Healthcare Quarterly

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# Improving Equity in Access to Palliative Care

BRIDGING THE GAP
THE POWER OF THE COLLECTIVE
WHAT LEADERS NEED TO KNOW
REFLECTIONS FROM OUR COLLABORATIVE JOURNEY

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# From the Guest Editor

Canada's palliative care systems were not built for people who are homeless or vulnerably housed. There have been pockets of innovation across the country, but until now, no national initiative of this scale. In February 2025, I received an e-mail from Dianne Foster-Kent, Editorial Director for *Healthcare Quarterly*, asking whether I would consider serving as guest editor for a special issue profiling the Improving Equity in Access to Palliative Care (IEAPC) collaborative. Led by the Canadian Partnership Against Cancer and Healthcare Excellence Canada, the collaborative aimed "to improve access to palliative care for those who are experiencing homelessness or vulnerable housing across Canada," and to "provide healthcare leaders with tools and strategies that they can adapt to their own jurisdictions to enhance access to palliative care for equity-deserving communities."

At the time, I was nine months into maternity leave and working part-time to keep my research program afloat. My bandwidth was limited, but the opportunity was one that I could not turn down. Improving access to palliative care for people experiencing homelessness or vulnerable housing has been a passion of mine for well over a decade. My very first research job in public health involved interviewing individuals at the Ottawa Mission about their experiences navigating primary care while homeless or vulnerably housed. Since then, I have been involved in several studies relevant to palliative care for this population in Baltimore, Toronto and Ottawa. I replied to Dianne's e-mail within 20 minutes.

## The Innovation of the Improving Equity in Access to Palliative Care Collaborative

Over the next two years, a series of conversations and iterations unfolded as we worked together to support the IEAPC collaborative in clearly and cogently representing the innovation of their initiative and the lessons learned. Across 23 communities in eight provinces, IEAPC demonstrated that palliative care can be redesigned to meet people where they are both literally and structurally. This achievement is unprecedented in Canadian palliative care, and the Canadian Partnership Against Cancer and Healthcare Excellence Canada should be applauded for their leadership in spearheading this work.

The IEAPC enhanced access to and quality of palliative care for people who were and are homeless or vulnerably housed, all while leveraging an approach grounded in community engagement, person-centredness, trauma-informed practice, and culturally safe(r) care. The breadth and depth of what unfolded since the IEAPC launched in 2022 is documented throughout this special issue, which is thoughtfully packaged to represent the initiative from multiple angles.

## Overcoming the Challenge of How to Evaluate Patient and Public Involvement and Engagement

Patient and public involvement and engagement in research and quality improvement initiatives is notoriously hard to do and hard to publish. Typical biomedical paradigms and positivist ontologies do not pair well with the nature of this work. Nevertheless, these authors and organizations assembled a comprehensive, customizable evaluation framework for each of the 23 communities. Were improvements captured with propensity-score-matched comparator groups or randomized participants? No, and nor would either have been feasible in the context in which IEAPC operated. And do we need this level of rigour to say the IEAPC improved lives? Also no.

As a researcher who works at the nexus of evidence, practice and policy, I often struggle with balancing gold-standard rigour with the urgency of implementing initiatives that improve lives. Sometimes, to achieve one, we must compromise the other. I once had a caregiver partner exclaim, after I presented results from nine years of meticulous research, "Stop studying this and start implementing it. We need these solutions now and not after a step-wedged multi-site randomized control trial!" The IEAPC went ahead and leveraged patient and public involvement and engagement to quickly and effectively implement solutions at a time of intersecting crises of housing instability, increased morbidity and mortality, aging, caregiver burden and the opioid crisis, to name a few.

## Key Takeaways From This Issue

For healthcare leaders, the lesson is clear: meaningful evaluation must fit the realities of the populations served. The IEAPC demonstrates that equity-oriented palliative care is not only possible but also scalable. The approaches showcased in this issue offer actionable insights for jurisdictions seeking to redesign palliative care with and for communities who have historically been excluded from it. Investing in community-engaged design, adapting trauma-informed approaches and embedding flexible evaluation frameworks are not optional; they are essential for equity-oriented system redesign. HQ

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# Improving Equity in Access to Palliative Care for Communities Experiencing Homelessness or Vulnerable Housing

Improving Equity in Access to Palliative Care Program Delivery Team (including* Clarissa Chan, Andrea Coronado, Kristen DeCaria, Emilie Desmottes, Amber Heyd, Mihaela Labbe, Kirstin Loates, Tanya MacDonald, Nicole Robinson, Raquel Shaw Moxam and Lindsay Yarrow)

**Key Takeaways**

- The Framework on Palliative Care in Canada recognizes the need to address gaps in access to and quality of palliative care for underserved populations, including people experiencing homelessness.
- Improving Equity in Access to Palliative Care brought together 23 communities across eight provinces to improve access to palliative care for people experiencing homelessness or vulnerable housing.
- This special issue shares impacts and insights from leading innovative models of equity-oriented palliative care for people experiencing homelessness, highlighting key considerations for design, implementation and evaluation for potential spread and scale.

**Abstract**

**Supporting progress toward the objectives of the Framework on Palliative Care in Canada, Healthcare Excellence Canada (HEC) and the Canadian Partnership Against Cancer (the Partnership) launched the Improving Equity in Access to Palliative Care (IEAPC) collaborative in 2022, bringing together people from health and social care sectors across the country to design, deliver and evaluate initiatives that drive measurable improvement in access to equity-oriented palliative care for people experiencing homelessness or vulnerable housing. This introductory article outlines the purpose of this special issue of *Healthcare Quarterly*, the IEAPC collaborative and the gaps in palliative care in Canada for individuals experiencing homelessness or vulnerable housing. As we look toward a future where everyone in Canada has access to safe and high-quality care, we hope this special issue will be a source of inspiration and encouragement for leaders across the healthcare system to improve equity in palliative care.**

## Introduction and Impetus

Improving access to high-quality palliative care at end of life continues to be a priority across Canada (Health Canada 2023). Palliative care aims to reduce suffering and improve the quality of life for people and their families throughout the course of their serious illness (e.g., cancer, dementia, organ failure and neurological diseases) (Cancer Care Ontario 2014; WHO 2020). Of those who died in Canada between 2021 and 2022, 58% received palliative care with only 36% having access to palliative home care (CIHI 2023). Lack of access to home and community-based palliative care supports can lead to increased emergency department use (CIHI 2023), putting additional strain on the healthcare system (Haas et al. 2023). While the number of people who were able to die at home with palliative home care has increased by 7% since 2016–2017 (CIHI 2023), access to palliative care at the end of life for people experiencing homelessness or vulnerable housing is often overlooked, with significant barriers impeding the ability for this population to die with dignity in the environment of their choice (Stajduhar et al. 2024).

Many palliative care services are often not designed for, nor do they address the social, structural and economic inequities that significantly impact health, illness and dying. People experiencing homelessness or vulnerable housing are

*in alphabetical order

significantly less likely to have access to palliative care services, further exacerbating the challenges they may experience in achieving dignity and comfort at the end of life (Stajduhar et al. 2019, 2024; Stajduhar and Gott 2023). Homelessness describes the situation of an individual, family or community without stable, permanent, appropriate housing, or the immediate prospect, means and ability of acquiring it (Canadian Observatory on Homelessness 2012). It is estimated that about 235,000 people in Canada experience homelessness each year (Gaetz et al. 2014).

## Policy Context

Gaps in access to and quality of palliative care for underserved populations, including people experiencing homelessness and vulnerable housing, were recognized across Canada with the publication of a Framework on Palliative Care in Canada (Health Canada 2018). The Framework was intended to provide a collective vision of palliative care access for all people living with serious illness in Canada to live well until the end of life. Given the complex nature of the healthcare system, the Framework identified four priority areas for action (Box 1).

**BOX 1.**
**Framework for palliative care in Canada – goals and priorities**

1. Palliative care training and education for healthcare providers and other caregivers
2. Measures to support palliative care providers and caregivers
3. Research and the collection of data on palliative care
4. Measures to facilitate equitable access to palliative care across Canada

To complement the Framework, a Federal Action Plan on Palliative Care was developed in 2019 and outlined a five-year plan focused on improving quality of life for people living with life-limiting illness, families and caregivers and enhancing access, quality of care and healthcare system performance (Health Canada 2019). The Action Plan clarified the steps needed to achieve the vision set out in the Framework. One of the key goals and actions was to foster improved access to palliative care for underserved populations – including those experiencing homelessness or vulnerable housing.

## In the Context of Structural Vulnerability and Homelessness

Our health outcomes and ability to access healthcare are deeply influenced by where we live, work and learn. The population of those experiencing homelessness or vulnerable housing is diverse in nature. It encompasses a range of intersecting demographics, including race and ethnicity, mental health status, age and gender and the social forces that shape who becomes and remains unhoused or vulnerably housed. The concept of structural vulnerability is often used to describe this diverse population to redirect our attention to systemic and structural factors that produce and maintain inequities (Stajduhar and Mollison 2018).

Persistent obstacles to accessing timely and high-quality care contribute to the exacerbation of health conditions, leading to a significant reduction in life expectancy among those experiencing homelessness (Roerig et al. 2024). For instance, people experiencing homelessness are 29 times more likely to have hepatitis C, five times more likely to have heart disease and four times more likely to develop cancer (St. Michael's Hospital 2017). In Toronto, the median age of death for people experiencing homelessness was 50 years of age compared to the general population whose median age of death was 82 (Toronto Public Health 2025).

Currently, care systems overlook many barriers that impact an individual's ability to navigate and receive care, including transportation, psychosocial support, food and shelter (Box 2). Overcoming these barriers also involves the navigation of multiple siloed systems, where the lack of continuity can ultimately result in individuals falling through gaps in care and not receiving the help they need (Stajduhar and Mollison 2018). A focus on securing needs for survival also makes it difficult to seek care. As such, awareness and provision of available palliative care, including advance care planning and discussions about death, often never occur (Stajduhar et al. 2019). For those who are identified for palliative care, this often occurs at late disease stages, once dying has already begun (Stajduhar and Mollison 2018). Furthermore, individuals who are homeless or vulnerably housed often have fewer social supports and have been observed to pass away alone in acute care, shelters, transitional housing or other areas away from family, friends and care workers in their communities (Stajduhar and Mollison 2018; Stajduhar et al. 2019).

**BOX 2.**
**Barriers to care**

The most common barrier raised by participants was the cost of transportation to and from their many appointments. Without access to vehicles and friends who had vehicles and could drive them, participants relied on public transportation. The farther they had to go, the more it cost. The challenge of public transportation was exacerbated as people became sicker and their health and mobility declined (Stajduhar et al. 2019).

## Overview of the Improving Equity in Access to Palliative Care Collaborative

As two Pan-Canadian Health Organizations with a history of partnership, collaboration and impact, Healthcare Excellence Canada (HEC) and the Canadian Partnership Against Cancer (the Partnership), were well positioned to respond to the Federal Action Plan on Palliative Care (Health Canada 2019).

In 2022, HEC and the Partnership embarked upon a four-year journey bringing together people from health and social care sectors across the country to design, deliver and evaluate initiatives that drive measurable improvement in access to palliative care for people experiencing homelessness or vulnerable housing through the Improving Equity in Access to Palliative Care (IEAPC) collaborative (HEC n.d.). IEAPC was thoughtfully co-designed with subject matter experts including patients; caregivers; First Nations and Métis advisors, Elders and coaches; and a steering committee who provided advice and guidance to the Program Delivery Team. The relational approach of the collaborative focused on building capacity, building partnerships through learning and growth while sustaining impact.

With over $2.2 million in seed funding from Health Canada, communities across Canada were invited to participate in the collaborative through an application process. Reflecting the values of the collaborative, the applications were reviewed by a diverse panel including people with lived and living experience; researchers; First Nations, Inuit and Métis Elders; health and social care providers; and policy makers.

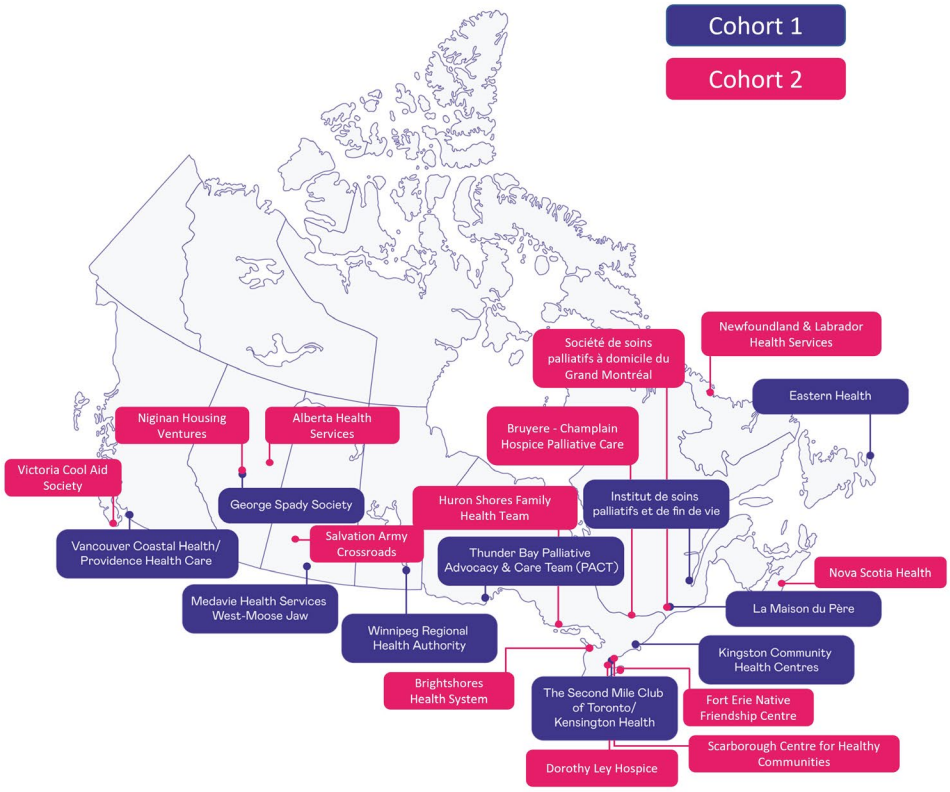
The assessment of applications considered:

- readiness, evidence of meaningful engagement;
- adequate consideration of the structural determinants of health;
- commitment to equity;
- diversity in team representation;
- clarity in population and potential patient reach; and
- potential for spread.

The first call for applications was launched in 2022 with 10 communities (Cohort 1) selected. The first phase of the program focused on identifying resources needed for the successful implementation of equity-oriented palliative care initiatives to inform the second phase of the collaborative. In 2024, a second call for applications was launched and an additional 13 communities (Cohort 2) were welcomed to the collaborative.

Ultimately, these 23 communities across eight provinces (see Figure 1) formed the IEAPC collaborative, each focused on developing new or adapting existing palliative care services to better meet the needs of people experiencing homelessness or vulnerable housing in their respective communities.

FIGURE 1.
**Improving equity in access to palliative care communities**



This collaborative was built upon evidence from leading innovative models of equity-oriented palliative care identified through two rapid reviews led by HEC (Bhuiya et al. 2022; Saragosa et al. 2022) and aligned with recommendations set out in the *Too Little, Too Late Report* (Stajduhar and Mollison 2018). These models emphasized going beyond formal healthcare settings, integrating care into the places where people live and die (Bhuiya et al. 2022; Saragosa et al. 2022).

These communities included a range of health and social care organizations, including but not limited to community health centres, health authorities, organizations that provide care to those experiencing homelessness and Indigenous-led organizations. They represented settings that include urban, rural and remote communities. Several initiatives included partners mandated and funded to provide palliative care.

Participating communities had access to seed funding of up to $100,000, coaching, in-person and virtual learning activities and evaluation support. An "all-teach-all-learn" approach was the foundation of this collaborative with communities engaging in over 150 peer-to-peer knowledge exchange opportunities and consulting with a network of 10 advisers and coaches with subject matter expertise in areas of health equity, culturally safer care, community-based care approaches and collaborating with communities.

**BOX 3.**
**Reframing equitable approaches to care**

This initiative might have been one of the most defining moments in my career, really reframing how I view care and equitable approaches to care. I believe that this will continue to follow me regardless of the role I hold – IEAPC Collaborative Team Member

The initiatives advanced through IEAPC are diverse, each designed with the strengths, resources and opportunities that exist in each community. The learnings in terms of delivering equity-oriented palliative care are vast (Box 3). They are enhanced by the deep and impactful learning the Program Delivery team has had in terms of the resources, supports and systems required to support improvement on this scale.

## Purpose of This Special Issue

As we look at the current state of palliative care in Canada, we can reflect on the Framework, Action Plan and the *Too Little, Too Late Report* as blueprints that outline the structures that enable palliative care provision, clarify the roles and responsibilities of key health system actors and identify opportunities for improvement. To continue progress toward increasing access to more equitable palliative care, it is therefore beneficial to mobilize learnings from the IEAPC implementation journey. These learnings are relevant to audiences in federal-, provincial-, territorial- and community-based health organizations and are transferable across the care continuum.

This special issue features voices from those with lived and living experience, health and social care professionals and team members who work with people experiencing homelessness or vulnerable housing. Each article in this special edition shares unique and important components of this work that, when brought together, demonstrate the complementary nature of interdisciplinary partnership and the strong progress that can arise through innovative collaboration. Readers will be presented with tools, strategies, promising practices, successes and valuable learnings that can be adapted and implemented in jurisdictions across Canada in various care settings to improve health equity for people experiencing homelessness.

Readers will learn about the impact of involving individuals with lived experience in the circle of care and how this role can contribute to overcoming barriers to care, how palliative care programs are delivered and transforming the way systems are designed in communities experiencing homelessness or vulnerable housing (Diner 2026). Recommendations for establishing meaningful and authentic partnerships with First Nations, Inuit and Métis individuals, organizations and communities are also discussed through the lens of culturally safer care (Prince 2026). In addition, as grief and bereavement are often overlooked within the context of homelessness, a dedicated article explores and recognizes the need for specialized grief supports and opportunities for improving the quality of care offered by integrating such supports for clients, providers and community (Black et al. 2026). Where possible, the articles also provide citations to additional sources and tools that may be of interest to the audience.

This gap in care for this population is explored further through a discussion addressing the social determinants of health that drive health outcomes and incorporating innovative trauma-informed and culturally safer approaches to palliative care (Bulle and Dosani 2026). We describe the 23 initiatives that participated in the collaborative and how those models can offer a roadmap for others doing work in equity-oriented palliative care with individuals experiencing homelessness or vulnerable housing (Bulle and Dosani 2026).

We also share evidence and lessons learned from this journey from the 23 participating communities and experts who have been instrumental in the design and implementation of this pan-Canadian collaborative. Over the course of the collaborative, communities shared that they have been able to increase access to equity-oriented palliative care for over 9,000 people, support over 2,000 care providers and provide training to over 3,700 people. Caverley (2026) shares the transformative process of applying a decolonized approach to evaluation practices, specifically the journey, learnings and impact of teams participating in the collaborative that grounded their work in Indigenous communities or around Indigenous practices. Two evaluation articles in this issue expand on how creating, understanding and sharing stories of this

collaborative further demonstrates the impact within respective communities experiencing homelessness or vulnerable housing, the collective impact of the collaborative and how this can inform continuous improvement (Caverley 2026; IEAPC Program Delivery Team 2026). The selected articles address prevalent themes and learnings throughout this collaborative around the context of innovative equity-oriented palliative care, including current care inequities and key considerations for healthcare leaders that can inform building a more inclusive and effective healthcare system for those experiencing homelessness or vulnerable housing (Stajduhar 2026).

## Conclusion

It is essential that we find new and innovative ways of working together to improve access to healthcare for underserved groups across Canada. This collaborative demonstrated the substantial impact that community-driven interventions that focus on equity as a foundational principle can have in improving the health of individuals and communities.

The articles in this special issue speak to how the challenges, enablers, opportunities, lived and living experiences and unique strengths of this collaborative work can be used as a catalyst for more equitable palliative care across the country.

While we recognize the complexity of the journey to embed equity-oriented approaches, whether in palliative care or in other parts of the healthcare system, we hope this special issue will be a source of inspiration for healthcare leaders as we look to shape a future where everyone has access to safe and high-quality healthcare. We hope you find this information useful and that it encourages you to consider how you can partner and work collaboratively within and across sectors to improve equity in palliative care for everyone in Canada. HQ

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### References

Bhuiya, A., T. Bain, S. Al-Khateeb, S. Soueidan, A. Wang, T. Jarvis et al. 2022, September 1. *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?* McMaster Health Forum. Retrieved August 25, 2026. <https://www.mcmasterforum.org/docs/default-source/product-documents/rapid-evidence-profiles/hec_rep-29.2_palliative-care-for-homeless_report-appendices_2022-09-22.pdf?sfvrsn=b6386a4b_10>.

Black, J., S. Laing, R. Carter, S. Landry, J.R. Graham and E. Hassan. 2026. Grief and Bereavement in the Context of Homelessness: Sharing Experiences and Learnings From British Columbia. *Healthcare Quarterly 29*(Special Issue): 22–28. doi:10.12927/hcq.2026.27967.

Bulle, S. and N. Dosani. 2026. Reflections on Innovative Models of Palliative Care Delivery. *Healthcare Quarterly 29*(Special Issue): 29–35. doi:10.12927/hcq.2026.27966.

Canadian Institute for Health Information (CIHI). 2023. *Access to Palliative Care in Canada*. Retrieved August 25, 2026. <https://www.cihi.ca/sites/default/files/document/access-to-palliative-care-in-canada-2023-report-en.pdf>.

Canadian Observatory on Homelessness. 2012. *Canadian Definition of Homelessness Canadian: Observatory on Homelessness*. Retrieved August 25, 2026. <https://www.homelesshub.ca/sites/default/files/COHhomelessdefinition.pdf>.

Cancer Care Ontario. 2014. *Tools for the Journey, Section B: Palliative Care, Diagnosis and Working Together*. Retrieved July 15, 2025. <https://www.cancercareontario.ca/sites/ccocancercare/files/assets/ACCUPalliativeCare.pdf>.

Caverley, N. 2026. Many Paths, Walking Together: Honouring Collective Reflections in Indigenous-Centred Palliative Care in Canada. *Healthcare Quarterly* 29(Special Issue): 46–56. doi:10.12927/hcq.2026.27964.

Diner, J. 2026. Bridging the Gap: Why Lived Experience Is Essential in Palliative Care for the Unhoused. *Healthcare Quarterly* 29(Special Issue): 11–14. doi:10.12927/hcq.2026.27969.

Gaetz, S., T. Gulliver and T. Richter. 2014. *The State of Homelessness in Canada 2014*. The Homeless Hub Press. Retrieved August 25, 2026. <https://homelesshub.ca/wp-content/uploads/2024/04/SOHC2014.pdf>.

Haas, R., F. Brundisini, A. Barbara, N. Darvesh, L. Ritchie, D. MacDougall et al. 2023. Emergency Department Overcrowding: An Environmental Scan of Contributing Factors and a Summary of Systematic Review Evidence on Interventions. *Canadian Journal of Health Technologies* 3(11): 1–64. doi:10.51731/cjht.2023.786.

Health Canada. 2018, December. *Framework on Palliative Care in Canada*. Retrieved August 25, 2026. <https://www.canada.ca/content/dam/hc-sc/documents/services/health-care-system/reports-publications/palliative-care/framework-palliative-care-canada/framework-palliative-care-canada.pdf>.

Health Canada. 2019, August. *Action Plan on Palliative Care: Building on the Framework on Palliative Care in Canada*. Retrieved August 25, 2026. <https://www.canada.ca/content/dam/hc-sc/documents/services/health-care-system/reports-publications/palliative-care/action-plan-palliative-care/action-plan-palliative-care-eng.pdf>.

Health Canada. 2023. *The Framework on Palliative Care in Canada – Five Years Later: A Report on the State of Palliative Care in Canada*. Retrieved August 25, 2026. <https://www.canada.ca/content/dam/hc-sc/documents/services/publications/health-system-services/framework-palliative-care-five-years-later/final-pdf-english-report-to-parliament-palliative-care.pdf>.

Healthcare Excellence Canada (HEC). n.d. *Improving Equity in Access to Palliative Care*. Retrieved June 29, 2026. <https://www.healthcareexcellence.ca/en/what-we-do/all-programs/improving-equity-in-access-to-palliative-care/>.

Improving Equity in Access to Palliative Care (IEAPC) Program Delivery Team. 2026. The Power of the Collective: Lessons Learned From Pan-Canadian Efforts to Improve Access to More Equitable Palliative Care. *Healthcare Quarterly* 29(Special Issue): 36–45. doi:10.12927/hcq.2026.27962.

Prince, H. 2026. Engaging in a Relational Approach: Addressing Inequities in Access to Palliative Care for Indigenous Peoples. *Healthcare Quarterly* 29(Special Issue): 15–21. doi:10.12927/hcq.2026.27968.

Roerig, M., M. Albert, H. Marani and S. Allin. 2024. *Supporting Equitable Access to Health and Social Services for People Experiencing Homelessness in Ontario*. North American Observatory on Health Systems and Policies. Rapid Review 44. Retrieved August 25, 2026. <https://naohealthobservatory.ca/wp-content/uploads/2024/08/NAO-Rapid-Review-44_EN.pdf>.

Saragosa, M., M. Morales-Vazquez, M. Roerig, S. Carbone and S. Allin. 2022. *Delivering Primary Care in Non-Traditional Healthcare Settings to Individuals Experiencing Homelessness*. North American Observatory on Health Systems and Policies. Rapid Review 34. Retrieved August 25, 2026. <https://naohealthobservatory.ca/wp-content/uploads/2022/04/NAO-Rapid-Review-34_EN.pdf>.

St. Michael's Hospital. 2017. *Palliative Care Services for People Experiencing Homelessness in Toronto: A Preliminary Needs Assessment*. Retrieved August 25, 2026. <https://icha-toronto.ca/sites/default/files/TC%20LHIN%20REPORT%20Pall%20Care%20Services%20for%20Homeless%20Needs%20Assess%20May%202017.pdf>.

Stajduhar, K. and M. Gott. 2023. Closing the Health Equity Gap in Palliative Care: The Time for Action Is Now. *Palliative Medicine* 37(4): 424–25. doi:10.1177/02692163231164729.

Stajduhar, K. I. 2026. What Leaders Need to Know About the Design and Delivery of Equity-Oriented Palliative Care. *Healthcare Quarterly* 29(Special Issue): 57–62. doi:10.12927/hcq.2026.27963.

Stajduhar, K.I., M. Giesbrecht, A. Mollison, K. Whitlock, P. Burek, F. Black et al. 2024. "You Can't Die Here": An Exploration of the Barriers to Dying-in-Place for Structurally Vulnerable Populations in an Urban Centre in British Columbia, Canada. *BMC Palliative Care* 23(1): 12. doi:10.1186/s12904-024-01340-7.

Stajduhar, K.I. and A. Mollison. 2018. *Too Little, Too Late: How We Fail Vulnerable Canadians as They Die and What to Do About It*. University of Victoria Institute on Aging and Lifelong Health. Retrieved August 25, 2026. <https://www.uvic.ca/research/groups/palliative/assets/docs/publications/report-too-little-too-late.pdf>.

Stajduhar, K.I., A. Mollison, M. Giesbrecht, R. McNeil, B. Pauly, S. Reimer-Kirkham et al. 2019. "Just Too Busy Living in the Moment and Surviving": Barriers to Accessing Health Care for Structurally Vulnerable Populations at End-of-Life. *BMC Palliative Care* 18(1): 11. doi:10.1186/s12904-019-0396-7.

Toronto Public Health. 2025, February 3. Toronto Public Health Releases Updated Data for Deaths of People Experiencing Homelessness in Toronto [Press Release]. Retrieved July 3, 2025. <https://www.toronto.ca/news/toronto-public-health-releases-updated-data-for-deaths-of-people-experiencing-homelessness-in-toronto/>.

World Health Organization (WHO). 2020. Health Impact Assessment. Retrieved August 12, 2025. <https://www.who.int/europe/health-topics/health-impact-assessment#tab=tab_1>.

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# Bridging the Gap: Why Lived Experience Is Essential in Palliative Care for the Unhoused

Julie Diner

**Key Takeaways**

- People experiencing homelessness face unique challenges that affect their ability to access equitable palliative care.
- Support workers who have lived experience are essential to bridge the gaps and overcome the barriers that exist for both clients and clinicians.
- Investment in lived-experience workers is needed to sustainably bridge the gaps in support for people experiencing homelessness.

