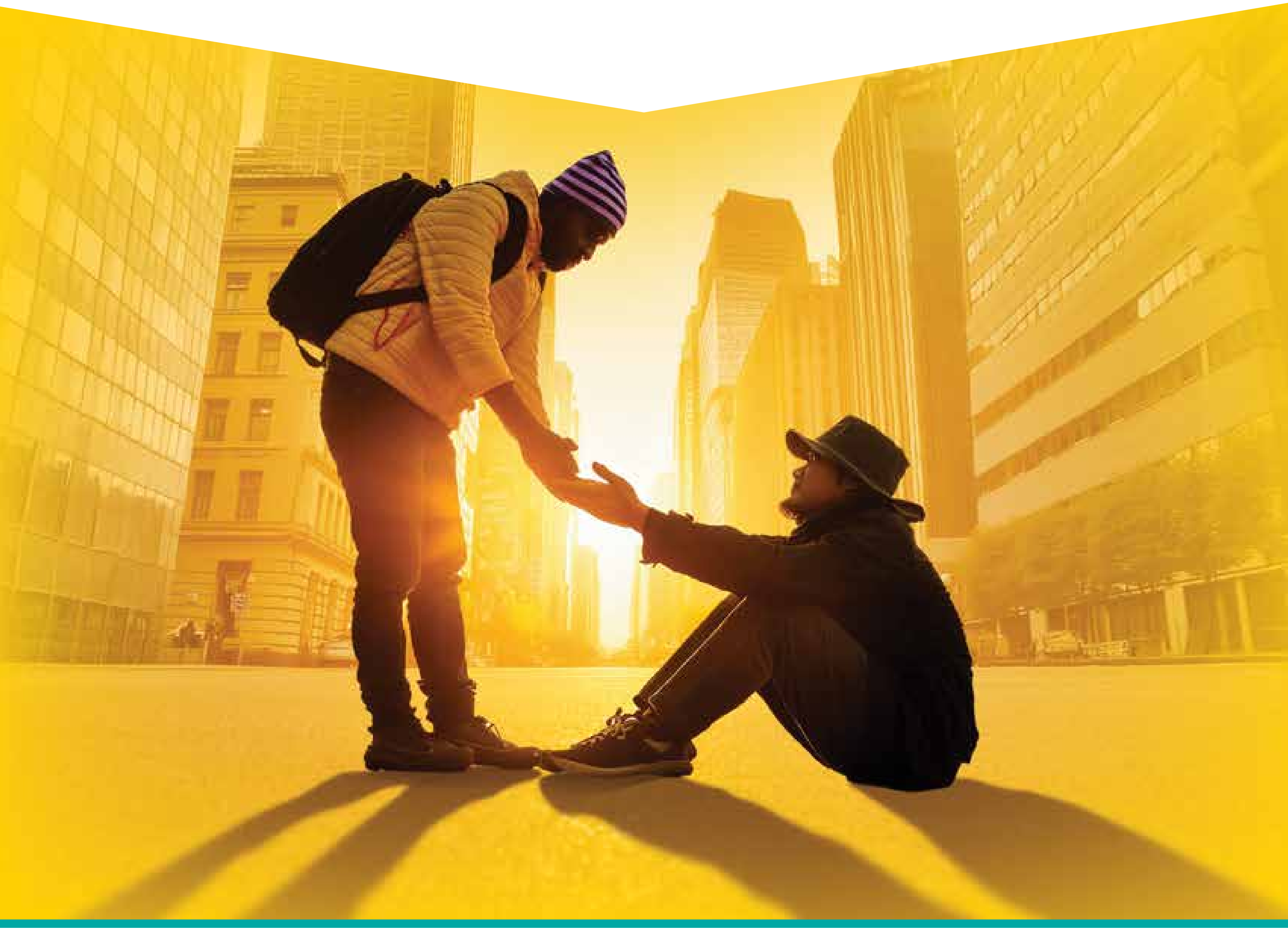
# Improving Equity in Access to Palliative Care Collaborative
## Evaluation Framework



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# Acknowledgements

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# Executive Summary

People experiencing homelessness or vulnerable housing often have complex health needs and may experience more negative health outcomes compared to their housed peers. For example, they may experience social isolation, poverty, substance use and mental illness. These health dimensions can lead to unique needs at the end of life and premature death.

When people struggle daily for basic amenities (for example, safe and stable housing, clean water and sanitation), their wholistic health needs (physical, mental, emotional and spiritual) move down the priority list. This process is worsened by experiences of stigma, racism, discrimination and barriers in accessing care in biomedical healthcare settings.

Health inequities and the effects of colonization in Canada are interrelated. Within the Canadian context, First Nations, Inuit and Métis homelessness can't be separated from ongoing dispossession from traditional lands, intergenerational trauma and violence, systemic racism and high rates of child apprehension. Overrepresentation of First Nations, Inuit and Métis Peoples among people experiencing homelessness or vulnerable housing is directly related to these factors rooted in settler-colonialism.

Despite well-known and researched health inequalities, people experiencing homelessness or vulnerable housing don't have the same access to palliative approaches to care in Canada as their housed peers, creating further inequities in care and health outcomes.

Though faced with immense challenges as noted above, people experiencing homelessness or vulnerable housing have demonstrated remarkable resilience, strength and community mobilization in advocating for their rights and improving health outcomes. Core values, cultures, worldviews, diverse communities and ways of being are important sources of strength for people experiencing homelessness or vulnerable housing, their chosen families and communities.

In response to the *Federal Action Plan on Palliative Care*, HEC and the Partnership (IEAPC Team) is delivering the Improving Equity in Access to Palliative Care (IEAPC) collaborative, a relational-oriented program. The IEAPC collaborative assists communities across Canada to design, deliver and evaluate initiatives that provide palliative approaches to care with and for people experiencing homelessness or vulnerable housing. The IEAPC Program Team is funding a total of 23 initiatives across Canada until 2026 to improve access to care, care experiences and health outcomes.

The IEAPC collaborative is committed to strengthening palliative care resources and improving equity in services for underserved populations, ensuring that their unique experiences are valued and supported.

Creating, understanding and sharing the stories of IEAPC-funded initiatives and the collaborative through evaluation is important.

Evaluation stories greatly assist in making continuous improvements in palliative approaches to care: being more equitable, becoming safe/safer and improving quality of care. Therefore, the IEAPC Evaluation Framework serves as a meaningful and flexible road map for the IEAPC collaborative and IEAPC-funded initiatives to evaluate their journey.

Taking a decolonized approach to program evaluation, the framework summarizes and organizes key dimensions of the IEAPC collaborative. The framework provides meaningful and reflective evaluation options to IEAPC-funded project teams in response to their evaluation and reporting state of readiness, organizational size, context and capacity. Taking this approach to evaluation aligns with the overall spirit and intent of equity in relation to the IEAPC collaborative and the work of the IEAPC-funded project teams.

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# Context

Palliative care programs in Canada have not always paid attention to the social and structural conditions that affect the needs of homeless people. According to Reimer-Kirkham et al.,

> most definitions of palliative care and current palliative care approaches do not make explicit the additional attention needed to address social and structural inequities that profoundly shape health, illness, and dying experiences for people who are made particularly vulnerable by a constellation of sociopolitical, economic, cultural, and historical forces. [1(p294)]

People experiencing homelessness or vulnerable housing often have complex health needs and may experience more negative health outcomes compared to their housed peers. For example, they may experience social isolation, poverty, substance use and mental illness. These health dimensions can lead to unique needs at the end of life and premature death.

When people struggle daily for basic amenities (for example, safe and stable housing, clean water and sanitation), their wholistic health needs (physical, mental, emotional and spiritual) move down the priority list. This process is worsened by experiences of stigma, racism, discrimination and barriers in accessing care in biomedical healthcare settings.

Health inequities and the effects of colonization in Canada are interrelated. Within the Canadian context, First Nations, Inuit and Métis homelessness can't be separated from ongoing dispossession from traditional lands, intergenerational trauma and violence, systemic racism and high rates of child apprehension. Overrepresentation of First Nations, Inuit and Métis Peoples among people experiencing homelessness or vulnerable housing is directly related to these factors rooted in settler-colonialism.[2,3,4]

Despite well-known and researched health inequalities, people experiencing homelessness or vulnerable housing don't have the same access to palliative approaches to care in Canada as their housed peers, creating further inequities in care and health outcomes.

Though faced with immense challenges as noted above, people experiencing homelessness or vulnerable housing have demonstrated remarkable resilience, strength and community mobilization in advocating for their rights and improving health outcomes. Core values, cultures, worldviews, diverse communities and ways of being are important sources of strength for people experiencing homelessness or vulnerable housing, their chosen families and communities.

To enrich meaningful engagement and corresponding action in equitable access to palliative care, all orders of government must actively participate in the form of partnerships and collaborations. They must work alongside people experiencing homelessness or vulnerable housing, their chosen families, communities, healthcare and social service providers to enhance capacity for palliative care. The more palliative care resources for people experiencing homelessness or vulnerable housing, their chosen families and communities, the better.

Culturally appropriate palliative approaches to care also play vital roles in addressing health disparities and promoting wholistic well-being.

The *Federal Action Plan on Palliative Care* highlights the importance of taking action to improve access to palliative care for underserved populations.

As a society, we look to shape a future where everyone in Canada has safe and high-quality healthcare. Improving equitable access to palliative approaches to care aims to help people experiencing homelessness or vulnerable housing (1) to receive appropriate care in a timely and safe way without discrimination, (2) to receive palliative care with dignity in the environment of their choice, and (3) to reduce emergency department visits and admissions while keeping in mind individuals' goals of care.

## Improving Equity in Access to Palliative Care Collaborative

In response to the *Federal Action Plan on Palliative Care*, HEC and the Partnership (IEAPC Program Team) is delivering the IEAPC collaborative, a relational-oriented program.

The IEAPC collaborative assists communities across Canada to design, deliver and evaluate initiatives that provide palliative approaches to care with and for people experiencing homelessness or vulnerable housing.

The IEAPC Program Team is funding a total of 23 initiatives across Canada until 2026 to improve access to care, care experiences and health outcomes.

Notable supports for IEAPC-funded initiatives include

- multi-year funding
- learning and networking opportunities
- capacity building support (for example, subject matter expert coaching)
- partnership development with people who have experienced homelessness or vulnerable housing
- partnership development with First Nations, Inuit and Métis communities
- co-development of resources that support partnerships and improve equitable access to palliative approaches to care

The IEAPC collaborative is committed to strengthening palliative care resources and improving equity in services for underserved populations, ensuring that their unique experiences are valued and supported.

Creating, understanding and sharing the stories of IEAPC-funded initiatives and the collaborative through evaluation is important. Evaluation stories greatly assist in making continuous improvements in palliative approaches to care: being more equitable, becoming safe/safer and improving quality of care.

For the purpose of this evaluation framework, the term 'palliative care' is intended to be inclusive. Therefore, 'palliative care' and 'palliative approaches to care' are used interchangeably.

## Purpose of the framework

### What is an Evaluation Framework?

Evaluation is the way a team arrives at understanding a program: What works? Why does it work? What has happened throughout the program journey?

An evaluation framework is a tool that presents an overview of the evaluation methods and practices.

