation procedure was completed (including cross-checks with key members). For those not included, the reasons and grounds for exclusion were clearly documented to maintain procedural transparency and traceability.

Phase 4: Questionnaire Survey and Data Validation

Structured questionnaires were designed and distributed to selected stakeholders to quantitatively validate the changes identified during interviews. The survey also explored the depth and frequency of changes, emotional indicators, and economic impacts as reference parameters for outcome valuation.

Phase 5: Outcome Validation and Feedback

After the preliminary SROI valuation was completed, a feedback meeting was held with representative stakeholders to review the findings and valuation ranges. This meeting assessed whether the results reasonably reflected their actual experiences and allowed for necessary adjustments to ensure the report's credibility and consensus foundation.

To ensure stakeholder participation and verification of the final analysis, we will use a dual-track approach during the draft revision period: first, provide real-time briefings by phone to explain key findings and required adjustments, gather feedback, and document responses; second, circulate the draft report before finalization, highlighting proposed revisions and their impact, to ensure stakeholder consultation is carried out.

3.2.1 Principles and Applicable Scenarios for Proxy Participation

Reasons for Non-Participation and How Perspectives Were Incorporated

In this assessment, some stakeholder groups identified as potentially experiencing material outcomes did not directly participate in the “*identifying other stakeholders*” stage. The primary reason was the large size of these groups, making full inclusion within the set timeline impractical; ***this is an operational arrangement, not a substantive exclusion***. To ensure their perspectives were still incorporated, the report used inputs from sampled respondents within the same group or carefully selected proxy groups, feeding into materiality judgments and subsequent analyses; such inputs were limited to stakeholder identification and initial materiality screening.

Scope of Proxy Participation and Selection Principles

Proxy participation was applied only to three large stakeholder groups: patients, family caregivers of patients, and cardiovascular center physicians; all other groups participated directly. The reasons for using proxies include the large group size and the fact that some patients' health conditions were not suitable for prolonged in-person discussions or interviews—both are operational considerations and not substantive exclusions. Representatives were selected based on predefined criteria, prioritizing willingness to participate, health status, and schedule flexibility, and applying a necessary coverage principle to ensure representation across major care stages and common case types; where feasible, eligible lists were randomly ordered to reduce bias.

Appropriateness of Proxy Participation

Patients are best positioned to describe changes before and after joining the program, with their accounts cross-referenced against medical and service records; family caregivers, through long-term presence, can observe functional fluctuations and daily changes and provide supplementary information; cardiovascular center physicians sit at the core of care decisions, holding clinical information and care context. This arrangement emphasizes representativeness and consistency, enabling a reasonable presentation of key perspectives from non-directly participating groups. If a patient's health condition is not suitable for prolonged in-person participation, a stakeholder from the same sub-group will conduct proxy interviews and discussions, with the primary clinical lead providing necessary supplementary input.

Table 3.2-1 Stakeholder Participation Summary

Stakeholder Type	Included Personnel (Stakeholder Subgroup)	# of People	Participation Method & Number of People					Remarks
			Consensus Meeting	SROI Workshop	In-depth Group Interview	Questionnaire Survey	Outcome Feedback	
Organizer	National Health Insurance Administration (NHIA)	1	1	1	1	1	1	Plays a policy-leading and performance-monitoring role; provides institutional and social benefit perspectives; meets criteria of participation and informational relevance.
Program Executors (TCVGH)	Program Leader	3	3	3	3	3	3	Responsible for care design and cross-institutional coordination; has critical influence on service processes and resource allocation; helps construct the overall chain of events.
	Cardiovascular Center Physicians	24	4	4	4	24	4	Primary care providers with long-term interaction with patients; able to observe health and behavior changes.
	Case Managers	2	2	2	2	2	2	Oversee the care process and multi-party communication; clearly reflect the impact of interventions on patients and families.
	Various Healthcare Professionals	10	10	10	10	10	10	Although their chains of events are similar, they handle different medical tasks; their professional roles and frequency of contact vary, resulting in different degrees of impact.

Stakeholder Type	Included Personnel (Stakeholder Subgroup)	# of People	Participation Method & Number of People					Remarks
			Consensus Meeting	SROI Workshop	In-depth Group Interview	Questionnaire Survey	Outcome Feedback	
Patients (Heart Failure NYHA FC II~III)	Patient Group 1: Heart Failure Patient (age over 80)	42	–	6	12	42	6	High-risk elderly group with distinct functional recovery and life changes; outcomes differ from other age groups and are representative.
	Patient Group 2: Heart Failure Patient (age 60–80)	82	–	8	51	82	8	Main service group of the program; large sample size reflects standard change trajectory for this age group, suitable for quantitative analysis.
	Patient Group 3: Heart Failure Patient (age under 60)	23	–	5	16	23	5	Mostly working-age individuals; notable social and economic transitions; chain of events involves family and workplace reintegration.
Caregivers of Heart Failure Patients	Family of Patient Group 1 (age over 80)	38	–	4	12	38	4	Elderly patients often require long-term care; significant caregiver burden; program outcomes greatly affect quality of life.
	Family of Patient Group 2 (age 60–80)	69	–	3	24	69	3	Experience dual burden of caregiving and employment; clearly feel reduced burden; reflects family function changes and support effect.
	Family of Patient Group 3 (age under 60)	19	–	3	5	19	3	Support younger patients' recovery process; program's intervention contributes to alleviating family stress and caregiving burden, offering a representative perspective.
Total (# of people)			20	49	140	313	49	

4 Identification and Valuation of Inputs

In line with SROI principles, to measure the social value created by this program, it is necessary to comprehensively identify all resources contributed by stakeholders during implementation and monetize them as the basis for calculating the Social Return on Investment (SROI) ratio. Through in-depth group interviews, the main inputs identified in this program include manpower, time, medical equipment, and healthcare services.

4.1 Identification of Stakeholder Inputs

In terms of manpower, the medical team — including the program leader, cardiovascular center physicians, case managers, and various healthcare professionals — contributed their professional time and collaborative effort. For valuation, only the total personnel cost of the program was disclosed. Patients and caregivers invested their time in medical visits, consultations, and care arrangements. These were valued using the replacement wage method to estimate their corresponding social value.

With respect to space and facilities, hospital beds were initially considered; however, their costs were already accounted for in the medical expenses of each patient, and to avoid double counting, they were excluded from the calculation. Medical equipment was integrated and allocated by the program leader based on clinical needs. As it formed part of the overall program design and care process, it was valued under the program leader's input.

In the cost estimation of individual cases (patients with heart failure), this report accounts for expenses incurred during the course of medical treatment. These include out-of-pocket medical costs under National Health Insurance (NHI), non-NHI medication expenses, transportation costs, and caregiver fees. The estimations are based on statistical data retrieved from the internal information system of Taichung Veterans General Hospital (TCVGH), and are supplemented by in-depth interviews with multiple patients and their caregivers to derive a comprehensive assessment of total expenditures.

For the medical team executing the program, their main input was the application of professional knowledge and medical skills. Emotional strain was not considered a core input; even though psychological burden may occur during clinical interactions, it is regarded as part of routine work and is not appropriate to quantify as an independent input for this program. Similarly, for patients and caregivers (family), while the course of illness may cause emotional fluctuations, these psychological changes typically occur as outcomes of receiving care and experiencing health improvement. They belong to “outcome results” rather than “input sources.” Therefore, this report excludes emotion-related variables from the valuation of inputs, focusing instead on resources that directly contribute to program implementation and have a quantifiable basis.

The primary input from the medical team was the application of professional knowledge and skills. Emotional strain was not considered a core input; although some psychological burden may occur during clinical interactions, it is regarded as part of routine work and is not suitable to quantify independently.

Similarly, for patients and caregivers, emotional fluctuations associated with the illness are viewed as outcomes of care and health improvement rather than inputs. Accordingly, this report excludes emotion-related variables from the valuation of inputs, focusing on tangible and quantifiable resources that directly support program implementation.

Table 4.1-1 Identification of Inputs and Input Items

Stakeholder Subgroup	#of People	Input Items and Quantity		
		Input Item (Time / Money / Goods / Skills)	Quantity	Unit
National Health Insurance Administration (NHIA)	1	Program subsidy/reward amount	1	entry
		out-of-pocket medical costs under NHI	5,228,957	points
Program Leader	3	Personnel costs	Total Annual Salary	
		Echocardiography machine (4D)	1	unit
		Ultrasound scanner	1	unit
		Cardiac catheterization machine	4	units
Cardiovascular Center Physicians	24	Personnel costs	Total Annual Salary	
Case Managers	2	Personnel costs	Total Annual Salary	
Various Healthcare Professionals	10	Personnel costs	Total Annual Salary	
Patient Group 1: Heart Failure Patient (age over 80)	42	Medical expenses	Total Expenditure	
		Non-NHI medications	Total Expenditure	
		Transportation costs	Total Expenditure	
		Caregiver costs	Total Expenditure	
		176 return visits		visits
		Average waiting time per visit: 3 hrs		hours
Patient Group 2: Heart Failure Patient (age 60–80)	82	Medical expenses	Total Expenditure	
		Non-NHI medications	Total Expenditure	
		Transportation costs	Total Expenditure	
		Caregiver costs	Total Expenditure	
		344 return visits		visits
		Average waiting time per visit: 3 hrs		hours
Patient Group 3: Heart Failure Patient (age under 60)	23	Medical expenses	Total Expenditure	
		Non-NHI medications	Total Expenditure	
		Transportation costs	Total Expenditure	
		Caregiver costs	Total Expenditure	
		97 return visits		visits
		Average waiting time per visit: 3 hrs		hours
Family of Patient (age over 80) Group 1	38	149 visits accompanying the patient		visits
		Average accompanying time per visit: 3 hrs		hours
		Average caregiving time: 14 hrs		hours
Family of Patient (age 60~80) Group 2	69	271 visits accompanying the patient		visits
		Average accompanying time per visit: 3 hrs		hours
		Average caregiving time: 7 hrs		hours
Family of Patient (age under 60) Group 3	19	74 visits accompanying the patient		visits
		Average accompanying time per visit :3 hrs		hours
		Average caregiving time: 3 hrs		hours

4.2 Valuation Methods and Basis of Inputs

In line with SROI principles, this report values the various inputs involved in the program using verifiable and representative data sources to monetize them. The valuation methods are categorized into four main types:

Manpower and Time Inputs: For human resources such as the medical team and case managers, the total personnel costs provided by the hospital were used. For the time costs of patients and their caregivers, the domestic minimum hourly wage served as the estimation basis.

Medical Services and Medication Inputs: This includes NHI-covered medical services, examination fees, and Non-NHI medications. The data were derived from the hospital's NHI point statistics and medical records during the program period. NHI points were converted at a rate of NTD 1 per point, though it was noted that this rate is subject to fluctuation. Expenses such as out-of-pocket medical expenses under NHI coverage, Non-NHI medications, transportation, and caregiver fees were estimated based on the hospital's internal information system and supplemented by in-depth interviews with multiple patients and caregivers.

Medical Equipment Inputs: This mainly covered medical equipment items such as 4D echocardiography machines, ultrasound scanners, and cardiac catheterization machines. The equipment was valued based on annual depreciation costs apportioned over their useful life, to avoid distortion of valuation due to large one-time expenditures.

Transportation and Caregiver Expenses: Transportation expenses incurred by patients and caregivers for medical visits, follow-up visits, and accompanying visits were estimated using care pathway data from the hospital and information collected through interviews. Representative expense ranges for each group were calculated and disclosed as total amounts to balance privacy and practical valuation needs.

Table 4.2-1 Identification and Valuation of Inputs

Stakeholder Subgroup	# of People	Input Items and Quantity			Financial Value (NTD)	Remarks
		Input Item (Time / Money / Goods / Skills)	Quantity	Unit		
National Health Insurance Administration (NHIA)	1	Program subsidy/reward	1	entry	640,500	Subsidy and additional reward
		out-of-pocket medical costs under NHI	5,228,957	points	5,228,957	Approx. NTD 1 per point
Program Leader	3	Personnel costs	Total Annual Salary		16,099,155	Total personnel cost disclosed only
		4D echocardiography machine	1	unit	2,270,724	Depreciation
		Ultrasound scanner	1	unit	6,132,870	Depreciation
		Cardiac catheterization machine	4	units	89,667,500	Depreciation
Cardiovascular Center Physicians	24	Personnel costs	Total Annual Salary		88,000,848	Total personnel cost disclosed only
Case Managers	2	Personnel costs	Total Annual Salary		1,671,656	Total personnel cost disclosed only
Various Healthcare Professionals	10	Personnel costs	Total Annual Salary		20,692,570	Total personnel cost disclosed only

Stakeholder Subgroup	# of People	Input Items and Quantity		Financial Value (NTD)	Remarks
		Input Item (Time / Money / Goods / Skills)	Quantity		
Patient Group 1: Heart Failure Patient (age over 80)	42	Medical expenses	Total Expenditure	11,411,197	Overall estimate
		Non-NHI medications	Total Expenditure	317,021	Overall estimate
		Transportation	Total Expenditure	214,011	Overall estimate
		Caregiver fees	Total Expenditure	214,011	Overall estimate
		176 return visits	visits	96,624	Overall estimate
		Average waiting time per visit: 3 hrs	hours		
Patient Group 2: Heart Failure Patient (age 60–80)	82	Medical expenses	Total Expenditure	22,279,005	Overall estimate
		Non-NHI medications	Total Expenditure	618,947	Overall estimate
		Transportation	Total Expenditure	417,831	Overall estimate
		Caregiver fees	Total Expenditure	174,041	Overall estimate
		344 return visits	visits	188,856	Estimated social value of return visits based on domestic minimum wage
		Average waiting time per visit: 3 hrs	hours		
Patient Group 3: Heart Failure Patient (age under 60)	23	Medical expenses	Total Expenditure	6,248,989	Overall estimate
		Non-NHI medications	Total Expenditure	173,607	Overall estimate
		Transportation	Total Expenditure	117,196	Overall estimate
		Caregiver fees	Total Expenditure	48,816	Overall estimate
		97 return visits	visits	53,253	Estimated social value of return visits based on domestic minimum wage
		Average waiting time per visit: 3 hrs	hours		
Family of Patient (age over 80) Group 1	38	149 visits accompanying the patient	visits	81,801	Estimated social value of return visits based on domestic minimum wage
		Average accompanying time per visit: 3 hrs	hours		
		Average caregiving time: 14 hrs	hours	935,130	Estimated social value of return visits based on domestic minimum wage
Family of Patient (age 60~80) Group 2	69	271 visits accompanying the patient	visits	148,779	Estimated social value of return visits based on domestic minimum wage
		Average accompanying time per visit: 3 hrs	hours		
		Average caregiving time: 7 hrs	hours	467,565	Estimated social value of return visits based on domestic minimum wage
Family of Patient (age under 60) Group 3	19	74 visits accompanying the patient	visits	40,626	Estimated social value of return visits based on domestic minimum wage
		Average accompanying time per visit: 3 hrs	hours		
		Average caregiving time: 3 hrs	hours	200,385	Estimated social value of return visits based on domestic minimum wage
Total Input Value (NTD)				274,727,603	

4.3 Approach to Avoid Double Counting, Overestimation, or Underestimation of Inputs

To ensure the accuracy and consistency of input valuation, this report paid special attention to avoiding the risks of double counting, overestimating, or underestimating actual resource inputs when converting the costs of personnel, time, medical resources, and equipment. First, regarding medical and administrative support resources associated with different stakeholders, if such inputs were already included in other valuation items (e.g., NHI reimbursements or medical expenses), they were not counted again, thereby preventing “double counting” of resources.

For inputs related to patients (heart failure), including out-of-pocket medical expenses under NHI coverage, Non-NHI medication costs, transportation expenses, and caregiver fees, the estimates were based on statistical data from Taichung Veterans General Hospital’s internal information system, and were supplemented by in-depth interviews with multiple patients and caregivers. Given the large number of patients and their individual differences, it is impractical to calculate actual spending for each individual. Therefore, the report adopted an average-by-group and total-estimate approach to avoid over- or underestimation caused by outliers.

In addition, to avoid underestimating implicit costs such as caregiver time or patient engagement in the care process, this report also valued unpaid inputs appropriately by integrating in-depth interviews and internal system data. Statutory wage standards were also applied to support their monetary value were applied. These ensured that important inputs were not overlooked.

Overall, all valuation procedures followed a conservative principle, selecting the most appropriate monetization basis according to data credibility and availability to ensure the reasonableness and consistency of the valuation method.

4.4 Limitations and Uncertainties in Valuation

During the input valuation process, this report made every effort to use available and representative data for reasonable translation into monetary terms. However, given the nature of medical services and institutional constraints, certain uncertainties and flexible disclosures remain in the valuation, as explained below:

First, for the use of medical resources, the diagnostic, treatment, medication, and examination services involved in the program were estimated based on NHI reimbursement standards, using point values as the pricing unit (each point approximately equals NTD 1). Although the NHI point value is subject to fluctuation, its widespread application and public availability make it a reasonable reference basis for valuation.

Second, regarding program personnel inputs, out of respect for the confidentiality of internal salary structures within medical institutions and to avoid inferring individual salaries from disclosed work hours and personnel data, the report presents total personnel costs rather than breaking down work hours or unit wage details. This approach preserves both the integrity and verifiability of the valuation while protecting privacy.

Additionally, for key medical equipment in the program (e.g., echocardiography machine (4D), ultrasound scanner, cardiac catheterization machine), the input valuation was calculated based on annual depreciation costs, and allocated according to

actual usage frequency and purpose. This method accounts for the long-term use of equipment and the proportion attributable to this program, avoiding overestimation of short-term input costs while maintaining reasonable valuation.

Regarding patient-side inputs (such as out-of-pocket medical expenses under NHI coverage, Non-NHI medication costs, transportation expenses, and caregiver fees), group-level estimates were produced by integrating statistical data from Taichung Veterans General Hospital and findings from in-depth interviews. Given the large patient population and diverse care pathways, it is not practical to match individual expenditures one by one. Therefore, the report discloses aggregated group averages or total amounts. This approach was confirmed by stakeholders to be representative, and effectively reflects the scale of inputs and expenditure structure.

5 Depicting Outcomes

5.1 Clearly Defined Outputs

In this program, “clearly defined outputs” refer to the concrete actions or recorded results that were actually completed and quantifiable during the implementation period, following the investment of personnel, resources, and institutional support. These outputs form the foundation for subsequent outcomes and social value assessments and play a critical role in conveying the trajectory of changes and the program’s effectiveness to stakeholders.

For the service recipients (heart failure patients and their caregivers), the clearly defined outputs include patient enrollment, condition assessments (e.g., NYHA classification, ADL, 6-minute walk distance), outpatient follow-ups, hospitalization records, rehabilitation sessions, participation in educational sessions, and caregiver assistance records. These outputs were comprehensively tracked through the hospital’s internal information system and case management records.

For the medical team, outputs include documentation of interdisciplinary care meetings, patient follow-up records, execution records of integrated care plans, and periodic performance review reports. These outputs demonstrate the operation of the interdisciplinary collaboration mechanism and the process of care strategy adjustments.

At the policy and institutional feedback level, the program produces a semi-annual “National Health Insurance Post-Acute Integrated Care Program Report.” The report includes statistical data on cases, service performance, readmission and mortality rates, and changes in functional status. It also consolidates clinical experience and institutional recommendations, serving as an important reference for the NHIA’s future policy advancement and our hospital’s strategic planning. Although such outputs are limited in number, they have a broad scope and high information density, making them highly representative and valuable as NHIA reference.

5.2 Construction of Chain of Outcomes

In accordance with the principles of Social Return on Investment (SROI), this report identified the activities of each stakeholder within the integrated care process and constructed corresponding pathways of change, comprising the three-stage structure of Inputs → Outputs → Outcomes. Based on data from internal records and in-depth interviews with stakeholders, outcome chains were developed for each group, serving as the basis for subsequent social value estimation and performance evaluation.

This analysis places particular emphasis on the diversity of outcomes; in addition to revealing expected outcomes, it also includes unintended outcomes and potential negative changes, in order to faithfully present the program's impact across clinical care, individual quality of life, and system-level advancement. All preliminary outcome chains were empirically validated by stakeholders, and differences were fully retained to respect participants' lived experiences.

During the "materiality assessment and outcome adjustment" stage, the team conducted a systematic review based on materiality, verifiability, and logical consistency: outcome chains that were essentially identical, had overlapping causal structures, or differed only in wording were consolidated; those with insufficient evidence, minimal effect size, or weak relevance to the program were removed. This approach aims to enhance clarity and quality of outcomes, reduce the risk of double counting in subsequent valuation, and, at the same time, preserve key heterogeneity to maintain representativeness and traceability (Figure 5.3-1 & Appendix C p.165). Based on the consolidation criteria and refinement steps described above, the outcome adjustments are as follows.

Excluded Outcomes

- Sense of Being Trusted, Sense of Burnout
 - Rationale: These outcomes are primarily influenced by external relationships and fluctuations in personal emotions, making them difficult to manage sustainably through program design. Their contribution to the core social value is relatively limited.
- Sense of Satisfaction
 - Rationale: This reflects an attitude or overall satisfaction indicator rather than a specific, attributable result; therefore, it does not constitute an outcome suitable for valuation.

Outcome Consolidation and Adjustment (Avoiding Overlap while Preserving Significance)

- Category A: Sense of Control · Confidence in Decision-Making
 - Merged outcomes: Sense of Control; Confidence in Decision-Making
 - Conceptual overlap: Both point to "a sense of control and confidence in medical and self-care decision-making," representing closely related facets within the same construct.
 - Consolidated and adjusted outcome: Strengthened Confidence in Program Governance and Decision-Making
- Category B: Achievement and Motivation
 - Merged outcomes: Sense of Accomplishment; Sense of Reward; Self-Confidence; Sense of Being Motivated

- Conceptual overlap: The above feelings are highly aligned at the construct level, all pointing to “positive motivation and increased confidence following goal attainment,” and represent closely related facets within the same outcome category; valuing them separately risks double counting similar value.
- Consolidated and adjusted outcome: Strengthened Professional Accomplishment; Confidence in Clinical Decision-Making; Confidence in Professional Capability are outcomes belonging to different stakeholder groups.
- Category C: Emotional Stability and Reassurance
 - Merged outcomes: Sense of Joy; Sense of Calm; Well-being; Sense of Reassurance; Sense of Intimacy; Sense of Being Supported
 - Conceptual overlap: Centers on well-being with reassurance as a primary driver, integrating related emotional dimensions to avoid double counting.
 - Consolidated and adjusted outcome: Enhanced Emotional Security; Caregiving Burden Relief
- Category D: Autonomy and Vitality
 - Merged outcomes: Sense of Autonomy; Sense of Vitality
 - Conceptual overlap: Both relate to daily functional capacity and energy, which are critical to self-care capability and the recovery trajectory.
 - Consolidated and adjusted outcome: Strengthen Self-Efficacy & Confidence

For detailed outcome explanations, please refer to Table 5.3-1 and Table 5.3.1-1.

5.2.1 Unintended and Negative Outcomes

Our outcome-definition process was designed from the outset to embed mechanisms for capturing unintended and negative outcomes. We used an open-ended questionnaire (Appendix C) that explicitly incorporated probes for negative/unintended changes and a follow-up logic to elicit expected and unintended outcomes within outcome chains during stakeholder interviews.

The design of the questions to capture expected/unintended outcomes was informed by relevant research¹. Taken together, this design and the supporting evidence ensure that the report not only presents expected outcomes but also fully includes unintended and negative outcomes. These are documented through an evidence chain and valued via dedicated (independent) valuation pathways, thereby ensuring representativeness, verifiability, and methodological consistency.

¹ LEVODOPA-BASED DEVICE-ASSISTED THERAPIES FOR THE TREATMENT OF ADVANCED PARKINSON’S DISEASE SROI ;

5.3 Selection of Key Outcomes in Each Chain

In the SROI analysis of the “National Health Insurance Post-Acute Integrated Care Program — Heart Failure,” every stakeholder’s chain of outcomes yielded clearly defined outcomes. Moreover, in this study design, each chain of outcomes has been successfully linked to specific and measurable “key outcomes” that can be included in the monetization analysis.

Through the integration of in-depth interviews and care records, the program was able to ascertain the duration, magnitude of change, and the number of beneficiaries for each outcome. Combined with reference market values, government announcements, or existing social value databases, each outcome met the following criteria:

- (1) Significance of impact: Produced a substantive change for stakeholders;
- (2) Representativeness and consistency: Occurred in the majority of service recipients or providers;
- (3) Feasibility of valuation: Capable of being translated into monetary terms in a reasonable manner.
- (4) Manageable: Outcomes for which data and/or information can be continuously collected in the course of subsequent implementation of the project, enabling ongoing management, monitoring, and improvement.

Figure 5.3-1 Process of Outcome Chain Development

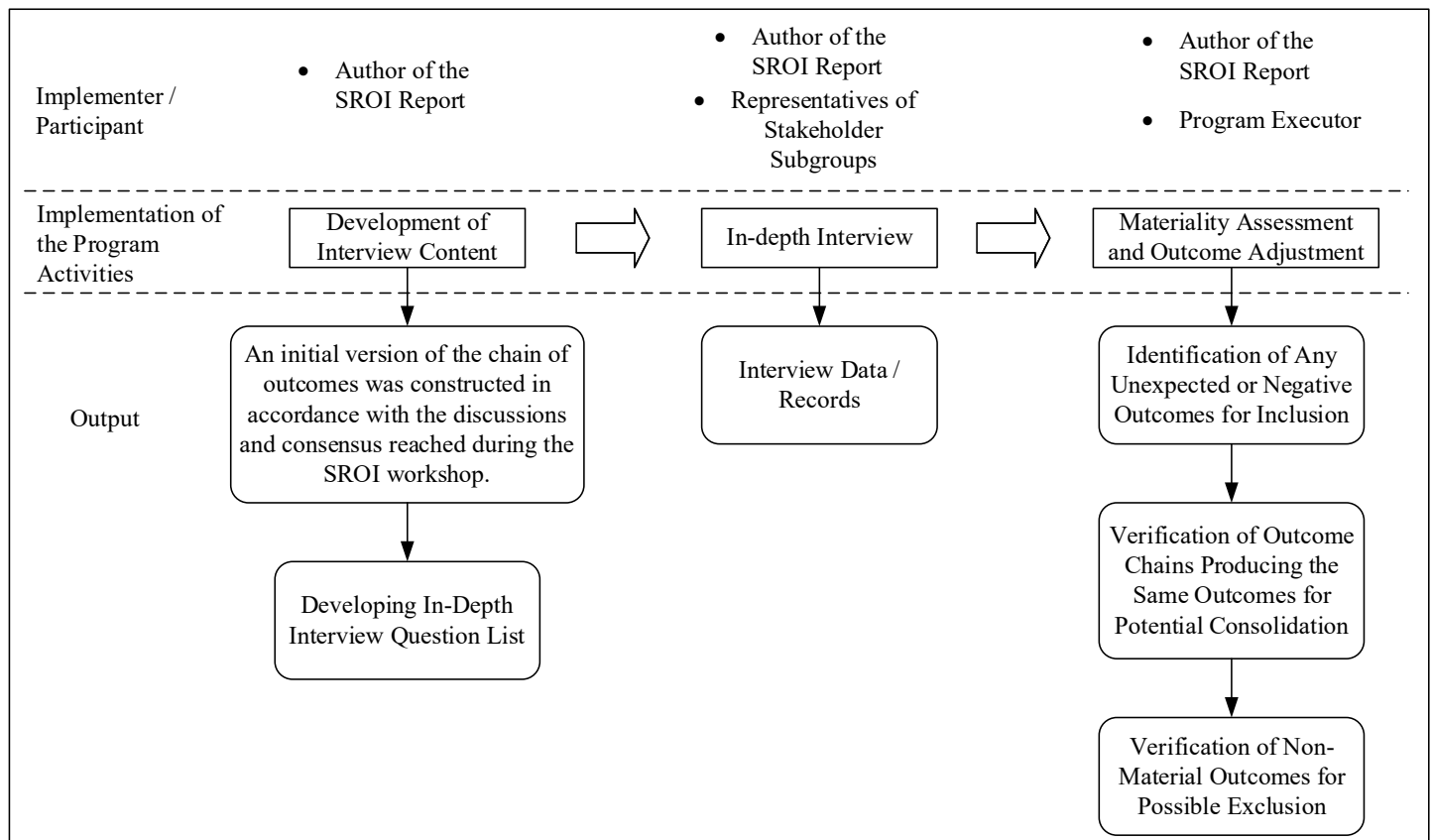


Table 5.3-1 Chains of Outcomes Description Table

Stakeholder Subgroup	Chains of Outcomes	Outcomes
National Health Insurance Administration (NHIA)	Promoted this program → Regularly monitored the achievement of various program indicators → Obtained reliable quantitative data → Standardized processes and templates → Improved decision-making efficiency → Optimized capabilities and resource allocation → More precise program goals → Visible, recognized program outcomes → Increased confidence in program governance and decision-making	Strengthened Confidence in Program Governance and Decision-Making
Program Leader	Implemented this program → Regularly monitored various information of this program → Received reliable information → Service/process improvements adopted → Visible and recognized performance positive outcomes → With frontline teams aligned to standard pathways and consistent communication, program leader feel strong professional accomplishment.	Strengthen Professional Accomplishment
Cardiovascular Center Physicians	Implemented this program → Regularly monitored the achievement of various program indicators → Obtained reliable quantitative data → Improve the probability of precise diagnosis and effective treatment → Feeling more confident in assessing acute cardiovascular cases, with more consistent decision speed and accuracy.	Confidence in Clinical Decision-Making
Case Managers	Participated in this program → Provided integrated consultation and services → Interprofessional collaboration and knowledge integration → Improved personal professional development → Feeling more confident in patient education and risk communication.	Confidence in Professional Capability
Various Healthcare Professionals	Participated in this program → Provided integrated consultation and services → Interprofessional collaboration and knowledge integration → Improved personal professional development → Feeling more confident in patient education and risk communication.	Confidence in Professional Capability

Stakeholder Subgroup	Chains of Outcomes	Outcomes
Patient Group 1: Heart Failure Patient (age over 80)	Enrolled in this program → Case manager follow-ups and education delivered→ Real-time medical consultation access implemented → Increased cross-specialty assistance and coordination → Patient’s Condition stabilized→ Patients feel more emotionally secure and reassured about their condition.	Enhanced Emotional Security
	Diagnosed with heart failure → Enrolled in this program → Case manager regularly followed up and provided education →Received comprehensive care → Adjusted lifestyle and eating habits → Self-management capacity improved → Patients feel more confident in managing heart failure and maintaining daily life.	Strengthen Self-Efficacy & Confidence
Patient Group 2: Heart Failure Patient (age 60–80)	Enrolled in this program → Case manager follow-ups and education delivered→ Real-time medical consultation access implemented → Increased cross-specialty assistance and coordination → Patient’s Condition stabilized→ Patients feel more emotionally secure and reassured about their condition.	Enhanced Emotional Security
	Diagnosed with heart failure → Enrolled in this program → Case manager regularly followed up and provided education →Received comprehensive care → Adjusted lifestyle and eating habits → Self-management capacity improved → Patients feel more confident in managing heart failure and maintaining daily life.	Strengthen Self-Efficacy & Confidence
	Diagnosed with heart failure → Enrolled in this program → Regular follow-up visits → Received proper treatment →Persistent functional limitation →Work role/volume reductions → Financial strain attributable to reduced work capacity →Because the financial pressure has increased and the work role has changed, the patient often feel frustrated.	Financial pressure arising
Patient Group 3: Heart Failure Patient (age under 60)	Enrolled in this program → Case manager follow-ups and education delivered→ Real-time medical consultation access implemented → Increased cross-specialty assistance and coordination → Patient’s Condition stabilized→ Patients feel more emotionally secure and reassured about their condition.	Enhanced Emotional Security
	Diagnosed with heart failure → Enrolled in this program → Case manager regularly followed up and provided education →Received comprehensive care → Adjusted lifestyle and eating habits → Self-management capacity improved → Patients feel more confident in managing heart failure and maintaining daily life.	Strengthen Self-Efficacy & Confidence
	Diagnosed with heart failure → Enrolled in this program → Regular follow-up visits → Received proper treatment →Persistent functional limitation →Work role/volume reductions → Financial strain attributable to reduced work capacity →Because the financial pressure has increased and the work role has changed, the patient often feel frustrated.	Financial pressure arising

Stakeholder Subgroup	Chains of Outcomes	Outcomes
Family of Patient Group 1 (age over 80)	Patient diagnosed with heart failure → Enrolled in this program → Case manager regularly followed up and provided education → Family caregiver executes the care protocol → Reduced uncertainty and risk → Patient's condition stabilized → Having this approach in place, the caregiver feels security and knows how to help the patient.	Enhanced Emotional Security
	Patient diagnosed with heart failure → Enrolled in this program → Patient received comprehensive care → Patient's Condition stabilized → Patient Required less caregiving time → Caregiver could have more self-directed time	Caregiving Burden Relief
Family of Patient Group 2 (age 60 – 80)	Patient diagnosed with heart failure → Enrolled in this program → Case manager regularly followed up and provided education → Family caregiver executes the care protocol → Reduced uncertainty and risk → Patient's condition stabilized → Having this approach in place, the caregiver feels security and knows how to help the patient.	Enhanced Emotional Security
	Patient diagnosed with heart failure → Enrolled in this program → Patient received comprehensive care → Patient's Condition stabilized → Patient Required less caregiving time → Caregiver could have more self-directed time	Caregiving Burden Relief
Family of Patient Group 3 (age under 60)	Patient diagnosed with heart failure → Enrolled in this program → Case manager regularly followed up and provided education → Family caregiver executes the care protocol → Reduced uncertainty and risk → Patient's condition stabilized → Having this approach in place, the caregiver feels security and knows how to help the patient.	Enhanced Emotional Security
	Patient diagnosed with heart failure → Enrolled in this program → Patient received comprehensive care → Patient's Condition stabilized → Patient Required less caregiving time → Caregiver could have more self-directed time	Caregiving Burden Relief

5.3.1 Well-defined Outcomes

This study adopts well-defined outcomes (Table 5.3.1-1) as the basis for outcome selection and valuation. A well-defined outcome is a clearly specified change for a particular stakeholder (individual or group) that offers the best opportunity to increase or decrease social value; identifying such outcomes enables more effective resource allocation to maximize social value. Outcomes are selected according to relevance, significance, and manageability, and are positioned within a clearly mapped causal chain to avoid double counting

In line with the materiality principle established by Social Value International (SVI), this study applies Depth $\geq 50\%$ as the sole threshold for inclusion. Outcomes meeting this threshold are incorporated into the valuation (Depth is applied only for inclusion or exclusion decisions and not as a multiplier).

