

**Exploring the Perspectives of Health Care Professionals Providing  
Palliative Care to Older Adults Experiencing Homelessness: A Qualitative Study**

by

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## THESIS EXAMINATION INFORMATION

Submitted by: **Hala Shamaa**

### **Master of Health Sciences in Community, Public and Population Health**

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An oral defense of this thesis took place on July 17, 2025 in front of the following examining committee:

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Chair of Examining Committee	Dr. Manon Lemonde
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The above committee determined that the thesis is acceptable in form and content and that a satisfactory knowledge of the field covered by the thesis was demonstrated by the candidate during an oral examination. A signed copy of the Certificate of Approval is available from the School of Graduate and Postdoctoral Studies.

## **ABSTRACT**

An interpretive phenomenological approach was used to examine the perspectives of health care professionals providing palliative care to older adults experiencing homelessness through the Palliative Education and Care for the Homeless (PEACH) model. The lived experiences of health care professionals were explored, along with the perceived facilitators, barriers, and recommendations to identify best practices in the delivery of palliative care for this vulnerable population. One-on-one interviews were conducted virtually with participants (n=11) from a Southeastern Ontario clinic and hub. Five themes emerged from the verbatim transcripts, using thematic analysis: advocacy for patients, facilitators, barriers relating to homelessness and healthcare, and future recommendations. The findings suggest the need to deliver palliative care in community-based settings through the co-location of medical and social services, using an interprofessional approach for low-barrier access. This study can help inform clinical practice, education, health policy, and future research to address the unique needs of this population.

**Keywords:** community-based palliative care; end-of-life care; homelessness; older adults; social determinants of health

## **AUTHOR'S DECLARATION**

I hereby declare that this thesis consists of original work of which I have authored. This is a true copy of the thesis, including any required final revisions, as accepted by my examiners.

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The research work in this thesis was performed in compliance with the regulations of the Research Ethics Board under **REB Certificate number 17824**.

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Hala Shamaa

## **STATEMENT OF CONTRIBUTIONS**

I hereby certify that I am the sole author of this thesis and that no part of this thesis has been published or submitted for publication. I have used standard referencing practices to acknowledge ideas, research techniques, or other materials that belong to others. Furthermore, I hereby certify that I am the sole source of the creative works and/or inventive knowledge described in this thesis.

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## LIST OF ABBREVIATIONS

ACP	Advanced Care Planning
COVID-19	Coronavirus Disease 2019
EOL	End-of-Life
ICHA	Inner City Health Associates
OAEH	Older Adults Experiencing Homelessness
PC	Palliative Care
PEACH	Palliative Education and Care for the Homeless
PEH	People Experiencing Homelessness
SDM	Substitute Decision-Maker
SDoH	Social Determinants of Health

## **Chapter 1. Introduction**

### **1.1 Homelessness in Canada**

Approximately 235,000 to 300,000 people are experiencing homelessness in Canada each year, with the rate of older adults aged 50 and older increasing their use of shelters over the last ten years (Alston et al., 2024; Gaetz et al., 2016; Public Service Alliance of Canada, 2024). PEH have a shorter life expectancy by 17 years, increased emergency room visits, and poorer health outcomes with at least one chronic disease (Rodriguez et al., 2021; Romaszko et al., 2017; Savage et al., 2010). Homelessness can be caused by societal or systemic barriers, cognitive, behavioral or physical challenges, the individual or household's financials, a lack of appropriate and affordable housing, racism and/or discrimination (Gaetz et al., 2012). Poverty, personal crisis, inappropriateness of current housing, discrimination, or the lack of available and affordable housing are other external factors that can also lead to homelessness or put an individual or household at an increased risk (Gaetz et al., 2012). As described by Saragosa et al. (2022) in their rapid review of delivering primary care in non-traditional healthcare settings to PEH, homelessness is a combination of these complex factors at the individual, family, and societal levels; not a linear pathway.

Gaetz et al. (2012) further defines the term, homelessness, as encompassing a range of living situations: (1) unsheltered; people living in a public or private place without consent or in a place not intended for human habitation, (2) emergency sheltered; people accessing emergency shelter and system supports, provided at no cost or minimal cost to the user from the government, non-profit, faith based organizations and/or volunteers, (3) provisionally accommodated; people accessing temporary housing

provided by the government or non-profit organization, or have made arrangements for a short-term accommodation, and (4) at risk of homelessness; an individual or household that lacks stability or security in their current housing that is intended for human habitation. Chronic homelessness is defined as the state of individuals that have spent time staying in any of the living situations stated above for a total of 6 months in a year or have recurrent episodes of homelessness across the span of 3 years with a cumulative duration of 18 months (Office of the Auditor General of Canada, 2022). According to Statistics Canada (2023), Canadians experiencing homelessness are more likely to report fair or poor mental health (38.0%) when compared to the overall population (17.3%). PEH are at a higher risk of developing medical conditions and geriatric syndromes that are common in older age when compared to individuals that have not experienced homelessness (Alston et al., 2024).

### ***1.1.1 Lack of Affordable Housing***

Housing is an important SDoH as it affects life expectancy, health outcomes, and one's overall wellbeing (Rolfe et al., 2020). Acceptable housing refers to housing being (1) *adequate* by not requiring major repairs, (2) *suitable* as there is enough bedrooms for the size and composition of the household according to the National Occupancy Standard, and (3) *affordable* as the housing cost is less than 30% of the household income before tax (Canada Mortgage and Housing Corporation [CMHC], 2024b). A household that does not have acceptable housing is in core housing need, "*if its housing does not meet one or more of the adequacy, suitability or affordability standards and it would have to spend 30% or more of its before-tax income to access acceptable local housing*" (CMHC, 2024b, para. 3). Based on the recent 2022 Canadian Housing Survey conducted by

Statistics Canada and CMHC, British Columbia (16.0%) and Ontario (14.5%) had the highest rates of households in core housing need while Quebec experienced the lowest at 5.5% (CMHC, 2024a). In Ontario, tenant households (45%) spend the highest rate of their total income on shelter, being more than 30% compared to other provinces (Association of Municipalities of Ontario [AMO], 2024). By 2025, it is estimated that 160,000 households will spend more than 50% of their income on rent and be at an increased risk of experiencing homelessness (AMO, 2024).

Housing instability, such as living in poor or overcrowded conditions, difficulty paying for rent or spending the majority of a household's income on housing related costs, are associated with an increased risk of homelessness as well as the direct and indirect impact on the overall health of an individual (Gu et al., 2023; Rowlands Snyder et al., 2021). The lack of housing affordability after the onset of the COVID-19 pandemic and inflation in 2020 and 2021, combined with fewer job vacancies and a higher unemployment rate has resulted in higher costs for products and services (Statistics Canada, 2023). These factors continue to put a financial burden on Canadian households, as 44% of Canadians reported being concerned about their household's ability to afford rent or adequate housing (Statistics Canada, 2023). Financial issues (41.8%) were reported as the leading cause of homelessness, followed by relationship issues (36.9%) with fleeing abuse (13.3%) being a common pathway for women (20.9%) and men (5.2%) into homelessness (Statistics Canada, 2023). The percentage of Canadians who reported that they often or sometimes experience financial difficulty due to the increased rent or mortgage payments nearly doubled from 2018 to 2022 (CMHC, 2024a).

### ***1.1.2 Older Adults Experiencing Homelessness***

Compared to housed individuals, PEH are at an increased risk of accelerated aging and the early onset of age-related conditions such as falls, immobility as well as cognitive and functional impairments (Mantell et al., 2023). OAEH are physically older than their chronological age and have worse physical health outcomes when compared to the general older adult population; thus, PEH are considered to be an older adult at the age of 50 and older (Espinova, 2024; McDonald et al., 2004). Due to the increased rise of OAEH, they are referred to as the “new homeless,” a “forgotten group,” or a “hidden group” (Om et al., 2022). Their health care needs are more complex and require specialized care when compared to the general housed population due to premature aging and higher rates of multimorbidity, with the presence of two or more chronic health conditions (Alston et al., 2024; Ye et al., 2019). Homelessness among older adults are differentiated between chronic homelessness, which is experienced throughout life and into the older adult years, and late-life homelessness, which refers to an individual experiencing homelessness for the first time as an older adult (Grenier et al., 2016).

Risk factors for homelessness include a functional status decline leading to the loss or limitation of income or housing, adverse childhood experiences both direct and indirect, food insecurity, and the lack of health insurance or assistive devices (Latimer et al., 2024; Liu et al., 2021). Substance use has been associated with prolonged and persistent episodes of homelessness among older adults with existing mental health conditions (Preti et al., 2024). Shelters fail to address the complex health needs of OAEH, including increased frailty and a higher prevalence of chronic health conditions such as Alzheimer’s disease and young-onset dementia (Alston et al., 2024; Babulal et al., 2022;

Booth et al., 2024). Based on the 2020-2022 Point-In-Time Count, 27% of PEH are over the age of 50 and 4% are over the age of 65, which has doubled since the last 2005-2009 National Shelter Study (Government of Canada, 2023; Segaert, 2012). The average lifespan of PEH in Toronto is 54 years of age for males and 48 years of age for females (City of Toronto, 2024). These numbers differ greatly from the life expectancy of the general population in Toronto, being 79 years of age for males and 84 years of age for females (City of Toronto, 2024).

## **1.2 Palliative Care**

The term, PC, first emerged in Canada in the mid-1970s to serve patients with cancer in hospital settings (Health Canada, 2023). Since then, the scope of PC has expanded to include all individuals with life-limiting illnesses (Health Canada, 2023). PC utilizes a person-centred approach, which shifts away from the biomedical model of health to better address the holistic needs of individuals (Health Quality Ontario, 2024). Furthermore, this approach aims to customize the care and treatment of each individual, based on their wishes, values, and goals (Health Quality Ontario, 2024). PC aims to prevent and relieve suffering through the early identification, correct assessment and treatment of pain and other symptoms, whether physical, psychosocial, or spiritual (World Health Organization, 2020).

PEH have higher unmet health care needs when attempting to access health programs or medical services due to the barriers experienced, including stigma, difficulty making appointments as well as the lack of transportation, health insurance, and personal identification (Kushel, 2015; Saragosa et al., 2022). Stigma experienced by PEH correlates with the discrimination and biases held by health care professionals

surrounding homelessness, mental health conditions, and substance use disorders, which further reduces their engagement with health services in traditional settings (Kushel, 2015; Saragosa et al., 2022). PEH often express feeling unwelcomed and discriminated against when accessing health care services due to their housing status (Ramsay et al., 2019). These negative experiences further manifest as a barrier to accessing health services due to the lack of trust in health care providers and poor therapeutic relationships (Ramsay et al., 2019). It can be difficult to identify the deterioration of health in this population due to the nature of the underlying physical, psychiatric, and pathology as well as the irregular interactions with healthcare services (James et al., 2023).

Accessing food and shelter over primary care needs, is also a reason why PEH have delayed diagnosis and treatments or missed appointments, resulting in poorer health outcomes and lower life expectancies (Hwang, 2001; Kushel, 2015). Premature deaths are often associated with acute and chronic medical conditions as opposed to substance misuse and mental health conditions (Saragosa et al., 2022). Integrating PC into the primary care of PEH with life-limiting or life-threatening illnesses can reduce their suffering while improving quality of life and survival, as this specialized care is introduced earlier in their illness trajectory (Evans et al., 2021; Hudson et al., 2016). In Canada, the approach to deliver primary care in non-traditional settings, such as shelters, streets, and parks, have been implemented to help meet the needs of PEH who do not access traditional home-based settings to receive PC (ICHA & Kensington Health [KH], 2024; Saragosa et al., 2022).

EOL is a form of PC provided to patients within the final months or weeks of life when curative treatments are no longer pursued, with a primary focus on comfort and

quality of life (Ontario Centres for Learning, Research and Innovation in Long-Term Care, 2018; Pan et al., 2023). ACP improves the overall experience of patients and their family members in EOL care by facilitating conversations that address the patient's goals of care, values, preferred place of death, and the selection of a SDM (Goswami, 2021). A SDM is a designated person that is authorized to make decisions on behalf of a patient who is not capable of making decisions about their care (Ontario Health atHome, 2025). The Health Care Consent Act (1996) sets a criteria for a patient to choose a SDM; the SDM must be willing to be available and make decisions on the patient's behalf, be above the age of 16, and not prohibited by court order or separation agreement.

### ***1.2.1 PEACH: Model of Outreach for PC***

The PEACH model is Canada's first mobile PC intervention that was developed in 2014 in Toronto by Dr. Naheed Dosani, a PC physician, with a focus on patients who require PC while experiencing homelessness (Buchanan et al., 2023; ICHA & KH, 2024). This model aims to provide early, integrated, and safe PC for PEH and vulnerable housed populations while prioritizing patient dignity (Buchanan et al., 2023; ICHA, 2024). Core values include trauma-informed care, harm reduction, an interprofessional approach, and the acknowledgment of structural oppression that intersects with homelessness (Buchanan et al., 2023). The PEACH model continues to be promoted by ICHA, through the delivery of the PEACH program across Toronto operating as a mobile unit providing care in communities, shelters, and streets to meet PEH where they are at with a focus on each patient's journey and goals (ICHA, 2024; ICHA & KH, 2024). Preferences for designating a SDM and resuscitation are also included in discussions with patients for ACP and to identify their goals of care (Schneider & Dosani, 2021).

ICHA is the largest homeless health organization in Canada, is funded by the Ontario Ministry of Health, and includes over 100 physicians and nurses (ICHA, 2020b). These health care professionals work in over 50 shelters and drop-ins across Toronto with the mission to set the standard of excellence in the delivery of care for homeless health services, address and confront the SDoH and homelessness, as well as advocate for peaceful, secure and dignified housing for all (ICHA, 2020b). Since the launch of the PEACH model, the program underwent an evaluation process with ICHA from July 1, 2014 to June 30, 2015, using patient experience surveys in five of their sites, and confirmed both the success of the model and the need for the specialized service (ICHA, 2016). PC providers across Canada began to recognize the PEACH program and became interested in learning more about their patient's experiences (ICHA, 2016).

In 2022, the PEACH model expanded as a partnership between ICHA, Kensington Health as well as Toronto Central Home and Community Care Support Services (ICHA & KH, 2024). A peer worker was recently added to the PEACH team, to better support clients and help provide insights into the delivery of care to this population, based on their lived experiences with homelessness (ICHA & KH, 2024). Previously, the team consisted of a physician and nurse that worked from a Honda Civic, visiting communities once a week; however, the team has now expanded to become a clinical delivery model twenty-four hours a day and seven days a week (ICHA & KH, 2024). The team now includes 6 PC physicians, nurse coordinator, home care coordinator, PEACH psychiatrist, peer worker, health navigator, and an interprofessional home care team (Buchanan et al., 2023; ICHA & KH, 2024).

Notably, the PC program is also based on the PEACH model at the Southeastern Ontario clinic and uses a team-based approach for frontline workers that provide palliative and EOL care to PEH (Local Health Integration Network [LHIN], 2018). During the completion of this thesis, the site for the PC program had changed since September 2024 and is currently being delivered at a Southeastern Ontario hub. This hub provides low-barrier access to essential supports, including social and primary care services. Frontline workers include shelter workers, registered nurses, personal support workers, and physicians (ICHA, 2020a). This program includes early diagnosis, support for ACP, pain and symptom management, and EOL care (LHIN, 2018). The rationale to select the PEACH model as the guiding framework for this study, was based on the model's core values, including trauma-informed care, harm reduction, and interprofessional collaboration (Buchanan et al., 2023). Moreover, as explored in Chapter 2, these approaches are considered crucial in the delivery of PC to this population (Buchanan et al., 2023; Johnson et al., 2023; MacWilliams et al., 2014). Currently, there are gaps in the literature as little is known about the delivery of PC using the PEACH model to OAEH, and in particular; the experiences of health care professionals providing this form of specialized care. This may be attributed to the PEACH model being recently developed in 2014, along with a rapid rise in the number of OAEH after the COVID-19 pandemic due to the lack of affordable housing as well as higher costs for products and services stemming from inflation (Government of Canada, 2023; ICHA & KH, 2024; Statistics Canada, 2023).

### **1.3 Study Purpose**

The purpose of this interpretive phenomenological study is to describe the lived

experiences of health care professionals that deliver PC at the Southeastern Ontario clinic to OAEH. The overarching research question is,

**“What are the perspectives of health care professionals that provide PC to older adults aged 50 and older that are experiencing homelessness at the Southeastern Ontario clinic?”**

The three sub-questions relating to the main research question are: (1) What does it mean to provide PC to OAEH?; (2) What facilitators and barriers are present when delivering PC to OAEH?; and (3) How can the delivery of PC be improved within this population?

#### **1.4 Significance of the Study**

The significance of this study is to explore how the PEACH model is applied in the delivery of PC services by health care professionals at the Southeastern Ontario clinic to OAEH. Study findings provide implications about how to support these health care professionals, facilitators and barriers present as well as the best practices in the delivery and implementation of PC services to OAEH. Furthermore, results from the one-on-one interviews conducted in this study can help inform medical training for health care professionals who interact with this population, improve workplace retention with the necessary information, and improve health outcomes for this population. The results of the study are not only applicable to current workers at the Southeastern Ontario clinic but also to other health care workers in traditional and non-traditional settings that provide PC to OAEH. Through the involvement of committee members, worksheets and/or infographics can be created to apply the findings of the study in clinical practice and further engage with health care professionals that deliver PC to this population.

## **1.5 Overview of Thesis**

In Chapter 2, I present a review of the literature, examining what is known about about PC that is provided by health care professionals to OAEH such as facilitators, barriers, and best practices. I further link the relevance to my research question, based on the existing research conducted in this area of study.

In Chapter 3, I discuss the methods used to conduct this study, including the theoretical framework, qualitative approach, setting, eligibility criteria of participants, sampling methods, ethical considerations as well as data collection, management, and analysis.

In Chapter 4, I present the results of the demographic questionnaire and one-on-one interviews.

In Chapter 5, I summarize the study's results, strengths, limitations, implications, and offer conclusions to inform clinical practice, education, health policy, and future research aimed at addressing the unique needs of this population.

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## **Chapter 2. Literature Review**

The purpose of this chapter is to review the existing literature about PC that is provided by health care professionals to OAEH. This literature review aims to:

- (1) Identify existing facilitators and barriers that impact OAEH in accessing PC within traditional and non-traditional healthcare settings;
- (2) Determine the best practices in delivering PC to OAEH to improve symptom management, health outcomes, and quality of life.

### **2.1 Inclusion and Exclusion Criteria**

The inclusion criteria included grey literature, journal articles and research papers published until January 2025. Grey literature included government documents, policy papers, non-government organization reports, conference abstracts, and poster abstracts. Search results were limited to articles published in English with a focus on the delivery of PC by health care professionals to older adults aged 50 and older experiencing homelessness in traditional and non-traditional healthcare settings. Health care professionals include physicians, care coordinators, such as a registered nurse, health navigators, psychiatrists as well as palliative pain and symptom management consultants. Preliminary searches revealed that little is known about the lived experiences of health care professionals delivering PC through the PEACH model to OAEH. Thus, the inclusion criteria was broadened to identify eligible articles if they include or refer to any model(s) of PC and provide recommendations regarding the delivery of PC to OAEH. Given that the PEACH model was established in 2014, this may have contributed to the limited availability of peer-reviewed studies evaluating or referencing this model of care in the context of delivering PC to OAEH in Canada and internationally.