**Abstract**

**Told through the lens of a care provider with lived experience, the stories of Carrie and Bobby highlight how many of the most vulnerable people in our communities are expected to fit into a system that was not built for them. Lived experience matters to the person receiving care and the person delivering care; it matters to a system in need of effective, timely efficiencies; and it matters because dignity and respect are central to humanity. This article explores how integrating lived understanding into the care and caring experience in deliberate, strategic and meaningful ways is the missing piece needed to fill the "cracks" that so many often fall through. This powerful collection of stories, insights, wisdom and practices offers a bridge to connect with people who are hardly reached by our healthcare system.**

## Introduction: Compassionate Human Connection

As an outreach worker on the Palliative Advocacy and Care Team (PACT), my role (and my passion!) is to support people in accessing the care they need and deserve. PACT is a program led by Hospice Northwest and NorWest Community Health Centres in partnership with several other organizations. Located in Thunder Bay, Ontario, we are one of the 23 communities that participated in the Improving Equity in Access to Palliative Care collaborative.

I am an individual with lived experience. The intentional hiring of individuals with lived and living experience is relatively common in community health settings, less so in palliative care. At this point in my own life, I had been on my sober journey for about 10 years and working with the vulnerably housed for eight years.

I provide a leadership role in our community and currently chair biweekly PACT meetings. These meetings bring together palliative care doctors, nurses and nurse practitioners, homecare providers and organizations working with the vulnerably housed across the city of Thunder Bay, creating a space where we can problem-solve and make sure that no one falls through the cracks. These meetings are an important aspect of PACT's work, a safety net in a system that is not designed to serve the clients I see every day.

As an outreach worker on the team, the days are rarely the same. I support clients in accessing radiation or chemotherapy through our cancer clinic; I go to tent city or our local shelters to ensure clients get to appointments; and I do things such as help individuals access food. I support the whole person on their journey, advocating for their needs and wishes, respecting their choices and helping bridge the gap between health, housing and other social care providers.

In addition to the direct care and impact on clients, my role within the PACT team creates benefits often overlooked in the broader healthcare system – both time and resources are saved. Palliative care doctors and their staff have direct access to me whenever they need help, allowing them to check in or ask for

immediate assistance. For example, if a client has a critical appointment coming up, the team can reach out to me, and I can help ensure that person gets there. We all work together to form a network that goes beyond the traditional healthcare system, providing support and access that is timely, effective and safe.

For many of these individuals, my role may provide the only stable, compassionate relationship they have, offering emotional support and dignity as they navigate a palliative diagnosis. Some of the ways I build these relationships include transporting to appointments, providing support during appointments, connecting with food resources, housing, helping with obtaining identification, addressing any legal and financial issues, all while trying to rebuild trust with healthcare workers. I do whatever I can to make people's journey as smooth as possible.

Having a lived-experience worker in this position is critical. Not only do we offer valuable insight into a client's needs, but we also prevent more costly interventions such as emergency room visits or ambulance calls. When a client is in crisis, rather than the automatic response being a 911 call, my team and I can address the issue with the right care, avoiding unnecessary hospitalizations and allowing us to handle the situation in a more personalized and cost-effective manner.

In this article, I share the stories of Carrie and Bobby as examples of the ways that people with lived experience can bridge the gaps in our healthcare system, making it easier for people to get the care that they need and deserve.

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### Carrie's Story: The System Was Not Built for Her, so We Built a Bridge

The first time I met *her*, she was struggling. She had bladder cancer, and it had already spread to her bones. She was trying to get help but kept missing appointments. Not because she did not care, but because she was homeless. No phone, no stable place to stay – just couch-surfing and trying to survive.

That was not her whole story. Carrie was more than a diagnosis or a medical condition; she is a person, a human who has a story and experiences that have made her the wonderful human that she is. Two years earlier, she lost her son – he was murdered. And that kind of grief? It does not just sit quietly in the background. It takes over your life. She started using more, partying harder and doing anything to escape. And really, who could blame her? Her parents gone, she felt alone in the world, drowning in grief and now cancer was coming for her too.

When I met her, we clicked right away. I think this was because I was open about my past. There is great power in sharing our stories, sharing how our struggles and successes have impacted our lives. When we share our stories, we share more of ourselves and, in doing so, can build trust and break down barriers to care. It acknowledges our own humanity, and although we can never walk in someone else's shoes, we can relate and be in relation to one another. She knew I was not some outsider trying to "fix" her – I had been there. And it turns out, her son had been friends with my daughter, so there was that connection too.

She was one of the kindest people I had ever met. The kind of person who would give away her last dollar if someone else needed it more. She did not have much, but whatever she had, she shared. Even when she was in pain, even when life had kicked her down over and over again.

Without the PACT collaboration, Carrie might have gone without the care she needed. Instead, we were able to find a way forward together.

Since then, I have been able to take her to and support her with almost all of her medical appointments. By sharing some of my own experiences with addiction and homelessness, I have gotten her trust and we have built a relationship. Carrie has told me that she would not be here if it were not for Dr. Bezanson (the PACT physician) and me.

Carrie's story highlights how inaccessible care can be for people without stable housing. It is built around assumptions and processes that do not stand true for everyone and, in some cases, exclude individuals from accessing care. After Carrie's nephrostomy tube surgery, she was discharged "home" – except she had no home, no bed of her own. She also had no vehicle, no income and no way to get to follow-up care. Appointments were made for her, and notices were sent by mail – mail she would never receive because she had no fixed address. At every step, the system assumed stability she simply did not have. Without PACT stepping in, she would have been left to navigate a system that was not built for her reality.

While we have helped her get to her appointments, found her a temporary place to stay and have tried to untangle the mess of her finances, it has not been easy. The system, as it is, made everything harder than it needed to be. Challenges with clear communication with social assistance/housing, paperwork and phone calls to multiple entities, including a lawyer, banks and government agencies, with more paperwork and navigation that was challenging for me. I cannot begin to imagine trying to do that on your own with a cancer diagnosis, homeless and phoneless. Nevertheless, she is fighting through it, and we fight alongside her.

### Bobby's Story: Trauma From the Past Can Inadvertently Close Doors; With Help, They Can Be Reopened

Then there was him. Bobby had cancer too, but that was not the biggest thing on his mind. He was living in a shelter, and he was a substance user and drinker – his focus every day was survival. Finding his next fix, managing withdrawal, just getting through another day ... Cancer? That was a distant problem compared with the immediate ones.

When doctors recommended radiation, Bobby agreed – at first. But after his first session, he told me he was not going back. No way. Turns out, they had to strap him down to keep him still for the treatment. And for Bobby, that was not just uncomfortable – it was traumatizing. It brought back memories of the days he went to residential school. The feeling of being trapped and powerless. He would rather die than go through that again.

If our team did not exist – that might have been the end of his treatment. The healthcare system is not designed to account for something like this. No one would have asked him why he never came back – they would have seen him as a no-show for his next radiation and considered him non-compliant, and he would have been discharged. Because I was there, because I had built trust with him, he confided in me what he had experienced in residential school, a terrifying experience. I took that information back to our team. A palliative care doctor on the team took that information to the radiation department, explained the situation and asked, "Can we do this without strapping him down?" They said yes.

This small adjustment – something that would not have happened without our advocacy – meant Bobby finished his treatment. We got him into a managed alcohol program (MAP). Instead of drinking whatever he could find, he was given measured doses of alcohol on a schedule with nurses monitoring him. He was in a safe environment, his health stabilized and eventually, he moved into long-term care. His quality of life improved dramatically.

Bobby's story illustrated the importance of those working in the healthcare system having the power to advocate, remove system barriers and problem-solve. When we work alongside individuals, listen to them, hear them and work to understand their experience, we can achieve person-centred care and, patient by patient, we can transform the way the system works. Without this advocacy and system navigation, where I could be a bridge to the healthcare system to support individuals whose needs are often ignored, Bobby may not have finished radiation. He might not have made it into the MAP. He might not have gotten into long-term care. The system was not built for him, so we had to build a bridge: the PACT team.

### How to Make the System Work for the Unhoused

Carrie's story. Bobby's story. They are not unique. I see this every day. The healthcare system is designed for people who have housing, family support, a phone, and a way to get to their appointments. The system is built on the idea that everyone has access to the same resources and all patients can follow the same plan. But for people who are unhoused, that is just not the reality.

This is how the healthcare system is failing them:

- *Missed appointments = lost care*. If you miss too many appointments, you are taken off the list. But if you do not have a phone, how can you confirm? If you do not have an address, phone or regular access to a computer and e-mail, how do you get appointment reminders? The system punishes people for not having stability. It does not have to be intentional to cause harm.
- *Transportation barriers*. Most people take for granted that they can drive, take a bus or call a friend for a ride to the hospital. But for someone staying in a shelter with no money, no car and no network, just getting to an appointment can be impossible.
- *Medical trauma and mistrust*. Many unhoused people have had awful experiences in hospitals – being judged, ignored or treated like they do not matter. Some have been through other traumatic institutions such as residential schools or prison. Walking into a hospital can feel like walking into enemy territory. Hypervigilance and the expectation of a negative outcome can cause a small misunderstanding to escalate exponentially. Trust is everything with this population.
- *Harm reduction is palliative care*. You cannot separate harm reduction from palliative care for unhoused people. Many are living with chronic illnesses, pain and a terminal diagnosis, all the while still actively using substances. If we do not meet people where they are, if we expect them to be "clean/sober" before they get care, then they will not get care at all. Everyone deserves compassion and access to care.
- *Dignified end-of-life care*. Many unhoused individuals die alone without support. A support worker with experience of homelessness, substance use and/or mental health diagnoses is the missing piece in bridging the gaps in healthcare. Trusting their decisions without judgement or stigmatization, allowing for connection and clear communication between community members and healthcare workers, a deep understanding of the barriers that exist, an ability to advocate for clients' needs and understanding the unique context in which they live – that is the value of lived experience.

## Lived Experience Is the Missing Piece in Healthcare

This is where people like me come in. This role – people with lived experience, who can work within healthcare and act as a bridge between the system and people who fall through its cracks. I walk beside vulnerable community members, navigating complex and concurrent systems and diagnoses in a way that I wish someone had been able to for me.

Why does this matter?

Because people like Carrie and Bobby will not always open up to a doctor. However, they will open up to someone they know who has been there. Someone who understands survival mode, withdrawal, the absence of safe friends or family and someone who knows what it is like to live in a shelter. Trust is the difference between someone continuing treatment or walking away.

Lived-experience workers understand that navigating the health system is difficult. They may know what it is like to lose your identification, your phone, your housing, your sense of safety – all at once. I know this. I have lived this. Most doctors and nurses – no matter how much they care – often do not know what it is like to navigate the world without stability. When we bring in people with lived experience as members of the care team, we bring perspectives that are often not present in other team members. Diverse perspectives are essential to ensuring that more people receive care and that access to care can happen for all.

Without us, palliative care will remain a system designed for housed people with support networks. Unhoused people – some of the most vulnerable patients – are left behind. This is not just about making the system better. It is about opening a door and making it work for people who have been ignored for too long.

Policy makers need to recognize this. Lived-experience workers should not be an afterthought or a nice addition to a team – they should be standard in healthcare settings that serve unhoused people. They are the missing piece. The bridge. If we want real equity in palliative care, it is time to sustainably integrate that bridge into the healthcare system itself.

By acting as a bridge between vulnerable clients and the healthcare system, we are not only improving their quality of care but also contributing to long-term cost savings. With fewer emergency calls and better continuity of care, we reduce the strain on emergency services and allow our palliative doctors and healthcare professionals to focus on proactive care rather than reactive crises. I have no doubt that the money saved by reducing emergency interventions far outweighs the investment in having a lived-experience worker on the team.

While I know it is important to highlight the "cost effectiveness" of this model and the positive implications for the entire healthcare system such as reduced emergency visits and hospitalizations, my personal reason for advocating for more roles such as these goes beyond the numbers. For me, it is about ensuring every person, regardless of their housing status, receives care rooted in compassion, respect and dignity. No one should have to face serious illness or end of life alone without support or comfort. These roles are the bridge between medical care and the human connection that everyone deserves. HQ

### About the author

**Julie Diner** works as a harm reduction support worker at Norwest Community Health Centres, Thunder Bay, ON. Born and raised in Thunder Bay and a mother of three, Julie has been working with the city's most vulnerable for the past 10 years at the Shelter House and NorWest Community Health Centres, Thunder Bay, ON. She is a facilitator of the St Elizabeth's Curriculum on Palliative Care for front-line workers at Hospice Northwest, Thunder Bay, ON. In her spare time, Julie is a dedicated member of Thunder Bay's recovery community and enjoys staying active.

# Engaging in a Relational Approach: Addressing Inequities in Access to Palliative Care for Indigenous Peoples

Holly Prince

**Key Takeaways**

- Indigenous Peoples experience significant health disparities, high rates of homelessness and inequitable access to health and social care at the end of life.
- Establishing meaningful and authentic partnerships with First Nations, Inuit and Métis communities is essential to address these challenges and improve access to care.
- The Improving Equity in Access to Palliative Care collaborative provides valuable lessons about the importance of integrating equity-oriented approaches into the healthcare system and providers' practices. Developing a First Nations, Inuit and Métis engagement strategy is also crucial to ensure that care models align with First Nations, Inuit and Métis values and worldviews.

**Abstract**

**First Nations, Inuit and Métis Peoples experience significant health disparities and inequitable access to health and social care at the end of life. They also experience higher rates of homelessness compared with their non-Indigenous counterparts. Together, these issues highlight the enduring impacts of colonialism on the social and structural determinants of health for First Nations, Inuit and Métis Peoples. Throughout the Improving Equity and Access to Palliative Care collaborative, which sought to improve the quality of life and enhance access to palliative care for individuals experiencing homelessness or vulnerable housing, many lessons were learned to address these challenges.**

## Introduction

This article emphasizes the importance of developing meaningful and authentic partnerships with First Nations, Inuit and Métis communities to address the complex health and social issues experienced at the end of life. It examines how colonial systems can be challenged by integrating equity-oriented approaches to care within the healthcare system and in care providers' practices. Furthermore, it underscores the importance of developing a First Nations, Inuit and Métis engagement strategy to ensure that models of care align with First Nations, Inuit and Métis values and worldviews.

## Locating Myself in the Work

Boozhoo, Wiiji'iwe nidishinikaas, Animbiigoo Zaagi'igan niindoonjibaa, Thunder Bay nindaa, makwa dodem, Anishinaabekwe in'dow. My English name is Holly Prince, and I am an Anishinaabekwe and a member of Opwaagaanisiing in Northwestern Ontario. I was raised on my ancestral territory of Animbiigoo Zaagi'igan, where my family has lived and thrived for generations. I want to begin by paying my respects to the Elders – past, present and future – for they hold the knowledge, teachings, traditions and future hopes of my people. This article is written through my Anishinabek lens and worldview. As an Indigenous scholar, it is important that I locate myself in my work, as this shows respect and authenticity to the communities and nations I engage with while also decolonizing my work.

## The Improving Equity and Access to Palliative Care Collaborative

The Improving Equity and Access to Palliative Care (IEAPC) collaborative aims to enhance the quality of life and improve access to palliative care for individuals experiencing homelessness or vulnerable housing. Throughout the collaborative, equity-oriented approaches to care were integrated into both the initiative and IEAPC community practices. Ongoing

engagement with First Nations, Inuit and Métis communities was essential for developing care models that better align with First Nations, Inuit and Métis values and worldviews.

This article discusses the impact of structural determinants of health on First Nations, Inuit and Métis Peoples. It emphasizes the importance of building strong relationships with First Nations, Inuit and Métis communities. In addition, it outlines a process for effectively engaging with these communities, including conducting preliminary engagement work, establishing a solid foundation, fostering relationships, co-designing an engagement plan and sustaining these relationships.

The strategies discussed in this article are not intended to be a conclusive guide but rather an initial resource for organizations and providers pursuing similar initiatives. It is important to recognize that engagement requires a tailored approach, as different nations and communities may have unique protocols and procedures not covered in this article.

## The Impact of the Structural Determinants of Health on First Nations, Inuit and Métis Peoples

First Nations, Inuit and Métis Peoples experience significant health disparities and are consistently ranked lower in almost every determinant of health compared with their non-Indigenous counterparts. These health disparities contribute to substantial health inequities, including higher rates of chronic and terminal illnesses when age-adjusted (Gracey and King 2009; United Nations 2016). The prevalence of these conditions increases with age, with almost half of First Nations, Inuit and Métis Peoples aged 60 years or older reporting four or more chronic health conditions (FNIGC 2012). Furthermore, First Nations, Inuit and Métis Peoples experience a reduced life expectancy, which is up to 15 years shorter than that of other Canadians (Indigenous Services Canada 2018). In addition, First Nations, Inuit and Métis have higher rates of homelessness compared with their non-Indigenous counterparts. While representing only 5% of the Canadian population, First Nations, Inuit and Métis Peoples are overrepresented, with over a third of people experiencing homelessness (Government of Canada 2024). First Nations, Inuit and Métis Peoples also report early experiences of homelessness, with 55% first experiencing homelessness as a child or youth, as compared with their non-Indigenous counterparts, who report first experiencing homelessness as an adult (Government of Canada 2024).

First Nations, Inuit and Métis Peoples also encounter numerous challenges to accessing healthcare, including care at the end of life (Caxaj et al. 2018; Fruch et al. 2016; Hampton et al. 2010; Kelley et al. 2018; Koski et al. 2017). There is jurisdictional ambiguity regarding the responsibility for the provision of healthcare for First Nations, Inuit and Métis Peoples (Gouldhawke 2021; Lavoie 2013; Richmond and Cook 2016). This ambiguity results in challenges with coordinated and integrated care, including difficulties in hospital discharge planning, transitioning clients through the two healthcare systems and miscommunication between the differently funded systems of care (Fruch et al. 2016; Hampton et al. 2010; Kelley et al. 2018; Koski et al. 2017). In addition, there is inequitable funding for healthcare programs in First Nations, Inuit and Métis communities, resulting in limited access to healthcare providers, programs, medications and equipment. As a result, individuals must leave their communities to receive care and access a healthcare system, which is often at odds with Indigenous ways of knowing and often does not correspond with culturally safe care. First Nations, Inuit and Métis Peoples may encounter racism within the westernized medical care system, which often leads to First Nations, Inuit and Métis Peoples delaying medical care until they are in the advanced stages of illness. This may increase the overall burden of disease to be addressed at the end of life.

To address the inequities in health and access to care for First Nations, Inuit and Métis, Loppie and Wien (2022) emphasize the importance of addressing the structural determinants of health affecting Indigenous populations. They argue that examining the deeply embedded ideological and political factors influenced by colonialism is essential, as these shape all other health determinants. Colonialism is based on racism and is defined as the "physical and ideological domination of peoples in order to separate them from their culture and resources, while creating external and internalized assumptions of the supremacy of the colonizer" (Pratt et al. 2018: 3). Colonialism is widely recognized as the primary reason behind the health inequities and unequal access to health services for Indigenous populations (Allan and Smylie 2015; Czyzewski 2011; Reading 2018; Richmond and Cook 2016; Truth and Reconciliation Commission of Canada 2015).

Healthcare programs in Canada are founded on Eurocentric westernized norms and settler-colonial knowledge systems. Colonialism perpetuates systemic and structural conditions that adversely impact and reduce the quality of life for Indigenous Peoples, resulting in complex health issues and additional challenges at the end of life. Within the colonial system of healthcare, programs and services designed to support people at the end of life, including palliative care, will never be truly "safe" for Indigenous Peoples. The programs do not align with the values and beliefs of Indigenous communities regarding caregiving, dying and death. They are, at times, in opposition to Indigenous ways of knowing, being and doing. As Elder Albert McLeod shares, unless healthcare systems are completely dismantled and rebuilt by Indigenous Peoples, the term "culturally safe-r care" may be more appropriate (Prince 2024).

Improving the quality of life for First Nations, Inuit and Métis Peoples who are experiencing homelessness or vulnerable housing and their access to equitable and culturally safe-r care

requires healthcare providers and organizations to challenge the systemic and structural issues, including colonialism and racism, by integrating equity-oriented approaches to care within the healthcare system and in providers' practice. In addition, it requires establishing collaborative partnerships with First Nations, Inuit and Métis Peoples through engagement strategies to ensure that care models align with First Nations, Inuit and Métis values and worldviews. As outlined in the introduction to this special issue (IEAPC Program Delivery Team 2026), the IEAPC collaborative provides lessons learned to address these challenges and improve access to palliative care for individuals experiencing homelessness or vulnerable housing.

### Integrating Equity-Oriented Approaches to Care Within the Healthcare System

Embedding equity-oriented approaches to care within the healthcare system is one means to improve health outcomes and enhance access to culturally safe-r care for Indigenous Peoples who are experiencing homelessness or vulnerable housing and facing life-limiting or life-changing illnesses. The goal of equity-oriented healthcare is to address structural inequities in access to care and the social determinants of health; reduce the negative health effects caused by racism, discrimination and stigma that often intersect; and recognize the frequent discrepancies between usual approaches to care and the needs of those most affected by health and social inequities (Browne et al. 2018). Browne et al. (2016) also identify key dimensions of equity-oriented care and offer 10 strategies that serve as health equity guidelines for organizations and providers.

Central to the IEAPC collaborative, the dimensions of cultural safety and humility at the organizational and individual healthcare provider levels were imperative in working toward addressing Indigenous health inequities. The First Nations Health Authority defines cultural safety as an "outcome, based on respectful engagement that recognizes and strives to address power imbalances inherent in the healthcare system" (n.d.: 10). It creates spaces where individuals feel safe and respected, with their culture, values and beliefs incorporated in their care. Eagle (2022) outlines a learning process for cultural safety. The first step involves creating an environment where discomfort is acknowledged and embraced, recognizing that this work will challenge both individual and organizational values, beliefs and privileges. Individuals must then learn from both the past and present while valuing diverse forms of knowledge. By doing so, individuals and organizations can think critically and recognize that certain knowledge systems have been overlooked in our historical and current contexts. With this awareness, individuals and organizations can develop the skills necessary to navigate these realities and experiences. Finally, Eagle (2022) suggests that once individuals and organizations have embraced discomfort and acquired the essential knowledge and skills, they can engage in collaborative action moving forward.

Healthcare organizations can begin providing culturally safe-r care within existing systems of care by embedding cultural safety and humility protocols into staff training, organizational policies and decision-making processes (First Nations Health Authority n.d.). Allen et al. (2020) further add to this by encouraging health organizations to use existing literature and reports to promote system changes on all levels. These reports include foundational documents such as the Royal Commission on Aboriginal Peoples (Dussault and Erasmus 1996), the United Nations Declaration on the Rights of Indigenous Peoples (United Nations 2007), the Truth and Reconciliation Commission of Canada (2015) and the National Inquiry into Missing and Murdered Indigenous Women and Girls (2019). Healthcare organizations should also develop, implement and evaluate processes for feedback and quality improvement; ensure that health human resources across all levels of the organization are reflective of the people they serve; make certain that leadership embraces and commits to cultural safety and humility protocols; and create culturally safe spaces and supportive environments (First Nations Health Authority n.d.).

**The goal of** equity-oriented healthcare is to address structural inequities in access to care and the social determinants of health; reduce the negative health effects caused by racism, discrimination and stigma …

Allen et al. (2020) also emphasize the need and responsibility to advocate and speak out in solidarity with Indigenous Peoples during professional and public forums to honour and appreciate Indigenous ways of knowing, being and doing.

On an individual level, healthcare providers can challenge their power structures and privilege to create spaces for respectful, authentic relationships and care. This requires that individuals approach their work through a lens of cultural humility. According to the First Nations Health Authority, cultural humility is defined as a "process of self-reflection to understand personal and systemic biases and to develop and maintain respectful processes and relationships based on mutual trust" (n.d.: 11). This concept requires healthcare providers to continuously learn and unlearn, reflecting on their own values, beliefs, power and privilege that influence their interactions and relationships with others. In doing so, they can acknowledge the social injustice that affects Indigenous Peoples' health and begin to recognize that the challenges

and issues Indigenous Peoples experience are embedded in over 150 years of racism, structural violence and harm rooted in colonization.

## Indigenous Engagement and Relationship Building

Healthcare organizations and providers can build meaningful relationships with Indigenous Peoples and organizations to foster Indigenous engagement in co-designing care models that align with First Nations, Inuit and Métis values and worldviews (Jacklin et al. 2017; John and Castleden 2025; Walker and Behn-Smith 2018). This engagement can lead to unique and innovative Indigenous-led health service partnerships and healthcare integration, improving access to care, adherence to care plans and many health outcomes (Allen et al. 2020). Engagement strategies can help ensure that models of care respond to the needs of Indigenous Peoples and challenge colonial systems of care.

In Canada, many insightful frameworks and models have been designed to foster meaningful engagement with Indigenous communities. Notable works include contributions from Ferland et al. (2021), the Talking Together to Improve Health Project Team (2018), the Shelter, Support and Housing Administration (2019) and the National Centre for Truth and Reconciliation (2023). Combined with the lessons learned through the IEAPC collaborative, these frameworks and models can provide valuable direction and guidance to support other healthcare organizations and providers looking to engage in similar work with Indigenous Peoples. The following highlights some important processes for engaging with Indigenous communities. They are not intended to serve as a conclusive guide but as an initial starting point for further explorations and discussions.

### "The work before the work"

To effectively engage and build relationships with Indigenous communities, healthcare organizations and providers must first do pre-engagement work, which includes background research and preparation (National Centre for Truth and Reconciliation 2023). Ferland et al. describe this as "the work before the work" (2021: 8). This phase involves seeking to understand the history and ongoing impact of colonialism, Indigenous resistance and resurgence and the unique ways of knowing, being and doing of the communities being engaged (Ferland et al. 2021).

Through a lens of cultural humility, healthcare providers can begin this process by committing to professional development, cultural safety training and Indigenous anti-racist training (Allen et al. 2020). This process should also involve reflecting on their perceptions, motivations and communication strategies (Ferland et al. 2021). To effectively engage with communities, providers should start by researching the territory, land, communities and people they intend to engage with. It is crucial to learn about the history, cultural practices and community protocols of these groups. Healthcare providers should also make an effort to correctly pronounce the traditional names of communities, as this demonstrates respect and acknowledgment of their identities.

Pre-engagement work facilitates critical self-reflection and challenges biases and sources of knowledge. Individuals should consider questions like: What insights have I gained regarding the historical and present-day experiences, challenges and strengths of Indigenous Peoples? Who shared this knowledge with me? What important information did I not learn? Why was there a lack of education about residential schools or treaties during my education? This reflection helps individuals to understand how they place themselves in relation to Indigenous Peoples, with a particular focus on the use of language. It is essential to avoid using possessive language such as "Canada's Indigenous Peoples" or "our First Nations," as these imply ownership. Engaging in critical self-reflection enables acknowledging mistakes and can lead to actionable items for improvement and change.

### Establishing the foundation

Next, healthcare organizations and providers must establish the foundations for trusting and reciprocal relationships (National Centre for Truth and Reconciliation 2023). This involves reaching out to community leaders, expressing your intention to engage and learning about community strengths, challenges and needs. The National Centre for Truth and Reconciliation describes this phase of engagement as "visiting by showing up, being present, asking questions and listening to learn about one another" (2023: 7). Healthcare organizations and providers should approach this work with cultural humility and adhere to principles that foster strong foundations and support effective engagement with Indigenous communities. The Talking Together to Improve Health Project Team (2018) outlines four principles – respect, trust, self-determination and commitment – that are necessary to build trusting relationships.

The first principle emphasizes genuine respect for the people and communities by acknowledging the historical and ongoing impacts of colonialism and recognizing their diversity (Talking Together to Improve Health Project Team 2018). It is imperative for non-Indigenous individuals to reflect on their own power and privilege in this context and understand how systemic inequalities have been upheld and perpetuated. The second principle emphasizes the importance of building trust and acknowledges and addresses the reasons for mistrust, such as racism and discrimination (Talking Together to Improve Health Project Team 2018). Trust must be earned and can be nurtured through early and ongoing engagement. The third principle is self-determination, which ensures that partnerships and decision-making processes are Indigenous-led, built on the

strengths and capacities of Indigenous communities and beneficial rather than harmful (Talking Together to Improve Health Project Team 2018). Self-determination is also recognized as a right of Indigenous Peoples in the United Nations Declaration on the Rights of Indigenous Peoples (United Nations 2007). Finally, the fourth principle emphasizes a commitment to the process, which involves co-learning and power sharing while maintaining the integrity of the relationship throughout the engagement process (Talking Together to Improve Health Project Team 2018).

### Building the relationship

Healthcare organizations and providers can build strong relationships by committing to engagement, seeking permission for participation and initiating open dialogue with Indigenous communities (National Centre for Truth and Reconciliation 2023). Healthcare providers need to prioritize getting to know the communities they are engaging with, including the values and beliefs that are significant to people (Allen et al. 2020). The National Centre for Truth and Reconciliation describes that this phase focuses on "listening to Truths and understanding what has happened and what they want to see happen. It involves bearing witness and learning about how the community would like to be engaged" (2023: 7).