Table 5.3.1-1 Well-defined Outcomes

Stakeholder Subgroup	Outcomes	Description of Outcomes	Outcomes Relevance	Significant and Manageable Outcome	Distinct Outcome
National Health Insurance Administration (NHIA)	Strengthened Confidence in Program Governance and Decision-Making	A governance and decision-making system grounded in consistent standards and reliable data. Its features include clear processes and accountability, stable monitoring mechanisms, and traceable information; evidence-based decisions with defined cadence and external explainability, strengthening internal and external confidence in program operations and judgments.	Organizer gains transparent, auditable milestones and risk views, strengthening confidence in governance; the execution team follows consistent processes and clear directives, boosting execution confidence; regulators and partners trust more due to improved predictability; beneficiaries experience stable quality, raising overall cooperation.	Through transparency and standardization, programs become more predictable, resources are used more precisely, decisions land faster, risks and waste drop in tandem, and scaling across teams becomes easier. To sustain this, keep running with clear rules and sound data practices, review and adjust regularly, keep what works and retire what doesn't, and let improvement become part of the everyday routine.	This outcome is the NHIA's sole outcome, so it is distinct outcome and it will not overlap with any other outcomes within this stakeholder subgroup.

Stakeholder Subgroup	Outcomes	Description of Outcomes	Outcomes Relevance	Significant and Manageable Outcome	Distinct Outcome
Program Leader	Strengthen Professional Accomplishment	Through systematic implementation and regular monitoring, the team obtains reliable information that drives frontline adoption of service and process improvements. With teams aligned to standard pathways and consistent communication, quality stabilizes, variation decreases, and patient experience strengthens—producing visible, recognized outcomes that reinforce program leader credibility and a strong sense of professional accomplishment as program leader.	The Program Leader gains timely, trustworthy program information and evidence of results, enabling clear guidance on standards and cadence and coordination across departments; visible, recognized outcomes foster a clear sense of professional accomplishment, stabilize team morale and retention, and strengthen external communication and scaling influence.	Systematic implementation with regular monitoring yields reliable data, enabling frontline adoption of service/process improvements. Aligned to standard pathways and consistent communication, teams stabilize quality, reduce variation, and enhance patient experience and resilience—producing visible, recognized outcomes that strengthen the Program Leader’s professional accomplishment and credibility.	This outcome is the program leader’s sole outcome, so it is distinct outcome and it will not overlap with any other outcomes within this stakeholder subgroup.
Cardiovascular Center Physicians	Confidence in Clinical Decision-Making	Program implementation with regular monitoring generates reliable data, increasing the likelihood of precise diagnosis and effective treatment; physicians feel more assured in assessing acute cardiovascular cases, with more consistent decision speed and accuracy, leading to a clear rise in overall confidence in clinical decision-making.	Cardiovascular center physicians directly use these quantitative data to refine clinical judgments; more consistent decision processes and outcome feedback help them maintain stable performance under pressure, strengthening confidence in professional judgment and team collaboration.	Faster, more accurate decisions shorten treatment delays, reduce variation, and improve patient safety and outcomes. Visible, recognized results strengthen physicians’ confidence and departmental credibility. With ongoing indicator monitoring, data quality assurance, standardized pathways, and case reviews, effective practices are institutionalized, guidance updated, and decision consistency and clinical confidence steadily enhanced.	This outcome is the cardiovascular center physicians’ sole outcome, so it is distinct outcome and it will not overlap with any other outcomes within this stakeholder subgroup.

Stakeholder Subgroup	Outcomes	Description of Outcomes	Outcomes Relevance	Significant and Manageable Outcome	Distinct Outcome
Case Managers	Confidence in Professional Capability	Program implementation with regular monitoring yields reliable quantitative data, increasing the likelihood of precise diagnosis and effective treatment. Case managers feel more assured in acute cardiovascular assessment and coordination, with more consistent decision speed and accuracy, leading to a marked increase in overall confidence in their professional capability.	Case managers directly use data and standard pathways to coordinate cross-team workflows, information handoffs, and patient flow. Consistent decision processes and feedback mechanisms reduce communication friction, helping them maintain steady performance under pressure and strengthen confidence in collaboration.,	Faster, more precise coordination shortens treatment delays, reduces variation, and improves patient safety and outcomes. Recognized results strengthen case managers' professional image and departmental credibility, fueling continuous improvement. With ongoing indicator monitoring, data quality assurance, standardized referrals/communication templates, and case reviews, effective practices are institutionalized, pathways updated, and coordination consistency and professional confidence steadily enhanced.	This outcome is the case managers' sole outcome, so it is distinct outcome and it will not overlap with any other outcomes within this stakeholder subgroup.
Various Healthcare Professionals	Confidence in Professional Capability	Program implementation with regular monitoring yields reliable quantitative data, increasing the likelihood of precise diagnosis and effective treatment. Various healthcare professionals feel more assured in acute cardiovascular assessment and collaboration, with more consistent decision speed and accuracy, leading to a marked rise in overall confidence in professional capability.	Various healthcare professionals directly use data and standard pathways to coordinate decisions and care delivery. Consistent processes and feedback mechanisms reduce communication friction, strengthening interprofessional collaboration and the stability of clinical performance.	Faster, more precise interprofessional coordination shortens treatment delays, reduces variation, and improves patient safety and outcomes. Recognized results strengthen the team's professional image and institutional credibility, fueling continuous improvement. Through ongoing indicator monitoring, data quality assurance, standardized pathways/communication templates, and cross-department case reviews, effective practices are institutionalized, guidance updated, and collaboration consistency and professional confidence steadily enhanced.	This outcome is the various healthcare professionals' sole outcome, so it is distinct outcome and it will not overlap with any other outcomes within this stakeholder subgroup.

Stakeholder Subgroup	Outcomes	Description of Outcomes	Outcomes Relevance	Significant and Manageable Outcome	Distinct Outcome
Patient Group 1: Heart Failure Patient (age over 80)	Enhanced Emotional Security	After enrollment, case manager follow-ups and education, combined with real-time consultation and cross-specialty coordination, stabilized the condition. Patients better understand their status and response steps, feel less panic and anxiety about warning signs, and experience a clear improvement in overall emotional security.	Older heart failure patients benefit from accessible professional responses and consistent care pathways. Patients receive clear points of contact and action guidelines, reducing uncertainty and anxiety and increasing confidence in at-home management and care-seeking decisions.	Stabilized patient emotions improve adherence, reduce unnecessary emergency department visits/readmissions, and enhance quality of life. Recognized reassurance strengthens patient–clinician trust, sustaining long-term care. With scheduled follow-ups, symptom/weight monitoring, consultation channels, standardized escalation/referral pathways, and education, a sustainable monitoring–feedback system ensures ongoing stability and emotional safety.	This outcome is distinct to outcome “Strengthen Self-Efficacy & Confidence”, thus it will not overlap with other outcomes within this stakeholder subgroup.
	Strengthen Self-Efficacy & Confidence	After diagnosis and enrollment, regular case manager follow-ups and education, integrated with comprehensive care, drive lifestyle and dietary adjustments and boost self-management capacity. Patients feel more capable of managing heart failure and maintaining daily function, with a clear increase in overall self-efficacy and confidence.	Older patients benefit directly from consistent care pathways, accessible consultation, and concrete action checklists. Patients receive clear warning indicators, increasing confidence in at-home management and care-seeking decisions, while reducing uncertainty and caregiving burden.	Greater patient self-efficacy and confidence boost adherence and symptom control, lowering acute deterioration and readmissions while improving quality of life and independence. With individualized goals, medication guidance, logs, follow-ups/telehealth, standardized escalation/referral, and education, a closed-loop system sustains and amplifies these gains.	This outcome is distinct to outcome “Enhanced Emotional Security”, thus it will not overlap with other outcomes within this stakeholder subgroup.

Stakeholder Subgroup	Outcomes	Description of Outcomes	Outcomes Relevance	Significant and Manageable Outcome	Distinct Outcome
Patient Group 1: Heart Failure Patient (age over 80)	Financial pressure arising	Functional limitations reduce work roles and hours, with declining income compounded by rising medical expenses, creating substantial financial pressure. Prolonged stress and role changes lead to frustration and helplessness, further undermining treatment motivation and day-to-day stability.	Adjusted workloads and role changes increase financial uncertainty, forcing them to navigate the dual challenges of disease management and economic pressure. Few of patients aged 60–80 may still bear household expenses or caregiving duties, so reduced income hits this group harder.	Financial pressure and frustration reduce adherence and clinic attendance, delay symptom management, raise readmission risk, and harm quality of life—driving costs up. Countermeasures: social work/financial counseling, insurance support, flexible return-to-work, cost optimization, transport/telehealth, and case management with psychological support to close the loop.	This outcome is the sole negative and unintended outcome, thus the outcome is distinct to outcomes “Enhanced Emotional Security“ & “Strengthen Self-Efficacy & Confidence“, and it will not overlap with other outcomes within this stakeholder subgroup.

Stakeholder Subgroup	Outcomes	Description of Outcomes	Outcomes Relevance	Significant and Manageable Outcome	Distinct Outcome
Patient Group 2: Heart Failure Patient (age 60–80)	Enhanced Emotional Security	After enrollment, case manager follow-ups with real-time consultation, cross-disciplinary collaboration, and education run in parallel, making the condition more controllable. Patients clearly recognize warning signs and response steps, reducing anxiety and panic, with a marked improvement in overall emotional security.	Having defined points of contact and standardized processes for this stakeholder subgroup can reduce uncertainty and tension, increasing confidence in at-home management and care-seeking decisions. Few of patients aged 60–80 juggle both family and work pressures, and they urgently need accessible, consistent, and rapid professional responses with clear action guidance.	Stabilized patient emotions improve adherence, reduce unnecessary emergency department visits/readmissions, and enhance quality of life. Recognized reassurance strengthens patient–clinician trust, sustaining long-term care. With scheduled follow-ups, symptom/weight monitoring, consultation channels, standardized escalation/referral pathways, and education, a sustainable monitoring–feedback system ensures ongoing stability and emotional safety.	This outcome is distinct to outcome “Strengthen Self-Efficacy & Confidence”, thus it will not overlap with other outcomes within this stakeholder subgroup.
	Strengthen Self-Efficacy & Confidence	Under regular case manager follow-ups and education, combined with medication adjustments and lifestyle support, patients gradually build self-monitoring and decision-making skills. They proactively recognize warning signs and take action; self-efficacy and confidence keep growing, with greater assurance in maintaining daily function.	Clear contact points, action checklists, and response timeframes enable this stakeholder subgroup to carry out self-care effectively, reducing uncertainty and hesitation. Few of patients aged 60–80 often face both family and workplace pressures, and they need accessible, consistent guidance to implement self-management.	Greater patient self-efficacy and confidence boost adherence and symptom control, lowering acute deterioration and readmissions while improving quality of life and independence. With individualized goals, medication guidance, logs, follow-ups/telehealth, standardized escalation/referral, and education, a closed-loop system sustains and amplifies these gains.	This outcome is distinct to outcome “Enhanced Emotional Security”, thus it will not overlap with other outcomes within this stakeholder subgroup.

Stakeholder Subgroup	Outcomes	Description of Outcomes	Outcomes Relevance	Significant and Manageable Outcome	Distinct Outcome
Patient Group 2: Heart Failure Patient (age 60–80)	Financial pressure arising	Functional limitations reduce work roles and hours, with declining income compounded by rising medical expenses, creating substantial financial pressure. Prolonged stress and role changes lead to frustration and helplessness, further undermining treatment motivation and day-to-day stability.	Adjusted workloads and role changes increase financial uncertainty, forcing them to navigate the dual challenges of disease management and economic pressure. Few of patients aged 60–80 may still bear household expenses or caregiving duties, so reduced income hits this group harder.	Financial pressure and frustration reduce adherence and clinic attendance, delay symptom management, raise readmission risk, and harm quality of life—driving costs up. Countermeasures: social work/financial counseling, insurance support, flexible return-to-work, cost optimization, transport/telehealth, and case management with psychological support to close the loop.	This outcome is the sole negative and unintended outcome, thus the outcome is distinct to outcomes “Enhanced Emotional Security“ & “Strengthen Self-Efficacy & Confidence“, and it will not overlap with other outcomes within this stakeholder subgroup.

Stakeholder Subgroup	Outcomes	Description of Outcomes	Outcomes Relevance	Significant and Manageable Outcome	Distinct Outcome
Patient Group 3: Heart Failure Patient (age under 60)	Enhanced Emotional Security	With case management follow-ups, real-time consultation, and education support, patients can recognize worsening signs and take action, establishing predictable response routines. Anxiety and panic decrease, a sense of control over daily life and the illness increases, and emotional security is markedly enhanced.	Many patients under 60 are at the peak of career and family responsibilities and may feel uneasy about disease progression and role changes. Accessible, consistent professional responses and clear points of contact help them coordinate work, family, and self-management more steadily.	Greater emotional security boosts adherence and self-monitoring, reduces acute exacerbations and readmissions, and sustains work and family functioning, while curbing overuse of care and decision fatigue to improve quality of life and long-term outcomes. To achieve this, deploy action checklists, real-time consultation channels, digital tracking and follow-ups, and family support with standardized escalation/referral pathways.	This outcome is distinct to outcome “Strengthen Self-Efficacy & Confidence”, thus it will not overlap with other outcomes within this stakeholder subgroup.
	Strengthen Self-Efficacy & Confidence	Through structured education, skills training, and clear action plans, patients gain confidence in symptom recognition, medication management, and activity adjustment. Visible small-step successes and feedback loops strengthen self-efficacy and confidence, reducing frustration and feelings of loss of control.	Patients under 60 often juggle work and family; functional limits and reduced hours can trigger financial strain and role instability. Strengthening self-efficacy helps sustain job performance and family engagement, while reducing healthcare-seeking and absenteeism driven by uncertainty and anxiety.	Boosting patients’ self-efficacy strengthens adherence and self-monitoring, enables earlier intervention, reduces acute exacerbations and readmissions, and helps sustain work continuity and social roles, while improving emotional resilience and quality of life for better long-term outcomes. Achieve this through self-monitoring, action checklists, adaptive medication/lifestyle measures, digital reporting with follow-ups, family support, and standardized escalation/referral pathways.	This outcome is distinct to outcome “Enhanced Emotional Security”, thus it will not overlap with other outcomes within this stakeholder subgroup.

Stakeholder Subgroup	Outcomes	Description of Outcomes	Outcomes Relevance	Significant and Manageable Outcome	Distinct Outcome
Patient Group 3: Heart Failure Patient (age under 60)	Financial pressure arising	Persistent functional limitations and reduced working hours lower income while medical and living costs rise, creating measurable financial strain (bills, debt, cash-flow tightness). This stress further undermines treatment adherence, care-seeking behaviors, and mental health, reinforcing a vicious cycle.	Patients under 60 often bear significant career responsibilities. Reduced roles/hours, sick leave, and difficult return-to-work disrupt household income and social roles; financial pressure directly heightens frustration and uncertainty, weakening self-management and the quality of care-seeking decisions.	Financial pressure undermines adherence, delays care, and raises risks of acute deterioration and readmission, while disrupting family functioning and quality of life. Early identification and intervention sustain treatment continuity and long-term outcomes. Implement screening, counseling, insurance/subsidy support, cost optimization, flexible return-to-work, transport/telehealth, and integrated case/psychological support to create an “identify–connect–relieve–follow-up” loop.	This outcome is the sole negative and unintended outcome, thus the outcome is distinct to outcomes “Enhanced Emotional Security“ & “Strengthen Self-Efficacy & Confidence “, and it will not overlap with other outcomes within this stakeholder subgroup.

Stakeholder Subgroup	Outcomes	Description of Outcomes	Outcomes Relevance	Significant and Manageable Outcome	Distinct Outcome
Family of Patient Group 1 (age over 80)	Enhanced Emotional Security	Clear care protocols and education help families grasp key points and when to escalate, reducing uncertainty and anxiety. Daily monitoring and feedback make the patient’s condition more predictable, giving caregivers a sense of security and direction to support needs more steadily.	Older patients have high comorbidity and frailty, and families often shoulder decisions and daily care. Enhanced emotional security improves family communication, task sharing, and help-seeking timing, reduces hypervigilance and misjudgment, and maintains care continuity and household routine.	Greater emotional security and clarity enhance care adherence and timely action, reducing acute deterioration and unnecessary emergency department visits, easing family stress, improving sleep and emotional health, and strengthening long-term patient stability and family functioning. Achieve this with symptom and weight monitoring, action checklists, escalation pathways, case management, rapid consultations, guidance on medication, diet, exercise, simple logs.	This outcome is distinct to outcome “Caregiving Burden Relief “, thus it will not overlap with other outcomes within this stakeholder subgroup.
	Caregiving Burden Relief	As the patient’s condition stabilizes and needs decrease, caregiving hours and real-time monitoring burdens drop. Family members regain self-directed time, with relief from fatigue and stress, allowing greater focus on high-value care and their own health, improving overall household efficiency and quality of life.	Care for older patients is often shouldered by family, lasting long and marked by high uncertainty. Reducing burden helps maintain work and family roles, lowers accompaniment and travel costs, improves parent-child and partner relationships, makes care more sustainable and flexible, and reduces caregiver burnout.	Reducing caregiving burden strengthens health, sleep, economic stability, and treatment continuity, lowering errors, acute deterioration, and unnecessary emergency department visits or hospitalizations. Implement symptom and weight monitoring, clear action checklists and escalation pathways, teleconsultations, social service referrals, respite care, case management, and family education to create a stable, sustainable care loop.	This outcome is distinct to outcome “Enhanced Emotional Security “, thus it will not overlap with other outcomes within this stakeholder subgroup.

Stakeholder Subgroup	Outcomes	Description of Outcomes	Outcomes Relevance	Significant and Manageable Outcome	Distinct Outcome
Family of Patient Group 2 (age 60 - 80)	Enhanced Emotional Security	Clear care protocols and ongoing education reduce uncertainty and anxiety. Through daily monitoring and feedback, the patient’s condition becomes more predictable, giving caregivers a sense of security and direction to support the patient more steadily while maintaining family rhythm and quality of life.	Greater emotional security enhances family communication and task sharing, improves recognition of when to seek help, reduces hypervigilance and misjudgment, and makes caregiving more continuous and flexible while balancing personal life.	Emotional security and clear workflows improve adherence and early intervention, reduce stress, and enhance sleep and emotional health. Over time, they stabilize caregiver well-being and family functioning, raising overall caregiving quality and efficiency.	This outcome is distinct to outcome “Caregiving Burden Relief“, thus it will not overlap with other outcomes within this stakeholder subgroup.
	Caregiving Burden Relief	Patient stabilization and reduced needs lower caregiving hours and real-time monitoring burdens. Family members regain self-directed time, with reduced stress and fatigue, enabling focus on high-value care and their own health, while household rhythm and overall quality of life improve in tandem.	Reducing burden helps maintain roles and income, lowers travel and leave costs, improves family communication and task sharing, and makes caregiving more sustainable and flexible.	Reducing caregiving burden improves health, sleep, and treatment continuity, cutting errors, acute deterioration, and unnecessary emergency department visits and hospitalizations. Implement monitoring, action checklists with escalation, guidance, rapid consults, reminders, case management, simple records, and family education to create a “simplify–early action–save time–reduce stress” loop.	This outcome is distinct to outcome “Enhanced Emotional Security“, thus it will not overlap with other outcomes within this stakeholder subgroup.

Stakeholder Subgroup	Outcomes	Description of Outcomes	Outcomes Relevance	Significant and Manageable Outcome	Distinct Outcome
Family of Patient Group 3 (age under 60)	Enhanced Emotional Security	Patient stabilization and reduced needs decrease caregiving hours and urgent responses. Family members gain more self-directed time, with lower stress and fatigue, enabling balance of work, family, and personal growth, while overall life rhythm and quality improve.	Greater emotional security enhances family communication and task sharing, improves recognition of when to seek help, reduces hypervigilance and misjudgment, and makes caregiving more continuous and flexible while balancing personal life.	Reducing caregiving burden improves physical and mental health, sleep, and treatment continuity, cutting errors, missed care, acute deterioration, and unnecessary emergency department visits and hospitalizations. Sustain gains by implementing symptom and weight monitoring, action checklists with escalation, medication/diet/exercise guidance, rapid consults and call-backs, reminders, case management, simple records, and family education to create a “simplify–early action–save time–reduce stress” loop.	This outcome is distinct to outcome “Caregiving Burden Relief “, thus it will not overlap with other outcomes within this stakeholder subgroup.
	Caregiving Burden Relief	Patient stabilization and reduced needs lower caregiving hours and urgent responses. Family members gain more self-directed time, with decreased stress and fatigue, enabling balance across work, family, and personal development, and improving overall life rhythm and quality.	Reducing burden helps maintain roles and income, lowers travel and leave costs, improves family communication and task sharing, and makes caregiving more sustainable and flexible.	Reducing caregiving burden improves physical and mental health, sleep, and treatment continuity, cutting errors, missed care, acute deterioration, and unnecessary emergency department visits and hospitalizations. Sustain gains by implementing symptom and weight monitoring, action checklists with escalation, medication/diet/exercise guidance, rapid consults and call-backs, reminders, case management, simple records, and family education to create a “simplify–early action–save time–reduce stress” loop.	This outcome is distinct to outcome “Enhanced Emotional Security “, thus it will not overlap with other outcomes within this stakeholder subgroup.

6 Proving Outcomes and Assigning Value

6.1 Setting and Confirming Outcome Indicators

In this report, the development and validation of outcomes followed the principles of Social Return on Investment (SROI). Through in-depth interviews and discussions with the stakeholder group, the complete Chain of Outcomes — from inputs, activities, and outputs to outcomes—was progressively depicted. Given the differences among stakeholders in contextual background, role expectations, and personal perceptions, the nature of outcomes and their perceived intensity also varied. To avoid overestimating or underestimating actual changes, this report adopted a conservative and evidence-based approach to constructing outcome indicators.

All outcome indicators were primarily based on the actual descriptions provided by stakeholders and were included in the subsequent questionnaires and supporting materials as the basis for measuring whether outcomes occurred. In addition to being constructed based on stakeholder feedback, the indicators were also reviewed and supplemented according to the following three principles:

- (1) In this report, all outcomes were qualitative emotions which were measured by using quantitative scale and proportion indicators. This decision reflects the program’s emphasis on the real experiences of patients and caregivers, and aligns with the core value of improving quality of life and the care process. Since heart failure is a long-term chronic condition, the effects of intervention are often reflected in patients’ attitudes toward life, satisfaction with care, and the quality of collaboration among the medical team. Such types of changes are not easily quantified with a single data point, yet they can be clearly presented through in-depth interviews and semantic analysis. The use of quantitative scale and proportion indicators allowed this report to remain close to the actual care context and faithfully reflect the changes and value perceived by multiple stakeholders.
- (2) The indicator statements are specific and action-oriented, emphasizing aspects such as when the outcomes began, the magnitude of improvement, the number of people who experienced the outcome, and the duration of the outcome, in order to enhance observability and measurability.

Guided by Social Return on Investment (SROI) principles, this evaluation uses high-quality indicators—consistent, in-depth, and traceable—as the basis for outcome verification and valuation. Indicators come from stakeholder interviews and data collection, reflecting changes in perceptions, behaviors, and viewpoints before and after participation. Outcome chains are built through stakeholder-engaged logic, and social value estimates rely on this evidence.

Final indicators were jointly confirmed by the medical team and research consultants, incorporating TCVGH information system data, program performance reports, and stakeholder feedback to validate outcomes and estimate value. Consistent, credible, and representative data provide a persuasive evidence base, ensuring representativeness, completeness, and verifiability in line with SROI principles.

