McMaster University | HEALTH FORUM

Rapid Evidence Profile #29.2

(12 September 2022)

Question

What do we know from evidence and experiences from Canadian provinces and territories, and other countries, about providing palliative care for those who are experiencing or at risk of homelessness?

What we found

To inform guidance and program development related to providing palliative care for those who are experiencing or at risk of homelessness, we identified evidence, as well as experiences from Canadian provinces and territories. We also identified experiences from several other countries in this update to the rapid evidence profile (see Box 1 for a description of our approach). We organized our findings using the framework below.

Box 1: Our approach

We identified evidence addressing the question by searching: 1) ACCESSSS; 2) HealthEvidence; 3) Health Systems Evidence; 4) Social Systems Evidence; 5) the COVID-END inventory of best evidence syntheses; and 6) PubMed. All searches were conducted between 16-18 March 2022. We conducted searches for this update on 11 August 2022 but did not identify any new relevant evidence. The search strategies used are included in Appendix 1. We identified jurisdictional experiences from all Canadian provinces and territories in the original rapid evidence profile, and from 11 other jurisdictions (Australia, New Zealand, Ireland, Brazil, Sweden, Finland, U.K., and four states of the U.S., California, Washington, Massachusetts, Oregon) by hand searching government and stakeholder websites for information relevant to the question. Countries were chosen by the requestor as typical comparator countries to Canada.

We searched for guidelines, full systematic reviews (or review-derived products such as overviews of systematic reviews), rapid reviews, protocols for systematic reviews, and titles/questions for systematic reviews or rapid reviews that have been identified as either being conducted or prioritized to be conducted.

We appraised the methodological quality of full systematic reviews and rapid reviews that were deemed to be highly relevant using AMSTAR. Note that quality appraisal scores for rapid reviews are often lower because of the methodological shortcuts that need to be taken to accommodate compressed timeframes. AMSTAR rates overall quality on a scale of 0 to 11, where 11/11 represents a review of the highest quality. It is important to note that the AMSTAR tool was developed to assess reviews focused on clinical interventions, so not all criteria apply to systematic reviews pertaining to delivery, financial or governance arrangements within health systems or to broader social systems. We appraised the quality of the highly relevant guidelines using three domains in AGREE II (stakeholder involvement, rigour of development, and editorial independence) and classified guidelines as high quality if they were scored as 60% or higher on each domain.

Organizing framework

- Who is palliative care provided to?
  - People experiencing homelessness (e.g., living on the street, in shelters, in encampments)
  - Those at risk for homelessness (e.g., those in precarious housing situations)
- What groups may palliative care need to be tailored to?
  - Black population
  - 2SLGBTQ+
  - Indigenous peoples
  - Newcomers and refugees
  - People with mental health challenges
  - People with addictions/substance-use issues
  - People with disabilities
  - Other people of colour
  - Veterans
  - Women
  - Youth
- What is included in palliative care models for those who are experiencing or at risk of homelessness?
  - Access to safe and stable housing
  - Mental health supports and treatment

  - Addictions support and treatment
  - Culturally sensitive care and support
  - Pain management
  - Personal-support services
  - Psychological supports
  - Other social services (e.g., income supports)
  - Spiritual and bereavement support
  - Caregiver support
  - Navigation support for health and social systems
- Who is involved in providing palliative care?
  - Physicians
  - Nurses
  - Pharmacists
  - Social workers
  - Case manager
  - Personal support workers
  - Rehabilitation professionals (e.g., occupational or physical therapists)
  - Community or outreach workers
  - Spiritual counsellors
  - Peer workers
  - Volunteers
- Where is palliative care provided?
  - Home-based environment
  - Hospice
  - Hospital
  - Long-term care
  - Corrections facilities
  - Shelter
  - Mobile or community-based
- What implementation barriers and enablers need to be considered or addressed?
  - For those accessing palliative care
  - For those providing palliative care
  - For organizations or systems to create new or enhance existing programs
- What are the outcomes?
  - Health related (including quality of life)
  - Equity related (e.g., did the intervention/program address the identified health disparities for the population it served)
  - Patient experience
  - Costs
  - Provider or organizational (e.g., community organizations) experience

We identified 14 evidence documents relevant to the question, of which we deemed 12 to be highly relevant (no new relevant evidence documents were identified in the updated search that was conducted in August 2022). The highly relevant evidence documents include:

- six full systematic reviews; and
- six single studies that provide additional insights.

We outline in narrative form below our key findings related to the question from highly relevant evidence documents and based on experiences from Canadian provinces and territories and other countries. We provide additional details in Table 1 (the type and number of all documents that were identified). In addition, detail about experiences from Canadian provinces and territories and other countries are provided in Table 2 and Table 3, respectively. A detailed summary of our methods is provided in Appendix 1, the full list of included evidence documents (including those deemed of medium and low relevance) in Appendix 2, and hyperlinks for documents excluded at the final stage of reviewing in Appendix 3.

Key findings from highly relevant evidence sources

Most of the identified research evidence described where palliative care is provided, and implementation barriers and enablers for those accessing or providing palliative care. We found limited literature on what groups palliative care may need to be tailored to, the components of different palliative care models, who is involved, and outcomes.

One high-quality systematic review published in April 2018 explored the concerns and palliative-care needs of individuals experiencing homelessness, and found that individuals often felt that their end-of-life care was not being prioritized, and substance dependence hindered adequate care. Additionally, there was limited insight into their condition by healthcare providers and little support from family and relatives. The review concluded that these concerns can be addressed by having a patient-centred, flexible, timely, and low-threshold approach when providing palliative care to the homeless. The authors suggested that that this approach may be accomplished through the training, education, and experience of healthcare professionals.

In another high-quality systematic review published in February 2017, there was some evidence that interventions to improve advance care planning, palliative care, and end-of-life care for people experiencing homelessness may be effective. Some examples of these interventions included support homes and shelter-based palliative care to help reduce costs, and coordination with harm-reduction services to increase access to care. While the review highlighted integration among palliative and homeless support services as a way to improve continuity of care for people who are homeless, the authors acknowledged that the effectiveness of this integration and other interventions remained uncertain, and that more high-quality studies of interventions are needed.

Two medium-quality studies explored barriers for homeless populations in accessing palliative care and identified several challenges, including: 1) the competing day-to-day priorities of the homeless; 2) the stigma in mainstream settings; 3) the high burden on hostel/shelter staff in supporting residents at the end of life; 4) patient, provider, and structural barriers; and 5) inflexibility in mainstream healthcare systems. One of the reviews pointed out that many obstacles in both the provision and receipt of palliative care may be addressed by building trust between people experiencing homelessness and health professionals, increasing collaboration between health and social-care services, and providing more training and support for all professionals and staff.

A medium-quality scoping review published in May 2021 identified three core themes related to palliative care for people experiencing homelessness and/or vulnerably housed. The first core theme on experiences, beliefs and wishes underscored that people experiencing homelessness held strong beliefs about what makes a death 'good' or 'bad', and perceived end-of-life care services to provide sufficient choice and dignity around death. The second core theme on relationships highlighted that people experiencing homelessness had more difficulties building trust in relationships, and that those providing palliative care could learn from the approaches used by homeless support services which commonly offer diverse and judgment-free person-centred care. Lastly, end-of-life care was the third core theme that focused on the need of training for workers providing services to the population, in addition to consistent, flexible, multidisciplinary, open, respectful and non-judgmental care at the service-provision level. The review concluded by indicating that approaches for addressing these concerns should be considerate and consistent, while bridging gaps among different care settings, social-care services, harm-reduction services, and primary-care services.