### Co-designing the engagement plan

Once a relationship has been established, healthcare organizations and providers can begin working with the community to co-design and implement an engagement plan. This formalizes the partnership and ensures that the goals, interests and benefits are mutual (National Centre for Truth and Reconciliation 2023). The plan outlines the processes and protocols, specifies who will be involved and responsible and details the timelines. In addition, it ensures that there is an appropriate budget for honoraria for Elders and Knowledge Carriers, as well as for others supporting the initiative within the community (National Centre for Truth and Reconciliation 2023). The plan should be continually revised and evaluated based on feedback from the community to ensure that the relationship meets their needs (National Centre for Truth and Reconciliation 2023).

### Sustaining the relationship

It is essential to sustain the relationship through relational accountability, which involves actively nurturing the connection with First Nations, Inuit and Métis Peoples and communities. To maintain ongoing engagement, organizations should be transparent, provide regular updates, listen to and address concerns and celebrate successes and milestones together (National Centre for Truth and Reconciliation 2023). This approach helps ensure that community leaders and members remain engaged in the decision-making process and provides a platform for their voices to be heard. In addition, assessing the impact on the community is crucial. This can be done by reviewing the outcomes agreed upon during the engagement and seeking feedback on how the community believes they have been affected. This process demonstrates respect and creates space for the possibility of future initiatives.

## Conclusion

The IEAPC collaborative offers valuable lessons learned for enhancing the quality of life and improving access to palliative care for First Nations, Inuit and Métis Peoples experiencing homelessness or vulnerable housing. The findings emphasize the need to integrate equity-oriented approaches into the healthcare system and the practices of healthcare providers. Furthermore, it highlights the importance of developing engagement strategies for working effectively with First Nations, Inuit and Métis communities, ensuring that care models align with First Nations, Inuit and Métis ways of knowing, being and doing. These promising and innovative practices can foster stronger relationships with Indigenous Peoples through meaningful engagement in healthcare. HQ

## References

Allan, B. and J. Smylie. 2015. *First Peoples, Second Class Treatment: The Role of Racism in the Health and Well-Being of Indigenous Peoples in Canada*. The Wellesley Institute. Retrieved January 15, 2018. <https://www.wellesleyinstitute.com/wp-content/uploads/2015/02/Summary-First-Peoples-Second-Class-Treatment-Final.pdf>.

Allen, L., A. Hatala, S. Ijaz, E.D. Courchene and E.B. Bushie. 2020. Indigenous-Led Health Care Partnerships in Canada. *CMAJ* 192(9): E208–16. doi:10.1503/cmaj.190728.

Browne, A.J., C. Varcoe, J. Lavoie, V. Smye, S.T. Wong, M. Krause et al. 2016. Enhancing Health Care Equity With Indigenous Populations: Evidence-Based Strategies From an Ethnographic Study. *BMC Health Services Research* 16: 544. doi:10.1186/s12913-016-1707-9.

Browne, A.J., C. Varcoe, M. Ford-Gilboe, C. Nadine Wathen, V. Smye, B.E. Jackson et al. 2018. Disruption as Opportunity: Impacts of an Organizational Health Equity Intervention in Primary Care Clinics. *International Journal for Equity in Health* 17: 154. doi:10.1186/s12939-018-0820-2.

Caxaj, C.S., K. Schill and R. Janke. 2018. Priorities and Challenges for a Palliative Approach to Care for Rural Indigenous Populations: A Scoping Review. *Health and Social Care in the Community* 26(3): e329–36. doi:10.1111/hsc.12469.

Czyzewski, K. 2011. Colonialism as a Broader Social Determinant of Health. *International Indigenous Policy Journal* 2(1): 1–14. doi:10.18584/iipj.2011.2.1.5.

Dussault, R and G. Erasmus. 1996. *Report of the Royal Commission on Aboriginal Peoples*. The Commission. Retrieved February 1, 2025. <https://bac-lac.on.worldcat.org/oclc/35945748>.

Eagle, H. 2022, April 12. *Connecting Indigenous Cultural Safety and Addressing Racism in the Health Care System*. UBC Learning Circle. Retrieved September 1, 2026. <https://learningcircle.ubc.ca/2022/03/21/harley-eagle-cultural-safety-and-addressing-racism-in-the-health-care-system/>.

Ferland, N., A. Chen and G. Villagrán Becerra. 2021. *Working in Good Ways: A Framework and Resources for Indigenous Community Engagement*. Community Engaged Learning, University of Manitoba. Retrieved February 10, 2025. <https://umanitoba.ca/sites/default/files/2021-05/framework-guide.pdf>.

First Nations Health Authority. n.d. *Creating a Climate for Change*. Retrieved March 1, 2025. <https://www.fnha.ca/Documents/FNHA-Creating-a-Climate-For-Change-Cultural-Humility-Resource-Booklet.pdf>.

First Nations Information Governance Centre (FNIGC). 2012. *First Nations Regional Health Survey (RHS) 2008/10: National Report on Adults, Youth and Children Living in First Nations Communities*. Retrieved March 31, 2018. <http://fnigc.ca/sites/default/files/First Nations Regional Health Survey (RHS) 2008-10 - National Report.pdf>.

Fruch, V., L. Monture, H. Prince and M.L. Kelley. 2016. Coming Home to Die: Six Nations of the Grand River Territory Develops Community-Based Palliative Care. *International Journal of Indigenous Health Research* 11(1): 50–74. doi:10.18357/ijih111201615303.

Gouldhawke, M. 2021, February 4. *The Failure of Federal Indigenous Healthcare Policy in Canada*. Yellowhead Institute. Retrieved February 1, 2025. <https://yellowheadinstitute.org/2021/02/04/the-failure-of-federal-indigenous-healthcare-policy-in-canada/>.

Government of Canada. 2024. *Everyone Counts 2020-2022 – Results From the Third Nationally Coordinated Point-in-Time Counts of Homelessness in Canada*. Retrieved March 1, 2025. <https://housing-infrastructure.canada.ca/alt-format/pdf/homelessness-sans-abri/reports-rapports/pit-counts-dp-2020-2022-results-resultats-en.pdf>.

Gracey, M. and M. King. 2009. Indigenous Health Part 1: Determinants and Disease Patterns. *Lancet* 374(9683): 65–75. doi:10.1016/S0140-6736(09)60914-4.

Hampton, M., A. Baydala, C. Bourassa, K. McKay-McNabb, C. Placsko, K. Goodwill et al. 2010. Completing the Circle: Elders Speak About End-of-Life Care With Aboriginal Families in Canada. *Journal of Palliative Care* 26(1): 6–14. doi:10.1177/082585971002600103.

IEAPC Program Delivery Team. 2026. Improving Equity in Access to Palliative Care for Communities Experiencing Homelessness or Vulnerable Housing. *Healthcare Quarterly* 29(Special Issue): 5-10 doi:10.12927/hcq.2026.27970.

Indigenous Services Canada. 2018. *Improving Health Outcomes*. Government of Canada. Retrieved July 30, 2020. <https://www.canada.ca/en/indigenous-services-canada/news/2018/01/improving_healthoutcomes.html>.

Jacklin, K.M., R.I. Henderson, M.E. Green, L.M. Walker, B. Calam and L.J. Crowshoe. 2017. Health Care Experiences of Indigenous People Living With Type 2 Diabetes in Canada. *CMAJ* 189(3): E106–12. doi:10.1503/cmaj.161098.

John, J. and H. Castleden. 2025. "Because You Love Us as Much as We Love You": The Role of Community Relationships in Facilitating Indigenous Engagement in Healthcare. *Social Science and Medicine* 365: 117532. doi:10.1016/j.socscimed.2024.117532.

Kelley, M.L., H. Prince, S. Nadin, K. Brazil, M. Crow, G. Hanson et al. 2018. Developing Palliative Care Programs in Indigenous Communities Using Participatory Action Research: A Canadian Application of the Public Health Approach to Palliative Care. *Annals of Palliative Medicine* 7(Suppl 2): S52–72. doi:10.21037/apm.2018.03.06

Koski, J., M.L. Kelley, S. Nadin, M. Crow, H. Prince, E. Wiersma et al. 2017. An Analysis of Journey Mapping to Create a Palliative Care Pathway in a Canadian First Nations Community: Implications for Service Integration and Policy Development. *Palliative Care and Social Practice* 10: 1–16. doi:10.1177/1178224217719441.

Lavoie, J.G. 2013. Policy Silences: Why Canada Needs a National First Nations, Inuit and Métis Health Policy. *International Journal of Circumpolar Health* 72(1). doi:10.3402/ijch.v72i0.22690.

Loppie, C. and F. Wien. 2022. *Understanding Indigenous Health Inequalities Through a Social Determinants Model*. National Collaborating Centre for Indigenous Health. Retrieved March 1, 2025. <https://www.nccih.ca/Publications/Lists/Publications/Attachments/10373/Health_Inequalities_EN_Web_2022-04-26.pdf>.

National Centre for Truth and Reconciliation. 2023, April. Creating an Engagement Plan With Indigenous Communities. Retrieved February 1, 2025. <https://ehprnh2mwo3.exactdn.com/wp-content/uploads/2024/06/Creating-an-Engagement-Plan-with-Indigenous-Communities.pdf>.

National Inquiry into Missing and Murdered Indigenous Women and Girls. 2019. *Reclaiming Power and Place: The Final Report of the National Inquiry Into Missing and Murdered Indigenous Women and Girls*. The National Inquiry. Retrieved July 30, 2021. <https://www.mmiwg-ffada.ca/final-report/>.

Pratt, Y.P., D.W. Louie, A.J. Hanson and J. Ottmann. 2018. Indigenous Education and Decolonization. In *Oxford Research Encyclopedia of Education*. Oxford University Press. doi:10.1093/acrefore/9780190264093.013.240.

Prince, H.M. 2024. *Zhiitaa-ook waa-ni onj-kiijig: Re-activating Anishinaabe Gikendaasowin (Knowledge) for Caregiving at the End of Life (Doctoral dissertation)*. Retrieved September 18, 2026. <https://lurepository.lakeheadu.ca/items/85dc97fc-6ccf-482e-85bb-3240ddd5ed0c>.

Reading, C. 2018. Structural Determinants of Aboriginal Peoples' Health. In M. Greenwood, S. de Leeuw and N.M. Lindsay, eds., *Determinants of Indigenous Peoples' Health, Beyond the Social: Beyond the Social* (pp. 3–18). Canadian Scholars' Press.

Richmond, C.A.M. and C. Cook. 2016. Creating Conditions for Canadian Aboriginal Health Equity: The Promise of Healthy Public Policy. *Public Health Reviews* 37: 2. doi:10.1186/s40985-016-0016-5.

Shelter, Support and Housing Administration. 2019. *Meeting in the Middle: Protocols and Practices for Meaningful Engagement with Indigenous Partners and Communities*. Retrieved February 1, 2025. <https://www.toronto.ca/wp-content/uploads/2019/12/8674-SSHA-Protocols-and-Practices-for-Indigenous-Engagement_Sept-9-2019.pdf>.

Talking Together to Improve Health Project Team. 2018. *Talking Together to Improve Health: Ontario Public Health Unit Survey*. Sudbury, ON: Locally Driven Collaborative Projects. Retrieved September 25, 2026. < https://www.publichealthontario.ca/-/media/documents/L/2018/ldcp-firstnations-engagament-survey-report.pdf?la=en>.

Truth and Reconciliation Commission of Canada. 2015. *Honouring the Truth, Reconciling for the Future: Summary of the Final Report of the Truth and Reconciliation Commission of Canada*. Retrieved July 30, 2019. <https://ehprnh2mwo3.exactdn.com/wp-content/uploads/2021/01/Executive_Summary_English_Web.pdf>.

United Nations. 2007. *United Nations Declaration on the Rights of Indigenous Peoples*. Retrieved August 21, 2020. <https://www.un.org/development/desa/indigenouspeoples/wp-content/uploads/sites/19/2018/11/UNDRIP_E_web.pdf>.

United Nations. 2016. *State of the World's Indigenous Peoples: Indigenous Peoples' Access to Health Services*. doi:10.18356/7914b045-en.

Walker, L. M. and D. Behn-Smith 2018. Medicine Is Relationship: Relationship is Medicine. In M. Greenwood, S. de Leeuw and N.M. Lindsay, eds., *Determinants of Indigenous Peoples' Health: Beyond the Social (2nd Ed.)* (pp. 320–32). CPS Books Inc.

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# Grief and Bereavement in the Context of Homelessness: Sharing Experiences and Learnings From British Columbia

Joshua Black, Stephanie Laing, Rachel Carter, Sherry Landry, John R. Graham and Eman Hassan

**Key Takeaways**

- People experiencing homelessness often lack safe spaces to process their grief.
- Many bereavement programs are designed with housed people in mind, highlighting the need for more accessible support.
- Cross-sector collaboration is essential to strengthen bereavement supports for people experiencing homelessness and the community support providers who serve them.

**Abstract**

**We explore the unique experiences of bereavement within the context of homelessness, offering insights from both individuals with lived experience and the community support providers. We describe experiences such as entering homelessness, exposure to deaths, how grief is manifested and coping with grief. In addition, we highlight barriers to effective grief support. To address these barriers, we propose strategies for improving support and share lessons learned from our research on this critical issue. These insights are relevant to pan-Canadian initiatives such as the Improving Equity in Access to Palliative Care and to others looking to improve the quality of palliative care services.**

## Introduction

The Framework on Palliative Care in Canada recognizes that bereavement support is fundamental to the provision of high-quality palliative care (Health Canada 2018). Bereavement is the period following the death of someone significant in which a person ("the bereaved") experiences grief and mourning (Collins English Dictionary 2012). Grief encompasses a range of natural responses to loss (such as losing your job, a home or a death), which are unique to each person.

For meaningful progress toward improving access to palliative care on a national scale, access to grief and bereavement services and supports is essential. Drawing on learnings from the recently developed province-wide bereavement action plan in British Columbia (BC) (BCCPC 2023), this article explores the unique grief and bereavement experiences of people experiencing homelessness or vulnerable housing, challenges and barriers to care and opportunities for improvement. These learnings are relevant to pan-Canadian initiatives such as the Improving Equity in Access to Palliative Care (IEAPC) collaborative and to others looking to improve the quality of palliative care services in their community. Throughout the IEAPC collaborative, grief and bereavement support in the context of inequity has been a frequent consideration for models of equity-oriented palliative care.

Not all grief in bereavement is treated equally. Grief is disenfranchised when it is not typically recognized or validated in communities and is not adequately supported (Doka 1989). This can be when the relationship to the deceased, the loss type or the griever is not recognized (Doka 1989). A literature review by Monk et al. (2024) found that bereaved people experiencing homelessness are often not recognized as grievers, as they are not adequately supported in their grief by community organizations, which impairs their ability to cope. This knowledge is reflected in the province-wide bereavement action plan in BC, which has stated the priority of supporting this population (BCCPC 2023).

Not only is the grief of people experiencing homelessness disenfranchised, but the research surrounding the topic of bereavement has been scarce and underexplored. The literature

review by Monk et al. (2024) found that most research articles lacked attention to detailed or in-depth explorations of bereavement in the context of homelessness. Despite these limitations, their analysis of the articles identified the importance of providing improved bereavement support for people experiencing homelessness and the important role community service workers have in their support.

To develop a greater understanding of this topic and explore suggestions for future support, the British Columbia Centre for Palliative Care (BCCPC) partnered with the Kelowna Homelessness Research Centre (KHRC) to conduct multiple research studies in this area (with community support workers and those with lived experience of bereavement in the context of homelessness) and develop knowledge translation materials on the topic, such as a free e-learning course and documentary film. We will share some of our reflections and learnings that we have gained on the topic to improve our knowledge and the care provided for bereaved people experiencing homelessness. We encourage readers to consider steps they can take at the individual, organizational and system levels to improve access to timely and effective grief and bereavement supports.

## What We Heard About Bereavement in the Context of Homelessness

### Entering homelessness

Bereavement is a risk factor for becoming homeless (Black and Landry 2024; Mayock et al. 2021; Monk et al. 2024), with many people connecting their bereavement to the time they felt life "fell apart" (i.e., it was the turning point for transitioning to homelessness). Specifically, this was the case for almost half of the 40 participants from our in-person study in Kelowna, BC. This aligns with previous research by Mayock et al. (2021), in which they found that 43% of the 40 participants reported this same turning point. It may be that their caregiver(s) died when they were children and they had to go into foster care (Black and Landry 2024; Mayock et al. 2021). These children then aged out and needed to live in a shelter. It may also be that the grief following the death was too overwhelming and impacted daily functioning (Black and Landry 2024; Mayock et al. 2021).

### Exposure to deaths

While experiencing homelessness, participants with lived experience reported a high volume of deaths among the people they care about. Many of those deaths were sudden and unexpected within their community. This aligns with a previous review by Monk et al. (2024). Those who are community support workers who serve this population have also stated the high exposure to death for this population (Monk et al. 2025; Stajduhar et al. 2019; Whitlock et al. 2025).

### How grief manifested

In general, participants with lived experience spoke to us about the impact of grief after a loss, encompassing a wide range of responses, including emotional (e.g., sadness), physical (e.g., sleep changes), behavioural/social (e.g., continuing a bond with the deceased), spiritual (e.g., searching for meaning and purpose after the loss) and mental (e.g., dreams and nightmares).

### Coping with grief

As noted, bereaved people experiencing homelessness are often unrecognized and unsupported grievers (Monk et al. 2024). People experiencing homelessness tend to seek support from those around them, with those they trust, including their family, friends, pets and community service workers (Black and Landry 2024; Monk et al. 2024, 2025). Formal grief service providers in their community were the least likely to be used, often because of participants' experiences of stigma and mistrust of available support. Bereaved people experiencing homelessness are often estranged from networks of support, leaving them to process their grief in isolation (Monk et al. 2024). It has been reported by staff and those with lived experience that using substances is a common way of managing their grief (Black and Landry 2024; Monk et al. 2024, 2025).

## Challenges and Barriers to Support

Participants in our various research studies identified different challenges and barriers to support (Black and Landry 2024; Monk et al. 2024, 2025). Key themes expressed by those with lived experience included the following:

- *Financial and structural challenges.* Having to navigate difficult circumstances, both financial and structural, means they have additional barriers to processing their grief and may miss out on experiences that would help them honour and remember the deceased. For example, not being able to attend a funeral, the inability to have a permanent memorial or the inability to keep items that would help them maintain a continued connection with them (e.g., photos or objects). They can also have fewer opportunities to safely grieve, as their living circumstances can include unpleasant and unsafe shelter conditions, a lack of privacy and additional grief and trauma that occur regularly.
- *Limited services and resources.* There are limited services and resources available to this community, with most of the available bereavement services designed for those who are housed, who speak English and who do not have the complex service needs common among those experiencing homelessness (e.g., mental health disorders, trauma, substance use, multiple deaths or a lack of safety and basic needs). Available formal grief support options typically

do not feel safe for many people who are experiencing homelessness (e.g., institutional mistrust from their years of negative experiences where they were judged or disrespected). In addition, many community support workers tend to have limited grief and bereavement literacy to support their clients (Monk et al. 2024, 2025).

- *Inaccessibility of services.* Grief services are not often accessible to people experiencing homelessness. Services can require them to have phone or Internet access, which can present challenges with communication and follow-up. In addition, available support can have long waitlists, involve financial constraints, require them to travel or have no place to store their belongings, leading to fears of theft.

## Opportunities to Improve Grief Support

Given that bereavement support is so limited in this community, it is essential to recognize that even a small step forward in offering support can make a significant difference when people are accustomed to having few opportunities. It is important when we think about support that we never force anyone to discuss their grief if they are not ready. Many of the support options that those with lived experience discussed wanting were less about needing traditional talk-based support groups or therapy and more about needing improved opportunities to have grief support conversations with people they trust (e.g., community or outreach workers), memorials or non-verbal outlets for their grief (e.g., art or gardening).

One way to increase the confidence of community support workers in discussing the topic is to provide additional training in this area (including how to support a client grieving, resources available and exploring client preferences), which was recommended in our research by those with lived experience and support workers (Black and Landry 2024). One free e-learning course that could be of benefit to organizational staff is "Fostering Grief and Bereavement Literacy in the Workplace for Those Who Serve People Experiencing Homelessness." It includes four modules that will help workers learn more about grief and bereavement, how to support a client grieving, grief in the workplace and self-care. A link to the course can be found at whitecart.ca.

Another approach to support those grieving who are experiencing homelessness is to develop a memorial space that people can go to honour the deceased when they would like to and have a yearly service to honour the grief that they carry. Those with lived experience expressed that they use memorials as a way of coping, and they would appreciate more opportunities for that (Black and Landry 2024; Monk et al. 2024, 2025). While considering implementation, it is important to include partners from different organizations (e.g., partnerships between housing services/shelters and grief organizations) to reduce the burden of taking on the full responsibility, and it is essential to ask those with lived experience what they would like to see (Black and Landry 2024). From our research, the creation of any memorial space should incorporate a way for others to add names to it. This could be the ability to write the name in a memorial book, on a wall in a mural or on a tag that can be hung on an art piece.

An example of a memorial for this population where names were written on tags and added to an art piece lives on the traditional and unceded territory of the Syilx Okanagan Nation in the city colonially known as Kelowna, BC. It was organized by members of our research team and the Lived Experience Circle on Homelessness (LECoH) in 2023. We gathered with Edna Terbasket of Ki-Low-Na Friendship Society and Westbank First Nations Elder Grouse Barnes. The memorial ceremony included an opening prayer, a eulogy to honour all those who have died, a drumming circle and smudging. We completed the event with food and developed a memorial art piece together, which was suggested by LECoH members – a white shopping cart with the initials NFA on the front, which stands for No Fixed Address (see Figure 1).

**BOX 1.**
**Improving grief supports: lived or living experience perspectives**

1. Support provided by people they trust, which may be people with lived experience, outreach workers or someone from the same cultural background.
2. Enhancing the capacity of outreach workers to provide grief support.
3. Increasing availability of both one-to-one support and group support.
4. Providing animal therapy at organizations and when connecting with outreach workers.
5. Developing programs that allow for creative and physical outlets for grief, such as art-based support, dance and access to a gym for exercise.
6. Increasing availability and accessibility of culturally specific supports (e.g., overall greater culturally appropriate supports, ceremonies, smudging, land-based teachings and more Indigenous counsellors).
7. Building community through activities with others who are bereaved (e.g., gardening, picnics or walks together).
8. Opportunities for memorials and celebrations.
9. Addressing substance use alongside grief. This may include harm reduction programs as part of grief support programming.

FIGURE 1.
**The white cart memorial art piece**




FIGURE 2.
**The white cart memorial art piece in OS4**



At the event, people took time to adorn the cart with the names of those they had lost. It was respectfully taken to Outdoor Sheltering Site 4 (OS4) in Kelowna, placed next to a rock memorial that honours the death of a beloved member of the community (see Figure 2). Unfortunately, in 2025, the rock memorial was mistakenly removed by city workers and no longer exists. Discussions are underway to make the white cart a permanent memorial.

We continued to leave markers and tags in the cart to encourage the memorial art piece to grow. We have heard many stories of how the cart has been accepted by the community and used to process their grief. For example, when someone is grieving the death of someone they cared about, a community member may push the cart to their tent and the bereaved will push it back when they are ready. This art piece was the focus of the documentary, "No Fixed Address: The White Cart Memorial" (Black and Laing 2025), which is available at whitecart.ca.

> What's haunting is that people are not able to say goodbye to their people. This white cart gives a place where people can. The white cart also catches people's attention very quickly, which we hope helps people to become more aware of their issues and open their hearts to this community (Sherry Landry).

## Lessons Learned From Our Experiences

### The importance of taking time to develop the right partnerships

It takes time to build trust with new organizations, and this cannot be rushed. The BCCPC and KHRC were a new partnership that had a similar passion to explore this topic further. It took time to build trust with each other, but as we did, we continued to work closely together on further projects. We each brought different developed partnerships to help these projects. KHRC had already established a relationship with LECoH from years of working together, and because of our partnership with LECoH and building the memorial white cart with them, we were able to get funding to do further research and knowledge translation projects together (e.g., the documentary film). In relation to health system leaders, this means partnering with organizations that have built trust with this community and going to these spaces to offer services, rather than requiring people to come to them.

### Building trust with the community

When doing research or knowledge translation projects, it is important to build trust with the community you are hoping to serve. Having the right partnerships is important with organizations they trust, and you need to go to them. You also need to build the right team to facilitate trust, as one member who causes additional trauma can fracture it. In our research, we had both an Indigenous peer researcher and a grief therapist complete the interviews to help support the emotions and experiences of the participants. We spent time thinking about how to create a safe(r) and supported environment for the bereaved. We provided choices in room design for participants (when possible), drop-in timeslots and appointments, lots of snacks and drinks to choose from, options of coping supplies and time to debrief following the interview. By honouring those who participated in our research and the community as a whole, we felt the memorial ceremony was an important way to give back and show our gratitude. There have been too many research teams who have come into these communities and just taken their stories to never be heard from again. In relation to health system leaders, trust has been broken many times, and it will take the required training and partnering with organizations to rebuild this.

### Importance of integrating Indigenous perspectives

It is important to recognize that there is a disproportionate number of First Nations, Inuit and Métis individuals experiencing homelessness. According to the 2020–2022 national Point-in-Time count (Government of Canada 2024), 31% of individuals experiencing homelessness in Canada identified as Indigenous, despite making up only 5% of the Canadian population according to Statistics Canada from the 2021 census (Statistics Canada 2023).

The history of colonization in Canada has had, and continues to have, profound impacts on Indigenous Peoples, including the loss of land, culture, language and lives (Prince 2026). This history directly relates to why these numbers are so disproportionate, as well as the grief and trauma people carry from past and ongoing impacts of colonization, including direct and intergenerational trauma from the Residential School System and other colonial structures, policies and systems. It is important to understand the importance of the calls to action for reconciliation. Co-author and Indigenous peer researcher, Sherry Landry, integrated her Indigenous beliefs into the research design, and we had additional Indigenous individuals who helped our team create knowledge translation projects. It is important that health system leaders provide cultural safety training to their workers, as well as integrate Indigenous perspectives into the programs and policies.

### Importance of supporting community service providers

Community service providers are often the main, if not only, support for those who are bereaved and experiencing homelessness. Service providers need to be better supported in the workplace to increase their grief and bereavement literacy (Monk et al. 2024, 2025). In addition, organizations and teams that serve those experiencing homelessness need to continue developing compassionate workplaces to honour the grief of the staff when a client dies. Research has found that it is common for these workers to have their own professional grief from the death of clients and that grief can be disenfranchised (Giesbrecht et al. 2023; Monk et al. 2024, 2025; Whitlock et al. 2025). One approach to improve the way we support workers is to provide collective grieving opportunities for staff, such as collective debriefing following a death(s) as a team (CBC Radio 2019; Equity in Palliative Approaches to Care 2023). In relation to health system leaders, this means recognizing the impact of workplace grief on staff and the need to honour it.

## Future Directions

Much work still needs to be done at the individual, organizational and system levels to ensure that we can create safer spaces for bereaved people experiencing homelessness to share their experiences and to grieve. This article highlights the need for greater support in the ways that participants have defined for themselves as needing. Only by working together can we build a greater support network for those experiencing homelessness and those who serve them. HQ

## References


BC Centre for Palliative Care (BCCPC). 2023. *Collaborative Action Plan for Accessible, Appropriate, and Equitable Grief and Bereavement Support in British Columbia: An Evidence-Informed Approach*. Retrieved February 21, 2025. <https://www.bc-cpc.ca/wp-content/uploads/2023/11/Bereavement-in-BC-Action-Plan-Full-Report.pdf>.

Black, J. and S. Laing (Directors). 2025. *No Fixed Address: The White Cart Memorial* [Film]. Paul Cotton Films.

Black, J. and S. Landry. 2024, August 7. *Bereavement in the Context of Homelessness*. BC Centre for Palliative Care – Grief & Bereavement ECHO. *YouTube*. Retrieved February 21, 2025. <https://www.youtube.com/watch?v=nEpQLK1_-98>.

CBC Radio. 2019, March 8. *Palliative Care Team Helps the Homeless Die "With Dignity," A Healing Circle Helps Them Grieve*. Retrieved February 21, 2025. <https://www.cbc.ca/radio/whitecoat/palliative-care-team-helps-the-homeless-die-with-dignity-a-healing-circle-helps-them-grieve-1.5048409>.

Collins English Dictionary. 2012. Bereavement. In *Collins English Dictionary – Complete & Unabridged 2021 digital edition*. Retrieved September 21, 2025. <https://www.collinsdictionary.com/dictionary/english/bereavement>.

Doka, K.J. 1989. *Disenfranchised Grief: Recognizing Hidden Sorrow (1st ed.)*. Jossey Bass.