Keywords to limit searches on the type of care provided by health care professionals include, “hospice care” OR “palliative care” OR “palliative medicine” OR “palliative treatment” OR “end-of-life” OR “end-of-life care” OR terminal OR “terminal care” OR “terminally ill” were used. In addition, the keywords homelessness OR unhoused OR unsheltered OR homeless OR “homeless person” OR “housing instability” OR “precarious housing” OR “inadequate housing” were used to limit the search to patients experiencing homelessness while receiving PC. Lastly, the keywords dementia OR “older adults” OR elder\* OR geriatric OR senior OR retired were used to help identify articles that are specific to older adults receiving PC and are experiencing homelessness. Broad search terms were used to help decrease the chance of missing relevant literature. The exclusion criteria included letters, dissertations, literature that do not specify an age range to define an OAEH and peer reviewed studies that include or refer to individuals aged 49 and below who do not experience homelessness while receiving PC. Additionally, studies that generalize results or findings towards PEH (not categorized by age range) and are written in a language other than English were not included in the literature review.

## **2.2 Search Strategy and Analysis**

The literature search was conducted using 3 of the Ontario Tech University library databases, which included CINAHL Plus with Full Text, MEDLINE via EBSCOhost, and PubMed. The same search terms and strategy were used in each database. A total 118 publications were retrieved from the databases, including 8 full-text qualitative articles from peer-reviewed journals (Bazari et al., 2018; Cagle, 2009; Johnson et al., 2023; Ko & Nelson-Becker, 2013; Kushel & Miaskowski, 2006; Latimer

et al., 2024; MacWilliams et al., 2014; Preti et al., 2024). Abstracts of peer-reviewed articles or introductions of publications were reviewed first for relevancy followed by the entire publication. Reference pages were also scanned to help identify relevant resources within the literature. Based on the inclusion criteria, a total of 8 full-text articles were selected for the literature review. A data extraction tool (Appendix B) was created using Microsoft Word to provide an overview of the selected articles based on their design, purpose, location, participants, and findings. Braun and Clarke's (2006) model of thematic analysis was used for data analysis in the initial coding process, creation of broader themes, and review of relevant themes from the selected articles.

## **2.3 Results and Discussion**

### ***2.3.1 Key Findings from Literature Review***

Based on the analysis of the selected literature, to identify existing facilitators, barriers and best practices in the delivery of PC to OAEH, 3 themes emerged. These themes include the mistrust of health care professionals as well as the need for trauma-informed care and improved knowledge and skills relating to homelessness.

### ***2.3.2 Mistrust as a Barrier to Access***

Among OAEH, a recurring theme of mistrust was identified in the literature and posed as a barrier to accessing PC (Ko & Nelson-Becker, 2013; Latimer et al., 2024; MacWilliams et al., 2014; Preti et al., 2024). In a study conducted by Ko and Nelson-Becker (2013), participants that lived in transitional housing and experienced or witnessed poor treatment from health care professionals, were hesitant to partake in ACP. Moreover, participants were unsure about signing a legal document to assign a SDM and prepare for future healthcare decisions (Ko & Nelson-Becker, 2013). However,

physicians were still preferred by participants to be designated as a SDM, based on their expertise and knowledge (Ko & Nelson-Becker, 2013). Another study conducted by Latimer et al. (2024) to adapt a Serious Illness Conversation Guide for OAEH found that participants want to ensure there is emotional safety, trust, and receptiveness in conversations of ACP with PC providers. Furthermore, participants requested conversations to be delivered with compassion and respect to ensure they are spoken *with* and not *at* (Latimer et al., 2024).

Another study that explored the experiences of residents in a new aged care home that were at-risk or had previous experiences of homelessness, revealed that guarding behaviour was exhibited for medical treatment and care due to their lack of trust with the staff (Preti et al., 2024). The mistrust of PC providers can manifest as other behaviours in OAEH, including missed appointments, care that is accessed late with advanced symptoms, or becoming “non-compliant” from not being willing to engage in the recommended care (MacWilliams et al., 2014). However, a case study of a 66-year-old man living with cancer by Kushel and Miaskowski (2006) as well as a study on OAEH living in temporary avoidance hotels during the COVID-19 pandemic (Johnson et al., 2023) did convey that a trusting relationship can be established between an OAEH and their PC provider. Approaches in PC, including harm reduction, incorporating an assessment of daily needs into care as well as conversations about pain management and decision making, were identified to be crucial in establishing a trusting relationship (Johnson et al., 2023; Kushel & Miaskowski, 2006). It is imperative that PC providers recognize their own biases and set them aside to help establish meaningful and trusting

conversations that are free from moral judgement and stigmatization of individuals experiencing homelessness (Cagle, 2009).

### ***2.3.3 Need for Trauma-Informed Care***

Trauma-informed care was recommended as an important approach to include in the delivery of PC to OAEH, as they are more likely to have a history of family violence, past trauma, mental health issues, and substance use disorders (Bazari et al., 2018; Cagle, 2009; Latimer et al., 2024; MacWilliams et al., 2014; Preti et al., 2024). Social isolation was identified to also be caused from past trauma and has made it challenging for OAEH to form and maintain social relationships (Bazari et al., 2018; MacWilliams et al., 2014). Adapting PC services to help address symptoms and provide trauma-informed care is imperative in the care of OAEH as prior trauma can worsen existing symptoms (Bazari et al., 2018). Preti et al. (2024) conveyed the importance of recognizing the specialized needs of OAEH as staff in their study experienced challenges in providing PC to this population, despite their previous experiences of working in an aged care home. Past trauma, substance use disorders, and higher care needs, such as the diagnosis of dementia, were identified as complexities in providing care to OAEH (Preti et., 2024). Similarly, Johnson et al. (2023) identified challenges in catering to the diverse needs of OAEH based on varying mental, psychosocial, spiritual, and behavioural aspects, further supporting the rationale for PC to be flexible and individualized. A decline in functional abilities and physical symptoms experienced at an earlier age are attributed to premature aging; thus, recognizing the unique healthcare needs of this population through the inclusion of trauma-informed care in the delivery of PC is imperative to help manage physical symptoms and optimize their quality of life (Bazari et al., 2018).

### ***2.3.4 Need to Improve Knowledge and Skills***

Given that OAEH have unique healthcare needs, it is recommended that PC providers improve their knowledge and skills relating to homelessness. Developing an increased sensitivity to the attitudes, values, and beliefs of this population can help achieve desired health outcomes and facilitate effective conversations about PC (Bazari et al., 2018; Johnson et al., 2023; Ko & Nelson-Becker, 2013; Latimer et al., 2024). In comparison to older adults that are housed, OAEH prioritize their efforts towards daily survival with securing food, housing and transportation over their health care needs, including PC services and EOL care (Ko & Nelson-Becker, 2013; Kushel & Miasowski, 2006). Living in a home or individualized setting while receiving PC was recognized as an important desire to achieve privacy, peace of mind, and improved physical symptoms (Bazari et al., 2018; Johnson et al., 2023). Latimer et al. (2024) also noted the importance of PC providers to increase the transparency of conversations with OAEH in ACP and consider the social and emotional aspects of being unhoused (Latimer et al., 2024). Transparency can be achieved by clearly stating the intent and purpose of conversations, which further helps to establish a trusting relationship and reduce power differentials between OAEH and PC providers (Latimer et al., 2024).

OAEH experience physical and cognitive limitations at an earlier age due to premature aging; however, aging was perceived positively as a source of strength, wisdom, and experience in learning to manage their physical symptoms (Bazari et al., 2018). Spirituality and religion should be considered with OAEH as it can impact their beliefs and attitudes towards PC care, particularly EOL care (Ko & Nelson-Becker, 2013). Ko and Nelson-Becker (2013) found that participants believed their life and death

were already predetermined by God, leading them to view ACP as an unnecessary act. Patient empowerment and a sense of independence are important values among OAEH and are linked to improvements in symptoms, adherence to treatment recommendations, and relationships with PC providers (Bazari et al., 2018; Johnson et al., 2023). The co-location of services to deliver PC and strengthen collaborations between health care professionals may help to facilitate and effectively coordinate PC that is patient-centred for OAEH (Johnson et al., 2023; MacWilliams et al., 2014).

#### **2.4. Implications and Conclusion**

Based on the existing body of literature, establishing trust between OAEH and health care professionals, integrating trauma-informed care as well as improving knowledge and skills relating to homelessness, is essential to better facilitate the delivery of PC and achieve ACP goals. Previous studies have not yet described the experiences of health care professionals that provide PC through the PEACH model to OAEH. Notably, the PEACH model implements the findings from this literature review, as it includes a trauma-informed approach, harm reduction, best practices in conversations about ACP, and an interprofessional team to meet the diverse needs of patients (Buchanan et al., 2023; ICHA, 2020). This model of care is however generalized to PEH and there is a lack of literature that explores how it is applied in the delivery of PC to OAEH within traditional and non-traditional settings. Exploring the perspectives of health care professionals that deliver PC through the PEACH model, especially with the growing population of PEH aged 50 and older in Canada, is imperative as the literature suggests for improvements in the delivery of this care to OAEH (Government of Canada, 2023; Segaert, 2012). It should also be noted that the studies included in this literature review

took place in the United States or Australia. Expanding upon the current literature to learn more about the perspectives of health care professionals that deliver PC to this population in Ontario, Canada can help identify recommendations for facilitators and best practices with the PEACH model (Buchanan et al., 2023; ICHA & KH, 2024).

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## **Chapter 3. Methodology**

### **3.1 Research Design**

#### ***3.1.1 Interpretive Framework***

The PEACH model was used to guide this study as it identifies recommendations to deliver PC to PEH in community-based settings and addresses the gaps found in the literature as described in Chapter 2 (ICHA, 2020). This model includes a variety of domains such as illness understanding, relationships, quality of life, one's legacy, setting to receive care, and treatment options (ICHA, 2020).

#### ***3.1.2 Rationale for Interpretive Phenomenological Approach***

There are two types of phenomenological approaches; interpretive phenomenology is oriented towards the meaning of lived experiences as well as includes interpretations of the researcher and professional knowledge whereas descriptive phenomenology aims to understand the phenomenon by descriptive means, without generating theories or explanations, and is biased-free (Matua & Van Der Wal, 2015). This study is grounded in interpretive phenomenology, as the meanings attributed to the lived experiences of various health care professionals are explored, incorporates the researcher's interpretations, and is informed by the existing literature (Matua & Van Der Wal, 2015; Smith & Nizza, 2022).

### **3.2 Setting and Participants**

#### ***3.2.1 Selection of Research Setting***

Dr. Dosani provided recommendations prior to ethical submission in March 2023 to focus on a smaller sample size at a specific site with health care professionals (e.g. physician, nurse) that provide PC to produce a feasible timeline for the research to be

conducted. Dr. Dosani also served as a gatekeeper, by initially connecting me with the lead health care professional at the Southeastern Ontario hub (Creswell, 2014).

### ***3.2.2 Inclusion and Exclusion Criteria***

The inclusion criteria of study participants included the following: (1) is a current OR previous health care professional (e.g., physician, nurse practitioner) at the Southeastern Ontario clinic; (2) delivers PC to adults aged 50 and older that are experiencing homelessness; (3) utilizes the PEACH model in their care to patients; and (4) speaks English. The exclusion criteria of study participants included the following: is not a current OR previous health care professional at the Southeastern Ontario clinic; delivers PC to adults aged 49 and below that are experiencing homelessness; does not utilize the PEACH model in their care to patients; and does not speak English.

### ***3.2.3 Recruitment and Sampling***

Participant recruitment was conducted from January to March 2025 at the Southeastern Ontario clinic and Southeastern Ontario hub, using recruitment posters and a snowball recruitment script. Snowball and purposive sampling strategies were employed to recruit participants who met the study's inclusion criteria to provide answers to the overarching research question and sub-questions, with additional participants referred to the researcher by initial participants (Coleman, 1958-1959; Patton, 1990). This sampling strategy was well-suited for efficiently recruiting participants that provide PC based on the PEACH model and can be harder to reach due to the high demands associated with their profession. To initiate recruitment, the researcher first contacted the lead health care professional at the Southeastern Ontario hub in January 2025 to coordinate the distribution of recruitment posters. The lead health care professional at the

Southeastern Ontario clinic was also approached to assist in identifying and contacting potential participants in the PC program. Health care professionals who expressed their interest and participated in the one-on-one interviews were asked by the researcher to help identify and refer other individuals who met the study's inclusion criteria. The referral of additional participants occurred through follow-up emails sent by participants after the online interview. The researcher then contacted the referred individuals to provide the relevant information to participate in the study. Following Creswell's (1998) guidance for phenomenological studies, the researcher aimed for a sample size between 5 to 25 individuals based on the time required to set up, conduct, and transcribe the interviews. Data saturation was achieved when no new information emerged during the interviews, resulting in a final sample of 11 participants (Creswell, 1998).

### **3.3 Data Collection**

#### ***3.3.1 Instruments and Methods***

An environmental scan was conducted before the participant recruitment posters (APPENDIX C) were placed at the Southeastern Ontario clinic and hub and distributed to staff using the snowball recruitment script (APPENDIX D). The Southeastern Ontario hub is a nearby building that recruitment also took place in, as it included eligible participants; health care professionals from the Southeastern Ontario clinic also work various shifts at the Southeastern Ontario hub. During the time of recruitment, it was identified from conversations with the healthcare team that the program for PC transitioned from the Southeastern Ontario clinic to the Southeastern Ontario hub.

The notebook was also used to create a list of participants for the study, to obtain each participant's first and last name, email address and work site address. The email

script for recruitment (Appendix E) was used to follow up and initiate online communication by email with participants that are interested in taking part of the study. Participants were asked to respond to the email to confirm their interest to arrange a day and time that works best with their availability to schedule the online one-on-one interview. Once a date and time was confirmed for the online interview, the email script for the interview invitation (Appendix F) was used to send the participant the consent form (Appendix G), demographic form (Appendix H), and preparatory checklist (Appendix I) at least 14 days before the scheduled online interview.

The participant was notified in the interview invitation email that the consent form must be reviewed and completed before completing the demographic form as well as participating in the scheduled online interview. If the participant was unable to attend due to a time conflict, the interview was rescheduled for another day and time that better accommodates their availability. A semi-structured interview guide (Appendix J) along with a backup audio recorder (Voice Memos app) was used with the Zoom software during each online interview in case the primary audio recorder fails or is not clear. The semi-structured interview guide consists of 8 questions with 2-3 probes to help address the study's overarching research question and three sub-questions.

Zoom creates independent audio-only and audio/video files when a meeting is being recorded. The audio/video file was deleted immediately after the interview. The interviews were transcribed with Zoom's live transcription feature to minimize the time to manually transcribe the audio recordings, proceed with data analysis while conducting the online interviews, and determine data saturation. The audio-only file, audio/video file, and verbatim transcript from each interview were only available after the interview

concluded on the researcher's device. The audio-only file and verbatim transcript were saved on a password protected and secure Google Drive hosted by Ontario Tech University belonging to the researcher. Access was limited to members of the research team. The verbatim transcripts were reviewed with the audio-only file for accuracy, de-identification, and anonymization for data analysis.

### ***3.3.2 Semi-Structured Interview Guide***

The semi-structured interview guide consists of 8 questions with 2-3 probes to help address the study's overarching research question and three sub-questions. The questions were open-ended with the aim of comparing the responses of each health care professional and to determine how the PEACH model is applied in their daily practice. The semi-structured interview guide was developed with the supervisor and pilot tested with a peer student of the same supervisor. The revisions were then reviewed by the supervisor before the online one-on-one interviews were conducted. This is another validation strategy to help establish credibility and trustworthiness of the study.

### **3.4 Data Analysis**

A Google Sheets codebook was created to conduct the thematic analysis of the verbatim transcripts from each one-on-one interview to arrange the data into codes followed by themes and sub-themes, while also selecting key quotes (Braun & Clarke, 2006). Braun and Clarke's (2006) model of thematic analysis guided the data analysis process, which involved 6 phases: (1) familiarization with the data set; (2) generating initial codes; (3) searching for themes; (4) reviewing themes; (5) defining and naming themes; and (6) producing the report. A theoretical approach to thematic analysis that is deductive in reasoning was used, based on the interpretive framework selected and

literature review (Braun & Clarke, 2006). Data analysis was driven by the researcher's theoretical interest in the phenomenon and employing an interpretive phenomenological approach, to provide answers to the overarching research question, sub-questions, and address gaps in the literature (Braun & Clarke, 2006). The meanings attributed to the lived experiences of health care professionals were explored through a detailed analysis of each verbatim transcript, followed by a comparative review of the transcripts to identify similarities and differences (Creswell, 2014; Smith & Nizza, 2022). The researcher continuously engaged in reflexive journaling throughout the research process to help identify unconscious biases that can stem from assumptions and personal values (Olmos-Vega et al., 2022). The decision not to use the NVivo software was based on the small sample size and preference for a more hands-on, flexible and recursive approach to data analysis (Braun & Clarke, 2006).

### **3.5 Reflexivity and Validity of Findings**

Lincoln and Guba's (1985) four-dimension criteria for establishing trustworthiness of the study's findings was utilized and includes credibility, transferability, dependability, and confirmability. Firstly, to establish confidence in the findings as credible, prolonged observations with the health care professionals were noted by the researcher throughout the entire research process (Lincoln & Guba's, 1985). Other methods of internal validity included member checking after the one-on-one interviews, to share the verbatim transcript and themes interpreted. Once the themes were identified, I engaged in member checking with each participant by email (Appendix K) to ensure that my analysis, interpretations, and conclusions were reflective of their experiences (Creswell, 2014; Lincoln & Guba, 1985). This approach helped to establish validity of

the research findings as it provided me with the opportunity to confirm interpretations of themes and give participants the opportunity to provide me with any additional information or feedback (Lincoln & Guba, 1985). Presenting discrepant information was also included within the analysis of the themes, as discussing contradictory information that contrasts from the general perspective of health care professionals helps to add credibility to the research findings (Creswell, 2014).

The triangulation of sources, to compare data from different points in time, settings, and viewpoints was a validation strategy to help establish credibility of the research findings. The data sources included the demographic questionnaire, transcripts, notes from the one-on-one interviews, and reflexive notes throughout the entire research process (Lincoln & Guba, 1985; Olmos-Vega et al., 2022).

Transferability includes the ability of the researcher to describe the phenomenon in sufficient detail and evaluate the extent to which the findings are transferable to other individuals, settings, situations, and times (Lincoln & Guba, 1985). The researcher explored perspectives of health care professionals at a specific site that provides PC to OAEH; however, the questions relating to the overarching research question and sub-questions identifies patterns of cultural and social relationships that pertain to the phenomenon of interest in the context of traditional and non-traditional healthcare settings in Southeastern Ontario. Moreover, the findings from the study can be applicable to other healthcare settings in Ontario that provide PC to populations that are vulnerable, including those experiencing homelessness, identify as an older adult, and/or require PC.

To establish dependability to show that the findings are consistent and can be repeated, the triangulation of methods and audit trail notes were included in the study to

increase the validation and credibility of the research findings (Lincoln & Guba, 1985; Patton, 1999). Data from the demographic questionnaire was obtained to help understand the basic information of the phenomenon and complement the qualitative data obtained to provide the most insights about the same phenomenon of interest (Lincoln & Guba, 1985). An audit trail was recorded to include process notes, materials relating to expectations and personal motivations, instrument developments of the semi-structured interview guide, connections to the existing literature, and summaries of condensed notes (Lincoln & Guba, 1985).

Confirmability was established with the peer auditor as another validation strategy as the researcher involved a graduate student with no prior involvement in the study to review the study's design, data collection methods, data analysis with the de-identified transcript and codebook, and interpretations of the research findings (Lincoln & Guba, 1985). This also provided the researcher with the opportunity to uncover any unconscious biases that may have not been previously considered (Creswell, 2014). Feedback relating to study strengths with the selected model of care and implications for clinical practice were recommended and included within the thesis after consideration.

