LEARNINGS

From the
2023 United Way British Columbia TAPS Programs Co-Creation Sessions

United Way British Columbia

Working with communities in BC's North, Interior, Lower Mainland, Central & Northern Vancouver Island

UNITED for seniors in need

ACKNOWLEDGEMENTS

We express our sincere gratitude to the numerous individuals and organizations whose contributions were essential to the success of the Therapeutic Activation Program for Seniors (TAPS) Demonstration Project conducted between 2020 and 2023.

We would like to extend special thanks to Howegroup's Wynona Giannasi, Jennifer Hystad, and Elayne McIvor for their leadership in the evaluation process. Their expertise, guidance, patience, and support have greatly enriched the project and played a crucial role in its progression.

Furthermore, we are thankful to all the organizations and individuals who participated in the demonstration project and shared their insights and experiences. Their valuable contributions have significantly enhanced the project, and we appreciate their collaboration.

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INTRODUCTION AND PURPOSE

This document outlines key data points that should be used to inform the development of the TAPS program manual. From October 2020 to April 2023, the Howegroup collected data from TAPS programs and participants to explore impact, as well as general program successes, challenges, and areas for improvement. Data was also collected from funded TAPS programs to inform the development of a stream-specific operating manual. Detailed findings from these data collection processes have been summarized in the following reports. Readers are encouraged to consult these documents for more contextual and in-depth information, if of interest.

Document	Purpose	Date of Completion
Higher Needs Interim Evaluation Reports #1 & 2	The interim evaluations assessed: program design and delivery; feedback on program supports; progress toward intended outcomes and impact; key successes, challenges, and areas for improvement; and factors supporting scaling and sustainability.	Report #1: June 2021 Report #2: April 2022
Summary Report: Informing the Development of a Manual for TAPS Programs	Data was collected from TAPS programs to inform the development of stream-based Program Guidelines, Best Practices, and Operating Procedures Manuals.	February 2023
TAPS Program Profiles	Individual profiles of TAPS programs were created to explore program-specific progress and areas for future support.	February 2023
Notes from 3 Co-Creation Sessions with TAPS Programs	Co-creation sessions were held to develop further consensus on TAPS program design and delivery, as well as to identify areas for future support.	Session 1: January 2023 Session 2: March 2023 Session 3: April 2023

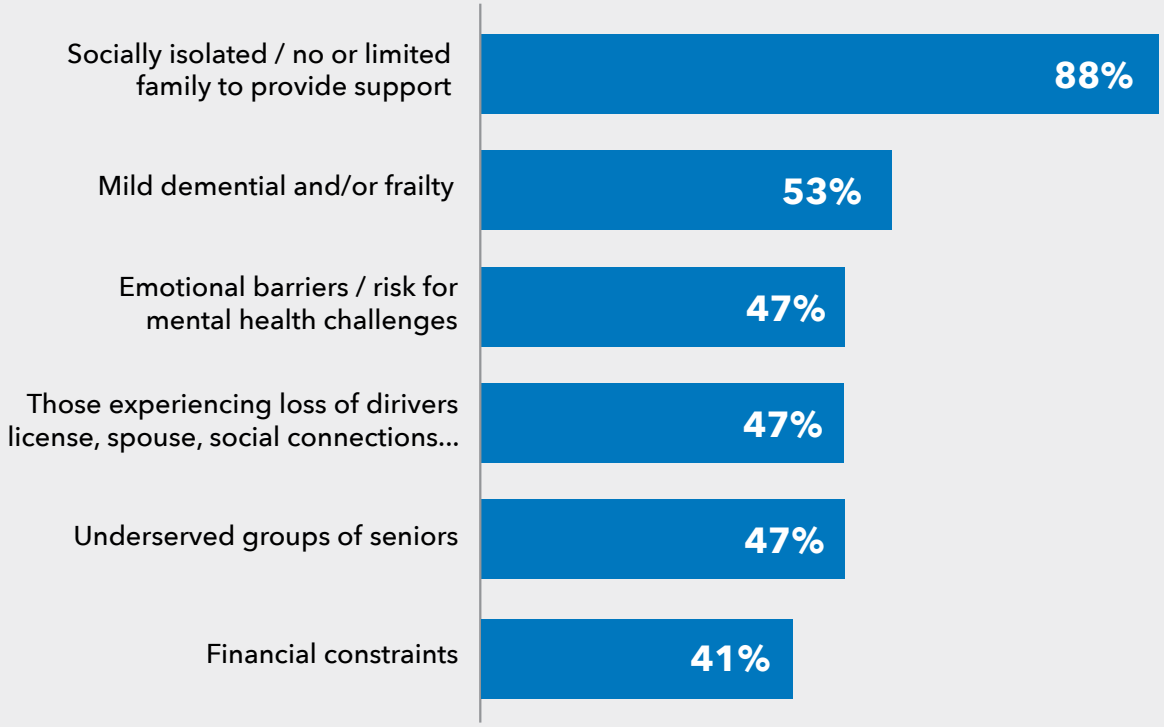
KEY DATA POINTS TO INFORM MANUAL DEVELOPMENT