Table 6.1-1 Outcome Indicator Measurement Table

Stakeholder Subgroup	Outcome	Outcomes measurement							
		Magnitude of outcomes				Duration of outcomes			How important is this outcome to stakeholders? (Weighting ²)
		Indicator Used to Measure Outcome	Indicator Source	Number of People Experiencing the Outcome (Scale)	Degree of Change per Stakeholder (Depth ¹)	Duration of Outcome (Years)	Start Time of Outcome	Total of Start Time and Duration (Years)	
National Health Insurance Administration (NHIA)	Strengthened Confidence in Program Governance and Decision-Making	Conduct interviews and surveys with programme organizer to measure changes of confidence in program governance and decision-making after participation (including the depth and importance of change), to be used as an outcome indicator.	In-depth group interview/questionnaire survey	1	85%	4	Period of activity	5	8.5
Program Leader	Strengthen Professional Accomplishment	Conduct interviews and surveys with programme leader to measure changes in accomplishment after participation (including the depth and importance of change), to be used as an outcome indicator.	In-depth group interview/questionnaire survey	3	90%	4	Period of activity	5	9

1. Maximum of depth: 100%
2. Maximum of depth: 10 points

Stakeholder Subgroup	Outcome	Outcomes measurement							How important is this outcome to stakeholders? (Weighting ²)
		Magnitude of outcomes				Duration of outcomes			
		Indicator Used to Measure Outcome	Indicator Source	Number of People Experiencing the Outcome (Scale)	Degree of Change per Stakeholder (Depth ¹)	Duration of Outcome (Years)	Start Time of Outcome	Total of Start Time and Duration (Years)	
Cardiovascular Center Physicians	Confidence in Clinical Decision-Making	Conduct interviews and surveys with program executors to measure changes of confidence in clinical decision-making after participation (including the depth and importance of change), to be used as an outcome indicator.	In-depth group interview/questionnaire survey	22	85%	4	Period of activity	5	8.5
Case Managers	Confidence in Professional Capability	Conduct interviews and surveys with program executors to measure changes of confidence in professional capability after participation (including the depth and importance of change), to be used as an outcome indicator.	In-depth group interview/questionnaire survey	2	90%	4	Period of activity	5	10
Various Healthcare Professionals	Confidence in Professional Capability	Conduct interviews and surveys with program executors to measure changes of confidence in professional capability after participation (including the depth and importance of change), to be used as an outcome indicator.	In-depth group interview/questionnaire survey	8	80%	4	Period of activity	5	8

1. Maximum of depth: 100% 2. Maximum of depth: 10 points

Stakeholder Subgroup	Outcome	Outcomes measurement							How important is this outcome to stakeholders? (Weighting ²)
		Magnitude of outcomes				Duration of outcomes			
		Indicator Used to Measure Outcome	Indicator Source	Number of People Experiencing the Outcome (Scale)	Degree of Change per Stakeholder (Depth ¹)	Duration of Outcome (Years)	Start Time of Outcome	Total of Start Time and Duration (Years)	
Patient Group 1: Heart Failure Patient (age over 80)	Enhanced Emotional Security	Conduct interviews and surveys with patient to measure changes in emotional security after participation (including the depth and importance of change), to be used as an outcome indicator.	In-depth group interview/questionnaire survey	42	85%	4	Period of activity	5	9
	Strengthen Self-Efficacy & Confidence	Conduct interviews and surveys with patient to measure changes in self-efficacy & confidence after participation (including the depth and importance of change), to be used as an outcome indicator.	In-depth group interview/questionnaire survey	40	80%	4	Period of activity	5	8.5

1. Maximum of depth: 100%
2. Maximum of depth: 10 points

Stakeholder Subgroup	Outcome	Outcomes measurement							How important is this outcome to stakeholders? (Weighting ²)
		Magnitude of outcomes				Duration of outcomes			
		Indicator Used to Measure Outcome	Indicator Source	Number of People Experiencing the Outcome (Scale)	Degree of Change per Stakeholder (Depth ¹)	Duration of Outcome (Years)	Start Time of Outcome	Total of Start Time and Duration (Years)	
Patient Group 2: Heart Failure Patient (age 60 - 80)	Enhanced Emotional Security	Conduct interviews and surveys with patient to measure changes in emotional security after participation (including the depth and importance of change), to be used as an outcome indicator.	In-depth group interview/questionnaire survey	82	90%	4	Period of activity	5	10
	Strengthen Self-Efficacy & Confidence	Conduct interviews and surveys with patient to measure changes in self-efficacy & confidence after participation (including the depth and importance of change), to be used as an outcome indicator.	In-depth group interview/questionnaire survey	82	85%	4	Period of activity	5	9
	Financial pressure arising	Conduct interviews and surveys with patient to measure changes in pressure after participation (including the depth and importance of change), to be used as an outcome indicator.	In-depth group interview/questionnaire survey	2	40%	3	Period of activity	4	4.5

1. Maximum of depth: 100%
2. Maximum of depth: 10 points

Stakeholder Subgroup	Outcome	Outcomes measurement							How important is this outcome to stakeholders? (Weighting ²)
		Magnitude of outcomes				Duration of outcomes			
		Indicator Used to Measure Outcome	Indicator Source	Number of People Experiencing the Outcome (Scale)	Degree of Change per Stakeholder (Depth ¹)	Duration of Outcome (Years)	Start Time of Outcome	Total of Start Time and Duration (Years)	
Patient Group 3: Heart Failure Patient (age under 60)	Enhanced Emotional Security	Conduct interviews and surveys with patient to measure changes in emotional security after participation (including the depth and importance of change), to be used as an outcome indicator.	In-depth group interview/questionnaire survey	23	95%	4	Period of activity	5	9
	Strengthen Self-Efficacy & Confidence	Conduct interviews and surveys with patient to measure changes in self-efficacy & confidence after participation (including the depth and importance of change), to be used as an outcome indicator.	In-depth group interview/questionnaire survey	23	80%	4	Period of activity	5	9.5
	Financial pressure arising	Conduct interviews and surveys with patient to measure changes in financial pressure after participation (including the depth and importance of change), to be used as an outcome indicator.	In-depth group interview/questionnaire survey	9	65%	3	Period of activity	4	6.5

1. Maximum of depth: 100%
2. Maximum of depth: 10 points

Stakeholder Subgroup	Outcome	Outcomes measurement							How important is this outcome to stakeholders? (Weighting ²)
		Magnitude of outcomes				Duration of outcomes			
		Indicator Used to Measure Outcome	Indicator Source	Number of People Experiencing the Outcome (Scale)	Degree of Change per Stakeholder (Depth ¹)	Duration of Outcome (Years)	Start Time of Outcome	Total of Start Time and Duration (Years)	
Family of Patient Group 1 (age over 80)	Enhanced Emotional Security	Conduct interviews and surveys with caregiver to measure changes in emotional security after participation (including the depth and importance of change), to be used as an outcome indicator.	In-depth group interview/questionnaire survey	38	85%	4	Period of activity	5	9
	Caregiving Burden Relief	Conduct interviews and surveys with caregiver to measure changes in burden relief after participation (including the depth and importance of change), to be used as an outcome indicator.	In-depth group interview/questionnaire survey	37	85%	4	Period of activity	5	8.5

1. Maximum of depth: 100%
2. Maximum of depth: 10 points

Stakeholder Subgroup	Outcome	Outcomes measurement							How important is this outcome to stakeholders? (Weighting ²)
		Magnitude of outcomes				Duration of outcomes			
		Indicator Used to Measure Outcome	Indicator Source	Number of People Experiencing the Outcome (Scale)	Degree of Change per Stakeholder (Depth ¹)	Duration of Outcome (Years)	Start Time of Outcome	Total of Start Time and Duration (Years)	
Family of Patient Group 2 (age 60 - 80)	Enhanced Emotional Security	Conduct interviews and surveys with caregiver to measure changes in emotional security after participation (including the depth and importance of change), to be used as an outcome indicator.	In-depth group interview/questionnaire survey	69	90%	4	Period of activity	5	9
	Caregiving Burden Relief	Conduct interviews and surveys with caregiver to measure changes in burden relief after participation (including the depth and importance of change), to be used as an outcome indicator.	In-depth group interview/questionnaire survey	65	80%	4	Period of activity	5	8

1. Maximum of depth: 100%
2. Maximum of depth: 10 points

Stakeholder Subgroup	Outcome	Outcomes measurement							How important is this outcome to stakeholders? (Weighting ²)
		Magnitude of outcomes				Duration of outcomes			
		Indicator Used to Measure Outcome	Indicator Source	Number of People Experiencing the Outcome (Scale)	Degree of Change per Stakeholder (Depth ¹)	Duration of Outcome (Years)	Start Time of Outcome	Total of Start Time and Duration (Years)	
Family of Patient Group 3 (age under 60)	Enhanced Emotional Security	Conduct interviews and surveys with caregiver to measure changes in emotional security after participation (including the depth and importance of change), to be used as an outcome indicator.	In-depth group interview/questionnaire survey	19	80%	4	Period of activity	5	8
	Caregiving Burden Relief	Conduct interviews and surveys with caregiver to measure changes in burden relief after participation (including the depth and importance of change), to be used as an outcome indicator.	In-depth group interview/questionnaire survey	19	80%	4	Period of activity	5	7.5

1. Maximum of depth: 100%
2. Maximum of depth: 10 points

According to the "Indicator Used to Measure Outcome" column in Table 6.1-1 above, this study uses the following questions as indicators to measure outcomes, with explanations of the question example:

Please respond to the following outcome indicator questions based on your stakeholder role. Reflect on the changes that have occurred as a result of the “National Health Insurance Post-Acute Care Program for Heart Failure” implemented by Taichung Veterans General Hospital (TVGH), and indicate or describe the impact you experienced.

Please assess the changes by comparing your situation “before” and “after” participation in the program.

Organizer (National Health Insurance Administration)

Indicator 1

This program, along with the following related statistical data, is believed to enhance the accuracy of future policy or program development, and provides ***Strengthened Confidence in Program Governance and Decision-Making*** program outcomes. (Stable case enrollment numbers ∙ Reduced repeat emergency visits ∙ Reduced hospital readmission rates ∙ Lower annual mortality rate ∙ Improved overall heart failure (HF) medication adherence indicators ∙ Improved patient mobility and exercise intensity ∙ Increased number and rate of follow-up visits to rehabilitation outpatient clinics)

- To what extent do you agree with the stated outcome of change? (%) _____ (Please enter a value between 0 and 100)

- How important is this outcome of change to you? (Score) _____ (Please enter a value between 0 and 10)

Note: For more details, please refer to Appendix B: Outcome Indicators - Question 4.

The indicators used to measure outcomes are based on the "Degree of Change per Stakeholder (depth)" and "How important is this outcome to stakeholders? (weighting)" data. 11 stakeholder sub-groups are asked to rate their corresponding outcomes (Table 5.3-1). The "Depth" is presented as a percentage to indicate whether the outcome has achieved the expected change, with a threshold of 50% used to assess whether the outcome has met expected changing (6.1.1). A Depth \geq 50% indicates that the outcome has achieved the expected changing, and an evaluation will be conducted on that outcome. "How important is this outcome to stakeholders? (weighting)" is rated on a scale of 0 to 10 to reflect the importance of the outcome to stakeholders. This rating can illustrate the value differences of various outcomes within the same sub-group and the value differences of the same outcome across different sub-groups when conducting outcome evaluations (6.2.1).

6.1.1 Determination of Outcome Materiality

This study follows the materiality principles of Social Value International (SVI), adopting $\text{Depth} \geq 50\%$ as the sole inclusion threshold: outcomes with a group-average $\text{Depth} < 50\%$ are excluded, and those with $\text{Depth} \geq 50\%$ are included. Depth is used only to determine inclusion and is not applied as a multiplier in valuation. To ensure comparability and traceability in materiality determinations, each outcome is defined with a clear operational definition, corresponding measurement items, and data sources, and is validated through standardized measurement and aggregation procedures. The measurement items and sources for each outcome are designed independently to avoid indicator overlap and are mapped within the outcome chain to mitigate the risk of double counting. Taken together, these mechanisms ensure that included outcomes meet the requirements of materiality, manageability, and valuation feasibility, thereby supporting a persuasive estimate of social value.

6.2 Valuing the Outcomes

This report valued the various outcomes it generated in a reasonable and verifiable manner, following the core principles of Social Return on Investment (SROI). To ensure transparency and consistency in the valuation process, the estimation adhered to the principles of “establishing a meaningful basis for comparison” and “avoiding overstatement of results,” prioritizing the use of social value databases (such as the UK Social Value Bank), publicly available government data, market prices, and existing research as references for valuation.

In the process of outcome valuation, the program team analyzed the impact intensity and affected groups for each outcome experienced by stakeholders — including emotional improvement, reduced caregiving burden, increased health awareness, and others — and selected the most representative and feasible outcomes for monetization.

This program employed the following three valuation methodologies:

- (1) Cost-based approach: Suitable for outcomes where the value is clearly reflected through market mechanisms, estimating social value based on actual costs incurred.
- (2) Well-being valuation approach: Applied to psychological and subjective outcomes that cannot be measured using market prices, this internationally recognized method estimates the monetary equivalent of changes in specific psychological states on personal life satisfaction.
- (3) Anchoring approach: Anchoring is one of the commonly used outcome valuation methods in SROI analysis. It is primarily applied to translate non-financial outcomes that are difficult to measure directly through market prices—such as psychological perceptions, confidence, and sense of security—into monetary values that are reasonable and verifiable.

The core principle of anchoring is not to achieve “precise pricing,” but rather to estimate the social value associated with outcomes actually experienced by stakeholders by referencing existing and credible benchmark values (anchors), supported by reasonable assumptions and transparent logic.

6.2.1 Valuation Consistency – Anchoring Approach

Stakeholder-Specific Anchor Selection

1. Case Managers & Various Healthcare Professionals subgroups
 - The outcome selected as the anchor: Confidence in Professional Capability
 - Rationale: These two stakeholder groups each have only one outcome, and the outcomes are identical. Using the anchoring method appropriately presents a comparison of valuation results for the same outcome across different stakeholder subgroups. We selected the price of the “Strengthening Logical Thinking: GAS Communication Framework” course as the valuation anchor because, based on discussions with stakeholders, this type of course best captures the value of the positive outcome “Confidence in Professional Capability” generated by the integrated care program for Case Managers and Various Healthcare Professionals.
2. Patient Group & Family of Patient subgroups
 - The outcome selected as the anchor: Enhanced Emotional Security
 - Rationale: First, Enhanced Emotional Security is the common outcome shared by these two stakeholder groups and received the highest score (10 points) for “importance to stakeholders.” Second, when reviewing the final outcome list, we noted that Enhanced Emotional Security did not have a suitable cost-based or revealed preference valuation option. We therefore turned to the literature² and identified a social well-being valuation case — “Relief from depression or anxiety”—which best reflects how the integrated care program reduces patients’ internal stress and anxiety about their condition and physical status, leading to the positive outcome of emotional security. After discussions with stakeholders and the project team, we decided to use a well-being approach as the valuation anchor for Enhanced Emotional Security.

This study adopts a standardized anchoring approach to harmonize monetary valuations of the same outcome across different stakeholder subgroups, as well as of different outcomes within the same stakeholder subgroup, thereby ensuring transparency, comparability, and consistency. When converting “subjective importance” into an “evaluable monetary amount,” we set a common anchor (e.g., weight at 10 points = NT\$1,102,980.00) to provide a shared reference baseline for all valuations. Linear scaling (e.g., weight at 9 points = NT\$992,682.00; 8.5 points = NT\$937,533.00) then maps differences in importance scores to monetary amounts in a straightforward and auditable manner, preventing logical inconsistencies such as different prices for the same score or the same price for different scores.

➤ Conversion formula:

$$\text{Outcome Value}_i = \text{Outcome Value}_{\text{Anchor}} \times \left(\frac{\text{Importance of Outcome Score}_i}{\text{Importance of Outcome Score}_{\text{Anchor}}} \right)$$

This study has specified, in the Value Map, two quantitative indicators for each outcome: outcome importance (1–10 points) and depth of change (Depth, %). The anchoring approach standardization uses only outcome importance as the proportional

² UKSVB- Valuing improvements in mental health https://socialvalueuk.org/wp-content/uploads/2017/10/HACT-WEMWBS-Report-8pp_PRINT.pdf

basis (with the same scale applied within the same stakeholder group). Depth is used at the materiality assessment stage and does not enter the anchoring proportion, in order to avoid double weighting.

For emotional outcomes in this study, some financial proxies are drawn from the UKSVB valuation for “Relief from depression/anxiety,” which is among the higher values available in the literature. Considering that the target group of this project is general heart failure patients rather than individuals with severe mental health conditions, the original valuation results (Table 6.2-1) are retained, while an additional anchoring approach is applied. The values are further adjusted for national applicability by referencing Taiwan’s disposable income levels and exchange rates, in order to avoid overestimation. This study incorporates the following conservative measures:

- (1) **Adjustment factors** – Deadweight, attribution, displacement, and drop-off factors collected through stakeholder survey responses are applied to each outcome valuation, ensuring that results are not overstated.
- (2) **Sensitivity check** – To test the uncertainty risk of potential overestimation in unit values, all outcome valuations were uniformly reduced by 10%.

Throughout the valuation process, the team selected the most appropriate valuation model for each outcome based on stakeholder interviews, internal databases, publicly available statistical data, and literature databases, while clearly disclosing valuation assumptions and data sources. This valuation strategy not only strengthens the presentation of the program’s value at both individual and societal levels but also complies with SROI principles regarding verifiability, transparency, and avoidance of overestimation.

Notably, when the initial version of the outcome list was completed, this study also applied the anchoring method primarily within the Patient Group and Family of Patient subgroups. In the Patient Group, the outcome “emotional security” was likewise used as the anchor, and the well-being method was used for anchoring valuation. Therefore, in the final valuation for the Patient Group, the consolidated and adjusted outcomes did not fundamentally affect the anchoring approach; the only consequence was a reduction in the number of outcomes, which in turn reduced the final social value.

As for the Family of Patient subgroup, the outcomes initially used as anchors — “Sense of Satisfaction” and “Sense of Being Supported”—were revisited during subsequent stakeholder and team discussions. Following outcome consolidation, adjustment, and removal, “Sense of Satisfaction” was removed, and “Sense of Being Supported” was merged with overlapping outcomes and reframed as “emotional security” (p. 30), which affected the anchoring approach and the valuation results for the Family of Patient subgroup. In addition, the reduction in the number of outcomes similarly led to a decrease in the final social value for the Family of Patient subgroup.

As for subgroups of the National Health Insurance Administration (NHIA), the Program Leader, and the Cardiovascular Center Physicians, after consolidation/adjustments (p. 30), each subgroup retained only one outcome, and these outcomes were different from one another. Consequently, the anchoring approach was no longer used; valuation was conducted solely using the cost-based method.

Table 6.2-1 Outcome Indicators Measurement

Stakeholder Subgroup	Outcome	Indicator for Outcome Measurement	Number of People Experienced the Outcome	Importance of Outcome	Outcome Valuation			Outcome Value
					Valuation Method	Proxy	Source of Information	Financial Proxy per Change (NTD)
National Health Insurance Administration (MHIA)	Strengthened Confidence in Program Governance and Decision-Making	Conduct interviews and surveys with programme organizer to measure changes of confidence in program governance and decision-making after participation (including the depth and importance of change), to be used as an outcome indicator.	1	8.5	Cost-based	Cost-based : PgMP (Program Management Professional) Course: Cross Project Decision Making, Strategic Alignment, Resource Allocation, and Value Governance	https://www.sharecourse.net/sharecourse/course/view/courseInfo/2788?locale=zh_TW	25,840.00

Stakeholder Subgroup	Outcome	Indicator for Outcome Measurement	Number of People Experienced the Outcome	Importance of Outcome	Outcome Valuation			Outcome Value
					Valuation Method	Proxy	Source of Information	Financial Proxy per Change (NTD)
Program Leader	Strengthen Professional Accomplishment	Conduct interviews and surveys with programme leader to measure changes in accomplishment after participation (including the depth and importance of change), to be used as an outcome indicator.	3	9	Cost-based	Self-efficacy enhancement course: A sense of safety typically arises from having more resources and strategies	https://edu.cpc.org.tw/class/content/559 (China Productivity Center)	3,700.00

Stakeholder Subgroup	Outcome	Indicator for Outcome Measurement	Number of People Experienced the Outcome	Importance of Outcome	Outcome Valuation			Outcome Value
					Valuation Method	Proxy	Source of Information	Financial Proxy per Change (NTD)
Cardiovascular Center Physicians	Confidence in Clinical Decision-Making	Conduct interviews and surveys with program executors to measure changes of confidence in clinical decision-making after participation (including the depth and importance of change), to be used as an outcome indicator.	22	8.5	Cost-based	Cost-based : Building Decision-Making Capability through Systems Thinking Training (Decision-Making)	https://edu.cpc.org.tw/class/content/65 (China Productivity Center)	4,500.00

Stakeholder Subgroup	Outcome	Indicator for Outcome Measurement	Number of People Experienced the Outcome	Importance of Outcome	Outcome Valuation			Outcome Value
					Valuation Method	Proxy	Source of Information	Financial Proxy per Change (NTD)
Case Manager	Confidence in Professional Capability	Conduct interviews and surveys with program executors to measure changes in confidence after participation (including the depth and importance of change), to be used as an outcome indicator.	2	10	Cost-based	Strengthening Logical Thinking: GAS Communication Framework	https://hahow.in/courses/5f3f2b2096a9d0e4faf63f21	2,890.00

Stakeholder Subgroup	Outcome	Indicator for Outcome Measurement	Number of People Experienced the Outcome	Importance of Outcome	Outcome Valuation			Outcome Value
					Valuation Method	Proxy	Source of Information	Financial Proxy per Change (NTD)
Various Healthcare Professionals	Confidence in Professional Capability	Conduct interviews and surveys with program executors to measure changes in confidence after participation (including the depth and importance of change), to be used as an outcome indicator.	8	8	Anchoring approach	Anchoring approach	Anchoring approach	2,312.00

Stakeholder Subgroup	Outcome	Indicator for Outcome Measurement	Number of People Experienced the Outcome	Importance of Outcome	Outcome Valuation			Outcome Value
					Valuation Method	Proxy	Source of Information	Financial Proxy per Change (NTD)
Patient Group 1: Heart Failure Patient (age over 80)	Enhanced Emotional Security	Conduct interviews and surveys with patient to measure changes in emotional security after participation (including the depth and importance of change), to be used as an outcome indicator.	42	9	Well-being valuation method (Anchor) ¹	According to UK Social Value Bank (UKSVB) Well being Valuation model, “relief from depression or anxiety” (£36,766)	https://socialvalueuk.org/wp-content/uploads/2017/10/HAC-T-WEMWBS-Report-8pp_PRINT.pdf	992,682.00
	Strengthen Self-Efficacy & Confidence	Conduct interviews and surveys with patient to measure changes in self-efficacy & confidence after participation (including the depth and importance of change), to be used as an outcome indicator.	40	8.5	Anchoring approach	Anchoring approach	Anchoring approach	937,533.00

Stakeholder Subgroup	Outcome	Indicator for Outcome Measurement	Number of People Experienced the Outcome	Importance of Outcome	Outcome Valuation			Outcome Value
					Valuation Method	Proxy	Source of Information	Financial Proxy per Change (NTD)
Patient Group 2: Heart Failure Patient (age 60 - 80)	Enhanced Emotional Security	Conduct interviews and surveys with patient to measure changes in emotional security after participation (including the depth and importance of change), to be used as an outcome indicator.	82	10	Anchoring approach	Anchoring approach	Anchoring approach	1,102,980.00
	Strengthen Self-Efficacy & Confidence	Conduct interviews and surveys with patient to measure changes in self-efficacy & confidence after participation (including the depth and importance of change), to be used as an outcome indicator.	82	9	Anchoring approach	Anchoring approach	Anchoring approach	992,682.00

Stakeholder Subgroup	Outcome	Indicator for Outcome Measurement	Number of People Experienced the Outcome	Importance of Outcome	Outcome Valuation			Outcome Value
					Valuation Method	Proxy	Source of Information	Financial Proxy per Change (NTD)
Patient Group 3: Heart Failure Patient (age under 60)	Enhanced Emotional Security	Conduct interviews and surveys with patient to measure changes in emotional security after participation (including the depth and importance of change), to be used as an outcome indicator.	23	9	Anchoring approach	Anchoring approach	Anchoring approach	992,682.00
	Strengthen Self-Efficacy & Confidence	Conduct interviews and surveys with patient to measure changes in self-efficacy & confidence after participation (including the depth and importance of change), to be used as an outcome indicator.	23	9.5	Anchoring approach	Anchoring approach	Anchoring approach	1,047,831.00

Stakeholder Subgroup	Outcome	Indicator for Outcome Measurement	Number of People Experienced the Outcome	Importance of Outcome	Outcome Valuation			Outcome Value
					Valuation Method	Proxy	Source of Information	Financial Proxy per Change (NTD)
Patient Group 3: Heart Failure Patient (age under 60)	Financial pressure arising	Conduct interviews and surveys with patient to measure changes in financial pressure after participation (including the depth and importance of change), to be used as an outcome indicator.	9	6.5	Anchoring approach	Anchoring approach	Anchoring approach	(716,937.00)

Stakeholder Subgroup	Outcome	Indicator for Outcome Measurement	Number of People Experienced the Outcome	Importance of Outcome	Outcome Valuation			Outcome Value
					Valuation Method	Proxy	Source of Information	Financial Proxy per Change (NTD)
Family of Patient Group 1 (age over 80)	Enhanced Emotional Security	Conduct interviews and surveys with caregiver to measure changes in emotional security after participation (including the depth and importance of change), to be used as an outcome indicator. Sources used:	38	9	Anchoring approach	Anchoring approach	Anchoring approach	992,682.00
	Caregiving Burden Relief	Conduct interviews and surveys with caregiver to measure changes in burden relief after participation (including the depth and importance of change), to be used as an outcome indicator.	37	8.5	Anchoring approach	Anchoring approach	Anchoring approach	937,533.00

Stakeholder Subgroup	Outcome	Indicator for Outcome Measurement	Number of People Experienced the Outcome	Importance of Outcome	Outcome Valuation			Outcome Value
					Valuation Method	Proxy	Source of Information	Financial Proxy per Change (NTD)
Family of Patient Group 2 (age 60 - 80)	Enhanced Emotional Security	Conduct interviews and surveys with caregiver to measure changes in emotional security after participation (including the depth and importance of change), to be used as an outcome indicator. Sources used:	69	9	Anchoring approach	Anchoring approach	Anchoring approach	992,682.00
	Caregiving Burden Relief	Conduct interviews and surveys with caregiver to measure changes in burden relief after participation (including the depth and importance of change), to be used as an outcome indicator.	65	8	Anchoring approach	Anchoring approach	Anchoring approach	882,384.00

Stakeholder Subgroup	Outcome	Indicator for Outcome Measurement	Number of People Experienced the Outcome	Importance of Outcome	Outcome Valuation			Outcome Value
					Valuation Method	Proxy	Source of Information	Financial Proxy per Change (NTD)
Family of Patient Group 3 (age under 60)	Enhanced Emotional Security	Conduct interviews and surveys with caregiver to measure changes in emotional security after participation (including the depth and importance of change), to be used as an outcome indicator. Sources used:	19	8	Anchoring approach	Anchoring approach	Anchoring approach	882,384.00
	Caregiving Burden Relief	Conduct interviews and surveys with caregiver to measure changes in burden relief after participation (including the depth and importance of change), to be used as an outcome indicator.	19	7.5	Anchoring approach	Anchoring approach	Anchoring approach	827,235.00

1. This study adopts a standardized anchoring approach to harmonize monetary valuations of the same outcome across different stakeholder groups, as well as of different outcomes within the same stakeholder group, thereby ensuring transparency, comparability, and consistency. When converting “subjective importance” into an “evaluable monetary amount,” we set a common anchor (10 points = NT\$1,102,980.00) to provide a shared reference baseline for all valuations. Linear scaling (e.g., weight at 9 points = NT\$992,682.00; 8.5 points = NT\$937,533.00) then maps differences in importance scores to monetary amounts in a straightforward and auditable manner, preventing logical inconsistencies such as different prices for the same score or the same price for different scores.
2. The emotional valuations provided by UKSVB are originally in British Pounds (GBP). To reflect the differences in living standards between the UK and Taiwan, all valuations from UKSVB are converted using the following formula:

Taiwan Valuation (NTD) = UK Valuation (GBP) × (Taiwan per capita disposable income NT\$631,000 / UK per capita disposable income NT\$840,000) × exchange rate (1 GBP = NT\$40) = UK Valuation (GBP) × 0.75 × 40.

6.3 Analysis of Reasons for Unachieved Outcomes

Not all anticipated outcomes were realized to a materially significant extent. In line with Social Value International (SVI) principles, this analysis includes only those outcomes representing meaningful change for stakeholders. A Depth threshold of 50% was applied as the materiality criterion: if a stakeholder group’s average degree of change (Depth) was below 50%, that outcome is classified as “not achieved” and excluded from the SROI valuation. This ensures that only substantive improvements are valued and avoids overstating impact by excluding changes that are widespread but shallow – an approach consistent with SVI’s Do Not Overclaim principle of only claiming value that the program’s activities truly created. In other words, the inclusion criteria focus on the depth of change rather than the number of people affected, preventing minor changes (even if experienced by many) from inflating the social value.

In addition to the magnitude of change, causal attribution was examined for each outcome. If an outcome’s change was primarily driven by external factors or pre-existing conditions rather than the program itself, its causal relevance to the intervention is considered low. Outcomes that could not be confidently attributed to the program were excluded on this basis. This ensures the SROI only credits the program for changes it actually brought about, reinforcing the credibility of the analysis. The rationale for excluding each “unachieved” outcome was thus grounded in two tests: (1) failing to meet the materiality threshold (Depth < 50%), and (2) lack of direct attribution to the program’s activities (lack of relevance).

Table 6.3-1 Analysis of Reasons for Unachieved Outcomes

Stakeholder Subgroup	Outcome	Number of People Experienced	Degree of Change per Stakeholder (Depth ¹)	Materiality Analysis	Relevance Analysis
Patient Group 2: Heart Failure Patient (age 60 - 80)	Financial pressure arising	2	40%	Although a measurable Depth was recorded, the average value is 30%, which is below the 50% materiality threshold; this level of change is insufficient to constitute a substantive impact and is therefore excluded.	The frustrations in this group mainly stem from the long-term effects of heart failure, such as declining health capacity, adjustments in job responsibilities, and economic impacts. These factors are independent of the follow-up and clinical support provided by this program. Therefore, the results show a low causal relationship with the intervention, and most of the changes cannot be attributed to this program.

1. Maximum of depth: 100%

In accordance with the SROI principle of Completeness of the Information, this report provides a comprehensive disclosure of outcomes for all stakeholder groups, including both those who experienced the intended outcomes and those who did not. Stakeholders who did not experience the intended outcomes have not been excluded from the analysis; instead, their actual circumstances, the reasons for non-achievement of outcomes, and the ways in which the program will manage and engage with these stakeholders are clearly explained.

Table 6.3-2 Analysis of Reasons for Unchanged Stakeholder

Stakeholder Subgroup	Outcomes	Unchanged People#	Main Reason	How it could be managed?
Cardiovascular Center Physicians	Confidence in Clinical Decision-Making	2	Everyday work routines diluted their awareness of the changes and experiences after participating in the program.	Send a monthly personal micro-dashboard (pathway adherence, decision time, related adverse event rates) to visualize improvement trends and pair it with peer sharing. Through a short “decide → feedback → calibrate” loop, Cardiovascular Center physicians can clearly perceive gains in clinical decision-making confidence in daily practice, reducing the diluting effect of routine work on perceived change.
Various Healthcare Professionals	Confidence in Professional Capability	2	Everyday work routines diluted their awareness of the changes and experiences after participating in the program.	Send a monthly personal micro-dashboard (pathway adherence, decision time, related adverse event rates) to visualize improvement trends and pair it with peer sharing. Through a short “decide → feedback → calibrate” loop, Cardiovascular Center physicians can clearly perceive gains in clinical decision-making confidence in daily practice, reducing the diluting effect of routine work on perceived change.

Stakeholder Subgroup	Outcomes	Unchanged People#	Main Reason	How it could be managed?
Patient Group 1: Heart Failure Patient (age over 80)	Strengthen Self-Efficacy & Confidence	2	Elderly patients already experience physical decline, so even after participating in an integrated treatment program, the effects may be diluted by age-related limitations. As a result, they may not strongly perceive changes related to strengthened self-efficacy and confidence.	Break self-efficacy into micro-goals for heart failure patients aged 80+ (e.g., 5 minutes of daily walking, weight and blood pressure monitoring, a 2 g sodium limit, and a brief breathlessness check), provide weekly phone/video micro-follow-ups to review adherence with positive feedback, and arrange peer/family micro-support from similar-age patients. Through these low-burden, visual, and supportive designs, small gains become tangible successes, naturally strengthening self-efficacy and confidence.
Patient Group 3: Heart Failure Patient (age under 60)	Financial pressure arising	14	The economic pressure primarily stems from health being significantly impacted by heart failure, with minimal direct relevance to the core program's intervention. Consequently, stakeholders' experience of this negative outcome is largely diluted by the above reasons.	Build an integrated medical–employment–welfare pathway: OT and social workers tailor job adjustments and provide employer documentation; launch welfare/insurance navigation with a one-time assessment for major illness certification, transport subsidies, emergency aid, and insurance claims; add peer support plus brief financial education (expense planning, basic debt negotiation) via short courses or online sessions—delivered by social workers or partner NGOs—for a sustainable, practical stress-relief program.