An evaluation framework:

-assists with identifying planned evaluation activities

-helps to clarify the scope and scale of an evaluation

-supports communication between the evaluation team and the evaluation participants

-documents impact through creating, understanding and sharing stories about the program journey

The IEAPC Evaluation Framework serves as a meaningful and flexible road map for the IEAPC collaborative and IEAPC-funded initiatives to evaluate their journey. The evaluation framework can help users create key questions, design the evaluation, collect and analyze data and share knowledge.

Specifically, the IEAPC Evaluation Framework ensures that evaluation processes, practices, methods, measures and timelines are representative and adaptable to the context of the IEAPC collaborative and IEAPC-funded initiatives.

# IEAPC Evaluation Framework

The IEAPC Evaluation Framework moves beyond a checklist by supporting IEAPC-funded project teams in creating, understanding and sharing their stories about improving equitable access to palliative approaches to care with and for people experiencing homelessness or vulnerable housing.

Taking a decolonized approach to program evaluation,[1] the framework summarizes and organizes key dimensions of the IEAPC collaborative. The framework provides meaningful and reflective evaluation options[2] to IEAPC-funded project teams in response to their evaluation and reporting state of readiness, organizational size, context and capacity. Taking this approach to evaluation aligns with the overall spirit and intent of equity in relation to the IEAPC collaborative and the work of the IEAPC-funded project teams.

**Decolonization in program evaluation**

Decolonization is the process of returning power to Indigenous Peoples, supporting self-determination and self-governance and respecting nation-to-nation governance.

In a program evaluation context, decolonization means confronting and challenging colonial evaluation practices, reflecting on the structure of evaluation (questions, design, data collection, analysis, knowledge sharing) and considering how project teams will tell the story of their IEAPC-funded initiatives.

Decolonization in program evaluation includes recognizing Indigenous data sovereignty as a cornerstone of cultural resurgence and nation (re) building, which involves collecting data and using it with the intent to benefit Indigenous Peoples, families and communities.

An urgent priority of decolonization is to eliminate discrimination and racism (includes anti-Indigenous racism) in the healthcare and social service systems and its effects on people experiencing homelessness or vulnerable housing.

Following are some examples of decolonizing practices in evaluation:

-Acknowledge and address the legacy and the continuous effects and implications of colonialism in evaluation, particularly evaluation on Indigenous Peoples and communities.

-Recognize that since evaluation has long been practiced with a colonizing approach, it is common for Indigenous groups, communities and organizations to mistrust evaluators, particularly external evaluators who represent orders of government. This heightened mistrust is due to the living history of colonial policies and laws affecting and influencing Indigenous communities over the generations.

-Have an open discussion (involving funders, program managers, Indigenous groups/communities/organizations, evaluators) about successful and less successful strategies to establish new partnerships and co-create trust throughout the evaluation journey. This process includes, when possible, supporting Indigenous-led and -informed evaluation journeys where Indigenous groups/communities/organizations determine their evaluation question(s).

-Use collaborative, ethical and culturally congruent guidelines that weave Indigenous knowledge with non-Indigenous evaluation methods and practices.

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[1] A decolonized approach to program evaluation recognizes strengths-based methodologies and data.

[2] Evaluation options include evaluation processes, practices, methodologies, sample measures and proposed timelines.

-Develop evaluation relationships that give space for dissent; that are non-extractive and inclusive; that privilege Indigenous knowledge, values and languages; and that promote relationships outside the evaluation space. These relationships provide a deeper connection with the group/community/organization such as learning about and participating in cultural events.

-Recognize that ethics are not uniform across all cultures. Rather, evaluators need to consider each group/community/organization's ethics to avoid exploitation, community damage and erroneous data.

-Co-create time and space for reflection during the lifecycle of the evaluation.

-Continue to sustain relationships with Indigenous groups/communities/organizations and communicate about opportunities that they may be interested in (for example, continuing evaluation in an identified area, building data management capacity, transforming evaluation stories into knowledge resources).

The IEAPC Evaluation Framework can provide

- structure to support the continuous improvement efforts of IEAPC-funded initiatives
- a knowledge base for how evaluations can aid in identifying lessons learned and promising practices by and for communities: that is, nothing about us, without us
- a way of documenting IEAPC case studies on innovative models of care that can be scaled, adapted and applied
- a common set of guiding principles for the IEAPC collaborative while respecting diverse equity-oriented approaches to palliative care across IEAPC-funded initiatives in Canada
- recognition that evaluation is integral to the IEAPC collaborative

The IEAPC collaborative benefits when it weaves evaluation, like the strands of a blanket, throughout the lifecycle of the initiative.

The IEAPC Evaluation Framework needs multi-year funding to be fully realized. Multi-year funding and related evaluation resources (technical and human) can strengthen and support the capacity needed to document the stories of IEAPC-funded initiatives in improving equitable access to palliative approaches to care with and for people experiencing homelessness or vulnerable housing.

## Who is the framework for?

The IEAPC Evaluation Framework is a resource for

- urban, northern and rural **IEAPC-funded project teams** across Canada
- **leadership and program staff from HEC and the Partnership** who are responsible for the design of strategies, programs and resources in improving equitable access to care
- **the funder**, Health Canada, who sets funding priorities in the continuum of care (includes palliative care) with provincial/territorial healthcare authorities, including policy and decision-makers

The IEAPC Evaluation Framework facilitates a meaningful and reflective approach in creating, understanding and sharing the stories of IEAPC-funded initiatives in improving equitable access to palliative approaches to care with and for people experiencing homelessness or vulnerable housing.

## Why should I use this framework?

To support sustainable program design and delivery in improving equitable access to palliative approaches to care with and for people experiencing homelessness or vulnerable housing, the IEAPC Evaluation Framework

- assists IEAPC-funded teams to weave customized evaluation planning into their initiatives
- uses a decolonized approach to program evaluation that recognizes strengths-based methodologies and data
- provides evaluation options for documenting the stories of IEAPC-funded initiatives
- promotes collaborations, networking and partnerships within and between IEAPC-funded initiatives about evaluation
- supports continuous improvement to further develop IEAPC evaluation planning, resource development and capacity building

IEAPC-funded project teams can use the IEAPC Evaluation Framework to reflect on guiding principles and shared understandings about the collaborative. From there, the framework aids in the application, adaptation and customization of evaluation activities that can support creating, understanding and sharing stories about the IEAPC journey in respective communities.

Overall, the framework provides pathways for IEAPC-funded initiatives in their proof of concept to make a case for long-term planning for sustainable program development, implementation and continuous improvement.

For a list of key terms used in the IEAPC Evaluation Framework, please refer to Appendix A.

# Introduction

The IEAPC collaborative benefits from having common guiding principles, shared understandings, and a meaningful and flexible suite of evaluation practices that support continuous improvement.

These practices include

- accessing up-to-date palliative and end-of-life care data to help fully address the social determinants of health and develop wholistic strategies in community-driven palliative approaches to care
- recognizing the importance of collecting relevant data to advocate for necessary changes to improve equitable access to palliative approaches to care with and for people experiencing homelessness or vulnerable housing

## What is palliative care?

Palliative care is an approach that aims at reducing suffering and improving the quality of life for people throughout the course of their serious illness. This care also includes supporting families in their grief and loss.

Examples of serious illnesses are cancer, dementia, organ failure and neurological diseases.

Palliative care focuses on the whole person and their chosen family, which includes providing physical, emotional, mental and spiritual support and honouring cultural protocols, values, beliefs and wishes.

According to the World Health Organization (WHO), palliative care[5]

- provides relief from pain and other distressing symptoms
- affirms life
- regards dying as a normal process
- neither hastens nor prolongs death
- integrates psychological and spiritual aspects of care
- offers a support system to help patients live actively as long as possible
- is a support system to help the family cope both before and after their loved one's death
- uses a team approach to address needs of people and their chosen families
- enhances quality of life
- is applicable early in the course of an illness

For some First Nations, Inuit and Métis Peoples, families and communities, the term palliative care means comfort care.[6]

Comfort care provides cultural contexts that acknowledge the role of values, identities, families and communities. With a focus on compassion, kindness and quality of life, comfort care honours the rights, spiritual beliefs, cultural protocols and practices of people living with a serious illness. In addition to care focusing on the whole person, comfort care supports the whole family and community surrounding people with a serious illness.[6] Furthermore, for many First Nations, Inuit and Métis Peoples, families and communities, dying and death are not just about biomedical and physical processes. They are about an individual's transition to the spirit world – social and spiritual events to be honoured and celebrated as a collective.[6]

Learn about First Nations, Inuit and Métis approaches to palliative and end-of-life care in Canada.

## What is equity-oriented palliative care?

Equity-oriented palliative care addresses social determinants of health, recognizes system barriers and seeks to address them, ensuring access to high-quality care.

Integrating an equity-oriented palliative approach to care means creating an environment where all people can access the support needed from the time of diagnosis of the serious illness. This integration includes addressing the social determinants of health and providing care that is free of racism, stigma and discrimination with a harm reduction approach to allow access to quality palliative care.

People experiencing homelessness or vulnerable housing should have a fair opportunity to die with dignity in ways that meet them where they are at.

Equity-oriented palliative care ranges from mobile and outreach services; bed-based and hospice services; hospitals and regional health authorities to serving First Nations, Inuit and Métis communities.

## Serious illnesses

Serious illnesses are most likely complex, progressive chronic diseases. The following table provides examples of serious illnesses.

| Serious illness | Description |
|---|---|
| **Cancer** | Cancer remains the leading cause of death in Canada.<br>Tumours are benign, precancerous or malignant. Cancer is organized into five main types: carcinoma (cancer of epithelial cells, for example, breast, lung and colon cancer); sarcoma (cancer of bones and soft tissues, for example, leiomyosarcoma, liposarcoma and osteosarcoma); lymphoma (cancer of the immune system) and myeloma (cancer of plasma cells); leukemia (cancer of the blood cells); and brain and spinal cord cancers (cancers of the central nervous system). |
| **Dementia** | This disease causes a deterioration of the brain. The disease progresses gradually and slowly. Dementia worsens over time and can result in aspiration (pneumonia) and decreased food intake. |
| **Heart disease and heart failure** | his disease involves damage to the heart, whereby the heart cannot properly pump blood throughout the body. Complications from heart disease include weakness and breathing difficulties. Heart failure may cause the buildup of fluid in the lungs, legs and abdomen. |

| Serious illness | Description |
|---|---|
| **Kidney failure** | This condition involves damage to the kidneys which decreases one’s ability to maintain normal body functions.<br>Complications with kidney failure include high blood pressure, anaemia (low blood count), buildup of toxic breakdown products from the body, weak bones and nerve damage. |
| **Liver failure** | This condition involves damage to the liver (cirrhosis) which puts one at higher risk of confusion, bleeding, blood clots and fluid accumulation, including in the legs and abdomen (ascites). Liver failure can also increase toxic substances in the blood. |
| **Neurological diseases** | Illnesses such as multiple sclerosis, amyotrophic lateral sclerosis and Parkinson’s disease affect the nervous system and can lead to weakness and impair movement. |
| **Pulmonary disease** | Lung disease, such as chronic obstructive pulmonary disease, emphysema and chronic bronchitis, causes breathing difficulties. Complications from lung disease can include infection and increased respiratory demand requiring oxygen. |

## Social determinants of health

In addition to understanding serious illnesses, we cannot fully transform palliative care for people experiencing homelessness or vulnerable housing without recognizing the social determinants of health and how settler-colonialism and health inequities affect palliative care (1) becoming more equitable, (2) becoming safe/safer and (3) improving in quality. Homelessness is a life-limiting condition.