1. Participants

Participants who benefit most

Programs had a high level of agreement that those who are socially isolated benefit most from the TAPS program, but did not have a consensus around additional characteristics (figure 1). Further discussions revealed programs agreed with the framing as *'those who will never be able to plan their own activities'*.

Figure 1. Agreement on characteristics of participants who benefit most from TAPS (N=16)



Short vs. long-term participants

Programs estimated that 85% of their participants are 'long-term' or have been involved for more than 3-months, while the remainder were considered 'short-term' or have been involved for 3-months or less.

2. Referrals

Referral sources to the TAPS Program

The following table provides an overview of the referrals to the programs and those the programs refer participants to. For TAPS programs, the majority of participants are referred from within the organization, home and community care, and family/friends. TAPS programs most commonly referred for information, food security, and exercise groups (table 1).

On average, the programs estimate that 40% of participants are self-referred (with a range of 0-90%).

Table 1. Referrals

Top referral sources (to the program)	• Advertisement: 7% • Family/friend: 43% • Health authority mental health services (physicians, allied health, etc.): 7% • Home and community care services (case managers, allied health, nurses, etc.): 57% • Hospital discharge planning (nurses, social workers, etc.): 7% • Other community-based agency: 36% • Our own organization: 86% • Primary care (e.g. physicians, nurse practitioners, nurses, etc.): 29% • Other: 0% • Radio: 0%
Top programs the programs refers to	• Allied health professional: 7% • Arts program: 21% • Educational opportunities: 36% • Exercise group or other physical activity opportunity: 64% • Food security services: 79% • Information and referral: 79% • Support group: 21%
% self referrals	• 40% (range 0-90%)

Developing relationships to support referrals

Community relationships

TAPS programs provided examples of what successful relationship building has looked like with community partners:

- Attending seniors fair/healthy aging fair
- City of Burnaby through the City Planner
- Hospice society (sharing space and partnership)
- Leveraging existing programming
- Non-profits in the community
- Practice with traditional culture
- Seniors' networks
- Seniors' working groups and seniors' coalition

Other less obvious community sources for relationship building and referrals:

- Beauty salons (particularly rural)
- Chamber of Commerce
- Community parades
- Credit unions
- English classes offered through various programs
- Farmers market
- Food bank
- Independent living residence
- Japanese language organizations
- Japanese-speaking lawyers
- Legion
- Lions Club
- Local newspapers (weekly columns and "tips for TAPS")
- Neighbours (word of mouth)
- Neighbourhood Houses
- Partnering with Problem and addiction gambling BC
- Programs for young mothers (to talk to their parents)
- Recreation centres
- Schools
- Seniors' halls
- Seniors housing/affordable housing
- Small business owners (provide volunteers)

Successful examples of building relationships with health professionals.

- BC 211 listing
- Case managers including central intake
- Community support workers out of physician offices
- Division of Family Practice
- Doctors of BC
- Health Select Committee meetings (community meetings)
- Home support offices
- Hospitals – discharge specifically
- Footcare nurse
- Integrated Care Coordinator through health authority
- Local Health Society
- Mental health nurses
- Older adult mental health team
- Paramedic program
- Pharmacies
- Primary Care Network
- Social workers

Factors that made it possible to build these relationships

- Alignment with Social Determinants of Health among the health care providers (impact of isolation on health)
- Being part of UW builds credibility
- Having the community behind the organizations demonstrated the impact relevant to doctors
- Perseverance
- Quick definition of what the program is about

Common referral form

Although important to the Social Prescribing and Family and Friend Caregiver streams, TAPS programs were not interested in developing a common referral form.