Stakeholder Subgroup	Outcomes	Unchanged People#	Main Reason	How it could be managed?
Family of Patient Group 1 (age over 80)	Caregiving Burden Relief	1	For caregivers of older and middle-aged patients, age-related functional decline—further compounded by heart failure—demands greater time and effort from families. This increased long-term care burden can dilute the perceived impact of the intervention, so caregivers may not feel a noticeable reduction in their workload.	To reduce the caregiving burden for families of older and middle-aged patients with heart failure, Chung-Rong can establish a low-burden, integrated support pathway: use a one-page care workflow card to standardize medication management, monitoring, and warning sign recognition, while proactively offering online peer-family groups and micro-courses on stress management to provide emotional and practical support.
Family of Patient Group 2 (age 60 - 80)	Caregiving Burden Relief	4	For caregivers of older and middle-aged patients, age-related functional decline—further compounded by heart failure—demands greater time and effort from families. This increased long-term care burden can dilute the perceived impact of the intervention, so caregivers may not feel a noticeable reduction in their workload.	To reduce the caregiving burden for families of older and middle-aged patients with heart failure, Chung-Rong can establish a low-burden, integrated support pathway: use a one-page care workflow card to standardize medication management, monitoring, and warning sign recognition, while proactively offering online peer-family groups and micro-courses on stress management to provide emotional and practical support.

7 Prevention of Overestimation Mechanisms

7.1 Impact Adjustment Factors

Before monetizing the social impact of this program, and in accordance with the principles of Social Return on Investment (SROI), four “impact adjustment factors” were applied to appropriately calibrate the value of outcomes. This ensures that the final reported social value is reasonable and truthful, and that outcomes not directly attributable to this program are excluded from the valuation. The program adjusted and disclosed the outcomes experienced by each stakeholder based on the following four factors:

Table 7.1-1 Impact Adjustment Factor Description Table

Impact Adjustment Factor	Definition
Deadweight	Refers to whether the outcome would have occurred naturally even without the intervention of this program. To avoid overestimating social impact by including changes that would have happened even if the program had not taken place, this portion must be deducted.
Displacement	Refers to whether the program “shifted” existing resources or changes to other individuals or time periods, potentially diminishing value elsewhere.
Attribution	Refers to whether the outcome was jointly facilitated by other programs, personnel, or systems. For example, if a participant also received assistance from other community resources or similar programs, the impact attributable to this program should be shared with those other contributors, and only the portion attributable to this program should be valued.
Drop-off	Refers to the natural weakening of outcomes over time, especially relevant for outcomes that persist beyond one year. Without continued intervention, part of the impact may decline year by year.

7.2 Results of Impact Factor Assessment and Adjustment Data

This program follows the Impact Principles proposed by Social Value International (SVI) by incorporating the four key impact adjustment factors—Deadweight, Attribution, Displacement, and Drop-off—into the outcome valuation adjustment process. The purpose is to prevent overestimation of outcomes and more accurately reflect the true social impact of the program.

The program emphasizes that “approximately right is better than precisely wrong”. Within the constraints of available resources, reasonable estimations are made based on effective information rather than expending excessive resources to pursue overly precise data collection. This approach is also aligned with SROI’s practice-oriented spirit, helping organizations effectively manage and optimize their social impact.

In this study, the adjustment factors—Deadweight (DW), Attribution (AT), Displacement (DP), and Drop-off—were directly taken from the percentage responses of stakeholders in the quantitative survey and entered into the Value Map without any further recalculation or weighting.

To ensure data consistency, the project team pre-determined classification thresholds during in-depth group interview and SROI workshops, which were used solely for consistency checks and narrative descriptions (Table 7.2-1). The questionnaire was designed with a dual-response format: percentage (0–100%) plus categorical range selection.

- When the two responses were consistent (e.g., the stakeholder entered 23% and selected the 21%–40% range), the raw percentage value was recorded.
- If an inconsistency occurs (for example, a respondent enters 23% but selects the 41%–60% category), the study does not alter the original data; the entry is only flagged internally as a “needs verification” quality control reminder. When necessary, researchers review the respondent’s interview notes and annotations to determine whether it was a mis-selection; ultimately, the original percentage value provided by the respondent is used, and the categorical band is for descriptive purposes only and is excluded from calculations.

No such “inconsistency requiring verification” occurred in this round of data collection. Because the survey was administered through one-on-one guidance by a researcher and a case manager, with responses completed in real time, there were no missing answers and no instances requiring post hoc imputation; likewise, no entries were flagged as “needs verification.”

The role of professional judgment and literature references was limited to the design stage (in-depth group interview /SROI workshops), where they were used to set classification thresholds, draft question explanations and examples.

Through this process, the collected survey data were directly entered into the Value Map and formed the basis for subsequent monetization analysis and social value calculation. Detailed figures and estimation logic are presented in the following tables (Tables 7.2.1-1 to 7.2.4-1).

Table 7.2-1 Impact Adjustment Factors — Grading Reference Table

Level	Proportion	Deadweight Explanation	Displacement Explanation	Attribution Explanation	Drop-off Explanation
Very Low	0%	The outcome would not occur without this program.	The outcome did not crowd out resources or services of other targets, nor did it cause value loss to other regions or stakeholders.	The outcome was entirely produced by the organization's activities, with no contribution from others.	Outcomes lasting more than one year experience no drop-off in the following year.
Low	1%~20%	Even without this program, there is a very small chance the outcome would occur.	The outcome slightly crowded out resources or services of other targets and caused a very minor value loss to other regions or stakeholders.	A very small part of the outcome was contributed by others.	Outcomes lasting more than one year experience a very minor drop-off in the following year.
Moderately Low	21%~40%	Even without this program, there is a small chance the outcome would occur.	The outcome crowded out some resources or services of other targets and caused a small value loss to other regions or stakeholders.	A small part of the outcome was contributed by others.	Outcomes lasting more than one year experience a small drop-off in the following year.
Medium	41%~60%	Even without this program, there is a moderate chance the outcome would occur.	The outcome crowded out part of the resources or services of other targets and caused a moderate value loss to other regions or stakeholders.	Part of the outcome was contributed by others.	Outcomes lasting more than one year experience a moderate drop-off in the following year.
Moderately High	61%~80%	Even without this program, the outcome is quite likely to occur.	The outcome crowded out a considerable part of the resources or services of other targets and caused considerable value loss to other regions or stakeholders.	A considerable part of the outcome was contributed by others.	Outcomes lasting more than one year experience considerable drop-off in the following year.

Level	Proportion	Deadweight Explanation	Displacement Explanation	Attribution Explanation	Drop-off Explanation
High	81%~99%	Even without this program, the outcome is highly likely to occur.	The outcome crowded out most of the resources or services of other targets and caused most of the value loss to other regions or stakeholders.	Most of the outcome was contributed by others.	Outcomes lasting more than one year experience a significant drop-off in the following year.
Very High	100%	The outcome would occur regardless of the program.	The outcome completely crowded out the resources or services of other targets and caused full value loss to other regions or stakeholders.	The outcome was entirely produced by others.	Outcomes lasting more than one year completely drop off in the following year.

Note: We referenced third party studies for cross validation and, based on in depth group interviews an discussions, established the impact adjustment factors classifications.

7.2.1 Deadweight

In the impact assessment of this project, the deadweight is used to evaluate whether and to what extent the outcomes could have occurred naturally without the intervention of the project.

- (1) **Set through in-depth interviews and surveys:** The deadweight percentages were determined through in-depth stakeholder interviews and survey results, combined with the professional judgment and past experience of the medical team, to reflect the reasonable likelihood that changes could have occurred without the project.
- (2) **Ensure conservative and credible valuation:** A conservative approach was adopted to avoid exaggerating the project's contribution and to ensure that the SROI results are objective, prudent, and verifiable.
- (3) **Outcome-specific adjustments:** Deadweight was adjusted according to the likelihood of natural occurrence of each specific outcome, taking into account the nature of the outcomes and the diversity of stakeholders' backgrounds.
- (4) **Research reference:** We referenced third-party studies for cross-validation and, based on in-depth group interviews an discussions, established the deadweight classifications.

Table 7.2.1-1 Impact Factor Adjustment Table – Deadweight

Stakeholder Subgroup	Outcome	Outcome Indicator	Deadweight		Reasoning
			Proportion	Level	
National Health Insurance Administration (NHIA)	Strengthened Confidence in Program Governance and Decision-Making	Conduct interviews and surveys with programme organizer to measure changes of confidence in program governance and decision-making after participation (including the depth and importance of change), to be used as an outcome indicator.	0%	Very Low	<p>(1) The outcome is highly dependent on the information output produced by this program. This outcome mainly comes from the two integrated reports generated by the program, which include clinical data, case changes, and care experience, providing first-hand and highly integrated data as a foundation for future policy promotion. Without this program, the outcome data would have been difficult to obtain from other existing sources. Therefore, it is estimated that the probability of the outcome occurring naturally without the program is extremely low.</p> <p>(2) This outcome is not a predetermined output of existing operations. During the consultation process, the NHIA clearly stated that the content of the program’s reports, in terms of format, integration, and data application, is specific and unique, which cannot be accomplished with routine administrative data alone. Therefore, this outcome is highly dependent on the implementation of this program.</p>
Program Leader	Strengthen Professional Accomplishment	Conduct interviews and surveys with programme leader to measure changes in accomplishment after participation (including the depth and importance of change), to be used as an outcome indicator.	0%	Very Low	<p>(1) The program provided a cross-domain sense of accomplishment different from routine clinical outcomes. Unlike the typical sense of achievement derived from individual treatment results, this program incorporated policy orientation, cross-team collaboration, and innovation in medical processes, making the source of accomplishment more diverse and meaningful in the long term.</p> <p>(2) Observing concrete outcomes strengthened the intensity of subjective accomplishment. Improvements in patient follow-up, successful integration of care models, and recognition from external entities (like NHIA) all enhanced the depth and sustainability of this sense of accomplishment, making it unique to this program.</p> <p>(3) Such emotional outcomes are not simply produced by routine work. Without program intervention and the accumulation of concrete results, it would be difficult for routine medical work to generate such strong and structured sense of accomplishment. Therefore, this outcome has high additionality.</p>

Stakeholder Subgroup	Outcome	Outcome Indicator	Deadweight		Reasoning
			Proportion	Level	
Cardiovascular Center Physicians	Confidence in Clinical Decision-Making	Conduct interviews and surveys with program executors to measure changes of confidence in clinical decision-making after participation (including the depth and importance of change), to be used as an outcome indicator.	0%	Very Low	<p>(1) This confidence in decision-making could not have arisen naturally from routine medical experience. In regular clinical environments, doctors’ understanding of cases is often fragmented and symptom-focused. Only through the interdisciplinary integration, regular follow-ups, and information-sharing mechanisms designed by this program can physicians gain a comprehensive understanding of patients’ living conditions and overall care outcomes, enabling them to make judgments and adjust treatment strategies with greater confidence.</p> <p>(2) The program provides continuous information feedback and fosters team support. The enhancement of decision-making confidence stems from the team’s provision of real-time data, patient feedback, and support from the expertise of other departments. This was made possible by the unique design of the program and would not naturally occur within standard medical workflows.</p>
Case Manager	Confidence in Professional Capability	Conduct interviews and surveys with program executors to measure changes in confidence after participation (including the depth and importance of change), to be used as an outcome indicator.	0%	Very Low	<p>(1) The project provided cross-disciplinary collaboration and integrated care experience. Case managers in this project were required to coordinate multiple resources and work closely with various healthcare professionals. This hands-on experience significantly enhanced their competencies in communication, coordination, and clinical judgment—opportunities that are rarely available in routine work.</p> <p>(2) Greater proactiveness and sense of responsibility compared to routine duties. The project granted case managers more autonomy—such as disease-course follow-up, health education design, and care plan adjustments—enabling them to build professional confidence and deepen their knowledge through practice, which brought tangible benefits to their career development.</p> <p>(3) Outcomes are not a natural extension of existing job responsibilities. Absent this project’s intervention, such learning and practice would be difficult to obtain through day-to-day duties, indicating that the outcomes have a high degree of additionality.</p>

Stakeholder Subgroup	Outcome	Outcome Indicator	Deadweight		Reasoning
			Proportion	Level	
Various Healthcare Professionals	Confidence in Professional Capability	Conduct interviews and surveys with program executors to measure changes in confidence after participation (including the depth and importance of change), to be used as an outcome indicator.	0%	Very Low	<p>(1) The project provided cross-disciplinary collaboration and integrated care experience. Various healthcare professionals in this project were required to coordinate multiple resources and work closely with various healthcare professionals and case manager. This hands-on experience significantly enhanced their competencies in communication, coordination, and clinical judgment—opportunities that are rarely available in routine work.</p> <p>(2) Greater proactiveness and sense of responsibility compared to routine duties. The project granted various healthcare professionals more autonomy—such as disease-course follow-up, health education design, and care plan adjustments—enabling them to build professional confidence and deepen their knowledge through practice, which brought tangible benefits to their career development.</p> <p>(3) Outcomes are not a natural extension of existing job responsibilities. Absent this project’s intervention, such learning and practice would be difficult to obtain through day-to-day duties, indicating that the outcomes have a high degree of additionality.</p>

Stakeholder Subgroup	Outcome	Outcome Indicator	Deadweight		Reasoning
			Proportion	Level	
Patient Group 1: Heart Failure Patient (age over 80)	Enhanced Emotional Security	Conduct interviews and surveys with patient to measure changes in emotional security after participation (including the depth and importance of change), to be used as an outcome indicator.	0%	Very Low	<p>(1) “Emotional Security” does not arise naturally. For elderly heart failure patients, the irreversible and recurring nature of the disease often leads to anxiety and unease. This integrated care program allowed them to receive stable and continuous medical support, making it easier to establish a sense of safety and reassurance even when facing disease relapses.</p> <p>(2) The program provided integrated care and interpersonal support. Through regular follow-ups, continuous contact with case managers, education, this structured support was a key factor in building a emotional security.</p>
	Strengthen Self-Efficacy & Confidence	Conduct interviews and surveys with patient to measure changes in self-efficacy & confidence after participation (including the depth and importance of change), to be used as an outcome indicator.	0%	Very Low	<p>(1) The program provided integrated care and interpersonal support. Through regular follow-ups, continuous contact with case managers, education, this structured support was a key factor in building a sense of self-Efficacy & Confidence.</p> <p>(2) Improvements were unlikely to occur without the program. Through regular follow-ups and continuous contact with case managers, patients receive timely feedback and corrections on symptom recognition, medication use, and daily management, transforming uncertainty into actionable strategies and directly enhancing self-efficacy; meanwhile, systematic health education and family involvement turn knowledge into executable daily support, enabling patients to have clear response steps when facing signs of deterioration and to build and sustain steady confidence by “being willing and able to act.”</p>

Stakeholder Subgroup	Outcome	Outcome Indicator	Deadweight		Reasoning
			Proportion	Level	
Patient Group 2: Heart Failure Patient (age 60 - 80)	Enhanced Emotional Security	Conduct interviews and surveys with patient to measure changes in emotional security after participation (including the depth and importance of change), to be used as an outcome indicator.	0%	Very Low	<p>(1) “Emotional Security” does not arise naturally. For middle age ~ elderly heart failure patients, the irreversible and recurring nature of the disease often leads to anxiety and unease. This integrated care program allowed them to receive stable and continuous medical support, making it easier to establish a sense of safety and reassurance even when facing disease relapses.</p> <p>(2) The program provided integrated care and interpersonal support. Through regular follow-ups, continuous contact with case managers, education, this structured support was a key factor in building a emotional security.</p>
	Strengthen Self-Efficacy & Confidence	Conduct interviews and surveys with patient to measure changes in self-efficacy & confidence after participation (including the depth and importance of change), to be used as an outcome indicator.	0%	Very Low	<p>(1) The program provided integrated care and interpersonal support. Through regular follow-ups, continuous contact with case managers, education, this structured support was a key factor in building a sense of self-Efficacy & Confidence.</p> <p>(2) Improvements were unlikely to occur without the program. Through regular follow-ups and continuous contact with case managers, patients receive timely feedback and corrections on symptom recognition, medication use, and daily management, transforming uncertainty into actionable strategies and directly enhancing self-efficacy; meanwhile, systematic health education and family involvement turn knowledge into executable daily support, enabling patients to have clear response steps when facing signs of deterioration and to build and sustain steady confidence by “being willing and able to act.”</p>

Stakeholder Subgroup	Outcome	Outcome Indicator	Deadweight		Reasoning
			Proportion	Level	
Patient Group 3: Heart Failure Patient (age under 60)	Enhanced Emotional Security	Conduct interviews and surveys with patient to measure changes in emotional security after participation (including the depth and importance of change), to be used as an outcome indicator.	0%	Very Low	<p>(1) The sense of security primarily resulted from the program’s intervention. Younger heart failure patients are highly sensitive to disease fluctuations and future health risks. It was the program’s comprehensive care, proactive case manager follow-ups, real-time consultations with the medical team, and integrated cross-specialty treatment that genuinely enhanced patients’ sense of control over their health status and their feeling of safety.</p> <p>(2) Such outcomes are unlikely to arise from routine healthcare processes. Although some younger patients have stronger self-learning or information-seeking abilities, the absence of systematic support leaves substantial uncertainty and anxiety about their condition. Without this program, the likelihood of establishing a sense of security would be limited.</p>
	Strengthen Self-Efficacy & Confidence	Conduct interviews and surveys with patient to measure changes in self-efficacy & confidence after participation (including the depth and importance of change), to be used as an outcome indicator.	0%	Very Low	<p>(1) The program provided integrated care and interpersonal support. Through regular follow-ups, continuous contact with case managers, education, this structured support was a key factor in building a sense of self-Efficacy & Confidence.</p> <p>(2) Improvements were unlikely to occur without the program. Through regular follow-ups and continuous contact with case managers, patients receive timely feedback and corrections on symptom recognition, medication use, and daily management, transforming uncertainty into actionable strategies and directly enhancing self-efficacy; meanwhile, systematic health education and family involvement turn knowledge into executable daily support, enabling patients to have clear response steps when facing signs of deterioration and to build and sustain steady confidence by “being willing and able to act.”</p>

Stakeholder Subgroup	Outcome	Outcome Indicator	Deadweight		Reasoning
			Proportion	Level	
Patient Group 3: Heart Failure Patient (age under 60)	Financial pressure arising	Conduct interviews and surveys with patient to measure changes in financial pressure after participation (including the depth and importance of change), to be used as an outcome indicator.	70%	Moderately High	<p>(1) This outcome is partly constrained by the natural course of the disease. Even with program intervention, the irreversible pathophysiology of heart failure prevents some younger patients from returning to full health. For those in high-intensity labor roles, job adjustments or workload reductions are a natural and common trajectory.</p> <p>(2) Not entirely attributable to the program. Impacts on economic status and the accompanying sense of helplessness largely stem from disease-related physiological limitations rather than the program itself. Therefore, this outcome is not fully program-induced and shows a significant Natural Baseline.</p>

Stakeholder Subgroup	Outcome	Outcome Indicator	Deadweight		Reasoning
			Proportion	Level	
Family of Patient Group 1 (age over 80)	Enhanced Emotional Security	Conduct interviews and surveys with caregiver to measure changes in emotional security after participation (including the depth and importance of change), to be used as an outcome indicator.	0%	Very Low	<p>(1) The sense of security primarily stems from the program’s dedicated channels and support. The built-in case management mechanism, medical consultation hotline, and the team’s real-time assistance enable family members to receive prompt professional responses when the patient’s condition changes, significantly reducing anxiety and enhancing caregiving confidence.</p> <p>(2) Unlikely to arise naturally under routine healthcare resources. Without the program, families would mostly rely on traditional pathways such as outpatient or emergency services, making it difficult to obtain timely and continuous care consultation; consequently, opportunities to build a sense of security are relatively limited.</p>
	Caregiving Burden Relief	Conduct interviews and surveys with caregiver to measure changes in burden relief after participation (including the depth and importance of change), to be used as an outcome indicator.	0%	Very Low	<p>(1) Burden relief primarily resulted from the program’s effectiveness. Through comprehensive medical care, rehabilitation, and case management, the patient’s condition stabilized, reducing dependence on family and the intensity of caregiving. This directly eased caregivers’ workload and pressure, creating more manageable routines and breathing space.</p> <p>(2) Low likelihood of burden relief without the program. Absent proactive intervention, the patient’s condition would be less stable, and families would continue shouldering intensive, long-term care. Natural reductions in caregiving burden—and the associated gains in wellbeing—would be unlikely.</p>

Stakeholder Subgroup	Outcome	Outcome Indicator	Deadweight		Reasoning
			Proportion	Level	
Family of Patient Group 2 (age 60 - 80)	Enhanced Emotional Security	Conduct interviews and surveys with caregiver to measure changes in emotional security after participation (including the depth and importance of change), to be used as an outcome indicator.	0%	Very Low	<p>(1) The sense of security primarily stems from the program’s dedicated channels and support. The built-in case management mechanism, medical consultation hotline, and the team’s real-time assistance enable family members to receive prompt professional responses when the patient’s condition changes, significantly reducing anxiety and enhancing caregiving confidence.</p> <p>(2) Unlikely to arise naturally under routine healthcare resources. Without the program, families would mostly rely on traditional pathways such as outpatient or emergency services, making it difficult to obtain timely and continuous care consultation; consequently, opportunities to build a sense of security are relatively limited.</p>
	Caregiving Burden Relief	Conduct interviews and surveys with caregiver to measure changes in burden relief after participation (including the depth and importance of change), to be used as an outcome indicator.	0%	Very Low	<p>(1) Burden relief primarily resulted from the program’s effectiveness. Through comprehensive medical care, rehabilitation, and case management, the patient’s condition stabilized, reducing dependence on family and the intensity of caregiving. This directly eased caregivers’ workload and pressure, creating more manageable routines and breathing space.</p> <p>(2) Low likelihood of burden relief without the program. Absent proactive intervention, the patient’s condition would be less stable, and families would continue shouldering intensive, long-term care. Natural reductions in caregiving burden—and the associated gains in wellbeing—would be unlikely.</p>

Stakeholder Subgroup	Outcome	Outcome Indicator	Deadweight		Reasoning
			Proportion	Level	
Family of Patient Group 3 (age under 60)	Enhanced Emotional Security	Conduct interviews and surveys with caregiver to measure changes in emotional security after participation (including the depth and importance of change), to be used as an outcome indicator.	0%	Very Low	<p>(1) The sense of security primarily stems from the program’s dedicated channels and support. The built-in case management mechanism, medical consultation hotline, and the team’s real-time assistance enable family members to receive prompt professional responses when the patient’s condition changes, significantly reducing anxiety and enhancing caregiving confidence.</p> <p>(2) Unlikely to arise naturally under routine healthcare resources. Without the program, families would mostly rely on traditional pathways such as outpatient or emergency services, making it difficult to obtain timely and continuous care consultation; consequently, opportunities to build a sense of security are relatively limited.</p>
	Caregiving Burden Relief	Conduct interviews and surveys with caregiver to measure changes in burden relief after participation (including the depth and importance of change), to be used as an outcome indicator.	25%	Moderately Low	<p>(1) Deadweight 25%: Some burden relief would likely occur naturally. Compared with 5% for older and middle-older families, a 25% deadweight in younger families indicates more “naturally occurring” relief. Because patients are younger with better recovery potential, and families often have greater flexibility (e.g., flexible work hours, peer support, digital tools), part of the caregiving burden may decrease as the condition stabilizes even without the program.</p> <p>(2) The program remains the primary driver, but with lower marginal contribution than in older groups. Integrated medical care, rehabilitation, and case management do reduce burden; however, relative to the 0% group, families under 60 have a higher natural baseline, lowering the share of net benefits attributable to the program. The 25% deadweight reflects a larger portion of effects arising outside the program.</p>

7.2.2 Displacement

In accordance with SROI evaluation principles, the displacement is used to assess whether the outcomes created by this program have displaced value or results that would have otherwise occurred in other domains, activities, or among other stakeholders. To ensure the social value is not over-claimed, this program evaluated the potential effects of displacement or resource reallocation for each outcome and designed the following approach:

- (1) In-depth stakeholder interviews and surveys: Gathered perspectives from stakeholders on whether the program's intervention influenced their original behaviors, resource allocation, or emotional sources.
- (2) Professional judgment and clinical experience: Assessed the potential substitutability or psychological displacement of various outcomes based on insights from medical professionals and researchers.
- (3) Outcome-specific adjustments: For emotional or psychological outcomes, the team assessed whether these might overlap or substitute for positive feelings previously derived from existing activities (e.g., community long-term care, home-based support services), and applied a displacement ratio accordingly.

The displacement in this program were set with an emphasis on completeness, objectivity, and transparency. By incorporating empirical evidence, expert evaluation, and conservative assumptions, all social value calculations accounted for any displacement, substitution, or resource reallocation—ensuring that only the portion of outcomes truly attributable to the program was included. This approach upholds the credibility and accuracy of the valuation.

Table 7.2.2-1 Impact Factor Adjustment Table – Displacement

Stakeholder Subgroup	Outcome	Outcome Indicator	Displacement		Reasoning
			Proportion	Level	
National Health Insurance Administration (NHIA)	Strengthened Confidence in Program Governance and Decision-Making	Conduct interviews and surveys with programme organizer to measure changes of confidence in program governance and decision-making after participation (including the depth and importance of change), to be used as an outcome indicator.	8%	Low	<p>(1) Enhanced policy confidence does not crowd out other issues. This project strengthens NHIA’s confidence in promoting integrated care policy for heart failure. This represents an improvement in the quality of policy execution and does not directly replace or undermine the development or confidence-building of other policy areas.</p> <p>(2) Limited resources in policymaking allow for the possibility of minor shifts. Given the finite nature of administrative resources and implementation capacity, if the NHIA allocates increased attention and resources to heart failure-related care, there may be a relative slowdown in the development of other health issues, such as care models for other chronic diseases.</p>
Program Leader	Strengthen Professional Accomplishment	Conduct interviews and surveys with programme leader to measure changes in accomplishment after participation (including the depth and importance of change), to be used as an outcome indicator.	15%	Low	<p>(1) Enhanced sense of accomplishment stems from the project’s uniqueness, not a replacement of everyday clinical rewards. This project delivers a systemic sense of accomplishment distinct from routine clinical practice through its integrated care and institutional innovation. It does not displace the sense of achievement obtained from other clinical or academic work.</p> <p>(2) Some emotional and mental resource transfer remains possible. While the outcome is a personal emotional and psychological accomplishment, considering the project leader’s limited time and professional resources, the heightened sense of accomplishment from this program may relatively reduce emotional and mental engagement in other medical program, research, or internal hospital development work.</p>

Stakeholder Subgroup	Outcome	Outcome Indicator	Displacement		Reasoning
			Proportion	Level	
Cardiovascular Center Physicians	Confidence in Clinical Decision-Making	Conduct interviews and surveys with program executors to measure changes of confidence in clinical decision-making after participation (including the depth and importance of change), to be used as an outcome indicator.	10%	Low	<p>(1) Increased decision-making confidence is a project-specific benefit with limited displacement of other tasks. Physicians gained significant confidence in managing heart failure due to the project's comprehensive care experience and data support. This does not directly displace decision-making in other medical conditions.</p> <p>(2) Physicians' decision styles and experience are cumulatively broad. Although some focus may tilt toward heart failure or chronic care, physicians' clinical experience and decision-making skills are highly transferable, with little impact on other areas.</p> <p>(3) A transfer factor is set to reflect limited resource reallocation. Considering physicians' limited capacity for professional focus, research, and learning resources, a displacement factor was applied to cautiously reflect the minor reallocation of resources across different clinical themes.</p>
Case Manager	Confidence in Professional Capability	Conduct interviews and surveys with program executors to measure changes in confidence after participation (including the depth and importance of change), to be used as an outcome indicator.	12%	Low	<p>(1) The sense of achievement stems from intensive involvement in integrated care. his sense of accomplishment generated by the program stemmed from the case managers' deep involvement in "integrated care" and "interdisciplinary collaboration," which are less common in their routine duties. Through long-term interaction and follow-up with patients, case managers gained a stronger sense of contribution to the stabilization and improvement of patient conditions. The resulting sense of achievement represents a unique psychological reward specific to this program.</p> <p>(2) Very low displacement but a minimal factor is retained. Although the emotional investment and sense of accomplishment experienced by case managers may be limited, it could still lead to a relatively reduced level of attention or focus toward non-program cases. Therefore, a displacement factor was applied.</p>

Stakeholder Subgroup	Outcome	Outcome Indicator	Displacement		Reasoning
			Proportion	Level	
Various Healthcare Professionals	Confidence in Professional Capability	Conduct interviews and surveys with program executors to measure changes in confidence after participation (including the depth and importance of change), to be used as an outcome indicator.	10%	Low	<p>(1) The project is a key driver of professional development. Various healthcare professionals gained extensive professional growth and practical experience through cross-team collaboration, coordinated care, and long-term tracking. This growth largely are attributed to the project's unique nature</p> <p>(2) Competency growth may slightly reduce participation in other work areas. Various healthcare professionals concentrated on professional development and skill enhancement related to this program, which may have relatively reduced their opportunities for learning and growth in other non-program work areas or training activities. A displacement factor was therefore applied to reflect the reallocation of limited resources.</p>

Stakeholder Subgroup	Outcome	Outcome Indicator	Displacement		Reasoning
			Proportion	Level	
Patient Group 1: Heart Failure Patient (age over 80)	Enhanced Emotional Security	Conduct interviews and surveys with patient to measure changes in emotional security after participation (including the depth and importance of change), to be used as an outcome indicator.	10%	Low	<p>(1) The sense of security was primarily fostered by the comprehensive care offered by this project, with minimal displacement effects. Most participants' sense of security stemmed from the project's integrated cross-disciplinary medical care, regular follow-ups, and case management—support not typically available through standard care.</p> <p>(2) Only a small portion of reassurance may originate from other support sources. For a minority of cases, family support, religious faith, or community long-term care may also provide a certain degree of reassurance. The program's intervention may indirectly replace the psychological contribution originally provided by these other support sources; therefore, a transfer factor is specified.</p>
	Strengthen Self-Efficacy & Confidence	Conduct interviews and surveys with patient to measure changes in self-efficacy & confidence after participation (including the depth and importance of change), to be used as an outcome indicator.	0%	Very Low	<p>(1) The program provided integrated care and interpersonal support. Through regular follow-ups, ongoing connections with case managers, health education, and coaching, this structured, interpersonal support is highly context-specific. It is nearly appropriate resources or outcome space from other programs.</p> <p>(2) Improvements are program-driven, not achieved by displacing other initiatives. Regular follow-ups and timely feedback on symptom recognition, medication use, and daily management turn uncertainty into actionable strategies, directly enhancing self-efficacy. Meanwhile, systematic health education and family involvement convert knowledge into executable daily support, enabling patients to respond clearly to signs of deterioration and to build and sustain steady confidence by being willing and able to act. These improvements stem from the program's dedicated interventions rather than from occupying other programs' resources or substituting their activities, hence the low displacement.</p>