Social determinants of health are complex and multifaceted social and economic factors that exert a profound influence on the overall health and well-being of populations. These determinants encompass a wide range of interconnected factors that extend beyond the realm of healthcare, shaping the living conditions, resources and opportunities available to individuals and communities. By affecting various aspects of their lives, social determinants significantly impact the daily physical, mental, emotional and spiritual well-being of people experiencing homelessness or vulnerable housing.

According to WHO, the following are examples of social determinants of health.[7] Where possible, these examples are adapted to contextualize the social determinants of health in relation to people experiencing homelessness or vulnerable housing.

| Social determinant of health | Description |
|---|---|
| **Income and social protection** | This determinant includes<br>-people and groups accessing equitable economic diversification and employment opportunities that provide income.<br>-people who can or would usually provide healthcare and social services for people experiencing homelessness or vulnerable housing who have serious illnesses.<br>-people with community responsibilities who may need to leave work to help with dying and death protocols and ceremonies for people experiencing homelessness or vulnerable housing. |
| **Employment and job security** | Income influences living conditions that affect health-related behaviours (for example, diet and nutrition, substance use). |
| **Education** | This determinant includes access to educational opportunities to support career-life development.<br>Education and literacy (including health literacy) barriers can prevent people experiencing homelessness or vulnerable housing and their chosen families from having clear communications with healthcare and social service providers and may prevent informed decision-making regarding access to healthcare services, social service resources and supports. |
| **Working life conditions** | This determinant focuses on the conditions and demands of employment on people. |
| **Food security** | This determinant includes people having access to food as one of the basic needs in life for health and human dignity.<br>Access to traditional food not only provides nourishment but (re) connection with cultural practices that relate to ceremonies and protocols, particularly as they relate to dying and death. |
| **Housing, basic amenities and the environment** | This determinant includes people experiencing homelessness or vulnerable housing having access to the basic needs in life (for example, housing, water quality).<br>People experiencing homelessness or vulnerable housing lack the necessary housing, basic amenities and environment to access equitable healthcare and social service supports such as palliative care. |

| Social determinant of health | Description |
|---|---|
| **Early childhood development** | This determinant includes people having access to economic, social and cultural resources to support healthy child development.<br>This determinant also influences future health and social service trends in areas such as palliative care. |
| **Social inclusion and non-discrimination** | This determinant includes colonization, racism, discrimination, lack of self-determination, oppression, marginalization, intergenerational trauma and social inequities.<br>Intergenerational trauma resulting from colonization has and continues to affect many people experiencing homelessness or vulnerable housing. These factors influence health decisions that affect the ability of people experiencing homelessness or vulnerable housing and their chosen families to access palliative care programs, services and resources.<br>This determinant includes the role of community as part of the continuum of care and social support circle for people experiencing homelessness or vulnerable housing and their chosen families.<br>This determinant also includes cultures and languages. Depending on where one has access to palliative care, the care may not be provided in languages or by providers that have knowledge of diverse cultures and protocols of people experiencing homelessness or vulnerable housing. |
| **Structures and systems** | This determinant includes history, governing processes, economic and social policies, infrastructures, resources and systems that affect access to quality healthcare, income, working life conditions, housing and education.<br>For many people experiencing homelessness or vulnerable housing, structures and systems such as the continuing effects of colonization influence whether resources necessary for health are equally distributed in society. Also, structures and systems influence cultural ways of life for many people experiencing homelessness or vulnerable housing and their chosen families. |
| **Access to affordable and high-quality health services** | This determinant includes access to affordable and high-quality health services, social services resources and supports (for example, palliative care). |

| Social determinant of health | Description |
|---|---|
| **Connection to land, geography and physical environments** | This determinant focuses on the role of geography.<br>Access to healthcare delivery and social services is largely determined by geography.<br>Geography influences where and how people experiencing homelessness or vulnerable housing and their chosen families access necessary infrastructure (for example, technology, water, heating, sewage facilities, medications, diagnostic testing, medical transportation) to remain in their communities.<br>Lack of infrastructure creates situations where some people experiencing homelessness or vulnerable housing must move far away from their chosen families and communities for healthcare and social services resulting in relocation, high travel costs, isolation, separation and the progression to advanced serious illness(es).<br>Geography disproportionately impacts wholistic care of peoples residing in rural and northern communities across Canada compared to those living in urban centres. |
| **Settler-colonialism** | This determinant (based on the work of Karina Czyzewski[8]) recognizes that settler-colonialism, racism, lack of self-determination and social exclusion affect and influence all of the WHO-defined social determinants of health.<br>While references are made to colonialism and racism in the 'structures and systems' and 'social inclusion and non-discrimination' social determinants of health, within a Canadian context, it is important that settler-colonialism is identified and acknowledged as a stand-alone determinant.<br>Settler-colonialism is an ongoing reality and one of persistent inequitable relationships in areas such as healthcare services (includes palliative care). |

## Indigenous-specific social determinants of health

While the WHO highlights social determinants of health for people across the globe, it is important to understand that the role of culture and community in the lives of First Nations, Inuit and Métis Peoples is a significant social determinant of health that influences self-determination, Indigenous identities and balance in one's life: mind, body and spirit.

A strengths-based approach for Indigenous-specific social determinants of health uses land-based healing, revitalizes languages and engages in traditional teaching and healing ceremonies.

These elements involve

- sharing wisdom
- (re)connecting to the land

- (re)connecting with people and communities
- (re)connecting with ancestors

This approach respects Indigenous rights to self-determination and empowers Indigenous Peoples through a focus on their inherent and unique skills and strengths on the land, in the water and in their relationships and in communities.

The following are examples of Indigenous-specific social determinants of health:

- Access to health services as a social determinant of First Nations, Inuit and Métis health
- Health inequities and social determinants of Aboriginal Peoples' health
- Social determinants of Inuit health in Canada
- Social determinants of Métis health

In particular, Elders, Knowledge Carriers/Keepers, Healers, Indigenous End-of-Life Guides and Helpers can provide vital information to help guide wholistic health care and social support, particularly as it relates to dying and death for people experiencing homelessness or vulnerable housing.

## Shared understandings

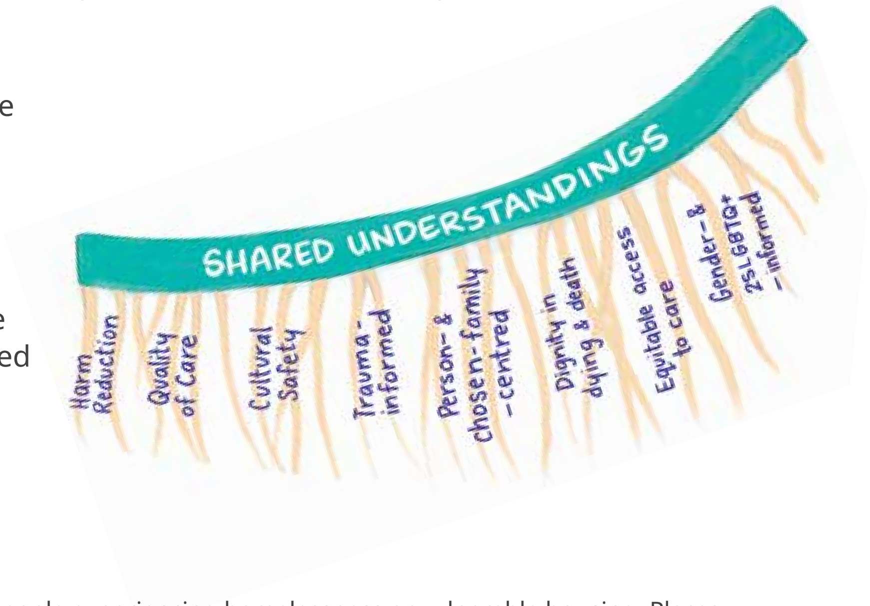
The following are shared understandings that bring together common dimensions of palliative care with the IEAPC collaborative's equity-oriented approach to care:

### *Common dimensions of palliative care*

**Quality of care.** Quality of care involves dignity of care, expressing compassion in one's words and actions and being timely and accessible in addressing unmet needs of people experiencing homelessness or vulnerable housing.

**Person- and chosen-family-centred.** This principle recognizes that the person and their chosen family occupy the centre of care, and the focus is on what they can do, not their serious illness. Support focuses on achieving the care goals of the person and their family and is customized to their needs and unique circumstances.

**Dignity in dying and death.** Dignity in dying and death involves creating an environment [3] where all people can access the support needed from the time of diagnosis of the serious illness. This principle includes being flexible in how palliative approaches to care are delivered and helping a person to die in a desired place.



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[3] Environment refers to a place or setting of choice for people experiencing homelessness or vulnerable housing. Places and settings may include the streets, shelters, single room occupancy (SROs) housing and related affordable housing, hospitals and hospices.

## *Equity-oriented approach to care*

**Harm reduction.** Harm reduction care uses practical, non-judgmental strategies to support safe/safer consumption of drugs while reducing the negative effects associated with substance use. The opioid crisis disproportionately affects people experiencing homelessness or vulnerable housing. Harm reduction programs can serve as an entry point into increased supports for those accessing palliative approaches to care.

Palliative approaches to care and harm reduction care share some similarities: they are person- and chosen-family-centred with an aim to reduce suffering and improve quality of life.

Indigenous harm reduction principles include relationships and care, knowledge and wisdom, strength and protection, and identity and transformation.

**Cultural safety.** Cultural safety involves ensuring that people experiencing homelessness or vulnerable housing feel respected, welcomed and comfortable being themselves and expressing all aspects of who they are. This safety assurance includes providing care that is free of racism, stigma and discrimination. Cultural safety is also about wholistic care, which includes spiritual, emotional, mental and physical safety.

**Trauma-informed.** Trauma-informed care is wholistic and addresses the root causes of trauma and violence across the lifespan, rather than just focusing on the symptoms. This care recognizes

- the prevalence of trauma and violence (for example, intergenerational trauma and violence)
- how trauma affects people, families and communities
- how people who experienced trauma and violence can be re-traumatized in biomedical healthcare settings
- ways to understand and share pathways towards care

Trauma-informed principles include acknowledgement of trauma, violence, safety, trust, choice and control, compassion, collaboration, empowerment (strengths-based) and peer support.

**Equitable access to care.** Equitable access to care is the absence of unfair systems, processes and policies that create inequalities in care. This principle includes addressing the social determinants of health and Indigenous-specific social determinants of health.

**Gender- and 2SLGBTQQIA+-informed.** A gender- and 2SLGBTQQIA+-informed approach to palliative care recognizes (through policies, programs, services and other initiatives) the voices and priorities of people with diverse gender identities and sexual orientations. This approach ensures that the unique needs and experiences of gender-diverse and 2SLGBTQQIA+ individuals are recognized, respected and addressed, promoting more equitable and inclusive care for all.

Learn more about palliative care competencies.