3. Program Elements

Core versus optional program elements of TAPS Programming

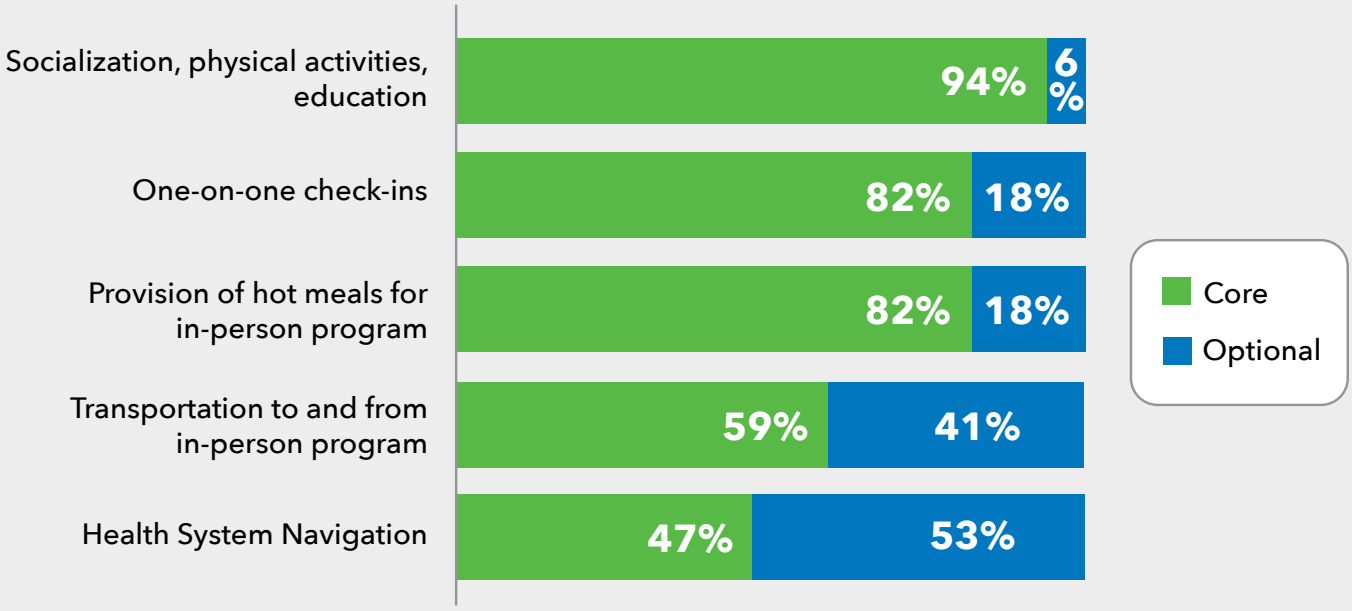
The majority suggested that the following should be core program elements (Figure 2):

- Socialization, physical activities, education
- One-on-one check-ins
- Provision of hot meals for in-person programming
- Transportation to and from in-person program

Most recommended that the following should be optional program elements:

- Health system navigation

Figure 2. Program votes on core vs. optional TAPS program elements (N=16)



Intake process

TAPS intake process were fairly consistent across programs. Most programs conducted in-person intakes, after 2-3 visits, once trust was established. Many TAPS programs invited new participants to an activity, such as lunch, to gauge interest on behalf of the senior and 'fit' with the program. A few programs offered drop-in options for participants before formally bringing them into the program. It is worth noting a great deal of variability exists around eligibility criteria for participants with some programs maintaining stringent requirements and others being very open.

Generally speaking the intake forms, other than collecting the PHN, were not seen as a barrier to the intake process. Collecting PHN was often sited as a barrier as a 'health number' was not aligned with an 'exercise and nutrition program' to many participants.

Person-centered support & co-creation of plans

TAPS programs deliver programs within the context of person-centered support (detailed below) however do not co-create formalized plans with participants. Seniors are assessed to determine needs and where referrals and wrap-around services are appropriate.