Equity in Palliative Approaches to Care. 2023. *Palliative Care Is … A Collective Response to Death, Dying, and Grief in the Inner City*. University of Victoria. Retrieved September 1, 2026. <https://palliativeapproaches.uvic.ca/wp-content/uploads/2024/03/Palliative-care-is-DIGITAL-2024-03-01.pdf>.

Giesbrecht, M., A. Mollison, K. Whitlock and K.I. Stajduhar. 2023. "Once You Open That Door, It's a Floodgate": Exploring Work-Related Grief Among Community Service Workers Providing Care for Structurally Vulnerable Populations at the End of Life Through Participatory Action Research. *Palliative Medicine* 37(4): 558–66. doi:10.1177/02692163221139727.

Government of Canada. 2024, January 26. *Everyone Counts 2020–2022 – Results From the Third Nationally Coordinated Point-in-Time Counts of Homelessness in Canada*. Retrieved February 21, 2025. <https://housing-infrastructure.canada.ca/homelessness-sans-abri/reports-rapports/pit-counts-dp-2020-2022-results-resultats-eng.html#toc_3>.

Health Canada. 2018, December 4. *Framework on Palliative Care in Canada*. Retrieved September 1, 2025. <https://www.canada.ca/content/dam/hc-sc/documents/services/health-care-system/reports-publications/palliative-care/framework-palliative-care-canada/framework-palliative-care-canada.pdf>.

Mayock, P., S. Parker and A. Murphy. 2021. Family "Turning Point" Experiences and the Process of Youth Becoming Homeless. *Child & Family Social Work* 26(3): 415–24. doi:10.1111/cfs.12823.

Monk, J., J. Black, R.Z. Carter and E. Hassan. 2024. Bereavement in the Context of Homelessness: A Rapid Review. *Death Studies* 48(6): 561–70. doi:10.1080/07481187.2023.2246134.

Monk, J., J. Black, R.Z. Carter and E. Hassan. 2025. *Frontline Workers' Perspectives Considering the Dual Experience of Bereavement in the Context of Homelessness in British Columbia, Canada* [Manuscript in preparation]. BC Centre for Palliative Care.

Prince, H. 2026. Engaging in a Relational Approach: Addressing Inequities in Access to Palliative Care for Indigenous Peoples. *Healthcare Quarterly* 29(Special Issue): 15–21. doi:10.12927/hcq.2026.27968.

Stajduhar, K.I., A. Mollison, M. Giesbrecht, R. McNeil, B. Pauly, S. Reimer-Kirkham et al. 2019. "Just Too Busy Living in the Moment and Surviving": Barriers to Accessing Health Care for Structurally Vulnerable Populations at End-Of-Life. *BMC Palliative Care* 18: 11. doi:10.1186/s12904-019-0396-7.

Statistics Canada. 2023, February 1. *Indigenous Peoples – 2021 Census Promotional Material*. Retrieved September 1, 2025. <https://www.statcan.gc.ca/en/census/census-engagement/community-supporter/indigenous-peoples>.

Whitlock, K., Z. Premji, A. Mollison, C. Posada, M. Arias-Rojas, C. Futcher et al. 2025. Work-Related Grief and Bereavement Experiences of Social and Community Service Workers Working With People Experiencing Social Disadvantage: A Rapid Scoping Review. *BMC Palliative Care* 24: 25. doi:10.1186/s12904-025-01668-8.


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# Reflections on Innovative Models of Palliative Care Delivery

Seana Bulle and Naheed Dosani

**Key Takeaways**

- Addressing the social determinants of health is a key palliative care intervention for people experiencing homelessness.
- Harm reduction approaches remove barriers to care.
- Trauma-informed care, cultural safety and cultural humility improve the quality of service delivery and contribute to safer care.
- Interprofessional collaborative approaches to care improve efficiency and effectiveness of palliative care delivery for people experiencing homelessness.
- Empowering people with lived experience to lead ensures that services best reflect the needs of communities being served.

**Abstract**

**Equity-oriented approaches and models of palliative care have emerged in Canada to address gaps in palliative care access and quality for people experiencing homelessness or vulnerable housing. These models focus on addressing the social determinants of health, trauma-informed approaches to care, harm reduction, and cultural safety. The 23 communities participating in the Improving Equity in Access to Palliative Care collaborative and their associated initiatives demonstrate a diverse range of innovative palliative care models. The effectiveness of these models across the collaborative in increasing access to safe and high-quality equity-oriented palliative care is highlighted and can serve as a foundation for similar initiatives in local contexts.**

## Introduction

Individuals who are homeless or vulnerably housed experience complex barriers to accessing healthcare, with current care systems failing to address the social determinants of health (SDoH) that directly impact and exacerbate poor health outcomes. In the context of palliative care, services often lack trauma-informed approaches and tailored supports that effectively address the SDoH and social well-being, which can further contribute to marginalization (Peeler et al. 2023; Purkey and MacKenzie 2019; Stajduhar and Gott 2023). These gaps have resulted in inadequate care for this structurally vulnerable population and call for urgent action to improve access to equity-oriented palliative care (Stajduhar and Gott 2023).

To reduce vast disparities in access to and quality of palliative care in Canada for people who are homeless, early models of equity-oriented palliative care such as the Diane Morrison Hospice at The Ottawa Mission in 2001 (HEC 2024a) and Toronto's Palliative Education and Care for the Homeless (PEACH) Program in 2014 (HEC 2024e) have emerged and provided an informative and inspirational foundation for the Improving Equity in Access to Palliative Care (IEAPC) collaborative. The Diane Morrison Hospice, based in Ottawa, Ontario, provides palliative care grounded in compassion, kindness, dignity and acceptance through a bed-based model encompassing physical, emotional and spiritual care (The Ottawa Mission 2021). Compared with the acute care system cost per patient of $900 per day, the Hospice per patient cost was only $70 per day, resulting in cost-savings to the healthcare system of $1.39 million per year (HEC 2024a; Podymow et al. 2006). In Toronto, Ontario, PEACH is recognized as the first mobile health team in Canada to deliver palliative care to individuals experiencing homelessness or vulnerable housing at shelters, on the streets and in other non-traditional settings (Buchanan et al. 2023; Schneider and Dosani 2021). PEACH has demonstrated improved care experiences and the opportunity to alleviate strains on the healthcare system, as 64% of patients had no emergency room visits or unplanned hospital

admissions, 78% of patients died in their location of choice and 83% were successfully reconnected with their family (HEC 2024e; ICHA 2016). These innovative programs and equity-oriented care models demonstrate the need to adapt flexible, person-centred care models to overcome barriers related to the SDoH and improve access to compassionate, safe palliative care.

Informed and inspired by equity-oriented initiatives in Canada as described earlier, the IEAPC collaborative was a pan-Canadian initiative aimed at addressing the significant challenges individuals experiencing homelessness and vulnerable housing face when accessing palliative care (HEC 2026b; IEAPC Program Delivery Team 2026). Funded by Health Canada and led by Healthcare Excellence Canada (HEC) and the Canadian Partnership Against Cancer (the Partnership), the IEAPC collaborative worked alongside 23 communities to transform models of care to better serve those experiencing homelessness or vulnerable housing. This article explores these initiatives in greater detail, along with their associated models of care, with an aim to elucidate how we can increase access to palliative care in additional communities across Canada.

## IEAPC's Equity-Oriented Palliative Care Initiatives

The 23 IEAPC-supported initiatives (see Appendix Table 1, available online at longwoods.com/content/27966) demonstrate a diverse range of innovative palliative care models and approaches, addressing the needs of urban, rural, remote, French-speaking, Inuit and First Nations communities across Canada. These initiatives have transformed the way that people experiencing homelessness and other structural vulnerabilities access palliative care in their respective communities (IEAPC Program Delivery Team 2026).

Although not possible within the scope of this article to explore all 23 initiatives, we highlight as many of these initiatives as possible via four main categories, or models, of equity-oriented approaches to palliative care: *mobile-based and outreach services, equity-oriented clinical pathways, bed-based end-of-life care and capacity building through engagement*. Of note, many of these initiatives do not neatly fit into a single category, as they are deeply informed by local contexts. These initiatives are meant to give the reader a sense of the depth and variety of initiatives and models possible with further promising practices and initiative summaries available for review and consultation (HEC 2026c).

### Hospice and bed-based care: Providing dedicated care resources

Hospice and bed-based care initiatives provide palliative care services to patients and their families within specialized care environments ranging from hospitals to housing services.

The George Spady Society in Alberta offers a low-barrier, client-centred model at George's House, where up to five residents receive care in a home-like setting that provides 24-hour care from an interprofessional palliative care team for structurally vulnerable individuals at the end of life (HEC 2024b). They provide compassionate, culturally informed palliative care for people who might otherwise die without support in Edmonton (George Spady Society 2020, 2024; HEC 2026a).

In Montreal, La Maison du Père offers a continuum of services for people experiencing homelessness or at risk of becoming homeless. Over the years, the organization has developed and strengthened a range of promising practices aimed (HEC 2024c) at preventing and reducing homelessness, while promoting stability, dignity and the individuals it serves. This continuum of services includes homelessness prevention services; an emergency shelter and intake, referral, and navigation services; assistance finding and maintaining housing; social reintegration services; a residence for seniors who have experienced homelessness; as well as Accès Santé, a specialized service that addresses the health needs of people experiencing homelessness, including those requiring palliative care. To ensure continuity of care and provide services tailored to the unique realities of this population, La Maison du Père has established partnerships with The Société de soins palliatifs à domicile du Grand Montréal (Palliative Home-Care Society of Greater Montreal), the Virage Foundation, and numerous community, institutional, and hospital partners. A palliative approach is woven into the organization's culture of care. Through Accès Santé, individuals experiencing homelessness who require palliative care have access to dedicated beds and specialized support, allowing them to receive care in a safe, dignified and supportive environment.

In Halifax, Nova Scotia, the team developed a bed-based model in an existing shelter where trust and existing relationships created a natural care environment and supported clients in receiving care in their location of choice. Nova Scotia Health partnered with Adsum, Northwood, VON and other community partners and was working toward dedicated beds within the Bridge shelter to serve residents with palliative care needs. Wrap-around medical supports are on site, representing health and social system integration.

### Mobile-based and outreach-based care: Bringing care to the person and community

Mobile and outreach-based initiatives involve interdisciplinary care teams delivering care in the location of the client's choice, thereby improving access, treatment and continuity of care (Buchanan et al. 2023). In the collaborative, we saw the spread of existing mobile palliative care models through the spread of the PEACH program into Scarborough (through a partnership with the Scarborough Centre for Healthy Communities and ICHA), and we also saw the development of new models in the community, such as Maison Mobile – a sustainable outreach

model that enables individuals to receive palliative care in their location of choice, led by the Palliative Home-Care Society of Greater Montreal and the project's co-founder, Dr. Marie-Hélène Marchand.

In the Grey-Bruce Region of Ontario, a collective of community health and social service organizations and care providers, the Grey-Bruce Ontario Health Team, partnered with the Brightshores Health System, Saugeen First Nations, Chippewas of Nawash Unceded First Nation, Grey and Bruce Counties, Southwest Ontario Aboriginal Health Access Centre, Ontario Health at Home, Grey Bruce Hospice, Safe n' Sound, the Grey Bruce Palliative Medicine Group and many other social and health service partners. They collaborated to assess community needs and co-design a dedicated social navigator role aimed at improving equity in access to palliative care for individuals who identify as Indigenous and/or who are homeless or vulnerably housed. The navigator position was created to directly extend a palliative approach to care for the priority populations and is a community-based mobile position (O'Connell 2026).

**Across these communities,** 72% (*n* = 544) of care recipients reported that they would not have sought care that day if they had not encountered the IEAPC team.

In contrast to Grey-Bruce's mobile navigator model, Medavie Health Services West in Moose Jaw, Saskatchewan (MHSW 2026: 12–14), uses a community paramedicine model that integrates palliative care within emergency medical services (HEC 2024d). Through its community paramedic program, the team and its partners focused on strengthening partnerships, enhancing care pathways and increasing awareness of palliative needs within community-based and non-traditional care settings through the development of wellness clinics (HEC 2024d). Over the course of the collaborative, they served over 1,800 people. By offering palliative-informed care in safe, familiar community settings, Medavie Health Services West – Moose Jaw reduced structural, cultural and psychological barriers for people who often avoid the health system due to trauma/stigma.

As part of a pilot data collection effort, four mobile and outreach teams in the collaborative asked care recipients whether "they would have sought care that day if their encounter with the initiative had not occurred." Across these communities, 72% (*n* = 544) of care recipients reported that they would not have sought care that day if they had not encountered the IEAPC team. These findings provide an example of how community-based and low-barrier approaches can reach individuals who would otherwise go without the care they need (CPAC and HEC 2026).

### Equity-oriented clinical pathways: Enhancing system integration

Equity-oriented clinical pathways are designed to improve system integration and care coordination by strengthening planning, development and collaboration across healthcare sectors. The pathways produced by these initiatives focus on reducing barriers to palliative care for structurally vulnerable populations by enhancing service delivery models, streamlining referral processes and incorporating lived experience into system design.

In Winnipeg, Manitoba, Winnipeg Regional Health Authority (WRHA) community outreach groups, palliative care, Indigenous Health and other non-WRHA housing and outreach groups, along with the George and Fay Yee Centre for Healthcare Innovation (n.d.), worked together to assess the need and possible responses to improving equity in access to palliative care for persons who were unhoused. They created visual tools, a low-barrier referral form and videos to improve access to care. In addition, they created a new low-barrier palliative care consult team with modified criteria for access and engagement. Importantly, they also worked to develop a process for emergency continuity care plans specific for palliative care clients to serve as a communication tool for those presenting to emergency departments for support.

Dorothy Ley Hospice and GPS Health Navigators in Greater Toronto and Hamilton Area, Ontario, address the barriers faced by refugee claimants experiencing housing insecurity when accessing palliative care. Together, these partners established a system navigation service for vulnerably housed refugees with Interim Federal Health Insurance and palliative care needs. They provided training, education and coaching sessions and focused on raising system awareness of insurance barriers for this population among community partners. With a scalable model, this program holds promising potential for expansion to additional jurisdictions.

### Capacity building through engagement: Communities addressing care needs

Capacity building initiatives strengthen care planning, service development and community-driven collaboration, ensuring that palliative care approaches are informed by the lived experiences and contexts of structurally vulnerable populations.

Newfoundland and Labrador Health Services – Labrador and Grenfell Zone incorporates Inuit ways of knowing and being into palliative care delivery at the Nain Community Clinic. This initiative, within a remote Inuit community, enabled community members to receive palliative care within their community and homes, reducing the number of individuals who must travel outside of their remote community to receive palliative care. Team members described how nurses, support staff, patients, families and communities developed an

understanding "that palliative care is something we can do together, that we provide competently and effectively, without community members having to ever leave the comforts of home." Together, they integrated effective pain management through the implementation of appropriate technology, offering education to support its use and the development of Indigenous-focused end-of-life approach to ensure standardized pain management with a culturally focused, holistic approach.

In British Columbia, Vancouver Coastal Health and Providence Health Care have been co-developing serious illness care planning resources with individuals experiencing homelessness, structural vulnerability and substance use disorders in Vancouver's Downtown Eastside. By co-designing resources with people serving and living in this community, this initiative aims to ensure that end-of-life care aligns with individual preferences, while also enhancing collaboration between health and social care teams.

In Alberta, Alberta Health Services partnered with Cold Lake First Nation to improve palliative care access in the local community. This initiative supported cultural safety and trauma-informed training for providers, engagement with local Elders and collaborative solutions to address systemic gaps in providing equitable palliative care. Their efforts have improved more choice for individuals living on Cold Lake First Nation to receive culturally safer palliative care within their community.

## Innovation and Impact of Equity-Oriented Palliative Care Initiatives

At the core of equity-oriented approaches to palliative care, we have seen within the collaborative a set of common themes that inform their effectiveness and sustainability. These themes help us better understand how we can design more impactful and innovative care models, especially for underserved communities. As we discuss these principles, we will also highlight initiatives within the IEAPC collaborative that show how these principles can be embedded in real-world environments.

### Addressing social determinants of health as a palliative care intervention

There is an explicit focus on addressing SDoH across initiatives. Factors including housing instability, poverty, education, employment and access to social supports directly impact an individual's health outcomes and ability to access care (Draper et al. 2024). For First Nations, Inuit and Métis, colonialism is recognized as the underlying factor driving all other determinants, health disparities and inequitable access to healthcare (Browne et al. 2016). Standard healthcare delivery models often fail to meet the needs of individuals without a fixed address; for instance, the inability to access a phone can create barriers to scheduling appointments, receiving follow-up care or coordinating care. In addition, certain treatments, such as chemotherapy, may be inaccessible for individuals who lack a stable residence. For example, Newfoundland and Labrador Health Services in St. John's recognizes housing instability as a critical barrier to end-of-life care by providing dedicated palliative care shelter beds for people experiencing homelessness. This approach ensures dignified, person-centred care while also reducing unnecessary hospitalizations and emergency department visits, demonstrating the value of integrating the SDoH into palliative care delivery for more sustainable, cost-effective healthcare delivery.

### Harm reduction

Harm reduction ensures that individuals who use substances can receive non-judgemental, compassionate and person-centred care and is a foundational principle of many equity-oriented palliative care models (Bartlett et al. 2013). By prioritizing trust, harm reduction approaches remove barriers to care and lead to safer, more inclusive care environments (Hawk et al. 2017). In Victoria, the Cool Aid Society works to integrate harm reduction principles with trauma-informed care, ensuring that palliative care environments remain safe, inclusive and responsive to the needs of individuals who use substances. Such practices can include supporting clinicians in ensuring that, regardless of substance use status, providers are comfortable facilitating access to prescribed medication and treatment. By acknowledging the complex realities faced by structurally vulnerable populations, these initiatives provide care that is rooted in love, dignity and understanding, rather than judgement or exclusion.

### Trauma-informed care, cultural safety and cultural humility

Trauma-informed care, cultural safety and cultural humility are also fundamental components of equity-oriented palliative care initiatives, ensuring that services are responsive to the lived experiences and cultural identities of structurally vulnerable populations (de Groot et al. 2023). For example, Fort Erie Native Friendship Centre and Hospice Niagara integrated cultural safety into their initiative by incorporating First Nations, Métis and Inuit practices, land-based healing and culturally relevant spaces that inspire connections to language, community and spiritual beliefs. The volunteer program developed recognizes that impactful models of palliative care for Indigenous communities must be community-driven, ensuring that services align with Indigenous ways of knowing, being and doing. As reinforced by Prince (2026) and Caverley (2026), by centring First Nations, Inuit and Métis knowledges and perspectives, these initiatives build trust, foster meaningful engagement and contribute to improved health outcomes, ultimately reducing disparities in palliative care access and delivery.

### Interprofessional, collaborative approaches to care

Interprofessional collaboration is a defining feature of these initiatives, uniting nurses, volunteers, paramedics, physicians, counsellors, social workers, volunteers, peer workers and hospice aides to deliver comprehensive and coordinated care. For example, Nova Scotia Health Authority has embedded clinical staff, including a nurse practitioner, into the Bridge shelter, allowing health and social services to bring their interprofessional team together to better meet the needs of clients. This collaborative, multidisciplinary approach enhances the efficiency and effectiveness of palliative care delivery by addressing the physical, emotional, social and spiritual dimensions of well-being.

### Empowering people with lived experiences to lead

We also see the importance of engaging and empowering individuals with lived experience to lead in the design and implementation of services. By actively involving community members, peer workers and Elders, these models ensure that care delivery is responsive, relevant and meets people where they are at (Haldane et al. 2019). The impact of lived experience as wisdom and leadership is illustrated in Figure 1, which visually represents the multi-faceted factors influencing equitable access to palliative care (illustrated by ThinkLink). Julie Diner shared her experience as an individual with lived experience as a member of the Palliative Advocacy and Care Team (PACT) program in Thunder Bay (Diner 2026; HEC 2024f). She speaks about how collaboration with peer workers and community organizations to co-develop resources for serious illness care planning ensures that services and resources align with the needs and preferences of marginalized populations. By centring community voices (Thunder Bay PACT 2024), these initiatives enhance efficiency, lower costs and improve health outcomes. Notably, when programs are designed by and for specific communities, they are more likely to be utilized and effective as they reflect the unique needs and values of those they intend to serve (Haldane et al. 2019).

FIGURE 1.
**Innovation and impact of equity-oriented palliative care initiatives**



## A Call to Action

To maintain the momentum and sustain the impactful work of the IEAPC collaborative and respective communities, it is important for future initiatives to prioritize sustainability, scalability and consider robust evaluation frameworks (IEAPC Program Delivery Team 2026). The IEAPC Evaluation Framework includes decolonized evaluation approaches involving mixed-method data sources, such as story sharing, to share the impact of the collaborative and can be used outside of the collaborative to support communities in measuring their improvement and capturing their journey to create more equitable, high-quality and safe care (IEAPC Program Delivery Team 2026). In addition, learnings and innovative models from this collaborative can be adapted in local communities and applied as a blueprint for future work focused on equity-oriented care for individuals experiencing homelessness or vulnerable housing. We have an obligation to use our power and privilege to design and deliver more equitable palliative care so that everyone has access to the palliative care they need and deserve. Access to safe and high-quality palliative care cannot and should not be dependent on our housing status.

## Moving Forward

In conclusion, the IEAPC collaborative highlights the impact that equity-oriented initiatives can have on access to safe and high-quality palliative care across diverse communities experiencing homelessness or vulnerable housing. These innovative, equity-oriented approaches to care demonstrate the effectiveness of integrating trauma-informed care that recognizes and addresses the SDoH. This delivery of care is also strengthened through encompassing aspects of harm reduction, cultural safety, lived experience and incorporating circles of care fostered by cross-collaboration.

Through the sharing of key components, learnings and new approaches arising from the IEAPC collaborative, momentum for improving equity-oriented palliative care continues to grow. With this collaborative serving as a foundation, the adaptation and scalability of similar initiatives in local contexts are encouraged to continue progress toward a healthcare system that is inclusive, compassionate and provides all individuals with access to safe, high-quality palliative care.

Finally, it is important to acknowledge that the IEAPC collaborative and its accomplishments would not be possible without the financial and strategic support of Health Canada, CPAC and HEC, whose investments in community-led approaches and cross-sector collaboration have contributed a pivotal role in improving equity-oriented palliative care delivery for populations experiencing homelessness or vulnerable housing. HQ

## References

Bartlett, R., L. Brown, M. Shattell, T. Wright and L. Lewallen. 2013. Harm Reduction: Compassionate Care of Persons With Addictions. *Medsurg Nursing* 22(6): 349–58.

Browne, A.J., C. Varcoe, J. Lavoie, V. Smye, S.T. Wong, M. Krause et al. 2016. Enhancing Health Care Equity With Indigenous Populations: Evidence-Based Strategies From an Ethnographic Study. *BMC Health Services Research* 16: 544–60. doi:10.1186/s12913-016-1707-9.

Buchanan, N., N. Dosani, A. Bond, D. Spaner, A. Tedesco, N. Persaud et al. 2023. Palliative Education and Care for the Homeless (PEACH): A Model of Outreach Palliative Care for Structurally Vulnerable Populations. *Healthcare Quarterly* 26(1): 24–30. doi:10.12927/hcq.2023.27055.

Canadian Partnership Against Cancer (CPAC) and Healthcare Excellence Canada (HEC). 2026. Improving Equity in Access to Palliative Care Collaborative: A Story of Collective Impact [Internal Document].

Caverley, N. 2026. Many Paths, Walking Together: Honouring Collective Reflections in Indigenous-Centred Palliative Care in Canada. *Healthcare Quarterly* 29(Special Issue): 46–56. doi:10.12927/hcq.2026.27964.

de Groot, J.M., D.C. Fehon, L. Calman, D.S. Miller and A. Feldstain. 2023. Trauma-Informed Palliative Care Is Needed: A Call for Implementation and Research. *Palliative Medicine* 37(10): 1470–73. doi:10.1177/02692163231206998.

Diner, J. 2026. Bridging the Gap: Why Lived Experience Is Essential in Palliative Care for the Unhoused. *Healthcare Quarterly* 29(Special Issue): 11–14. doi:10.12927/hcq.2026.27969.

Draper, E.C., H.J. Burgess, C. Chisholm, E.L. Mazerolle and C. Barker. 2024. Front-Line Insights Into the Social Determinants of Health in Housing Instability: A Multi-Province Study. *Journal of Primary Care & Community Health* 15. doi:10.1177/21501319241292131.

George and Fay Yee Centre for Healthcare Innovation. n.d. Your Centre for Health Research and Health System Improvement. Retrieved August 31, 2026. <https://chimb.ca/>.

George Spady Society. 2020. George's House Palliative Care Program. Retrieved August 31, 2026. <https://www.gspady.org/georges-house-1>.

George Spady Society. 2024. A Morning at George's House. *YouTube*. Retrieved December 5, 2025. <https://www.youtube.com/watch?v=I1etuhihHsY>.

Global News. 2025, November 24. *Montreal Health-Care Program Offers Palliative Care to the Unhoused*. Retrieved August 31, 2026. <https://globalnews.ca/video/11541914/montreal-health-care-program-offers-palliative-care-to-the-unhoused/>.

Haldane, V., F.L.H. Chuah, A. Srivastava, S.R. Singh, G.C.H. Koh, C.K. Seng et al. 2019. Community Participation in Health Services Development, Implementation, and Evaluation: A Systematic Review of Empowerment, Health, Community, and Process Outcomes. *PLoS One* 14(5): e0216112. doi:10.1371/journal.pone.0216112.

Hawk, M., R.W.S. Coulter, J.E. Egan, S. Fisk, M.R. Friedman, M. Tula et al. 2017. Harm Reduction Principles for Healthcare Settings. *Harm Reduction Journal* 14: 70. doi:10.1186/s12954-017-0196-4.

Healthcare Excellence Canada (HEC). 2024a. *Promising Practice: Diane Morrison Hospice*. Retrieved August 31, 2026. <https://a-ca.storyblok.com/f/850807391887861/27dc221788/promisingpractice-dianemorrisonen-20240102v3.pdf>.

Healthcare Excellence Canada (HEC). 2024b. *Promising Practice: George's House*. Retrieved August 31, 2026. <https://a-ca.storyblok.com/f/850807391887861/cc0e72c73c/pp-georgeshouseen2024v2.pdf>.

Healthcare Excellence Canada (HEC). 2024c. *Promising Practice: La Maison du Père*. Retrieved August 31, 2026. <https://a-ca.storyblok.com/f/850807391887861/da8f7ed1d5/pp-maison-du-pereen-2024v2.pdf>.

Healthcare Excellence Canada (HEC). 2024d. *Promising Practice: Medavie Community Paramedicine (Improving Equity in Access to Palliative Care – Wellness Clinics)*. Retrieved August 31, 2026. <https://a-ca.storyblok.com/f/850807391887861/d3fe16c0d9/promisingpractice-medavieen-20240102v3.pdf>.

Healthcare Excellence Canada (HEC). 2024e. *Promising Practice: Palliative Education and Care for the Homeless (PEACH)*. Retrieved August 31, 2026. <https://a-ca.storyblok.com/f/850807391887861/2d7aa501cc/pp-peachen-2024v2.pdf>.

Healthcare Excellence Canada (HEC). 2024f. *Promising Practice: Thunder Bay Palliative Advocacy & Care Team (PACT)*. Retrieved August 31, 2026. <https://a-ca.storyblok.com/f/850807391887861/b9ba645bb1/promisingpractice-pacten-20240102v5.pdf>.

Healthcare Excellence Canada (HEC). 2026a, March 27. *From Framework to Impact: Equity Oriented Care in Practice*. Retrieved August 31, 2026. <https://www.youtube.com/watch?v=_Sg9RRMKCtw&t=2s>.

Healthcare Excellence Canada (HEC). 2026b. *Improving Equity in Access to Palliative Care*. Retrieved August 30, 2026. <https://www.healthcareexcellence.ca/programs/improving-equity-in-access-to-palliative-care/>.

Healthcare Excellence Canada (HEC). 2026c. *Promising Practices for Improving Equity in Access to Palliative Care*. Retrieved August 31, 2026. <https://www.healthcareexcellence.ca/resources/improving-equity-in-access-to-palliative-care-promising-practices/>.

Improving Equity in Access to Palliative Care (IEAPC) Program Delivery Team. 2026. The Power of the Collective: Lessons Learned From Pan-Canadian Efforts to Improve Access to More Equitable Palliative Care. *Healthcare Quarterly* 29(Special Issue): 36–45. doi:10.12927/hcq.2026.27962.

Inner City Health Associates (ICHA). 2016. *Annual Report 2015–2016 [Report]*. Retrieved August 30, 2026. <https://www.icha-toronto.ca/new-site/wp-content/uploads/Annual-Report-2015-2016-External_0.pdf>.