Stakeholder Subgroup	Outcome	Outcome Indicator	Displacement		Reasoning
			Proportion	Level	
Patient Group 2: Heart Failure Patient (age 60 - 80)	Enhanced Emotional Security	Conduct interviews and surveys with patient to measure changes in emotional security after participation (including the depth and importance of change), to be used as an outcome indicator.	10%	Low	<p>(1) The sense of security was primarily fostered by the comprehensive care offered by this project, with minimal displacement effects. Most participants' sense of security stemmed from the project's integrated cross-disciplinary medical care, regular follow-ups, and case management—support not typically available through standard care.</p> <p>(2) Only a small portion of reassurance may originate from other support sources. For a minority of cases, family support, religious faith, or community long-term care may also provide a certain degree of reassurance. The program's intervention may indirectly replace the psychological contribution originally provided by these other support sources; therefore, a transfer factor is specified.</p>
	Strengthen Self-Efficacy & Confidence	Conduct interviews and surveys with patient to measure changes in self-efficacy & confidence after participation (including the depth and importance of change), to be used as an outcome indicator.	0%	Very Low	<p>(1) The program provided integrated care and interpersonal support. Through regular follow-ups, ongoing connections with case managers, health education, and coaching, this structured, interpersonal support is highly context-specific. It is nearly appropriate resources or outcome space from other programs.</p> <p>(2) Improvements are program-driven, not achieved by displacing other initiatives. Regular follow-ups and timely feedback on symptom recognition, medication use, and daily management turn uncertainty into actionable strategies, directly enhancing self-efficacy. Meanwhile, systematic health education and family involvement convert knowledge into executable daily support, enabling patients to respond clearly to signs of deterioration and to build and sustain steady confidence by being willing and able to act. These improvements stem from the program's dedicated interventions rather than from occupying other programs' resources or substituting their activities, hence the low displacement.</p>

Stakeholder Subgroup	Outcome	Outcome Indicator	Displacement		Reasoning
			Proportion	Level	
Patient Group 3: Heart Failure Patient (age under 60)	Enhanced Emotional Security	Conduct interviews and surveys with patient to measure changes in emotional security after participation (including the depth and importance of change), to be used as an outcome indicator.	10%	Low	<p>(1) The sense of security was primarily fostered by the comprehensive care offered by this project, with minimal displacement effects. Most participants' sense of security stemmed from the project's integrated cross-disciplinary medical care, regular follow-ups, and case management—support not typically available through standard care.</p> <p>(2) Only a small portion of reassurance may originate from other support sources. For a minority of cases, family support, religious faith, or community long-term care may also provide a certain degree of reassurance. The program's intervention may indirectly replace the psychological contribution originally provided by these other support sources; therefore, a transfer factor is specified.</p>
	Strengthen Self-Efficacy & Confidence	Conduct interviews and surveys with patient to measure changes in self-efficacy & confidence after participation (including the depth and importance of change), to be used as an outcome indicator.	0%	Very Low	<p>(1) The program provided integrated care and interpersonal support. Through regular follow-ups, ongoing connections with case managers, health education, and coaching, this structured, interpersonal support is highly context-specific. It is nearly appropriate resources or outcome space from other programs.</p> <p>(2) Improvements are program-driven, not achieved by displacing other initiatives. Regular follow-ups and timely feedback on symptom recognition, medication use, and daily management turn uncertainty into actionable strategies, directly enhancing self-efficacy. Meanwhile, systematic health education and family involvement convert knowledge into executable daily support, enabling patients to respond clearly to signs of deterioration and to build and sustain steady confidence by being willing and able to act. These improvements stem from the program's dedicated interventions rather than from occupying other programs' resources or substituting their activities, hence the low displacement.</p>

Stakeholder Subgroup	Outcome	Outcome Indicator	Displacement		Reasoning
			Proportion	Level	
Patient Group 3: Heart Failure Patient (age under 60)	Financial pressure arising	Conduct interviews and surveys with patient to measure changes in financial pressure after participation (including the depth and importance of change), to be used as an outcome indicator.	0%	Very Low	<p>(1) The source of economic pressure is health limitations, not displacement. Health constraints (such as reduced physical capacity, increased hospitalizations, and prolonged recovery periods) lead to fewer working hours, lower income, and higher medical expenses, directly intensifying the household's economic pressure. This is not a secondary effect caused by the program appropriating resources from other initiatives or substituting external support.</p> <p>(2) There are no substitutable or transferable resource sources. The components of increased economic pressure (reduced income and increased expenses) do not rely on the reallocation or substitution of resources from other programs; their causes are closely tied to health limitations themselves. Therefore, they do not compress or replace external programs or resources, and the displacement degree is 0%.</p>

Stakeholder Subgroup	Outcome	Outcome Indicator	Displacement		Reasoning
			Proportion	Level	
Family of Patient Group 1 (age over 80)	Enhanced Emotional Security	Conduct interviews and surveys with caregiver to measure changes in emotional security after participation (including the depth and importance of change), to be used as an outcome indicator.	10%	Low	<p>(1) The outcomes originate exclusively from this program. The sense of security primarily stems from timely access to professional medical consultation and case-manager support. These are dedicated service mechanisms established by this program and do not appropriate, occupy, or replace support from other initiatives.</p> <p>(2) Low overlap with other programs. This program focuses on specific populations and care contexts (e.g., caregiving for elderly patients with heart failure). Its intervention processes and tools (hotline, pre-/post-outpatient coordination, symptom and medication coaching) differ from those of other programs, and therefore do not compress their outcome space.</p> <p>(3) Only a small portion of reassurance may originate from other support sources. For a minority of cases, family support, religious faith, or community long-term care may also provide a certain degree of reassurance. The program’s intervention may indirectly replace the psychological contribution originally provided by these other support sources; therefore, a transfer factor is specified.</p>
	Caregiving Burden Relief	Conduct interviews and surveys with caregiver to measure changes in burden relief after participation (including the depth and importance of change), to be used as an outcome indicator.	30%	Moderately Low	<p>(1) Burden relief brings direct and substantial benefits Through the program to stabilize participants’ health (better symptom management, fewer acute episodes, reduced hospitalizations), family caregivers spend less time and mental effort on caregiving, medical visits, nighttime care, and emergencies. This tangible burden reduction yields more discretionary time, improving daily routines, rest quality, and opportunities for self-actualization—a direct outcome of the program’s intervention.</p> <p>(2) Some portion of burden relief may originate from other support sources. For a minority of cases, some families already employ professional caregivers and obtain services through other social resource channels (e.g., community long-term care, home-based support services). In such circumstances, the program’s intervention may indirectly replace—or overlap with—the psychological benefits provided by existing supports; therefore, a transfer factor is specified to reflect this partial displacement.</p>

Stakeholder Subgroup	Outcome	Outcome Indicator	Displacement		Reasoning
			Proportion	Level	
Family of Patient Group 2 (age 60 - 80)	Enhanced Emotional Security	Conduct interviews and surveys with caregiver to measure changes in emotional security after participation (including the depth and importance of change), to be used as an outcome indicator.	10%	Low	<p>(1) The outcomes originate exclusively from this program. The sense of security primarily stems from timely access to professional medical consultation and case-manager support. These are dedicated service mechanisms established by this program and do not appropriate, occupy, or replace support from other initiatives.</p> <p>(2) Low overlap with other programs. This program focuses on specific populations and care contexts (e.g., caregiving for elderly patients with heart failure). Its intervention processes and tools (hotline, pre-/post-outpatient coordination, symptom and medication coaching) differ from those of other programs, and therefore do not compress their outcome space.</p> <p>(3) Only a small portion of reassurance may originate from other support sources. For a minority of cases, family support, religious faith, or community long-term care may also provide a certain degree of reassurance. The program’s intervention may indirectly replace the psychological contribution originally provided by these other support sources; therefore, a transfer factor is specified.</p>
	Caregiving Burden Relief	Conduct interviews and surveys with caregiver to measure changes in burden relief after participation (including the depth and importance of change), to be used as an outcome indicator.	10%	Low	<p>(1) Burden relief brings direct and substantial benefits Through the program to stabilize participants’ health (better symptom management, fewer acute episodes, reduced hospitalizations), family caregivers spend less time and mental effort on caregiving, medical visits, nighttime care, and emergencies. This tangible burden reduction yields more discretionary time, improving daily routines, rest quality, and opportunities for self-actualization— a direct outcome of the program’s intervention.</p> <p>(2) Only a small portion of burden relief may originate from other support sources. For a minority of cases, some families already employ professional caregivers and obtain services through other social resource channels (e.g., community long-term care, home-based support services). In such circumstances, the program’s intervention may indirectly replace—or overlap with—the psychological benefits provided by existing supports; therefore, a transfer factor is specified to reflect this partial displacement.</p>

Stakeholder Subgroup	Outcome	Outcome Indicator	Displacement		Reasoning
			Proportion	Level	
Family of Patient Group 3 (age under 60)	Enhanced Emotional Security	Conduct interviews and surveys with caregiver to measure changes in emotional security after participation (including the depth and importance of change), to be used as an outcome indicator.	10%	Low	<p>(1) The outcomes originate exclusively from this program. The sense of security primarily stems from timely access to professional medical consultation and case-manager support. These are dedicated service mechanisms established by this program and do not appropriate, occupy, or replace support from other initiatives.</p> <p>(2) Low overlap with other programs. This program focuses on specific populations and care contexts (e.g., caregiving for elderly patients with heart failure). Its intervention processes and tools (hotline, pre-/post-outpatient coordination, symptom and medication coaching) differ from those of other programs, and therefore do not compress their outcome space.</p> <p>(3) Only a small portion of reassurance may originate from other support sources. For a minority of cases, family support, religious faith, or community long-term care may also provide a certain degree of reassurance. The program's intervention may indirectly replace the psychological contribution originally provided by these other support sources; therefore, a transfer factor is specified.</p>
	Caregiving Burden Relief	Conduct interviews and surveys with caregiver to measure changes in burden relief after participation (including the depth and importance of change), to be used as an outcome indicator.	0%	Very Low	<p>(1) Burden relief brings direct and substantial benefits Through the program to stabilize participants' health (better symptom management, fewer acute episodes, reduced hospitalizations), family caregivers spend less time and mental effort on caregiving, medical visits, nighttime care, and emergencies. This tangible burden reduction yields more discretionary time, improving daily routines, rest quality, and opportunities for self-actualization— a direct outcome of the program's intervention.</p>

7.2.3 Attribution

In monetizing social value, this report follows SROI principles by assessing and assigning attribution factors to all outcomes, in order to reasonably reflect the “contribution level” of this program to the observed changes, and to avoid attributing all changes solely to the program. This ensures objectivity and conservatism in valuation.

Process and basis for setting attribution:

- (1) Stakeholder interviews and surveys: Insights were gathered from in-depth interviews and questionnaires with various stakeholders regarding their experiences and perceptions of what contributed to the outcomes.
- (2) Professional judgment and literature review: Integrate the medical team’s professional observations, clinical practice experience, and relevant academic literature, supplemented by sound professional judgment.
- (3) Outcome-specific adjustments: Based on the mechanisms through which each outcome is generated, the analysis distinguishes between the direct impact of the program and the potential influence of stakeholders themselves or other external factors, assigning specific attribution proportion accordingly.

Table 7.2.3-1 Impact Factor Adjustment Table – Attribution

Stakeholder Subgroup	Outcome	Outcome Indicator	Attribution		Reasoning
			Proportion	Level	
National Health Insurance Administration (NHIA)	Strengthened Confidence in Program Governance and Decision-Making	Conduct interviews and surveys with programme organizer to measure changes of confidence in program governance and decision-making after participation (including the depth and importance of change), to be used as an outcome indicator.	13%	Low	<p>(1) The specific contribution of the program Although confidence-building stems from multiple factors, this program offered comprehensive clinical data, a care model, and diverse feedback. In particular, it contributed substantively to confidence-building for future similar policies through empirical evidence and feasibility validation.</p> <p>(2) Confidence-building arises from cumulative sources As the competent authority for policy promotion, the NHIA has continuously monitored and analyzed related issues. Its policy confidence is built not only on the outcome validation of this program, but also on a variety of sources such as prior policy experience, pilot results from other healthcare institutions, and international trend observations. Therefore, an attribution factor was assigned.</p>
Program Leader	Strengthen Professional Accomplishment	Conduct interviews and surveys with programme leader to measure changes in accomplishment after participation (including the depth and importance of change), to be used as an outcome indicator.	30%	Moderately Low	<p>(1) Direct contribution of the program In the process of designing and implementing this cross-disciplinary integrated care program, the program leader personally observed improvements in patient outcomes and team collaboration through systematic care processes, demonstrated clinical effectiveness, and teamwork. This experience generated a strong sense of achievement. It represents a direct and distinct impact of the program.</p> <p>(2) Influence of other professional sources In the course of their regular duties and career development, the program lead also engages in other clinical, teaching, and research activities, which inherently provide sources of professional growth and a sense of accomplishment. Therefore, the emotional feedback derived from achievements in these other areas should not be overlooked.</p>

Stakeholder Subgroup	Outcome	Outcome Indicator	Attribution		Reasoning
			Proportion	Level	
Cardiovascular Center Physicians	Confidence in Clinical Decision-Making	Conduct interviews and surveys with program executors to measure changes of confidence in clinical decision-making after participation (including the depth and importance of change), to be used as an outcome indicator.	30%	Moderately Low	<p>(1) Direct contribution of the program Through systematic tracking and collection of quantitative data, the program provided cardiovascular center physicians with scientific evidence and dynamic information—specifically focused on functional indicators, condition changes, and recovery progress of heart failure cases. This significantly enhanced their confidence and accuracy in clinical decision-making, representing a core benefit directly attributable to the program.</p> <p>(2) Influence of other professional experiences Cardiovascular center physicians possess extensive clinical experience and established diagnostic standards. For certain routine clinical decisions, they can still rely on past experience and medical literature. Therefore, even without the program’s data, their confidence in decision-making would remain at a baseline level.</p>
Case Managers	Confidence in Professional Capability	Conduct interviews and surveys with program executors to measure changes in confidence after participation (including the depth and importance of change), to be used as an outcome indicator.	15%	Low	<p>(1) Direct contribution of the program Through cross-team collaboration, enhanced disease knowledge, case follow-up, and application of health education techniques, the program significantly improved the case managers’ professional skills and functional performance. This outcome is closely tied to the program’s integrated care approach and standardized processes, reflecting a high degree of direct contribution.</p> <p>(2) Other contributions from accumulated professional experience Case managers also have opportunities to participate in other training programs, medical projects, or self-directed learning in their routine work, all of which may contribute to partial improvements in their competencies.</p>

Stakeholder Subgroup	Outcome	Outcome Indicator	Attribution		Reasoning
			Proportion	Level	
Various Healthcare Professionals	Confidence in Professional Capability	Conduct interviews and surveys with program executors to measure changes in confidence after participation (including the depth and importance of change), to be used as an outcome indicator.	15%	Low	<p>(1) Direct contribution of the program Through integrated care and interdisciplinary collaboration, the program enabled various healthcare professionals to acquire new knowledge, apply skills, and gain practical experience in cross-disciplinary teamwork during the care process. This directly and clearly contributed to their professional development.</p> <p>(2) Other possible sources of influence Healthcare professionals already have opportunities within medical institutions to engage in regular continuing education, professional training, or participation in other medical projects. Therefore, part of their professional development may stem from existing workplace training programs or career advancement mechanisms.</p>

Stakeholder Subgroup	Outcome	Outcome Indicator	Attribution		Reasoning
			Proportion	Level	
Patient Group 1: Heart Failure Patient (age over 80)	Enhanced Emotional Security	Conduct interviews and surveys with patient to measure changes in emotional security after participation (including the depth and importance of change), to be used as an outcome indicator.	15%	Low	<p>(1) Direct contribution of the program The project designed a comprehensive integrated care process specifically for elderly heart failure patients, encompassing medical services, care support, health education, and regular follow-up. This significantly enhanced patients' sense of trust in the accessibility and professionalism of medical resources, directly contributing to their sense of reassurance.</p> <p>(2) Other possible sources of influence For a minority of patients, their sense of reassurance may also stem from family support, an existing trusting relationship with their regular attending physician, or prior experience with utilizing medical resources, rather than being entirely attributable to the intervention of this project.</p>
	Strengthen Self-Efficacy & Confidence	Conduct interviews and surveys with patient to measure changes in self-efficacy & confidence after participation (including the depth and importance of change), to be used as an outcome indicator.	0%	Very Low	<p>(1) The program provides integrated care and interpersonal support. Through regular follow-ups, continuous connections with case managers, health education, and coaching, this structured interpersonal support is highly context-specific. Its intervention mechanisms and outcome space have minimal overlap with the resources or results of other programs.</p> <p>(2) The outcomes are program-driven, delivered through highly professional medical services—not easily achieved by substituting other initiatives. Regular follow-ups and timely feedback convert uncertainty into actionable strategies (symptom recognition, medication, daily management), boosting self-efficacy. Systematic health education and family involvement turn knowledge into daily support, enabling clear responses to deterioration and steady, action-based confidence.</p>

Stakeholder Subgroup	Outcome	Outcome Indicator	Attribution		Reasoning
			Proportion	Level	
Patient Group 2: Heart Failure Patient (age 60 - 80)	Enhanced Emotional Security	Conduct interviews and surveys with patient to measure changes in emotional security after participation (including the depth and importance of change), to be used as an outcome indicator.	20%	Low	<p>(1) Direct contribution of the program The project designed a comprehensive integrated care process specifically for elderly heart failure patients, encompassing medical services, care support, health education, and regular follow-up. This significantly enhanced patients' sense of trust in the accessibility and professionalism of medical resources, directly contributing to their sense of reassurance.</p> <p>(2) Other possible sources of influence For a minority of patients, their sense of reassurance may also stem from family support, an existing trusting relationship with their regular attending physician, or prior experience with utilizing medical resources, rather than being entirely attributable to the intervention of this project.</p>
	Strengthen Self-Efficacy & Confidence	Conduct interviews and surveys with patient to measure changes in self-efficacy & confidence after participation (including the depth and importance of change), to be used as an outcome indicator.	0%	Very Low	<p>(1) The program provides integrated care and interpersonal support. Through regular follow-ups, continuous connections with case managers, health education, and coaching, this structured interpersonal support is highly context-specific. Its intervention mechanisms and outcome space have minimal overlap with the resources or results of other programs.</p> <p>(2) The outcomes are program-driven, delivered through highly professional medical services—not easily achieved by substituting other initiatives. Regular follow-ups and timely feedback convert uncertainty into actionable strategies (symptom recognition, medication, daily management), boosting self-efficacy. Systematic health education and family involvement turn knowledge into daily support, enabling clear responses to deterioration and steady, action-based confidence.</p>

Stakeholder Subgroup	Outcome	Outcome Indicator	Attribution		Reasoning
			Proportion	Level	
Patient Group 3: Heart Failure Patient (age under 60)	Enhanced Emotional Security	Conduct interviews and surveys with patient to measure changes in emotional security after participation (including the depth and importance of change), to be used as an outcome indicator.	20%	Low	<p>(1) Direct contribution of the program The project designed a comprehensive integrated care process specifically for elderly heart failure patients, encompassing medical services, care support, health education, and regular follow-up. This significantly enhanced patients' sense of trust in the accessibility and professionalism of medical resources, directly contributing to their sense of reassurance.</p> <p>(2) Other possible sources of influence For a minority of patients, their sense of reassurance may also stem from family support, an existing trusting relationship with their regular attending physician, or prior experience with utilizing medical resources, rather than being entirely attributable to the intervention of this project.</p>
	Strengthen Self-Efficacy & Confidence	Conduct interviews and surveys with patient to measure changes in self-efficacy & confidence after participation (including the depth and importance of change), to be used as an outcome indicator.	0%	Very Low	<p>(1) The program provides integrated care and interpersonal support. Through regular follow-ups, continuous connections with case managers, health education, and coaching, this structured interpersonal support is highly context-specific. Its intervention mechanisms and outcome space have minimal overlap with the resources or results of other programs.</p> <p>(2) The outcomes are program-driven, delivered through highly professional medical services—not easily achieved by substituting other initiatives. Regular follow-ups and timely feedback convert uncertainty into actionable strategies (symptom recognition, medication, daily management), boosting self-efficacy. Systematic health education and family involvement turn knowledge into daily support, enabling clear responses to deterioration and steady, action-based confidence.</p>

Stakeholder Subgroup	Outcome	Outcome Indicator	Attribution		Reasoning
			Proportion	Level	
Patient Group 3: Heart Failure Patient (age under 60)	Financial pressure arising	Conduct interviews and surveys with patient to measure changes in financial pressure after participation (including the depth and importance of change), to be used as an outcome indicator.	0%	Very Low	<p>(1) Economic pressure is highly attributable to health limitations, not caused by any program.</p> <p>Health constraints (such as reduced physical capacity, increased hospitalizations, and prolonged recovery periods) lead to fewer working hours, lower income, and higher medical expenses, directly intensifying the household's economic pressure. This is not a secondary effect caused by the program appropriating resources from other initiatives or substituting external support.</p>

Stakeholder Subgroup	Outcome	Outcome Indicator	Attribution		Reasoning
			Proportion	Level	
Family of Patient Group 1 (age over 80)	Enhanced Emotional Security	Conduct interviews and surveys with caregiver to measure changes in emotional security after participation (including the depth and importance of change), to be used as an outcome indicator.	25%	Moderately Low	<p>(1) Direct contribution of the program Family members felt a significant sense of emotional security due to the support of case managers and the availability of prompt consultation with the medical team provided by the program. This reassurance is highly attributable to the service mechanisms established by the program.</p> <p>(2) Other possible sources of influence Some family members already had access to personal medical contacts, family physicians, or other community healthcare resources that could provide health consultations or support. Therefore, an attribution was set to reflect the portion of emotional security derived from these non-program sources.</p>
	Caregiving Burden Relief	Conduct interviews and surveys with caregiver to measure changes in burden relief after participation (including the depth and importance of change), to be used as an outcome indicator.	30%	Moderately Low	<p>(1) Direct contribution of the program Through integrated care and stabilization of the patient's condition, the program reduces families' time and mental effort spent on caregiving (e.g., fewer and less intensive needs for clinical communication, symptom monitoring, medication management, and handling acute events). This burden reduction directly creates more discretionary time and psychological bandwidth, thereby enhancing families' perceived reduction in burden; this improvement is highly attributable to the program's intervention.</p> <p>(2) Other possible sources of influence Burden reduction may also be influenced by other life factors, such as lower work stress, increased social support professional caregiver, or improved household task sharing. These non-program positive changes can concurrently decrease caregiving load and reduce perceived burden.</p>

Stakeholder Subgroup	Outcome	Outcome Indicator	Attribution		Reasoning
			Proportion	Level	
Family of Patient Group 2 (age 60~ 80)	Enhanced Emotional Security	Conduct interviews and surveys with caregiver to measure changes in emotional security after participation (including the depth and importance of change), to be used as an outcome indicator.	25%	Moderately Low	<p>(1) Direct contribution of the program Family members felt a significant sense of emotional security due to the support of case managers and the availability of prompt consultation with the medical team provided by the program. This reassurance is highly attributable to the service mechanisms established by the program.</p> <p>(2) Other possible sources of influence Some family members already had access to personal medical contacts, family physicians, or other community healthcare resources that could provide health consultations or support. Therefore, an attribution was set to reflect the portion of emotional security derived from these non-program sources.</p>
	Caregiving Burden Relief	Conduct interviews and surveys with caregiver to measure changes in burden relief after participation (including the depth and importance of change), to be used as an outcome indicator.	15%	Low	<p>(1) Direct contribution of the program Through integrated care and stabilization of the patient's condition, the program reduces families' time and mental effort spent on caregiving (e.g., fewer and less intensive needs for clinical communication, symptom monitoring, medication management, and handling acute events). This burden reduction directly creates more discretionary time and psychological bandwidth, thereby enhancing families' perceived reduction in burden; this improvement is highly attributable to the program's intervention.</p> <p>(2) Other possible sources of influence Burden reduction may also be influenced by other life factors, such as lower work stress, increased social support professional caregiver, or improved household task sharing. These non-program positive changes can concurrently decrease caregiving load and reduce perceived burden.</p>

Stakeholder Subgroup	Outcome	Outcome Indicator	Attribution		Reasoning
			Proportion	Level	
Family of Patient Group 3 (age under 60)	Enhanced Emotional Security	Conduct interviews and surveys with caregiver to measure changes in emotional security after participation (including the depth and importance of change), to be used as an outcome indicator.	25%	Moderately Low	<p>(1) Direct contribution of the program Family members felt a significant sense of emotional security due to the support of case managers and the availability of prompt consultation with the medical team provided by the program. This reassurance is highly attributable to the service mechanisms established by the program.</p> <p>(2) Other possible sources of influence Some family members already had access to personal medical contacts, family physicians, or other community healthcare resources that could provide health consultations or support. Therefore, an attribution was set to reflect the portion of emotional security derived from these non-program sources.</p>
	Caregiving Burden Relief	Conduct interviews and surveys with caregiver to measure changes in burden relief after participation (including the depth and importance of change), to be used as an outcome indicator.	5%	Low	<p>(1) Direct contribution of the program Through integrated care and stabilization of the patient's condition, the program reduces families' time and mental effort spent on caregiving (e.g., fewer and less intensive needs for clinical communication, symptom monitoring, medication management, and handling acute events). This burden reduction directly creates more discretionary time and psychological bandwidth, thereby enhancing families' perceived reduction in burden; this improvement is highly attributable to the program's intervention.</p> <p>(2) Other possible sources of influence Burden reduction may also be influenced by other life factors, such as lower work stress, increased social support professional caregiver, or improved household task sharing. These non-program positive changes can concurrently decrease caregiving load and reduce perceived burden.</p>

7.2.4 Drop-off

In the process of monetizing social value, this report follows SROI principles by assessing and setting a drop-off for all outcomes. This aims to reasonably reflect the diminishing effect of outcomes over time, prevent overestimation of the project's long-term impact, and ensure a prudent and conservative valuation.

Process and Basis for Determination:

(1) Stakeholder Interviews and Surveys

Through in-depth interviews and questionnaire surveys with various stakeholders, we assessed the perceived sustainability of outcomes and stakeholders' actual experiences of the stability of impact.

(2) Professional Judgment and Literature Support

We combined the medical team's professional experience, clinical observations, and existing research literature to evaluate potential mechanisms and rates of decline for each outcome—for example, psychological effects may fade over time, and physical conditions may fluctuate due to changes in illness.

(3) Adjustment by Outcome Characteristics

Based on the mechanisms through which outcomes were generated, we differentiated between direct effects of the project and potential influences from stakeholders themselves or external factors. Drop-off proportions were then set accordingly for each type of outcome.