A low-quality systematic review focused on end-of-life care of people who use substances, but found limited evidence. Most studies within the systematic review emphasized the need for comprehensive assessments and screening with healthcare providers to help people with substance-use issues to manage pain.

The six highly relevant single studies focused on similar themes as the systematic reviews described above. Specifically, the studies focused on:

- the lack of access to and education about end-of-life care for people experiencing homelessness in the United Kingdom, stigma from both the general public and healthcare providers, and lack of suitable places to deliver palliative care for the population (e.g., inflexible services, low tolerance for substance misuse);
- the barriers to palliative care for people experiencing homelessness in Toronto, which consisted of impaired trust and individual respect, underdevelopment of palliative care, and lack of promotion of prevention and protection;
- perspectives about end-of-life care among people experiencing homelessness in the U.S. and Ontario, including fear of dying violently, alone or unnoticed, remaining unidentified after death, burial and notification of family members, painful stigma and shame that superseded health complaints and previous trauma, a sense of being perpetually surrounded by death or the threat of death when on the street, receiving inadequate care or pain medication, being resuscitated against their wishes, and being buried in an unmarked grave if there was no one to claim their body;
- the reported higher rates of advance directive (AD) completion amongst the population with advance care planning (ACP) interventions that involve clinician involvement rather than self-guided interventions; and
- the spiritual beliefs of people experiencing homelessness in the U.S. that have been documented as a barrier to ACP, even though research is still needed on religious beliefs and spiritual experiences for people experiencing homelessness considering end-of-life issues.

Key findings from the jurisdictional scan

There is growing recognition and support at the Canadian federal level to improve access to palliative care for people experiencing homelessness. A report released in June 2021 by Health Canada, Home and Community-based Palliative Care: Shaping the Future from Lessons Learned during the COVID-19 Pandemic, highlighted that pre-existing inequities in timely and fair access to palliative care led many people (including those experiencing homelessness, living in rural and remote communities, and Indigenous peoples) to face the most hardship due to isolation protocols and the shift to virtual care. The report highlighted priorities such as improved access to technology, increased intersectoral collaboration, and the need to embed a palliative approach to care within all health and social services. As part of Health Canada's five-year Action Plan on Palliative Care, the government aims to improve access to palliative care for underserved populations by convening discussions with stakeholders to share knowledge, and supporting the development of linguistically and culturally appropriate tools for advance care planning.

Our jurisdictional scans of Canadian provinces and territories yielded some insights related to experiences about providing palliative care for those who are experiencing or at risk of homelessness. We identified some examples of palliative-care models across Canadian cities such as:

- Palliative Outreach Resource Team (PORT) in Victoria, British Columbia, which is a consultation-based mobile unit in collaboration with community partners (e.g., University of Victoria, Victoria Cool Aid Society, Island Health, and Victoria Hospice) to provide palliative care for people experiencing homelessness and other barriers to care, with the overall goal to improve clinical and healthcare utilization outcomes (i.e., emergency-room visits and average length of stays);

- Calgary's Allied Mobile Palliative Program (CAMPP) in collaboration with Alberta Health Services and Connect to Care (C2C) program, which is a mobile unit that provides early integrated palliative care to individuals experiencing homelessness, in addition to education and advocacy for individuals, healthcare providers and social-service providers about care approaches;
- the 10-bed hospice and transitional care facility operated by Sanctum Care Group (a non-profit organization) with funding from the Saskatoon Health Region, which provides palliative care for people experiencing or at risk of homelessness and other marginalized populations, with support from healthcare and community-care providers (e.g., primary-care physicians, nurses, case managers, spiritual carers, peer workers, mental health and addictions outreach workers);
- Palliative Education and Care for the Homeless (PEACH) in Toronto, which is a mobile unit that provides palliative care focusing on pain and symptom management, and psychological goals for people living on the streets and in shelters;
- Ottawa Inner City Health Hospice, which is a shelter-based program that provides palliative care and harm-reduction approaches by a team of physicians, nurses, and client care workers who are readily available 24 hours a day; and
- Maison du Père, which is a social-services organization based in Montreal that provides palliative care such as symptom management to men experiencing homelessness, in collaboration with community partners such as the Palliative Care Society of Greater Montreal and the oncology department of The Centre hospitalier de l'Université de Montréal (CHUM).

Additionally, some of the palliative-care models reported barriers and enablers that need to be considered or addressed during implementation. Some of the reported barriers include:

- difficulties with navigating multiple social-support systems (e.g., housing, social assistance, food banks);
- inconsistencies in continuity of care;
- stigma and discrimination faced by people experiencing homelessness while receiving care;
- inflexible policies and lack of harm-reduction and intersectional approaches;
- personal safety concerns from providers and staff; and
- lack of accessible services in care settings preferred by people experiencing homelessness.

To address some of the barriers, a preliminary needs assessment based in Toronto, Ontario and a report by the Ontario Palliative Care Network suggested implementation considerations such as:

- delivering care outside of traditional healthcare settings (e.g., mobile units, shelter-based palliative care at emergency shelters, drop-in shelters, and harm-reduction sites) while instilling harm-reduction, anti-oppressive and intersectional approaches and principles;
- utilizing screening tools to determine health and social care needs;
- training interdisciplinary teams of healthcare providers and social-service programs on the unique needs of people experiencing homelessness accessing palliative care;
- engaging care coordinators within palliative-care services who can help people navigate the health system;
- providing people who are experiencing homelessness with tailored health and social care services (e.g., tailored pain management, psychological supports);
- developing mitigation strategies to ensure the safety of providers; and
- promoting values such as empowerment and autonomy during advance care planning with the intended population.

Key findings from international jurisdictional scan

In our update to this rapid evidence profile, we identified limited new insights from our jurisdictional scan of other countries' experiences with providing palliative care for people experiencing or at risk of homelessness. Generally, palliative care was defined among the countries as comprehensive healthcare for people of any age with serious life-limiting illness, and very few countries had program or plans that focused specifically on providing palliative care for the homeless.

Some of the barriers to accessing palliative-care services for people experiencing or at risk of homelessness that were identified include distrust of institutions and authority by the homeless, unsafe living environments, service providers' lack of knowledge, training and experience in providing care for people experiencing homelessness, cultural barriers around death and dying associated with lack of financial security and education, and lack of support-care planning by health and social-care agencies.

We identified several approaches that countries have taken to improve the care experience and quality of life of people who are experiencing homelessness and in need of palliative care, which include:

- Australia's Department of Health and Aged Care provides key resources for planning and providing end-of-life care for people experiencing homelessness, and released a report in 2020 that identified flexible homeless support services and care environments, education and training in culturally appropriate and trauma-informed approaches, and the adoption of a harm-reduction approach as promising strategies for improving care for the homeless;
- New Zealand's Palliative Care Action Plan that proposes a person-centred model of adult palliative care that moves the focus from a resource and capability framework to a more holistic approach to supporting people at the end of their lives;
- The Swedish National Board of Health and Welfare having identified several areas to improve its national approach to palliative care, including enhancing provider training and requiring more support services for people requiring palliative care at the end of life; and
- A service that has been developed in the U.K. by St. Mungo's and Marie Curie Cancer Care to improve end-of-life care for people experiencing homelessness across England by bringing together primary and secondary healthcare providers, specialist palliative-care service providers, and social-care agencies to provide one-on-one, holistic care to their residents.