Medavie Health Services West [MHSW]. 2026. *Mobile Integrated Health Program Community Paramedicine Program Booklet*. Retrieved August 31, 2026. <https://medaviewest.ca/files/images/MobileIntegratedHealthProgram_booklet.pdf>.

O'Connell, E. 2026, March 4. *Walking With People – Equity in Palliative Care in Grey and Bruce (IEAPC)* [Video]. Retrieved September 2, 2026. <https://vimeo.com/1170460333/e3ffa971dd?share=copy&fl=sv&fe=ci>.

Peeler, A., A. Doran, L. Winter-Dean, M. Ijaz, M. Brittain, L. Hansford et al. 2023. Public Health Palliative Care Interventions That Enable Communities to Support People Who Are Dying and Their Carers: A Scoping Review of Studies That Assess Person-Centered Outcomes. *Frontiers in Public Health* 11: 1180571. doi:10.3389/fpubh.2023.1180571.

Prince, H. 2026. Engaging in a Relational Approach: Addressing Inequities in Access to Palliative Care for Indigenous Peoples. *Healthcare Quarterly* 29(Special Issue): 15–21. doi:10.12927/hcq.2026.27968.

Podymow, T., J. Turnbull and D. Coyle. 2006. Shelter-Based Palliative Care for the Homeless Terminally Ill. *Palliative Medicine* 20(2): 81–86. doi:10.1191/0269216306pm1103oa.

Purkey, E. and M. MacKenzie. 2019. Experience of Healthcare Among the Homeless and Vulnerably Housed a Qualitative Study: Opportunities for Equity-Oriented Health Care. *International Journal for Equity in Health* 18(1): 101. doi:10.1186/s12939-019-1004-4.

Schneider, E. and N. Dosani. 2021. Retrospective Study of a Toronto-Based Palliative Care Program for Individuals Experiencing Homelessness. *Journal of Palliative Medicine* 24(8): 1232–35. doi:10.1089/jpm.2020.0772.

Stajduhar, K. and M. Gott. 2023. Closing the Health Equity Gap in Palliative Care: The Time for Action is Now. *Palliative Medicine* 37(4): 424–25. doi:10.1177/02692163231164729.

The Ottawa Mission. 2021. *The Ottawa Mission Hospice at 20 Report* [Report]. Retrieved August 31, 2026. <https://ottawamission.com/wp-content/uploads/2026/06/Hospice-Report-20-Years.pdf>.

Thunder Bay Palliative Advocacy and Care Team (PACT). 2024. *Vulnerably Housed Promo* [Video]. Retrieved August 29, 2026. <https://vimeo.com/899861505/b68c4df190?share=copy>.

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# The Power of the Collective: Lessons Learned From Pan-Canadian Efforts to Improve Access to More Equitable Palliative Care

Improving Equity in Access to Palliative Care Program Delivery Team (including* Clarissa Chan, Andrea Coronado, Kristen DeCaria, Emilie Desmottes, Amber Heyd, Mihaela Labbe, Kirstin Loates, Tanya MacDonald, Nicole Robinson, Raquel Shaw Moxam and Lindsay Yarrow)

**Key Takeaways**

- When participating communities designed care around the needs of people who were structurally excluded from many current models, they expanded access, strengthened partnerships, advanced safer care and created more person-centred approaches that better reflect the realities of the people they serve.
- There is no single path to improving equitable access to palliative care. Rather, lasting change is achieved when communities are supported to lead, adapt, learn from one another and build solutions that reflect the strengths, needs and priorities of the people they serve.
- Sustaining and expanding access to palliative care requires ongoing investment in partnerships, community leadership and knowledge sharing, alongside continued efforts to embed equitable palliative approaches to care within health and social systems.

## Abstract

**This article examines the evaluation approach and learnings of the Improving Equity in Access to Palliative Care collaborative, a pan-Canadian initiative that supported 23 communities to improve palliative care access for people experiencing homelessness or vulnerable housing. Grounded in health equity and cultural safety, the collaborative developed a flexible evaluation framework with shared understanding and guiding principles. While the initiatives differed in their settings, partnerships and approaches, a common story emerged across the collaborative: when communities redesigned palliative approaches to care around the needs of people who have been structurally excluded from many current models, they expanded access, strengthened partnerships and advanced culturally safer care. The article calls for continued action: the lessons learned offer guidance for communities, organizations and partners seeking to improve equitable access to care, while reinforcing that lasting change is built through relationships, flexibility and a commitment to learning together.**

## Introduction

Across Canada, access to palliative approaches to care is not equitable, especially for people experiencing homelessness or vulnerable housing, who often face many barriers to diagnosis, treatment and support needs through existing models of palliative care. Recognizing this, Healthcare Excellence Canada (HEC) and the Canadian Partnership Against Cancer (the Partnership) formed the Improving Equity in Access to Palliative Care (IEAPC) collaborative (the IEAPC collaborative) to support community-led approaches designed specifically for and with these populations. Between 2022 and 2026, this collaborative brought together 23 communities across Canada who sought to improve access to timely,

*in alphabetical order

equity-oriented palliative approaches to care, reduce avoidable emergency department visits and hospital admissions, reach people who are often excluded from existing care models and support people to receive the care they need with dignity and in the environment of their choice.

All 23 communities participated in the pan-Canadian evaluation and informed the results shared within this article. In recognition of the opportunity to apply a decolonized approach to evaluation, Turtle Island Consulting Services Inc. (TICS Inc.) supported additional evaluation activities and provided evaluation support to five teams that formed the Indigenous-centred community of practice and further learnings from that work can also be found in this special edition (Caverley 2026).[1] This article seeks to highlight key findings, implementation lessons as well as promising practices and overall lessons learned from the pan-Canadian evaluation.

## How We Measured Impact

This mixed-methods evaluation was designed to tell the pan-Canadian impact story of the IEAPC collaborative, highlighting how participating communities advanced equitable, safer and high-quality palliative approaches to care for people experiencing homelessness or vulnerable housing. The evaluation explored the collaborative's achievements, challenges and promising practices to inform future efforts within communities and across the broader health system.

This evaluation draws on two primary sources of evidence: (1) standardized reports from teams and (2) focus groups conducted with members of the participating teams, project coaches and advisors. Together, these data sources provide both quantitative information about collaborative activities, progress and reach; and qualitative insights into implementation experiences, challenges and lessons learned. Wherever possible, opportunities to share examples and narratives were woven into data collection tools and methods.

### Standardized reports

- *Description:* Participating teams completed regular status reports every six months to document progress, activities, outcomes and emerging learnings. These reports included both quantitative measures (e.g., number of clients reached, number of trainings delivered) and qualitative reflections (stories of impact, implementation successes, challenges and adaptations).
- *Analysis as completed by Cathexis Consulting:* Data from each status report were cleaned and analyzed. Quantitative data were summarized descriptively for each reporting period, while qualitative responses underwent thematic analysis to identify common patterns and emerging themes across teams. Following completion of the final status report, key quantitative indicators from all reporting periods were compiled and aggregated to produce cumulative results across the duration of the collaborative.

### Focus groups with participating teams

- Cathexis Consulting, in collaboration with TICS Inc. held two rounds of focus groups.[2] A series of virtual focus groups were held in September 2025, and in-person focus groups were conducted in February 2026 in Winnipeg, MB. These discussions explored participants' experiences implementing their initiatives, building partnerships, promising practices, challenges, perceived impacts and lessons learned for future work in this field.
- *Analysis as completed by Cathexis Consulting:*
  - Analysis approaches differed slightly across the virtual and in-person focus groups. Virtual focus group recordings were transcribed and analyzed using thematic analysis. A preliminary coding approach was refined as transcripts were reviewed, allowing new concepts and themes to emerge from the data. Themes were subsequently synthesized across groups and summarized.
  - For the in-person focus groups, participants contributed directly to the initial analysis through facilitated reflection activities using sticky notes and chart paper to respond to questions, identify key themes, promising practices, challenges and lessons learned. These participant-generated themes formed the foundation for subsequent analysis, which involved synthesizing and refining themes across groups to produce the final findings presented in this report.

### Focus group with coaches and advisers

In February 2026, an in-person focus group was held with 12 coaches and advisers from the IEAPC collaborative in Winnipeg, MB. The purpose of this discussion was to explore coach and adviser perspectives on changes and impacts observed and identify promising practices and lessons learned for future initiatives.

- *Analysis as completed by Cathexis Consulting:* Participants contributed directly to the initial analysis through facilitated reflection activities using sticky notes and chart paper to respond to questions, identify key themes, promising practices, challenges and lessons learned. These participant-generated themes formed the foundation for subsequent analysis, which involved synthesizing and refining themes to produce a focus group summary. This summary was then shared back with participants for validation and additional input, prior to informing this final report.

### Additional inputs

While the above methodology served as the primary sources of evidence for the evaluation, findings were also informed by a partner survey conducted by HEC, ongoing engagement with HEC and the Partnership (supporting documentation) and insights generated through parallel evaluation activities and subsequent reporting.

## Evaluation Context and Framework

The IEAPC Evaluation Framework (Figure 1; HEC and CPAC n.d. 2026b) provided an important foundation for the design and implementation of the pan-Canadian evaluation work. This framework was co-developed by TICS Inc. with input from the Cohort 1 communities, Elders, coaches, Steering Committee, Evaluation Committee, patient partners, HEC and the Partnership.

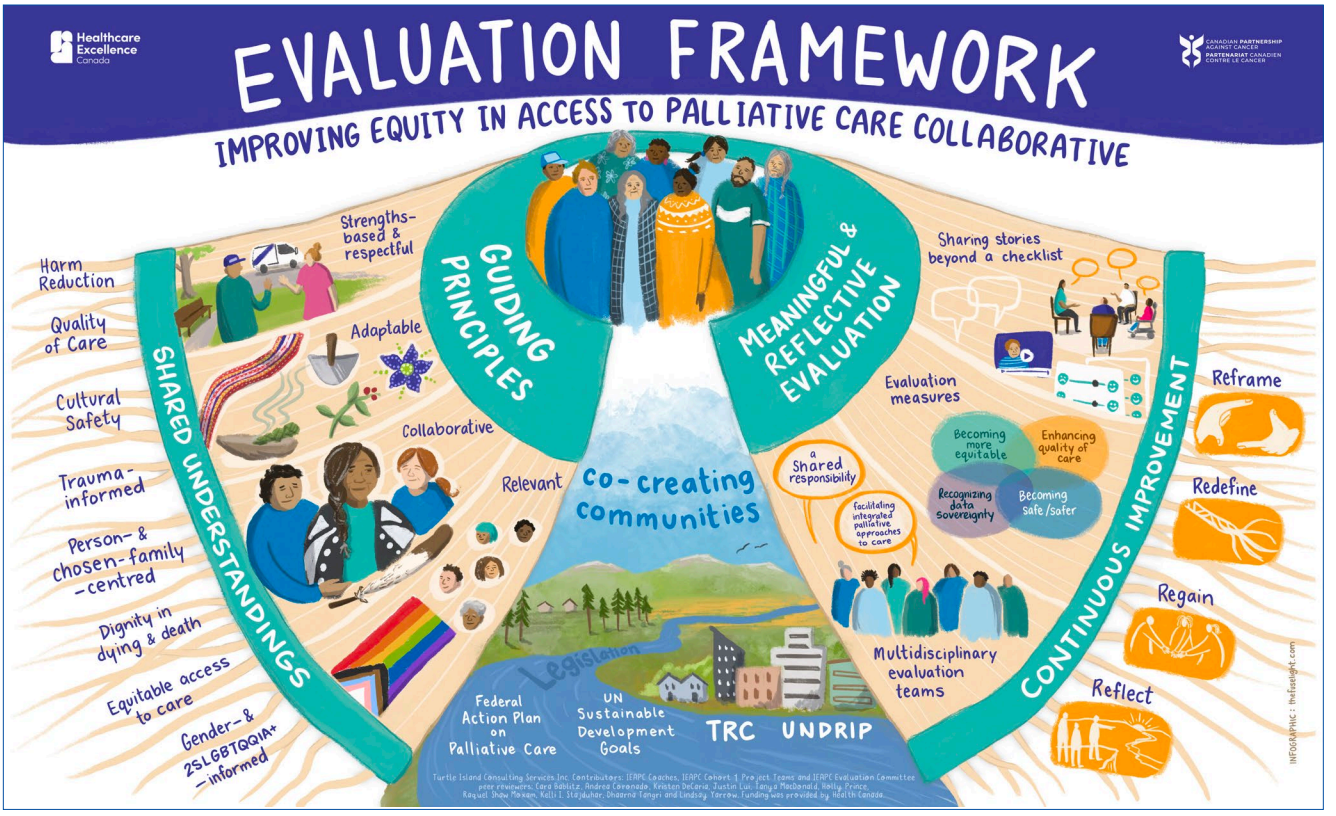
The figure depicts the IEAPC Evaluation Framework using the metaphor of a woven blanket to represent an integrated, relational and adaptive approach to evaluation. The framework centres communities of people experiencing homelessness or vulnerable housing, alongside their chosen families and care providers and illustrates the weaving together of guiding principles and shared understandings of equity-oriented palliative care. Foundational reports and declarations are positioned centrally, indicating their role in grounding the collaborative's commitments and evaluation approach.

While the framework was intentionally designed to be flexible and adaptable across diverse team contexts, several core principles informed the approach for the pan-Canadian evaluation. These included commitments to strengths-based inquiry, collaboration, adaptability and relevance to participating teams and communities, along with recognition of multiple ways of knowing and sharing knowledge (Figure 2).

These principles shaped how the collaborative operationalized the evaluation work. Examples are as follows:

- Evaluation activities emphasized relationship-building and collaboration wherever possible
- Data collection tools and processes were designed to support teams in sharing their experiences, observations, impacts and lessons learned in ways that were meaningful and relevant to their local contexts

FIGURE 1.
**A visual overview of the IEAPC Evaluation Framework (HEC and CPAC n.d. 2026a)**




IEAPC = Improving Equity in Access to Palliative Care.

- Qualitative approaches emphasized reflection, storytelling and practice-based learning alongside more traditional quantitative evaluation measures and indicators (e.g., reach)

Conversations about evaluation emphasized equal interest in the journey of each team and *how* their initiative unfolded as the outcomes and impact of the evaluation also recognized the importance of ethical engagement and cultural safety throughout the process.

## What We Found

### Bringing palliative approaches to care into communities

A common thread across many of the teams was the delivery of palliative approaches to care in community, ensuring that care models were adapting to local needs, contexts and priorities, while meeting people where they were (Box 1).

### Creating more flexible, low-barrier and person-centred pathways to care

Across participating communities, teams described how their initiatives expanded access to palliative approaches to care for underserved populations through flexible, community-based and person-centred models, which were often delivered in non-traditional settings (e.g., mobile health vans, outdoor spaces, encampments). In many cases, the team reported that they were reaching individuals who may not have otherwise accessed care, helping people access services earlier or providing care in ways that better aligned with their needs.

### Meeting people where they are

While their approaches varied, teams consistently described a shift away from expecting individuals to navigate healthcare systems on their own. Initiatives focused on reducing barriers and adapting services to meet people where they were in their community.

> Community paramedics have helped me in a few different ways. They have helped me by changing my bandages for me which save's me about 20 dollars every dressing change; also they have advocated for me at the hospital so I wasn't mistreated because of being an addict (Client testimonial shared by Medavie, Health Services West – Moose Jaw).

### Reducing barriers to access

Stories from teams emphasized that access to care involved more than clinical services alone. Many initiatives provided holistic care by supporting individuals with needs such as transportation, housing, obtaining identification, food security and navigating legal or probation-related requirements.

FIGURE 2.
**Guiding principles from the IEAPC Evaluation Framework, TICS Inc. (HEC and CPAC n.d. 2026b)**




IEAPC = Improving Equity in Access to Palliative Care; TICS = Turtle Island Consulting Services.

BOX 1.
**By The Numbers: number of people reached across four years of the IEAPC collaborative**

**11,888**
individuals reached by the 23 IEAPC teams across four years of the collaborative, including:

**9,019**
people (76%) were direct patients, clients, family, friends or support persons who received a palliative approach to care in their community.

**2,869**
staff members (24%) received palliative approaches to care supports or services, such as bereavement or grief services.

**3,750**
individuals trained to meet the palliative care needs of care recipients.

IEAPC = Improving Equity in Access to Palliative Care.

### Building trust and relationships

We also heard how this work is contributing to a broader shift in how care was delivered, with an emphasis on the importance of building genuine relationships and establishing trust with clients. To do so, teams adopted more flexible, relationship-based and harm-reduction-oriented approaches to care, rather than relying primarily on existing or curative models. Mobile and outreach models were particularly important for individuals who were hesitant to engage with many current care settings or who had previously experienced barriers, stigma or distrust within healthcare settings.

### Improved health and social outcomes

Team members shared examples of how these approaches to care contributed to improved health and social outcomes, with individuals receiving earlier interventions, accessing more comprehensive supports, developing trusting relationships with care providers and experiencing greater continuity of care.

> The peer worker initiative created pathways for people experiencing homelessness and other vulnerable populations to access hospice care in a way that was relational, non-judgemental and trauma informed. If their patients did not have access to the hospice, they would likely have been admitted and died in an emergency department. By embedding peers with lived experience into the care team, patients who might otherwise avoid formal healthcare felt understood, respected and welcomed.
>
> For example, peer workers accompanied patients from the streets into the hospice and to medical appointments. These medical appointments were crucial in their care journey as without them, these patients would have ended up in hospital. Peers advocated for care preferences and provided consistent emotional support which helped us build trust with patients who did not want to be here. The peers acted like a bridge between the people we serve and the care team (Second Mile Club of Toronto and Kensington Health).

In some communities, teams reported that these efforts supported improved housing stability, enhanced quality of life for both care recipients and their loved ones and reduced reliance on emergency services and other acute care settings.

### Providing alternatives to emergency department care

Participating teams shared how their initiatives created alternatives to emergency department use for some care recipients. Through outreach, home visits, community paramedicine programs and improved clinical pathways and coordination among providers, individuals were able to receive support earlier and in settings that aligned with their needs.

> By building networks with social workers at cancer centres, we were able to allow providers to suggest alternatives to getting care outside of the emergency department. For example, to do PICC line care, the cancer centre staff initially would say to come to ER to have this done if there was no room at the cancer centre. However, with our support, we were able to get nursing and wound care supplies at the patient's home to divert ED usage (GPS Health Navigators and Dorothy Ley Hospice).

Examples included providing wound care and nursing support in the home rather than directing patients to the emergency department and supporting families and caregivers to manage changes in health status at home. Some teams also worked with emergency medical services, community paramedics and hospital partners to create alternative pathways when urgent needs arose.

### Supporting trauma-informed care

Teams described how care became safer, more responsive and more aligned with the needs, values and circumstances of the people they served. Across participating communities, teams emphasized taking trauma-informed and non-judgemental approaches to care, with dignity and respect at the centre. Safer care often began with recognizing and responding to these experiences individuals brought with them.

> We now approach care through a more intentional equity and trauma-informed lens, particularly for individuals who are homeless or vulnerably housed. This has helped ensure that clients receive end-of-life care that is dignified, compassionate, nonjudgmental and high-quality, regardless of their circumstances, particularly for individuals who are homeless or vulnerably housed (Scarborough Centre for Healthy Communities and Inner City Health Associates).

### Cultural safety

Beyond trauma-informed care, many teams also emphasized the importance of culturally safer and culturally meaningful approaches, particularly when supporting First Nations, Inuit and Métis care recipients, families and communities. Examples included partnering with Indigenous organizations in the community, connecting individuals and families with cultural supports and wellness programs, facilitating access to Elders and cultural resources and building staff knowledge through cultural safety training. Addressing the experiences of stigma, racism and trauma helped create safer environments where individuals felt respected and able to engage in care.

### Choice, dignity and meaningful end-of-life experiences

Teams shared stories of how safer care meant supporting choice, dignity and self-determination throughout end-of-life journeys. Examples shared by teams included supporting access to culturally meaningful end-of-life practices and ceremonies (e.g., being sung home); navigating end-of-life choices such as place of death; assisting an individual in accessing medical assistance in dying as per their wishes; and a group of peer workers helping a patient fulfill a wish to write and publish a book before their death.

### Supporting family members, friends, caregivers and loved ones

Across communities, teams supported loved ones by helping them navigate services, access community resources, participate in care planning, prepare for end-of-life transitions and providing grief and bereavement services before and after a loved one's death. Teams described supporting family reunification, helping loved ones travel from other parts of the country to be present at the end of life, creating welcoming spaces for overnight visits and shared family meals, coordinating cultural ceremonies, celebrations of life and other meaningful gatherings.

### Building capacity and collaboration to provide equitable palliative approaches to care

The impacts of the collaborative extended beyond individual care experiences. We heard how participating in the collaborative strengthened the capacity of staff to provide equitable, low-barrier and person-centred care. Teams described increased awareness of palliative approaches to care, changes in confidence working with and delivering care to vulnerable populations and strengthened partnerships among organizations supporting underserved populations.

A key objective of the collaborative was to build the knowledge, skills and capacity required to provide equitable palliative approaches to care. Teams both participated in and delivered trainings (Box 2).

**BOX 2.**
**Number of people trained to meet palliative care needs**

3,750

individuals trained to meet the palliative care needs of care recipients (reported by 23 teams).

Training topics included: Serious Illness Conversation, harm reduction, cultural competency, Advanced Care Planning, Learning Essential Approaches to Palliative Care and other tailored topics.

Across communities, teams shared examples of stronger collaboration and system-navigation skills, supported by increased awareness of available resources, clearer referral pathways and more open and intentional communication among partner organizations.

Teams described staff roles that moved beyond task-based clinical care to more integrated, interdisciplinary and intersectoral coordination. IEAPC collaborative teams also described staff becoming stronger advocates for equitable and person-centred care in their communities. Teams emphasized a shift in awareness of the need to adapt services to individual circumstances, particularly for people with histories of trauma, experiences of discrimination or complex social needs.

### Increased knowledge, skills and confidence

Teams described how participating in the collaborative contributed to increased knowledge, skills and confidence among staff and partners, particularly as they relate to equity-oriented care and supporting underserved populations. Team members reported using new tools and approaches to support individuals with serious illness, raising awareness among colleagues and partners and reframing their work through an equity lens.

As a result of the training, teams noted a change in staff engagement, feeling more prepared and comfortable having end-of-life care conversations.

### Lessons in implementation

*Factors influencing implementation*

Despite strong progress across the IEAPC collaborative, teams encountered challenges while implementing their initiatives. Teams described the realities of introducing new approaches to care within already stretched systems, while balancing the relationship-building, coordination and adaptation required to support equitable palliative approaches to care. At the same time, teams identified several factors that helped them overcome barriers and sustain momentum throughout implementation.

*Common challenges: Implementation takes time, people and coordination*

The work undertaken by the IEAPC collaborative teams was highly relationship-, people- and coordination-intensive.

*Relationship-building:* The most commonly reported implementation challenge was finding sufficient time and resources to build and sustain relationships with community partners. Developing trust and rapport with partner organizations, service providers and community members was foundational and required significant staff time, organizational resources and support from leadership.

> Establishing trust with individuals facing life-limiting illnesses takes time, sensitivity, and consistent engagement. It's not only the participants who need to build trust – regional providers and the broader medical

> system also need time to understand and trust the navigational role (The Grey-Bruce Ontario Health Team and Brightshores Health System).

*Staffing and capacity pressures:* Challenges with staffing, including limited staff time and capacity, affected implementation. Many teams described balancing project activities alongside their existing responsibilities and competing organizational priorities.

*Competing priorities and expectations:* Teams also shared challenges with managing competing partner interests and priorities. Many partners saw value in the initiative and advocated for their own ideas, which teams had to balance with program realities.

*Other challenges* included working with transient populations that affected continuity of care; navigating bureaucracy, administrative barriers and siloed community services; and building shared understanding about harm-reduction, low-barrier and trauma-informed approaches.

#### *Enabling factors: Shared learning, committed people and strong partnerships*

Shared learning through the IEAPC collaborative, committed people and strong partnerships were key factors supporting teams' local implementation.

*Collaborative learning and support:* More than two-thirds of teams identified IEAPC supports as a key implementation facilitator, including opportunities to learn from the other teams through in-person collaborative workshops, site visits and other knowledge sharing activities.

*Passionate people and supportive leadership:* Several teams highlighted the importance of dedicated, passionate and engaged leadership. Collaboration between leadership and staff helped create strong foundations for implementation, while peer workers and individuals with lived experience strengthened initiatives through their unique perspectives.

> Participation in the in-person collaborative sessions has re-energized our work and provided valuable opportunities to learn from others who are navigating similar challenges. These sessions have fostered connection, reflection, and renewed motivation for our team (NL Health Services – Eastern Health Rural/Urban Zones).

*Strong community partnerships and shared commitment:* Teams described how open communication and familiarity between partners enabled ongoing reflection on what worked, what did not and how to improve. They learned from community partners and felt supported throughout implementation.

### Partnerships as a foundation for implementation

Teams consistently emphasized the importance of collaboration with local partners in designing and delivering their initiatives. These partnerships were critical for reaching individuals experiencing homelessness or vulnerable housing, helping teams identify individuals in need, in building trust, coordinating services and connecting care recipients to the supports they required. Teams noted that improving access to care required engagement beyond healthcare services, bringing together organizations and individuals from across health, housing, social services, harm reduction, municipal services, Indigenous organizations and those with living and lived experience.

> I think it's really taught our community, as well as our [local health team] how important integrating with other partners, not just health partners, but the social services and beyond, how critical it is to really meeting the healthcare needs of our local population (IEAPC Team Member).

Across participating teams, 1,890 individuals were engaged in program design, delivery, and/or evaluation activities. This included at least 555 individuals with lived or living experience and 457 individuals who were identified as First Nations, Inuit or Métis.

Building and sustaining these partnerships required significant time and effort. Teams described investing in the ongoing work of establishing trust, maintaining relationships and creating opportunities for collaboration among organizations with different mandates, priorities and ways of working.

Teams emphasized the importance of flexibility and shared problem-solving in sustaining partner engagement. This was particularly important as partnerships evolved, with new organizations and sectors joining as project needs and plans evolved. Team members described how finding a common interest or priority, such as housing, can be a helpful grounding tool to bring together multiple community partners on the initiative. Rather than expecting any one organization to meet all client needs, teams focused on leveraging the strengths and resources of partners to create more coordinated and responsive systems.

### Lived and living experience in program design and delivery

People with lived and living experiences played an important role in shaping the design and delivery of many IEAPC initiatives. Teams sought input through advisory groups, community tables, surveys, interviews, peer support roles and ongoing conversations with community members. This feedback helped to shape care pathways, referral processes, communication materials and service delivery approaches. Other teams involved people with lived and living experience directly in program delivery through peer worker and adviser roles, which contributed unique perspectives, helped build trust and provided practical insights to strengthen care and support.

> Peer workers are now integrated into care rounds with staff. They help us reframe in a way that's really beautiful, and they'll let us know when we're saying things that can cause harm.
> (IEAPC Team Member).

At the same time, teams recognized that meaningful engagement did not always occur through formal structures. Several teams described initial challenges engaging people with lived experience in advisory or planning activities, noting that participation in structured meetings was not always a priority for individuals managing serious illness, housing instability or other immediate needs. As a result, teams adapted their approaches, relying on trusted relationships, community partner organizations, front-line staff and informal conversations to gather feedback and perspectives. These experiences reinforced the importance of flexibility, relationship-building and meeting people where they are when seeking to incorporate lived and living experience into program design and delivery.

#### Building relationships with First Nations, Inuit and Métis partners and communities

Building relationships with First Nations, Inuit and Métis communities was identified as a core component of the curriculum and collaborative design for all communities.

Many IEAPC teams worked intentionally to engage with First Nations, Inuit and Métis partners in the design, delivery and evaluation of their initiatives. Approaches varied across communities and reflected the local relationships, priorities and contexts. Examples included: involving Elders and Indigenous leaders in working groups and advisory tables; partnering with Indigenous health centres, navigators and community organizations; participating in land-based learning opportunities about Indigenous healing and decolonized approaches to care; and seeking guidance on program design, delivery and service delivery.

> We have an Indigenous Elder as part of the working group. She opens all our meetings and grounds the work we do. She has been a spiritual leader and support, often creating space for working group members who have experienced vicarious trauma and burnout. Additionally, she has informed the language we use when collecting demographic information (Kingston Community Health Centres).

Engaging Indigenous navigators, cultural helpers and Indigenous-serving organizations helped to guide referrals, strengthen relationships and ensure services reflect community needs and priorities. At the same time, many teams acknowledged that building meaningful partnerships with First Nations, Inuit and Métis communities is ongoing work.

## Promising Practices

As the IEAPC collaborative came to a close, participating teams, coaches and advisers reflected on what helped create change, what is needed to sustain momentum and what lessons may be valuable for others undertaking similar work in the future. This section begins by exploring sustainability and spread, including the conditions needed to maintain and build on progress. It then highlights promising practices for implementing equitable palliative approaches to care.