Table 7.2.4-1 Impact Factor Adjustment Table – Drop-off

Stakeholder Subgroup	Outcome	Outcome Indicator	Drop-off		Reasoning
			Proportion	Level	
National Health Insurance Administration (NHIA)	Strengthened Confidence in Program Governance and Decision-Making	Conduct interviews and surveys with programme organizer to measure changes of confidence in program governance and decision-making after participation (including the depth and importance of change), to be used as an outcome indicator.	15%	Low	<p>(1) Direct impact of the program intervention Through comprehensive clinical data, performance indicators, and empirical statistics, this project directly supported the NHIA in obtaining quantitative evidence for policy advancement. This, in turn, strengthened its confidence and reference base for the development of related or similar programs in the future. These data and experiences are considered interim outcomes that made a substantial contribution to enhancing policy confidence.</p> <p>(2) Potential factors influencing drop-off However, over time, changes in medical technology, care models, and the policy environment will gradually generate new data and research findings, thereby diluting the exclusive influence of this project’s data on policy confidence. In addition, pilot experiences from other medical institutions or international case studies may also serve as future sources of confidence. Therefore, a drop-off was applied to reflect the gradual decline in the influence of these outcomes over time.</p>
Program Leader	Strengthen Professional Accomplishment	Conduct interviews and surveys with programme leader to measure changes in accomplishment after participation (including the depth and importance of change), to be used as an outcome indicator.	20%	Low	<p>(1) Direct impact of the program intervention During the implementation of the project, the project lead received continuous positive feedback from multiple stakeholders—including the NHIA, medical teams, patients, and their families—and directly perceived the program’s social value and contribution. This led to a strong sense of achievement. Such emotional feedback was relatively rare in past experiences and is considered a clearly stimulated outcome of this project.</p> <p>(2) Potential factors influencing drop-off The sustainability of this sense of achievement may still be influenced by external environments, future hospital policies, or competition from other new programs. Over time, in the absence of follow-up projects or continued work, this sense of achievement may gradually be replaced. or diminished by other professional accomplishments or medical challenges.</p>

Stakeholder Subgroup	Outcome	Outcome Indicator	Drop-off		Reasoning
			Proportion	Level	
Cardiovascular Center Physicians	Confidence in Clinical Decision-Making	conduct interviews and surveys with program executors to measure changes of confidence in clinical decision-making after participation (including the depth and importance of change), to be used as an outcome indicator.	20%	Low	<p>(1) Direct impact of the program intervention This project established a systematic process for data collection and analysis, enabling the project lead to support clinical judgment with quantitative evidence. This significantly enhanced confidence and accuracy in decision-making and represents a direct and unique outcome of the project.</p> <p>(2) Potential factors influencing drop-off Over time, if data is not continuously updated or if there is a lack of follow-up support from similar programs, the reference value and relevance of the original data for decision-making will gradually diminish. At the same time, ongoing advancements in medical knowledge and technology may lead to portions of decision-making confidence being reinforced by new academic or clinical insights.</p>

Stakeholder Subgroup	Outcome	Outcome Indicator	Drop-off		Reasoning
			Proportion	Level	
Case Managers	Confidence in Professional Capability	Conduct interviews and surveys with program executors to measure changes in confidence after participation (including the depth and importance of change), to be used as an outcome indicator.	15%	Low	<p>(1) Direct impact of the program intervention Through integrated care and interprofessional collaboration, this project provided case managers with opportunities to strengthen competencies beyond those required in routine work, particularly in areas such as condition assessment, cross-team collaboration, and case follow-up. These enhancements represent direct outcomes of the project intervention.</p> <p>(2) Potential factors influencing drop-off While the project made a clear contribution to professional development, continued learning and professional training within the hospital or through other projects may reduce reliance on this project as the sole source of growth. Additionally, some of these skills may be further developed and transformed through future work experience.</p>
Various Healthcare Professionals	Confidence in Professional Capability	Conduct interviews and surveys with program executors to measure changes in confidence after participation (including the depth and importance of change), to be used as an outcome indicator.	15%	Low	<p>(1) Direct impact of the program intervention Through interdisciplinary collaboration, integrated care processes, and in-depth various healthcare professionals, the project enabled various healthcare professionals to achieve significant professional development in areas such as subject-matter expertise, communication and coordination, and healthcare management. These enhanced competencies were largely the result of direct participation in and execution of the project.</p> <p>(2) Potential factors influencing drop-off The sustainability of professional development depends on whether future work environments provide opportunities for continued application and growth. If various healthcare professionals no longer engage in similar tasks or lack access to further training and practical settings, certain skills or levels of knowledge proficiency may gradually decline over time.</p>

Stakeholder Subgroup	Outcome	Outcome Indicator	Drop-off		Reasoning
			Proportion	Level	
Patient Group 1: Heart Failure Patient (age over 80)	Enhanced Emotional Security	Conduct interviews and surveys with patient to measure changes in emotional security after participation (including the depth and importance of change), to be used as an outcome indicator.	30%	Moderately Low	<p>(1) Direct impact of the program intervention Through comprehensive integrated medical care, cross-team collaboration, and regular follow-ups, elderly patients with heart failure received multi-dimensional support that significantly reduced uncertainty around seeking medical care and enhanced their “sense of security”. This represents a direct psychological outcome resulting from the project intervention.</p> <p>(2) Potential factors influencing drop-off “The sense of security” is a highly psychological and time-sensitive feeling. As the project concludes, follow-up visits become less frequent, and care intensity returns to routine levels, patients’ sense of security may diminish due to reduced medical interaction, changes in health status, or life circumstances. In addition, the memory characteristics of elderly patients and their strong reliance on medical support make this outcome difficult to sustain in the long term.</p>
	Strengthen Self-Efficacy & Confidence	Conduct interviews and surveys with patient to measure changes in self-efficacy & confidence after participation (including the depth and importance of change), to be used as an outcome indicator.	5%	Low	<p>(1) The program provides integrated care and interpersonal support with low sensitivity to decay factors. Regular follow-ups, case-manager continuity, health education, and coaching sustain intervention fidelity. Minimal overlap with other programs reduces dilution, substitution, and crowd-out.</p> <p>(2) Outcomes are program-driven and resilient. Professional medical services, timely feedback, and routine follow-ups turn uncertainty into actionable strategies, strengthening self-efficacy. Health education and family involvement embed knowledge in daily practice, buffering against external or substitutive decay.</p>

Stakeholder Subgroup	Outcome	Outcome Indicator	Drop-off		Reasoning
			Proportion	Level	
Patient Group 2: Heart Failure Patient (age 60 - 80)	Enhanced Emotional Security	Conduct interviews and surveys with patient to measure changes in emotional security after participation (including the depth and importance of change), to be used as an outcome indicator.	20%	Moderately Low	<p>(1) Direct impact of the program intervention Through comprehensive integrated medical care, cross-team collaboration, and regular follow-ups, elderly patients with heart failure received multi-dimensional support that significantly reduced uncertainty around seeking medical care and enhanced their “sense of security”. This represents a direct psychological outcome resulting from the project intervention.</p> <p>(2) Potential factors influencing drop-off “The sense of security” is a highly psychological and time-sensitive feeling. As the project concludes, follow-up visits become less frequent, and care intensity returns to routine levels, patients’ sense of security may diminish due to reduced medical interaction, changes in health status, or life circumstances.</p>
	Strengthen Self-Efficacy & Confidence	Conduct interviews and surveys with patient to measure changes in self-efficacy & confidence after participation (including the depth and importance of change), to be used as an outcome indicator.	5%	Low	<p>(1) The program provides integrated care and interpersonal support with low sensitivity to decay factors. Regular follow-ups, case-manager continuity, health education, and coaching sustain intervention fidelity. Minimal overlap with other programs reduces dilution, substitution, and crowd-out.</p> <p>(2) Outcomes are program-driven and resilient. Professional medical services, timely feedback, and routine follow-ups turn uncertainty into actionable strategies, strengthening self-efficacy. Health education and family involvement embed knowledge in daily practice, buffering against external or substitutive decay.</p>

Stakeholder Subgroup	Outcome	Outcome Indicator	Drop-off		Reasoning
			Proportion	Level	
Patient Group 3: Heart Failure Patient (age under 60)	Enhanced Emotional Security	Conduct interviews and surveys with patient to measure changes in emotional security after participation (including the depth and importance of change), to be used as an outcome indicator.	20%	Moderately Low	<p>(1) Direct impact of the program intervention Through comprehensive integrated medical care, cross-team collaboration, and regular follow-ups, elderly patients with heart failure received multi-dimensional support that significantly reduced uncertainty around seeking medical care and enhanced their “sense of security”. This represents a direct psychological outcome resulting from the project intervention.</p> <p>(2) Potential factors influencing drop-off “The sense of security” is a highly psychological and time-sensitive feeling. As the project concludes, follow-up visits become less frequent, and care intensity returns to routine levels, patients’ sense of security may diminish due to reduced medical interaction, changes in health status, or life circumstances.</p>
	Strengthen Self-Efficacy & Confidence	Conduct interviews and surveys with patient to measure changes in self-efficacy & confidence after participation (including the depth and importance of change), to be used as an outcome indicator.	5%	Low	<p>(1) The program provides integrated care and interpersonal support with low sensitivity to decay factors. Regular follow-ups, case-manager continuity, health education, and coaching sustain intervention fidelity. Minimal overlap with other programs reduces dilution, substitution, and crowd-out.</p> <p>(2) Outcomes are program-driven and resilient. Professional medical services, timely feedback, and routine follow-ups turn uncertainty into actionable strategies, strengthening self-efficacy. Health education and family involvement embed knowledge in daily practice, buffering against external or substitutive decay.</p>

Stakeholder Subgroup	Outcome	Outcome Indicator	Drop-off		Reasoning
			Proportion	Level	
Patient Group 3: Heart Failure Patient (age under 60)	Financial pressure arising	Conduct interviews and surveys with patient to measure changes in financial pressure after participation (including the depth and importance of change), to be used as an outcome indicator.	5%	Low	<p>(1) The rise in economic pressure is primarily driven by health limitations and is not sensitive to external decay factors.</p> <p>Declines in physical capacity, increased hospitalizations, and prolonged recovery reduce working hours, lower income, and raise medical expenses, directly heightening household economic pressure. This increase is not significantly attenuated by other external factors or by the passage of time—unless the patient’s health truly improves.</p>

Stakeholder Subgroup	Outcome	Outcome Indicator	Attribution		Reasoning
			Proportion	Level	
Family of Patient Group 1 (age over 80)	Enhanced Emotional Security	Conduct interviews and surveys with caregiver to measure changes in emotional security after participation (including the depth and importance of change), to be used as an outcome indicator.	30%	Moderately Low	<p>(1) Direct impact of the program intervention Through comprehensive integrated care, cross-team collaboration, and regular follow-ups, the program provides multi-dimensional support to family members (primary caregivers) of patients with heart failure, significantly reducing uncertainty around seeking care and enhancing their sense of security. This is a direct psychological outcome of the intervention.</p> <p>(2) Potential factors influencing drop-off A “sense of security” is highly psychological and fluctuates over time. As the program ends, visit frequency decreases, and care intensity returns to routine, family members’ (primary caregivers’) safety and security may decline due to reduced medical interaction or changes in health status and life circumstances.</p>
	Caregiving Burden Relief	Conduct interviews and surveys with caregiver to measure changes in burden relief after participation (including the depth and importance of change), to be used as an outcome indicator.	15%	Low	<p>(1) Direct impact of the program intervention Integrated care, health education, case management, and psychological support help caregivers regain daily functioning and adjust psychologically after stabilization, directly producing a reduced-burden feeling rooted in support and security.</p> <p>(2) Potential factors influencing drop-off This perceived burden reduction is subjective and time-sensitive; fluctuations in caregivers’ physical/mental state, disease course, or life changes can gradually diminish it.</p>

Stakeholder Subgroup	Outcome	Outcome Indicator	Attribution		Reasoning
			Proportion	Level	
Family of Patient Group 2 (age 60 - 80)	Enhanced Emotional Security	Conduct interviews and surveys with caregiver to measure changes in emotional security after participation (including the depth and importance of change), to be used as an outcome indicator.	35%	Moderately Low	<p>(1) Direct impact of the program intervention Through comprehensive integrated care, cross-team collaboration, and regular follow-ups, the program provides multi-dimensional support to family members (primary caregivers) of patients with heart failure, significantly reducing uncertainty around seeking care and enhancing their sense of security. This is a direct psychological outcome of the intervention.</p> <p>(2) Potential factors influencing drop-off A “sense of security” is highly psychological and fluctuates over time. As the program ends, visit frequency decreases, and care intensity returns to routine, family members’ (primary caregivers’) safety and security may decline due to reduced medical interaction or changes in health status and life circumstances.</p>
	Caregiving Burden Relief	Conduct interviews and surveys with caregiver to measure changes in burden relief after participation (including the depth and importance of change), to be used as an outcome indicator.	10%	Low	<p>(1) Direct impact of the program intervention Integrated care, health education, case management, and psychological support help caregivers regain daily functioning and adjust psychologically after stabilization, directly producing a reduced-burden feeling rooted in support and security.</p> <p>(2) Potential factors influencing drop-off This perceived burden reduction is subjective and time-sensitive; fluctuations in caregivers’ physical/mental state, disease course, or life changes can gradually diminish it.</p>

Stakeholder Subgroup	Outcome	Outcome Indicator	Attribution		Reasoning
			Proportion	Level	
Family of Patient Group 3 (age under 60)	Enhanced Emotional Security	Conduct interviews and surveys with caregiver to measure changes in emotional security after participation (including the depth and importance of change), to be used as an outcome indicator.	35%	Moderately Low	<p>(1) Direct impact of the program intervention Through comprehensive integrated care, cross-team collaboration, and regular follow-ups, the program provides multi-dimensional support to family members (primary caregivers) of patients with heart failure, significantly reducing uncertainty around seeking care and enhancing their sense of security. This is a direct psychological outcome of the intervention.</p> <p>(2) Potential factors influencing drop-off A “sense of security” is highly psychological and fluctuates over time. As the program ends, visit frequency decreases, and care intensity returns to routine, family members’ (primary caregivers’) safety and security may decline due to reduced medical interaction or changes in health status and life circumstances.</p>
	Caregiving Burden Relief	Conduct interviews and surveys with caregiver to measure changes in burden relief after participation (including the depth and importance of change), to be used as an outcome indicator.	5%	Low	<p>(1) Direct impact of the program intervention Integrated care, health education, case management, and psychological support help caregivers regain daily functioning and adjust psychologically after stabilization, directly producing a reduced-burden feeling rooted in support and security.</p> <p>(2) Potential factors influencing drop-off This perceived burden reduction is subjective and time-sensitive; fluctuations in caregivers’ physical/mental state, disease course, or life changes can gradually diminish it.</p>

7.3 Calculating Impact

In this SROI evaluation, the calculation of “impact” is in accordance with the principles of SROI. Through comprehensively estimating the project’s outcomes and applying a series of impact adjustment factors, the true social value created by the project is derived. The calculation process begins with the monetized value of each outcome. From this, we sequentially deduct the “deadweight” to account for changes that would have occurred anyway, then apply the “attribution” to reflect the portion of outcomes attributable to other organizations or external factors, and adjust for “displacement” to consider whether the project may have displaced other resources or impacts. Finally, we apply the “drop-off” to account for the diminishing influence of outcomes over time and discount the future value of each year’s social impact using an appropriate “discount rate”, to reflect the time value of money.

Through the systematic adjustment of the above impact factors, this evaluation ensures that the calculated impact accurately and prudently reflects the “additional” social value created by the program, effectively avoiding overestimation. This calculation process also aligns with the SROI principle of “Do not over-claim,” ensuring that the social impact of Taichung Veterans General Hospital’s Heart Failure Care Program is presented with transparency, verifiability, and in accordance with professional standards of prudent assessment.

Table 7.3-1 Impact Assessment Table

Stakeholder Subgroup	Outcome	Impact Value (NTD)	Proportion (%)
National Health Insurance Administration (NHIA)	Strengthened Confidence in Program Governance and Decision-Making	20,682.34	0.0050%
Program Leader	Strengthen Professional Accomplishment	6,604.50	0.0016%
Cardiovascular Center Physicians	Confidence in Clinical Decision-Making	62,370.00	0.0152%
Case Managers	Confidence in Professional Capability	4,323.44	0.0011%
Various Healthcare Professionals	Confidence in Professional Capability	14,149.44	0.0035%
Patient Group 1: Heart Failure Patient (age over 80)	Enhanced Emotional Security	31,894,872.66	7.7847%
	Strengthen Self-Efficacy & Confidence	37,501,320.00	9.1531%
Patient Group 2: Heart Failure Patient (age 60–80)	Enhanced Emotional Security	65,119,939.20	15.8940%
	Strengthen Self-Efficacy & Confidence	81,399,924.00	19.8675%
Patient Group 3: Heart Failure Patient (age under 60)	Enhanced Emotional Security	16,438,813.92	4.0123%
	Strengthen Self-Efficacy & Confidence	24,100,113.00	5.8822%
	Financial pressure arising	-1,935,729.90	-0.4725%
Family of Patient Group 1 (age over 80)	Enhanced Emotional Security	25,462,293.30	6.2147%
	Caregiving Burden Relief	16,997,473.29	4.1486%

Stakeholder Subgroup	Outcome	Impact Value (NTD)	Proportion (%)
Family of Patient Group 2 (age 60~80)	Enhanced Emotional Security	46,234,164.15	11.2845%
	Caregiving Burden Relief	43,876,544.40	10.7091%
Family of Patient Group 3 (age under 60)	Enhanced Emotional Security	11,316,574.80	2.7621%
	Caregiving Burden Relief	11,198,693.81	2.7333%

8 Calculating the SROI Value

8.1 Projecting Future Benefits

In an SROI evaluation, the purpose of projecting future benefits is to fully capture the total social value generated by the project, rather than limiting the assessment to the immediate outcomes achieved during the intervention period. According to SROI principles of “Understand what changes” and “Only include what is material”, it is essential to extend the measurement of impact over a reasonable period to reflect the project’s longer-term contributions to society, the economy, and the environment.

This project, through its care interventions for heart failure patients, not only improved patients’ health stability, reduced readmission rates, and enhanced quality of life in the short term, but also brought about lasting behavioral changes and positive effects for patients, families, healthcare professionals, and policymakers through health education, case management, and interdisciplinary collaboration. These impacts do not disappear immediately after the program ends; instead, they tend to continue over time, while also potentially diminishing gradually. Therefore, it is necessary to quantify them through projections of future benefits.

The SROI framework for projecting future benefits is based on the following elements:

- (1) Duration: Each outcome is expected to persist for a certain number of years after the intervention, requiring an assessment of the reasonable length of its influence.
- (2) Drop-off: As time progresses, the impact of outcomes may gradually decline each year, making it necessary to set an annual drop-off rate.
- (3) Discount Rate: Future social value must be discounted to present value to reflect the time value of money.

By forecasting future benefits, the evaluation not only adheres to the SROI emphasis on comprehensiveness and materiality, but also provides decision-makers with a foundation for assessing the project’s long-term social value. It further serves as a key reference for future policy scaling, model replication, and resource allocation.

Impact Value Calculations for Year 0 to Year 5:

- (1) Year 0 (2022) Impact Value = Sum of all impact values from each stakeholder and outcome = NTD 409,713,126.35
- (2) Year 1 (2023) Impact Value = Year 0 Impact Value \times (1 – Drop-off rate) = NTD 341,481,307.64
- (3) Year 2 (2024) Impact Value = Year 1 Impact Value \times (1 – Drop-off rate) = NTD 289,929,458.89
- (4) Year 3 (2025) Impact Value = Year 2 Impact Value \times (1 – Drop-off rate) = NTD 251,927,665.06
- (5) Year 4 (2026) Impact Value = Year 3 Impact Value \times (1 – Drop-off rate) = NTD 0
- (6) Year 5 (2027) Impact Value = Year 4 Impact Value \times (1 – Drop-off rate) = NTD 0

Net Present Value (NPV) of Impact from Year 0 to Year 5:

(1) NPV = Present Value of Benefits – Investment Value

(2) Present Value of Benefits = Year 0 Impact Value + (Year 1 Impact Value / (1 + r)) + (Year 2 Impact Value / (1 + r)²) + (Year 3 Impact Value / (1 + r)³) + (Year 4 Impact Value / (1 + r)⁴) + (Year 5 Impact Value / (1 + r)⁵)

Year	Base Year (2022)	Year 1 (2023)	Year 2 (2024)	Year 3 (2025)	Year 4 (2026)	Year 5 (2027)
Annual Impact Value	409,713,126.35	341,481,307.64	289,929,458.89	251,927,665.06	0.00	0.00
Annual Discount Factor	-	1.035	(1.035) ²	(1.035) ³	(1.035) ⁴	(1.035) ⁵
Annual Present Value of Impact	409,713,126.35	329,933,630.57	270,652,252.22	227,224,319.86	0.00	0.00
Present Value of Benefits	1,237,523,329.00					
Discount Rate (r)	The discount rate is set at 3.5%, in reference to the recommended value in the UK Green Book, common practices by SVUK/SVI, and Taiwan's Directorate-General of Budget, Accounting and Statistics (DGBAS) guidelines for cost-benefit analysis (ranging from 3% to 6%). This rate is adopted in this report to reflect the time value of social impact.					
Investment Value	274,727,603					
Net Present Value	962,795,726.00					

[Note] The valuation in this project is calculated in New Taiwan Dollars (NTD).

Calculation Method for the SROI ratio

In healthcare and care-related programs, financial or medical indicators often fail to fully capture the positive changes brought to society, patients, and families. By calculating the Social Return on Investment (SROI), intangible social value can be translated into tangible metrics, enabling decision-makers, funders, and stakeholders to clearly understand the social benefits generated from each dollar invested.

For this project, the calculation of the SROI carries the following value and objectives:

- (1) **Demonstrating Value Contribution:** This involves converting the multiple impacts of the program on patient health, the quality of family caregiving, the efficiency of the healthcare system, and the advancement of related policies into concrete, monetized value.
- (2) **Strengthening Resource Allocation Rationale:** The SROI indicator reveals the relationship between input and output, supporting future scale-up, budget planning, and resource optimization.
- (3) **Supporting Policy Advancement and Scaling:** By presenting a quantified return on investment, this helps demonstrate the necessity and benefits of such investments, thereby enhancing the confidence of authorities, NHIA, and other public agencies in promoting similar care models.
- (4) **Facilitating cross-sector communication and consensus:** By presenting concrete data on investment returns, the analysis facilitates a shared language among sectors such as healthcare, social welfare, and economic development, helping to build legitimacy for promoting multi-sector collaboration.

Thus, the calculation of SROI is not only a bridge between financial and social value, but also a critical tool for ensuring that sustainable care programs possess the persuasive power, actionable momentum, and potential for wider dissemination. The purpose of calculating the SROI is to understand the value generated over a certain period from a given investment. For instance, if each dollar invested generates NTD 9 in value within five years, then the SROI is 9:1 = 9. The formula is as follows:

$$\text{SROI} = \text{Present Value of Benefits} / \text{Value of Inputs}$$

In this project, the present value of benefits is NTD 1,237,523,329.00, and the value of inputs is NTD 274,727,603. As a result, the calculated SROI is 4.50, indicating that for every NTD 1 invested in the “Post-Acute Integrated Care Program – Heart Failure,” a value of NTD 4.50 was created during the evaluation period (2022–2027).

8.2 Payback Period

In Social Return on Investment (SROI) analysis, the payback period is a key indicator used to assess the economic and social returns of a project. It refers to the amount of time required for the accumulated present value of social benefits generated by the project to equal or exceed the initial investment. This indicator allows us to pinpoint when the project's financial and social contributions break even, helping to evaluate the efficiency and sustainability of the investment. In this assessment, the payback period is calculated by comparing the cumulative annual present value of social outcomes against the total project investment. The point at which the cumulative value first surpasses the investment is considered the payback point. This calculation aligns with the SROI principles of “not over-claiming” and “transparency,” as it prevents overestimating the program’s impact while also enabling stakeholders to clearly understand the timeframe and pace at which outcomes are generated following the investment. Presenting the payback period serves not only as an evaluation metric for this project but also as a strategic reference for policymakers and funders when considering future investment or scaling decisions.

Payback Period Calculation:

$$\begin{aligned} \text{Payback Period (months)} &= (\text{Present Value of Year 1} / \text{Investment Value}) \times 12 \\ &= 274,727,603 / 409,713,126.35 \times 12 = 8.05 \text{ months} \end{aligned}$$

In this SROI evaluation, the results show that the social value (social present value) generated in the first year already exceeds the total investment—indicating that the project “broke even within the same year.” This means that the project began producing substantial social benefits immediately upon implementation, without requiring multi-year value accumulation.

This outcome demonstrates the project's strong capacity to generate value and reflects the immediacy and stability of its social return.

9 Sensitivity Analysis and Potential Risks

9.1 Sensitivity Analysis

To ensure the robustness and credibility of the SROI evaluation results, a sensitivity analysis was conducted based on the Social Return on Investment (SROI) methodology. This analysis tests the extent to which key variables affect the final SROI value. By adjusting different assumptions, it assesses the variability of outcome valuations and the stability of the calculation results, helping to prevent bias caused by any single parameter setting.

This report examines the sensitivity of the following key parameters:

- (1) Duration: Assessing how extending or shortening the length of outcome persistence affects the SROI.
 - When the outcome duration for the two major stakeholder groups, namely patients and their primary caregivers (family members), is extended to 5 years, the SROI increases from 4.50 to 5.19.
 - When the outcome duration for the program organizer and executor is extended to 5 years, the SROI remains at 4.50.
 - Conclusion: Outcomes for patients and primary caregivers (family members) should be considered as key targets for monitoring and management in relation to the duration of outcomes.
- (2) Drop-off: Testing how different annual drop-off rates affect the present value of outcomes.
 - If the drop-off for patients and primary caregivers (family members) is set to 50% (medium level), the SROI drops from 4.50 to 2.73.
 - If the drop-off for program organizer and executors is set to 50% (medium level), the SROI remains at 4.50.
 - Conclusion: Outcomes for patients and primary caregivers (family members) should be considered as key targets for monitoring and management in relation to the drop-off of outcomes.
- (3) Attribution: Adjusting the contribution attributed to the program to observe its effect on SROI.
 - If the attribution for patients and primary caregivers (family members) is set to 50% (medium level), the SROI drops from 4.50 to 2.59.
 - If the attribution for program organizer and executors is set to 50% (medium level), the SROI remains at 4.50.
 - Conclusion: Outcomes for patients and primary caregivers (family members) should be considered as key targets for monitoring and management in relation to the attribution of outcomes.
- (4) Deadweight: Testing the impact of increased deadweight assumptions on total outcome value.
 - If deadweight for patients and primary caregivers (family members) is set to 50% (medium level), the SROI drops from 4.50 to 2.25.
 - If deadweight for program organizer and executors is set to 50% (medium level), the SROI remains at 4.50.

- Conclusion: Outcomes for patients and primary caregivers (family members) should be considered as key targets for monitoring and management in relation to the deadweight of outcomes.
- (5) Displacement: Testing the effect of increased displacement assumptions on total outcome value.
- If displacement for patients and primary caregivers (family members) is increased to 50% (medium level), the SROI drops from 4.50 to 2.42.
 - If displacement for program organizer and executors is set to 50% (medium level), the SROI remains at 4.50.
 - Conclusion: Outcomes for patients and primary caregivers (family members) should be considered as key targets for monitoring and management in relation to the displacement of outcomes.
- (6) Discount Rate: Calculating with different discount rates to assess their impact on the return on investment.
- If the discount rate is adjusted from 3.5% to 2.5%, the SROI increases from 4.50 to 4.55.
 - If the discount rate is adjusted from 3.5% to 4.5%, the SROI drops from 4.50 to 4.45.
 - If the discount rate is adjusted from 3.5% to 5.5%, the SROI drops from 4.50 to 4.39.
 - If the discount rate is adjusted from 3.5% to 6.5%, the SROI drops from 4.50 to 4.34.
 - Conclusion: Changes in the discount rate have a certain level of impact on the SROI value. However, compared to the variations in duration and factor values in items (1) to (5), the influence of discount rate adjustments on the SROI value remains relatively limited.
- (7) To examine the impact of uncertainty in the well-being valuation method on the overall conclusions, all unit values derived from this method—and those anchored to it—were uniformly reduced by 10%, while all other parameters (number of beneficiaries experiencing change, depth of change, deadweight, attribution, displacement, drop-off, and discount rate) remained unchanged. The SROI decreased from 4.50 to 3.77, a difference of -16.22% ($\pm 10\text{--}20\%$ = moderate sensitivity), which falls within the moderate sensitivity range. The main conclusions remain unaffected, indicating robustness of the results.

In Social Return on Investment (SROI), Cost–Benefit Analysis (CBA), and impact valuation practice, $\pm 10\%$ is commonly regarded as the “baseline band” for model robustness testing and typically does not alter the main conclusions; $\pm 10\text{--}20\%$ indicates changes that warrant attention but are usually secondary; changes greater than $\pm 20\%$ are more likely to affect value rankings or resource allocation recommendations.³

This sensitivity analysis indicates that the SROI results are more sensitive to changes in parameters related to patients and their family members. This is primarily because they constitute the absolute majority of stakeholders in the program, with

³Based on the sensitivity analysis principles set out in the Green Book, OECD, and SROI guidance, this study evaluates model robustness using percentage variations. Although there is no official rule prescribing fixed thresholds, in practice $\pm 10\%$ is commonly used as a baseline test band, $\pm 10\text{--}20\%$ as a range that warrants attention, and changes greater than $\pm 20\%$ as potentially affecting rankings or resource allocation. These intervals are internal conventions adopted for this study.

a wide range of diverse outcome items. Their contribution to the overall social value is also the highest. Thus, adjustments in their parameters lead to more significant changes in the overall SROI value.

In contrast, the program organizer and implementer groups have fewer members and outcome items, so even if the valuation or impact parameters of individual outcomes are adjusted, the overall effect on the SROI remains relatively limited. This result reflects the distribution structure of value creation among stakeholders and does not imply that the value of any group is being underestimated or overestimated.

In addition, this project has conducted comprehensive testing on key variables such as valuation, deadweight, attribution, displacement, and drop-off rate. The SROI value did not undergo fundamental reversals or extreme fluctuations under these tests, indicating that the evaluation results demonstrate a certain degree of robustness and explanatory power. This aligns with the SROI methodological principles of “transparency in explanation” and “not over-claiming.”

If the project is to be scaled up or more in-depth analysis is to be conducted for specific stakeholder groups in the future, the results of this sensitivity analysis can serve as a foundation for designing more targeted outcome tracking and valuation strategies.

9.2 Potential Sources of Error and Risk Disclosure

This SROI evaluation adheres to international standards for impact management and social value measurement, aiming to ensure data accuracy and valuation reasonableness. However, based on the implementation context and analytical approach of this project, certain potential sources of error and risks remain. These are disclosed here as a basis for future improvements.

1. Outcome measurement primarily based on qualitative data

The outcome indicators in this evaluation are primarily informed by qualitative stakeholder interviews. While structured interview protocols, thematic synthesis, and questionnaires with defined measurement scales were used to promote consistency, subjective responses may be influenced by individual expression, emotional condition, or interview timing. Accordingly, some degree of uncertainty may remain in the assessment of outcome intensity.

Mitigation Strategy: To reduce individual interviewer bias, this project adopted a standardized interview protocol developed by a cross-disciplinary interview team. Multiple evaluators conducted cross-checking of qualitative data. In addition, all qualitative findings were validated through stakeholder engagement workshops to ensure the coherence and credibility of the outcome chains.

2. Appropriateness of valuation sources

Some of the valuations for emotional and psychological outcomes were based on international social value databases, such as the UK Social Value Bank (UKSVB). Although localization adjustments were applied using purchasing power parity (PPP) or per capita GDP ratios, differences in lifestyle and cultural context may still lead to underestimation or overestimation of the actual value in the Taiwanese setting.

Mitigation Strategy: To reduce the potential discrepancies arising from cross-national valuation, this project adopted purchasing power parity (PPP) adjustments as the primary method of localization, converting valuations from countries such as the UK to reflect Taiwan's relative purchasing power. In addition, local benchmarks such as average wages, consumer price indices, and typical consultation fees in Taiwan were referenced to support the reasonableness of the estimates. Although it was not possible to match every valuation with Taiwan-specific research, sensitivity analysis was conducted to ensure that the estimates remained within a reasonable range, thereby minimizing the impact of uncertainty on the final social value.

In addition, for outcomes for which no locally applicable wellbeing valuation proxies are available, a cost-based approach was applied as a supplementary estimation method. All valuation assumptions and data sources were transparently disclosed and subjected to sensitivity testing, in order to reduce the risk of bias arising from valuation uncertainty.

3. Subjectivity in impact factor judgment

The four key impact factors—deadweight, attribution, displacement, and drop-off—were determined based on professional judgment and stakeholder feedback. However, due to limitations in data completeness and variations in individual perspectives, a certain degree of judgment error within a reasonable range remains possible.

Mitigation Strategy: The project adopted stakeholder engagement sessions and surveys to assess the four impact factors including deadweight, attribution, displacement, and drop-off. Through multiple workshops and discussion meetings with the core medical team, case managers, and program participants, factor settings for each indicator were refined through consensus-building and iterative adjustments. This process prevented reliance on any single individual's subjective judgment, ensuring that all assumptions were grounded in frontline implementation experience and direct stakeholder feedback. The final factor settings were further validated through sensitivity analysis to confirm their reasonableness and robustness.

4. Uncertainty regarding the sustainability of program benefits

The assumptions regarding outcome duration and drop-off in the SROI evaluation were based on current clinical and management experience. However, changes in the policy environment, availability of medical resources, patient composition, or the broader social support system may affect both the longevity and intensity of these outcomes in the future.

Mitigation Strategy: Although this project did not initially establish a formal follow-up or re-evaluation mechanism, it aims to gradually develop a simplified performance monitoring and recording model by leveraging existing patient follow-up data, case management records, and routine medical team meetings. These data and insights, naturally accumulated through clinical and care processes, can serve as reference for future SROI re-evaluations. In the event of major policy changes or service model adjustments, the evaluation model can be reviewed and revised in a timely manner to ensure the continued relevance and accuracy of the analysis.

5. Partial Indirect Exclusion of Stakeholder Perspectives

Due to time and resource constraints during the evaluation, the perspectives of certain indirect stakeholders, such as other hospitals or long-term care facilities, were not comprehensively collected, which may affect the completeness of outcome assessment.