We also found that Finland is in a unique position due to the impact of its Housing First Model for providing new housing for the homeless along with reformed services that can meet their needs. Under the Housing First Model, residents are connected to palliative-care services through healthcare units, specialized care in hospitals, and outpatient clinics, or through models of palliative care that occur at home or through other residential services. Using this model, Finland has seen a significant decline in homelessness since the 1980s.

From our scan of four U.S. states – California, Washington, Massachusetts, Oregon – we did not identify any system-level approaches to providing palliative care for those experiencing or at risk of homelessness. However, we did find some programs in these states that provide and support health services, including palliative care for people who are homeless, which include:

- The Homeless Hospice Pilot in California that provides end-of-life care to people experiencing homelessness in Los Angeles County through county-operated recuperative-care centres and permanent support-housing sites;
- The Seattle & King County's Healthcare for the Homeless Network and the Harborview Medical Center in Washington that provide respite services for people experiencing homelessness, including harm-reduction and recuperative care;
- The Barbara McInnis House in Massachusetts that provides short-term medical and recuperative services for homeless people who are too ill to use shelters, but not ill enough to receive hospital-based care; and

- The Blackburn Center in Oregon that offers chronic-health condition management programs and on-site clinical services at its 124 units of affordable housing.

Additional details on the experiences of other countries with providing palliative care for those experiencing or at risk of homelessness can be found in Table 3.

Table 1: Overview of type and number of documents that were identified about providing palliative care for those who are experiencing or at risk of homelessness

Type of document	Total	Cross-cutting/general focus across the organizing framework	Who is palliative care provided to?	What groups palliative care may need to be tailored to?	What is included in palliative-care models for those who are experiencing or at risk of homelessness?	Who is involved in providing palliative care?	Where is palliative care provided?	What implementation barriers and enablers need to be considered or addressed?	What are the outcomes?
Guidelines	0	-	-	-	-	-	-	-	-
Full systematic reviews	8	1	8	1	1	2	1	4	1
Rapid reviews	0	-	-	-	-	-	-	-	-
Protocols for reviews that are underway	0	-	-	-	-	-	-	-	-
Titles/questions for reviews that are being planned	0	-	-	-	-	-	-	-	-
Single studies	6	1	6	0	1	3	3	6	2

Table 2: Experiences in Canada with providing palliative care for those who are experiencing or at risk of homelessness

Province	Summary of experiences
Pan-Canadian	• In August 2017, the Government of Canada allocated $6 billion over 10 years to provinces and territories to improve access to home and community care, including palliative care o The government also allocated $184.6 million over five years to improve home and palliative care for Indigenous communities • The Framework on Palliative Care in Canada (tabled in Parliament in December 2018) serves as a reference point for governments, stakeholders and caregivers to identify common directions and opportunities, and is informed by the guiding principles of providing person- and family-centred palliative care that is holistic, equitable, and adequately resourced o The framework highlights Palliative Education and Care for the Homeless (PEACH) as a best practice initiative that facilitates equitable access to palliative care for the homeless and vulnerably housed by using a mobile unit and providing care for those with life-limiting illness on the streets, in shelters, and in collaboration with community services in Ontario (see Ontario experiences for more information) • Health Canada has a five-year Action Plan on Palliative Care that includes a goal of fostering improved access to palliative care for underserved populations, including the homeless, by: o supporting the dissemination of resources online and supports for caregivers and community members in English and French o convening discussions with stakeholders to explore ways to improve access to and share knowledge about palliative care for underserved populations that is culturally appropriate o supporting the development of linguistically and culturally appropriate tools for advance care planning o supporting other federal departments in their efforts to improve palliative-care delivery to their mandated populations • A report released in June 2021 by Health Canada, Home and Community-based Palliative Care: Shaping the Future from Lessons Learned during the COVID-19 Pandemic, highlighted that pre-existing inequities in timely and fair access to palliative care led many people who were homeless, living in rural and remote communities, and Indigenous peoples to face the most hardship due to isolation protocols and the shift to virtual care o Priorities that were identified to move forward included improved access to technology, increased intersectoral collaboration, and the need to embed a palliative approach to care within all health and social services
British Columbia	• A research report by the University of Victoria's Institute on Aging & Lifelong Health was released in November 2018, that described experiences to accessing care for 'structurally vulnerable people' (i.e., those in poverty, at risk of or experiencing homelessness, racialized people, living with disability, and mental health and addictions), barriers and facilitators to improving quality of care, and recommendations for improving access to care o Barriers for those accessing palliative-care supports were reported to include challenges with navigating multiple social support systems (e.g., housing, social assistance, food banks), and maintaining consistency and continuity of care o The report stated that housing conditions (e.g., over-crowded housing, shelters, single room occupancy hotels) of individuals was a barrier for home-care supports

Province	Summary of experiences
	o Patients reported positive experiences with quality of life and end-of-life care (e.g., compassionate care, access to additional medical, income and social supports) when they were connected to healthcare providers with an understanding of palliative care o The report provided several recommendations for implementation considerations to improve quality and access to palliative care for structurally vulnerable people, such as: 1) providing training and educational supports to healthcare providers and non-medical workers to learn about barriers to care; 2) promoting and developing strategies to improve coordination and continuity of care between healthcare and social services, and addressing risk management policies that present barriers to care; and 3) engaging and supporting informal support caregivers (e.g., street-family) in providing care • An interim report released in February 2020 by the Equity in Palliative Approaches to Care (ePAC) collaborative group, describes the impacts of the Palliative Outreach Resource Team (PORT) in Victoria, B.C. o PORT is a consultation-based mobile unit that aims to improve quality and access to palliative care and supports for individuals facing barriers to care, such as poverty, people experiencing homelessness, and stigmatized and racialized groups o This initiative was developed in collaboration with community partners such Victoria Cool Aid Society, Victoria Hospice, the University of Victoria, and Island Health in 2019 o PORT is staffed by a palliative consultant physician and a palliative nurse consultant who conduct assessments, care planning, and connect individuals to community-based health services o The report suggests that this service may reduce emergency-room visits and average length of stays • According to a news report, palliative-care programs should consider culturally appropriate care and needs of Indigenous peoples who make up roughly 30% of Victoria's homeless population
Alberta	• Alberta Health Services works closely with the Allied Mobile Palliative Program (CAMPP), a palliative-care program for homeless and unstably housed populations living in Calgary, Alberta o The program seeks to bridge complex care, harm reduction, and palliative care for individuals who are homeless or unstably housed with complex medical needs and co-morbidities o CAMPP's goals are to: 1) provide education and advocacy to improve palliative care of people who experience complex needs and multiple barriers in accessing services; 2) provide early integrated palliative-care consultation; 3) educate, support, and build capacity among healthcare providers and inner-city health, housing/shelter, and social services about palliative approaches to care in marginalized and vulnerable populations; and 4) liaison between existing services and address any existing gaps in care for vulnerable populations o CAMPP collaborates with the Connect to Care (C2C) program, which is a partnership between Calgary's Urban Project Society (an organization offering community-based programs and services), Alpha House (services in Calgary offering shelter housing), and the O'Brien Institute at the University of Calgary o Sources of referrals via C2C are from acute care, palliative-care services, urgent care, primary-care providers, and community paramedics