#### Looking ahead: Sustainability and spread

While plans for sustaining their initiatives varied, IEAPC collaborative team members consistently described a shift from establishing new initiatives toward embedding, maintaining and expanding upon the progress they have made. Sustainability planning focused on securing future funding, integrating equity-oriented approaches into existing systems, strengthening partnerships and sharing lessons learned with others.

Overall, teams emphasized that sustaining momentum will require continued investment, ongoing partnerships, leadership support and opportunities for shared learning. Many team members shared how the collaborative has provided the foundation for continued growth and system change.

#### Promising practices for local implementation

Drawing on the collective experiences of the 23 teams in the IEAPC collaborative, the following promising practices highlight approaches that supported equitable, person-centred, low-barrier and culturally safer palliative approaches to care. The promising practices below may help inform others seeking to improve equity in access to palliative care within their own communities.

1. *Meet people where they are.* Initiatives adapted care to fit the realities of people's lives rather than expecting them to navigate traditional healthcare systems. Outreach, mobile services, shelter-based care, community paramedicine and other flexible approaches reduced barriers and connected individuals with care in comfortable, supportive settings.
2. *Invest in relationships, trust and community leadership.* Building trust with care recipients, families, community partners and people with lived experience was foundational to success. Teams emphasized that meaningful relationships take time and are strengthened through authentic engagement, shared decision making and partnerships.
3. *Keep culture at the centre of care.* Culturally meaningful and safer care helped ensure that services reflected the identities, values and priorities of those served. Teams described the importance of cultural safety, Indigenous navigators and cultural support roles, ceremony, language, storytelling and connections to community in supporting meaningful end-of-life experiences. They emphasized that culturally meaningful care was closely tied to safety. When care

reflected an individual's culture, values, language, traditions and community connections, people were more likely to feel respected, understood and supported throughout their care journey.

4. *Integrate health, social, housing and community supports.* Equitable palliative approaches to care require attention to the social determinants of health that influence access. Successful initiatives recognized that no single organization can address these complex needs alone, bringing together health, housing, social, cultural and community partners to provide coordinated, person-centred care and improve system navigation. Addressing these social determinants of health is key to equitable interventions, demonstrating impact and importance for this and many underserved populations.
5. *Build capacity through learning and knowledge sharing.* Training, coaching, shared learning opportunities and communities of practice helped build staff and partner confidence and capacity. Teams also highlighted the value of storytelling and knowledge sharing as ways to strengthen relationships, support reflection and promote ongoing learning opportunities.

## Considering Both Impact and Value

Improving access to palliative approaches to care directly in the community has implications beyond direct patient outcomes. Emerging evidence suggests that these approaches can also contribute to more efficient use of healthcare resources by reducing reliance on emergency and acute services. Although there was not an opportunity to complete an economic analysis of any of the 23 participating teams, an economic analysis was completed during the collaborative on three Equity-Oriented Mobile Palliative Care (EOMPC) programs in Canada that serve individuals experiencing homelessness and/or vulnerable housing (HEC and CPAC 2026a). These three programs – in Victoria, BC, Edmonton, AB, and Toronto, ON – served as models of care for promising practices that supported spread and scale in the collaborative, and each of their physicians provided coaching and mentorship support to the participating communities.

The findings of the economic evaluation found that by improving access to palliative care for underserved populations, care quality can improve, pressure on emergency services can be reduced and healthcare resources can be used more efficiently:

- Enrolment in EOMPC was associated with a 33% reduction in emergency department attendances and a 32% reduction in emergency ward admissions.
- The EOMPC programs studied generated an estimated $9,560 in net avoided emergency healthcare costs per patient, with a net return on investment of $1.65. This means that for every $1 invested in EOMPC programs, an additional $1.65 in emergency healthcare costs can be avoided elsewhere in the system (HEC and CPAC 2026a).

Together, the findings suggest that investments in equitable, community-based palliative approaches to care have the potential to generate benefits at multiple levels.

## Conclusion

The IEAPC collaborative demonstrated that improving equity in access to palliative approaches to care is both possible and effective when communities are supported to design and implement solutions that reflect their local context.

Across 23 communities, teams expanded access to care for people experiencing homelessness and vulnerable housing through low-barrier, person-centred and culturally safer approaches that strengthened partnerships, built local capacity and connected health, housing, social and community services in new ways. While each community's journey looked different, a common thread emerged: meaningful change was achieved by meeting people where they are, building trusting relationships and working collaboratively across sectors to address complex needs.

The IEAPC collaborative also created opportunities for shared learning, innovation and system change. Teams consistently described increased confidence, stronger partnerships and new ways of thinking about palliative approaches to care, while the collaborative itself demonstrated the value of flexible implementation, coaching and sustained investment in relationship-building.

The work of the IEAPC collaborative provides a strong foundation for continued action. Sustaining and expanding this work will require ongoing investment in partnerships, community leadership and knowledge sharing, alongside continued efforts to embed equitable palliative approaches to care within health and social systems. The lessons learned through this collaborative offer guidance for communities, organizations and pan-Canadian partners seeking to improve equitable access to palliative approaches to care, while reinforcing that lasting change is built through relationships, flexibility and a commitment to learning and improving together. HQ

### Acknowledgments

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participating communities for the generosity in sharing these collective learnings and impacts so that they can be shared more broadly to support organizations and communities in Canada and beyond in advancing their own equity-oriented improvement work.

### Disclaimer

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### Notes:

1. The Indigenous-centred Improving Equity in Access to Palliative Care Community of Practice chose to use the term "Indigenous" to respectfully represent the collective identities of First Nations, Inuit and Métis.
2. Turtle Island Consulting Services Inc. hosted dialogue sessions with the five teams from the Indigenous-centred Community of Practice; the themes from those dialogue sessions were incorporated into this report. Note: The Indigenous-centred community of practice chose to use the term "Indigenous" to respectfully represent the collective identity of First Nations, Inuit and Métis.

### References

Caverley, N. 2026. Many Paths, Walking Together: Honouring Collective Reflections in Indigenous-Centred Palliative Care in Canada. *Healthcare Quarterly* 29(Special Issue): 46–56. doi:10.12927/hcq.2026.27964.

Healthcare Excellence Canada (HEC) and Canadian Partnership Against Cancer (CPAC) n.d. *Improving Equity in Access to Palliative Care Collaborative Evaluation Framework*. Retrieved August 27, 2026. <https://a-ca.storyblok.com/f/850807391887861/e763804b85/ieapc-evaluation-framework-english-web-final-ver-3.pdf>.

Healthcare Excellence Canada (HEC) and Canadian Partnership Against Cancer (CPAC). 2026a. *Investing in Equity: An Economic Analysis of Equity-Oriented Mobile Palliative Care Models in Canada*. Retrieved September 15, 2026. <https://www.healthcareexcellence.ca/resources/investing-in-equity>.

Healthcare Excellence Canada (HEC) and Canadian Partnership Against Cancer (CPAC). 2026b. *Listening, Learning and Walking Together: Shared Insights From an Indigenous-Centred Community of Practice on Improving Equitable Access to Palliative Care* [Internal report – Not publicly available].

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# Many Paths, Walking Together: Honouring Collective Reflections in Indigenous-Centred[1] Palliative Care in Canada

Natasha Caverley

**Key Takeaways**

- Gaps in access to palliative approaches to care for First Nations, Inuit and Métis Peoples stem from ongoing colonialism and anti-Indigenous racism, not chance. Improving approaches to palliative care means naming and addressing these harms, building relationships grounded in dignity and cultural safety and supporting community-led approaches rather than top-down systems.
- A whole-person, community-centred approach strengthens equity, safety and quality of palliative care by building on community strengths, respecting diverse ways of knowing and recognizing Indigenous Knowledge translation such as storytelling, metaphors and expressive arts as a valid and meaningful form of evidence and impact.
- Using a decolonizing and equity-focused approach to evaluation for the Improving Equity in Access to Palliative Care collaborative helped address the systemic barriers and inequities that shape people's experiences of care. It also supported First Nations, Inuit and Métis communities to share their own stories, in their own ways, and carry that knowledge forward for future generations.
- Making evaluation an integral part of ongoing learning and improvement helps to create palliative care systems that are more just, inclusive and responsive to the needs, values and priorities of the people and communities they serve.

**Abstract**

**The Improving Equity in Access to Palliative Care collaborative supported five Indigenous-centred initiatives across Canada (2024–2026) that strengthened access to palliative care for First Nations, Inuit and Métis experiencing vulnerable housing and systemic barriers to care. Grounded in relationships and Indigenous Knowledge systems, the initiatives showed palliative care is more than clinical support. It is also cultural and community-based. Together, the initiatives demonstrated that safer, high-quality and equitable care is most effective when First Nations, Inuit and Métis lead the work, (re)define care in their own ways and support connection to culture, family, community and self-determination.**

## Introduction

People experiencing housing insecurity[2] often face multiple and interconnected challenges including poverty, isolation, substance use and mental health struggles, all of which can contribute to poorer health and earlier death. When basic needs such as safe housing are unmet, it becomes much harder to support physical, emotional, mental and spiritual well-being (Bulle and Dosani 2026). These realities are often made worse by discrimination and barriers within mainstream healthcare systems (Stajduhar 2026; Stajduhar and Gott 2023).

In Canada, these inequities are closely tied to colonization. First Nations, Inuit and Métis Peoples are overrepresented among people experiencing homelessness or vulnerable housing because of land dispossession, violence, intergenerational trauma and ongoing anti-Indigenous racism (Gabriel 2023). These experiences are interconnected and continue to shape quality of life and access to healthcare (Prince 2026).

The Improving Equity in Access to Palliative Care (IEAPC) collaborative was launched in 2022 to respond to these realities and increase access to palliative approaches to care for people experiencing homelessness or vulnerable housing. The

collaborative was a shared effort to do things differently. Rather than relying on top-down models, the collaborative focused on building relationships, listening to communities and supporting local leadership. It brought together people across Canada who are working to make palliative approaches to care more accessible, equitable, safer and higher quality for people too often excluded from care.

*Many Paths, Walking Together* brings together shared learnings, outcomes and promising practices from five of the 23 initiatives. Indigenous-centred IEAPC initiatives worked with and served First Nations, Inuit and Métis Peoples and communities. Together, they formed a community of practice (CoP) and chose the name "Indigenous-centred IEAPC CoP"[3,4] to reflect their shared commitment to centring First Nations, Inuit and Métis ways of knowing, being and doing.

The article also explores how the IEAPC as a collective collaborative took a decolonizing approach to using the IEAPC Evaluation Framework. This meant going beyond including Indigenous perspectives in an existing framework to centring Indigenous Knowledge, relationships, values and ways of working in how the framework was understood and applied. This article outlines the IEAPC collaborative's decolonizing approach, shares key findings from the five Indigenous-centred IEAPC initiatives and the CoP, and explores one Indigenous-centred IEAPC initiative in greater depth. It concludes by considering what these findings mean for palliative care.

## Decolonizing and Equity-Centred Evaluation

The IEAPC collaborative chose to co-create an evaluation approach rooted in decolonization and equity: shaped by people with diverse lived experience, scholars and practitioners in palliative care and related health equity spaces. It focuses on three key areas: making care more equitable, making care safer and improving the quality of palliative care while creating space for reflection, shared learning and ongoing adaptation (IEAPC Program Delivery Team 2026). It was developed in such a way that it could be used by communities looking to take a decolonizing approach to evaluation (HEC and CPAC n.d.). It was designed for use for the collaborative, while there was recognition that it may be useful to others in their work and thus is publicly accessible and available through HEC (HEC and CPAC n.d.).

A decolonizing approach to evaluation means supporting First Nations, Inuit and Métis Peoples' self-determination and shifting decision-making power back to communities (Cohen-Fournier et al. 2021; Rix et al. 2019). It challenges settler-colonial evaluation practices that have historically excluded or undervalued Indigenous Knowledge systems, cultural practices and languages. Instead, it places First Nations, Inuit and Métis perspectives, priorities and definitions of impact at the centre of evaluation (Bremner and Bowman 2023; Dodge Francis et al. 2023; Firestone et al. 2020; Fraser 2022; Hurlbut and Brousselle 2023; Iseke 2013; Locklear et al. 2023; O'Connor et al. 2023). An equity-centred approach to evaluation recognizes how colonization, racism and other systemic inequities shape people's access to care, participation and outcomes. It ensures that people most affected by these inequities help shape the questions, methods and meaning of the evaluation. This includes attention to the experiences of people facing homelessness or vulnerable housing and the ongoing effects of anti-Indigenous racism in healthcare and social service systems.

For the five Indigenous-centred IEAPC initiatives, evaluation was not about proving success or failure. It was about learning together by asking:

- What matters most to communities?
- What has changed?
- What are we learning?
- How can Indigenous-centred palliative approaches to care continue to grow in meaningful ways?

Using a decolonizing and equity-centred approach to evaluate the five Indigenous-centred IEAPC initiatives supported the sharing of stories in ways that went beyond checklists and reporting requirements. Their evaluation approach focused on learning, relationships and community leadership rather than judging or extracting information. It grounded evaluation in fairness, respect and the lived realities of First Nations, Inuit and Métis Peoples (Cohen-Fournier et al. 2021; Rix et al. 2019).

## A Shared Journey

Supporting community leadership and building local capacity were at the heart of the IEAPC collaborative model. Support for the Indigenous-centred initiatives included:

- *Co-created group safety guidelines:* As a CoP, the five initiatives co-developed shared guidelines to help create a respectful space for listening, learning and open dialogue. The focus was on curiosity, reciprocity and relational accountability, with everyone sharing responsibility for supporting one another.
- *Coaching and evaluation support:* Coaches walked alongside teams rather than directing them. Their role was to support local leadership, knowledge and community priorities, not to lead the work.
- *Workshops and gatherings:* Online and in-person gatherings created opportunities to build trust, share stories and learn from one another. Learning was grounded in relationships and shared experience rather than hierarchy or top-down approaches.
- *Community-based site visits:* Visits helped ground the work

in lived experience and create space for ceremony, storytelling and reflection, while recognizing the harms many First Nations, Inuit and Métis Peoples have experienced in healthcare systems. Indigenous Knowledge systems were treated as essential.
- *Peer learning and collaboration:* Teams learned with and from one another through peer support, deep listening and relationship building.
- *Sharing circles:* Sharing circles created respectful, non-judgemental spaces for discussing challenges, making decisions and strengthening connection.
- *Reflective practice:* Team members were encouraged to reflect on how they show up in their work and relationships with First Nations, Inuit and Métis communities. This included building self-awareness, examining power and privilege, supporting one another and advocating for equitable, culturally safer care.
- *Elder involvement:* Elders helped ground the work by supporting connections to land, place, community and shared responsibility in palliative care work alongside First Nations, Inuit and Métis Peoples.



Members of the Indigenous-centred IEAPC CoP listening to Inuk Elder Meeka Kakudluk during a sharing circle session.

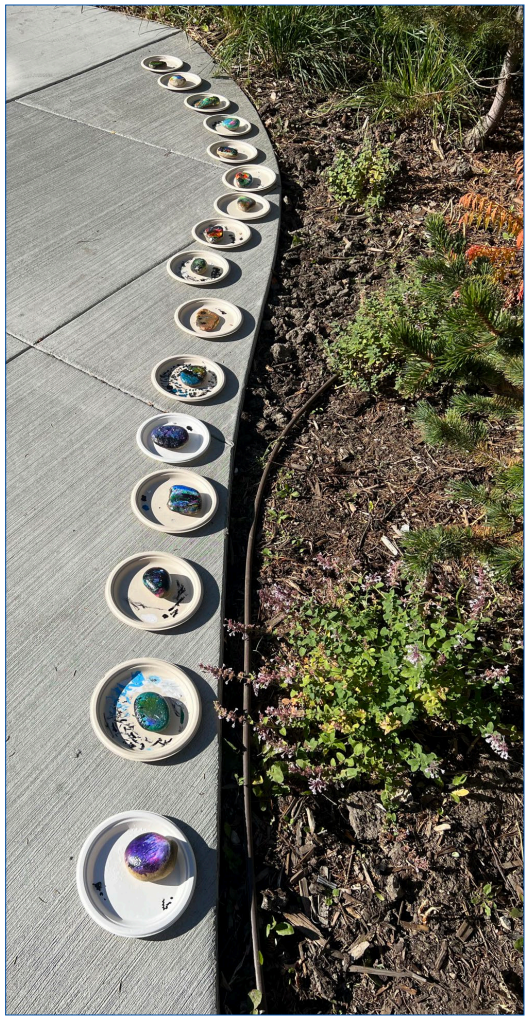
- *Arts-based and story-based approaches:* Activities such as creating infographics, talking sticks, rock paintings, collages and zines supported knowledge sharing beyond written reports and formal research methods.

## The Framework in Action

Across Alberta, Ontario and Newfoundland and Labrador, the initiatives showed that palliative approaches to care are not only clinical care. They are relational, cultural and grounded in community, land, language and ceremony. Rather than designing programs for communities, this work was created with communities and guided by local knowledge, lived experience and relationships.

Stories, images, expressive arts and shared experiences were central to understanding impact. These approaches honoured Indigenous ways of knowing and helped communities identify what was working, what needed to change and how care could better support dignity, connection and choice across the continuum of care. In Table 1, what follows is a snapshot of the five initiatives:







From top to bottom: Members of the Indigenous-centred IEAPC CoP making a talking stick; members of the CoP engaging in rock painting.




Members of the Indigenous-centred IEAPC CoP developed a "culture as medicine" zine.

**TABLE 1.**
**Snapshot of the five Indigenous-centred IEAPC initiatives (2024–2026)**

| Initiative | Where it took place | What it was about | Evaluation methods | What changed |
|---|---|---|---|---|
| Culture as Medicine: Journeying with an Indigenous Palliative Care Auntie (Edmonton, AB) | Homes, shelters, hospitals, community spaces | Relationship-based care led by an Indigenous Palliative Care Auntie, grounded in trust, presence and connection to culture, ceremony and community<br>Included smudging, pipe ceremonies, traditional songs, time on the land, working with medicine and connecting with Elders and Knowledge Keepers | Indigenous Knowledge translation (storytelling, metaphors, expressive arts)<br>Care satisfaction surveys<br>Testimonials and feedback from the Palliative Care Auntie, community partners, patients and families | Patients reported:<br>• Feeling less alone and more at peace<br>• Greater trust in care<br>• Cultural practices became part of care<br>Families and staff reported they felt more supported and confident |
| Gathering Voices, Honouring Care: A Journey in Culturally Safer Palliative Care (Bonnyville, AB) | Community gathering spaces, homes, care settings | Partnership between AHS and Cold Lake First Nations focused on listening, shared learning and shaping palliative approaches to care together<br>Included community engagement and related trauma-informed care sessions | Indigenous Knowledge translation (storytelling, metaphors, expressive arts)<br>Self-reported feedback and testimonials from this IEAPC team (members of the AHS and Cold Lake First Nations) | IEAPC team (members of the AHS and Cold Lake First Nations) reported:<br>• Stronger relationships and coordination between Cold Lake First Nations, hospitals and care teams<br>• More choice in where and how people received care<br>• Greater respect for Dene knowledge and ways of caring |
| ONGWEHÓN:WEH: All Indigenous Peoples and the Journey Home (Fort Erie, ON) | Community-based settings | Partnership between Fort Erie Native Friendship Centre and Hospice Niagara to co-create a peer support training program grounded in trust, cultural safety and supporting people through serious illness, dying and grief | Indigenous Knowledge translation (storytelling, metaphors, expressive arts)<br>Self-reported feedback from team (members of the Fort Erie Friendship Centre and Hospice Niagara) and peer support-trained volunteers and helpers | IEAPC team (members of the Fort Erie Friendship Centre and Hospice Niagara) and peer support-trained volunteers and helpers reported:<br>• Volunteers gained skills and confidence<br>• Hospice spaces felt more welcoming<br>• Patients felt more informed and empowered in their care choices |
| Our Collaborative Journey: Culture as Medicine in Palliative Care (Nain, NL) | Homes, community, clinics, hospital | Community-driven approach supporting palliative care close to home, grounded in culture, family and choice<br>Included training and community engagement dialogue sessions | Indigenous Knowledge translation (storytelling, metaphors, expressive arts)<br>Self-reports from team, along with feedback and testimonials from families and providers | IEAPC team, families and providers reported:<br>• More people received care at home<br>• Stronger teamwork<br>• Greater access to resources and understanding of palliative approaches to care |
| Walking Through the Doorway: Inuit Knowledge Guiding Palliative Approaches to Care (Ottawa, ON) | Community agencies, congregate settings, hospice | Inuit-centred approach grounded in relationships, storytelling and cultural and spiritual care<br>Included training sessions, community engagement and journey mapping conversations | Indigenous Knowledge translation (storytelling, metaphors, expressive arts)<br>Self-reports from team and feedback from community members, care providers, caregivers and organizational partners | IEAPC team and feedback from community members, care providers, caregivers and organizational partners reported:<br>• More culturally safer spaces were provided<br>• Stronger connections to language, food and community<br>• Inuit participants felt more supported and understood |

AB = Alberta; AHS = Alberta Health Services; IEAPC = Improving Equity in Access to Palliative Care; NL = Newfoundland and Labrador; ON = Ontario.

## Learnings From the Indigenous-Centred IEAPC CoP

An important aspect for these five initiatives was their work via the CoP.[4] This was more than a series of meetings. It became a circle for sharing stories, supporting one another and learning together. Elders, Knowledge Keepers, direct care workers, researchers, healthcare providers, people with lived experience and community leaders all contributed to this shared learning space.

Across the CoP, one message became clear: palliative approaches to care must reflect people's real lives. When care honours culture, language, ceremony, land, family and community, people are more likely to feel safe, respected and supported. Relationships, trust, humility and listening were at the heart of this work.

Conversations with members of the CoP highlighted how the CoP created space for First Nations, Inuit and Métis learning where teachings, experiences and approaches to palliative care could be shared in a good way. As one CoP member stated, "The Indigenous-centred IEAPC community of practice was a key part of our work. It was about many paths coming together." Others shared how they each brought their own experiences and knowledge to a space centred on connection to culture, land, community and spirit. CoP members spoke of how the united focus supported them in exploring what Indigenous-centred palliative care looked like in their own contexts: "We were all walking in the same direction: toward palliative care that is more just, more connected and more grounded in the strengths of the communities we serve."

This work showed that culturally grounded, community-led palliative approaches to care can create safer, more equitable systems of care. Continuing this work means following the leadership of First Nations, Inuit and Métis communities, valuing Indigenous Knowledge systems equally and committing to ongoing learning, relationship building and change.

## Sharing a Case Study in Indigenous-Centred Palliative Care

Storytelling, metaphors and expressive arts were central to the evaluation process. They were not simply ways to explain ideas. They were ways of knowing, learning and sharing meaning. Through stories, symbols and lived experience, Indigenous-centred IEAPC initiatives expressed relationships to land, community, culture and one another. In palliative approaches to care, this created deeper and more meaningful understandings of impact.

One example is the *Culture as Medicine: Journeying with an Indigenous Palliative Care Auntie* initiative, a partnership between NiGiNan Housing Ventures and Kokums Helper Society in Edmonton, Alberta. Led by Jackie DeCoteau-Gill, an Indigenous Palliative Care Auntie,[5] the initiative supported people nearing the end of life, many of whom had experienced harm, exclusion or racism within healthcare systems. Jackie DeCoteau-Gill walked alongside people wherever they were in their journey, offering care grounded in trust, relationship, ceremony, culture and community.

This work was not about creating another program. It was about showing up with consistency, compassion and respect. Through Jackie DeCoteau-Gill's work, culture became a living, everyday part of care. Care included sitting at the bedside, helping people get to appointments, sharing food and listening deeply. It also meant creating space for spiritual care and connection to culture through smudging, beading, making baby moccasins and ribbon skirts, sharing traditional songs, round dancing, participating in ceremony and spending time on the land. Furthermore, Jackie DeCoteau-Gill created space to talk, listen and learn from Elders and Knowledge Keepers, supporting people through grief and helping people reconnect with themselves, their communities and their ancestors. Activities such as equine therapy, grief circles, storytelling and simply holding hands became part of care and connection. Care took place in hospitals, shelters, housing settings, homes and community spaces, recognizing that palliative care happens wherever people live, gather and connect.

One of the clearest learnings from this initiative was simple: culture is medicine. As an Indigenous Palliative Care Auntie, Jackie DeCoteau-Gill's presence was not separate from care; she was part of the care itself. Ceremony, connection and spiritual care were essential to dignity, comfort and meaning at the end of life.

Feedback from patients, families, staff and partners showed that culturally grounded care helped people feel less isolated, more connected and more at peace. Practical changes emerged, including increased attendance at medical appointments, reduced fear of care and greater inclusion of cultural practices such as smudging, cedar care and traditional songs in palliative care settings.

The initiative also identified priorities for the future, including stable funding for Indigenous cultural care roles, more Indigenous care providers, flexible work structures that honour ceremony and family responsibilities, access to cultural supplies and spaces. As Jackie DeCoteau-Gill shared: "Having an Indigenous person care for Indigenous Peoples … it creates opportunities for learning, for community and for breaking down barriers."

The following infographic (see Figure 1) centres Jackie DeCoteau-Gill as a guide and Knowledge Carrier. Through symbols such as a ribbon skirt, circles, a rainbow road and scenes from urban and rural Alberta, it reflects connection, transition, community, land and spirit in relation to culturally safer palliative approaches to care.

FIGURE 1.
**Culture as Medicine: Journeying with an Indigenous Palliative Care Auntie infographic.**




Design credit: Fuselight Creative

Together, this story and infographic show how Indigenous storytelling, metaphors, expressive arts and community-led evaluation can honour lived experience, centre voices often pushed to the margins and support learning in ways that respect emotional, spiritual and relational ways of knowing.

## What Was Learned

As this work grew across the five Indigenous-centred IEAPC teams and their CoP, shared understandings began to emerge.

- *Culture is medicine.* It is not an add-on. Culture lives in relationships, ceremony, language, land and community, and supports people and families through their continuum of care across the lifespan.
- *There is no single path.* Each community leads and (re) defines palliative approaches to care in their own way.

As one Indigenous-centred IEAPC initiative lead shared: "Our palliative care initiative did not follow a straight or predictable path, but some shared patterns emerged … We created space to slow down and feel what needed to be felt, without pressure to fix or move quickly … There was a growing ability to name the gaps and systems that cause harm, rather than placing blame on individuals … We also supported reconnection with Inuit culture, language and living history in ways that felt meaningful and self-determined."

- *Stories matter.* Storytelling builds connection, shares knowledge and helps people make sense of their experiences.
- *Palliative care must be community-led.* Communities are decision makers, shaping palliative care based on their own values and knowledge: Communities are not just included; they are decision makers who shape services, guide priorities and define what matters in care.

In Nain, Labrador, *Our Collaborative Journey: Culture as Medicine in Palliative Care* was grounded in a simple but powerful idea: people should have the choice to remain in their community, surrounded by family, language, land, sea and traditions as they begin their journey into the spirit world. This work required flexibility, patience and respect, while recognizing that community members already carry deep knowledge about how to care for one another.

## What Helped This Work Succeed

- *Leadership matters at every level.* Leadership was not only found in formal roles. Across all five initiatives, people showed leadership through everyday actions and a shared commitment to equity, cultural safety and quality palliative care.
- *Time, support and resources are essential.* Teams needed time and space to learn, reflect and grow, along with stable funding, people and tools. Building culturally safer care also meant supporting an Indigenous-informed health workforce that understands trauma and centres family and community in care.

For example, the *ONGWEHÓN:WEH: All Indigenous Peoples and the Journey Home* initiative strengthened relationships between the Fort Erie Native Friendship Centre and Hospice Niagara in Fort Erie, Ontario. Through this partnership, communities and providers shared knowledge and created new ways to support Indigenous Peoples through illness, dying and grief. *ONGWEHÓN:WEH: All Indigenous Peoples and the Journey Home* trained volunteer helpers, many from local Indigenous communities, to provide palliative care peer support. The initiative also developed practical tools, including training materials and community resources. As reflected by Wanjiku Ngamau-Fulton and Eden Ewert, co-champions of *ONGWEHÓN:WEH: All Indigenous Peoples and the Journey Home:* "What is clear moving forward is that palliative care is a right. Systems need to better support community leadership, invest in relationships and remove barriers to access."

- *Culture stays at the centre.* Palliative care was most effective when culture was recognized as part of healing, not something separate. Ceremony, language, land-based practices and connections to family, community and ancestors were central to care.
- *Relationships come first.* Meaningful palliative care work depended on trust, respect and reciprocity. The focus was not on taking knowledge from First Nations, Inuit and Métis communities, but on building relationships over time through co-design, shared decision making and honouring lived experience and Indigenous ways of knowing.