Mitigation Strategy: Although indirect stakeholders' opinions were not fully included during the evaluation phase, a plan for follow-up interviews and stakeholder engagement has been reserved. Through existing networks with the hospital and the NHIA, the perspectives of other key stakeholders, including long-term care facilities and referral hospitals, will be gradually incorporated to enhance the comprehensiveness of the evaluation.

10 Reporting, Application, and Institutionalization of SROI

10.1 Reporting to Stakeholders

This program is in accordance with the SROI principles, emphasizing transparent disclosure and responsible feedback. Thus, the results of the SROI evaluation will be communicated to various stakeholders primarily through a formal report. This report will comprehensively present the social value created, the impact assessment, and the monetization outcomes of the project, ensuring that stakeholders can fully understand the tangible benefits delivered to patients, family members, the healthcare system, and policy advancement. This not only demonstrates Taichung Veterans General Hospital's commitment to stakeholder accountability, but also aligns with the core SROI principles of "transparency" and "responsible reporting".

For internal stakeholders (such as program leader, medical teams, case managers, and various healthcare professionals), the results and findings of the SROI will be shared through professional meetings and training sessions. These activities will enhance their understanding of the project outcomes and serve as a basis for future system optimization, policy development, and care model improvements.

For NHIA, such as patients, family members, and the general public, the hospital will announce the results via its website. This will allow participants and the broader community to understand the project's contribution to improving patient health, care quality, and family support systems.

This reporting mechanism not only fulfills the SROI principles of "transparency" and "stakeholder engagement", but also helps build a shared recognition of the program's social value among cross-sectoral partners, thereby supporting the hospital's ongoing efforts and leadership role in promoting sustainable healthcare.

10.2 Application of SROI

Following the completion of the SROI evaluation for this project, in accordance with SROI principles, the findings will not merely serve as a calculation or report. Instead, they will guide Taichung Veterans General Hospital's future policy planning, resource allocation, and service optimization. The established outcome chains, indicator system, and valuation methodology from this assessment will form a critical foundation for ongoing monitoring and management of heart failure care outcomes. By revealing the impact, the evaluation enables a clearer understanding of how different stakeholders perceive the value of the program and what they truly need. This insight supports the refinement of care processes, enhancement of support systems for case managers and healthcare teams, and improvement of the patient and caregiver care interface.

Moreover, the results of this SROI evaluation serve as a professional basis for dialogue with policy agencies such as the National Health Insurance Administration to support future program expansion, policy integration, and resource advocacy efforts. The evaluation also positions the TCVGH to lead by example in sustainable healthcare and social value creation. Looking ahead, by conducting SROI evaluations on a regular basis, the hospital can establish a systematic impact management mechanism that ensures the investments in heart failure care continue to deliver long-term, positive value to society, the healthcare system, and policy development.

Table 10.2-1 Application of SROI Evaluation

Application Area	Practical Application
Internal Communication	<p>The SROI evaluation of this project quantitatively assessed the social value generated by the TCVGH heart failure care program for different stakeholder groups, including patients, family members, medical executors, and policymakers. Through the quantification of outcomes and the construction of theory of change, the hospital can transform performance metrics that were previously limited to clinical or administrative levels into concrete data on social impact, thereby enhancing understanding and consensus across departments and functions. For example, SROI reports can serve as a communication tool among medical decision-makers, quality management units, and frontline healthcare professionals to coordinate resource allocation and guide service improvement. They can also support future hospital efforts in sustainable governance, social responsibility, and healthcare quality enhancement.</p> <p>The SROI indicators can also be internalized into hospital KPIs or balanced scorecards, institutionalizing non-financial value within performance evaluations and embedding impact management into the system.</p>
Identifying and Managing Risks and Opportunities	<p>Throughout the SROI evaluation process, adjustments for attribution, deadweight, displacement, and drop-off were applied to each outcome indicator and valuation condition. This not only revealed the current strength of the program’s outcomes but also identified potential risks of impact dilution or loss. Based on these insights, the hospital can further optimize intervention strategies for high-risk outcomes—for example, by strengthening telemedicine, expanding community-based care resources, or enhancing family support systems. Meanwhile, outcomes that have demonstrated significant positive effects—such as patients’ sense of security and healthcare professionals’ confidence in clinical decisions—represent key opportunities for future scaling and policy engagement.</p>
Assess the Impact on Stakeholders	<p>The outcome chain developed through the SROI process, along with interviews and survey data collection, prompted the hospital to conduct a comprehensive review of how different stakeholders perceive, experience, and value the program. This analysis enables the hospital to:</p> <ol style="list-style-type: none"> (1) Clarify the roles and benefits of each stakeholder group in the process of value creation. (2) Identify specific groups (such as case managers, younger patients, or family members) that demonstrate particularly strong responses or impacts from certain outcomes, allowing for more targeted interventions. (3) Avoid evaluating program effectiveness solely through a single lens (e.g., clinical indicators), thereby preventing the oversight of patients’ and families’ real experiences and social value changes.

	<p>Going forward, the hospital can build on this framework to establish a regular stakeholder feedback mechanism and develop a long-term database for impact evaluation.</p>
<p>Evaluating Total Value and/or Net Impact</p>	<p>Through a comprehensive process of valuation, adjustment, and discounting, this SROI evaluation calculated the program’s SROI value. Sensitivity analysis and impact factor adjustments were conducted to ensure the results remain conservative and credible.</p> <p>These findings not only support internal investment evaluations and resource allocation but also serve as a basis for external policy advocacy, fundraising, and public value communication.</p> <p>By presenting the net impact, the hospital is able to clearly identify which outcomes contribute most significantly to social value creation and which require further strengthening or adjustment. This provides a foundation for continuous improvement and supports the hospital’s long-term goals in sustainable healthcare and social impact management.</p>

10.3 SROI Institutionalization

To implement the principles of impact management, Taichung Veterans General Hospital (TCVGH) views this SROI evaluation as the starting point for establishing a system of impact tracking and management in healthcare services, rather than a one-time study. In accordance with SROI principles, the hospital will gradually promote the “institutionalization” of impact evaluation to ensure continued value creation and program improvement.

First, the outcome chains, indicators, and valuation models developed in this evaluation will be internalized into the TCVGH heart failure care program’s performance tracking mechanism. By regularly collecting data on key outcomes (such as patients’ emotional security, readmission rates, and caregiver stress), the hospital will gradually build a cross-year impact database that supports quality of care, social value analysis, and resource allocation.

Secondly, future SROI evaluations will be updated periodically or as needed based on program developments and policy requirements, in order to reflect social changes, healthcare trends, and evolving stakeholder concerns. By continuously reviewing key adjustment factors such as deadweight, attribution, displacement, and drop-off, the valuation can maintain both its accuracy and conservativeness.

Lastly, the hospital will foster cross-departmental collaboration to gradually build capacity for impact management, strengthening the understanding of social value thinking among clinical, administrative, and managerial staff. In this way, SROI will not merely serve as an evaluation tool, but evolve into a management framework for healthcare decision-making, service innovation, and sustainable governance.

Through this mechanism, Taichung Veterans General Hospital aims to continually apply the principles and methodologies of SROI to other key medical services or public health initiatives, thereby cultivating a culture and system of impact management within the hospital and amplifying the institution’s long-term influence on society.

10.4 Follow-up Recommendations

As this report represents a forecast SROI analysis, the program team will assess the actual results once the intervention has been fully implemented. A structured process will be established to collect real outcome data and compare it with the projected outcomes presented in this forecast. This assessment will examine the extent to which the anticipated changes were achieved, identify any variances between forecasted and actual results, and analyze the underlying reasons for such differences. The findings from this comparison will form the basis for developing evidence-based recommendations to refine program design, strengthen service delivery, and enhance the overall social value generated. This forward-looking commitment ensures that the forecast SROI remains an active tool for learning, accountability, and continuous improvement, in line with the principles of Social Value International.

In accordance with SROI principles, impact management should not end with a single evaluation but should involve continuous tracking and assessment to ensure the credibility and potential for improvement of the social value being created. For the TCVGH Heart Failure Care Program, the following ongoing efforts are recommended:

(1) Regularly Update Outcome Indicators and Data

The current evaluation has established a complete outcome chain and corresponding indicators. It is recommended to update outcome data at least once a year, including patient recovery, emotional changes, caregiver burden, and team morale. This will help track whether meaningful changes are sustained over time and provide a foundation for future evaluations.

(2) Dynamically Review Impact Factors

With changes in policy, healthcare environment, and social resources, key impact factors including deadweight, attribution, displacement, and drop-of should be reviewed and adjusted periodically to ensure valuation remains reasonable, conservative, and reflective of external conditions.

(3) Expand Stakeholder Engagement

It is recommended that future follow-up incorporate more diverse stakeholder feedback, especially from patients, family members, and healthcare professionals regarding their perceptions of the program's sustainability and value. This feedback can help optimize service design and improve the program's acceptance and relevance.

(4) Establish Longitudinal Impact Analysis

It is recommended to accumulate and analyze multi-year data to identify long-term outcome trends, such as sustained improvements in well-being, health status, and social participation. This also supports evaluation of actual outcome duration and degree of drop-off.

(5) Incorporating impact management into decision-making and practical application

Tracking results should serve as a basis for internal decision-making and policy dialogue, including the allocation of medical resources, optimization of care models, and improvement of cross-departmental collaboration. This approach ensures that SROI evaluation results are genuinely integrated into daily operations and long-term sustainability strategies.

Through these follow-up recommendations, the TCVGH heart failure care program can move beyond the static results of a single SROI evaluation and establish a mechanism for influence management that enables “continuous verification and dynamic optimization”. This will enhance the social value of healthcare services and consistently respond to the expectations of patients and society.

Acknowledgements

The successful completion of this report was made possible by the strong support and cross-departmental collaboration of the Taichung Veterans General Hospital Cardiovascular Center and the Sustainable Development Committee. We extend our deepest gratitude for their contributions. Special thanks go to Director Dr. Hung-Chin Ho and Case Manager Ms. Lin-Yuan Chang of the Cardiovascular Center for providing detailed clinical information and frontline insights, which greatly enriched the relevance of this SROI evaluation to the real experiences of patients.

We also sincerely thank Executive Director Mr. Hung-Wen Tsai, Executive Secretary Ms. Yuan-Hui Lai, and Secretaries Ms. Ying-Ye Jiang and Ms. Chia-Hui Hung of the Sustainable Development Committee for their professional guidance and ongoing assistance in coordinating interviews, integrating administrative resources, and discussing key elements of the report.

In addition, we express our heartfelt appreciation to all stakeholders who participated in the interviews and surveys for this project. This includes representatives from the National Health Insurance Administration, patients, family members, caregivers, and the administrative support team. Their active engagement and sincere feedback significantly enriched the outcome chains and the social impact dimension of this report.

The completion of this report reflects the collective wisdom, efforts, and experiences of many. It not only captures the authentic voices and needs of diverse stakeholders, but also aspires to serve as a valuable reference for advancing people-centered care models, promoting Value-Based Healthcare, and establishing mechanisms for measuring social value. With sincere gratitude, we acknowledge and appreciate every contribution made.

Appendix A: Social Return on Investment (SROI) Value Map

Stage 1		Stage 2				Stage 3				Stage 4									
Who and how many?		At what cost?		What changes?		How much?		How long?		How valuable?		How much caused by the activity?		Still material?					
Stakeholders	Inputs	Outputs	Outcomes	Indicator and source	Quantity (scale)	Amount of change per stakeholder (depth) (max. 100%)	Duration of outcomes	Outcomes start	Outcomes end	Express the relative importance (value) of the outcome		Deadweight % (牺牲因子)	Displacement % (排挤因子)	Attribution % (贡献因子)	Drop off % (折旧因子)	Impact calculation			
Who do we have an effect on?	How many in group?	What will/did they invest and how much (money, time)?	Financial value for the total population for the accounting period	Summary of activity in numbers.	What is the change experienced by stakeholders?	Describe how you will measure the described outcome (including any sources used)	Number of people experiencing described outcome	N.B. Data inputted in this column does not affect the calculation and is provided for transparency purposes only. Describe the average amount of change experienced (or to be experienced) per stakeholder.	How long (in years) does the outcome last for?	Does the outcome start in Period of activity or in the Period after?	Hidden column	Weighting N.B. Later inputted in this column does not affect the calculation and is provided for transparency purposes only. How important is this outcome to stakeholders? (e.g. on a scale of 1-10) N.B. To make comparison between outcomes possible, your analysis should be consistent in the type of measurement used.	Describe the monetary valuation approach used to express the relative importance (value) of each outcome (N.B. If your analysis does not use monetary valuation of outcomes, please use the Value Map (non-SROI) tab of this spreadsheet).	How important is the outcome to stakeholders (expressed in monetary terms)?	What will happen/what would have happened without the activity?	What activity would/did you displace?	Who else contributed to the change?	Does the outcome drop off in future years?	Number of people (quantity) times value, less deadweight, displacement and attribution
National Health Insurance Administration (NHIA)	1	Program subsidy/reward	648,500	The Program Issued Two Reports on the Post-Acute Care Integration Program for Heart Failure under the National Health Insurance	Promoted this program → Regularly monitored the achievement of various program indicators → Obtained reliable quantitative data → Effectively improved the accuracy of future policy/program promotion	Indicator: Sense of Control Sources used: In-depth Group Interview/Questionnaire Survey	1	70%	3	Period of activity	1	4	3,700.00	5%	5%	10%	10%	3,005.33	
		out of pocket medical costs under NHIA	5,228,957	3 Clinical assessment records (e.g., NYHA classification, Activities of Daily Living (ADL), six-minute walk test results), subsequent follow-up records, hospitalization history	Promoted this program → Regularly monitored the achievement of various program indicators → Obtained reliable quantitative data → Increased sense of accomplishment in promoting the program	Indicator: Sense of Accomplishment Sources used: In-depth Group Interview/Questionnaire Survey	1	85%	3	Period of activity	1	4	45,000.00	8%	8%	13%	10%	33,136.56	
		Personnel costs	16,099,155	4D echocardiography machine	Implemented this program → Regularly monitored the achievement of various program indicators → Observed good performance of the indicators → Grately felt the joy of helping others	Indicator: Sense of Joy Sources used: In-depth Group Interview/Questionnaire Survey	2	80%	1	Period of activity	1	2	1,102,980.00	12%	5%	15%	16%	1,567,555.18	
Program Leader	3	Cardiac catheterization machine	89,662,500	Ultrasound scanner	Implemented this program → Regularly monitored the achievement of various program indicators → Observed good performance of the indicators → Increased willingness to participate in similar or related programs in the future	Indicator: Sense of Trust Sources used: In-depth Group Interview/Questionnaire Survey	3	85%	4	Period of activity	1	5	4,200.00	15%	7%	15%	17%	8,466.26	
		Personnel costs	88,000,848	24	Participated in this program → Regularly held meetings and consultations with other specialties → Strengthened team cohesion	Indicator: Sense of Being Supported Sources used: In-depth Group Interview/Questionnaire Survey	18	80%	4	Period of activity	1	5	15,000.00	10%	5%	14%	10%	126,313.00	
		Personnel costs	1,671,656	2	Participated in this program → Provided integrated consultation and services → Tracked and cared about patient's recovery → Increased closeness with patient	Indicator: Sense of Being Tracked Sources used: In-depth Group Interview/Questionnaire Survey	2	95%	5	Period of activity	1	4	5,000.00	5%	5%	7%	10%	8,399.23	
Cardiovascular Center Physicians	24	Personnel costs	88,000,848	24	Participated in this program → Regularly held meetings and consultations with other specialties → Strengthened team cohesion	Indicator: Sense of Being Supported Sources used: In-depth Group Interview/Questionnaire Survey	18	80%	4	Period of activity	1	5	15,000.00	10%	5%	14%	10%	126,313.00	
		Personnel costs	1,671,656	2	Participated in this program → Provided integrated consultation and services → Tracked and cared about patient's recovery → Increased closeness with patient	Indicator: Sense of Being Tracked Sources used: In-depth Group Interview/Questionnaire Survey	2	95%	5	Period of activity	1	4	5,000.00	5%	5%	7%	10%	8,399.23	
		Personnel costs	20,693,570	10	Participated in this program → Provided integrated consultation and services → Tracked patient's recovery → Could communicate with patients in real time → Received patients' gratitude/respect → Felt encouraged	Indicator: Sense of Being Tracked Sources used: In-depth Group Interview/Questionnaire Survey	9	90%	5	Period of activity	1	6	5,850.00	5%	5%	8%	5%	9,919.03	
Case Managers	2	Personnel costs	1,671,656	2	Participated in this program → Provided integrated consultation and services → Improved personal professional development	Indicator: Self-Confidence Sources used: In-depth Group Interview/Questionnaire Survey	2	80%	4	Period of activity	1	5	4,650.00	5%	5%	5%	5%	7,973.59	
		Personnel costs	20,693,570	10	Participated in this program → Provided integrated consultation and services → Tracked patient's recovery → Could communicate with patients in real time → Received patients' gratitude/respect → Felt encouraged	Indicator: Sense of Being Tracked Sources used: In-depth Group Interview/Questionnaire Survey	9	90%	5	Period of activity	1	6	5,850.00	5%	5%	8%	5%	9,919.03	
		Personnel costs	1,671,656	2	Participated in this program → Provided integrated consultation and services → Improved personal professional development	Indicator: Self-Confidence Sources used: In-depth Group Interview/Questionnaire Survey	2	80%	4	Period of activity	1	5	4,650.00	5%	5%	5%	5%	7,973.59	
Various Healthcare Professionals	10	Personnel costs	20,693,570	10	Participated in this program → Regularly held meetings and consultations with other specialties → Increased closeness among colleagues	Indicator: Sense of Being Supported Sources used: In-depth Group Interview/Questionnaire Survey	9	85%	4	Period of activity	1	5	15,000.00	5%	5%	5%	10%	64,903.33	
		Personnel costs	1,671,656	2	Participated in this program → Provided integrated consultation and services → Tracked and cared about patient's recovery → Increased closeness with patient	Indicator: Sense of Being Tracked Sources used: In-depth Group Interview/Questionnaire Survey	2	95%	5	Period of activity	1	4	5,000.00	5%	5%	7%	10%	8,399.23	
		Personnel costs	20,693,570	10	Participated in this program → Provided integrated consultation and services → Tracked patient's recovery → Could communicate with patients in real time → Received patients' gratitude/respect → Felt encouraged	Indicator: Sense of Being Tracked Sources used: In-depth Group Interview/Questionnaire Survey	9	90%	5	Period of activity	1	6	5,850.00	5%	5%	8%	5%	9,919.03	
Various Healthcare Professionals	10	Personnel costs	20,693,570	10	Participated in this program → Provided integrated consultation and services → Improved personal professional development	Indicator: Self-Confidence Sources used: In-depth Group Interview/Questionnaire Survey	2	80%	4	Period of activity	1	5	4,650.00	5%	5%	5%	5%	7,973.59	
		Personnel costs	20,693,570	10	Participated in this program → Provided integrated consultation and services → Tracked patient's recovery → Could communicate with patients in real time → Received patients' gratitude/respect → Felt encouraged	Indicator: Sense of Being Tracked Sources used: In-depth Group Interview/Questionnaire Survey	9	90%	5	Period of activity	1	6	5,850.00	5%	5%	8%	5%	9,919.03	
		Personnel costs	1,671,656	2	Participated in this program → Provided integrated consultation and services → Improved personal professional development	Indicator: Self-Confidence Sources used: In-depth Group Interview/Questionnaire Survey	2	80%	4	Period of activity	1	5	4,650.00	5%	5%	5%	5%	7,973.59	

Appendix B: Social Return on Investment (SROI) Evaluation Questionnaire

SROI Stakeholder Evaluation Questionnaire

Greetings, and thank you for taking part in this evaluation questionnaire.

This survey is part of the Social Return on Investment (SROI) assessment conducted by Taichung Veterans General Hospital (hereinafter referred to as **TVGH**) for the **National Health Insurance Post-Acute Care Program for Heart Failure Patients**.

All personal information included in this questionnaire—such as names, health conditions, and treatment records—has been collected with the informed consent of patients and their family members by case managers. These data will be used solely for the purpose of evaluating the social impact of the aforementioned program using the SROI methodology, supporting TVGH in assessing and managing the program's effectiveness and value creation.

Please proceed to complete the questionnaire as instructed. We sincerely thank you once again for your participation and valuable support.

■ Basic Information

Question 1

Your Name: _____

Question 2

What type of stakeholder (role) are you in relation to this program? *Stakeholder Subgroup*

- Organizer (National Health Insurance Administration)
- Program Executors (TVGH) 1 - Program Leader
- Program Executors (TVGH) 2 - Cardiovascular Center Physicians
- Program Executors (TVGH) 3 - Case Managers
- Program Executors (TVGH) 4 - Various Healthcare Professionals
(including rehabilitation physicians, palliative care physicians, nurse practitioners, ward nurses, pharmacists, physical therapists, dietitians, social workers)
- Patient (Heart Failure NYHA FC II~III) Group 1: Heart Failure Patient (age over 80)
- Patient (Heart Failure NYHA FC II~III) Group 2: Heart Failure Patient (age 60–80)
- Patient (Heart Failure NYHA FC II~III) Group 3: Heart Failure Patient (age under 60)
- Caregivers of Heart Failure Patients - Family of Patient (age over 80) Group 1
- Caregivers of Heart Failure Patients - Family of Patient (age 60–80) Group 2
- Caregivers of Heart Failure Patients - Family of Patient (age under 60) Group 3

■ Program Input

Question 3

Q3.1 What activities have you primarily contributed to or carried out in this program? (Select all that apply)

- Program planning and implementation
- Diagnosis and treatment of patient conditions
- Providing specialized consultation and services
- Funding the implementation of program activities
- Delivering integrated services

(e.g., outpatient referral, communication, health education, post-discharge follow-up)

- Data collection, tracking, and analysis/reporting
- Home care or caregiving provided by others
- Self-managed home care by the patient
- Inpatient diagnosis and condition monitoring
- Other (please specify): _____

Q3.2 Have you contributed any financial resources, material resources, or time to this program?

3.2.1 Financial Contribution (NTD) (Calculation period: 2022/01/01 to 2022/12/31)

Program Subsidy Amount

- Subsidy/Incentive Amount for the Program (NTD): _____ (To be completed by TVGH)
- NHI-Covered Medication Costs (NTD): _____ (To be completed by TVGH)
- Personnel Expenses Invested in This Program (NTD): _____ (To be completed by TVGH; refers to the average annual salary in 2022 for each role from Program Executors (TVGH) 1~4)

Out-of-Pocket Expenses for the Program

- Medical Equipment Assets (NTD): _____ (To be completed by TVGH; please calculate based on the depreciated residual value as of the end of 2022)
- Medical Consumables Expenses (NTD): _____ (To be completed by TVGH)

Medical Diagnosis and Treatment Expenses

- Medical Expenses (NTD): _____ (To be completed by TVGH; includes registration fees, surgery fees, and hospitalization costs...etc.)
- Out-of-Pocket Medication Expenses (NTD): _____ (To be completed by TVGH)
- Transportation Costs (NTD): _____ (To be completed by the patient)
- Caregiver Costs (NTD): _____ (To be completed by the patient)
- Other (please specify) (NTD): _____

3.3.2 Time (Days / Occurrences / Hours) (Calculation period: 2022/01/01 to 2022/12/31)

- Number of follow-up visits: _____ times (To be completed by TVGH)
- Average waiting time per follow-up visit: _____ hours (To be completed by the patient)
- Number of times accompanying the patient to visits: _____ times (To be completed by the

patient's family member)

- Average time spent accompanying each visit: _____ hours (To be completed by the patient's family member)
- Average caregiving time: _____ hours (To be completed by the patient or family member)
- Other (please specify): _____ (days / times / hours)

■ **Outcome Indicators**

Question 4

Please respond to the following outcome indicator questions based on your stakeholder role. Reflect on the changes that have occurred as a result of the “National Health Insurance Post-Acute Care Program for Heart Failure” implemented by Taichung Veterans General Hospital (TVGH), and indicate or describe the impact you experienced.

Please assess the changes by comparing your situation *“before” and “after”* participation in the program.

Organizer (National Health Insurance Administration)

Indicator 1

This program, along with the following related statistical data, is believed to enhance the accuracy of future policy or program development, and provides *Strengthened Confidence in Program Governance and Decision-Making* program outcomes. (Stable case enrollment numbers, Reduced repeat emergency visits, Reduced hospital readmission rates, Lower annual mortality rate, Improved overall heart failure (HF) medication adherence indicators, Improved patient mobility and exercise intensity, Increased number and rate of follow-up visits to rehabilitation outpatient clinics)

- To what extent do you agree with the stated outcome of change? (%) _____ (Please enter a value between 0 and 100)
- How important is this outcome of change to you? (Score) _____ (Please enter a value between 0 and 10)
- Other comments (if any): _____

Program Executors (TVGH) 1 – Program Leader

Indicator 2

Regular monitoring of the program’s performance indicators and access to reliable quantitative data have enhanced the hospital’s precision in setting improvement targets, contributing to a greater *Strengthen Professional Accomplishment* over the program.

- To what extent do you agree with the stated outcome of change? (%) _____ (Please enter a value between 0 and 100)
- How important is this outcome of change to you? (Score) _____ (Please enter a value between 0 and 10)
- Other comments (if any): _____

Program Executors (TVGH) 2 – Cardiovascular Center Physicians

Indicator 3

Access to reliable quantitative data has enhanced *confidence in clinical decision-making* during the treatment process.

- To what extent do you agree with the stated outcome of change? (%) _____ (Please enter a value between 0 and 100)
- How important is this outcome of change to you? (Score) _____ (Please enter a value between 0 and 10)
- Other comments (if any): _____

Program Executors (TVGH) 3 – Case Managers

Indicator 4

Providing integrated consultation and services has enhanced personal professional development and increased *Confidence in Professional Capability*.

- To what extent do you agree with the stated outcome of change? (%) _____ (Please enter a value between 0 and 100)
- How important is this outcome of change to you? (Score) _____ (Please enter a value between 0 and 10)
- Other comments (if any): _____

Program Executors (TVGH) 4 – Various Healthcare Professionals

Indicator 5

Providing integrated consultation and services has enhanced personal professional development and increased *Confidence in Professional Capability*.

- To what extent do you agree with the stated outcome of change? (%) _____ (Please enter a value between 0 and 100)
- How important is this outcome of change to you? (Score) _____ (Please enter a value between 0 and 10)
- Other comments (if any): _____

Patient (Heart Failure NYHA FC II~III) Group 1: Heart Failure Patient (age over 80)

Indicator 6

Receiving comprehensive medical care has provided a strong *Emotional Security*.

- To what extent do you agree with the stated outcome of change? (%) _____ (Please enter a value between 0 and 100)
- How important is this outcome of change to you? (Score) _____ (Please enter a value between 0 and 10)
- Other comments (if any): _____

Indicator 7

Receiving comprehensive and integrated care has contributed to stable recovery, improved physical condition, and enhanced quality of life—leading to *Strengthen Self-Efficacy & Confidence*.

- To what extent do you agree with the stated outcome of change? (%) _____ (Please enter a value between 0 and 100)
- How important is this outcome of change to you? (Score) _____ (Please enter a value between 0 and 10)
- Other comments (if any): _____

Patient (Heart Failure NYHA FC II~III) Group 2: Heart Failure Patient (age 60–80)

Indicator 8

Receiving comprehensive medical care has provided a strong *Emotional Security*.

- To what extent do you agree with the stated outcome of change? (%) _____ (Please enter a value between 0 and 100)
- How important is this outcome of change to you? (Score) _____ (Please enter a value between 0 and 10)
- Other comments (if any): _____

Indicator 9

Receiving comprehensive and integrated care has contributed to stable recovery, improved physical condition, and enhanced quality of life—leading to *Strengthen Self-Efficacy & Confidence*.

- To what extent do you agree with the stated outcome of change? (%) _____ (Please enter a value between 0 and 100)
- How important is this outcome of change to you? (Score) _____ (Please enter a value between 0 and 10)
- Other comments (if any): _____

Indicator 10

Health has not fully returned to pre-illness levels, resulting in necessary adjustments or reductions in job responsibilities or workload. This has affected financial stability and led to ***Financial pressure arising.***

- To what extent do you agree with the stated outcome of change? (%) _____ (Please enter a value between 0 and 100)
- How important is this outcome of change to you? (Score) _____ (Please enter a value between 0 and 10)
- Other comments (if any): _____

Patient (Heart Failure NYHA FC II~III) Group 3: Heart Failure Patient (age under 60)

Indicator 11

Receiving comprehensive medical care has provided a strong ***Emotional Security.***

- To what extent do you agree with the stated outcome of change? (%) _____ (Please enter a value between 0 and 100)
- How important is this outcome of change to you? (Score) _____ (Please enter a value between 0 and 10)
- Other comments (if any): _____

Indicator 12

Receiving comprehensive and integrated care has contributed to stable recovery, improved physical condition, and enhanced quality of life—leading to ***Strengthen Self-Efficacy & Confidence.***

- To what extent do you agree with the stated outcome of change? (%) _____ (Please enter a value between 0 and 100)
- How important is this outcome of change to you? (Score) _____ (Please enter a value between 0 and 10)
- Other comments (if any): _____

Indicator 13

Health has not fully returned to pre-illness levels, resulting in necessary adjustments or reductions in job responsibilities or workload. This has affected financial stability and led to ***Financial pressure arising.***

- To what extent do you agree with the stated outcome of change? (%) _____ (Please enter a value between 0 and 100)
- How important is this outcome of change to you? (Score) _____ (Please enter a value between 0 and 10)
- Other comments (if any): _____

Caregivers of Heart Failure Patients – Family of Patient Group 1 (age over 80)

Indicator 14

Receiving comprehensive medical consultation services and complete health education guidance has provided a strong ***Emotional Security***.

- To what extent do you agree with the stated outcome of change? (%) _____ (Please enter a value between 0 and 100)
- How important is this outcome of change to you? (Score) _____ (Please enter a value between 0 and 10)
- Other comments (if any): _____

Indicator 15

As the patient’s condition has stabilized and improved, the time required for caregiving has decreased, allowing for more personal discretionary time and a greater ***Burden Relief***.

- To what extent do you agree with the stated outcome of change? (%) _____ (Please enter a value between 0 and 100)
- How important is this outcome of change to you? (Score) _____ (Please enter a value between 0 and 10)
- Other comments (if any): _____

Caregivers of Heart Failure Patients – Family of Patient Group 2 (age 60–80)

Indicator 16

Receiving comprehensive medical consultation services and complete health education guidance has provided a strong ***Emotional Security***.