Province	Summary of experiences
	• Alberta's palliative and end-of-life care strategy in the recently published 2021 provincial framework addendum states that Alberta Health Services is continuing to deliver care across Alberta in five geographically defined administrative zones: North, Edmonton, Central, Calgary, and South ○ Calgary and Edmonton continue to have well-integrated and comprehensive palliative and end-of-life programs and services, and have begun partnerships with community organizations to better address the needs of the homeless and other marginalized populations (e.g., Indigenous communities) • As of 2021, there has been a call from Calgary's homeless agencies and organizations for further funding of palliative-care beds ○ Currently, there are only two palliative-care beds in Calgary that cater specifically to people experiencing homelessness
Saskatchewan	• On November 3, 2015, the non-profit organization Sanctum Care Group opened a 10-bed hospice and transitional care facility in Saskatoon, Saskatchewan for individuals living with HIV or AIDS, and experiencing or at risk of homelessness, poverty, and mental health and addictions ○ This initiative provides seven beds for supportive care for individuals diagnosed with HIV and require addictions support and treatment; two beds for end-of-life care for individuals who are HIV-positive and received a palliative diagnosis; and one bed for respite care for stays up to 14 days ○ Saskatoon Health Region provided Sanctum with $836,000 in its first year for operational funding ○ Several healthcare and community-service providers are involved in providing care, including: primary-care physicians, nurses, case managers, spiritual care, peer workers, and mental health and addictions outreach workers
Manitoba	• No information identified
Ontario	• A report released by Ontario Palliative Care Network in April 2019 provided recommendations to improve palliative care in Ontario ○ The delivery framework acknowledges that palliative care for homeless and vulnerable populations need to be mobile and flexible to reach outside traditional healthcare settings and meet individuals where they are, regardless of physical location or stage of illness ○ It is recommended that providers working in social-service programs (shelters, mental health programs, substance-abuse programs) and healthcare settings receive education and training around identifying palliative-care needs in homeless and vulnerably housed populations ○ The palliative-care team should be interdisciplinary, including providers from Home and Community Care and social-service programs, and these groups should have effective means of communication and information sharing ○ Palliative-care programs and social-service agencies need to establish strong relationships with First Nations, Inuit, Metis, and urban Indigenous community organizations and providers to provide support to homeless Indigenous individuals ○ Policies to mitigate risks and provide safety support to providers are needed especially for geographic neighbourhoods where care providers cannot enter due to personal-safety concerns ○ Trauma-informed, harm reduction, and anti-oppressive training are important for providers of palliative care to homeless or vulnerably housed populations

Province	Summary of experiences
	• Palliative Education and Care for the Homeless (PEACH) is a Toronto palliative-care program for individuals experiencing homelessness o The Canadian Toronto-based PEACH program, a mobile unit which provides care on the streets and in shelters, was launched to better support those experiencing homelessness with life-limiting illness, and focuses on the pain, symptoms, and psychosocial goals related to each patient's end of life o 63 individuals were included in the analysis, of which 35% of the cohort resided in shelters, 26.2% were in supportive/transitional housing, and 3.2% were sleeping on the streets o Cancer was the most common diagnosis (61.9%), followed by 58.7% of the individuals having mental health diagnoses, and 61.9% had substance-use issues o Locations of death included palliative-care units and hospices (44.4%), hospitals (23.8%), supportive housing (12.6%), and shelters (7.9%) • An example of shelter-based palliative care is Ottawa Inner City Health Hospice, which is a pilot shelter-based program with a harm-reduction approach whereby physicians, nurses, and a client care worker are available 24 hours a day, which was ultimately effective and cost saving • A preliminary needs assessment published on 12 May 2017 described the barriers and selected approaches to accessing high-quality palliative-care services for people experiencing homelessness in Toronto, Ontario, which reported key barriers: o Shelters and mainstream palliative services are not flexible and lack necessary training in addiction, mental health and palliative care; service providers also need to learn to be comfortable talking about death o Harm-reduction services are still not accepted or understood by many service providers o People experiencing homelessness fear services will be withheld from them at end of life, and others internalize discrimination and believe that they do not deserve these services o Participants fear dying alone or anonymously, and worry about what will happen to their physical body after death o People might also have a hard time attending appointments and staying connected with service providers o People experiencing homelessness might also have a difficult time adhering to treatment o The suggested palliative care approaches for homeless populations are as follows: ▪ Shelter-based palliative care (at emergency shelters, drop-in shelters, and harm reduction sites) has generated higher levels of satisfaction and lower costs than hospital care ▪ Using harm-reduction strategies has also been beneficial, such as providing alcohol to patients on an hourly basis to promote comfort while preventing withdrawal, or providing sterile syringes to use drugs outside of the institution ▪ Advance care planning promotes empowerment and autonomy and lowers feelings of uncertainty in marginalized individuals; having a one-on-one counsellor helped facilitate completion of advanced directives ▪ Having a coordinator within palliative-care services who can help patients navigate the system and access care while mitigating marginalization is important ▪ Tailored pain management, especially for patients who have developed a high tolerance to medications ▪ Providers should provide a questionnaire to patients to better understand the needs of the patient and how best to offer support; Sick Kids Hospital has developed a social determinant of health screening tool for palliative patients

Province	Summary of experiences
	▪ Service provider training on the unique needs of homeless patients accessing palliative care was recommended • A needs assessment report published on 15 May 2018 summarized survey findings from palliative-care service users and providers ○ The majority of service users surveyed identified as Indigenous and many did not have stable housing ○ Many service users did not have a primary healthcare provider and used emergency rooms or walk-in-clinics when they were sick ○ Holistic treatment and traditional healing were identified as important to service users ○ Most service providers articulated that they offered palliative care in their workplace, yet over half have not received any formal training on palliative care ○ Areas of concern involved the lack of seeking treatment by the vulnerable population, difficult/discriminatory admission criteria, a lack of knowledge concerning palliative services available for the population, a need for more accessible service in remote communities, and other educational resources
Québec	• Maison du Père is a social-services organization based in Montreal that provides palliative-care rooms for men experiencing homelessness ○ The model is built in collaboration with community partners such as the Palliative Care Society of Greater Montreal and the oncology department of The Centre hospitalier de l'Université de Montréal (CHUM) ○ Staff members and volunteers are trained in palliative and end-of-life care, such as managing symptoms and reconnecting with family members
New Brunswick	• No information identified
Nova Scotia	• No information identified
Prince Edward Island	• No information identified
Newfoundland and Labrador	• No information identified
Yukon	• No information identified
Northwest Territories	• No information identified
Nunavut	• No information identified

Table 3: Experiences in other countries with providing palliative care for those who are experiencing or at risk of homelessness