As a partnership between Alberta Health Services and Cold Lake First Nations, *Gathering Voices, Honouring Care: A Shared Journey in Culturally Safer Palliative Care* brought together nurses, physicians, community health workers, Elders, leadership and families into a shared circle of care. Education sessions and community gatherings helped care teams deepen their understanding of grief, trauma and culturally safer care. These gatherings also created space for honesty, where people could share frustrations, build understanding and find solutions together.

- *Keep learning and adapting.* Teams engaged in reflection, shared learnings, adapted along the way and stayed grounded in community needs, recognizing that every community's journey is different.

What mattered most to the Indigenous-centred IEAPC teams and their CoP was walking together: learning, unlearning and shaping palliative approaches to care in ways that honour spirit, relationships, culture and community. The supports, shared learnings and promising practices in this article can be adapted across different palliative care settings while remaining grounded in local knowledge, relationships and community priorities.

## Conclusion

The work of the IEAPC collaborative and, in particular, these five initiatives and their CoP makes clear that the gaps many First Nations, Inuit and Métis Peoples experience in palliative care are rooted in ongoing colonial systems and barriers, not individual circumstances. Meaningful change requires recognizing and addressing these realities.

These initiatives show that palliative approaches to care are about more than services. They are about relationships, dignity and connection to family, community, culture and land. When care is grounded in these values, people are more likely to feel safer, respected and supported.

Throughout this work, relationships, trust, reciprocity and community leadership have been central. Cultural safety is not a one-time action but an ongoing commitment to listening, learning and changing how care is provided. Decolonizing and equity-centred approaches to learning and evaluation also matter. They value Indigenous Knowledge systems, storytelling and lived experience alongside other forms of knowledge and ask whose voices are being centred and who continues to be left out.

There is no single path forward. Each community will (re) define palliative approaches to care in ways that reflect their own strengths, knowledge and priorities. What matters is that communities are supported to lead and that their voices guide decisions at every level.

The path ahead is about continuing to walk together with respect, accountability and care, so that equitable, culturally safer and high-quality palliative approaches to care are available to all First Nations, Inuit and Métis Peoples in ways that honour their lives, identities and connections. HQ



Members of the Indigenous-centred IEAPC CoP.
*Note:* Missing from the photo is the Nain IEAPC team.

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**Notes:**

1. The Indigenous-centred Improving Equity in Access to Palliative Care (IEAPC) community of practice chose to use the term "Indigenous" to respectfully represent the collective identities of First Nations, Inuit and Métis.
2. In this article, "housing insecurity" is interchangeable with "homelessness" and "vulnerable housing."
3. The Indigenous-centred Improving Equity in Access to Palliative Care (IEAPC) community of practice (CoP) chose to use the term "Indigenous" to respectfully represent the collective identities of First Nations, Inuit and Métis.
4. A "community of practice" is a group of people who come together around a shared concern or goal. They build relationships, share knowledge and learn from one another through conversation, shared experiences and community wisdom. What matters most is their commitment to learning together and supporting each other in meaningful ways.
5. An Indigenous Auntie is a trusted and respected community member who helps care for, guide and support others. An Auntie may or may not be a biological relative. The role is grounded in relationships, responsibility, knowledge sharing and care. Aunties often share cultural teachings, offer emotional and practical support and help strengthen connection, belonging and community well-being. Their wisdom and leadership are important in keeping communities strong and connected.

## References


Bremner, L. and N. Bowman. 2023. Roots and Relations: Celebrating Good Medicine in Indigenous Evaluation. *Canadian Journal of Program Evaluation* 38(1): 1–3. doi:10.3138/cjpe.77058-en.

Bulle, S. and N. Dosani. 2026. Reflections on Innovative Models of Palliative Care Delivery. *Healthcare Quarterly 2*9(Special Issue): 29–35. doi:10.12927/hcq.2026.27966.

Cohen-Fournier, S.M., G. Brass and L.J. Kirmayer. 2021. Decolonizing Health Care: Challenges of Cultural and Epistemic Pluralism in Medical Decision-Making With Indigenous Communities. *Bioethics* 35(8): 767–78. doi:10.1111/bioe.12946.

Dodge Francis, C., N. Bowman and S. King. 2023. Kinship Pathways: Nurturing and Sustaining Resilient, Responsible, and Respected Indigenous Evaluators. *New Directions for Evaluation* 2023(177): 145–52. doi:10.1002/ev.20537.

Firestone, M., R. Maddox, P. O'Campo, J. Smylie, C. Bourgeois, S. Wolfe et al. 2020. Indigenous Health Service Evaluation: Principles and Guidelines From a Provincial "Three Ribbon" Expert Panel. *Canadian Journal of Program Evaluation* 34(3): 413–24. doi:10.3138/cjpe.68831.

Fraser, J.E. 2022. Relational Accountability: A Path Towards Transformative Reconciliation in Nursing Education. *Quality Advancement in Nursing Education* 8(3): 8. doi:10.17483/2368-6669.1360.

Gabriel, M. 2023. Our Home is Native Land: Teachings, Perspectives, and Experiences of Indigenous Houselessness. *Canadian Journal of Nonprofit and Social Economy Research* 14(S1): 93. doi:10.29173/cjnser574.

Healthcare Excellence Canada (HEC) and Canadian Partnership Against Cancer (CPAC). n.d. *Improving Equity in Access to Palliative Care Collaborative Evaluation Framework*. Retrieved August 27, 2026. <https://a-ca.storyblok.com/f/850807391887861/e763804b85/ieapc-evaluation-framework-english-web-final-ver-3.pdf>.

Hurlbut, K. and A. Brousselle. 2023. Arts-Based Evaluation. *Canadian Journal of Program Evaluation* 38(2): 408–16. doi:10.3138/cjpe-2023-0024.

Improving Equity in Access to Palliative Care (IEAPC) Program Delivery Team. 2026. The Power of the Collective: Lessons Learned From Pan-Canadian Efforts to Improve Access to More Equitable Palliative Care. *Healthcare Quarterly* 29(Special Issue): 36–45. doi:10.12927/hcq.2026.27962.

Iseke, J. 2013. Indigenous Storytelling as Research. *International Review of Qualitative Research* 6(4): 559–77. doi:10.1525/irqr.2013.6.4.559.

Locklear, S., M. Hesketh, N. Begay, J. Brixey, A. Echo-Hawk and R. James. 2023. Reclaiming Our Narratives: An Indigenous Evaluation Framework for Urban American Indian/Alaska Native Communities. *Canadian Journal of Program Evaluation* 38(1): 8–26. doi:10.3138/cjpe.75518.

O'Connor, J., M. Parman, N.R. Bowman and S. Evergreen. 2023. Decolonizing Data Visualization: A History and Future of Indigenous Data Visualization. *Journal of Multidisciplinary Evaluation* 19(44): 62–79. doi:10.56645/jmde.v19i44.783.

Prince, H. 2026. Engaging in a Relational Approach: Addressing Inequities in Access to Palliative Care for Indigenous Peoples. *Healthcare Quarterly* 29(Special Issue): 15–21. doi:10.12927/hcq.2026.27968.

Rix, E.F., S. Wilson, N. Sheehan and N. Tujague. 2019. Indigenist and Decolonizing Research Methodology. In P. Liamputtong, ed., *Handbook of Research Methods in Health Social Sciences* (pp. 253–67). Springer. doi:10.1007/978-981-10-5251-4_69.

Stajduhar, K.I. 2026. What Leaders Need to Know About the Design and Delivery of Equity-Oriented Palliative Care. *Healthcare Quarterly* 29(Special Issue): 57–62. doi:10.12927/hcq.2026.27963.

Stajduhar, K. and M. Gott. 2023. Closing the Health Equity Gap in Palliative Care: The Time for Action Is Now. *Palliative Medicine* 37(4): 424–25. doi:10.1177/02692163231164729.


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# What Leaders Need to Know About the Design and Delivery of Equity-Oriented Palliative Care

Kelli I. Stajduhar

**Key Takeaways**

- Individuals experiencing structural inequities often have more complex health needs, yet face significant barriers to accessing care, including palliative care.
- Healthcare leaders are uniquely positioned to improve health equity in palliative care in their role as decision makers, through shaping policy, allocating funding and setting priorities in the design and delivery of care.
- Inequities in care can be reduced by embedding an equity lens which can improve both access and outcomes.

**Abstract**

**Social and structural inequities disproportionately affect individuals who are experiencing homelessness or vulnerable housing, leading to poorer health outcomes and barriers to equitable, timely access to care. Building on lessons learned from the Improving Equity in Access to Palliative Care collaborative focused on this vulnerable population, this article encourages healthcare leaders to drive system-level change in palliative care by prioritizing and adopting an equity lens to build a more inclusive and effective healthcare system for those experiencing homelessness or vulnerable housing. Specifically, key considerations for the design and delivery of equity-oriented palliative care and implications for healthcare leaders are explored.**

## Background on Inequities Impacting Health

It is well established that people facing social and structural inequities, such as those experiencing homelessness or vulnerable housing, systematic discrimination and mental health or substance use challenges, experience persistent barriers to healthcare access and poorer health outcomes (McNeil and Guirguis-Younger 2012; Reilly et al. 2022; Roerig et al. 2024; Stajduhar et al. 2019). Individual experiences of inequity are considered social and structural because of ongoing and deeply embedded disadvantages within societal structures, institutions and policies that create unequal outcomes for certain groups of people compared with others (Reimer-Kirkham et al. 2016; Weinstein et al. 2017). Instead of positioning ill health as a consequence of individual-level circumstances, the concept of health equity, and by extension, inequity, acknowledges that individuals are nested within larger social, institutional, economic, historical and political structures that predispose them to negative health outcomes (Nixon 2019; Reimer-Kirkham et al. 2016; Sítima et al. 2024). The "cure" for inequities in health, therefore, lies in removing obstacles to health such as poverty, discrimination and deep-seated social and systemic barriers that prevent certain groups from accessing healthcare and other essential resources that promote health and well-being (Braveman et al. 2018, p. 3).

Structural inequities accelerate aging-related health conditions, leading to disproportionately higher rates of cancer and other chronic diseases (Bourgeois et al. 2023; Santos Salas et al. 2023), especially among First Nations, Inuit and Métis (Browne et al. 2016; Nguyen et al. 2020). Despite their complex health needs, people who experience inequities encounter significant challenges in accessing healthcare, including at the end of life (Hudson et al. 2016; Shulman et al. 2018; Stajduhar et al. 2019). Palliative care aims to improve quality of life for individuals with serious illnesses and has a longstanding history of providing person-centred care that prioritizes the unique needs, values and preferences of

individuals living with life-limiting conditions (Reason and Paltser 2023). Grounded in a holistic approach, palliative care has been instrumental in improving quality of life, enhancing symptom management and ensuring dignity at the end of life. Through its integration into mainstream healthcare systems, palliative care has contributed to the development of networks of support that engage families, healthcare providers and broader social structures in care. This approach has led to improved healthcare experiences, more appropriate utilization of services and overall reductions in healthcare costs by preventing unnecessary hospitalizations and ensuring that care is delivered in the most appropriate settings (CIHI 2023).

## Palliative Care in the Context of Structural Vulnerabilities

Palliative care in Canada has made significant strides in improving the quality of life for individuals with serious illnesses. These advances have strengthened healthcare systems and fostered the development of compassionate communities and care teams that can support improved person-centred care experiences at the end of life for Canadians who are able to receive such services.

While palliative care has been highly effective in meeting the needs of mainstream populations, it has, to a large degree, not equitably serviced individuals facing structural inequities. People experiencing poverty, homelessness or vulnerable housing, racial discrimination and geographic barriers – such as those living in rural and remote communities – continue to encounter significant challenges in accessing high-quality palliative care (Stajduhar et al. 2020b). Structural vulnerabilities, including inadequate housing, lack of culturally safe care and systemic biases within healthcare institutions, mean that many people facing inequities do not receive the same level of person-centred, compassionate care as others (Purkey and MacKenzie 2019). While substantial attention has been directed toward addressing health inequities at the population health and systems levels across Canada, until now, little progress has been made in identifying approaches to reduce health inequities in the context of palliative and end-of-life care.

A key priority in Canada's Action Plan for Palliative Care (Health Canada 2019) is to foster improved access to palliative care for underserved populations. One mechanism for addressing this key priority has been through the establishment of the Improving Equity in Access to Palliative Care collaborative, a partnership between Healthcare Excellence Canada and the Canadian Partnership Against Cancer (detailed further in IEAPC Delivery Team 2026a and IEAPC Delivery Team 2026b).

This article shares key considerations for delivering equity-oriented palliative care and engaging healthcare leaders to build a more inclusive and effective healthcare system for those experiencing homelessness or vulnerable housing. We hope that this article can inspire others to embark upon or continue their own improvement journeys to make palliative care more accessible to every person, including those who experience greater inequity in access to care.

## Key Considerations for the Design and Delivery of Equity-Oriented Palliative Care

Over the years, extensive research has identified the key components of high-quality palliative care, including effective symptom management, integrating family members into the care circle, ensuring that individuals can die in their preferred setting – most often at home – and taking into account emotional, psychosocial and spiritual aspects of care that are aligned with a person's needs and wishes. Palliative care is unique in its focus not only on care of the person as they are living and dying, but also on the family through recognition of the importance of support through grief and bereavement (Giesbrecht et al. 2023). These principles have shaped mainstream approaches to palliative care and have contributed to improved end-of-life experiences for many. However, for individuals facing structural inequities, these ideals are often out of reach due to systemic barriers such as inadequate access to culturally safe care, financial instability, housing insecurity and experiences of discrimination within the healthcare system (Klop et al. 2018; Sítima et al. 2024; Stajduhar et al. 2020a). Equity-oriented palliative care requires a shift beyond conventional models to actively recognize these key challenges and barriers to care while also understanding that the current ideals set forth within palliative care services require contextualization and adaptation if we are to realize equity in palliative care.

Key considerations include the following:

1. Recognizing that palliative care services and the potential benefits of palliative care are largely unknown to people who experience inequities and the sectors (i.e., housing, harm reduction, outreach, mental health and addictions services, etc.) that commonly support them (Henry et al. 2017; Roerig et al. 2024; Stajduhar et al. 2019).
2. Understanding that, in the context of inequity, addressing the social determinants of health is a key palliative care intervention that must be prioritized (Henry et al. 2017; Horvick and Dias 2024).
3. Appreciating that the need to prioritize daily survival (for food and shelter) often makes accessing palliative care services a low priority for many people who experience structural inequities (Stajduhar et al. 2019, 2024).
4. Acknowledging that most healthcare and palliative care services are not designed for populations experiencing inequities (Giesbrecht et al. 2018; Stajduhar et al. 2019; West et al. 2020).
5. Realizing that significant gaps exist between healthcare,

social services and mental health and addictions services, leaving vulnerable individuals without proper support when they are on a palliative trajectory (McNeil and Guirguis-Younger 2012; Stajduhar et al. 2020a; Stajduhar et al. 2020b; Webb et al. 2024).

6. Identifying those who could benefit from palliative care is complex in high-risk communities where many are at risk of dying (Stajduhar et al. 2020a; Stajduhar et al. 2020b).
7. Recognizing that family caregivers – those who provide most of the care in the community and of which palliative care services are dependent upon – are not often present for people who experience structural inequities (Mollison et al. 2025; Rosenwohl-Mack et al. 2019; Stajduhar et al. 2020b).
8. Realizing that community service workers providing care act as de facto family members and experience profound but unrecognized grief because of their care work (Giesbrecht et al. 2023; Stajduhar et al. 2020a). See article by Black and Laing in this issue for a detailed commentary on this topic (Black et al. 2026).
9. Understanding that there exists a lack of knowledge related to integrating palliative approaches to care among community service workers and tools to support them in their work, while at the same time recognizing that much of the work associated with care of the dying lies outside the scope of their workplace roles (Stajduhar et al. 2020a, 2024).
10. Acknowledging the need to shift our care approaches and models to "meet people where they are at," including supporting outreach, bed-based and community models as key promising practices for the design and delivery of equitable access to palliative care (Johnson et al. 2024; Robinson et al. 2022; Stajduhar et al. 2024) that recognizes the need for trauma- and violence-informed approaches to care, promotion of substance use health and implementation of culturally safe care practices (Ko et al. 2015; Quinn et al. 2024).

Recognizing and responding to the social determinants of health, integrating community-based and culturally relevant supports and ensuring flexible, person-centred approaches that prioritize the needs and voices of structurally marginalized populations is key to realizing equity in palliative care. Without these considerations, palliative care risks reinforcing inequities rather than alleviating them.

### Implications of These Key Considerations for Healthcare Leadership

Healthcare leaders must recognize that not all populations have equitable access to high-quality palliative care. Without an intentional focus on equity, palliative care can unintentionally reinforce these disparities, leaving the most marginalized individuals without the support they need at the end of life. An equity-oriented approach to palliative care requires addressing these systemic barriers by integrating culturally responsive care, reducing logistical and financial obstacles and ensuring that policies and programs are designed with the needs of structurally vulnerable populations in mind. Unpublished pilot data also suggest cost-saving to the healthcare system by the implementation of equity-oriented models of palliative care. For example, in a preliminary analysis of healthcare utilization data from Victoria's mobile Palliative Outreach Resource Team (PORT) in its first year of operations, 71% of emergency room and 57% of hospital admissions were avoided. Applying the key considerations described in this article, Medavie Community Paramedicine in Moose Jaw, Saskatchewan (part of the Improving Equity in Access to Palliative Care collaborative) has launched community-based palliative wellness clinics in familiar settings such as the John Howard Society. Staffed with advanced care/community paramedics, these clinics deliver vital-sign monitoring, wound assessments and seamless referrals to health and social support services and increased access to care. Between April 2023 and March 2024, they received over 412 initial referrals and conducted more than 1,072 follow-up visits, averting an estimated 595 emergency department visits and hospital admissions by providing timely care within a trusted community environment. These data, while preliminary, suggest that programs and services such as these not only improve care outcomes but also have the potential to avoid healthcare utilization costs.

**Beyond policy and** resource allocation, healthcare leaders also play a critical role in fostering a culture of equity within their institutions.

Healthcare leaders are uniquely positioned to advance equity in palliative care. Leaders have the influence, resources and strategic oversight needed to drive meaningful change. As decision makers in health systems, leaders shape policies, allocate funding and set priorities that determine who receives care and how it is delivered. By embedding equity into their organizational mandates, leaders can ensure that palliative care services are accessible, culturally responsive and tailored to the needs of people who face structural inequities.

Beyond policy and resource allocation, healthcare leaders also play a critical role in fostering a culture of equity within their institutions. Specifically, healthcare leaders can support policy and service redesign that prioritizes structurally vulnerable populations facing end of life, promote cross-sector collaboration to reduce silos in care, implement training opportunities for healthcare providers and community workers

to support high-risk communities in accessing equity-oriented palliative approaches to care and encourage innovative and scalable models of care to enhance accessibility. They also have the authority to implement workforce training that enhances cultural humility, advocate for care delivery models that integrate the social determinants of health and establish partnerships with community organizations that serve underserved populations. Leaders can also champion research and data collection that highlight gaps in palliative care access, using this evidence to advocate for system-wide reforms. Ultimately, healthcare leaders have a responsibility to ensure that the principles of high-quality palliative care – dignity, choice and comfort – are available to all, regardless of socioeconomic status, race, geography or other factors. By prioritizing equity, leaders can help create a healthcare system where every person receives the compassionate, person-centred care they deserve at the end of life.

## Conclusion

Healthcare systems can unintentionally deepen health inequities, particularly for people who often face stigma, discrimination and systemic barriers when seeking care. By prioritizing equity in palliative care, healthcare leaders can drive system-level change that improves outcomes for the most underserved populations. Building on lessons learned from the Improving Equity in Access to Palliative Care collaborative and over a decade of Canadian research on equity-oriented palliative care, Canada is well positioned to improve timely access to high-quality palliative care through an equity lens. For healthcare leaders, adopting this lens is not only a matter of social justice but also a crucial step toward building a more inclusive and effective healthcare system. HQ

## References


Black, J., S. Laing, R. Carter, S. Landry, J.R. Graham and E. Hassan. 2026. Grief and Bereavement in the Context of Homelessness: Sharing Experiences and Learnings From British Columbia. *Healthcare Quarterly 29*(Special Issue): 22–28. doi:10.12927/hcq.2026.27967.

Bourgeois, A., T.C. Horrill, A. Mollison, L.K. Lambert and K.I. Stajduhar. 2023. Barriers to Cancer Treatment and Care for People Experiencing Structural Vulnerability: A Secondary Analysis of Ethnographic Data. *International Journal for Equity in Health* 22(1): 58. doi:10.1186/s12939-023-01860-3.

Braveman, P., E. Arkin, T. Orleans, D. Proctor, J. Acker and A. Plough. 2018. What Is Health Equity? *Behavioral Science & Policy* 4(1): 1–14. doi:10.1353/bsp.2018.0000.

Browne, A.J., C. Varcoe, J. Lavoie, V. Smye, S.T. Wong, M. Krause et al. 2016. Enhancing Health Care Equity With Indigenous Populations: Evidence-Based Strategies From an Ethnographic Study. *BMC Health Services Research* 16(1): 544. doi:10.1186/s12913-016-1707-9.

Canadian Institute for Health Information (CIHI). 2023. *Access to Palliative Care in Canada*. Retrieved May 08, 2025. <https://www.cihi.ca/sites/default/files/document/access-to-palliative-care-in-canada-2023-report-en.pdf>.

Giesbrecht, M., A. Mollison, K. Whitlock and K.I. Stajduhar. 2023. "Once You Open That Door, It's a Floodgate": Exploring Work-Related Grief Among Community Service Workers Providing Care for Structurally Vulnerable Populations at the End of Life Through Participatory Action Research. *Palliative Medicine* 37(4): 558–66. doi:10.1177/02692163221139727.

Giesbrecht, M., K.I. Stajduhar, A. Mollison, B. Pauly, S. Reimer-Kirkham, R. McNeil et al. 2018. Hospitals, Clinics, and Palliative Care Units: Place-Based Experiences of Formal Healthcare Settings by People Experiencing Structural Vulnerability at the End-of-Life. *Health & Place* 53: 43–51. doi:10.1016/j.healthplace.2018.06.005.

Health Canada. 2019, October. *Action Plan on Palliative Care: Building on the Framework on Palliative Care in Canada.* Retrieved May 08, 2025. <https://www.canada.ca/content/dam/hc-sc/documents/services/health-care-system/reports-publications/palliative-care/action-plan-palliative-care/action-plan-palliative-care-eng.pdf>.

Henry, B., N. Dosani, L. Huynh and N. Amirault. 2017. Palliative Care as a Public Health Issue: Understanding Disparities in Access to Palliative Care for the Homeless Population Living in Toronto, Based on a Policy Analysis. *Current Oncology* 24(3): 187–91. doi:10.3747/co.24.3129.

Horvick, S. and N. Dias. 2024. Palliative Care Providers' and Administrators' Perspectives on Integrating Community-Based Palliative Care Using the Social Determinants of Health Framework. *Palliative Medicine Reports* 5(1): 81–85. doi:10.1089/pmr.2023.0048.

Hudson, B.F., K. Flemming, C. Shulman and B. Candy. 2016. Challenges to Access and Provision of Palliative Care for People Who Are Homeless: A Systematic Review of Qualitative Research. *BMC Palliative Care* 15(1): 96. doi:10.1186/s12904-016-0168-6.

Improving Equity in Access to Palliative Care (IEAPC) Program Delivery Team. 2026b. Improving Equity in Access to Palliative Care for Communities Experiencing Homelessness or Vulnerable Housing. *Healthcare Quarterly* 29(Special Issue): 5–10. doi:10.12927/hcq.2026.27970.

Improving Equity in Access to Palliative Care (IEAPC) Program Delivery Team. 2026. The Power of the Collective: Lessons Learned From Pan-Canadian Efforts to Improve Access to More Equitable Palliative Care. *Healthcare Quarterly* 29(Special Issue): 36–45. doi:10.12927/hcq.2026.27962.

Johnson, I.M., A.C. Traver and M.A. Light. 2024. Resident Care in the "In-Between Time": Cross-Sector Perspectives on Enhancing Synergy Between Palliative Care and Permanent Supportive Housing. *Journal of Health and Human Services Administration* 47(3–4): 76–88. doi:10.1177/10793739241253222.

Klop, H.T., A.J.E. de Veer, S.I. van Dongen, A.L. Francke, J.A.C. Rietjens and B.D. Onwuteaka-Philipsen. 2018. Palliative Care for Homeless People: A Systematic Review of the Concerns, Care Needs and Preferences, and the Barriers and Facilitators for Providing Palliative Care. *BMC Palliative Care* 17(1): 67. doi:10.1186/s12904-018-0320-6.

Ko, E., J. Kwak and H. Nelson-Becker. 2015. What Constitutes a Good and Bad Death?: Perspectives of Homeless Older Adults. *Death Studies* 39(7): 422–32. doi:10.1080/07481187.2014.958629.

McNeil, R. and M. Guirguis-Younger. 2012. Illicit Drug Use as a Challenge to the Delivery of End-of-Life Care Services to Homeless Persons: Perceptions of Health and Social Services Professionals. *Palliative Medicine* 26(4): 350–59. doi:10.1177/0269216311402713.

Mollison, A., M. Gagnon, R. McNeil, A. Stewart, M. Giesbrecht, A. Bourgeois et al. 2025. "None of It Turned Out the Way She Wanted, so It Left a Hole in Me": Informal Caregiving at the End of Life in Contexts of Inequity. *Health & Social Care in the Community* 2025: 8788241. doi:10.1155/hsc/8788241.

Nguyen, N.H., F.B. Subhan, K. Williams and C.B. Chan. 2020. Barriers and Mitigating Strategies to Healthcare Access in Indigenous Communities of Canada: A Narrative Review. *Healthcare* 8(2): 112. doi:10.3390/healthcare8020112.

Nixon, S.A. 2019. The Coin Model of Privilege and Critical Allyship: Implications for Health. *BMC Public Health* 19(1): 1637. doi:10.1186/s12889-019-7884-9.

Purkey, E. and M. MacKenzie. 2019. Experience of Healthcare Among the Homeless and Vulnerably Housed a Qualitative Study: Opportunities for Equity-Oriented Health Care. *International Journal for Equity in Health* 18(1): 101. doi:10.1186/s12939-019-1004-4.

Quinn, S., L. Ferguson, D. Read and N. Richards. 2024. "The Great Escape": How an Incident of Elopement Gave Rise to Trauma Informed Palliative Care for a Patient Experiencing Multiple Disadvantage. *BMC Palliative Care* 23(1): 61. doi:10.1186/s12904-024-01374-x.

Reason, B. and G. Paltser. 2023. Access to Palliative Care in Canada. *Healthcare Quarterly* 26(2): 6–8. doi:10.12927/hcq.2023.27140.

Reilly, J., I. Ho and A. Williamson. 2022. A Systematic Review of the Effect of Stigma on the Health of People Experiencing Homelessness. *Health & Social Care in the Community* 30(6): 2128–41. doi:10.1111/hsc.13884.

Reimer-Kirkham, S., K. Stajduhar, B. Pauly, M. Giesbrecht, A. Mollison, R. McNeil et al. 2016. Death is a Social Justice Issue: Perspectives on Equity-Informed Palliative Care. *Advances in Nursing Science* 39(4): 293–307. doi:10.1097/ANS.0000000000000146.

Robinson, L., L. Trevors Babici, A. Tedesco, D. Spaner, T. Morey and N. Dosani. 2022. Assessing the Impact of a Health Navigator on Improving Access to Care and Addressing the Social Needs of Palliative Care Patients Experiencing Homelessness: A Service Evaluation. *Palliative Medicine* 37(4): 646–51. doi:10.1177/02692163221146812.

Roerig, M., M. Albert, H. Marani and S. Allin. 2024, May. *Supporting Equitable Access to Health and Social Services for People Experiencing Homelessness in Ontario*. North American Observatory on Health Systems and Policies. Retrieved May 08, 2025. <https://naohealthobservatory.ca/wp-content/uploads/2024/08/NAO-Rapid-Review-44_EN.pdf>.

Rosenwohl-Mack, S., M. Kushel, C. Ramsey, M. Handley and K.R. Knight. 2019. "We Really Help, Taking Care of Each Other": Older Homeless Adults as Caregivers. *Gerontology and Geriatric Medicine* 5: 2333721419894765. doi:10.1177/2333721419894765.

Santos Salas, A., C. Bablitz, H. Morris, L. Vaughn, O. Bardales, J. Easaw et al. 2023. Improving Access to Palliative Care for People Experiencing Socioeconomic Inequities: Findings From a Community-Based Pilot Research Study. *Chronic Diseases in Canada* 43(8): 365–74. doi:10.24095/hpcdp.43.8.02.