### ***3.5.1 Role and Reflexivity of the Researcher***

As a student who is passionate about health advocacy, holistic care, and strengthening health systems, my interest to explore the lived experiences of health care professionals who deliver PC stems from my personal and academic experiences. My previous research experience as an undergraduate student in the Faculty of Health Sciences with Dr. Sun has equipped me with the necessary skills and tools to conduct this study. I worked collaboratively with two of her students at the time in a mixed methods

study that aimed to evaluate the experiences of patrons experiencing homelessness and access services in two community hubs, funded by the Durham Region. Moreover, I helped to develop and distribute posters to recruit participants, conducted an environmental scan, administered surveys, analyzed the data, provided the incentives for participation, and completed various manuscripts. Our findings highlighted the need for improved management of chronic diseases, given the high prevalence of comorbidities among individuals experiencing homelessness. My involvement in this study also sparked my interest in research on PC for PEH, as they often experience higher rates of comorbidity, and this form of care addresses various domains of health through a holistic approach. In the health sciences program, I completed an advanced qualitative research methods course, which helped me to further develop and refine my skills to create an interview guide, arrange interviews, lead a focus group, analyze and summarize the data. Dr. Winnie Sun's expertise in gerontology and dedication to supporting older adults in aging in place have inspired me to focus this research on older adults, acknowledging their unique and specific needs.

### ***3.5.2 Relationship with Participants***

Throughout the study, I focused on building a rapport with participants early on during the recruitment process by describing the goals of the study and actively listening to their stories in the interviews. I had also followed up with the incentive to thank them for their efforts for participating in the study and communicated in a way that best suited each participant to engage in the debriefing process to validate their opinions. I had no prior relationship with participants however I engaged in reflexive journaling after each interview and clarified any questions to help identify any potential biases or

misinterpretations. I obtained support from my supervisor to best accommodate the time and availability of each participant, considering the demands and high paced environment of delivering PC, especially in community-based settings. During the one-on-one interviews, I maintained a neutral facial expression to avoid influencing participants' responses. I focused on observing and recording participants' non-verbal cues to capture additional insights. I considered the power differential between health care professionals and patients, acknowledging how this dynamic can influence their interpretations and lived experiences, and incorporated this consideration into the discussion of the findings and limitations of the study. Member checking was conducted via email, as this was identified as the preferred method of communication for each participant. The participants that engaged in member checking with the researcher agreed with the themes, but some had concerns about the grammar associated with the quotes. The researcher assured those participants that the main goal of the quotes is to capture the authentic voice and language of participants, even if there are grammatical errors or hesitation. One participant importantly identified that the Southeastern Ontario hub has been approved by the Ontario Ministry of Health to receive overnight and short-term beds. This opportunity provided the researcher with more insights about the site as the participant identified that in 2026, some beds will be designated to PC as discussed in section 5.4.

### ***3.5.3 Reporting Study Findings***

Direct quotes from participants are included in Chapter 4 to support the themes and findings, as they provide context for the analysis (Creswell, 2014). Personal identifiers (e.g. position name) from quotes were removed using the following indicator, [...] before the data analysis process to help prevent the identification of participants. Data

reported from the verbatim transcripts are generalized to prevent the direct identification of the clinic, hub, or health care professionals. For example, the clinic is referred to as the [Southeastern Ontario clinic] and the site that PC program transitioned to is referred to as the [Southeastern Ontario hub]. The codes for the participant responses (e.g., P1 = Participant 1) were utilized to anonymize study participants in direct quotes.

### **3.6 Ethical Considerations**

A research ethics board (REB) application was submitted to Ontario Tech University's Research Ethics Board (REB #17824) and was approved on June 6, 2024. Ethical review and approval from the Southeastern Ontario clinic's Research Ethics Board and Executive Leadership team was received on August 15, 2024. This included the review of the REB application that was submitted to Ontario Tech University and answering further questions through email. Approval from the Southeastern Ontario hub was obtained by email communication with the lead nurse practitioner and site manager to hang up recruitment posters for the study.

Participants were asked to complete the electronic consent forms before participating in the one-on-one interview. The consent form outlines the study's purpose, potential benefits, potential risks or discomforts, use and storage of data, confidentiality, voluntary participation, right to withdraw, compensation for voluntary participation, debriefing and dissemination of results, participants rights and concerns, and a section to provide informed consent. Participants provided their informed consent by electronically signing the consent form prior to starting the online interviews and were encouraged to reach out with any questions throughout the study. A Data Management Plan (DMP) was created (Appendix L) and approved by Ontario Tech University's Research Ethics Board

(REB #17824). This document further outlines the best practices for managing the research data that was collected throughout the study, and how the data was organized, stored, and shared.

Conducting one-on-one interviews rather than a focus group ensured the privacy and confidentiality of participants as well as their identifying information and shared experiences. The one-on-one interviews were conducted online to accommodate the time of each health care professional as they work in various locations to deliver PC to this population and are affiliated with different organizations. The preparatory checklist outlines the criteria to help participants prepare for the interview and help avoid technical issues associated with the Zoom software. Participants were asked to (1) install Zoom on their computer or mobile device in advance; (2) confirm their name on the display or use a pseudonym if preferred prior to joining the interview; (3) check the internet connection and battery percentage with a charger nearby; (4) ensure they are located in a quiet, distraction-free location; and (5) ensure their background is blurred or plain.

### ***3.6.1 Incentive for Participation***

After completion of the one-on-one interview, a twenty-dollar electronic Tim Hortons gift card was sent to participants by email using the email script to thank participants (Appendix M) as a small token of appreciation for their time and participation in the study. The funds for the gift cards were received from the researcher's supervisor. No participants withdrew from the study.

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## Chapter 4. Results

This chapter presents the results obtained from the research, which includes a description of the demographic questionnaire to describe the characteristics of the participants and the emerging themes from the qualitative analysis. To maintain participant privacy and confidentiality, pseudonyms were used for all names and personal identifiers have been replaced with the following indication, [...].

### 4.1 Demographic Questionnaire

Eleven (n=11) health care professionals were recruited from the Southeastern Ontario clinic and hub; Table 4.1 outlines the demographic characteristics of participants.

Table 4.1 Demographic Characteristics of Health Care Professionals

Study Sample (n=11)		No.	Percentage (%)
Profession	Nurse Practitioner	3	27%
	Physician	3	27%
	Registered Nurse	4	36%
	Registered Practical Nurse	1	9%
Age Range	30-39	3	27%
	40-49	3	27%
	50-59	4	36%
	60-69	1	9%

Gender	Male	1	9%
	Female	10	91%
Highest Level of Education	Bachelor's Degree	3	27%
	College Degree	2	18%
	Doctor of Medicine Degree	3	27%
	Master's Degree	3	27%
Employment Status	Full-Time	10	91%
	Part-Time	1	9%
Years Working in Profession	<5 years	2	18%
	10-20 years	5	46%
	21-30 years	3	27%
	>30 years	1	9%
Years Working in PC with OAEH	<5 years	8	73%
	6-10 years	2	18%
	11-15 years	1	9%

### Abbreviations

OAEH: Older Adults Experiencing Homelessness

PC: Palliative Care

The health care professionals included three nurse practitioners, three physicians, four registered nurses, and one registered practical nurse. The ages of participants ranged from 30 to 69 years of age and the majority were female (91%). The highest level of education varied, as three completed a bachelor's degree, two completed a college degree, three completed a Doctor of Medicine (MD) degree, and three completed a master's degree. Most participants worked full-time (91%), worked in their profession between ten to twenty years (46%), had less than five years of experience working in PC with OAEH (73%) and completed a LEAP program (36%).

Participants completed other trainings programs: ACP in PC and EOL care (18%); added competence in PC (9%); comprehensive advanced PC education (9%); care of the elderly (9%); clinical rotation - PEACH (9%); continuing education - PC (9%); dementia education (9%); extension for community healthcare outcomes (9%); enhanced fundamentals of hospice PC (9%); foundations in oncology nursing practice (9%); motivational interviewing (9%); P.I.E.C.E.S - physical. intellectual. emotional. capabilities. environment. social. (9%); and serious illness conversation guide (9%).

#### **4.2 Semi-Structured Interviews**

A total of 5 themes emerged from the semi-structured interviews: advocacy, facilitators, barriers relating to homelessness and healthcare, as well as future recommendations. Figure 4.1 provides an overview of the thematic tree, depicting 4 of the themes, relating to advocacy for patients, facilitators as well as barriers relating to homelessness and healthcare in delivering PC to OAEH. The fifth theme relating to future recommendations in the delivery of PC to this population are summarized in Table 4.2 in Section 4.2.5.

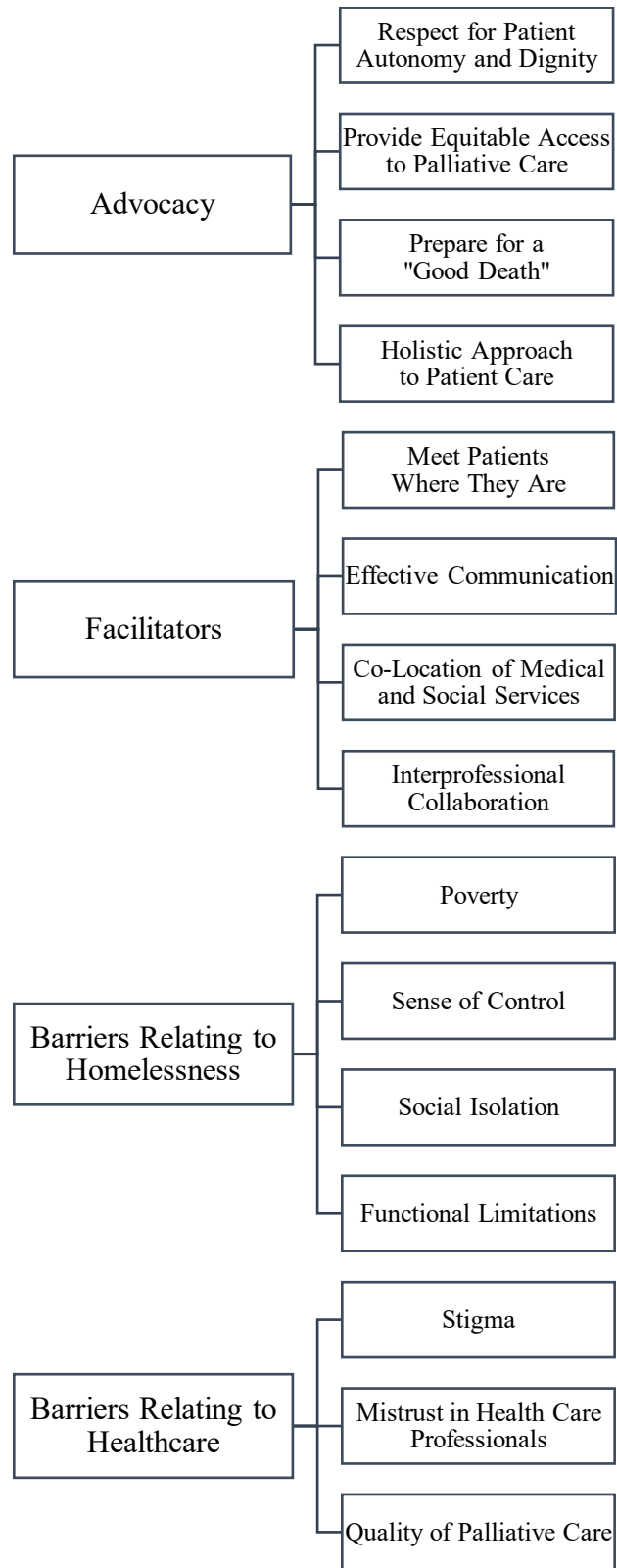


Figure 4.1 Thematic Tree

The key barriers that impact OAEH from accessing PC at the micro, meso, and macro levels are outlined below in Figure 4.2.

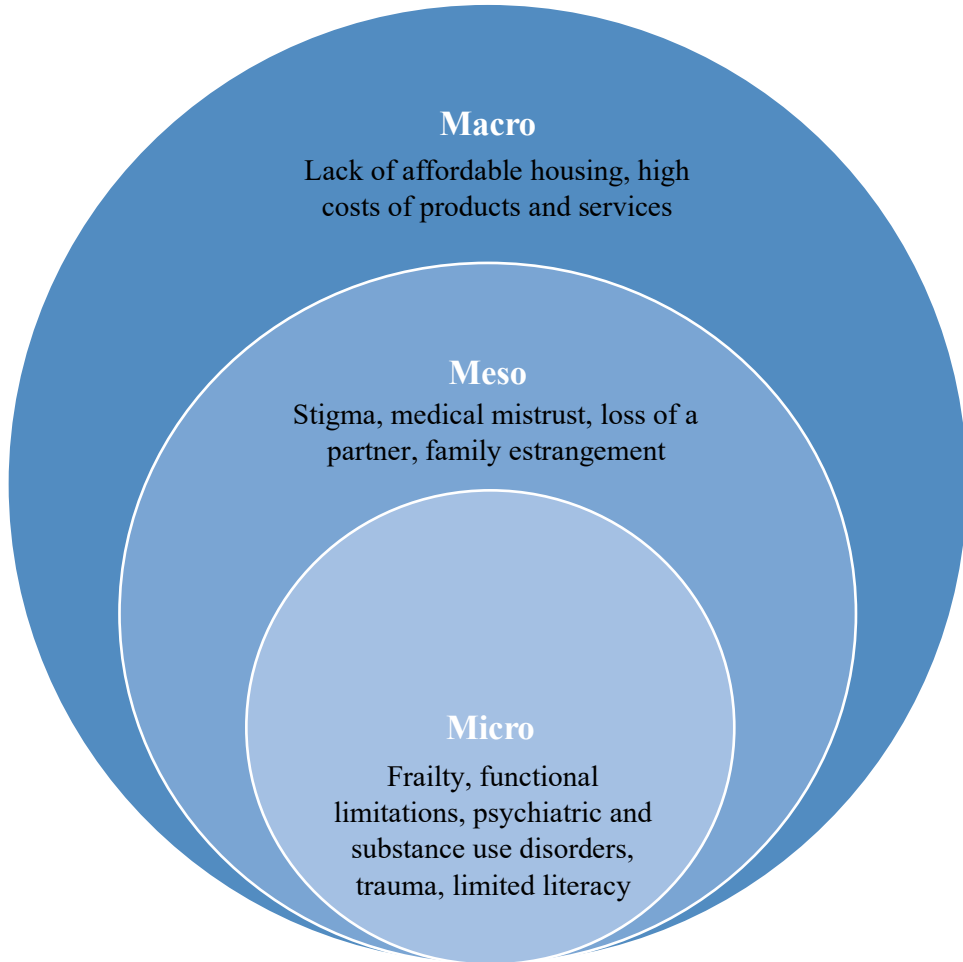


Figure 4.2 Key Barriers Impacting OAEH

#### ***4.2.1 Advocacy for Patients***

When asked about their personal motivations for delivering PC to this population and what PC means to them based on their individual experiences. Participants expressed a strong desire to engage in advocacy by respecting patient autonomy and dignity, ensuring equitable access to PC, helping patients prepare for a “good death,” and providing a holistic approach to patient care.

**a) Respect for Patient Autonomy and Dignity**

Respect for patient autonomy and dignity is a sub-theme identified in the context of ACP for EOL care. One participant identified how traditional settings like the hospital may not be ideal and thereby the importance of helping patients die with dignity in the setting they prefer, such as their place of residence:

*“It is getting better now, but after I started, I realized that there are other roles in healthcare that are very much necessary, like helping those die with dignity in their place of choice, whether that be choosing end-of-life in the hospital, a residential hospice, or in the community and their homes. And the work just continued to fill my cup in a different way that other [...] positions I’ve had hadn’t. It can be just as you know satisfying to help those wanting to as morbid as it sounds, die at home because dying in the hospital is not for everybody. And if we can at least help those who have been diagnosed with a terminal illness, live life to the fullest as much as they can you know, while going through the palliative journey then we’ve done our job.” [P6]*

Another participant described their role as being similar to that of an advocate, helping to re-connect OAEH with their family members to further support patients in achieving their wishes and preferences during EOL care:

*“She also had bipolar and her goal was to die in her motel room. She did not have a phone, there was no access to get her a phone. She didn’t really want a phone and her goals of care were to find her children. And every time that we talked about her children, or she spoke about them. We had built a trusting relationship, she was very resistant to believing or wanting to see her mother but*

*did agree after we talked to her about maybe if you saw your mom she could hug you. She could tell you about your children because she had three children who didn't want to see her, three adult children. In any case [pause] her mom came to see her last Friday along with her three brothers, her children didn't want to come and she died the next day. And we really feel that was and I've seen this happen, and this is just my personal opinion and many others who worked with her, she was able to let go. Her spirit, her mind, her body was at rest. She reconnected with her family after 15 years. So we feel very good about that [pause] that she died not necessarily the way she wanted in her motel room but that last sort of thing we did for her was to reconnect her with those people. We don't know how her life was I mean she's told us things, but that mother, and I quote, wanted to hold her child one more time.” [P8]*

Another participant noted the importance of advocating for OAEH to die with dignity, based on their personal lived experiences:

*“I've got a lot of empathy for people that are end-of-life or want to die with dignity. My own [...] had COPD, she didn't have a good end-of-life. My [...] had dementia and a brain infection and his could have been better. So I definitely have empathy for people that are going through it and I want to, especially the older adults that, you know, even those that are homeless, that have no support network to try to support them to be able to die with dignity where they want to and how they want to and provide supports as much as possible.” [P10]*

Another participant described PC to be a way to address pain and symptoms to improve quality of life and patient autonomy:

*“Palliative care comes from previous terms like an oyster shell. It's a way to protect the patient and have a good quality life. So quality of life care is what palliative care is about. And so the two being domains is that it improves patient autonomy and sense of themselves, who they are, by giving them greater sense of control. And then second, it addresses the pain and symptoms so that, again what they're able to enjoy for quality of life is there. With pain and symptoms, it becomes less enjoyable and their quality of life decreases. So those are the two main factors with illness any illness causes it's typically not expected. It's typically unplanned illness [pause] it's an interruption in somebody's life.” [P2]*

**b) Provide Equitable Access to PC**

Ensuring that there is equitable access to PC, regardless of the patient's socioeconomic status is a recognized priority:

*“I believe in equity, and I believe everybody should have access to palliative care. If I can contribute however big or small [inhales] that's important to me. And just being an immigrant to this country and coming from a healthcare system where such a [pause] palliative care really doesn't exist. So, yeah, I think that's what motivates me is the fact that I think everybody should have access to some form of palliative care wherever they're sitting, whether they're vulnerably housed [pause] to living in a mansion, I think is very important.” [P1]*

Similarly, a participant noted:

*“My motivation towards all of that work is ultimately grounded in like an interest in palliative care, first and foremost, being motivated to help people in death and dying, but then also the um more morally, ethically driven desire to help people*

*who are systematically marginalized by our healthcare system to have the kind of death that they otherwise don't generally have the access to.” [P11]*

The opportunity to access Medical Assistance in Dying (MAID) should also be considered as a component of EOL care:

*“I'm surprised they don't get connected with MAID yet...It should be offered. The issue is you've got a lot of the older providers that don't believe in it. And they're scared of it. So I think it should be offered.” [P10]*

Another participant emphasized the importance of meeting the unique needs of this population:

*“My motivation was really to re-define or more appropriately define primary care for this population and I learned really quickly that palliative care needed to be part of the primary care picture for the homeless population for many different reasons. So, I'm motivated in general, improve and or even yes, improve access to care for this population. And really look at how health care providers can and must reorganize themselves around the needs of this population who are lower functioning.” [P5]*

### **c) Prepare for a “Good Death”**

Helping patients to live comfortably at the EOL, as one participant described, involves a holistic approach that addresses not only physical pain and symptoms but also emotional and spiritual needs.