Country	Summary of experiences
Australia	• PalliAGED, a palliative-care evidence and practice information resource for the Australian aged care sector, funded by the Australian Government's Department of Health and Aged Care, provides key resources for planning and providing end-of-life care for people experiencing homelessness, especially for care coordination between families and health and community service providers • Australia's Department of Health and Aged Care released a report in 2020 that describes key barriers and promising approaches for improving the experience of palliative care for people experiencing homelessness, including advance care planning and improvements to access and quality of care o Some significant barriers to accessing services for people experiencing homelessness include distrust of institutions and authority, unsafe living environments, and service providers' lack of knowledge, training and experience in providing care for people experiencing homelessness o Promising approaches identified in the report include education and training in culturally appropriate and trauma-informed approaches, collaboration between palliative care and homeless support services, flexible services and care environments, and adopting a harm-reduction approach
New Zealand	• New Zealand's Ministry of Health defines palliative care as care for a person of any age who has life-limiting illness o A palliative-care team has been established to coordinate a palliative-care work plan and to lead national palliative-care development and improvement work • The Palliative Care Action Plan emphasized that palliative care should be provided in a way that meets the unique needs of particular communities and groups, including the homeless o The plan proposes a person-centred model of adult palliative care that moves the focus from a resource and capability framework to a more holistic view of supporting people at the end of their lives o There are no specific recommendations related to providing palliative care for the homeless
Ireland	• A case series from 2015 by the RCSI and St. Francis Hospice indicated that there are over 3,800 people experiencing homelessness, with most people living in emergency accommodation followed by long-term accommodation
Brazil	• The Brazilian government defines palliative care as active and comprehensive healthcare provided to people with serious, progressive, and life-threatening disease • A study by Silva et al. published in June 2021 studying how palliative care is delivered to people living in Brazilian favelas found that cultural barriers around death and dying associated with lack of financial security and education presented as key barriers of access to palliative care o These barriers are further exacerbated by the piecemeal approach to palliative-care delivery in Brazil
Sweden	• The Swedish National Board of Health and Welfare has adopted a national approach to evaluating palliative care at the end of life and has identified several areas for improvement, including enhancing ongoing provider training and requiring more support services for people requiring palliative care at the end of life • There was no specific information found about how palliative care is provided for the homeless in Sweden

Finland	• The Finnish Institute for Health and Welfare defines palliative care as active and comprehensive care of a patient with a life-limiting illness with the goal of relieving suffering and improving quality of life ○ Palliative care includes supporting family and friends and might be provided over the course of several years, with end-of-life defined as the last phase of palliative care consisting of weeks or days of life • Since the 1980s, Finland has used a Housing First Model to connect residents to health and social services, including palliative care, which has led to a drastic decline in homelessness while most countries have seen homelessness rise over the same period ○ The Housing First program provides palliative-care services through healthcare units, specialized care in hospitals, and outpatient clinics, or through models of palliative-care delivery that occur at home or through other residential services
United Kingdom (U.K.)	• St. Mungo's and Marie Curie Cancer Care developed a project that involved closely working with St. Mungo's frontline staff, primary and secondary healthcare providers, specialist palliative-care service providers, and social-care agencies, to create a service at St. Mungo's that has succeeded in: ○ providing one-to-one support to residents; ○ identifying potential end-of-life indicators; ○ delivering training to frontline hostel staff; ○ rolling out training to other homelessness agencies across the United Kingdom; ○ co-producing a number of booklets and resources, including resource packs for hostels across the U.K.; and ○ developing a pilot bereavement services with St. Mungo's for residents and frontline staff. • A resource pack was developed by St. Mungo's and Marie Curie Cancer Care for advancing the skills and knowledge of managers and frontline staff working with those who are experiencing or at risk of homelessness, including those working in supported accommodation, assertive outreach, drug and alcohol services, and homeless day centres • Pathway, the U.K.'s leading homeless healthcare charity agency, in collaboration with St. Mungo's, Marie Curie, University College London, and Coordinate My Care (a National Health Service (NHS) service for urgent care) published research that explored the key challenges for people experiencing homelessness and provided three key challenges to help services better support homeless people with advanced ill health 1) Parallel planning approach that considers multiple future courses 2) Establishing regular review multi-agency meetings to collaborate and support care planning 3) Increasing in-reach of health and social-care services into hostels and day centres to support both hostel staff and residents • The research also highlighted the need for greater provision and access, including a bespoke 24-hours service and support for people experiencing homelessness
U.S. – California	• The Medi-Cal program within the California Department of Health Care Services developed the Housing for a Healthy California Program (HHC), which aims to reduce the financial burden on local and state resources ○ Clients are offered a care coordinator and care team, and the program provides comprehensive care management, care coordination, health promotion, comprehensive transitional care, member and family supports, and referral to community and social supports

	• The HHC and community-based organization Brilliant Corners were awarded a $1.75-million two-year grant to fund the Homeless Hospice Pilot to provide end-of-life care to people experiencing homelessness in Los Angeles County through county-operated recuperative care centres and permanent support housing sites
U.S. – Washington	• The Washington State Department of Health defines palliative care as specialized care for people living with serious illness ○ Care is focused on relief from the symptoms and stress of the illness and treatment to improve and sustain quality of life for the patient, loved ones and other care companions ○ Palliative care facilitates patient autonomy, access to information, and choice, with the palliative-care team helping patients and families understand the nature of their illness, and make timely, informed decisions about care ○ No initiatives for providing palliative care to homeless or precariously housed populations were identified • The Seattle & King County's Healthcare for the Homeless Network provides healthcare services to people experiencing homelessness, and training to healthcare and homeless service providers to better meet the needs of this population ○ A 34-bed respite service is provided by this group for those experiencing homelessness to receive care over a period of time, however, this service is not directed towards those needing palliative care ○ Although guidelines to best serve people experiencing homelessness with healthcare needs are provided, no explicit guidance is provided for palliative care • Harborview Medical Center has a respite program which provides harm reduction and recuperative care to people experiencing homelessness who are too sick to return to the shelter or streets, but do not require a hospital level of care ○ Homeless patients can receive daily nursing care for up to six weeks, and people living with serious illness can stay there for up to six months ○ This centre focuses on acute care rather than long-term or palliative care • No systems-level approaches to providing palliative care for those experiencing or vulnerable to homelessness were identified
U.S. – Massachusetts	• The Massachusetts Department of Health and Social Services defines palliative care as a comprehensive treatment of the discomfort, symptoms and stress of serious illness ○ Palliative care is defined as giving care and comfort along the entire course of disease or illness, as opposed to hospice care which concerns end-of-life care • The Barbara McInnis House provides short-term medical and recuperative services for homeless people who are too sick for life in shelters, but not sick enough to receive hospital-based care ○ This house contains 104 beds for homeless individuals ○ While most patients are discharged within a few weeks, exceptions are made for people without citizenship or immigration documents who are unable to receive care at a nursing facility or hospice ○ End-of-life care training is provided to all medical staff at the McInnis House • No systems-level approaches to providing palliative care for those experiencing or vulnerable to homelessness were identified
U.S. – Oregon	• The Blackburn Center in Oregon offers 124 units of affordable housing with an on-site clinic and services for medical and mental health and recovery ○ This centre offers chronic-health condition management programs, as well as mental health and addictions services to those experiencing or who are vulnerable to homelessness

	○ However, this centre does not specifically provide palliative care • No systems-level approaches to providing palliative care for those experiencing or vulnerable to homelessness were identified

Bhuiya A, Bain T, Al-Khateeb S, Soueidan S, Wang A, Jarvis T, Sood T, De Maio P, Mehta V, Wilson MG. Rapid evidence profile #29.2: What do we know from evidence and experiences from other jurisdictions about providing palliative care for those who are experiencing or at risk of homelessness? Hamilton: McMaster Health Forum, 12 September 2022.