# Meaningful and Reflective Evaluation

Using a decolonized approach to program evaluation, the IEAPC Evaluation Framework supports sharing IEAPC stories beyond a checklist. Decolonizing program evaluation involves valuing all data sources (qualitative methods, quantitative methods, Indigenous knowledge translation, expressive arts and the use of metaphors[4]) equally in terms of creating, understanding and sharing stories of lived and living experience.

As the IEAPC collaborative focuses on improving equitable access to palliative approaches to care, creating, understanding and sharing stories of IEAPC-funded initiatives will most likely be culturally nuanced and context-specific for both the initiatives and corresponding evaluations. Therefore, culture and context guide the evaluation's key questions, design, data collection, analysis and knowledge sharing.

Storytelling and metaphor also serve as methods to transform data into symbolic and textual references that often hold profound relationships to people, place, community and setting.

Transformed into an infographic, key dimensions of the IEAPC Evaluation Framework form a blanket image: a universal symbol of safety and protection.

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[4] Examples of expressive arts and metaphors are songs, poetry, drama, prayers, drawings, paintings, dance and movement, sculptures, graphic design images, infographics, photography and videography.

The framework honours

- diverse ways of providing palliative approaches to care: from mobile and outreach services; bed-based and hospice services; hospitals and regional health authorities to serving First Nations, Inuit and Métis communities
- shared learning and wisdom of the non-hierarchical collaboration between the IEAPC collaborative and its initiatives across Canada

The blanket wraps around the community of people experiencing homelessness or vulnerable housing and around their chosen families and providers who are improving equitable access to palliative approaches to care. The left side of the blanket image represents the weaving together of the guiding principles and shared understandings of equity-oriented palliative care in the fabric of the IEAPC Evaluation Framework.

## Guiding principles

The following notable reports and declarations ground the guiding principles of the IEAPC Evaluation Framework:

- Federal Action Plan on Palliative Care
- Truth and Reconciliation Commission of Canada's Calls to Action
- United Nations Declaration on the Rights of Indigenous Peoples
- United Nations Sustainable Development Goals

The IEAPC Evaluation Framework infographic positions these notable reports and declarations in the centre, showing that they are foundational to the IEAPC collaborative.

For more information about notable documents informing the IEAPC Evaluation Framework, please refer to Appendix B.

The IEAPC Evaluation Framework guiding principles are at the centre of the evaluation: they recognize broadly held values within and across the IEAPC collaborative and IEAPC-funded initiatives while remaining meaningful and flexible in evaluation methods and practices.

The following four principles, shown on the left side of the blanket image, guide the IEAPC Evaluation Framework. The table shows the core elements of the framework and the corresponding ways in which they can be adapted, scaled and customized to the evaluation of IEAPC-funded initiatives.

| IEAPC Evaluation Framework Guiding Principles | IEAPC Evaluation Stories (Processes and Practices) |
|---|---|
| **Strengths-based and respectful**<br>-recognizes and emphasizes strengths, resilience and self-determination of people experiencing homelessness or vulnerable housing and their chosen families and communities<br>-shifts the focus of evaluation from a deficit perspective to one that acknowledges and builds upon the strengths that people experiencing homelessness or vulnerable housing possess<br>-allows for creativity and self-expression in creating, understanding and sharing stories about improving equitable access to palliative approaches to care<br>-uses multiple ways to measure the journey of the IEAPC collaborative and IEAPC-funded initiatives<br>-negotiates information and data sovereignty | Stories can be expressed through multiple measures using qualitative methods, expressive arts and the use of metaphors, quantitative or mixed methods<br>Stories from IEAPC-funded project teams make connections between their project activities and ways that they are contributing to community |
| **Adaptable**<br>-is responsive<br>-(re)defines evaluation in terms of methods and practices that fit context, meaning and self-determined needs<br>-respects that 'one-size-does-not-fit-all' in terms of improving equitable access to palliative approaches to care | Stories articulate cultural nuances and contextual information about the people experiencing homelessness or vulnerable housing and their chosen families and communities<br>Stories consider how cultural nuance and contextual information impacts and influences IEAPC-funded initiatives both in terms of process and outcomes |

| IEAPC Evaluation Framework Guiding Principles | IEAPC Evaluation Stories (Processes and Practices) |
|---|---|
| **Collaborative**<br>-means community development, engagement and partnerships in planning and implementing evaluation<br>-aids in addressing inequities in palliative approaches to care<br>-potentially involves grassroots not-for-profit organizations, orders of government (for example, Indigenous governments/communities, provincial/territorial governments and the federal government) and regional health authorities<br>-includes multidisciplinary evaluation supports and resources that expand across sectors (for example, health, justice, skills development and employment and social services)<br>-encourages communities and organizations to work cooperatively with IEAPC-funded initiatives to ensure evaluation is timely, accessible and culturally congruent | Stories benefit from being community-led or -informed and using participatory practices: engaging key rightsholders and stakeholders, which includes individuals and groups with lived and living experience, and local healthcare and social service providers |
| **Relevant**<br>-honours the specific context and its importance in creating, understanding and sharing stories on improving equitable access to palliative approaches to care with and for people experiencing homelessness or vulnerable housing<br>-situates the IEAPC collaborative and IEAPC-funded initiatives by describing relationships to community, setting and place, which includes the living history, socio-economic, cultural and health context, and the individuals affected | Evaluation is woven into the IEAPC-funded initiatives, preferably right from the beginning of the journey<br>Evaluation teams meet with key rightsholders and stakeholders to discuss evaluation planning and ways of ensuring evaluation methods and practices are selected and adapted that align with the spirit and intent of the IEAPC collaborative, the respective IEAPC-funded project and the community it serves |

## Evaluation measures

In recognition of the diversity within and between IEAPC-funded initiatives across Canada, there will most likely be variation in the project teams' state of readiness for using the IEAPC Evaluation Framework.

State of readiness may vary according to project scope, organizational size and capacity. For example, some project teams may already have program evaluation resources (human, technical and financial) in place, while other project teams may be starting their journey to set up their own program evaluation work plan.

As part of determining the state of readiness for using the IEAPC Evaluation Framework, IEAPC-funded initiatives may identify strengths and challenges in applying the framework to their organizational setting.

This step may also include identifying ways to leverage strengths and address gaps and challenges in applying the IEAPC Evaluation Framework in a community or regional context.

One does not achieve equity, cultural safety and quality of care. Rather, one works toward these outcomes: It is a journey rather than an endpoint.

IEAPC evaluation measures focus on creating, understanding and sharing stories about becoming more equitable, becoming safe/safer and enhancing quality of care.

In a decolonized approach to evaluation, there is no right way to create, understand and share stories. Instead, this approach is about discussing key dimensions of each IEAPC-funded project and how each dimension relates to outcomes for improving equitable access to palliative approaches to care with and for people experiencing homelessness or vulnerable housing.

The IEAPC Evaluation Framework does not include an exhaustive list of all evaluation measures that relate to improving equitable access to palliative approaches to care with and for people experiencing homelessness or vulnerable housing. The framework provides examples of methods and practices for creating, understanding and sharing stories from IEAPC-funded initiatives: evaluation questions, design, data collection, analysis and knowledge sharing.

With regards to (1) becoming more equitable, (2) becoming safe/safer, (3) enhancing quality of care, the framework encourages IEAPC-funded project teams to reflect on and document the following in their evaluation impact stories:

**Project purpose**

- Key IEAPC-funded initiative objectives and proposed outcomes

**Community**

- Context for IEAPC-funded initiative, including understanding the community, setting and place
- Relationships between IEAPC-funded initiative activities and outcomes
- IEAPC-funded initiative outcomes to date
- Strengths, opportunities, challenges and gaps in designing and implementing the IEAPC-funded initiative
- Lessons learned, promising practices and areas for improvement throughout the IEAPC-funded project lifecycle: from engagement and project design to implementation and knowledge sharing

**Operations, finance, and learning and growth**

- IEAPC-funded initiative activities, relationship to one another and outcomes

- IEAPC-funded initiative collaboration and engagement, particularly with individuals and groups with lived and living experience; and First Nations, Inuit and Métis partners
- IEAPC-funded project supports/resources and outcomes in designing and implementing the IEAPC-funded initiative
- Strengths, opportunities, challenges and gaps in designing and implementing the IEAPC-funded initiative
- Lessons learned, promising practices and areas for improvement throughout the IEAPC-funded project lifecycle: from engagement and project design to implementation and knowledge sharing

The above elements (community, operations, finance, and learning and growth) arose from facilitated virtual dialogue sessions in 2024 with IEAPC coaches, IEAPC Cohort 1 Project Teams and the IEAPC Evaluation Committee. Overall, these elements are interrelated with the IEAPC areas of focus (becoming more equitable, becoming safe/safer and enhancing quality of care). These elements provide a wholistic perspective to evaluating IEAPC-funded initiatives and articulating their impact.

Based on state of readiness in using the IEAPC Evaluation Framework, IEAPC-funded project teams can consider some or all of the following evaluation measures when creating, understanding and sharing project stories:

- **Nominal.** Nominal refers to qualitative methods to collect and analyze primarily verbal data (includes storytelling, expressive arts and metaphor). Though not exclusive to a particular setting, grassroots community organizations often use nominal evaluation measures based on the nature and type of programs and services they provide.
- **Ordinal.** Teams can combine quantitative methods with qualitative responses. For example, ordinal measures may be in the form of response scales to structured questions, such as ‘never,’ ‘rarely,’ ‘sometimes,’ ‘often,’ and ‘always.’ In some cases, programs housed in clinics or smaller hospital or social service settings use ordinal evaluation measures.
- **Interval/ratio.** Quantitative methods with structured response scales may be used with administrative data such as staffing levels, emergency department visits, hospital admissions and financial data. Larger hospitals, health authorities and social service agencies generally use interval/ratio measures.

Regardless of where IEAPC-funded initiatives are situated, teams can ideally use data collected and analyzed using one or more of these evaluation measures to address the same key questions about improving equitable access to palliative approaches to care with and for people experiencing homelessness or vulnerable housing.

Examples of evaluation measures are based on strengths, ways of knowing and experiences shared by Cohort 1 IEAPC-funded project teams, IEAPC Evaluation Committee members and IEAPC coaches who participated in facilitated discussions in 2024 about IEAPC evaluation framework planning. However, promising practices in IEAPC evaluation may vary from one project team, community or jurisdiction to the next.

Please refer to Appendix C for examples of IEAPC evaluation measures and related considerations in creating, understanding and sharing stories of IEAPC-funded initiatives.

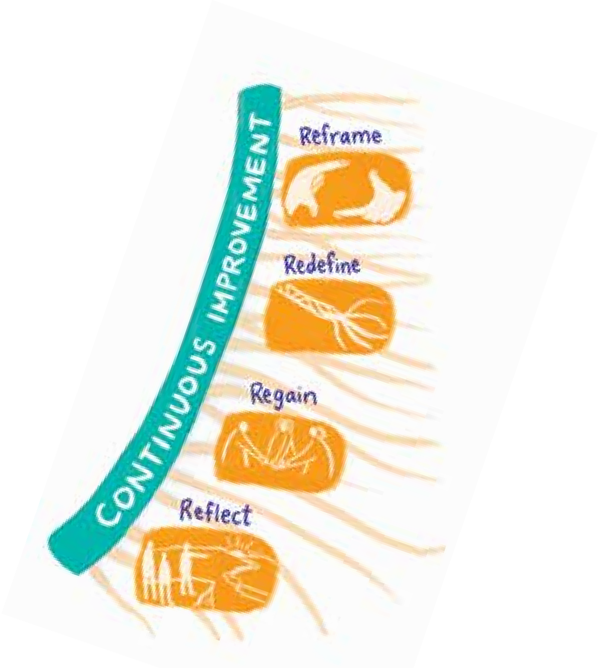
In support of continuous improvement and sustainability, IEAPC-funded project teams set the pace in creating, understanding and sharing their IEAPC stories. Therefore, readers are invited to **adapt, scale and apply** information in the IEAPC Evaluation Framework to support the implementation of their evaluation plan.