*“Palliative care can be comfort care. It can be no DNR. It can be helping them to live while they're dying the way they want to. So it brings in all allied health care, your religious beliefs, your family support, your [pause] like anybody in*

*community care, home care, anybody that can help you live comfortably with an end-of-life diagnosis and palliative care can be anybody with cancer, COPD, dementia, anything that their ailment will eventually lead to their demise.” [P10]*

Another participant expressed their commitment to supporting OAEH in making their EOL experience as positive and meaningful as possible:

*“He used to read a Bible, he said. You know, and he lost it along the way so I was able to go like to a thrift store and get him a King James Bible. That's what he wanted and I found it. And again, another tool to help him in what you know whatever way he needed that but he feels he has failed for a long time he's bad or he's trying to prepare you know, he's trying to get ready as he put it. Because he wants to go that way....I always bring it back to quality of life how we can make your end, your death, whatever you call it, the best it can be. And that looks very different for everyone.” [P8]*

Opioid Agonist Treatment (OAT) was suggested as an effective approach for managing opioid use disorders in palliative and EOL care:

*“If you're able to engage somebody in OAT, you know you're going to prevent those fatal overdoses. If you're able to engage in OAT and you're able to address that pain component associated, let's say, with the end-of-life, cancer diagnosis, let's say okay. Then yeah, you will retain in treatment. If you retain in treatment, you have a lot better chances of having access to the client and saying, hey, [George], how are you doing this week? Hey, [George], I think you should go for radiation therapy. Or, hey, [George], let's try whatever you know so yeah, I think the better [pause] I'm going to call it wellness you can achieve in your client, the*

*better that client will engage in care and hopefully the better the outcome knowing we're in a palliative care, end-of-life. But the better outcome and you will have a better comfortable death as opposed to a totally distraught under a tree trouble with pain.” [P9]*

#### **d) Holistic Approach to Patient Care**

A participant emphasized the importance of providing PC as it addresses the various domains of health including physical, emotional, psychological, social, and spiritual needs to ensure holistic support for OAEH:

*“Palliative care is an approach to care. It starts at time of diagnosis and it supports people in many different domains to make it a holistic approach. So, their physical, their medical, their psychosocial, their social, their spiritual, their ADL so functional, their end-of-life planning, loss and bereavement all the way through. It's helped to support them along that journey as best as we possibly can in all of those realms to have the best quality of life possible, until they die.” [P3]*

Meeting the patient’s needs in a holistic way was identified as a key aspect of PC, to ensure the varying domains of health are addressed throughout the patient’s journey:

*“Palliative care is a way [pause] it's a philosophy of care to assist people in shouldering the burden of whatever their life limiting illness might be. So that focus is not, you know, it's not to say that someone is palliative or it's more of an approach to care, encompassing the whole person so that you're not looking at only physical symptoms like pain or other symptoms, but it's a whole approach to treat the whole person and ease their suffering in whatever they say it is.” [P7]*

Another participant described the importance of acknowledging the patient's circumstances, particularly the unique challenges faced by those who are unhoused:

*“Providing addiction medicine is not providing the medical part only. It's all about the motivational counseling. It's about looking at the person, I know it's very easy stereotypic to say that but as a whole and not just as a sick person. And it's saying, hey it's really cold this week. How did you do?” [P9]*

One participant noted that PC should be viewed as an approach to supporting patients, rather than as a label that defines them by the type of care they receive:

*“So palliative care really is alleviating suffering and promoting people to live their best life until the end. Um [pause] and as a [...], um [pause] I hear like phrases being tossed up there that, oh, you know, he's palliative, she's palliative and it's just really trying to re-educate clinicians, health care providers, that palliative care is a philosophy of care and it's an approach to care.” [P1]*

#### **4.2.2 Facilitators to the Delivery of PC**

Four key factors were identified to enhance the effectiveness of PC delivery in a community-based setting: meeting patients where they are, effective communication, co-locating medical and social services, and interprofessional collaboration.

##### **a) Meet Patients Where They Are**

A participant emphasized the value of understanding and learning from the lived experiences of family members, noting how this perspective informs their approach to meeting patients where they are in their own journeys:

*“My [...] had a history with drug abuse and she was homeless for a long time, as well as I had a [...] who had a history of drug abuse and she and he was homeless*

*for a very long time. So, I've learned to understand and learn from listening through them. How people think, so how they're safe in their little community, right? And understanding that sometimes they don't feel safe going to a shelter. They don't feel safe reaching out to health care professionals or being placed in a hotel program because where they feel safe is on the street. That's where they found safety because they ran away from definitely unsafe environments a lot of times.” [P3]*

Maintaining the patient's sense of control was prioritized by allowing her to make decisions about her care and daily routines. The frontline care team included nurses and personal support workers (PSWs), depicting a patient-centred approach that meets patients where they are at in their illness trajectory:

*“So maintaining her sense of control, okay, we let her decide this is how she wanted to care for this, fine. She wanted to only stay in bed and have the things within reach, fine. The nurse would reorganize her supplies. We came up with a plan of ordering supplies like on the same day for the same delivery every week. The PSW did her laundry, the PSW organized her food she had things set up on the bed with her so she could always reach food and drink.” [P7]*

Meeting patients in the setting where they feel most comfortable and pacing conversations based on what they wish to discuss are central elements to providing patient-centred care:

*“I used to see this one gentleman who unfortunately passed away, but I think I did help with his end-of-life. I met him on the steps of his apartment. He didn't feel comfortable bringing me in at the time. He didn't want anybody in because it was*

*an invasion of his privacy, plus he was embarrassed. He lived in a rooming home like six other people. He didn't have much belongings. He had a sister who was advocating for his health. But I met him where he was at. Eventually he did, whether it was the illness or whether his comfort level increased. He did allow people into his home. But for the most part, people are maybe anxious, but you meet them where they're at. You go to their home, you meet them in a coffee shop if necessary. And it's not always structured task-oriented meetings. It's where you see what they need at that time. Discuss what their care, their need, what their plan of care is but the biggest issue at that time is.” [P10]*

Another participant noted that the PC program at the Southeastern Ontario hub is similar to the PEACH model, highlighting that “meeting the patient where they are” is an effective approach in the delivery of PC:

*“The palliative education and care for the homeless program is definitely born out of those principles of meeting people where they're at...Facilitate dignity for people who are otherwise not often afforded dignity within the healthcare system, harm reduction, trauma-informed care, absolutely, those are all underpinning. The program looks rather similar, although PEACH is much farther ahead at this point in time in terms of how deeply entrenched they are, their referral system, the volume of care providers, the volume of patients that they serve, the geographic area. So, it's a well-established program that's well funded.” [P11]*

#### **b) Effective Communication**

Participants identified specific skills that help facilitate effective communication in conversations about PC for patients with cognitive limitations, such as keeping

discussions brief, revisiting conversations and avoiding medical jargon. One participant highlighted the approach to revisit conversations with patients, noting that returning to important topics can help achieve PC goals:

*“One of the things we learned fairly early on in our work with [PC program] is that we really needed to modify the advanced care plan discussion. It really has to be brief but revisited often...For us, you know, we have to be cognizant of when we raise that point of discussion and we really need to be aware of the person's capacity to engage in that discussion. Like very rarely can we sit down with someone in this setting and have like an hour-long conversation so we end up having to really do things briefly and in stages, if you will.” [P5]*

Brief conversations were identified to be effective in mitigating communication challenges with OAEH who experience functional limitations:

*“If they have any kind of [pause] like if they might have some degree of hearing loss. They might have some cognitive challenge, some forms of dementia. One client or most of I'd say, a fair number have some early signs of dementia. So, it's small amounts of information and focusing on one or two sort of areas, instead of covering large amounts...Before I go into these visits, I have access to their hospital chart if they've accessed [hospital located East], right? So, I prepare, I have all that history in front of me to determine those areas where I have to modify or change to accommodate for people who have particular disabilities or even the way they learn. The way people take in information, right?” [P8]*

A participant emphasized the importance of providing support that is tailored to each patient's individual needs, ensuring that care is responsive and personalized:

*“I acknowledge what they're going through, definitely validate their concerns or feelings. Especially if I come out and say, and even just do my introduction you know, I'm calling from [...]. And then if I hear that hesitation and they're like, I'm not hospice yet, then I will start with explaining to them it's an early approach to care and it's as much support or as little support as you will want and need right now. And then that can change along the way. A lot of what we do is education and supporting all the decisions that you want to make, the goals of care.” [P6]*

The use of plain language in conversations can help reduce the power differential between health care professionals and patients:

*“I personally, I'm talking to my patients regardless of who they are like they are normal people, like I'm not talking down to them. I'm trying to be conversational. I think particularly with this population, trying to eradicate the hierarchy and the power differential that naturally exists between a clinician and a patient becomes really important. Because like the systems that have harmed them are so hierarchical and sort of exercise power over them in these ways that they don't have a lot of control over. So practically speaking, you know, I introduce myself by my first name. I let them know that they can call me [Katie] if they want, but most of them don't, which I appreciate. Speaking in terms that they can understand, like taking the time to explain things rather than just delivering information. So doing a lot of you know sort of writing things out, drawing things out giving them the time to sort of like absorb and contemplate things that are shared with them. Always making sure that people understand that they have the power. So, when I'm making a recommendation, they are in no way, shape or*

*form required to follow through on that. And if they don't, like there's not going to be any punishment or judgment and that I'm always just going to be there to go at their pace and demonstrating that in action.” [P11]*

**c) Co-Location of Medical and Social Services**

The co-location of medical services, including PC, as well as social services, such as meals, clothing, and temporary housing, promotes longitudinal engagement, the opportunity to build trusting relationships, and the earlier identification of PC needs. Accessing PC in a single location helps facilitate low-barrier access, simplifying the process for OAEH with functional limitations:

*“This hub is a key driver of coordination of services. It becomes a one-stop shop for these folks who have multiple complex multidisciplinary needs. To be able to access services in a low-barrier manner at one city and one stop.” [P2]*

Another participant shared:

*“They have their volunteers, they have the food, they have clothing...they have the medical group. And now they have our navigation team involved to help support as well. So, I think all of that, if people, if the homeless people choose to use those services that will help to give them back control over their life. And then we can work on, okay, finances, housing, all these different things that they may need. But it's just getting them through the door and the trust there.” [P3]*

A participant emphasized the benefits of accessing medical services without a scheduled appointment at the Southeastern Ontario hub:

*“We as service providers need to get out in the community and engage with our folks in that way. But I also feel that it's really critically important that individuals*

*who are homeless have an opportunity to step into a place that understands their needs and has sort of built you know the components that they require into the setting. So, like people know that they can come here, they can get food and rest and great health care that is trauma-informed and like there's some continuity. We don't just see them today and forget about them. We actually will present them at rounds the following day. Discuss them with the other team members and talk about how we're going to stay on top of things with that person. How we're going to stay connected? What's the next point of discussion within the care plan? Who really needs to be involved at that point and then how will we know when it's time to bring other folks into it? I just think that co-location is really important, that the access piece is on point. You don't want people to come and have to wait to see this person, wait to see that person, can't get a hold of that person, that person's not here today. That service isn't available until a month from now. It's really like, how do we line it all up? So that I as the palliative care patient who is low functioning and struggling with just a multitude of barriers that I can come in and have a relatively seamless experience.” [P5]*

Another participant noted that this environment can help create a safe space for this population to access medical and social services, fostering a sense of comfort, trust, and belonging that encourages OAEH to seek as well as engage with PC services:

*“The reason this works is because you have the provision of basic necessities in the same space as medical care. You're someone who is experiencing homelessness and has scarce opportunity to eat food. They're not going to prioritize taking care of their infection or coming to do preventative screening*

*over getting a meal. And so, when you put them in the same place, you're creating an opportunity for engagement...They're not just going to walk into a clinic one day. They want to feel comfortable in that environment. They want to feel physically and emotionally safe in that environment. And so, if they have been a patron of the [Southeastern Ontario hub] for a few months and they're feeling comfortable now. They might then walk that extra 200 meters back to the clinic. They may have had many conversations with other patrons who are clients in the clinic who have said, like they're actually going to listen to you in there and my experiences have been good. And so they collect [pause] they collect those testimonies from their peers.” [P11]*

#### **d) Interprofessional Collaboration**

Collaboration among multiple health care professionals, along with partnerships across various organizations, enhances the delivery of PC services by enabling a more coordinated approach to patient-centred care. One participant highlighted that an interprofessional approach supports the earlier identification of patients who could benefit from PC:

*“The team is working diligently to early identify patients who would benefit from an early approach to palliative care and identifying them sooner. And I know in our round meetings that we've been having [pause] there's been a few patients that have been discussed and being early identified who aren't receiving any home care services yet. But they've been discussed with the team to say, we have this patient, here's the problem, list of health issues they have, here's their situation. You know, maybe we've seen them once or twice. Here's where we're*

*thinking of going and the team's talking, you know, have you thought of this?*

*What about that? Before things are even formally in place for that person. Which I think is really helpful because they're really trying to early identify you know, those more complex patients who, yeah, maybe their health is changing, maybe identifying them early is going to benefit them.” [P7]*

Another participant added that collaborative discussions help facilitate holistic assessments and connect patients with the appropriate supports, ensuring that PC addresses the full range of their individual needs:

*“Yeah, so we do talk about the person, like I said, in a holistic manner, what is going on with [pause] what are their issues? What are their needs? What are their social needs? Do they need housing? Do they need food? Do they need clothing? Do we need to limit with ODSP or Ontario Works or get them any kind of supports in. So, we do look at them, look at the person holistically to see what they need and then reach out into the community to get that for them. Because a lot of times they don't know that these supports are out there.” [P3]*

A participant noted the importance of working with community paramedics as their involvement enhances the delivery of PC to OAEH in the community:

*“When you provide care to that vulnerable population with addiction and mental health, 90-95% of them will not want to come in. Certainly 99% will not want to go to the emergency room, do not want to go to the hospital. So, we need to find other ways of supporting them the best we can. So yes, some of them will come to [program at the Southeastern Ontario hub]. If they won't come in, then what we do is the primary care provider will do virtual visits and it's going to be the exact*

*same thing with the [PC] program. So, it's bringing the service to the client when you cannot expect or it's unrealistic to expect that that client, first of all, they don't have money. How are they going to get themselves to [Southeastern Ontario hub]? You can't say, hey, show up on Tuesday at 10:12 for your appointment. Okay, that's just not going to work. They can't leave their encampment. If they leave the encampment, they're going to come back, everything will have been stolen. There's a lot [pause] and there's a lot of violence in there. So, the community paramedics is one tool to bringing the service.” [P9]*

Partnerships with external organizations and the bi-weekly rounds at the Southeastern Ontario hub with the PC team can also help support the delivery of patient-centred care by expanding upon available resources and ensuring that care is tailored to meet the unique needs of each patient:

*“We want to meet people where they're at, not just medically, but also spiritually, functionally, and in this case, like even more so socially right? So, if we're looking at trying to help someone who is unstably housed and who maybe doesn't trust the system who also has an addiction, like just as an example, you're going to need the multitude of players that we have at the table. And so, we're really lucky to have partnerships with people from Ontario Health atHome, but also organizations like the PCCT or palliative care community team that will go out and build relationships with people and provide psychosocial support to them, help them access various services. So we do our rounds and there are like 10 people on those rounds and usually everyone has something to contribute or they might have experienced something with that patient that we haven't because that*

*person is quite transient and so it's all of those different channels of information, different forms of expertise that allow us to actually help care for people who are kind of, if I can say like sort of slippery and hard to get a hold on.” [P11]*

#### **4.2.3 Barriers Relating to Homelessness**

Participants identified four barriers that relate to homelessness and can affect the ability of OAEH to access PC services: poverty, a sense of control, social isolation, and functional limitations.

##### **a) Poverty**

The lack of money for personal needs and transportation, often associated with poverty or low socioeconomic status, poses a significant barrier to accessing PC. One participant shared the challenge of a patient not having a cell phone:

*“I find generally speaking they don't have a cell phone. If they do, it often gets stolen very quickly after they acquire it. Or they have the cell phone, but they often run out of minutes like they can't afford a plan like you and I, so they don't have guaranteed data available to them. They're just kind of purchasing minutes as they go, depending on what money they have left and then they run out of minutes so they're unreachable or can't communicate with other people.” [P11]*

The lack of money for transportation to appointments also poses as a barrier to receiving a formal diagnosis required for PC:

*“There are financial barriers for sure and absolutely transportation, getting to appointments. They're depending on outreach workers, etcetera, who typically you know, work 8 to 4 say. I've had clients happen to be at like MRIs or tests and things at the hospital at 7 a.m. and they're late and that gets them really anxious*

*and then the people who are working there again judgment, stigma, not being very supportive, saying you should have been here, we told you etcetera.*

*Definitely, you know, don't have the ability financially to get an Uber or taxi or whatever and again, the biggest one is the communication.” [P8]*

Additionally, the lack of insurance was identified for OAEH:

*“I probably got to know her for about over about 2 to 3 months before she started accepting some medications. And of course, with her, she has no drug coverage and that's another barrier... because she's been out of the system for so long, she's lived in the woods.” [P2]*

OAEH with limited literacy skills may struggle to read and complete legal forms required for ACP:

*“Like how you kind of disseminate what a substitute decision-maker is, how they benefit you and your health. I think that's a big part of it. But it can definitely be a barrier when you're looking at forms and things like that. And then you have to think about the literacy level, like although it's just a signature.” [P1]*

#### **b) Sense of Control**

Exerting a sense of control over one's situation has been identified as a challenge when delivering PC. One participant described how a patient above the age of 50 wished to manage their health condition independently:

*“This last patient that I had she really didn't want to take any suggestions or advice from myself or the [...] nurse about how to manage [pause] she had some drainage out of a fistula. It was a mess of going through a lot of supplies and we talked about, you know, there's some other ways that could make this easier for*

*you. Make it easier, cleaner, make it less work for you. And she was like, no, this is how I want to do it like kind of shut it down...And maybe that's stemming from past trauma or addiction issues or whatever has led them to be homeless in the first place. They want to have control over whatever they can.” [P7]*

A sense of control over one’s situation further manifests as a limitation to receiving care in one’s setting:

*“She had a fistula in her groin that was leaking fluid and stool. So, we had suggested putting an ostomy pouch on it to collect the drainage, rather than it just draining everywhere. Because she was just using gauze to clean it and there was stool everywhere. Like she was laying in bed and her hands were dirty, she couldn't get up and walk to the bathroom. She was just in bed, so she would just change her diapers in bed. She couldn't change her own clothes, but she could use gauze to take care of the [inaudible], baby wipes, that type of thing. She didn't want to entertain any other way of looking after it other than just using the pads, you know, gauze, abdominal pads and the diapers.” [P7]*

Another participant shared a similar experience caring for an older adult with a substance use disorder:

*“Dealing with people that have a previous substance use disorder, you have to be careful with narcotic use. And a lot of the choices Methadone or Suboxone because it can be controlled. He didn't want that because that didn't allow him to take care of his pain. And you have to realize the pain is subjective. It's how they state it, but also you're liable if you over [pause] overdose or you provide the medication to them. So that didn't go well and he actually fired me. But I think it*

*was just he wanted to be in control no matter who was seeing him, I actually referred him to [James] eventually and he didn't want to be seen by him. He did consult him. He had a lot of faith in his home care worker and trusted her a lot. But I think it was his lack of control.” [P10]*

**c) Social Isolation**

**i) Estranged from Friends and Family**

Being estranged from friends and family was identified as another barrier to accessing PC. One participant shared:

*“These folks are typically having mental illness, addictions, and homelessness, and that is meaning that most of the time they have not just poverty of finances, they have poverty of relationships. They have no social network. They have no social safety net and they don't trust anybody.” [P2]*

A participant expressed how, in the absence of familiar connections, patients often form meaningful relationships within their community, seeking support and a sense of belonging from those around them:

*“They are often estranged from their families and friends. They often create networks of friends within their community from living on the street or from the motel programs, people who live in the same buildings.” [P8]*

Isolation from human trafficking can also lead to the loss of social connections:

*“A lot of times they do lack a social network. Maybe they have their friends where they're living on the streets. They have a close circle a lot of times but there's others [pause] like we've seen patients that have been trafficked, right? And they*

*have no social network. So, they need that support, and they need to build that one-to-one trust with us.” [P3]*

Another participant described the negative impacts of chronic homelessness among OAEH:

*“I think unfortunately that's true of many older adults in our society, kind of regardless of their housing status but especially for this group, many of the [pause] it's kind of a feat to live to be an older adult within this population. And so many people they knew have died. They've just experienced a lot of loss. And then often the housing that is available to these folks is, you know, like maybe a motel program room, which is great. It's stable shelter but it doesn't really facilitate a lot of community. They're often sort of geographically because of gentrification like gentrification located outside of the areas where other members of their community congregate. So, they're not you know, they're not really close physically to other people. It's not always the case, but I do find that they're socially isolated.” [P11]*

ii) Lack of a SDM

The lack of connections with family and friends can result in the inability to select a SDM who truly knows the patient, making it challenging to ensure that care decisions reflect the patient’s values and preferences:

*“So, most times there isn't a substitute decision-maker. And part of my role as a [...] was to kind of drive those conversations and encourage them to assign either a friend or a family member. So that particular client I was talking about,*

*thankfully she did have a lot of siblings that were trying to support her, did have a SDM, but typically, no that's usually not done..." [P1]*

A participant noted other challenges experienced by OAEH in selecting a SDM, including family estrangement:

*"From a palliative care perspective, it becomes very difficult to find substitute decision-makers for many of these folks. It's really common to hear that they just have not, they've not been in contact with members of their family for many years. They're estranged from their kids if they have kids. They're estranged from their siblings. They may have friends, but to establish someone as a substitute decision-maker requires additional steps that can be difficult for some people to engage with, like establishing a POA. And those friends are often quite vulnerable as well. So yeah, it's a challenge for sure." [P11]*

A participant shared that aging is often linked to a lack of social ties or the loss of a partner, which can increase the risk of social isolation among OAEH:

*"The first thing that we kind of take a look at is their diagnosis and what kind of familiar or what kind of supports they have socially. We do tend to find, unfortunately, those who are a little bit older if their partner has passed. They tend to be alone if they haven't had any kids." [P6]*

#### **d) Functional Limitations**

The cognitive decline associated with premature aging was identified as having a negative impact on the abilities of OAEH as one participant shared:

*“Their level of awareness, they become more disabled, and they may not remember things as well because of their symptoms or their illness that's getting in the way.” [P2]*

The psychological diagnosis of dementia, schizophrenia, or bipolar disorder is common:

*“Many of them have dementia and many of them have a diagnosis of I would say some sort of bipolar picture [pause] uh schizophrenic sort of typical, this [pause] not schizophrenia, but the schizo type.” [P8]*

Changes in the brain, along with the long-term impacts of homelessness, are significant factors affecting the cognitive functioning of OAEH:

*“Significant psychiatric illness, so schizophrenia, bipolar disorders, psychosis. We see a lot of severe addictions, so brain changes as a result of addiction and of course just the longstanding impact of being homeless.” [P5]*

Similarly, a participant noted that substance use disorders, when compounded with the experience of chronic homelessness, negatively impact the health of OAEH, contributing to premature aging:

*“They often, not always, of course, but often have experienced chronic substance misuse or substance use disorders. Many of them have been on psychotropic medications for a long time for chronic mental illness. The sort of pro-inflammatory state that's associated with chronic homelessness has also contributed to a deterioration in their health that's probably more rapid than someone who isn't experiencing homelessness at that same age. So, their brain really has experienced a great deal of stress and deterioration.” [P11]*

Functional limitations can be associated with a decline in cognitive functioning:

*“As the functioning of a person decreases, they become less mobile. They're needing assistance for mobility, getting from place to place.” [P2]*

#### **4.2.4 Barriers Relating to Healthcare**

Three barriers relating to healthcare were highlighted by participants to affect the ability of OAEH to access PC services in institution- and community-based settings: stigma, mistrust in health care professionals, and quality of PC.

##### **a) Stigma**

Stigma associated with homelessness, the use of illicit substances, and substance use disorders poses a significant barrier to accessing PC services. One participant shared that the current structure to receive PC services needs to be changed to better address these challenges and ensure that care is accessible and inclusive for OAEH:

*"Hospitals inaccessible, because of the stigma and the trauma that they face.  
Physicians inaccessible, because of the trauma and the stigma that they face.  
They don't make appointments, these folks. So, unless there's a different structure for these folks, they're not going to get palliative care.” [P2]*

Another participant noted that stigma associated with substance use can influence the way pain medication is administered, often resulting in inadequate pain management for patients:

*"Because of the fear, because of the trust, because of the stigmatism, if they're using alcohol or using other substances, they don't want to go to the doctor and be completely honest. They're afraid of that because they are in immense pain,*

*and they probably need a higher dose of pain medication than a normal person that doesn't use substances would because they're used to substances." [P3]*

A participant also confirmed that negative experiences often arise from stigma and judgment expressed by health care professionals, highlighting how these attitudes can create barriers to care and negatively impact patient well-being:

*"15 years ago, I'd rush in and try to do all the work quickly. But now, it's a process. It takes a long time to build that trust... they've had really negative experiences for the most part with a great deal of stigma and judgment with health care providers." [P8]*

#### **b) Mistrust in Health Care Professionals**

Mistrust experienced by OAEH stems from various factors, such as negative patient experiences and high employee turnover.

##### **i) Negative Patient Experiences**

OAEH are devalued and treated poorly when seeking help from health care professionals in traditional care settings (e.g., hospital). A participant identified the lack of trust to be linked with the avoidance of seeking PC services:

*"...A lot of times they will go into the healthcare system legitimately suffering from pain or other conditions and be treated like they are drug seeking. And we see that a lot. So, the trust is not there." [P3]*

A participant noted that any prior negative experience with a health care professional can reduce the likelihood of OAEH to seek PC and may increase their suspicion or distrust of the healthcare system:

*“It becomes a huge barrier for them to re-engage once they've had some kind of experience with the system. And it only takes one person, right? Any person that represents a system, if they've had a bad experience, they take that with them to their next encounter with the system, next appointment, next intervention that they need. And everything is viewed through a lens of that suspicion that, oh, I'm going to be hurt again. It becomes much harder to actually get the care they need.” [P2]*

Another participant shared:

*“They have experienced racial trauma, they have experienced discriminatory trauma, and they've experienced from my point of view, institutional betrayal. This is a publicly funded system that's supposed to serve all people. But they know from the many times, like anyone who's experiencing chronic homelessness, they have sought care in the emergency department, that they will be immediately labelled as drug seeking, uncooperative, agitated, aggressive. And what could be a genuine medical emergency may be written off as an excuse for them to find a warm place to be. I don't blame any of them for not wanting to go to the hospital. And I've been quite appalled by some of the things that my colleagues in the emergency department have done to these patients.” [P11]*

In contrast, a participant shared a positive experience, noting that hospitals provide not only medical care but also opportunities for connection and support:

*“They might be coming in for Demerol, Imitrex for a migraine, headache. But now, I think if I had the time although I had the time you know, these people are not necessarily coming for this, it's maybe the social interaction they're coming for. They don't have any supportive home. They're maybe in an abusive*

*relationship. They don't have food at home, they'll get snacks here. It's really looking at the patient as a whole, not just what their disease process is. And that's a lot to do with [PC program] you're not just looking at the disease. Yes, you know, if they have this, this, and this, you know what their trajectory should look like, but you're looking at them as a whole.” [P10]*

ii) High Employee Turnover

A high employee turnover rate was also identified as a factor contributing to mistrust among OAEH:

*“You're at the whim of what community nurses are available, what PSWs are available. It'd be nice just to have dedicated staff because you know, I think that's what builds the trust in this particular population. If you're always seeing different faces and things like that, how do you [pause] build that trust? I think with having the nurse practitioner and just having that team within [PC program] being the regular people is great, but they're not the everyday people, right? The everyday people are the people that are providing the frontline services, which is your personal support worker, your community nurses.” [P1]*

Another participant noted:

*“In long-term care, the turnover is ridiculous. They don't get paid the same as hospital, right? Staff don't get paid. Same as in community. They get paid a lot less...But they don't get paid the same wage and it should be across the board that everybody, if you're an RN, RPN, PSW, whatever, you get paid the same wage. Because as soon as, especially in the community, we'll get a new nurse because it's also new. It's always in new grads a lot of times, right? And we'll start to get*

*them educated and a job will come up at the hospital and they'll jump on it. And then we have somebody else that we have to now start again. Providing good holistic palliative care is next to impossible when there's constant turnover.” [P3]*

The emotional strains associated with delivering PC can also contribute to high rates of employee turnover:

*“There is a lot of changeover because what we do can be quite heavy, and so compassion fatigue is huge.” [P6]*

### **c) Quality of PC**

The design of services, such as structured appointment times, limited opportunities for communication with providers in community-based settings, as well as insufficient skills and competencies to address the unique needs of OAEH, poses another barrier to accessing PC services. These structural limitations can prevent OAEH from receiving timely, appropriate, and person-centred care.

#### **i) Structured Appointment Times**

Allocated appointment times hinder access to PC; one participant described how this limitation can prevent the completion of necessary diagnoses required to access PC services in a hospital setting:

*“Because those clients don't access the traditional investigation, medical, etcetera, we don't have a diagnosis. Without a diagnosis, how do you access hospital palliative care?” [P9]*

Furthermore, the participant shared a scenario that is commonly encountered:

*“[Gary], let's do some investigations for you. Again, let's book you for a follow-up CT or MRI. How is [Gary] going to get to that appointment? How is he going*

*to remember that appointment is Thursday? He doesn't have a watch. Worse of that, he doesn't have a phone. How is the follow-up for that MRI, CT going to happen? There is no way we can contact that client. So, do you see how the system doesn't work? The system is not designed for that population so they are [pause] setting them for failure.” [P9]*

A participant who provided PC at the previous site (Southeastern Ontario clinic) also described how structured appointment times posed as a barrier, limiting patients from accessing PC services:

*“...Referrals for the [PC] program would actually come from the [Southeastern Ontario hub] and there's [pause] a lot of difficulty with intaking the clients just because of some limitations that come with a clinic like ours that has very structured appointment times for clients.” [P4]*

Receiving a diagnosis is challenging due to the constraints of structured appointment times, which may not accommodate the complex needs and unpredictable circumstances of OAEH:

*“Even simple things like you know in the traditional system, you refer a client for a diagnostic procedure. Well, to get an appointment date and time date that works and that we can assist with navigation for, it takes a lot of coordination, it's unique working with this population. You can't just say to the patient, hey, you have a pulmonary function test Tuesday morning at 9 a.m.” [P5]*

#### ii) Lack of Communication

The lack of communication between health care professionals was identified as a barrier to accessing PC. One participant shared their experience of not receiving any

follow-up communication after making a referral to a primary care provider, highlighting how this gap may disrupt the continuity of care for patients:

*“Whereas a family physician, like you write them an update to say, hey, by the way, this client's being supported by our team, do you have any questions or is there anything that we need to know to support da da da da da? And you almost never get any feedback.” [P1]*

Updates on patients receiving community-based PC and are admitted to the hospital are not being shared with health care providers at the Southeastern Ontario hub:

*“One solution would be to have just one eMAR and documentation, which I know has been brought up, but I feel like that is quite far from being completed unfortunately, or I don't know, if it's actually in the works. But if we had just one generalized documenting system slash communicating system where like if we could page each other saying, oh, you know what your client, your [PC program] client is now in hospital because they overdosed. I feel like the transitions of care from again community, etcetera, would be a little bit smoother. And then we could still be in the know rather than all of a sudden getting a call, hey, did you know this person's hospital? Like, no, I didn't.” [P6]*

Additionally, there is a lack of follow-up for OAEH who are referred to hospital settings from the Southeastern Ontario hub for speciality care:

*“Doctor that's there says, hey, this is your patient. I go, yeah, of course. We'll look after them in primary care, not a problem. But you guys are specialty care, you can always look after them too.” [P2]*

iii) Lack of Skills & Competency

The lack of skills relating to the delivery of PC to OAEH in community-based settings was identified as another barrier:

*“I think the primary care physicians are not educated on how the palliative care team works in the community because I've had my own experiences where I would ask for a referral or I will say, will you keep this client on for end-of-life or for palliative approach to care? And they don't get it. It just either there's some feedback or there's no feedback. Or they'll say, I've referred this client to the palliative team and the referral got rejected because the client doesn't meet the criteria, but it's just like, well, palliative care is not only the palliative physician, it's your hospice team, it's the community, it's more than that, right?” [P1]*

Another participant noted:

*“Outside the sort of ideological frameworks that people bring to their ideas about people who are experiencing homelessness, they're challenging people to take care of sometimes, right? That's because of the ways that these individuals have learned to communicate with and interact with the healthcare system to try to get what they want and need. That's a survival mechanism. It's also because it's very complex to care for people who have chronic mental illness and substance use disorders. And so medical professionals who encounter them I have found if they do not have the skills and the time and the desire to treat these people with dignity, then they will dismiss them because it's too hard to do otherwise.” [P11]*

Conversations about do-not-resuscitate (DNR) orders within ACP are often not explained appropriately to OAEH:

*“Somebody with an advanced disease. It's completely different, right? They're already dying. Their body's already dying So most likely you're not going to come back if your heart was to stop. Or if you do, like I said, you'll come back in worse shape because you're more fragile. We're going to break bones. We could puncture lungs. We can do all types of things, all types of damage doing that. But you're also still coming back to that dying body that you're already in. Is that worth it? So, it's really trying to let them know what is and what it isn't, which isn't always explained very well.” [P3]*

The inability of health care professionals to accurately assess and manage pain in OAEH with substance use disorders hinders the delivery of effective pain management:

*“The pain perception is a huge problem. A lot of it sounds from staff to treat pain thinking that, you know, you're going to over sedate the patient, you're not going to. So, unless you have that comfort level, it's not being provided to clients.” [P9]*

#### **4.2.5 Future Recommendations to Improve the Delivery of PC**

Table 4.2 summarizes the four recommendations to improve the delivery of PC to this population which includes: (1) fostering mentorship opportunities; (2) skills and competency development; (3) improving access to patient records; and (4) the need for PC beds in shelters and hospice residences.

Table 4.2 Future Recommendations

Sub-Themes	Implications	Examples from Transcripts
1. Foster Mentorship	(1) Create opportunities to foster mentor-mentee	<i>“I feel like the nurses should be following a few people and then</i>

<p>Opportunities</p>	<p>relationships within the PC team.</p> <p>(2) Share supports and resources to best support patients and team members to prevent burnout and improve workplace retention.</p> <p>(3) Promote team building to foster a shared sense of purpose, build trust, and provide feedback.</p>	<p><i>taking what different people do and making it their own so they're comfortable with having these conversations, they're comfortable with providing that care, they're comfortable with consoling the patient and family, but it doesn't happen a lot. That mentorship I find that when I graduated, mentorship was huge.” [P3]</i></p> <p><i>“I'm not sure what the word is, but we are all in our different portfolios and different organizations. That's the one thing I feel that's lacking, that we come on these calls on Zoom. I think something's lacking with the [pause] if we had a face-to-face or some sort of training I suppose or team building or that sort of thing.” [P8]</i></p> <p><i>“It's beneficial for the patient and</i></p>
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		<p><i>for the providers...I work in a collaborative team now and it's supposed to really help work-life balance and to prevent burnout. Because when you're the only one and you don't have anybody to bounce ideas off or to, you know, they have more experience, then you really feel isolated.” [P10]</i></p>
<p>2. Skills and Competency Development</p>	<p>Implement mandatory trainings to improve professional and interpersonal skills, reduce employee turnover, improve workplace retention, and promote awareness of the PEACH model. Domains of care include trauma-informed care, harm reduction and effective pain management.</p>	<p><i>“So, for me in this role, I would just like the team to engage with, that are looking to improve the process of delivering palliative care. My only challenge is having like two or three people from that team that can work with me so we can just improve the delivery of the palliative care there. I mean, they provide wonderful care, but how do we make it better and make it more accessible.” [P1]</i></p>

		<p><i>“I always stress this with them...you worked so hard for your license, so hard. And in order to continue to do the job you're in, you need to know the population that you're dealing with. You need to know exactly the symptoms that you're going to be managing and how you manage them. You need to understand your position inside and out, if that's med-surg, if that's palliative care, if that's labour and delivery, you really need to continue to learn.” [P3]</i></p> <p><i>“I mean, definitely when I was going through the [PC] program or like starting with the program, it would have been helpful to already have some of those foundational courses rather than working to get that over time as I already started in the role.” [P4]</i></p>
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		<p><b>Trauma-Informed Care</b></p> <p><i>“...trauma-informed care is really critical. And I would say a good like a good knowledge of the healthcare system because you have to have enough experience and insight to pinpoint or be aware of the pitfalls within the system so that, you know, you can't come to the visit and make recommendations in terms of a trajectory that would be considered traditional. Because we already know that doesn't work. So that access piece, I think you really have to have a firm understanding or an experienced understanding of what your patient's functional ability is and how the system does not actually exist in a way that supports their forward movement.” [P5]</i></p>
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		<p><i>“People with lived experience of homelessness again, who often have mental illness and substance use disorders, although of course not always, they interact with others differently than some people than many of us do. They form relationships and have relationships that are different from others. And I think [pause] that's often influenced by the way that they've learned over time to cope with the trauma of poverty and homelessness, the trauma of so much death around them, the traumas that they may have experienced early in life, which is often the case for many of these individuals. They've learned how to cope with that, and they've learned how to advocate for themselves in non-traditional ways to get what they want. And so, some of those</i></p>
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		<p><i> coping strategies are unpleasant and can be challenging to engage with. So that might be like [pause] people raising their voice more readily, getting what seems to be agitated and demanding. It could be, recognizing where someone in the healthcare role is just not going to give them what they want so they leave, or they sort of discharge themselves against medical advice.” [P11]</i></p> <p><b>Harm Reduction</b></p> <p><i>“At the beginning, my goal was to have all my clients sober. It's not about [me], okay? It's about [Gary]. So, [Gary], what do you want? It's not about what my stigma about what you should be doing and what you should not be doing and where you should be living, okay? So, most of my clients that</i></p>
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		<p><i>are unhoused do not want to be housed.” [P9]</i></p> <p><i>“Communicating both verbally and in the way that you interact with a patient and provide medical care that they are in control, that they have autonomy, you know? Always asking for permission, like really leaning into those fundamental principles of trauma-informed care and harm reduction.” [P11]</i></p> <p><b>Effective Pain Management</b></p> <p><i>“The biggest thing that I see is an ability to ascertain how we can manage both addictions and pain. That's something that's traditionally not done very well for the palliative population that are homeless and or have addictions. There's this misperception that we're doing harm by treating the pain because</i></p>
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		<p><i>there's that contextual piece of addictions, but that's really not correct. So, we really seek to at that point when we're talking, we're on a palliative trajectory. The client's goals are likely not focused on reducing or being abstinent from illicit substances. And if it is, that's great because what we do is we provide the controlled [pause] the controlled option. But we don't shy away from the use of pain management, which traditionally happens in the system. And it's just so unfortunate.” [P5]</i></p> <p><i>“I spoke with my collaborative physician about it as well and I said, you know, I'm really struggling with this because I know that he has pain, justified pain, but he also has the underlying addiction. How do I [pause] and he</i></p>
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		<i>didn't even know how to manage him better, so it was hard.” [P10]</i>
3. Improve Access to Patient Records	<p>(1) Enhanced coordination of efforts and resources is needed to effectively assess each patient’s individual needs and goals.</p> <p>(2) Reduce readmission rates, resulting in cost savings for the healthcare system.</p> <p>(3) Improve patient outcomes and reduce the incidence of medical errors.</p>	<p><i>“...for someone to create a system where we can communicate multiple organizations across but keep it confidential, only those involved in that person's care, it seems like a huge undertaking unfortunately. Municipal, federal, anybody that would be willing to listen, but I find that you know, healthcare is kind of lacking. Everybody kind of says that they're going to do something and then nothing really happens unfortunately.” [P6]</i></p> <p><i>“Then we don't have to make patients repeat themselves. Or you're up to date on, oh, this person already had that conversation if you're reviewing what's happened</i></p>

		<p><i>since I last saw them. Yeah, certainly that in any healthcare, whether it's home care, hospital, clinic, that would be ideal.” [P7]</i></p> <p><i>“There has to be a way to loop everyone in to see what's going [pause] we're working on that. We're not there yet... let's say this client kind of had a respiratory issue and went to the [Southeastern Ontario hub], I won't know. Unless the client tells me or I'm on this meeting every two weeks.” [P8]</i></p>
<p>4. Need for PC Beds in Shelters and Hospice Residences</p>	<p>Increase the availability of beds dedicated to PC in community shelters and hospice residences to improve access to this type of care for OAEH.</p>	<p><i>“We need beds for end-of-life for this population. So, at a hospice residence ideally, not at the hospital. Hospital is more clinically more kind of medical system-like. Whereas hospice residence tend to be more home-like. And so having a hospice residence bed where we</i></p>

		<p><i>have an availability to transition patients for their last days would be important.” [P2]</i></p> <p><i>“Within the [PC program at the Southeastern Ontario hub], we do need access to beds that can serve a clinical function.” [P5]</i></p> <p><i>“I think they will have to leverage their physicians to try and find a solution to transition some of those clients possibly in hospitals and then hospices. Will they want and be comfortable to take care of those unhoused people? They will need education and if that doesn't happen, we will need within the shelter systems.” [P9]</i></p>
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## **Chapter 5. Discussion**

This study explored the lived experiences of health care professionals that deliver PC at the Southeastern Ontario clinic to OAEH, focusing on three secondary research questions: (1) What does it mean to provide PC to OAEH?; (2) What facilitators and barriers are present when delivering PC to OAEH?; and (3) How can the delivery of PC be improved within this population? The findings are organized into five key areas: advocacy for patients, facilitators to the delivery of PC, barriers relating to homelessness and healthcare, and recommendations to improve the delivery of PC. This chapter further discusses the significance of the findings, interprets the key findings within the context of the literature, discusses the strengths and limitations of the study, as well as presents recommendations for clinical practice, education, health policy, and future research.