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Appendix 1: Methodological details

We use a standard protocol for preparing rapid evidence profiles (REP) to ensure that our approach to identifying research evidence as well as experiences from Canadian provinces and territories are as systematic and transparent as possible in the time we were given to prepare the profile.

Identifying research evidence

For this REP, we identified full systematic reviews and single studies from searches of the following evidence sources:

1. ACCESSSS;
2. HealthEvidence;
3. Health Systems Evidence;
4. Social Systems Evidence;
5. the COVID-END inventory of best evidence syntheses; and
6. PubMed.

In ACCESSSS we searched for relevant documents using the following terms: (homeless* OR hous*) AND (palliative OR hospice OR end-of-life OR end of life). In HealthEvidence we searched using the following combination of terms: (homeless* OR hous*) AND (palliative OR hospice OR end-of-life OR end of life). In Health Systems Evidence, we searched for overviews of systematic reviews, systematic reviews of effects and systematic reviews addressing other questions using the following terms in the open search: (homeless* OR hous*) AND (palliative OR hospice OR end-of-life OR end of life). In Social Systems Evidence we searched for overviews of systematic reviews, systematic reviews of effects and systematic reviews addressing other questions using the following terms in the open search: (homeless) AND (palliative OR hospice OR end-of-life OR end of life) AND care. In the COVID-END inventory of best evidence syntheses we searched for: (homeless*) AND (palliative OR hospice OR end-of-life OR end of life) AND care. Lastly, in PubMed we searched using the filters for reviews and systematic reviews using the following terms: (homeless*) AND (palliative OR hospice OR end-of-life OR end of life).

Search results were screened by one team member for relevant documents. A final inclusion assessment is performed both by the person who did the initial screening and the lead author of the rapid evidence profile, with disagreements resolved by consensus or with the input of a third reviewer on the team. The team uses a dedicated virtual channel to discuss and iteratively refine inclusion/exclusion criteria throughout the process, which provides a running list of considerations that all members can consult during the first stages of assessment.

During this process we include published, pre-print and grey literature. We do not exclude documents based on the language of a document. However, we are not able to extract key findings from documents that are written in languages other than Chinese, English, French or Spanish. We provide any documents that do not have content available in these languages in an appendix containing documents excluded at the final stages of reviewing.

Identifying experiences from Canadian provinces and territories

For each REP we search several sources to identify experiences. This includes government-response trackers that document national responses to the pandemic, as well as relevant government and ministry websites. For example, we search websites from relevant federal and provincial governments, ministries and agencies (e.g., Public Health Agency of Canada).

While we do not exclude countries based on language, where information is not available through the government-response trackers, we are unable to extract information about countries that do not use English, Chinese, French or Spanish as an official language.

Assessing relevance and quality of evidence

We assess the relevance of each included evidence document as being of high, moderate or low relevance to the question. We then use a colour gradient to reflect high (darkest blue) to low (lightest blue) relevance.

If we had found guidelines, two reviewers would have independently appraised the quality of the guidelines we identified as being highly relevant using AGREE II. We used three domains in the tool (stakeholder involvement, rigour of development and editorial independence) and classified guidelines as high quality if they were scored as 60% or higher across each of these domains.

Two reviewers independently appraise the methodological quality of systematic reviews and rapid reviews that are deemed to be highly relevant. Disagreements are resolved by consensus with a third reviewer if needed. AMSTAR rates overall methodological quality on a scale of 0 to 11, where 11/11 represents a review of the highest quality. High-quality reviews are those with scores of eight or higher out of a possible 11, medium-quality reviews are those with scores between four and seven, and low-quality reviews are those with scores less than four. It is important to note that the AMSTAR tool was developed to assess reviews focused on clinical interventions, so not all criteria apply to systematic reviews pertaining to health-system arrangements or to economic and social responses. Where the denominator is not 11, an aspect of the tool was considered not relevant by the raters. In comparing ratings, it is therefore important to keep both parts of the score (i.e., the numerator and denominator) in mind. For example, a review that scores 8/8 is generally of comparable quality to a review scoring 11/11; both ratings are considered 'high scores.' A high score signals that readers of the review can have a high level of confidence in its findings. A low score, on the other hand, does not mean that the review should be discarded, merely that less confidence can be placed in its findings and that the review needs to be examined closely to identify its limitations. (Lewin S, Oxman AD, Lavis JN, Fretheim A. SUPPORT Tools for evidence-informed health Policymaking (STP): 8. Deciding how much confidence to place in a systematic review. *Health Research Policy and Systems* 2009; 7 (Suppl1):S8.

Preparing the profile

Each included document is hyperlinked to its original source to facilitate easy retrieval. For all included guidelines, systematic reviews, rapid reviews and single studies (when included), we prepare a small number of bullet points that provide a brief summary of the key findings, which are used to summarize key messages in the text. Protocols and titles/questions have their titles hyperlinked given that findings are not yet available. We then draft a brief summary that highlights the total number of different types of highly relevant documents identified (organized by document), as well as their key findings, date of last search (or date last updated or published), and methodological quality.

Appendix 2: Key findings from evidence documents that address the question, organized by document type and sorted by relevance to the question and COVID-19

Type of document	Relevance to question	Key findings	Recency or status
Guidelines	None identified		
Full systematic reviews	• Who is palliative care provided to? o People experiencing homelessness (e.g., living on the street, in shelters, in encampments) o Those at risk for homelessness (e.g., those in precarious housing situations) • Who is involved in providing palliative care? o Social workers o Peer workers o Community or outreach workers • Where is palliative care provided? o Shelter o Mobile or community-based • What implementation barriers and enablers need to be considered or addressed? o For those accessing palliative care o For organizations or systems to create new or enhance existing programs	• This review identified 11 descriptive themes related to palliative care for homeless and vulnerably housed people; three of these were identified as core themes • The first core theme identified was experiences, beliefs and wishes o Homeless people were found to hold strong beliefs about what makes a 'good' or 'bad' death due to their exposure to and experiences with deaths o Homeless and vulnerably housed people were found to perceive end-of-life care services to provide sufficient choice and dignity around death o This review identified challenges in advance directives and advance care planning for homeless and vulnerably housed people, and suggested further research to better understand and adapt advance directives and advance care planning to these populations • The second identified core theme was relationships o Homeless and vulnerably housed people were identified to have more difficulty building trust in relationships o The potential for hostels to provide support to this population was identified, however, limitations exist concerning the type of care that can be provided by hostels o Shelter-based care was identified as cost-effective, however, the effectiveness of this is also unclear o Those providing palliative care to homeless and vulnerably housed people could learn from the approaches used by services specializing in supporting homeless and vulnerably housed people which commonly offer diverse and judgment-free person-centred care	Published May 2021

		o A systematic exclusion in accessing care at end of life for this population was identified, as well as a lack of communication between homeless services and healthcare services • The third identified core theme was end-of-life care o A need for training for workers providing services to this population was identified to address the complex and changing needs of this population o Open communication can allow harm-reduction and shelter outreach workers to better identify social needs of homeless people that need to be addressed, such as housing, food, hygiene and security o The harm-reduction approach to manage substance use at end of life could offer benefits to homeless and vulnerably housed people o A need for consistent, flexible, multidisciplinary, open, respectful and non-judgmental care was identified at the service-provision level • A need to combine expertise in palliative care, expertise in the care of homeless and vulnerably housed people, and expertise from homeless and vulnerably housed people was identified • Suggested approaches should be considerate and consistent, while bridging gaps in hostels, social, harm-reduction and primary-care services Source (AMSTAR rating 5/9)	
	• Who is palliative care provided to? o People experiencing homelessness (e.g., living on the street, in shelters, in encampments) • What implementation barriers and enablers need to be considered or addressed? o For those accessing palliative care o For those providing palliative care	• This scoping review explored the barriers for homeless people in accessing palliative care • Six themes emerged from the 57 relevant articles identified: o Characteristics of homeless persons who require end-of-life care o Preferences and concerns of homeless persons approaching the end of life o The role of spirituality for homeless persons at the end of life o Barriers to care at the patient, provider, and institutional or structural levels	Literature last searched March 2018