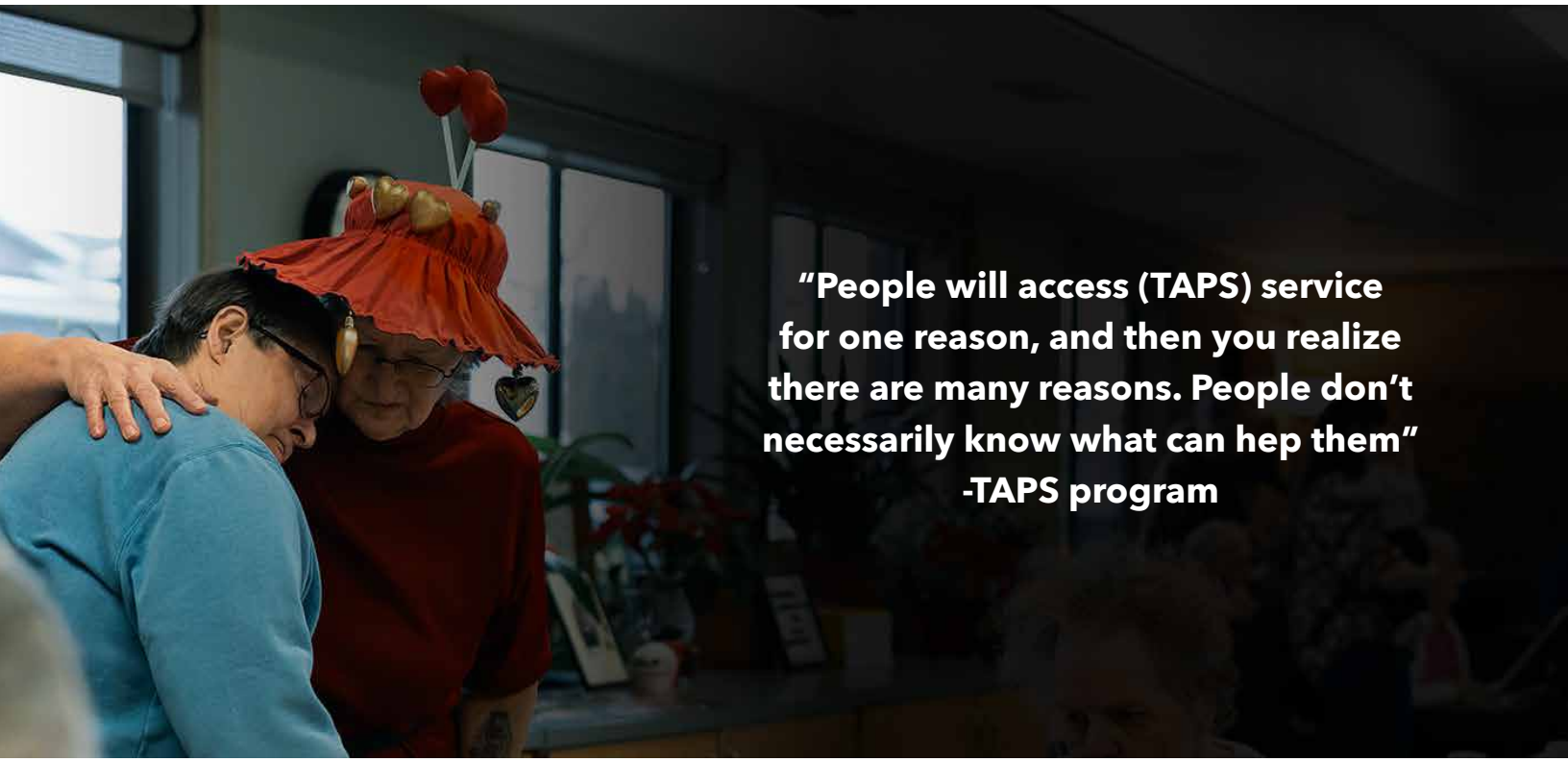
For TAPS programs, co-creation looked like:

- Listening to needs and comfort level
- Understanding strengths
- Highlighting programs/services that may be a good fit
- Monitoring participants
- Supporting each senior in their own way
- Placing people together who have similar needs, personality 'fit'
- Encouraging participation and contribution

Person-centered support for TAPS programs includes:

- Patience
- Empathy
- Meeting seniors where they are at; allowing them to chose programming
- Recognizing their challenges