# Continuous Improvement

Transformed into an infographic, key dimensions of the IEAPC Evaluation Framework form a blanket image: a universal symbol of safety and protection.

The blanket wraps around the community of people experiencing homelessness or vulnerable housing and around their chosen families and providers who are improving equitable access to palliative approaches to care.

The left side of the blanket image represents the weaving together of the guiding principles and shared understandings of equity-oriented palliative care in the fabric of the IEAPC Evaluation Framework.



The right side of the blanket image represents continuous improvement in the IEAPC Evaluation Framework: the strands of the blanket can be woven anew based on lessons learned, promising practices and reflections during the IEAPC collaborative journey.

This metaphor of weaving the strands anew for continuous improvement suggests the importance of ongoing learning and capacity building, which is further expanded upon with these four verbs:

- **Reframe.** Reframing means recognizing that IEAPC evaluation is an evolving journey centred through decolonized ways of knowing and aligning it with shared understandings about equity-oriented palliative care.
- **Redefine.** Redefining means recognizing diverse ways of knowing and methods in the evaluation planning and implementation.
- **Regain.** Regaining means involving individuals, groups and communities with lived and living experience in the evaluation journey to reclaim their voices and perspectives in their stories on improving equitable access to palliative approaches to care.
- **Reflect.** Reflecting means ensuring that there is space for self-reflection throughout the evaluation journey to improve IEAPC-funded initiatives for the benefit of people experiencing homelessness or vulnerable housing.

## Data sovereignty

Data sovereignty involves rights, standards and knowledge of relevant jurisdictional laws that apply to the collection, storage and access to information.

Data sovereignty is an important aspect of ethical and professional practices in evaluation. Following are examples of data sovereignty practices.

- maintaining comprehensive records, which may include documenting professional activity; ensuring clarity, timeliness, legibility, appropriateness, adequacy and accuracy of records; maintaining security and preservation of records; and recognizing and addressing factors affecting confidentiality, access to information and transfer of information and records to others
- using technology in palliative care (for example, using technology for communication, program monitoring, report writing, problem solving, record-keeping, and case management in a secure and professional manner)
- using a decolonizing approach that includes strengths-based health methodologies and data and includes recognizing Indigenous data sovereignty as a cornerstone of cultural resurgence and nation (re)building

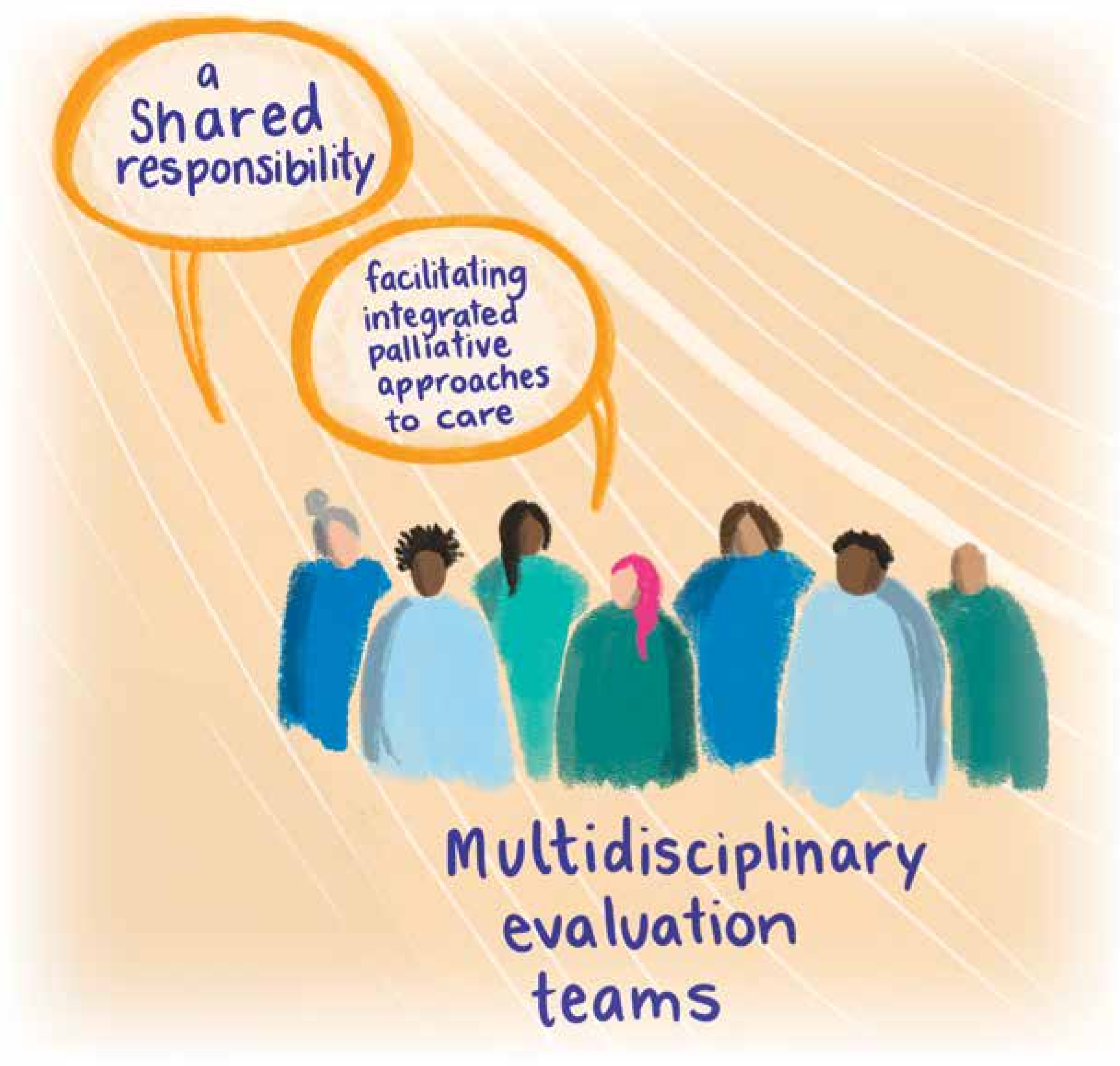
With regards to First Nations, Inuit and Métis palliative care data, evaluation and continuous improvement, the following documents contain promising practices that pertain to ethical guidelines in Indigenous-led and -informed evaluation: National Inuit Strategy on Research, OCAP (Ownership, Control, Access and Possession) Principles and Principles of Ethical Métis Research.

## Multidisciplinary evaluation teams

The IEAPC Evaluation Framework recognizes that evaluation begins in the creation of communities within and across the IEAPC-funded project teams and the IEAPC collaborative.

Capacity building in evaluation involves developing competencies (knowledge, skills and abilities) to empower IEAPC-funded project teams and their partners to participate in any or all aspects of evaluation decision-making in their communities, regions, provinces/territories and the country as a whole.

The coordination of multidisciplinary evaluation teams brings together competencies to create, understand and share stories of IEAPC-funded initiatives to enhance wholistic palliative approaches to care, from planning and development to implementation and continuous improvement. Multidisciplinary evaluation teams can enhance high-quality, culturally safe/safer and responsive palliative approaches to care for people experiencing homelessness or vulnerable housing.



# Conclusion

The IEAPC collaborative benefits from having common guiding principles, shared understandings, and a meaningful and flexible suite of evaluation practices that support continuous improvement. These practices include

- accessing up-to-date palliative and end-of-life care data to help fully address the social determinants of health and develop wholistic strategies in community-driven palliative approaches to care
- recognizing the importance of collecting relevant data to advocate for necessary changes to improve equitable access to palliative approaches to care with and for people experiencing homelessness or vulnerable housing

As the IEAPC collaborative focuses on improving equitable access to palliative approaches to care, creating, understanding and sharing stories of IEAPC-funded initiatives will most likely be culturally nuanced and context-specific for both the initiatives and corresponding evaluations. In recognition of the diversity within and between IEAPC-funded initiatives across Canada, there will most likely be variation in the project teams' state of readiness for using the IEAPC Evaluation Framework.

Using a decolonized approach to program evaluation, the IEAPC Evaluation Framework supports sharing IEAPC stories beyond a checklist.

Decolonizing program evaluation involves valuing all data sources (qualitative methods, quantitative methods, Indigenous knowledge translation, expressive arts and the use of metaphors) equally in terms of creating, understanding and sharing stories of lived and living experience about improving equitable access to palliative approaches to care with and for people experiencing homelessness or vulnerable housing.

The IEAPC Evaluation Framework provides readers with sample measures and examples of methods and practices for creating, understanding and sharing stories from IEAPC-funded initiatives: evaluation questions, design, data collection, analysis and knowledge sharing.

With regards to (1) becoming more equitable, (2) becoming safe/safer, (3) enhancing quality of care, this framework encourages IEAPC-funded project teams to reflect on and document their evaluation impact stories by considering areas for continuous improvement, sustainability, data sovereignty and coordination of multidisciplinary evaluation teams.

One does not achieve equity, cultural safety and quality of care. Rather, one works toward these outcomes: It is a journey rather than an endpoint.

# Appendix A: Key Terms

- **2SLGBTQQIA+.** This initialism stands for Two-Spirit, Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, Intersex, Asexual, and additional sexual orientations and gender identities.
- **Biomedical.** Biomedical refers to science and study of life from a clinical medicine perspective.
- **Capacity building.** Capacity building includes developing competencies to participate in any or all aspects of decision-making in communities, regions, provinces/territories and in Canada as a whole. Capacity building also includes program planning, development, implementation and evaluation intended to enhance wholistic palliative approaches to care for people experiencing homelessness or vulnerable housing.
- **Comfort care.** Comfort care provides necessary cultural contexts that acknowledge the role of values, identities, families and communities when harmonized with palliative approaches to care. With a focus on kindness, compassion and quality of life, comfort care honours the spiritual beliefs, cultural protocols and practices of people living with serious illnesses. In addition to care focusing on the whole person, comfort care includes support for the chosen family and community of people living with serious illnesses.
- **Competencies.** Competencies are specific and observable knowledge, skills, attitudes and behaviours associated with effective functioning in a job. They can be measured against well-accepted standards, and they can be improved through education and skills development.
- **Cultural safety.** "A culturally safe environment is physically, socially, emotionally and spiritually safe. There is recognition of, and respect for, the cultural identities of others, without challenge or denial of an individual's identity, who they are, or what they need. Culturally unsafe environments diminish, demean or disempower the cultural identity and well-being of an individual."[9] **Of note, First Nations, Inuit and Métis health leaders advise us that care based on the biomedical approach can never be safe; it can only be 'safer.' Honouring this perspective, the term 'safer' is used in this evaluation framework with no comparative.**
- **Decolonization.** Decolonization is the process of returning power to Indigenous Peoples, supporting self-determination and self-governance and respecting nation-to-nation governance. In a program evaluation context, decolonization means confronting and challenging colonial evaluation practices and reflecting on the structure of evaluation (questions, design, data collection, analysis, knowledge sharing) and how project teams will tell the story of their IEAPC-funded initiatives. Decolonization in program evaluation also includes recognizing Indigenous data sovereignty as a cornerstone of cultural resurgence and nation (re)building, which

involves collecting data and using it with the intent to benefit First Nations, Inuit and Métis Peoples, families and communities. An urgent priority of decolonization is to eliminate discrimination and racism (includes anti-Indigenous racism) in the healthcare system and its effects on people experiencing homelessness or vulnerable housing.