		○ Inclusive models of palliative care ○ Implications for policy and practice • The review highlights that there is a need to address patient, provider and structural barriers in parallel, and that many obstacles in both the provision and receipt of palliative care must be negotiated by practitioners and homeless persons • There is a lot of potential and opportunity to improve the quality of life at the end of life for this vulnerable population Source (AMSTAR rating 5/9)	
	• Who is palliative care provided to? ○ People experiencing homelessness (e.g., living on the street, in shelters, in encampments) • What is included in palliative care models for those who are experiencing or at risk of homelessness? ○ Pain management	• Health and social-care professionals face challenges in meeting the end-of-life needs of people who use substances • Addressing issues like safely prescribing drugs for pain management becomes more difficult in the context of substance use, requiring flexible service provision from both alcohol/substance use services and end of life care providers • The evidence identified from this review were categorized into three broad themes: ○ Pain management ○ Homeless and miscellaneous populations ○ Alcohol-related • There was limited evidence found overall on end-of-life care for people with substance problems • Most studies emphasized the need for comprehensive assessments with clinicians to help people using substances to manage pain, as well as the importance of screening for alcohol problems as substance users may try to compensate for inadequate pain relief at the end of life • The review recommended that models of good practice be developed considering co-existing substance use and end-of-life conditions, and that prevalence studies should be conducted to provide a wider context for policy development • Source (AMSTAR rating 4/9)	Literature last searched August 2017

	- Who is palliative care provided to?
	  - People experiencing homelessness (e.g., living on the street, in shelters, in encampments)
	- What are the outcomes?
	  - Health related (including quality of life)
	  - Patient experience
	  - Costs
		- There is some evidence that interventions to improve advance care planning, palliative care, and end-of-life care interventions for homeless persons (such as support homes, cost reduction through shelter-based palliative care, and better access via coordination with harm-reduction services) may be effective, but their effectiveness remains uncertain
		- Advance care planning for this population is feasible and should be encouraged
		- Continuity of care for homeless individuals may be improved by integrating and coordinating among palliative and homelessness-related services
		- Interventions should be intensive, comprehensive, and flexible in delivering services to this population
		- High-quality, rigorous studies of interventions that consider and reflect the unique and complex circumstances of homeless populations, and that investigate patient-related outcomes, caregiver burden, and cost-effectiveness, are needed
		Source (AMSTAR rating 8/11)
			Published February 2017

	- Who is palliative care provided to?
	  - People experiencing homelessness
	- What implementation barriers and enablers need to be considered or addressed?
	  - For those accessing palliative care
	  - For those providing palliative care
	  - For organizations or systems to create new or enhance existing programs
		- This systematic review explores the challenges for palliative-care access and delivery to homeless populations, and potential suggestions for facilitating access and delivery
		- A thematic analysis was conducted to explore similarities, differences, and relationships between studies and to develop an understanding of the perspectives of the homeless populations and the professionals providing support
		- Some of the challenges to access and provision to palliative care for homeless populations included:
		  - Chaotic lifestyles sometimes associated with being homeless
		  - Challenges to the delivery of palliative care within a hostel/shelter for homeless people due to inadequate resources
			Published December 2016

		o Lack of and uptake of available palliative-care options in mainstream healthcare for homeless people due to multiple issues, including co-morbidities, substance use, distrust in the health system and health professionals • Obstacles were related to homeless populations' competing day-to-day priorities, the stigma in mainstream settings, the high burden on hostel/shelter staff in supporting residents at the end of life, and inflexibility in mainstream healthcare systems • Suggestions that were identified for improving access to palliative care included: o Building trust between homeless persons and health professionals o Increasing collaboration between services o Providing more training and support for all professionals Source (AMSTAR rating 5/9)	
	• Who is palliative care provided to? o People experiencing homelessness (e.g., living on the street, in shelters, in encampments) • What implementation barriers and enablers need to be considered or addressed? o For those accessing palliative care o For those providing palliative care	• Individuals experiencing homelessness often expressed concerns regarding palliative care related to end-of-life care not being a priority, substance dependence hindering adequate care, limited insight into their condition, as well as little support from family and relatives • Barriers and facilitators for palliative care often concerned the attitude of healthcare professionals towards homeless people • Respect, both in approach and for dignity, is important in good-quality palliative care • Overall, a patient-centred, flexible, and low-threshold approach which embodies awareness of the concerns of people experiencing homelessness is needed for appropriate palliative care to be provided in a timely manner • This may be accomplished with the help of training and educating professionals, as well as their experiences Source (AMSTAR rating 9/9)	Literature last searched May 2016

	• Who is palliative care provided to? o People experiencing homelessness (e.g., living on the street, in shelters, in encampments) • What groups may palliative care need to be tailored to? o People with addictions/substance-use issues o Veterans	• A high prevalence of tobacco use and respiratory conditions were found in homeless populations • The majority of studies identified in this review investigated the prevalence of respiratory conditions, including COPD, asthma, respiratory-related cancers and tuberculosis • This review found that a low proportion of homeless people with respiratory diagnoses were receiving care, despite the provision of dedicated services for this population • This review found no studies exploring issues relating specifically to supporting palliative care in homeless populations • Further research is suggested to be done on how to deliver palliative care to homeless populations, as well as the barriers and facilitators that currently exist • Research about the impact on, and role of, family, friends, or informal networks in the provision of palliative care is also needed Source (AMSTAR rating 4/9)	Published September 2020
	• Who is palliative care provided to? o People experiencing homelessness (e.g., living on the street, in shelters, in encampments) • Who is involved in providing palliative care? o Nurses	• The healthcare-delivery system may leverage the skills of registered nurses to make positive health-related changes for the homeless populations, improving their overall quality of life • Existing interventions include having nurses as primary contacts for interventions, nurse case-managed delivered interventions, nurse-delivered educational interventions, and nurse-delivered group therapy intervention • The overarching recommendation is to employ a holistic nursing approach when working to improve outcomes for homeless populations; this aims to ensure optimal treatment for their complex physical, mental, and social health needs and problems Source (AMSTAR rating 3/10)	Published October 2018
Rapid reviews	None identified		

Protocols for reviews that are already underway	None identified		
Titles and questions for reviews being planned	None identified		