- Refraining from offering solutions
- Wrapping services around senior in however they are presenting
- Balancing between ensuring they grow and ensuring they feel safe
- Validating participants about the trauma of the pandemic
- Respecting cultural differences
- Respecting choices and decisions in a non-judgemental way
- Providing available resources so seniors may make decisions on their own
- Establishing and building a trusting relationship
- Calling seniors "participants" or "members"
- Strengths-based perspective, encouraging people in what they can do
- Creating opportunities for ownership; goal is that everyone is involved to their capacity and comfort level (can't run the program unless everyone does their part)
- Continuing to invite input into what is happening, people become excited to participate



4. Benefits for Participants

The following participant benefits have been identified:

- Increased access to social, physical, and nutritional supports
- Improved physical and mental health (e.g. participation in physical activity, improved ability to feel seen and heard)
- Increased sense of belonging, social connectedness, and connection to the community
- Upstream prevention programming to avoid medical issues being left unaddressed (identification of health issues, recommendations to community resources, and suggestions participant seeks medical care)
- Improved quality of life
- Increased their awareness of services in their communities, ability to access them, and confidence to participate
- Knowing they can reach out for help and information when needed

5. Skills & Attributes for Program Leads/Coordinators

TAPS program leads/coordinators had varied educational backgrounds, levels of experience, and attributes (Table 3). Overwhelmingly, we heard the importance of working well with seniors, understanding the aging process, and being flexible and having a "doing whatever it takes to make it work" approach.

Table 2. Program coordinator skills and attributes

Education	• Graduate (Master's/Doctorate) degree: 7% • Bachelor's degree: 43% • College diploma: 29% • High school diploma or equivalent: 14%
Specific program diplomas	• Social work • Mental health and addictions • Counselling • Yoga instructor • Blind studies/ linguistics • Gerontology
Work experience in a similar field	• 5 years or more: 50% • Less than 5 years: 43% • Unknown: 7%
Coordinator Skills	• Ability to build relationships with health providers: 71% • Ability to help participant see the value in answering the questions needed for Outcome Reporting: 7% • Ability to identify programming gaps and figure out creative ways to address these gaps: 86% • Ability to support the participant to try new things, move out of their comfort zone, take on new challenges: 86% • Ability to work with a group of volunteers to support their role: 100% • Capacity to build trusting and meaningful relationships with vulnerable older adults: 71% • Community development skills: 79% • Knowledge of community resources and programs: 93% • Motivational interviewing skills: 64%

TAPS program leads and coordinators had varied skills and experience however most agreed the lead had to be flexible, able to build trust, work well with work with seniors (and love to work with seniors), and have strong organizational skills. Other skills and attributes include:

- A love of being with seniors
- Ability to create an inclusive space, build connections
- Ability to create trust
- Administration/organization skills
- Computer skills
- Counsellor
- Cultural competency, respecting differences
- Empathy
- Established in the community; knowledge of community resources/ services
- Experience with social services, health care, mental health
- Flexibility, fluid
- Genuine kindness
- Gerontology
- Humorous, lighthearted
- Openness/willingness
- Patience
- Recreational mindset
- Seniors need to see themselves in the service providers
- Sustaining a program through volunteers

Training for program leads/coordinators

The top 5 training opportunities to support the delivery of TAPS programs were:

- System navigation as a form of advocacy (94%)
- Peer counselling for volunteers (88%)
- Identifying elder abuse, elder neglect (82%)
- Grief and helping others with their journey, for staff as well (76%)
- Staff recruitment and retention, workplace conflict (47%)

6. Communication

Programs provided key messaging for participants, community, and healthcare providers.

Program participants & community

Messaging supporting introduction of programs to a community group or to a potential participant:

- Avoid agism language
- Avoid talking about cognitive loss as there is stigma around this
- Avoid: low income, mobility challenges
- Barrier free/free of cost
- Concrete examples
- Filling gaps
- Focus on Elders
- Focus on inclusivity
- Keep it positive and light/focus on wellness and health
- Keep it simple and focus on the actual program and activities
- Socialization
- Those that would benefit from a supportive and therapeutic environment
- Those with complex needs or some physical mobility or cognition needs
- Using familiar language such as challenges attending a community program they've always loved

*TAPS name is often confusing and many programs do not use it

- Many felt it was critical to get the right balance of positive wording while still recruiting the correct participants
- The term "recreation" was used by many, although they acknowledged it is not quite the right description
- Make sure to include "fun" and "joy" in the messaging for participants
- Create interesting and engaging names for groups, then indicate "TAPS funded" rather than calling the program a TAPS program
- Do not use term 'complex needs' with participants but is correct for health care professionals