- **Ethics.** Ethics are principles that define behaviour as right, good and proper. Ethics are about our actions: how we act and what we do.
- **Environment.** Environment refers to a place/setting of choice for people experiencing homelessness or vulnerable housing. Environment may include the streets, shelters, single room occupancy (SROs) housing and related affordable housing, hospitals and hospices.
- **Family.** Family refers to peoples' birth family, family through marriage and/or their family of choice. Family also includes legal guardians, friends and caregivers. Elders, older adults, people with disabilities and people living with a serious illness may identify family (or families) they would like included in any encounters with the healthcare and social service systems.
- **First Nations Peoples.** First Nations Peoples are the First Peoples of Canada, both Status and Non-Status. Status (or registered) Indians are people who are registered according to the *Indian Act* and members of a band (First Nations community). Status Indians receive supports and related services (for example, housing assistance) from Indigenous Services Canada (ISC). Non-Status Indians are people that are not recognized as Indians under the *Indian Act.* At present, over 600 First Nations communities in Canada represent more than 50 Nations and language groups.
- **Home.** Encompassing more than a physical dwelling, First Nations, Inuit and Métis accounts of home highlight networks of responsibilities and include ties to the land, water, Earth, and territories as well as connections to human kinship networks, teachings, songs, names, stories and ancestors. Home is a wholistic and layered concept that is simultaneously relational, material, spiritual and emotional and interplays with a sense of rootedness, a sense of identity and community bonds.[10]
- **Homelessness.** Homelessness is "the situation of an individual, family or community without stable, safe, permanent, appropriate housing or the immediate prospect means and ability of acquiring it."[11]
    - **Indigenous homelessness.** Indigenous homelessness is a human condition that describes First Nations, Métis and Inuit individuals, families or communities lacking stable, permanent, appropriate housing, or the immediate prospect, means or ability to acquire such housing. Unlike the common colonialist definition of homelessness, Indigenous homelessness is not defined as lacking a structure of habitation; rather, it is more fully described and understood through a composite lens of Indigenous worldviews. These include: individuals, families and communities isolated from their relationships to land, water, place, family, kin, each other, animals, cultures, languages and identities. Importantly, Indigenous People experiencing these kinds of homelessness cannot culturally, spiritually, emotionally or physically reconnect with their Indigeneity or lost relationships.[4]

- **Inuit.** The Inuit are Indigenous Peoples from Arctic Canada, particularly though not exclusively residing in Inuit Nunangat: Inuvialuit (Northwest Territories), Nunatsiavut (Northern Coastal Labrador), Nunavik (Northern Quebec) and Nunavut. These geographic areas comprise approximately 40 percent of Canada's total land mass. The Inuit population is much younger than the non-Indigenous population. The traditional language of Inuit is Inuktitut. Inuktitut dialects differ among and within regions, as different vocabulary, pronunciations and terms developed and migrated with nomadic families and clans.
- **Jurisdiction.** A jurisdiction is a law-making authority.
- **Métis People.** Métis People are of historic Métis ancestry. Specifically, they have historical lineage rooted in the areas of land in West Central North America. Métis People were important players in shaping Canada, particularly Western Canada. The traditional languages spoken by Métis People include Cree and Michif.
- **Outcomes.** Outcomes are statements that describe what effectiveness would look like in advancing a goal. Measures are incorporated into an outcome statement to assess progress over time.
- **Palliative approaches to care.** Palliative approaches to care aim to reduce suffering and improve the quality of life for people throughout the course of their serious illness. Examples of serious illnesses are cancer, dementia, organ failure and neurological diseases. Palliative approaches to care also include supporting families in their grief and loss. Furthermore, palliative approaches to care focus on the whole person and their family which includes physical, emotional, mental and spiritual support and honouring cultural protocols, values, beliefs and wishes.
- **Person- and chosen-family-centred.** This phrase means that the person and their chosen family occupy the centre of care and the focus is on what they can do, not their accessibility need or serious illness. Support concentrates on achieving the care goals of the person and their chosen family and is customized to their needs and unique circumstances.
- **Promising practices.** Groups or communities ground their promising practices in their strengths and ways of knowing in palliative approaches to care for people experiencing homelessness or vulnerable housing. Practices may vary from one group, community or jurisdiction to the next.
- **Racism.** Racism is a set of mistaken assumptions, opinions and actions resulting from the belief that one group of people categorized by colour or ancestry is inherently superior to another. It results in the inequitable distribution of opportunity, benefit or resources across ethnic/racial groups. Types of racism include the following:
    - **Anti-Indigenous racism.** Anti-Indigenous racism is the ongoing race-based discrimination, negative stereotyping, and injustice experienced by Indigenous Peoples in Canada.
    - **Systemic discrimination or racism.** Systemic discrimination is enacted through societal systems, structures and institutions (for example, policies, legislation and practices) that perpetuate and maintain avoidable inequities across ethnic or racial groups.

- **Rightsholders.** Rightsholders are individuals and groups that can make legitimate claims to rights. Indigenous Peoples and communities across Canada are rightsholders. In the spirit of self-determination, Indigenous Peoples have inherent rights, and there is a duty to consult Indigenous Peoples in Canada. In evaluation, this duty means working in a mutually respectful way to explore effective evaluation methods, practices and related decision-making models.
- **Settler-colonialism.** In settler-colonialism, settlers displace Indigenous Peoples and form permanent societies on their lands. Settler-colonialism practices include the residential school system, Indian hospitals and the Sixties Scoop, forced relocation, forced removal of Indigenous Children from their families, cultural assimilation, medical experiments and unethical procedures. In settler-colonialism, settler-colonizers impose their own cultural values and make laws and policies that do not favour Indigenous Peoples.
- **Social determinants of health.** Social determinants of health are the major factors impacting and influencing people's and communities' collective physical, mental, emotional and spiritual well-being. They are shaped and deeply rooted by the distribution of money, power and resources in society and are responsible for the differences and inequities in health status within and between communities.
    - **Indigenous-specific social determinants of health.** Indigenous-specific social determinants of health recognize the effects that intergenerational trauma, colonialism and systemic racism play in accessing quality health services. In response, Indigenous approaches to health are strengths-based and trauma-informed across the cycle of life. They support self-determination, land-based healing, revitalization of cultures and languages, engage in traditional teaching, healing ceremonies, and foster a strong self-identity. These elements often involve sharing wisdom where culture is deemed medicine: (re)connecting to the land, (re)connecting with people and communities, and (re)connecting with ancestors.[12]
- **Social return on investment (SROI).** Social return on investment is a methodology that allows for a deeper understanding of the social, health, environmental and economic values created by initiatives. It measures and accounts for the value created by a program or initiative beyond a financial value. It incorporates social, health, environmental and economic costs and benefits.[13]
- **Stakeholders.** Stakeholders are individuals and groups who have a direct vested interest in, and may be affected by, the program evaluation. Stakeholders should be involved early, actively, and continuously in the program evaluation process.
- **Wholistic.** Wholistic refers to an approach that considers the entire system or whole entity, recognizing the interdependence of various elements and the importance of addressing all aspects of something to achieve a balance. The spelling of the term **"wholistic"** is intentional because this perspective acknowledges the **whole** person and reflects the need for interconnectedness among the spiritual, emotional, mental and physical aspects of self.

# Appendix B: Notable Reports and Declarations

The following are notable reports, declarations and guiding documents that inform the IEAPC Evaluation Framework.

## Federal government palliative care plan

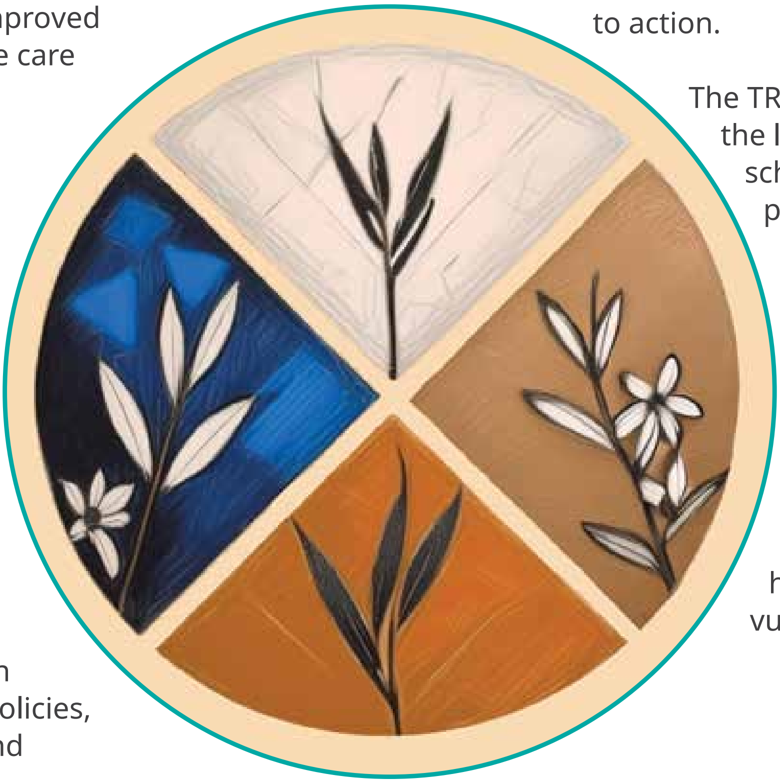
In 2019, Health Canada released the *Action Plan on Palliative Care: Building on the Framework on Palliative Care in Canada.*

The document outlines Health Canada's five-year plan to look into innovative approaches and early-stage research aimed at improving health system performance and quality of care for people living with a serious illness and their caregivers.

As it pertains to improving equitable access to palliative approaches to care with and for people experiencing homelessness or vulnerable housing, notable goals are as follows:

- Goal #4. Foster improved access to palliative care for underserved populations
- Goal #5. Improve access to culturally sensitive palliative care for Indigenous communities

Health Canada recognizes that there is a need for timely and culturally congruent palliative approaches to care (in terms of strategies, policies, programs, funding and resources) that acknowledge shared yet unique priorities, perspectives and considerations for people experiencing homelessness or vulnerable housing, their chosen families and communities across Canada.



## Truth and Reconciliation Commission of Canada (TRC) Calls to Action

From 2008 to 2014, the TRC heard stories of abuse (for example, mental, emotional, sexual, physical) from thousands of residential school survivors. The purpose of the TRC was to document the history and impacts of the residential school system in Canada. The TRC provided former residential school survivors with an opportunity to share their experiences during public and private meetings held across Canada.