Single studies	- Who is palliative care provided to?
	  - People experiencing homelessness
	- What is included in palliative care models for those who are experiencing or at risk of homelessness?
	  - Spiritual and bereavement support
		- This narrative literature review explored what is currently known about the spiritual concerns of people experiencing homelessness towards the end of life
		- The literature search yielded 11 literature reviews, in which most of them are based in the United States
		- The findings show that for the U.S. homeless populations, spiritual beliefs have been documented as a barrier to advance care planning
		- One U.S. study revealed that 75% of the homeless participants feared that no one would know they had died, and that 85% worried about the end-of-life care that they would receive
		- Other U.S. studies confirm the primacy of religious beliefs and spiritual experience for homeless people considering end-of-life issues
		- However, research reporting the end-of-life priorities of homeless populations is sparse, particularly research drawing from global perspectives
		Source
			Published 2 September 2018

	- Who is palliative care provided to?
	  - People experiencing homelessness (e.g., living on the street, in shelters, in encampments)
	- Who is involved in providing palliative care?
	  - Nurses
	- Where is palliative care provided?
	  - Hospital
	  - Mobile or community-based
	- What implementation barriers and enablers need to be considered or addressed?
	  - For those accessing palliative care
		- The literature review aimed to understand why people experiencing homelessness in the U.K. cannot access palliative-care services to address their complex needs
		- The authors identified that there is difficulty in predicting disease trajectory and existing gaps in the health system for people experiencing homelessness
		- The review determined that there is a lack of education about end-of-life and complex needs of people experiencing homelessness (e.g., complex physical and mental health, substance misuse), stigma from both the general public and healthcare providers, and lack of suitable places to deliver palliative care for the population
			Published 2 April 2019

	o For organizations or systems to create new or enhance existing programs • What are the outcomes? o Health related (including quality of life) o Equity related (e.g., did the intervention/program address the identified health disparities for the population it served) o Patient experience	(e.g., inflexible services, low tolerance for substance misuse) • The authors suggested that nurses could facilitate collaboration with other health professionals to improve end-of-life outcomes Source	
	• Who is palliative care provided to? o People experiencing homelessness (e.g., living on the street, in shelters, in encampments) • Who is involved in providing palliative care? o Nurses • Where is palliative care provided? o Shelter o Mobile or community-based • What implementation barriers and enablers need to be considered or addressed? o For those accessing palliative care o For organizations or systems to create new or enhance existing programs • What are the outcomes? o Health related (including quality of life) o Patient experience	• This narrative literature review assessed advance care planning (ACP) interventions for end-of-life (EOL) care for people experiencing homelessness • The review found high rates of advance directive (AD) completion (27%-50% overall) amongst homeless populations with ACP interventions, with clinician-assisted interventions having significantly higher rates than self-guided interventions • Settings in which the included study interventions took place included drop-in service sites in Minnesota, U.S., homeless shelters in Toronto, Canada, and transitional housing in California, U.S. • EOL concerns among the homeless included fear of dying alone or unnoticed, dying violently, and remaining unidentified after death, as well as burial and notification of family members • Participants across the included studies expressed differing views about healthcare providers, with some trusting the judgment of physicians to make decisions about their EOL care and others perceiving them as overly controlling • The review highlighted that education of homeless populations about different types of EOL care is important, and that public-health nurses are well-suited to promote ACP for this population Source	Published September 2017
	• Who is palliative care provided to?	• The study reviewed disparities in access to palliative care for the homeless population in Toronto	Published 27 June 2017

	○ People experiencing homelessness (e.g., living on the street, in shelters, in encampments) • What implementation barriers and enablers need to be considered or addressed? ○ For those accessing palliative care ○ For organizations or systems to create new or enhance existing programs	• The authors indicated that barriers to palliative care involved impaired trust and individual respect, underdevelopment of palliative care, and lack of promotion of prevention and protection • The study described a retrospective study about shelter-based palliative care, which reported that harm-reduction practices, boundary setting, intensive case-management approaches, and patient contracting enabled staff and other hostel residents to feel safe • The authors recommended that a public-health approach that involves care integration and partnerships with homeless shelters and service providers may help bring palliative care to where people experiencing homelessness feel comfortable Source	
	• Who is palliative care provided to? ○ People experiencing homelessness (e.g., living on the street, in shelters, in encampments) • Where is palliative care provided? ○ Hospital • What implementation barriers and enablers need to be considered or addressed? ○ For those accessing palliative care ○ For organizations or systems to create new or enhance existing programs	• A qualitative study examined the perspectives of people experiencing homelessness or vulnerable housing in southeastern Ontario about accessing hospital-based services, including palliative care • The authors acknowledged that palliative care for homeless and vulnerable populations needs to be mobile and flexible, as there were some examples of current inflexibility in a requirement to have housing before receiving treatment, and a lack of openness to a harm-reduction approach • In some cases, stigma and shame were so painful that they superseded health complaints, previous trauma, or other concerns a patient might have • Participants articulated the responsibility of healthcare providers to provide empathic care to everyone, regardless of their socio-economic status, substance-use history, or life circumstances • Participants felt welcomed when providers upheld dignity, autonomy, and choice for patients Source	Published 1 July 2019

	• Who is palliative care provided to? ○ People experiencing homelessness (e.g., living on the street, in shelters, in encampments) • What implementation barriers and enablers need to be considered or addressed? ○ For those accessing palliative care ○ For organizations or systems to create new or enhance existing programs	• A qualitative study explored the experience, goals, fears, and hopes surrounding death in settings of homelessness or vulnerable housing • Participants described a sense of being perpetually surrounded by death or the threat of death when on the street; one participant had been in a near palliative situation after a cancer diagnosis, receiving chemotherapy while on the street, and was kicked out of shelters because he was vomiting too much • Fears included not being afraid of death, but rather, a fear of dying alone; receiving inadequate care or pain medication; being resuscitated against their wishes; or being buried in an unmarked grave if there was no one to claim their body • Participants articulated home as an ideal space to die, followed by a comfortable and flexible institution that allowed their loved ones to be with them • Participants suggested improving palliative care by having it delivered by people with lived experience of homelessness and substance use and having care that is welcoming and flexible, minimizes stigma and enhances dignity, and respects people's desires to use substances at end of life • Participants advised to improve access to affordable housing, allowing people to access homecare and die at home Source	Published 7 May 2019

Appendix 3: Documents excluded at the final stages of reviewing

Type of document	Hyperlinked title
Guidelines	None identified
Full systematic reviews	Hospice care access inequalities: A systematic review and narrative synthesis Palliative care needs and models of care for people who use drugs and/or alcohol: A mixed methods systematic review Effects of Housing First approaches on health and well-being of adults who are homeless or at risk of homelessness: systematic review and meta-analysis of randomised controlled trials A systematic review of interventions by healthcare professionals to improve management of non-communicable diseases and communicable diseases requiring long-term care in adults who are homeless Health supports needed for homeless persons transitioning from hospitals Homeless persons' experiences of health- and social care: A systematic integrative review
Rapid reviews	None identified
Protocols for reviews that are already underway	None identified
Titles and questions for reviews being planned	None identified
Single studies	Palliative care for a homeless person Hearing their voice: Advance care planning for the homeless

McMaster University
HEALTH FORUM

>> Contact us
1280 Main St. West, MML-417
Hamilton, ON, Canada L8S 4L6
+1.905.525.9140 x 22121
forum@mcmaster.ca

>> Find and follow us
mcmasterforum.org
healthsystemsevidence.org
socialsystemsevidence.org
mcmasteroptimalaging.org
mcmasterforum