### **5.1 Advocacy for Patients**

Participants expressed a strong commitment to advocating for their patients, emphasizing the importance of respecting patient autonomy and dignity, ensuring equitable access to PC, helping them prepare for a "good death," and providing a holistic approach to patient care. Respect for patient autonomy and dignity, equitable access to high-quality care, and trauma-informed care are central goals and objectives of the PEACH program (ICHA, 2024). Participants noted that OAEH are more likely to have experienced trauma, which can result from negative interactions with health care professionals in institution-based settings. The PEACH model emphasizes the importance of meeting people where they are; participants echoed this approach to deliver equitable access to PC for OAEH in community-based settings (Buchanan et al., 2023).

In addition to addressing the physical, psychological, and emotional aspects, spirituality was identified in Chapter 2 as a vital component in the delivery of PC to OAEH. Ko et al. (2015) identified among OAEH that a good death is associated with spiritual connection and making amends with others. Another study by Ko and Nelson-Becker (2013) found that most OAEH chose not to engage in ACP, based on the belief that death is beyond individual control. Health care professionals at the Southeastern Ontario clinic and hub noted that for some patients, spirituality may play a role in the preparation for a “good death” in their preferred setting. However, spirituality did not significantly influence decisions relating to ACP in the context EOL care among this population. The reliance on interviews with PC providers warrants further investigation with the direct involvement of OAEH and their caregivers.

## **5.2 Facilitators to the Delivery of PC**

Four key areas were highlighted to improve access to PC for this population: meeting patients where they are, effective communication, co-locating medical and social services, and interprofessional collaboration. Participants described the importance of meeting patients where they are, particularly when delivering community-based PC, as this is a central element of patient-centred care. The literature refers to those being unhoused as being less likely to seek medical care, adhere to treatment plans, and follow up with medical appointments (Hwang, 2001; Kushel, 2015; Stevens, 2024). Collaborating with outreach services, such as community paramedics as well as co-locating medical and social services in a single location were described as effective approaches to meet patients where they are, throughout their illness journey. The collaboration of community services and community paramedics can reduce barriers to

accessing care as they deliver direct care, while providing the necessary resources and supports (Medavie Health Services West, 2023; Taplin et al., 2023).

Johnson et al. (2023) conducted a qualitative study to better understand the health experiences of OAEH who were living in temporary avoidance hotels during the COVID-19 pandemic. The temporary avoidance hotels helped OAEH to maintain a sense of control, adhere to treatment recommendations, and improve quality of life and symptom management (Johnson et al., 2023). However, challenges were identified in addressing the diverse needs (i.e., medical, mental, psychosocial, spiritual, behavioural) of older adults, including the geographical separation from formal services and informal community care (Johnson et al., 2023). The co-location of medical services, mobile health, and increased capacity for telehealth were recommended to help improve the quality of life for residents, reach individual goals, and reduce the burden on the healthcare system (Johnson et al., 2023).

Peters et al. (2024) suggested that improved quality of life among PEH are linked to the co-location of medical and social services. However, the medical services provided at the time of that study did not include PC. Participants at the Southeastern Ontario hub described the increased likelihood of patients to engage with PC services as it is located within the same setting as social services, including support for housing, meals, and clothing. Low-barrier access to support services encourages prolonged engagement, a sense of trust, and improved adherence to medical interventions. Establishing a trusting relationship between health care professionals and OAEH is essential to facilitate effective discussions about PC (Klop et al., 2018). Interprofessional collaboration built on trust among health care professionals is also an important aspect in providing PC as it

significantly optimizes patient health outcomes, while addressing their unique needs (Blocki, 2022; Coverdale & Murtagh, 2024).

Study findings suggest that access to PC in community settings can improve patient reach, engagement, safety, and help achieve their preferred place of care. Prior evidence supports this rationale as the collaboration of health care professionals in community-based settings have been found to be more effective in supporting the unique needs of this population, compared to traditional or institution-based settings (i.e. hospital or clinic) (Coverdale & Murtagh, 2024). A health care model rooted in patient-provider trust is necessary to help address the barriers associated with accessing PC services (Latimer et al., 2024; Purkey & Mackenzie, 2019). A study conducted by Latimer et al. (2024) highlighted participants' requests for compassionate and respectful communication, to feel heard, valued and included. Similarly, participants from the Southeastern Ontario clinic and hub identified how effective communication in conversations about PC can be supported by skills such as returning to topics as well as keeping conversations brief and concise. A qualitative study by Collins et al. (2022) also emphasized the use of simple sentences and building rapport with patients with moderate-to-severe dementia, to help them feel at ease and facilitate conversations.

### **5.3 Barriers to Accessing PC**

Participants described various barriers relating to homelessness and healthcare that prevent OAEH from accessing PC services. The barriers relating to homelessness include poverty, functional limitations, social isolation and a sense of control. The barriers relating to healthcare include stigma, mistrust in health care professionals and quality of PC. Studies have identified mistrust as a significant barrier to accessing PC

services, particularly among OAEH (Ko & Nelson-Becker, 2013; Latimer et al., 2024; MacWilliams et al., 2014; Preti et al., 2024). Stigma and negative patient experiences are identified in the literature as contributing factors (Cagle, 2009; de Veer et al., 2018; Reilly et al., 2022; Saragosa et al., 2022); however, the findings of this study not only confirmed these factors but also identified a relationship between high employee turnover and mistrust in health care professionals.

PC is a continuous and ongoing process that supports patients throughout their illness trajectory, from the initial diagnosis to EOL care (O'Connor & Pesut, 2024). Employee retention among PC providers in community-based settings was identified by participants as essential for building trust, ensuring effective communication, and fostering therapeutic relationships with patients. While recruitment of health care professionals is key, employers should focus on employee retention, especially when delivering PC to marginalized populations to help achieve a sense of community and belonging (Peters et al., 2022; Silver et al., 2024; Voronov et al., 2023). Levesque et al. (2021) conducted a mixed-methods study with frontline staff in the homelessness support sector, linking insufficient wages and burnout to high employee turnover. However, little research has been conducted to identify the causes of employee turnover in the homeless service sector, including community-based settings (Voronov et al., 2023).

The barriers relating to homelessness are consistent with those identified in the literature review and include the lack of transportation, insurance, and social connections along with difficulty making appointments and prioritizing immediate needs (Bazari et al., 2018; Kushel, 2015; MacWilliams et al., 2014; Saragosa et al., 2022). The lack of social networks was identified to be a challenge in the delivery of PC to OAEH due to the

inability to select an individual as a SDM who fully understand the patient, based on their individual wishes, values, and goals. A SDM plays a critical role when a patient loses the capacity to make their own decisions; in such situation, this responsibility is assigned to the individual designated as Power of Attorney for Personal Care (Government of Ontario, 2024). Johnson et al. (2023) compared various housing options and found that COVID-19 avoidance hotels helped OAEH to maintain a greater sense of control, security, and comfort, while also contributing to improved health outcomes. Participants providing PC at the Southeastern Ontario clinic and hub acknowledged that, while a sense of control over one's situation is an important value for patients, this desire can also act as a barrier and hinder the effective delivery of PC.

#### **5.4 Recommendations to Improve the Delivery of PC**

Fostering mentorship opportunities to share supports and promote key goals to deliver PC can help reduce employee turnover and improve workplace retention (Krishna et al., 2020; Levesque et al., 2021). Participants emphasized that they preferred learning from their team members rather than completing specific trainings to improve their knowledge and skills in providing PC, due to their demanding work schedules. This finding supports the rationale for connecting an experienced clinician with a junior clinician through a mentorship program that takes on a formal or informal approach (Krishna et al., 2020). A formal approach provides the clearer identification of goals, objectives, codes of conduct, and responsibilities whereas an informal approach lacks transparency, oversight, and support (Krishna et al., 2020). The integration of a mentorship program within an organization is feasible with the identification of the program's goals, potential mentees and mentors, expectations, and structure (Canadian

Medical Association, 2025). The integration of mandatory trainings can enhance the confidence and competency of health care professionals, ensure the consistent application of skills to deliver PC, and help decrease the risk of compassion fatigue (Alruwaili et al., 2024; Calver et al., 2025; Garnett et al., 2023; Shiri et al., 2023). Shiri et al. (2023) found in their systematic review that mandatory trainings can improve the quality of care for patients, their safety, and is related to a decreased risk of employees leaving their position. A qualitative study conducted by Calver et al. (2025) found that nurses and personal support workers in long-term care expressed a desire to access training modalities and a mentor through a co-worker or shadowing opportunities to help improve staffing stability. Participants also identified areas to improve clinical competencies in palliative and dementia care, including personal skills such as stress management and coping with anxiety, as well as leadership skills relating to time management and preceptorship (Calver et al., 2025).

The PEACH model can serve as a guiding framework to support health care professionals with the necessary skills for trauma-informed care and harm reduction (Buchanan et al., 2023). One participant completed a mandatory clinical rotation with the PEACH program; however, most participants did not undergo any training involving this program or the PEACH model. The need for effective pain management was emphasized for OAEH with a substance use disorder. As identified by a participant, OAT is currently the most effective harm reduction strategy for individuals with opioid use disorders, involving the administration of opioid agonists such as methadone or buprenorphine (Government of Canada, 2024). Moreover, this therapy aims to prioritize comfort by treating the pain associated with withdrawal symptoms and reducing the harms linked to

the use of unregulated opioids, including the risks of infectious disease transmission, overdose and mortality (Centre for Addiction and Mental Health, 2016; Government of Canada, 2024). The integration of Palliative Pain and Symptom Management Consultants can help to improve the skills and competency of health care professionals through formal educational sessions (Victorian Order of Nurses, 2025). Improved access to patient records can provide health care professionals with a more efficient understanding of each patient's history. As a result, participants recommended implementing a single database to improve the communication between health care professionals in community- and institution-based settings. Advocating for funding from the Ministry of Health is essential to support the development and implementation of this database. While conducting member checking, a participant confirmed that the Ontario Ministry of Health's Homelessness and Addiction Recovery Treatment program will fund beds at the Southeastern Ontario hub in 2026. This approval will help to address the need for specialized PC beds to improve the delivery of care for OAEH.

### **5.5 Study Strengths and Limitations**

Strengths of this study include the use of various validation strategies, which included pilot testing the interview guide, member checking with nine participants, triangulation, a peer auditor, and reflexive journaling. These are important approaches to establish the credibility of the research findings and help reduce biases (Lincoln & Guba, 1985). Another strength of the study was the use of interpretive phenomenology and the PEACH model to explore the lived experiences of various categories of health care professionals as they provide PC to a vulnerable population (Matua & Van Der Wal, 2015). The interview guide was semi-structured and included questions to explore and

interpret the meaning of the health care professionals' lived experiences in the delivery of PC to OAEH at the Southeastern Ontario clinic and hub.

This methodology values the perspectives and voices of participants, empowering them to share their stories and contribute to a deeper understanding of their lived experiences in delivering PC to this vulnerable population. The use of snowball and purposive sampling was imperative in reaching the target sample size and helped mitigate challenges related to contacting health care professionals due to their busy schedules (Coleman, 1958-1959; Patton, 1990). This method of sampling was particularly useful as the health care professionals were not familiar with the researcher. The use of Braun and Clarke's (2006) model of thematic analysis offered flexibility during data analysis, enabling the identification of the main themes and sub-themes.

This study had some limitations, including potential bias due to the predominance of female participants, a small sample size, homogeneous patient population, and a lack of cultural diversity among patients receiving PC. There were also limited opportunities to connect and build rapport with participants, and the study focused on a single PC program in Southeastern Ontario. Another limitation was that two participants did not engage in member checking, most likely due to their busy schedules and time commitments. The researcher attempted to recruit additional male participants, but the only other male worker identified at the site was not interested to participate in the study. The findings suggest the importance of providing medical and social services in a single location for low-barrier access to PC among this vulnerable population. Furthermore, the implications help address the gaps in the literature that proposed the provision of medical and other formal services in a single location to serve OAEH. However, it should be

noted that community hubs can be beneficial with secured funding in urban settings as opposed to rural settings to provide centralized services and build social cohesion within a community (Government of Ontario, 2025).

Key skills for communicating with OAEH who have cognitive disorders, such as dementia, were identified and can help inform future medical training and education for clinicians. Future research can explore the perspectives of OAEH that are accessing the co-location of medical services, including PC, and social services to identify factors that help establish a trusting relationship between PC providers and patients. However, vulnerabilities as well as cognitive and functional limitations should be carefully considered. Power differentials must also be considered both between researchers and participants as well as health care professionals and patients. Personal opinions held by health care providers can influence their responses, treatment recommendations, and perspectives toward OAEH. The inclusion of patients and their caregivers is key to better understanding the perspectives of this vulnerable population and helping address health disparities in accessing PC. The findings from this study help address gaps in the literature by identifying barriers and facilitators in the delivery of PC to OAEH. Moreover, there is a need for non-traditional approaches, the co-location of medical and social services, interprofessional teams, and specialized skills to deliver this form of holistic care. This study supports the rationale for community-based care as an effective alternative to institution-based care to better address the PC and unique needs of OAEH (Coverdale & Murtagh, 2024).

## 5.6 Implications and Conclusion

In summary, this study used a qualitative interpretive phenomenological approach to explore the perspectives of health care professionals providing PC to OAEH at the Southeastern Ontario clinic and hub. The research question aimed to gain a deeper understanding of the lived experiences of health care professionals as well as to identify perceived barriers, facilitators, and recommendations for best practices in the delivery of PC to this population. The study's findings addressed the three sub-questions, along with the gaps in the literature and provide implications for clinical practice, education, health policy, and future research to address the unique needs of this population. Moreover, the key barriers, facilitators, and future recommendations identified provide important context for the delivery of PC to this population in Ontario, Canada. Mistrust in health care professionals continues to pose a major barrier for this population in accessing PC services in institutional settings; thus, the involvement of an interprofessional team to provide holistic care in community settings is emerging as an effective alternative approach. Participants identified key benefits of integrating medical and social services through an interprofessional team in a single location to provide low-barrier access to this vulnerable population.

A high employee turnover hinders effective access to PC by causing inconsistencies in patient care, disrupting continuity of support, and making it challenging to maintain a skilled and experienced workforce. The application of clinical approaches such as the implementation of a mentorship program, mandatory trainings and educational sessions, a single database to access patient records, and the increased access to PC beds are imperative to improve the delivery of PC to OAEH. The integration

of the PEACH model into mandatory training programs, including educational sessions, can be considered a feasible approach to addressing identified gaps in the delivery of PC. Workplace retention is necessary to promote longitudinal engagement with patients, build therapeutic relationships, and help foster a shared sense of purpose among health care professionals. The evaluation of factors associated with improved workplace retention in community-based settings is crucial for maintaining a stable and effective workforce to deliver high-quality PC. Future research can explore the perspectives of those directly involved in or impacted by community-based PC services, including OAEH, their caregivers, volunteers, health care workers, and community partners.

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## APPENDICES

### Appendix A: REB Approval

*Date:* June 05, 2024

*To:* Dr. Winnie Sun

*From:* Melissa Sidhu, Research Ethics Officer on behalf of Dr. Joseph Eastwood,  
REB Chair

*File # & Title:* 17824 - Exploring the Perspectives of Health Care Professionals Providing  
Palliative Care to Older Adults Experiencing Homelessness

***Status:*** APPROVED

***Review Type:*** Delegated Review

***REB Expiry Date:*** June 01, 2025

***Notwithstanding this approval, you are required to obtain/submit, to Ontario Tech Research Ethics Board, any relevant approvals/permissions required, prior to commencement of this project.***

The Ontario Tech Research Ethics Board (REB) has reviewed and approved the research study named above to ensure compliance with the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS2), the Ontario Tech Research Ethics Policy and Procedures and associated regulations. As the Principal Investigator (PI), you are required to adhere to the research protocol described in the REB application as last reviewed and approved by the REB. In addition, **you are responsible for obtaining any further approvals that might be required to complete your project.**

Under the TCPS2, the PI is responsible for complying with the continuing research ethics reviews requirements listed below:

**Renewal Request Form:** All approved projects are subject to an annual renewal process.

Projects must be renewed or closed by the expiry date indicated above (“Current Expiry”). Projects not renewed prior to the expiry date will be automatically suspended by the REB. If no response is received from suspended projects, the REB will permanently close your study for administrative non-compliance at the next scheduled REB meeting. Once your file has been formally closed, a new submission will be required to open a new file.

**Change Request Form:** If the research plan, methods, and/or recruitment methods should change, please submit a change request application to the REB for review and approval prior to implementing the changes.

**Adverse or Unexpected Events Form:** Events must be reported to the REB within 72 hours after the event occurred with an indication of how these events affect (in the view of the Principal Investigator) the safety of the participants and the continuation of the protocol (i.e. un-anticipated or un-mitigated physical, social or psychological harm to a participant).

**Research Project Completion Form:** This form must be completed when the research study is concluded.

Always quote your REB file number **(17824)** on future correspondence. We wish you success with your study.