In June 2015, the Commission released a report based on these hearings, resulting in 94 calls to action.

The TRC calls to action address the legacy of residential schools and advance the process of Canadian reconciliation.

The following TRC calls to action relate to improving equitable access to palliative approaches to care with and for people experiencing homelessness or vulnerable housing:

- TRC call to action #19. We call upon the federal government, in consultation with Aboriginal peoples, to establish measurable goals to identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities, and to publish annual progress reports and assess long-term trends. Such efforts would focus on indicators such as: infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services.
- TRC call to action #22. We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients.
- TRC call to action #23. We call upon all levels of government to:
    i. Increase the number of Aboriginal professionals working in the health-care field.
    ii. Ensure the retention of Aboriginal health-care providers in Aboriginal communities.
    iii. Provide cultural competency training for all health-care professionals.
- TRC call to action #24. We call upon medical and nursing schools in Canada to require all students to take a course dealing with Aboriginal health issues, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, and Indigenous teachings and practices. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism.
- TRC call to action #55. We call upon all levels of government to provide annual reports or any current data requested by the National Council for Reconciliation so that it can report on the progress towards reconciliation. The reports or data would include, but not be limited to:
    iv. Progress on closing the gaps between Aboriginal and non-Aboriginal communities in a number of health indicators such as: infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services.

## United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)

UNDRIP was adopted by the United Nations General Assembly on September 13, 2007 and by Canada in 2016.

This declaration establishes a comprehensive international framework of minimum standards for the survival, dignity and well-being of the Indigenous Peoples of the world. It elaborates on existing human rights standards and fundamental freedoms as they apply to the specific situation of Indigenous Peoples.

The following notable articles from the United Nations Declaration on the Rights of Indigenous Peoples relate to improving equitable access to palliative approaches to care with and for people experiencing homelessness or vulnerable housing:

- Article 7(1): Indigenous individuals have the rights to life, physical and mental integrity, liberty, and security of person.
- Article 21(1): Indigenous [P]eoples have the right, without discrimination, to the improvement of their economic and social conditions, including inter alia, in the areas of education, employment, vocational training and retraining, housing, sanitation, health and social security.
- Article 23: Indigenous [P]eoples have the right to determine and develop priorities and strategies for exercising their right to development. In particular, Indigenous [P]eoples have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions.
- Article 24(2): Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right.

## United Nations Sustainable Development Goals

Adopted by the United Nations in 2015, the Sustainable Development Goals (SDGs) are a universal call to action to end poverty, protect the planet and ensure that by 2030 all people across the world enjoy peace and prosperity.

There are 17 SDGs. Action in one SDG area affects outcomes in others. As a collective, the SDGs are intended to balance social, economic and environmental sustainability.

The following notable SDGs relate to improving equitable access to palliative approaches to care with and for people experiencing homelessness or vulnerable housing:

- Goal #1: No poverty. Eradicating poverty in all its forms remains one of the greatest challenges facing humanity.... End poverty in all forms and dimensions by 2030. This involves targeting the most vulnerable, increasing basic resources and services, and supporting communities affected by conflict and climate-related disasters.
- Goal #3: Good health and well-being. Universal health coverage will be integral to achieve SDG 3, ending poverty and reducing inequalities.... Multisectoral, rights-based and gender-sensitive approaches are essential to address equalities and to build good health for all.[14]
- Goal #11: Sustainable cities and communities. Making cities sustainable means creating...safe and affordable housing, and building resilient societies and economies.

## Government of Canada actions to address anti-Indigenous racism in health systems[15]

Anti-Indigenous racism in the healthcare system is systemic and widespread.[16,9]

In 2020 and 2021, the Government of Canada (via Indigenous Services Canada) held a series of national dialogue sessions to address anti-Indigenous racism and systemic discrimination, enhance access to culturally safe/safer services across Canada and ensure Indigenous Peoples have access to equitable and compassionate care.

Based on reports from these dialogue sessions along with the *Ignored to Death: Systemic Racism in the Canadian Healthcare System* report,[16] the *In Plain Sight: Addressing Indigenous-specific*

*Racism and Discrimination in BC Health Care* report[9] and the findings from the Val-d'Or *Public Inquiry Commission on Relations Between Indigenous Peoples and Certain Public Services in Quebec* report,[17] the Government of Canada has committed to ending anti-Indigenous racism in health systems across Canada with a focus on fostering cultural safety and humility and recognizing traditional approaches to health and safe patient navigation for Indigenous Peoples.

## *United Nations Declaration on the Rights of Indigenous Peoples Act*[18(p5)]

On June 21, 2021, the *United Nations Declaration on the Rights of Indigenous Peoples Act* (UNDA) received Royal Assent in the federal House of Commons and came into force. This Act provides a roadmap for the Government of Canada and First Nations, Inuit and Métis Peoples to work together to implement UNDRIP based on lasting reconciliation, healing and cooperative relations.

With regards to health, UNDA indicates that "Indigenous [P]eoples have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions"[19] (Article 23) and "Indigenous [P]eoples have the right to their traditional medicines and to maintain their health practices" and "Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health"[19] (Article 24).

The Government of Canada released the *UN Declaration Act Action Plan*, developed in consultation and cooperation with First Nations, Inuit and Métis Peoples from across Canada, on June 21, 2023. The implementation of the Action Plan and of the UN Declaration will contribute to the Government of Canada's continued efforts to address challenges, systemic racism and discrimination, close socio-economic gaps and promote greater equality and prosperity for Indigenous Peoples.

## Joyce's Principle[20]

Declared in 2020, Joyce's Principle aims to guarantee to all Indigenous Peoples the right to equitable access, without any discrimination, to all social and health services, as well as the right to enjoy the best possible physical, mental, emotional and spiritual health. This principle requires the recognition and respect of Indigenous Peoples' traditional and living knowledge in all aspects of health.

# Appendix C: Examples of IEAPC Evaluation Measures and Related Considerations

IEAPC project teams determine their own evaluation methods and practices to describe IEAPC stories and impact within their own context of community, place and setting.

We developed the IEAPC Evaluation Framework around four guiding principles (strengths-based and respectful, adaptable, collaborative, relevant) that emerged from facilitated discussions with IEAPC Cohort 1 teams, IEAPC Evaluation Committee members and IEAPC coaches. However, this framework invites IEAPC-funded initiatives to reflect on their own community guiding principles or values and consider how these principles can influence their evaluations.

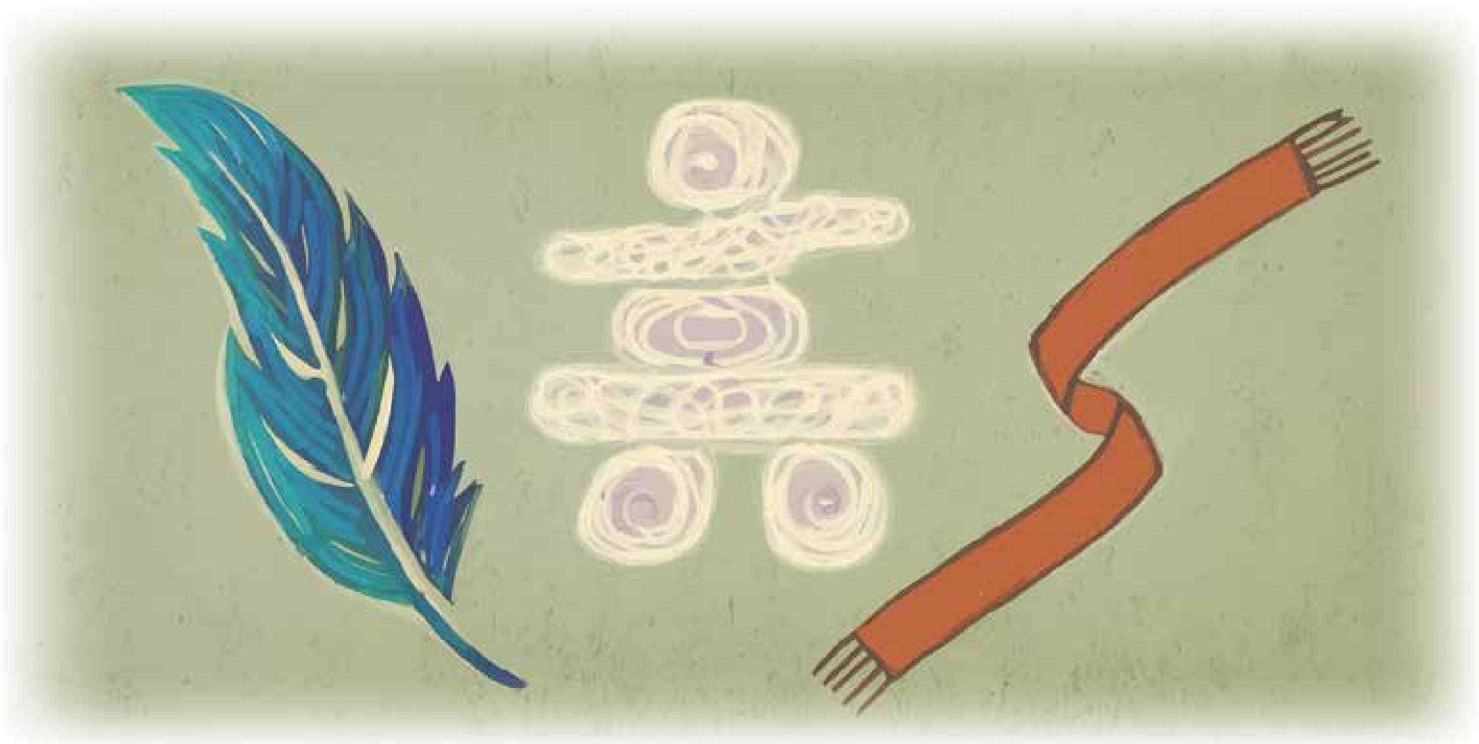
The framework guides IEAPC-funded project teams to determine their choices of evaluation methods and informs the practices they use to respect cultures and engage communities in improving equitable access to palliative approaches to care with and for people experiencing homelessness or vulnerable housing.