Reviewing agency materials

- Popular
  - Burnaby Neighbourhood House materials
  - Japanese program (Tonari Gum)
  - Nanaimo Family Life
- Materials
  - One brief postcard and another document with more information (ie brochure)
- Participant identification
  - Use language of older adult AND seniors
  - Self-identification questions helpful to determine eligibility
    - E.g. do you have hearing loss? Vision loss?
- Photos
  - Best to use real images over stock photos. Action shots of participants
- Wording
  - Brief
  - TAPS language on some, not others
  - Clear descriptions of what participants can expect
  - Don't use acronyms
  - Simple language
  - Different languages on materials
  - Use of questions to help identify 'who can come?'
- Design
  - High contrast
  - Large font needed
  - Preference for rack cards
  - Clear and concise
  - Consistent use of UW logo

Materials desired from UWBC

- Preference for a common brochure with some room for local information and acknowledgement of other funders, with preference to use the local title with small print below the title to say --- also known as the TAPS program
- Desire for a separate brochure for health professionals that uses different language to describe who would most benefit for the program and possibly key program elements as well (e.g. reminders of the program days)
- Interest in a rack card simplified version of the brochure, also some preference for a poster

7. Peer Support Networking and Communities of Practice

- Chairing the COPs
  - Most expressed interest in having the content experts chair the COPs. There was interest in having a program co-chair the COPs but only if this was for an extended term (i.e., 6-12 months) with very limited scope due to lack of capacity within the programs
  - Consider experience (voice) of rural/urban for co-chair model as needs are very different
- Frequency & meeting types
  - Monthly meetings were preferred with attendance being mandatory for half (i.e., 12 COPs a year and programs chose which they will attend based on relevance and availability)
- Topics
  - Programs expressed interest in discussing a range of topics at future COPs, such as:
    - Brainstorming around transportation
    - Conversation about when TAPS is not the appropriate service – when needs are too high
    - Dementia training
    - Diabetic education
    - Difficult conversations
    - Falls prevention

    - How to bridge gap to counselling/coaching services for participants. Staff need training on how to do some counselling
    - How to reach higher needs people who are homebound
    - How to support clients in journeys to LTC
    - Mens' programming
    - Success stories
    - Use program case studies moving forward to lead groups
    - Volunteer program trainings
- *Peer counselling for volunteers:
    - Jewish Seniors Alliance – 3 different types of training available with different numbers of hours for different training (Grace Han). Staff to be trained as well as volunteers. Customized program about 15 hours
    - Gordon House program (Jenn Mason) will facilitate connection to JSA and UWBC
    - Approach UWBC about financially supporting this training
    - Lionsview Seniors Planning Society has a well established peer support program; also working with Silver Harbour on volunteer training support for seniors
- Logistics
    - Programs would like to have schedule for meetings to be determined asap
    - Consider having one meeting per year in-person given benefits of connecting with each other face-to-face
    - Consider having urban and rural/remote COPs once or twice a year
    - Interested in having more break out rooms during COPs
    - Would like to see an annual plan (calendar)
    - Possibly change the time of the TAPS COP moving forward
- Other recommendations for future COPs
    - Would like content experts for certain sessions
    - Continue to bring issues/ actions forward that have surfaced during the co-creation so participants are aware of what is happening 'behind the scenes'
    - Would like permission/space to talk about negative/vulnerable issues in the future

8. Balancing Standardization with Local Flexibility

The flexibility built into the TAPS program was seen by the majority as its greatest strength, and greatest success factor in building strong programs particularly coming out of the pandemic. The following areas were seen as important for local flexibility:

Most mentioned:

- Transportation: urban vs. rural/remote; access to bus route; organization van and driver
- Demographics: income level and need for 'other' supports; newcomers need more support
- Language of participants
- Facility meeting room/kitchen, owning, or renting
- Gaps in community services to meet the needs of seniors
- Existing community services and avoiding duplication

Other:

- Agency culture: if there is a requirement for evening access, would depend on agency policies
- Readiness for participants to gather (i.e. fear of COVID)
- Relationship with local First Nations to participate/collaborate
- Needs of the community to ensure filling a need (avoid duplication)
- Strengths of the community