Sincerely,

Melissa Sidhu, Research Ethics  
Officer, on behalf of  
Dr. Joseph Eastwood, PhD  
REB Chair  
Joseph.Eastwood@ontariotechu.ca

## Appendix B: Extraction Tool for Literature Review

#	Study	Design	Purpose	Location	Participants	Key Findings, Conclusions & Recommendations
1	Bazari et al., 2018	Qualitative (Longitudinal Study)	To characterize the experience, understanding, and management of physical, psychological, social, and existential symptoms among older homeless adults.	United States	20 participants experiencing homelessness between the ages of 52 to 78.	<p>Existential, psychological, and social symptoms result in as much distress as physical symptoms. Needing to rely on others to meet basic needs led to feelings of dependency and a lack of dignity. Childhood abuse leads to symptoms in adulthood, manifesting as depression or post-traumatic stress disorder. Premature aging was emphasized by participants for their decreased functional ability and physical symptoms. However, participants viewed aging as their source of strength, wisdom, and experience in learning to manage their symptoms.</p> <p>Substance use, religion and social support were described as coping strategies by participants for mental health issues and/or symptoms. All participants suggested that having a home would alleviate their symptoms as they could determine their daily routines and find peace of mind. It was recommended to adapt PC services to help address symptoms and provide trauma-informed care, as prior trauma can worsen existing symptoms. Managing symptoms, optimizing quality of life and managing emotional conversations are important in the delivery of PC to OAEH.</p>
2	Cagle, 2009	Qualitative (Narrative Literature Review)	Explore the issues involved in providing hospice care in various	United States	34 publications were described in the literature review, based on the reference list. Two databases were identified	OAEH and those who are chronically homeless have limited social support, which can be due to their history of substance abuse, domestic violence, or mental health issues. OAEH are more likely to experience

settings to PEH, with a focus on OAEH.

in the search strategy: Medline and Google Scholar. The inclusion and exclusion criteria were not stated.

homelessness for the first time, rather than a chronic state. A study comparing OAEH and housed individuals, revealed that being male, younger, limited social support, and no history of long-term employment are factors that can increase an individual's risk of homelessness. PC providers should set their biases aside to help enable a conversation that is free from stigmatization and moral judgement. In the United States, older adults living with a disability or are from a lower socioeconomic background, including homelessness, are likely to qualify for Medicaid coverage and benefits.

3	Johnson et al., 2023	Qualitative (Interpretive Description)	Understand the health experiences of older adults with severe conditions living in and moving through temporary avoidance hotels during the COVID-19 pandemic.	United States	Field notes from observing PC team meetings (n=12) and 14 of the PC team's patient charts were selected, based on the inclusion criteria that a patient (1) lived in hotels and motels for at least one day between March 11, 2020, and September 1, 2021, and (2) was above the age of 45.	COVID-19 avoidance hotels have helped patients to receive PC that is flexible and individualized in their own space. Independence was maintained for patients with a history of family conflict. For example, a 50-year-old woman with breast cancer was able to access marijuana as a pain management tool, which improved her symptoms and relationship with staff. This outcome was not possible at the shelter she was living in previously. Outreach services were tailored by staff around harm reduction and to reduce the transmission of COVID-19. Three patients living in the avoidance hotels were able to secure permanent housing, creating a pathway for long-term stability. The co-location of formal medical services was recommended as a future research direction.
4	Ko & Nelson-Becker, 2013	Qualitative (Grounded Theory)	Explore the perspectives, needs, and concerns of ACP among OAEH.	United States	21 participants aged 60 and older experiencing homelessness and are	Most participants were hesitant to talk about ACP and EOL care, based on religious beliefs. Death and dying were perceived to be temporary matters, participants thought

residents of a transitional housing facility.

dwelling on the matter of discussing their EOL situation to be undesirable. Moreover, spirituality and religion were found to be important among the participants. Physicians are preferred as decision makers regarding EOL treatments and to make the best decision for them, based on their expertise and knowledge. Participants also viewed EOL to not be a priority, as thinking about the future was not realistic and would rather focus on their daily survival. Increased sensitivity was recognized to be important to help gain trust between this population and health care professionals.

5	Kushel & Miaskowski, 2006	Qualitative (Case Study)	Explore the story of a 66-year-old African American man and his PC physician.	United States	A 66-year-old man anonymized as Mr. K, who is chronically homeless and receives PC as well as his PC physician, Dr. E.	Daily needs such as secure housing, food and transportation complicate the delivery of PC for patients experiencing homelessness like Mr. K; thus, incorporating an assessment of daily needs into critical care is necessary. Mr. K's appointments to manage his pain from cancer are written on paper as he does not have a mailing address or telephone. Mr. K and his physician, Dr. E, established a trusting relationship through discussions relating to the management of his pain, goals of care, decision making, and housing options. Living in a nursing home was not desired by Mr. K as there are prohibitions against illicit drugs as well as rules and restrictions that he may find it challenging to accommodate to.  Dr. E prioritized pain control by selecting medications for Mr. K with a lower risk of diversion, overdose, or harm, and by dispensing smaller monthly quantities with no early refills. Dr. E also created a written pain agreement with instructions on the responsible
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						use of pain medication. This approach helped Mr. K to stop his addiction of using illicit drugs and reduce his temptation to sell or trade prescription medications. Facilitating access to PC services for PEH in hospitals is recommended to provide a setting for EOL care, as they are more likely to receive care in public hospitals.
6	Latimer et al., 2024	Qualitative (Multiphase Iterative)  Framework to guide adaptations was utilized from Davidson et al. (2013): Tool Kit of Adaptation Approaches.	Adapt the SICG for use with OAEH by PC providers.	United States	11 OAEH between the ages of 53 and 72; 10 homelessness service providers to OAEH; 9 PC providers to OAEH.	<p>Suggestions to promote OAEH empowerment, autonomy and patient-centred care; participants reinforced the need for facilitators to ensure emotional safety, trust, and receptiveness before starting and throughout conversations. The inclusion of a trauma-informed approach in ACP were recommended, based on the adaptations in the SICG to reinforce and increase transparency to the social and emotional aspects of being unhoused.</p> <p>Additionally, recommendations include increasing transparency about the purpose and intent of conversations with homelessness service providers, become sensitive to the realities of fragmented healthcare, and aligning with the scope of practice for diagnostic and prognostic awareness. Adaptations to the SICG also included language to help decrease power differentials between providers and OAEH.</p>
7	MacWilliams et al., 2014	Qualitative (Case Study)	Identify best practices for managing the PC needs of clients experiencing homelessness in a community setting and to guide their policies.	Australia	Case study: 54-year-old man given the pseudonym, “Ray,” living in insecure low-cost housing. 6 staff workers from hospital and community organizations	Ray had challenges in coordinating his care due to the unclear communication between multiple service providers, was socially isolated and lacked social supports. He was described as non-compliant with drug regimens and treatment protocols, frequently

					who provide health services, including PC, and accommodations for PEH.	<p>self-discharged after hospital admissions, did not attend his appointments, and struggled to establish and maintain trusting relationships with staff.</p> <p>There is a lack of coordination between services; a case manager is recommended to coordinate care, offer training opportunities to care for PEH, encourage the appropriate post-hospital accommodation, and create stronger collaborations between health providers and shelters. Staff workers shared that their patients usually presented unwell as accessing care is late, are unwilling to engage in the recommended health care, and see higher incidences of drug dependence, which led to complexities to opioid treatments, including storage, compliance and safety.</p>
8	Preti et al., 2024	Qualitative (Grounded Theory)	Explore the experiences of the residents and staff in a new aged care home.	Australia	32 residents living in an aged care home between the ages of 61 to 87 who experienced homelessness or were at risk of homelessness. 13 staff members who were living and working in the aged care home.	<p>Residents' views on their 6-month experience living in the aged care home were positive, as it provided stability and helped improve their mental health. This finding is linked to the nurses, volunteers, and staff members that regularly interacted with the residents, creating a safe and supporting environment.</p> <p>Complex behaviours resulting from substance use disorders or past trauma made it challenging for staff to care for residents with high needs, despite their prior experience working in aged care homes. Some residents exhibited guarding behaviour and an unwillingness or inability to trust staff for medical treatment and care.</p> <p>There is a need to define a residential care service that supports OAEH with high care needs, including the diagnosis of dementia or</p>

a complex health condition, requiring high level care. Clearer communication with key stakeholders surrounding admission criteria is necessary to facilitate the flow of appropriate referrals, which further supports the occupancy and financial requirements of the aged care home.

**Abbreviations**

ACP: Advanced Care Planning

COVID-19: Coronavirus Disease 2019

EOL: End-of-Life

OAEH: Older Adults Experiencing Homelessness

PC: Palliative Care

PEH: People Experiencing Homelessness

SICG: Serious Illness Conversation Guide

## Appendix C: Participant Recruitment Poster



# Research Participants Needed For Online Qualitative Study

## Who can participate?

- A past or current health care worker providing palliative care through the [REDACTED] program to older adults aged 50 and older at [REDACTED]
- Speaks English and can utilize the Zoom software
- Able to provide voluntary and informed consent



## What is this study about?

Researchers from Ontario Tech University are interested in exploring the perspectives of health care professionals providing palliative care to older adults experiencing homelessness. An online one-on-one interview through Zoom will be conducted for approximately 1 hour to better understand your experiences.

## What are the benefits of participation?

Study findings will help to provide implications about how to support health care workers who provide palliative care to this population as well as existing barriers and facilitators to improve the delivery of palliative care. A 20 dollar electronic gift card will be given to each participant as a small token of appreciation for their time and participation in the study.

## Interested in participating or have any questions?

Please contact the student lead by email at [hala.shamaa@ontariotechu.net](mailto:hala.shamaa@ontariotechu.net).

This study has been reviewed by the Ontario Tech University Research Ethics Board (REB #17824) on [06/05/2024] and [REDACTED].

## Appendix D: Snowball Recruitment Script

Hello [individual's name],

My name is Hala Shamaa, I am a second year Master of Health Sciences Graduate Student at Ontario Tech University and am under the supervision of Dr. Winnie Sun. My thesis work focuses on exploring the perspectives of health care professionals that provide palliative care through the [redacted] program at the [redacted] [redacted] to older adults (aged 50 and older) who are experiencing homelessness. [redacted] (is referred to as [redacted] [redacted]) is a non-profit organization where referral takes places for the [redacted] program at [redacted].

This study has been reviewed by the Ontario Tech University Research Ethics Board (REB #17824) on 06/05/2024.

Do you refer patients from the [redacted] to receive palliative care services at [redacted]?

[If not] Do you deliver palliative care through the [redacted] program to older adults at [redacted]? [If yes], I believe your insights will be highly valuable to my thesis research. Would you be interested in participating in an online one-on-one interview via Zoom for approximately one hour? Your participation in this study is voluntary and requires informed consent. A 20 dollar electronic gift card will be sent after the interview by email as a small token of appreciation for your time and participation in the study.

Do you know another health care professional that works at [redacted] and provides palliative care to older adults that are experiencing homelessness? [If yes], where? You can contact me via email at [hala.shamaa@ontariotechu.net](mailto:hala.shamaa@ontariotechu.net) with any questions that you may have.

Thank you for your time, I look forward to hearing from you.

Sincerely,

**Hala Shamaa**

Master of Health Sciences Graduate Student, Ontario Tech University  
Email: [hala.shamaa@ontariotechu.net](mailto:hala.shamaa@ontariotechu.net)

## Appendix E: Email Script for Recruitment

Hello [individual's name],

My name is Hala Shamaa, I am a second year Master of Health Sciences Graduate Student at Ontario Tech University and am under the supervision of Dr. Winnie Sun. My thesis work focuses on exploring the perspectives of health care professionals that provide palliative care through the [REDACTED] program at the [REDACTED] [REDACTED] to older adults (aged 50 and older) who are experiencing homelessness. The [REDACTED] (is referred to as [REDACTED] [REDACTED] is a non-profit organization where referral takes places for the [REDACTED] program at [REDACTED].

This study has been reviewed by the Ontario Tech University Research Ethics Board (REB #17824) on 06/05/2024.

Do you refer patients from the [REDACTED] to receive palliative care services at [REDACTED]?

[If not] Do you deliver palliative care through the [REDACTED] program to older adults at [REDACTED]? [If yes], I believe your insights will be highly valuable to my thesis research. Would you be interested in participating in an online one-on-one interview via Zoom for approximately one hour? Your participation in this study is voluntary and requires informed consent. A 20 dollar electronic gift card will be sent after the interview by email as a small token of appreciation for your time and participation in the study.

Do you know another health care professional that works at [REDACTED] and provides palliative care to older adults that are experiencing homelessness? [If yes], where? You can contact me via email at [hala.shamaa@ontariotechu.net](mailto:hala.shamaa@ontariotechu.net) with any questions that you may have.

Thank you for your time, I look forward to hearing from you.

Sincerely,

**Hala Shamaa**

Master of Health Sciences Graduate Student, Ontario Tech University

Email: [hala.shamaa@ontariotechu.net](mailto:hala.shamaa@ontariotechu.net)

## **Appendix F: Email Script for Interview Invitation**

Hello [individual's name],

Thank you again for sharing your interest to participate in the study that I am conducting for my master's thesis, which aims to explore the perspectives of health care professionals that provide palliative care through the [REDACTED] program at the [REDACTED] [REDACTED] to older adults (aged 50 and older) who are experiencing homelessness.

I am confirming that the online interview will take place on [insert date] at [insert time] through the Zoom platform. I have included three attachments in this email: the consent form, demographic form, and preparatory checklist. Please ensure that you carefully review and sign the consent form before completing the demographic form. The demographic form will help me better understand your basic characteristics for the study and is to be completed after you have reviewed and completed the consent form. If you have any questions about the consent form, please contact me via email at [hala.shamaa@ontariotechu.net](mailto:hala.shamaa@ontariotechu.net) with any questions beforehand as I can also arrange a Zoom meeting to discuss the form. The participant checklist will ensure that you are prepared for the online interview as it utilizes the Zoom platform.

Thank you for your time, I look forward to hearing from you.

Sincerely,

**Hala Shamaa**

Master of Health Sciences Graduate Student, Ontario Tech University

Email: [hala.shamaa@ontariotechu.net](mailto:hala.shamaa@ontariotechu.net)

## Appendix G: Participant Consent Form



### Participant Consent Form

**Title of Research Study:** Exploring the Perspectives of Health Care Professionals Providing Palliative Care to Older Adults Experiencing Homelessness.

**Name of Principal Investigator (PI):** Dr. Winnie Sun  
**Contact information:** winnie.sun@ontariotechu.ca

**Student Lead (SL):** Hala Shamaa  
**Contact information:** hala.shamaa@ontariotechu.net

**Department and institutional affiliation:** Faculty of Health Sciences, Ontario Tech University

#### **Introduction:**

You are invited to participate in a research study entitled, **Exploring the Perspectives of Health Care Professionals That Provide Palliative Care to Older Adults Experiencing Homelessness.**

Please read the information about the study presented in this form. The form includes details on the study's procedures, risks, and benefits that you should know about before you decide if you would like to take part. Please take as much time as you need to make your decision and ask the SL to explain anything that you do not understand.

You should make sure all your questions have been answered before signing the consent form. Your participation in this study is voluntary.

This study has been reviewed by the Ontario Tech University Research Ethics Board (REB #17824) on 06/05/2024. If you have any questions about your rights as a participant in this study, please contact the **Research Ethics Office** at 905-721-8668 ext. 3693 or [researchethics@uoit.ca](mailto:researchethics@uoit.ca).

#### **Purpose and Procedures:**

*Purpose:*

The purpose of this study is to explore the perspectives of health care professionals that provide palliative care through the [REDACTED] program to older adults that are experiencing homelessness at [REDACTED]. Previous studies have not described the experiences of health care professionals that provide palliative care through the PEACH model to older adults who are experiencing homelessness.

The healthcare needs of older adults that are experiencing homelessness are more complex when compared to the general population due to the early onset of aging. Therefore, this proposed research will aim to provide insights on the lived experiences of health care professionals that deliver palliative care through the [REDACTED] program to older adults aged 50 and older who are experiencing homelessness. Results from the study will help the research team (1) to understand what it means to provide care to older adults that are experiencing homelessness, (2) to explore the perceived barriers and facilitators that are present when delivering palliative care to older adults, and (3) to identify how the delivery of care can be improved within this population.

You have been invited to participate in this study because you are:

- A current or previous health care professional (i.e. physician, lead nurse practitioner, hospice navigator) at [REDACTED] and can share your experience of delivering palliative care through the [REDACTED] program to older adults experiencing homelessness.
- Able to provide informed and voluntary consent.

### ***Procedures:***

This study will be conducted online using the Zoom platform to better accommodate your availability of time and geographic location. The Student Lead will provide you with a copy of the detailed participant consent form, demographic questionnaire, and preparatory checklist by email to fully explain the study project in detail at least 2 weeks before the scheduled one-on-one interview. Examples of demographic questions from the demographic form include age, gender, academic background, current occupation, number of years working in occupation, and training program(s) in palliative care/the care of people experiencing homelessness. Participants who require additional information, questions, or clarification prior to signing the informed consent form can request to meet with the researcher before through Zoom at the email listed at the end of this form. Participants must return the electronically signed informed consent form and completed demographic questionnaire using a word document to the researcher by email before the scheduled one-on-one interview.

The preparatory checklist will help you prepare for the Zoom call as it is approximately 60 minutes in duration. This checklist includes installing Zoom on your computer, displaying your name (you may use a pseudonym, if you wish), checking the internet connection and battery percentage (recommended to have a charger nearby), ensuring

you are in a quiet, distraction-free location, and ensuring the background of your display is blurred or displays a plain background. The Zoom link will also be provided, and it is recommended to join 10 minutes prior to the start time of the interview. If you are unable to attend the interview due to a time conflict, please contact the SL as soon as possible by email to reschedule the interview.

The SL will facilitate the one-on-one interview and you will be asked 6-8 questions using a semi-structured interview guide. The interview will be transcribed and sent back to you by the SL using an Ontario Tech University email account, for confirmation that everything you shared was captured and portrayed accurately.

The SL will gather information in the following ways during the online interview:

- Notes about how you participate, comments you make and/or ideas shared.
- While the interview will be recorded, only the audio files will be kept. Zoom creates independent audio-only and audio/video files when a meeting is recorded. The audio/video file will be deleted immediately after the meeting and the audio-only file will be used for transcription.
- Backup audio recorder for the interview is an online app, Voice Memos, in the case that the primary audio recorder fails or is not clear.

### **Potential Benefits:**

Your knowledge and experience of delivering palliative care at [REDACTED] through the [REDACTED] program will help to provide implications to health care providers, clinicians, and/or policy makers about the best practices in facilitating the delivery and implementation of palliative care services to older adults experiencing homelessness and existing barriers that may be present. The research findings may be used to inform training and/or create an advanced care planning worksheet for health care professionals who interact with this population as well as potentially improving workplace retention with the necessary tools, skills, and information.

### **Potential Risks or Discomforts:**

There are minimal risks for potential psychological risks or discomforts (including feeling worried or upset) associated with taking part in this study. However, the risks mentioned are anticipated to occur in very low frequency, if at all. If you experience any risk or discomfort before or after participating in the study, please contact Hala Shamaa (contact information above) by email to connect you with the appropriate crisis support(s). The following crisis supports are available on their website: (1) BounceBack; and (2) Distress and Crisis Ontario will be shared with the participant if any of the minimal psychological risks stated above occurs: [REDACTED]

### **Use and Storage of Data:**

A participant list will be recorded by pen and the same notebook to obtain the participant's first and last name, email address and work site address. The notebook will be securely kept in a locked cabinet located in the Supervisor's office at Ontario Tech University. All electronic data will be stored using a password protected and secure Google Drive hosted at Ontario Tech University belonging to the Student Lead.

Personal information such as email address, will be collected, which will be used to send the interview preparation details to participants. Interview questions will be asked verbally during the interview. Data from the interview includes audio-only recording, as well as researcher's notes and anonymized audio transcripts. Video will be destroyed immediately after the call. The researcher will utilize the live transcription feature on Zoom to transcribe the interview.