Shulman, C., B.F. Hudson, J. Low, N. Hewett, J. Daley, P. Kennedy et al. 2018. End-of-Life Care for Homeless People: A Qualitative Analysis Exploring the Challenges to Access and Provision of Palliative Care. *Palliative Medicine* 32(1): 36–45. doi:10.1177/0269216317717101.

Sítima, G., C. Galhardo-Branco and P. Reis-Pina. 2024. Equity of Access to Palliative Care: A Scoping Review. *International Journal for Equity in Health* 23(1): 248. doi:10.1186/s12939-024-02321-1.

Stajduhar, K.I., A. Mollison, M. Giesbrecht, R. McNeil, B. Pauly, S. Reimer-Kirkham et al. 2019. "Just Too Busy Living in the Moment and Surviving": Barriers to Accessing Health Care for Structurally Vulnerable Populations at End-of-Life. *BMC Palliative Care* 18(1): 11. doi:10.1186/s12904-019-0396-7.

Stajduhar, K.I., M. Giesbrecht, A. Mollison, K. Whitlock, P. Burek, F. Black et al. 2024. "You Can't Die Here": An Exploration of the Barriers to Dying-in-Place for Structurally Vulnerable Populations in an Urban Centre in British Columbia, Canada. *BMC Palliative Care* 23(1): 12. doi:10.1186/s12904-024-01340-7.

Stajduhar, K.I., M. Giesbrecht, A. Mollison and M. d'Archangelo. 2020a. "Everybody in This Community is at Risk of Dying": An Ethnographic Exploration on the Potential of Integrating a Palliative Approach to Care Among Workers in Inner-City Settings. *Palliative & Supportive Care* 18(6): 670–75. doi:10.1017/S1478951520000280.

Stajduhar, K.I., M. Giesbrecht, A. Mollison, N. Dosani and R. McNeil. 2020b. Caregiving at the Margins: An Ethnographic Exploration of Family Caregivers Experiences Providing Care for Structurally Vulnerable Populations at the End-of-Life. *Palliative Medicine* 34(7): 946–53. doi:10.1177/0269216320917875.

Webb, L., G. Yarwood, G. Witham, S. Wright and S. Galvani. 2024. Providing Holistic End-of-Life Care for People With a History of Problem Substance Use: A Mixed Methods Cohort Study of Interdisciplinary Service Provision and Integrated Care. *BMC Palliative Care* 23(1): 86. doi:10.1186/s12904-024-01416-4.

Weinstein, N.J., A. Baciu, A. Geller and Y. Negussie. 2017. The Root Causes of Health Inequity. In *Communities in Action: Pathways to Health Equity* A. Baciu, Y. Negussie, A. Geller, and J.N. Weinstein (Eds.) (pp. 99–184). National Academies Press.

West, K.J., B. Wrobel, S. Pallotta and A. Coatsworth. 2020. Bearing Witness: Exploring the End-of-Life Needs of Homeless Persons and Barriers to Appropriate Care. *Omega: Journal of Death and Dying* 82(1): 63–91. doi:10.1177/0030222818801150.

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# Reflections From Our Collaborative Journey: A Collective Vision for Palliative Care in Canada

Improving Equity in Access to Palliative Care Program Delivery Team (including* Clarissa Chan, Andrea Coronado, Kristen DeCaria, Emilie Desmottes, Amber Heyd, Mihaela Labbe, Kirstin Loates, Tanya MacDonald, Nicole Robinson, Raquel Shaw Moxam and Lindsay Yarrow)

**Key Takeaways**

- It is essential that we find new and innovative ways of working together to improve access to healthcare for people experiencing homelessness or vulnerable housing across Canada. This collaborative has highlighted the art of the possible and helped identify key elements that are needed for organizational-, community- and system-level changes to improve equitable access to care.
- There is no single model for equity-oriented palliative care; care needs to be tailored to local needs and address social determinants of health. The collaborative found that effective approaches vary by community and may include mobile care teams, outreach services, bed-based programs, integrated clinical pathways and capacity-building initiatives.
- Opportunities for future investments and work in palliative care include redesigning and exploring new models of care that are purpose-built to meet the needs of individuals and communities who face challenges in accessing many current palliative care services. In addition to improving equitable access to care, these models may offer cost- and resource-saving benefits by making more effective use of healthcare and community resources. There are communities doing this work well, and they can serve as a guidepost to others.

**Abstract**

**In this concluding article, Healthcare Excellence Canada (HEC) and the Canadian Partnership Against Cancer (the Partnership) reflect on a collective journey with 23 communities across the country to improve equitable access to palliative care. Responding to lessons learned shared throughout this special issue, HEC and the Partnership offer key takeaways and actions to shape a future where everyone has access to safe and high-quality palliative care.**

## Introduction

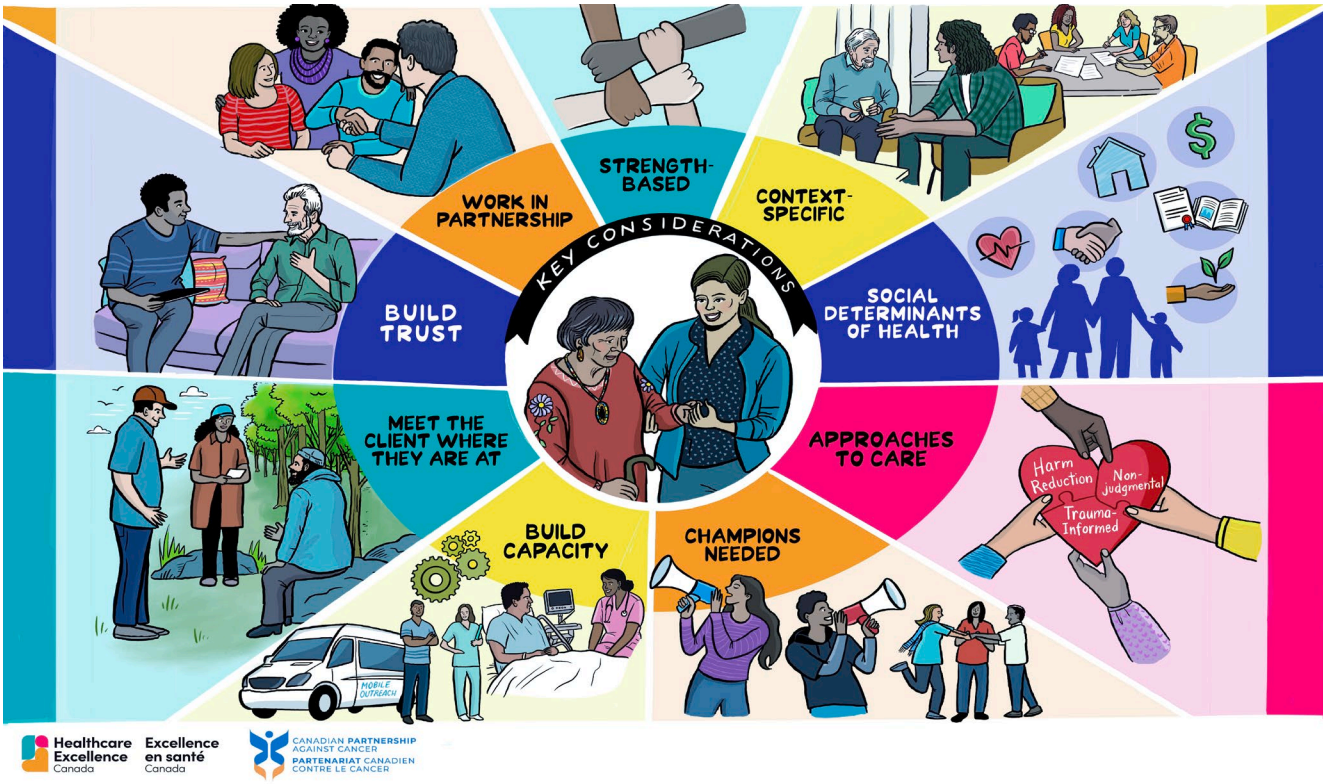
To support progress toward the objectives of the Framework on Palliative Care in Canada (Health Canada 2018) and the Federal Action Plan on Palliative Care (Health Canada 2019), Healthcare Excellence Canada (HEC) and the Canadian Partnership Against Cancer (the Partnership) launched the Improving Equity in Access to Palliative Care (IEAPC) collaborative in 2022 with the aim to foster improved access to care for people experiencing homelessness or vulnerable housing (HEC 2026a). This collaborative sought to live the values of inclusion, innovative partnership and meaningful engagement by bringing together health, housing, social service, harm reduction and First Nations, Inuit and Métis partners to co-design community-led solutions grounded in lived experiences. With over $2.2 million in seed funding from Health Canada, this collaborative brought together 23 communities across eight provinces to develop new or adapt locally tailored models of equity-oriented palliative care. A defining feature of the collaborative was its emphasis on learning across communities through coaching, peer-to-peer networking, site visits and an all-teach-all-learn approach. The collaborative also prioritized meaningful engagement of people with lived and living experience and First Nations, Inuit and Métis guidance, including a dedicated Indigenous-centred[1] community of practice and evaluation process.

*In alphabetical order.

The IEAPC collaborative improved equitable access to care by supporting low-barrier, trauma-informed and culturally safer models that brought care directly to people in shelters, supportive housing, community agencies, homes and outdoor settings. Rather than expecting people to navigate complex health systems, teams focused on meeting people where they were, building trust, integrating health and social supports and addressing practical barriers to care. As a result of the 23 IEAPC initiatives, over 11,000 patients, caregivers and providers were reached. In addition, the collaborative has been able to demonstrate the economic benefit of equity-oriented mobile models of palliative care. A cross-provincial economic analysis demonstrated that equity-oriented mobile models of palliative care have the potential to result in high-quality, safer care while also resulting in considerable cost savings (IEAPC Program Delivery Team 2026). The analysis found cost savings such as $9,600 in net avoided emergency costs per patient who accessed the program studied. At scale, the evaluators found that a $1 million investment in equity-oriented mobile models of palliative care could result in $2.65 million in avoided emergency costs (Edge Health 2026).

Through this work, 11 promising practices were identified as leading innovative equity-oriented palliative care models serving people experiencing homelessness or vulnerable housing in Canada (HEC 2026b). These promising practices highlight key considerations of equity-oriented palliative care to inform the design, delivery and evaluation of initiatives both within and beyond the IEAPC collaborative (see Figure 1). For the 23 teams and their coaches, they have served both as foundation practices as well as inspiration for many of the initiatives supported through the collaborative.

FIGURE 1.
**Promising practices in improving equity in access to palliative care**




While this special issue describes a collaborative initiative to improve access to equity-oriented palliative care for people experiencing homelessness or vulnerable housing, the implications of this work are transferable across the continuum of care for underserved populations. This special issue features perspectives and key learnings on applying a decolonizing evaluation approach, wise practices for relational engagement, innovative service delivery models, integrating workers with lived and living experience into the care team and grief and bereavement in the context of homelessness.

In this concluding article, we share reflections on the collaborative, our learnings and our shared vision for palliative care in Canada. Beyond this collaborative, we present a series of opportunities for decision makers to consider as we look to shape a future where everyone has access to safe and high-quality care.

## Reflections From Our Collaborative Journey

### Addressing structural inequities as a foundation for care

A central lesson emerging from the collaborative is that equitable access to palliative care cannot be achieved without addressing the structural and social determinants of health. Across the articles, authors consistently demonstrate that inequities driven by racism, colonization, stigma and social exclusion shape both access to care and health outcomes. Improving access therefore requires models that intentionally respond to the broader realities of people's lives. Diner (2026) shares stories of patients who have accessed care that highlight these inequities and how they drive access and outcomes in care.

Bulle and Dosani (2026) framed how individuals experiencing homelessness or vulnerable housing face unique and often unaddressed challenges in accessing care. They highlighted that effective and impactful models of palliative care delivery must address the social determinants of health as a core component of care delivery and gave us examples of programs that have successfully done this including La Maison du Père in Quebec and George's House in Alberta. Prince (2026) extends this discussion by examining the enduring impacts of colonization on First Nations, Inuit and Métis Peoples and the need to address structural barriers to care. Similarly, Stajduhar (2026) emphasizes that equity-oriented palliative care must place the social determinants of health at its centre, noting that interventions that fail to do so risk perpetuating inequities rather than reducing them.

Collectively, these contributions reinforce a key lesson from IEAPC: equity-oriented palliative care is a person-centred approach that recognizes and responds to the conditions that shape people's ability to access care.

### Designing context-specific and wholistic models

A second theme across the special issue is the importance of designing palliative care models that are responsive to local context. Rather than promoting a single model of care, the authors emphasize the value of common principles that can be adapted to meet the unique needs, strengths and priorities of individual communities.

For example, we know that care in rural and remote communities may inherently look different than care in urban centres as the resources and strengths of each of these communities are unique (CIHI 2023). As Stajduhar (2026) explained, equity-oriented palliative care goes beyond mainstream approaches to recognize and address system barriers, requiring a shift toward developing policies and programs with the needs of those who are underserved in mind. Building on this concept, Bulle and Dosani (2026) identify four emerging approaches across the IEAPC collaborative: mobile-based care and outreach services, equity-oriented clinical pathways, bed-based end-of-life care and capacity-building through engagement. While these approaches differed across communities, they shared a commitment to reducing barriers, meeting people where they are and leveraging local strengths and partnerships. This diversity reflects one of the collaborative's key learnings: successful models are community-driven rather than prescribed. The ability of teams to adapt principles to their local context enabled innovation and responsiveness, while remaining grounded in a shared commitment to equity.

**... equity-oriented palliative** care is a person-centred approach that recognizes and responds to the conditions that shape people's ability to access care.

### Flexible and inclusive approaches to evaluation

The special issue also highlights the importance of evaluation approaches that reflect the complexity, diversity and relational nature of equity-oriented work. Many existing evaluation methods alone may not adequately capture community impact, relationship-building, cultural relevance, local definitions of success or the ways change unfolds within complex systems. Instead, evaluation must be responsive to context, meaningful to communities and capable of integrating multiple forms of knowledge and evidence (Ward et al. 2018).

The IEAPC Evaluation Framework (HEC and CPAC n.d.), described by the IEAPC Program Delivery Team (2026), was intentionally designed as a flexible roadmap rather than a prescriptive reporting tool. Developed through a co-creation process involving community teams, advisers with lived and living experience, Elders, First Nations, Inuit and Métis advisers and subject matter experts, the framework was grounded in principles of equity, collaboration, adaptability and relevance. Recognizing that communities varied significantly in evaluation readiness, resources and capacity, the framework allowed teams to document and interpret progress in ways that reflected their local context while remaining aligned with shared goals of improving equity, safety and quality of care.

Caverley (2026) further expands on these ideas by emphasizing the importance of decolonizing evaluation practices. Through the Indigenous-centred community of practice, evaluation incorporated storytelling, art, metaphor, community reflection and Indigenous ways of knowing alongside more mainstream measures. These approaches challenged

traditional assumptions about what constitutes evidence and demonstrated how evaluation can honour culture, relationships, lived experience and community knowledge while still generating valuable insights for improvement.

Collectively, this approach demonstrates that evaluation is most effective when it is adaptable, inclusive and grounded in the realities of the communities involved. Flexible evaluation approaches that value relationships, local context, multiple ways of knowing and both process and outcome measures are required for understanding and advancing equitable access to care.

### Building relationships and working in partnership

Across the articles in this special issue, relationships emerge as a foundational requirement for improving equitable access to care. Several authors emphasize the building or rebuilding of trust and development of relationships between individuals, communities and the healthcare system as well as partnering in meaningful ways to collectively leverage community strengths to improve access to care. In part, this involves deep consideration of the historical and ongoing impacts that contribute to mistrust in the healthcare system for many underserved groups (Diner 2026; Prince 2026). Caverley (2026) reinforced this in her article, where she highlights a key evaluation finding that relationships are the foundation of meaningful palliative care.

It is well known that access to First Nations, Inuit and/or Métis-led and culturally safer palliative care is lacking with disparities often being even more pronounced in rural and remote areas where individuals have to travel outside of their communities to access care in settings that can be unsafe (CIHI 2023). Prince (2026) discusses the necessity of building trust and establishing meaningful partnerships with First Nations, Inuit and Métis in the journey toward more equitable and culturally safer care. But before this can happen, Prince reinforces that pre-engagement work is a requirement of organizations and individuals including examples such as engaging in critical self-reflection, cultural safety training and learning about the historical and ongoing impacts of colonialism as precursors to effective engagement and relationship building. Caverley demonstrates what this work can look like through the lens of five teams via the Indigenous-Centered community of practice and shares lessons learned that can be incorporated into future work, including putting relationships first, keeping culture at the centre and finding ways to honour spirit, relationships and community.

Partnerships are also highlighted as critical at organizational and system levels. Stajduhar (2026) highlights the responsibility of healthcare leaders to establish meaningful partnerships with community-based organizations that already serve people experiencing homelessness or vulnerable housing. These organizations often have the closest connection to underserved populations but may lack the capacity to provide palliative approaches to care without healthcare system partners. This is consistent with findings from Black et al. (2026), indicating the need for greater collaboration between housing services/shelters and grief and bereavement organizations as a shared opportunity to build capacity and improve supports.

Relationship building and partnership must also occur at the interdisciplinary team level. Diner (2026) highlighted how inaccessible the healthcare system can be for people experiencing structural vulnerabilities. Workers with lived and living experience offer the human connection, dignity and compassion needed to establish trusting relationships and can leverage their expertise to bridge care gaps.

### Strength-based approaches and meeting people where they are at

Finally, the special issue highlights the importance of approaches that recognize people's strengths, dignity and humanity. Across diverse models and settings, authors consistently emphasize that equitable care requires providers to meet people where they are.

Diner (2026) shares her experience of working within the system, providing a rich illustration of the importance of meeting people where they are at, both figuratively and literally. Compounded by racism, discrimination and stigma from previous experiences in institutional settings, workers with lived experience recognize and understand that building trusting relationships takes time and can be the difference between someone continuing with care or walking away. Recognizing and valuing the inherent strengths, dignity and humanity of each person is fundamental in this effort.

Bulle and Dosani (2026) identify approaches such as trauma-informed care and harm reduction as foundation principles in many collaborative initiatives and promising practices, stating "by acknowledging the complex realities faced by structurally vulnerable populations, these initiatives provide care that is rooted in love, dignity and understanding, rather than judgement or exclusion." (p. 32)

The importance of supporting not only individuals but also families, chosen families, communities and care providers is further reinforced by Black et al. (2026), who highlight the often-overlooked impact of grief and bereavement among people experiencing homelessness. They remind us that supports must be flexible, culturally safe and delivered by trusted community members. Similarly, Caverley (2026) underscores the role of community, connection and Indigenous ways of knowing in fostering healing, belonging and compassionate care.

Taken together, these reflections suggest that equity-oriented palliative care is most effective when it builds on individual and community strengths, honours relationships and adapts care to the realities of people's lives rather than expecting people to adapt to the system.

## Advancing Equity in Access to Palliative Care in Canada

As we conclude this special issue, we outline the conditions required to advance equitable access to palliative care in Canada.

### 1. Support the implementation, spread and scale of equity-oriented models of palliative care in familiar and trusted settings

The current palliative care system is highly integrated in mainstream healthcare, including hospitals and home care where substantial structural barriers to care exist for people experiencing homelessness or vulnerable housing and other structurally vulnerable populations. Equity-oriented mobile models of care are just one example of how care outside of hospital can help us improve access to care. Across the IEAPC collaborative, teams that served patients directly delivered care in community agencies, shelters, supportive housing and other non-traditional settings, reaching more than 11,000 patients and caregivers who may otherwise have remained disconnected from care. Through outreach services, home visits, community paramedicine programs and improved clinical pathways and coordination among providers, individuals were able to receive support earlier and in settings that aligned with their needs (IEAPC Program Delivery Team 2026). Economic evaluation findings from mobile-based palliative care models demonstrate that equity-oriented mobile palliative care models could avoid approximately $9,600 in emergency healthcare costs per patient accessing the program and generate a positive return on investment (HEC and CPAC 2026; IEAPC Program Delivery Team 2026).

### 2. Develop care pathways that offer low-barrier services to individuals experiencing structural vulnerabilities

In many provinces and territories, palliative care referral pathways are limited through traditional homecare services, creating further structural barriers with respect to access. Creating low-barrier referral processes and embedding care where individuals with structural vulnerabilities already receive care and feel safe can improve access to and quality of care delivered. Evaluation findings from mobile and outreach teams found that 72% of care recipients surveyed reported they would not have sought care that day if it were not for the local program, highlighting the importance of bringing services directly into communities (IEAPC Program Delivery Team 2026).

### 3. Design equity-oriented models of care with sustainability in mind to fully realize their benefits

Services and staffing models that provide palliative care to people experiencing homelessness or vulnerable housing and other structurally vulnerable populations need to be embedded in existing healthcare systems and structures and where necessary provided sustainable funding. Providing funding to equity-oriented models has the potential for cost savings across the broader system and ensuring care is delivered in the right place at the right time as shared in the economic evaluation findings above (HEC and CPAC 2026; IEAPC Program Delivery Team 2026).

### 4. Enable flexible compensation and funding models to improve access to care

Physician compensation models often require clients to be enrolled in a publicly funded provincial/territorial health plan (i.e., have a health card), therefore limiting access to care in the absence of alternative billing options to care for individuals without a health card. Centering care around the individual requires flexibility in billing and funding structures for physician and care teams. IEAPC collaborative teams often shared that administrative barriers, insurance requirements and difficulties navigating healthcare systems can create significant access challenges for people experiencing homelessness, vulnerable housing and other forms of structural vulnerability. Teams consistently emphasized the importance of low-barrier approaches that prioritize patient needs over administrative requirements and enable providers to deliver care in flexible, community-based settings.

### 5. Expand safer, trauma-informed, culturally responsive care closer to home and community

Improving access to care in rural and remote areas would reduce the number of individuals required to travel outside of their community to access this care. Engaging the community, leveraging interprofessional care models, providing infrastructure to support end-of-life (e.g., pain pumps, narcotics lock boxes in homes), improving cultural safety of care and incorporating Indigenous ways of knowing and doing are just some of the ways we can increase access to care closer to home and community. Within the IEAPC collaborative, over 3,500 individuals received training to strengthen access to palliative care closer to home and community, including harm reduction, cultural safety training and advanced care planning. Across communities, teams consistently identified these approaches as essential to help people feel respected, understood and able to engage in care.

## Conclusion

While it is evident that we are not at the finish line, we hope to have illustrated through this special issue that improving access to care and creating an equitable healthcare system is an ongoing collaborative journey. And like most system transformations, it must happen by working together. This collective journey is filled with promise and hope, but to be successful in achieving our intended outcomes, we must be prepared to do things differently. This includes engaging the community, considering new and innovative models of care, building relationships and partnerships, moving beyond the walls of the hospital and bringing care to the places where people are and where they feel safe. We must work across systems with new partners who bring strengths and expertise to this work that may not exist within the healthcare system. We must consider the ongoing and historical impacts of colonization and commit to culturally safer care through meaningful engagement with First Nations, Inuit and Métis and centering their experience and knowledge.

The Federal Framework on Palliative Care outlined a path forward by identifying opportunities for improvement across the healthcare system with reference to existing efforts and best practices to help guide the way. The IEAPC collaborative has provided important insights into the conditions required to advance equitable access to palliative care in Canada. It has accelerated learning, strengthened evidence for effective approaches and demonstrated the value of collaborative action across sectors. While significant work remains, the findings provide a strong foundation for the spread and scale of proven innovations and support ongoing efforts to ensure all people in Canada have access to safe, high-quality palliative care. HQ

### Acknowledgment

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### Disclaimer

This work is supported by HEC. HEC works with partners across the country to shape a future where everyone in Canada has safe and high-quality healthcare. We bring together people, evidence and action to move Care Forward – spreading and scaling quality and safety improvements, strengthening capacity and collective leadership and catalyzing policy and practice change. HEC is an independent, not-for-profit charity funded primarily by Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.

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### Note:

1. The Indigenous-centred community of practice chose to use the term "Indigenous" to respectfully represent the collective identities of First Nations, Inuit and Métis.

### References

Black, J., S. Laing, R. Carter, S. Landry, J.R. Graham and E. Hassan. 2026. Grief and Bereavement in the Context of Homelessness: Sharing Experiences and Learnings From British Columbia. *Healthcare Quarterly 29*(Special Issue): 22–28. doi:10.12927/hcq.2026.27967.

Bulle, S. and N. Dosani. 2026. Reflections on Innovative Models of Palliative Care Delivery. *Healthcare Quarterly 29*(Special Issue): 29–35. doi:10.12927/hcq.2026.27966.

Canadian Institute for Health Information (*CIHI*). 2023. *Access to Palliative Care*. Retrieved March 17, 2025. <https://www.cihi.ca/sites/default/files/document/access-to-palliative-care-in-canada-2023-report-en.pdf>.

Caverley, N. 2026. Many Paths, Walking Together: Honouring Collective Reflections in Indigenous-Centred Palliative Care in Canada. *Healthcare Quarterly* 29(Special Issue): 46–56. doi:10.12927/hcq.2026.27964.

Diner, J. 2026. Bridging the Gap: Why Lived Experience Is Essential in Palliative Care for the Unhoused. *Healthcare Quarterly* 29(Special Issue): 11–14. doi:10.12927/hcq.2026.27969.

Edge Health. 2026. Report on Equity-Oriented Mobile-Based Palliative Care Programs in Canada [Internal Report].

Health Canada. 2018. *Framework on Palliative Care in Canada*. Retrieved February 25, 2025. <https://www.canada.ca/content/dam/hc-sc/documents/services/health-care-system/reports-publications/palliative-care/framework-palliative-care-canada/framework-palliative-care-canada.pdf>.

Health Canada. 2019. *Action Plan on Palliative Care: Building on the Framework on Palliative Care in Canada*. Retrieved February 25, 2025. <https://www.canada.ca/content/dam/hc-sc/documents/services/health-care-system/reports-publications/palliative-care/action-plan-palliative-care/action-plan-palliative-care-eng.pdf>.

Healthcare Excellence Canada (HEC). 2026a. *Improving Equity in Access to Palliative Care*. Retrieved September 1, 2026. <https://www.healthcareexcellence.ca/en/what-we-do/all-programs/improving-equity-in-access-to-palliative-care/>.

Healthcare Excellence Canada (HEC). 2026b. *Promising Practices for Improving Equity in Access to Palliative Care*. Retrieved September 1, 2026. <https://www.healthcareexcellence.ca/resources/improving-equity-in-access-to-palliative-care-promising-practices>.

Healthcare Excellence Canada (HEC) and Canadian Partnership Against Cancer (CPAC). 2026, September. *Investing in Equity: An Economic Analysis of Equity-Oriented Mobile Palliative Care Models in Canada.* <https:// https://www.healthcareexcellence.ca/resources/investing-in-equity>.

Healthcare Excellence Canada (HEC) and Canadian Partnership Against Cancer (CPAC). n.d. *Improving Equity in Access to Palliative Care Collaborative Evaluation Framework*. Retrieved August 27, 2026. <https://a-ca.storyblok.com/f/850807391887861/e763804b85/ieapc-evaluation-framework-english-web-final-ver-3.pdf>.

Improving Equity in Access to Palliative Care (IEAPC) Program Delivery Team. 2026. The Power of the Collective: Lessons Learned From Pan-Canadian Efforts to Improve Access to More Equitable Palliative Care. *Healthcare Quarterly* 29(Special Issue): 36–45. doi:10.12927/hcq.2026.27962.

Prince, H. 2026. Engaging in a Relational Approach: Addressing Inequities in Access to Palliative Care for Indigenous Peoples. *Healthcare Quarterly* 29(Special Issue): 15–21. doi:10.12927/hcq.2026.27968.

Stajduhar, K.I. 2026. What Leaders Need to Know About the Design and Delivery of Equity-Oriented Palliative Care. *Healthcare Quarterly* 29(Special Issue): 57–62. doi:10.12927/hcq.2026.27963.

Ward, M., A.J. Schulz, B.A. Israel, K. Rice, S.E. Martenies and E. Markarian. 2018. A Conceptual Framework for Evaluating Health Equity Promotion Within Community-Based Participatory Research Partnerships. *Evaluation and Program Planning* 70: 25–34. doi:10.1016/j.evalprogplan.2018.04.014.

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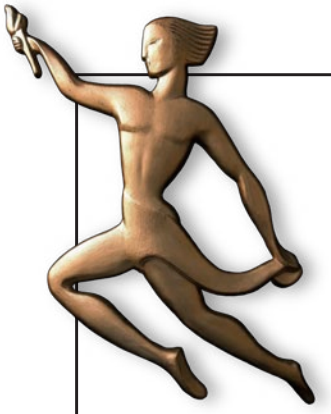
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