- To what extent do you agree with the stated outcome of change? (%) _____ (Please enter a value between 0 and 100)
- How important is this outcome of change to you? (Score) _____ (Please enter a value between 0 and 10)
- Other comments (if any): _____

Indicator 17

As the patient’s condition has stabilized and improved, the time required for caregiving has decreased, allowing for more personal discretionary time and a greater ***Burden Relief***.

- To what extent do you agree with the stated outcome of change? (%) _____ (Please enter a value between 0 and 100)
- How important is this outcome of change to you? (Score) _____ (Please enter a value between 0 and 10)
- Other comments (if any): _____

Indicator 18

Receiving comprehensive medical consultation services and complete health education guidance has provided a strong *Emotional Security*.

- To what extent do you agree with the stated outcome of change? (%) _____ (Please enter a value between 0 and 100)
- How important is this outcome of change to you? (Score) _____ (Please enter a value between 0 and 10)
- Other comments (if any): _____

Indicator 19

As the patient's condition has stabilized and improved, the time required for caregiving has decreased, allowing for more personal discretionary time and a greater *Burden Relief*.

- To what extent do you agree with the stated outcome of change? (%) _____ (Please enter a value between 0 and 100)
- How important is this outcome of change to you? (Score) _____ (Please enter a value between 0 and 10)
- Other comments (if any): _____

■ **Do not Over Claim**

Question 5 Duration

How long do you think the outcomes you indicated in Question 4 (i.e., the changes you experienced) will continue to have an impact one year from now?

Subgroup	Indicators		Duration
Organizer (National Health Insurance Administration)	Indicator 1	Strengthened Confidence in Program Governance and Decision-Making	<input type="checkbox"/> 1y <input type="checkbox"/> 2y <input type="checkbox"/> 3y <input type="checkbox"/> 4y <input type="checkbox"/> 5y
Program Executors (TVGH) 1 - Program Leader	Indicator 2	Strengthen Professional Accomplishment	<input type="checkbox"/> 1y <input type="checkbox"/> 2y <input type="checkbox"/> 3y <input type="checkbox"/> 4y <input type="checkbox"/> 5y
Program Executors (TVGH) 2 - Cardiovascular Center Physicians	Indicator 3	Confidence in Clinical Decision-Making	<input type="checkbox"/> 1y <input type="checkbox"/> 2y <input type="checkbox"/> 3y <input type="checkbox"/> 4y <input type="checkbox"/> 5y
Program Executors (TVGH) 3 - Case Managers	Indicator 4	Confidence in Professional Capability	<input type="checkbox"/> 1y <input type="checkbox"/> 2y <input type="checkbox"/> 3y <input type="checkbox"/> 4y <input type="checkbox"/> 5y
Various Healthcare Professionals	Indicator 5	Confidence in Professional Capability	<input type="checkbox"/> 1y <input type="checkbox"/> 2y <input type="checkbox"/> 3y <input type="checkbox"/> 4y <input type="checkbox"/> 5y
Patient (Heart Failure NYHA FC II~III) Group 1: Heart Failure Patient (age over 80)	Indicator 6	Enhanced Emotional Security	<input type="checkbox"/> 1y <input type="checkbox"/> 2y <input type="checkbox"/> 3y <input type="checkbox"/> 4y <input type="checkbox"/> 5y
	Indicator 7	Strengthen Self-Efficacy & Confidence	<input type="checkbox"/> 1y <input type="checkbox"/> 2y <input type="checkbox"/> 3y <input type="checkbox"/> 4y <input type="checkbox"/> 5y
Patient (Heart Failure NYHA FC II~III) Group 2: Heart Failure Patient (age 60–80)	Indicator 8	Enhanced Emotional Security	<input type="checkbox"/> 1y <input type="checkbox"/> 2y <input type="checkbox"/> 3y <input type="checkbox"/> 4y <input type="checkbox"/> 5y
	Indicator 9	Strengthen Self-Efficacy & Confidence	<input type="checkbox"/> 1y <input type="checkbox"/> 2y <input type="checkbox"/> 3y <input type="checkbox"/> 4y <input type="checkbox"/> 5y
	Indicator 10	Financial pressure arising	<input type="checkbox"/> 1y <input type="checkbox"/> 2y <input type="checkbox"/> 3y <input type="checkbox"/> 4y <input type="checkbox"/> 5y
Patient (Heart Failure NYHA FC II~III) Group 3: Heart Failure Patient (age under 60)	Indicator 11	Enhanced Emotional Security	<input type="checkbox"/> 1y <input type="checkbox"/> 2y <input type="checkbox"/> 3y <input type="checkbox"/> 4y <input type="checkbox"/> 5y
	Indicator 12	Strengthen Self-Efficacy & Confidence	<input type="checkbox"/> 1y <input type="checkbox"/> 2y <input type="checkbox"/> 3y <input type="checkbox"/> 4y <input type="checkbox"/> 5y
	Indicator 13	Financial pressure arising	<input type="checkbox"/> 1y <input type="checkbox"/> 2y <input type="checkbox"/> 3y <input type="checkbox"/> 4y <input type="checkbox"/> 5y
Caregivers of Heart Failure Patients - Family of Patient Group 1 (age over 80)	Indicator 14	Enhanced Emotional Security	<input type="checkbox"/> 1y <input type="checkbox"/> 2y <input type="checkbox"/> 3y <input type="checkbox"/> 4y <input type="checkbox"/> 5y
	Indicator 15	Strengthen Self-Efficacy & Confidence	<input type="checkbox"/> 1y <input type="checkbox"/> 2y <input type="checkbox"/> 3y <input type="checkbox"/> 4y <input type="checkbox"/> 5y

Subgroup	Indicators		Duration
Caregivers of Heart Failure Patients - Family of Patient Group 2 (age 60–80)	Indicator 16	Enhanced Emotional Security	<input type="checkbox"/> 1y <input type="checkbox"/> 2y <input type="checkbox"/> 3y <input type="checkbox"/> 4y <input type="checkbox"/> 5y
	Indicator 17	Strengthen Self-Efficacy & Confidence	<input type="checkbox"/> 1y <input type="checkbox"/> 2y <input type="checkbox"/> 3y <input type="checkbox"/> 4y <input type="checkbox"/> 5y
Caregivers of Heart Failure Patients - Family of Patient Group 3 (age under 60)	Indicator 18	Enhanced Emotional Security	<input type="checkbox"/> 1y <input type="checkbox"/> 2y <input type="checkbox"/> 3y <input type="checkbox"/> 4y <input type="checkbox"/> 5y
	Indicator 19	Strengthen Self-Efficacy & Confidence	<input type="checkbox"/> 1y <input type="checkbox"/> 2y <input type="checkbox"/> 3y <input type="checkbox"/> 4y <input type="checkbox"/> 5y

Question 6 Deadweight

Even without the implementation of the "National Health Insurance Post-Acute Care Integration Program – Heart Failure", *how likely* do you think the changes you experienced (as described in Question 4) would have occurred anyway in your life?

For example: Some improvements in a patient’s health may have resulted from their pre-existing habit of regular exercise, rather than being directly triggered by participation in the program. In such cases, the benefits are considered deadweight — outcomes that would have happened regardless of the intervention — and will be excluded from the SROI impact calculation, as they cannot be fully attributed to the program implemented by Taichung Veterans General Hospital (TVGH).

Note: After selecting the appropriate range, please write the specific value from the selected range in the blank space.

Example:

0 1–20 21–40 41–60 61–80 81–99 100 23%

Subgroup	Indicators		Probability of the outcome occurring anyway (%)
Organizer (National Health Insurance Administration)	Indicator 1	Strengthened Confidence in Program Governance and Decision-Making	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 _____%
Program Executors (TVGH) 1 - Program Leader	Indicator 2	Strengthen Professional Accomplishment	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 _____%
Program Executors (TVGH) 2 - Cardiovascular Center Physicians	Indicator 3	Confidence in Clinical Decision-Making	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 _____%
Program Executors (TVGH) 3 - Case Managers	Indicator 4	Confidence in Professional Capability	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 _____%
Program Executors (TVGH) 4 - Various Healthcare Professionals	Indicator 5	Confidence in Professional Capability	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 _____%

Subgroup	Indicators		Probability of the outcome occurring anyway (%)
Patient (Heart Failure NYHA FC II~III) Group 1: Heart Failure Patient (over 80)	Indicator 6	Enhanced Emotional Security	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 ____%
	Indicator 7	Strengthen Self-Efficacy & Confidence	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 ____%
Patient (Heart Failure NYHA FC II~III) Group 2: Heart Failure Patient (60~80)	Indicator 8	Enhanced Emotional Security	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 ____%
	Indicator 9	Strengthen Self-Efficacy & Confidence	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 ____%
	Indicator 10	Financial pressure arising	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 ____%
Patient (Heart Failure NYHA FC II~III) Group 3: Heart Failure Patient (under 60)	Indicator 11	Enhanced Emotional Security	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 ____%
	Indicator 12	Strengthen Self-Efficacy & Confidence	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 ____%
	Indicator 13	Financial pressure arising	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 ____%
Caregivers of Heart Failure Patients - Family of Patient Group 1 (over 80)	Indicator 14	Enhanced Emotional Security	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 ____%
	Indicator 15	Strengthen Self-Efficacy & Confidence	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 ____%
Caregivers of Heart Failure Patients - Family of Patient Group 2 (60~80)	Indicator 16	Enhanced Emotional Security	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 ____%
	Indicator 17	Strengthen Self-Efficacy & Confidence	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 ____%
Caregivers of Heart Failure Patients - Family of Patient Group 3 (under 60)	Indicator 18	Enhanced Emotional Security	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 ____%
	Indicator 19	Strengthen Self-Efficacy & Confidence	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 ____%

Question 7 Attribution Factor

Were the outcome changes you described in Question 4 jointly influenced by *other organizations* or programs in addition to the National Health Insurance Post-Acute Care Program for Heart Failure?

If yes, what is the approximate percentage of contribution from these *other organizations*?

Estimated contribution of other organizations to the outcome (%)

Note: After selecting the appropriate range, please write the specific value from the selected range in the blank space.

Example:

0 1–20 21–40 41–60 61–80 81–99 100 23%

Subgroup	Indicators		Percentage of the outcome attributable to other organizations (%)
Organizer (National Health Insurance Administration)	Indicator 1	Strengthened Confidence in Program Governance and Decision-Making	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 ____%
Program Executors (TVGH) 1 - Program Leader	Indicator 2	Strengthen Professional Accomplishment	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 ____%
Program Executors (TVGH) 2 - Cardiovascular Center Physicians	Indicator 3	Confidence in Clinical Decision-Making	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 ____%
Program Executors (TVGH) 3 - Case Managers	Indicator 4	Confidence in Professional Capability	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 ____%
Program Executors (TVGH) 4 - Various Healthcare Professionals	Indicator 5	Confidence in Professional Capability	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 ____%

Subgroup	Indicators		Percentage of the outcome attributable to other organizations (%)
Patient (Heart Failure NYHA FC II~III) Group 1: Heart Failure Patient (over 80)	Indicator 6	Enhanced Emotional Security	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 ____%
	Indicator 7	Strengthen Self-Efficacy & Confidence	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 ____%
Patient (Heart Failure NYHA FC II~III) Group 2: Heart Failure Patient (60~80)	Indicator 8	Enhanced Emotional Security	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 ____%
	Indicator 9	Strengthen Self-Efficacy & Confidence	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 ____%
	Indicator 10	Financial pressure arising	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 ____%
Patient (Heart Failure NYHA FC II~III) Group 3: Heart Failure Patient (under 60)	Indicator 11	Enhanced Emotional Security	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 ____%
	Indicator 12	Strengthen Self-Efficacy & Confidence	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 ____%
	Indicator 13	Financial pressure arising	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 ____%
Caregivers of Heart Failure Patients - Family of Patient Group 1 (over 80)	Indicator 14	Enhanced Emotional Security	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 ____%
	Indicator 15	Strengthen Self-Efficacy & Confidence	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 ____%
Caregivers of Heart Failure Patients - Family of Patient Group 2 (60~80)	Indicator 16	Enhanced Emotional Security	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 ____%
	Indicator 17	Strengthen Self-Efficacy & Confidence	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 ____%
Caregivers of Heart Failure Patients - Family of Patient Group 3 (under 60)	Indicator 18	Enhanced Emotional Security	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 ____%
	Indicator 19	Strengthen Self-Efficacy & Confidence	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 ____%

Question 8 Drop-off Factor

Please indicate the estimated percentage by which you believe the impact of the outcomes identified in Question 4 will *decrease in the next year*. This reflects the drop-off rate, which helps ensure an accurate estimation of long-term social value.

Note: After selecting the appropriate range, please write the specific value from the selected range in the blank space.

Example:

0 1-20 21-40 41-60 61-80 81-99 100 23%

Subgroup	Indicators		Rate of Outcome Drop-off (%)
Organizer (National Health Insurance Administration)	Indicator 1	Strengthened Confidence in Program Governance and Decision-Making	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 ____%
Program Executors (TVGH) 1 - Program Leader	Indicator 2	Strengthen Professional Accomplishment	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 ____%
Program Executors (TVGH) 2 - Cardiovascular Center Physicians	Indicator 3	Confidence in Clinical Decision-Making	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 ____%
Program Executors (TVGH) 3 - Case Managers	Indicator 4	Confidence in Professional Capability	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 ____%
Program Executors (TVGH) 4 - Various Healthcare Professionals	Indicator 5	Confidence in Professional Capability	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 ____%

Subgroup	Indicators		Rate of Outcome Drop-off (%)
Patient (Heart Failure NYHA FC II~III) Group 1: Heart Failure Patient (over 80)	Indicator 6	Enhanced Emotional Security	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 _____%
	Indicator 7	Strengthen Self-Efficacy & Confidence	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 _____%
Patient (Heart Failure NYHA FC II~III) Group 2: Heart Failure Patient (60~80)	Indicator 8	Enhanced Emotional Security	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 _____%
	Indicator 9	Strengthen Self-Efficacy & Confidence	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 _____%
	Indicator 10	Financial pressure arising	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 _____%
Patient (Heart Failure NYHA FC II~III) Group 3: Heart Failure Patient (under 60)	Indicator 11	Enhanced Emotional Security	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 _____%
	Indicator 12	Strengthen Self-Efficacy & Confidence	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 _____%
	Indicator 13	Financial pressure arising	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 _____%
Caregivers of Heart Failure Patients - Family of Patient Group 1 (over 80)	Indicator 14	Enhanced Emotional Security	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 _____%
	Indicator 15	Strengthen Self-Efficacy & Confidence	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 _____%
Caregivers of Heart Failure Patients - Family of Patient Group 2 (60~80)	Indicator 16	Enhanced Emotional Security	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 _____%
	Indicator 17	Strengthen Self-Efficacy & Confidence	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 _____%
Caregivers of Heart Failure Patients - Family of Patient Group 3 (under 60)	Indicator 18	Enhanced Emotional Security	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 _____%
	Indicator 19	Strengthen Self-Efficacy & Confidence	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 _____%

Question 9 Displacement Factor

Do you think the outcomes generated by this program might have *come at the expense of others* (e.g., other patients), other organizations, or other points in time?

In other words, if you had not benefited, do you believe these resources *might have otherwise been allocated to other individuals, organizations, or time periods?*

Note: After selecting the appropriate range, please write the specific value from the selected range in the blank space.

Example:

0 1-20 21-40 41-60 61-80 81-99 100 23%

Subgroup	Indicators		Percentage Displacement (%)
Organizer (National Health Insurance Administration)	Indicator 1	Strengthened Confidence in Program Governance and Decision-Making	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 _____%
Program Executors (TVGH) 1 - Program Leader	Indicator 2	Strengthen Professional Accomplishment	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 _____%
Program Executors (TVGH) 2 - Cardiovascular Center Physicians	Indicator 3	Confidence in Clinical Decision-Making	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 _____%
Program Executors (TVGH) 3 - Case Managers	Indicator 4	Confidence in Professional Capability	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 _____%
Program Executors (TVGH) 4 - Various Healthcare Professionals	Indicator 5	Confidence in Professional Capability	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 _____%

Subgroup	Indicators		Percentage Displacement (%)
Patient (Heart Failure NYHA FC II~III) Group 1: Heart Failure Patient (over 80)	Indicator 6	Enhanced Emotional Security	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 _____%
	Indicator 7	Strengthen Self-Efficacy & Confidence	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 _____%
Patient (Heart Failure NYHA FC II~III) Group 2: Heart Failure Patient (60~80)	Indicator 8	Enhanced Emotional Security	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 _____%
	Indicator 9	Strengthen Self-Efficacy & Confidence	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 _____%
	Indicator 10	Financial pressure arising	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 _____%
Patient (Heart Failure NYHA FC II~III) Group 3: Heart Failure Patient (under 60)	Indicator 11	Enhanced Emotional Security	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 _____%
	Indicator 12	Strengthen Self-Efficacy & Confidence	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 _____%
	Indicator 13	Financial pressure arising	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 _____%
Caregivers of Heart Failure Patients - Family of Patient Group 1 (over 80)	Indicator 14	Enhanced Emotional Security	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 _____%
	Indicator 15	Strengthen Self-Efficacy & Confidence	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 _____%
Caregivers of Heart Failure Patients - Family of Patient Group 2 (60~80)	Indicator 16	Enhanced Emotional Security	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 _____%
	Indicator 17	Strengthen Self-Efficacy & Confidence	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 _____%
Caregivers of Heart Failure Patients - Family of Patient Group 3 (under 60)	Indicator 18	Enhanced Emotional Security	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 _____%
	Indicator 19	Strengthen Self-Efficacy & Confidence	<input type="checkbox"/> 0 <input type="checkbox"/> 1~20 <input type="checkbox"/> 21~40 <input type="checkbox"/> 41~60 <input type="checkbox"/> 61~80 <input type="checkbox"/> 81~99 <input type="checkbox"/> 100 _____%

Question 10

If the “Post-Acute Care Program for Heart Failure under National Health Insurance” has caused any negative impacts or changes to you, please describe them below:

(Free-text response area)

Thank you for taking the time to complete this questionnaire!

Appendix C: Stakeholder Engagement Materials

Consensus meeting

This question set was used during the consensus meeting to validate the completeness of stakeholder identification, prevent omission of relevant groups, and assess which stakeholders should or should not be included in the SROI model.

I. Your role in the program?

II. Identifying stakeholders who may have been missed

Q1: Based on your experience, are there individuals or groups affected by the program who have not yet been included?

Q2: How do these individuals or groups interact with the program, and what is the level of impact on them?

Q3: Would including these groups provide a more complete and fair representation of the stakeholder population?

III. Identifying stakeholders who may reasonably be excluded

Q1: Are there stakeholders who interact with the program but, in your experience, do not experience any meaningful change as a result of it?

Q2: Are there groups whose involvement is purely routine, meaning they interact with the program but do not experience attributable outcomes?

Q3: For such groups, would it be reasonable to exclude them from the SROI analysis? Why or why not?

Q4: Are there any groups whose impact is extremely indirect or minimal and therefore may not demonstrate outcomes required for inclusion in the SROI model?

IV. Ensuring fair representation of stakeholder groups

Q1: Do the currently included stakeholder groups adequately represent the broader service population or affected groups?

Q2: Are there any stakeholder groups whose representation is insufficient or missing?

Q3: Which groups should be added or strengthened to ensure fair representation?

SROI workshop

The SROI workshop used structured open-ended questions to identify stakeholders with non-routine changes and clarify interactions. We checked whether inclusion improves completeness, representativeness, and supports impact/weighting. Each decision had concise, traceable reasons against set criteria (impact, relevance/weight, participation/affectedness, critical inputs, verifiability, social value). Routine-only roles with no attributable change were marked low materiality and excluded.

I. Your role in the program? Your Ages?

II. Identifying additional stakeholders

Q1. Based on observed practice, list individuals or groups affected but not yet included. Provide a brief note of the observed change.

Q2. For each listed individual or group, describe the interaction with the program and the nature of impact. Refer to the following aspects as applicable:

- Direct participation in the care process or clear effect from changes in care
- Critical services or inputs that led to non-routine changes
- Ability to provide important perspectives on outcomes
- Reflection of social-level value effects

Q3: Indicate whether including these individuals or groups improves the stakeholder list's completeness and representativeness for subsequent analysis. If a role is routine with no attributable change, note as "low materiality" and do not include in primary analysis.

III. Confirmation of representation & justification

Q1: State whether the identified stakeholders adequately represent the service population and affected groups, supporting interpretation of outcome pathways and valuation.

Q2: Recommend add / keep / exclude decisions, with a brief rationale. Use the points below only as needed:

- Observed program-related change (impact)
- Helps interpret outcome pathways or determine weights (relevance/weight)
- Directly involved in care or clearly affected by care changes
- Provided critical services or inputs leading to non-routine changes
- Can provide important perspectives
- Reflects social-level value
- Routine-only participation with no attributable change → low materiality (exclude from primary analysis)

Q3: Note how the recommended adjustment affects coverage and reasonableness (e.g., covers a care-stage gap, includes a key support role, reflects policy-level effects, or excludes a routine-only role).

IV. Stakeholder Categorization

Q1: List the care delivery team roles that should be treated as distinct subgroups, and explain why they are separated (for example: patient interaction frequency, care stages involved, level of influence, or outcome differences).

Q2: Describe each subgroup's main involvement points in the care pathway (for example: intake, assessment, intervention, follow-up) and their typical contributions (for example: decision-making, coordination, follow-up, communication with family).

Q3: If age-based patient segmentation is needed, explain the segmentation method and criteria, and describe the specific differences (for example: health outcomes, recovery level, life needs, care dependence, emotional response).

Q4: If segmenting primary caregivers by the patient's age is needed, explain the segmentation method and criteria, and describe the specific differences (for example: time invested, burden level, life impact, role conflict).

Q5: Explain the evidence sources and access methods that support the above segmentations (for example: what records, who holds them, how to retrieve, expected timeline).

V. Confirmation of Stakeholders

Q1: For each listed subgroup, state whether non-routine changes are present, what key perspectives can be provided, and how these contribute to interpreting the impact pathway and valuation/weighting.

Q2: For each listed subgroup, provide a decision of add, retain, or exclude, and explain the main reason; if excluded, state that it is low materiality or lacks evidence and specify the concrete cause.

Q3: Explain how these decisions affect overall coverage and analytical soundness (for example: covering a specific care stage, including key support roles, reflecting policy-level effects, excluding routine-only roles).

VI. Preliminary establishment of the outcome chain and materiality criteria

Q1: How did you engage with the program? Which components did you participate in, and how frequently?

Q2: What resources or support did you receive or offer? Before changes occurred, what immediate actions or results took place?

Q3: Since joining, what are the most important changes you experienced? How did these changes unfold step by step (sequence of events/outcomes)? Which changes best represent the program's impact, and why?

Q4: How long did the initial changes last? What subsequent and final (long-term) outcomes emerged, and how long did each last?

Q5: Did any unexpected (unintended) changes occur (positive or negative)? Did the program cause inconvenience, stress, or other negative effects?

In-depth Group Interview

I. Which sub-group of stakeholders you are? Your Ages?

II. Input, Activity, and Output

Q1: What resources or support did you receive/offer from/in the program?

Q2: Which components of the program did you participate in?

Q3: What immediate results or actions happened before change occurred?

III. Identifying outcomes & locating them within a chain of outcomes

Q1: What important changes have you experienced since participating in the program?

Q2: How did these changes occur? Please describe the sequence of events or chain of outcomes leading to the change.

- In this chain of events, which elements are the antecedents (triggers or conditions), which are the intermediate processes, and which are the final outcomes?
- Which outcome do you believe best represents the program's impact? Why not the other stages?
- If the program had not existed, which parts of the chain would still occur, and which would not occur or would be weaker?
- Approximately when did this outcome emerge, and which specific activities or touchpoints was it connected to?

Q3: Which of these changes best represent the program's impact, and why?

IV. Final Outcomes Identification

Q1: How long did the initial changes last after you first joined the program?

Q2: What subsequent changes occurred, and how long did each of these changes last?

Q3: What long-term outcomes did these changes eventually lead to, and for how long have these long-term outcomes continued?

V. Unintended and negative outcomes

Q1: Have any unexpected changes occurred - positive or negative?

Q2: Did the program cause any difficulties, inconvenience, added stress, or other negative effects?

In-depth Group Interview

Well-defined Outcomes

I. Which sub-group of stakeholders you are? Your Ages?

II. Materiality

Q1: How important is this outcome to the primary stakeholders? (1 = Not at all important; 5 = Extremely important)

Q2: Do the number of people affected (or share of services) and the intensity of impact meet the inclusion threshold? (1 = Clearly insufficient; 5 = Significantly met)

Q3: Do the affected stakeholders generally care about this outcome and expect it to be reported? (1 = Hardly concerned; 5 = Highly concerned)

III. Manageability

Q1: Is the causal link between this outcome and the project activities clear, and can it be sustained through project design? (1 = Unclear / difficult to control; 5 = Clear and controllable)

Q2: Are existing resources (personnel, time, systems) sufficient to track and continuously improve this outcome? (1 = Insufficient; 5 = Sufficient)

Q3: Can negative or unintended effects related to this outcome be identified and managed without offsetting the primary impact? (1 = Uncontrollable; 5 = Controllable)

IV. Measurable/Valuable

Q1: Are there existing or reasonably obtainable data and records to quantify this outcome? (1 = Nearly impossible; 5 = Clearly feasible)

Q2: Can this outcome be linked to a credible valuation method (e.g., market substitute, avoided cost, willingness-to-pay, or standard shadow prices)? (1 = No suitable method; 5 = Method is clear)

Q3: Is this outcome independent (i.e., does not overlap causally or in value with other outcomes) and suitable for standalone valuation? (1 = Highly overlapping; 5 = Independent and clear)

V. Overall Considerations

Q1: Single-choice item: Recommendation for this outcome chain

A. Retain for Outcome List

B. Merge (please specify merge target: _____)

C. Defer/Remove (briefly state the main reason: insufficient materiality / not manageable / not measurable for valuation)

Q2: Are there any other aspects that need to be considered?

In-depth Group Interview

Outcome Materiality Threshold Discussion Questions

I. Materiality assessment and confirming inclusion/exclusion

Q1: Based on your level of involvement with the program, which changes are most important to you, and why?

Q2: To what extent did these changes affect your life, health, workload, or workflow...etc.?

Q3: Among all stakeholder groups, whose changes were the most significant or valuable?

Q4: Are there stakeholders who interact with the program but do not experience meaningful changes, and therefore may not be suitable for inclusion in the SROI analysis?

II. Materiality Threshold Discussion Questions

Q1: What types of changes should be considered as having a significant depth for stakeholders?

- Does the change meaningfully affect daily life, health, emotional well-being, financial burden, or family functioning...etc.?
- Does it represent a clear, noticeable, and meaningful changes?

Q2: According to “Amount of change per stakeholder (depth)” in SROI Value Map, at what percentage level should a change be considered “significant”?

- Is a Depth score of 50% or higher (lower) an appropriate representation of a meaningful or substantial change?
- Does a Depth score below 50% indicate insufficient strength or limited impact?

Q3: How should we determine whether a change is significant at the group level?

- Does a group average Depth \geq 50% mean that most stakeholders genuinely experience meaningful improvement?
- If a group average Depth $<$ 50%, does this indicate that the change is not strong enough to be included in the SROI analysis?

Q4: Why might 50% be an appropriate cut-off point for materiality?

- Does 50% represent a clear dividing line between minor and substantial change?
- Does it reflect that at least half of the stakeholders experience a meaningful, non-trivial changes?
- Is this value consistent with stakeholders’ perception of what constitutes significant changes?

Q5: Should outcomes with a group average Depth $<$ 50% be excluded? Why or why not?

- Does this indicate limited or insufficient impact?
- Does it suggest that most stakeholders did not meaningfully benefit?

Q6: Should outcomes with a group average Depth \geq 50% be included? Why or why not?

- Does this reflect genuine value experienced by stakeholders?
- Does it meet the principle of materiality defined by stakeholders?

Q7: Further considerations regarding materiality.

- If more than half of the stakeholders experienced the change, but the group average Depth is less than 50%, should this outcome be considered material? Why or why not?
- If fewer than half of the stakeholders experienced the change, but the group average Depth $\geq 50\%$, should this outcome be considered material? Why or why not?

In-depth Group Interview

Impact Adjustment Factors - Determining the Number of Levels (How many levels?)

Q1: How many levels do we need?

- In your view, how many levels are needed to represent differences in stakeholder outcomes or impact?
For example: 3 levels, 5 levels, or 7 levels?
- Would a greater number of levels allow us to capture more nuanced differences, or would it create unnecessary complexity for participants?
- Would fewer levels simplify the assessment, or would it fail to reflect important variations in stakeholder experiences?

Q2: Please complete the following table based on the discussion outcomes from Question 1 and with reference to the Impact Adjustment Factor Description Table provided below.

Level	Proportion	Deadweight Explanation	Displacement Explanation	Attribution Explanation	Drop-off Explanation
This field may be completed with examples such as: Very Low, Low, Moderately Low, Medium, Moderately High...etc.	Please fill in this field with the corresponding percentage range for each level (e.g., 0%, 1% - 20%, 10% - 20%, etc.).	Please complete this section by matching each level and its corresponding percentage range with the appropriate adjustment factor description, referring to the Impact Adjustment Factor Description Table below.			
Example for reference					
Low	1%~20%	Even without this program, there is a very small chance the outcome would occur.	The outcome slightly crowded out resources or services of other targets and caused a very minor value loss to other regions or stakeholders.	A very small part of the outcome was contributed by others.	Outcomes lasting more than one year experience a very minor drop-off in the following year.
Moderately Low	21%~40%	Even without this program, there is a small chance the outcome would occur.	The outcome crowded out some resources or services of other targets and caused a small value loss to other regions or stakeholders.	A small part of the outcome was contributed by others.	Outcomes lasting more than one year experience a small drop-off in the following year.
...					

Impact Adjustment Factor Description Table

Impact Adjustment Factor	Definition
Deadweight	Refers to whether the outcome would have occurred naturally even without the intervention of this program. To avoid overestimating social impact by including changes that would have happened even if the program had not taken place, this portion must be deducted.
Displacement	Refers to whether the program “shifted” existing resources or changes to other individuals or time periods, potentially diminishing value elsewhere.
Attribution	Refers to whether the outcome was jointly facilitated by other programs, personnel, or systems. For example, if a participant also received assistance from other community resources or similar programs, the impact attributable to this program should be shared with those other contributors, and only the portion attributable to this program should be valued.
Drop-off	Refers to the natural weakening of outcomes over time, especially relevant for outcomes that persist beyond one year. Without continued intervention, part of the impact may decline year by year.

Reference

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7. **Principle 1_Involve Stakeholders**
8. **Principle 2_Understanding what Changes**
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