Your participation and all information collected during the study, including your name, email address, work site address and audio recording, will be kept confidential and will not be shared with anyone outside the study unless required by law. The information will be accessible only to the research team. Your participation and information will not be shared with ██████ to maintain participant privacy and confidentiality. Study-related documents that identify participants will be kept for up to 1 year after the study ends. This allows for a sufficient length of time to debrief with participants as needed.

Physical storage of information, including a notebook, will be destroyed through a secure shredding service that is available at Ontario Tech University and this will comply with the privacy and confidentiality policy.

Electronic storage of information on the secure Google Drive hosted at Ontario Tech University belonging to the Student Lead will be destroyed by selecting the option "delete forever," after the file has been moved to the "trash" folder. This process ensures that the data files are unrecoverable.

The researcher plans to retain research data for approximately 4 years. Results from the study will contribute to the student's thesis work, research dissemination, and/or publications in scientific journals and conferences that follows. Direct quotes that are used will be de-identified using pseudonyms.

If there is a data breach, the SL will contact the Ontario Tech University Research Ethics Board to discuss the recommendations for the next steps of action.

### **Confidentiality:**

The following process will be used to ensure your confidentiality is maintained: (1) After a pseudonym (fake name) has been created for the data, direct identifiers will be removed

(e.g. position name) and replaced with the following indication, [...]. (2) Throughout the study, only the named researchers will have access to this information. (3) To safeguard participants' right to confidentiality and anonymity, verbal and written information on the study's objectives will be available throughout the study period.

Electronic data collected will be stored using a password protected and secure Google Drive hosted at Ontario Tech University belonging to the Student Lead. Physical data (the notebook) will be securely kept in a locked cabinet located in the PI's office at Ontario Tech University. Data will only be accessible to study researchers.

Please note that confidentiality cannot be guaranteed while data are in transit over the Internet. Your privacy shall be respected. No information about your identity will be shared or published without your permission unless required by law. Confidentiality will be fully provided possibly by law, professional practice, and ethical codes of conduct.

Study findings may be published in journals and presented at conferences. Your identity will remain anonymous and if quotes are used, participants will be referred to using pseudonyms.

### **Voluntary Participation:**

Your participation in this study is **voluntary** and you may partake in only those aspects of the study in which you feel comfortable. You may refuse to answer any question you do not want to answer. You may also decide not to be in this study, or to be in the study now, and then change your mind later. You may leave the study at any time, without affecting your relationship with the institution. You will be given information that is relevant to your decision to continue or withdraw from participation. Such information will need to be subsequently provided.

### **Right to Withdraw:**

You may withdraw from the study at any time without penalty. You can choose not to answer specific questions. If you decide not to participate, you can end involvement in the activity by notifying the SL that you want to withdraw from the study and exit the Zoom call. You may communicate refusal verbally or nonverbally.

You should not feel obligated or compelled to participate in the research for any reason. Participation in the research is entirely optional and you will not be penalized in any way if you do not participate. Withdrawing from the study will not impact your relationship with Ontario Tech University or ██████████. Your choice to participate or not to participate in this project, as well as any information shared during your interview, will not impact your employment status in any way. If you would like to withdraw from the study after participating in the one-on-one interview, you can ask that any data that you have shared will not be included in the study and you do not need to offer any reason for

making this request. You will have 74 days after completing the interview to ask for your data to not be included, as it includes the time period to receive and review the verbatim transcript. The verbatim transcript will be sent electronically to the participant's email within 60 days after the scheduled interview has taken place via Zoom to ensure that their ideas were portrayed accurately. The participant will have up to 14 days to review the verbatim transcript and notify the researcher of any feedback or can choose to withdraw from the study if you would no longer like to participate.

Please note it is not feasible to withdraw your results once your data has been anonymized and aggregated for data analysis as it will be impossible to trace it back to you after the elimination of direct identifiers. It will also be difficult, if not impossible, to withdraw results once they have been published or otherwise disseminated.

If you have any questions, please contact Hala Shamaa at [hala.shamaa@ontariotechu.net](mailto:hala.shamaa@ontariotechu.net).

**Conflict of Interest:**

There are no known conflicts of interest to be declared for this study.

**Compensation:**

A 20 dollar electronic gift card will be sent after the interview by email as a small token of appreciation for your time and participation in the study.

**Debriefing and Dissemination of Results:**

A copy of the verbatim transcript from the one-on-one interview will be shared by the SL within 14 days after the scheduled interview by the email provided by the participant to ensure that their words have been accurately depicted. Findings from this project may be published in journals and presented at conferences. Your identity will remain anonymous and if quotes are used, participants will be referred to using pseudonyms. Participants that would like to be notified about any publications or presentations that may come from this study will be independently notified by email through the email address that has been set up for these studies ([hala.shamaa@ontariotechu.net](mailto:hala.shamaa@ontariotechu.net)) by the SL. Those that would like to be notified will have the opportunity to provide their optional consent by initialling the end of this consent form.

**Participant Rights and Concerns:**

If you have any questions concerning the research study or experience any discomfort related to the study, please contact the Student Lead, Hala Shamaa, by email at [hala.shamaa@ontariotechu.net](mailto:hala.shamaa@ontariotechu.net) or phone at 416-XXX-XXX. If you have any questions about your rights as a participant in this study, complaints, or adverse events, please

contact the Research Ethics Office at (905) 721-8668 ext. 3693 or researchethics@ontariotechu.ca.

**Consent to Participate In Study (Required):**

By signing this consent form to participate in the study, you are not waiving your rights to legal recourse in the event of research-related harm.

**Online Consent (signed electronically)**

- 1.I have read the consent form and understand the study being described.
- 2.I have had an opportunity to ask questions and those questions have been answered.
- 3.I am free to ask questions about the study in the future.
- 4.I freely consent to participate in the research study, understanding that I may discontinue participation at any time without penalty.

I agree.

I do not agree.

\_\_\_\_\_

Print Full Name of Study Participant

Date

Signature

My signature means that I have explained the study to the participant named above. I have answered all questions.

\_\_\_\_\_

Print Full Name of Person Obtaining

Date

Signature

**Consent to be Informed About Future Publications (Optional):**

By providing your initials, you will be informed through email by the Student Lead about any publications or presentations that may come from this study.

**Online Consent (initialled electronically)**

- 1. I freely consent to be informed by email about any publications or presentations that may come from this study.
- 2. I would like to be contacted by the email I provided to the Student Lead to participate in the study.

\_\_\_\_\_ Yes

\_\_\_\_\_ No

## Appendix H: Demographic Form

**Participant Name:**

**Date:**

To help us better understand your basic characteristics, please answer the questions below in this demographic form. Please ensure that you have completed the consent form prior to reviewing and completing this form. If you have any questions about this form, please contact Hala Shamaa by email at [hala.shamaa@ontariotechu.net](mailto:hala.shamaa@ontariotechu.net).

**1. Please select the profession you are currently working in (or had previously worked in) at [REDACTED]. If none of the options apply to you, please select the *other* option, and indicate the type of profession.**

- Lead Nurse Practitioner
- Physician
- Victorian Order of Nurses (VON)
- Representative from Home Community Care
- Hospice Navigator
- Palliative Pain and Symptom Consultant
- Other (please specify): \_\_\_\_\_

**2. What is your age range? Please select one answer.**

- 18-29
- 30-39
- 40-49
- 50-59
- 60-69
- 70+

**3. What is your gender? Please select one answer.**

- Male
- Female
- Genderqueer / genderfluid

- Nonbinary
- Transgender
- Prefer to self-describe: \_\_\_\_\_
- Prefer not to say

**4. What is the highest level of education you have completed? Please select one answer.**

- Bachelor's degree
- Master's degree
- Doctorate degree
- Prefer not to say
- Other (please specify): \_\_\_\_\_

**5. How would you describe your current employment status? If none of the options apply to you, please select the *other* option, and indicate the type of employment.**

- Full-time
- Part-time
- Casual
- Prefer to not disclose
- Other (please specify): \_\_\_\_\_

**6. How long have you been working in your profession? Please indicate with a number of estimated months or years. \_\_\_\_\_**

**7. How long have you been working with older adults experiencing homelessness and requiring palliative care (months/years)? \_\_\_\_\_**

**8. When was the last time you completed a training program in palliative care and the care of people experiencing homelessness? Please indicate the name, number, duration, and year the course/program was taken along with the focus (i.e. palliative care, people experiencing homelessness, and/or older adults).**



## Appendix I: Preparatory Checklist



### Preparatory Checklist

[Insert date]

Dear Participant,

In preparation for the online one-on-one interview on [insert date], at [insert time] via Zoom, I have prepared this checklist for your convenience:

- Install Zoom on your computer or mobile device in advance
- Confirm name on the display (please use a pseudonym, if preferred)
- Check the internet connection and battery percentage (recommended to have a charger nearby)
- Ensure you are located in a quiet, distraction-free location
- Ensure your background is blurred, or displays a plain background

**Please join this Zoom link at least 10 minutes prior to the start time in case technical issues arise:** [insert link].

If you have questions concerning the research study, please contact:

**Graduate Student (GS):** Hala Shamaa

**Contact information:** hala.shamaa@ontariotechu.net

**Department and institutional affiliation:** Faculty of Health Sciences, Ontario Tech University

Any questions regarding your rights as a participant, complaints or adverse events may be addressed to the Research Ethics Board Office at (905) 721-8668 ext. 3693 or [researchethics@ontariotechu.ca](mailto:researchethics@ontariotechu.ca).

This study has been reviewed by the Ontario Tech University Research Ethics Board (REB #17824) on 06/05/2024.

Thank you for participating in this research study.

Sincerely,

**Hala Shamaa**

Master of Health Sciences Graduate Student, Ontario Tech University

Email: [hala.shamaa@ontariotechu.net](mailto:hala.shamaa@ontariotechu.net)

## Appendix J: Semi-Structured Interview Guide

### Interview Guide

Welcome and thank you for participating in this online one-on-one interview. My name is Hala Shamaa, I am a Master of Health Sciences Graduate Student at Ontario Tech University and am under the supervision of Dr. Winnie Sun. The purpose of this study is to explore your perspectives of delivering palliative care to older adults that are experiencing homelessness through the [REDACTED] program at the [REDACTED] (I will use the abbreviation [REDACTED] throughout this interview). All information collected during the study will not be shared with [REDACTED] to maintain participant privacy and confidentiality.

This interview will take approximately 60 minutes of your time. Do you have any questions related to the information and consent form before we begin? The information that you share will be confidential. To protect your privacy, a pseudonym will be used instead in the verbatim transcript. Your position name will not be included in the transcript used for data analysis and any form of the results. If the position name is mentioned within the interview, it will be replaced with the following indication, [...], to maintain participant privacy and confidentiality. At any time during our conversation, please feel free to let me know if you have any questions or if you would prefer not to answer any specific questions. You can also stop the interview at any time for any reason. I will be taking notes of our conversation. Do you have any questions? Do I have your permission to begin the audio recording?

(If there are no questions) Alright, let's begin!

1. Can you describe your motivations to work as the [position name] and deliver palliative care to older adults experiencing homelessness at [REDACTED]?
  - a. What does the term, palliative care, mean to you based on your knowledge and expertise?
    - i. How do you feel about your knowledge base about palliative care?

- ii. How does your delivery of palliative care to older adults vary from each individual? (i.e. age, ethnicity, gender, socio-economic status, stage of end-of-life)
  - b. Please walk me through a typical day in your role as a [position name], working with older adults experiencing homelessness.
    - i. What are your main tasks to deliver palliative care and support needs of older adults experiencing homelessness?
    - ii. What is it like to deliver palliative care to older adults experiencing homelessness in comparison to other age groups?
- 2. What are the most common medical concerns or needs you see in older adults experiencing homelessness?
  - a. Are there specific skills and/or training required to meet their needs?
  - b. Would you consider their care needs to be acute or chronic? If so, please describe this further.
- 3. How do your clients access palliative care services?
  - a. Please describe the referral process.
    - i. Is there a specific site and/or health care professional that initiates this process?
  - b. What would make it easier for your clients to access care?
    - i. Has there been an increase in awareness to identify older adults with palliative care needs? If so, how are these needs being identified? (i.e. types of assessment and tools?)
    - ii. Are there resources available to assist older adults experiencing homelessness and with palliative care needs?
  - c. Are there other factors that have helped you successfully provide palliative care to this population?
    - i. (if yes) What do these factor(s) entail? Were they learned or acquired from training? (if yes) At the start of your position or over time while working at [REDACTED]?

4. Can you describe the formal training(s) you have received from [REDACTED] Durham?
- a. What aspects of your training was most effective?
    - i. How has this impacted your delivery of care to older adult clients?
    - ii. Can you describe what skills you have acquired?
    - iii. Can you provide examples of training that you find most useful to support your delivery of palliative care and people experiencing homelessness?
  - b. Is there any other knowledge or skills that you would like to acquire to improve your understanding in the delivery of palliative care to older adults experiencing homelessness?
    - i. What are the missing components from the training(s) that are important?
5. The [REDACTED] program at [REDACTED] is based on the PEACH model. Please tell me about your understanding about the PEACH model.
- a. (if yes) Has this influenced your delivery of palliative care to older adults experiencing homelessness at [REDACTED]? If so, how?  
What are your suggestions to better address the needs and fill the current gaps in services for older adults experiencing homelessness and palliative care? (i.e. what can be improved and what needs to be changed)?
  - b. (if not) The PEACH model is Canada's first mobile palliative care intervention that was developed in 2014 in Toronto by Dr. Naheed Dosani, a palliative care physician, with a focus on patients who require palliative care while experiencing homelessness. The PEACH model continues to be promoted by Inner City Health Associates, through the delivery of the PEACH program across Toronto operating as a mobile unit providing care in communities, shelters, and streets to meet people experiencing homelessness where they are at with a focus on each client's journey and goals.

6. Can you describe any challenges and barriers that you have experienced in your delivery of palliative care to older adults experiencing homelessness? If so, please provide some examples and stories that happened to describe these experiences.
  - a. With clients and/or other health care workers?
    - i. Inadequate palliative care education and training.
    - ii. Attitudes, biases, beliefs around palliative care.
  - b. Are there barriers that prevent or delay the delivery of palliative care?
    - i. Non-traditional settings to receive palliative care.
    - ii. Financial barriers, language, culture.
    - iii. Geographic barriers (location).
  - c. What changes do you feel would help to minimize the impact of [name of barrier(s)] that is present?
  - d. Are there any policies on an organizational level that pose as a barrier to delivering palliative care to this population?
  
7. How can the delivery of palliative care services be improved for this population?
  - a. What would you improve first, based on the need of this population?
    - i. Recommendations to improve the experience of health care workers delivering palliative care services?
    - ii. Recommendations to improve the experience of older adults accessing palliative care services?
    - iii. Recommendations for the existing structural design of the building and/or team, referral process, funding, policies, resources/services available?
  - b. How can the workplace of [REDACTED] better support health care professionals like yourself?
  
8. Is there anything else you would like to share with me? Do you have any questions?

This brings us to the end of the interview. Thank you so much for your participation in this one-on-one interview. The interview will be transcribed and sent back to you from myself using an Ontario Tech University email account, for confirmation that everything you shared today was captured and portrayed accurately. If you have any other questions, please feel free to reach out to me via email at [hala.shamaa@ontariotechu.net](mailto:hala.shamaa@ontariotechu.net).

## **Appendix K: Email Script for Member Checking**

Hello [individual's name],

Thank you for participating in the online interview on [insert date] at [insert time] through the Zoom platform for the study titled, *Exploring the Perspectives of Health Care Professionals That Provide Palliative Care to Older Adults Experiencing Homelessness*. Attached is the verbatim transcript from the online interview. Please carefully review the transcript to ensure that your ideas and thoughts were portrayed accurately. If you have any questions, please contact me at [hala.shamaa@ontariotechu.net](mailto:hala.shamaa@ontariotechu.net) as we can arrange a meeting through Zoom. If you do not have any questions and approve this transcript to be used for data analysis, I kindly ask that you notify me within 14 days of receiving this email.

Thank you for your time, I look forward to hearing from you.

Sincerely,

**Hala Shamaa**

Master of Health Sciences Graduate Student, Ontario Tech University

Email: [hala.shamaa@ontariotechu.net](mailto:hala.shamaa@ontariotechu.net)

## **Appendix L: Data Management Plan**

### **Data Management Plan**

#### *Types of Data:*

Participant's full name, email address, and work site address; de-identified demographic questionnaire; audio recordings (raw data); de-identified verbatim transcripts; de-identified direct quotes.

#### *Data Access & Storage:*

A participant list will be recorded by pen and the same notebook to obtain the participant's first and last name, email address and work site address. The notebook will be securely kept in a locked cabinet located in the Principal Investigator's (PI) office (Dr. Winnie Sun) at Ontario Tech University. The electronic data from the consent form, de-identified demographic questionnaire, audio recordings (raw data), de-identified verbatim transcripts and direct quotes will be stored on a password protected and secure google drive hosted at Ontario Tech University. Management of all the data will be done by the Student Lead (SL), Hala Shamaa, through the password protected and secure Google Drive hosted at Ontario Tech University.

Study-related documents that identify participants (full name, email address and work site address) through the SL' notebook, audio recordings, and electronically signed consent forms obtained will be retained for 1 year after the study ends (2026/07/15), at this point the data will be shredded and destroyed. This allows for a sufficient length of time to debrief with participants as needed.

Study related documents that are electronic and de-identified (demographic questionnaire, verbatim transcripts, direct quotes) will be retained for 4 years after the study ends (2029/07/15), at this point all electronic files will be destroyed.

Physical storage of information, including a notebook, will be destroyed through a secure shredding service that is available at Ontario Tech University and this will comply with the privacy and confidentiality policy. Electronic storage of information on the secure Google Drive hosted at Ontario Tech University belonging to the Student Lead will be destroyed by selecting the option "delete forever," after the file has been moved to the "trash" folder. This process ensures that the data files are unrecoverable.

This allows for a sufficient length of time for the SL to use the de-identified results from the study and complete the thesis report, research dissemination, and/or publications that follows. Position names will not be included during the data analysis process or final report.

- Participant ID (first/last name, work site address) and contact information (email) that is obtained by the SL using a notebook will be securely kept in a locked cabinet located in the PI's office at Ontario Tech University. Access will be limited to the SL and PI.
- The consent form will be saved onto the password protected and secure Google Drive hosted at Ontario Tech University. Access will be limited to members of the research team.
- The de-identified demographic questionnaire will be saved onto the password protected and secure google drive hosted at Ontario Tech University. Access will be limited to members of the research team.
- Audio Recordings (Zoom and Backup Recording): will be saved to the password protected and secure Google Drive hosted by Ontario Tech University. Access will be limited to members of the research team.
- De-identified verbatim transcripts will be saved onto the password protected and secure Google Drive hosted at Ontario Tech University. Access will be limited to members of the research team.
- De-identified direct quotes will be saved onto the password protected and secure Google Drive hosted at Ontario Tech University. Access will be limited to members of the research team.
  - Personal identifiers (e.g. position name) from quotes will be removed using the following indicator, [...]. Data reported will be generalized to prevent the direct identification of the clinic location. For example, the clinic will be referred to as a clinic located in Southeastern Ontario and the codes for the participant responses (e.g., P1, P30) will be utilized to anonymize study participants in direct quotes.

## **Appendix M: Email Script to Thank Participants**

Hello [individual's name],

I would like to thank you for participating in the study titled, *Exploring the Perspectives of Health Care Professionals That Provide Palliative Care to Older Adults Experiencing Homelessness*. Included in this email is a 20 dollar electronic gift card as a small token of appreciation for your time and participation in the study.

Sharing your experiences can help to better health care professionals, barriers present as well as the best practices in facilitating the delivery and implementation of palliative care services to older adults experiencing homelessness.

If you have any questions, please contact me.

Sincerely,

**Hala Shamaa**

Master of Health Sciences Graduate Student, Ontario Tech University

Email: [hala.shamaa@ontariotechu.net](mailto:hala.shamaa@ontariotechu.net)