Following are sample IEAPC evaluation measures that project teams can apply, adapt and scale for each IEAPC-funded initiative as a means of bringing together different levels of measurements to share impact stories about initiatives. Heading each of the three tables is a question about the 1) equity, 2) safety and 3) quality of palliative approaches to care.

| Evaluation questions | Data collection methodology | Level of measurement | Measures | Timelines |
|---|---|---|---|---|
| **FOR PALLIATIVE APPROACHES TO CARE TO BECOME MORE EQUITABLE, WHAT ARE THE MAIN CHANGES THAT YOU ARE SEEING IN YOUR IEAPC-FUNDED PROJECT?** | | | | |
| **Community** | Mixed methods<br>-Indigenous knowledge translation (storytelling, expressive arts and metaphor)<br>-qualitative (interviews, sharing circles)<br>-quantitative (surveys, document/file reviews) | Nominal, ordinal, interval/ratio | **Nominal**<br>Who is accessing the IEAPC-funded project? Demographics (includes housing status)<br>How do people experiencing homelessness or vulnerable housing see themselves in the IEAPC-funded project?<br>Examples of experiences that suggest<br>-palliative approaches to care are becoming more equitable (in designing and implementing the IEAPC-funded project). What is working?<br>-challenges/gaps in palliative approaches to care becoming more equitable (in designing and implementing the IEAPC-funded project). What is not working?<br>-ways to improve equity in palliative approaches to care (in designing and implementing the IEAPC-funded project)<br>Type(s) of serious illnesses of people experiencing homelessness or vulnerable housing who are accessing the IEAPC-funded project<br>For teams developing guidelines or related resource<br>-description of the journey in developing guidelines or related resources<br>**Ordinal**<br>Level of agreement or satisfaction with the relationship between identified equitable care IEAPC-funded project activities and corresponding outcomes<br>**Interval/Ratio**<br># of emergency department visits<br># of hospital admissions<br># of people experiencing homelessness or vulnerable housing accessing IEAPC-funded project<br>Pre/post comparison for visits or new IEAPC-funded project service users – in terms of # of visits and impacts of these visits<br># of patients and caregivers (intended beneficiaries) directly reached by IEAPC-funded project<br>Estimated reach (directly and indirectly) by IEAPC-funded project<br>For teams developing guidelines or related resources<br>-# of collaborative meetings<br>-# of engagement sessions with community partners | Quarterly or twice a year |

| Evaluation questions | Data collection methodology | Level of measurement | Measures | Timelines |
|---|---|---|---|---|
| **Operations** | Mixed methods<br>-Indigenous knowledge translation (storytelling, expressive arts and metaphor)<br>-qualitative (interviews, sharing circles)<br>-quantitative (surveys) | Nominal, ordinal, interval/ratio | **Nominal**<br>Description of the context for the IEAPC-funded project<br>Description of the major IEAPC-funded project activities<br>Description of the IEAPC-funded project outcomes to date<br>Examples of experiences that suggest<br>-palliative approaches to care are becoming more equitable (in designing and implementing the IEAPC-funded project). What is working?<br>-challenges/gaps in palliative approaches to care becoming more equitable (in designing and implementing the IEAPC-funded project). What is not working?<br>-ways to improve equity in palliative approaches to care (in designing and implementing the IEAPC-funded project)<br>Examples of experiences that suggest how the IEAPC-funded project team is recognizing<br>-First Nations-, Inuit- and/or Métis-led and -informed priorities in improving equitable access to palliative care<br>-priorities of people with lived and living experience in improving equitable access to palliative care<br>Examples of experiences that suggest how the IEAPC-funded project team is collaborating with<br>-First Nations, Inuit and Métis partners<br>-people with lived/living experience<br>**Ordinal**<br>Level of agreement or satisfaction with the relationship between identified equitable care IEAPC-funded project activities and corresponding outcomes<br>**Interval/Ratio**<br># of staff trained to meet needs of patients to provide more equitable palliative approaches to care | Quarterly or twice a year |
| **Finances** | Quantitative (document/file review | Nominal, Interval/ratio | **Nominal**<br>How are resources from the IEAPC-funded project distributed?<br>**Interval/Ratio**<br>$ to operate IEAPC-funded project<br>Return on investment (ROI): subtracting the initial cost of the project from its value, then dividing this number by the cost of the investment and multiplying it by 100<br>Social return on investment (SROI): dividing the social and environmental value created by the financial cost of the investment and multiplying it by 100 | Quarterly and annual<br>For calculating ROI and SROI on an annual basis, health economics or related assistance from the IEAPC Program Team may be required |

| Evaluation questions | Data collection methodology | Level of measurement | Measures | Timelines |
|---|---|---|---|---|
| **Learning and growth** | Mixed methods<br>-Indigenous knowledge translation (storytelling, expressive arts and metaphor)<br>-qualitative (interviews, sharing circles)<br>-quantitative (surveys) | Nominal, ordinal, Interval/ratio | **Nominal**<br>Examples of promising or wise practices arising from the IEAPC-funded project with regards to palliative approaches to care becoming more equitable<br>**Ordinal**<br>Level of agreement or satisfaction with IEAPC-funded project human resources (includes organizational capacity building and professional development) with regard to the relationship between identified equitable care IEAPC-funded project activities and corresponding outcomes | Quarterly |



| Evaluation questions | Data collection methodology | Level of measurement | Measures | Timelines |
|---|---|---|---|---|
| **FOR PALLIATIVE APPROACHES TO CARE TO BECOME SAFE/SAFER, WHAT ARE THE MAIN CHANGES THAT YOU ARE SEEING IN YOUR IEAPC-FUNDED PROJECT?** | | | | |
| **Community** | Mixed methods<br>-Indigenous knowledge translation (storytelling, expressive arts and metaphor)<br>-qualitative (interviews, sharing circles)<br>-quantitative (surveys) | Nominal and ordinal | **Nominal**<br>Examples of experiences that suggest<br>-palliative approaches to care are becoming safe/safer. What is working?<br>-challenges/gaps in palliative approaches to care becoming safe/safer. What is not working?<br>-ways to improve cultural and physical safety in palliative approaches to care<br>For project partners, examples of experiences related to<br>-the engagement journey with the IEAPC-funded project team. What is working? What is not working? What can be improved?<br>-the collaboration journey with the IEAPC-funded project team. What is working? What is not working? What can be improved?<br>**Ordinal**<br>Level of agreement or satisfaction with the relationship between each identified safe/safer care IEAPC-funded project activity and corresponding outcome | Twice a year |
| **Operations** | Mixed methods<br>-Indigenous knowledge translation (storytelling, expressive arts and metaphor)<br>-qualitative (interviews, sharing circles, direct observation/site visit)<br>-quantitative (surveys, document/file review) | Nominal, ordinal, interval/ratio | **Nominal**<br>Examples of IEAPC-funded project activities that suggest<br>-palliative approaches to care are becoming safer. What is working?<br>-challenges/gaps in palliative approaches to care becoming safer. What is not working?<br>-ways to improve cultural safety in palliative approaches to care<br>-how the IEAPC-funded project team is recognizing First Nations-, Inuit- and/or Métis-led and -informed priorities in improving cultural safety in palliative care<br>-how the IEAPC-funded project team is collaborating with First Nations, Inuit and Métis partners in improving cultural safety in palliative care<br>-how the IEAPC-funded project team is recognizing priorities of people with lived and living experience in improving cultural safety in palliative care<br>-how the IEAPC-funded project team is collaborating with people with lived and living experience in improving cultural safety in palliative care<br>**Ordinal**<br>Level of agreement or satisfaction with the relationship between identified safe/safer care IEAPC-funded project activities and corresponding outcomes<br>**Interval/Ratio**<br># of staff trained to meet needs of patients to provide safe/safer palliative approaches to care | Quarterly or twice a year |

| Evaluation questions | Data collection methodology | Level of measurement | Measures | Timelines |
|---|---|---|---|---|
| **Finances** | Quantitative (document/file review) | Interval/ratio | **Interval/Ratio**<br>$ to operate IEAPC-funded project<br>Return on investment (ROI): subtracting the initial cost of the project from its value, then dividing this number by the cost of the investment and multiplying it by 100<br>Social return on investment (SROI): dividing the social and environmental value created by the financial cost of the investment and multiplying it by 100 | Quarterly and annual<br>For calculating ROI and SROI on an annual basis, health economics or related assistance from the IEAPC Program Team may be required |
| **Learning and growth** | Mixed methods<br>-Indigenous knowledge translation (storytelling, expressive arts and metaphor)<br>-qualitative (interviews, sharing circles, direct observations/site visits)<br>-quantitative (surveys, document/file review) | Nominal and ordinal | **Nominal**<br>Examples of promising or wise practices arising from the IEAPC-funded project with regards to palliative approaches to care becoming safe/safer<br>Examples for how the IEAPC-funded project is using the *Beginning the Journey into the Spirit World*<br>**Ordinal**<br>Level of agreement or satisfaction with IEAPC-funded project human resources (includes organizational capacity building and professional development) with the relationship between various safe/safer care IEAPC-funded project outcomes<br>The extent to which IEAPC-funded project team used the *Beginning the Journey into the Spirit World* knowledge product | Quarterly and annual |

| Evaluation questions | Data collection methodology | Level of measurement | Measures | Timelines |
|---|---|---|---|---|
| **TO IMPROVE THE QUALITY OF PALLIATIVE APPROACHES TO CARE, WHAT ARE THE MAIN CHANGES THAT YOU ARE SEEING IN YOUR IEAPC-FUNDED PROJECT?** | | | | |
| **Community** | Mixed methods<br>-Indigenous knowledge translation (storytelling, expressive arts and metaphor)<br>-qualitative (interviews, sharing circles)<br>-quantitative (surveys) | Nominal and ordinal | **Nominal**<br>Examples of experiences that suggest<br>-quality of palliative approaches to care is being improved. What is working?<br>-challenges/gaps in improving the quality of palliative approaches to care. What is not working?<br>-ways to improve quality in palliative approaches to care<br>**Ordinal**<br>Level of agreement or satisfaction with the relationship between each identified quality care IEAPC-funded project activity and corresponding outcome<br>The extent to which people experiencing homelessness or vulnerable housing die in a desired place | Quarterly or twice a year |

| Evaluation questions | Data collection methodology | Level of measurement | Measures | Timelines |
|---|---|---|---|---|
| **Operations** | Mixed methods<br>-Indigenous knowledge translation (storytelling, expressive arts and metaphor)<br>-qualitative (interviews, sharing circles, direct observation/site visit)<br>-quantitative (surveys, document/file review) | Nominal, ordinal, interval/ratio | **Nominal**<br>Description of the major IEAPC-funded project activities<br>Description of the IEAPC-funded project outcomes to date<br>Examples of experiences that suggest<br>-palliative approaches to care are improving in quality (in designing and implementing the IEAPC-funded project). What is working?<br>-challenges/gaps in palliative approaches to care improving in quality (in designing and implementing the IEAPC-funded project). What is not working?<br>-ways to improve quality in palliative approaches to care (in designing and implementing the IEAPC-funded project)<br>Examples of experiences that suggest how the IEAPC-funded project team is recognizing<br>-First Nations-, Inuit- and/or Métis-led and -informed priorities in improving quality to palliative care<br>-priorities of people with lived and living experience in improving quality in palliative care<br>Examples of experiences that suggest how the IEAPC-funded project team is collaborating with<br>-First Nations, Inuit and Métis partners<br>-people with lived/living experience<br>**Ordinal**<br>Level of agreement or satisfaction with the relationship between identified safe/safer care IEAPC-funded project activities and corresponding outcomes<br>**Interval/Ratio**<br># of staff trained to meet needs of patients to provide safe/safer palliative approaches to care | Quarterly or twice a year |
| **Finances** | Quantitative (document/file review) | Interval/ratio | **Interval/Ratio**<br>$ to operate IEAPC-funded project<br>Return on investment (ROI): subtracting the initial cost of the project from its value, then dividing this number by the cost of the investment and multiplying it by 100<br>Social return on investment (SROI): dividing the social and environmental value created by the financial cost of the investment and multiplying it by 100 | Quarterly and annual<br>For calculating ROI and SROI on an annual basis, health economics or related assistance from the IEAPC Program Team may be required |

| Evaluation questions | Data collection methodology | Level of measurement | Measures | Timelines |
|---|---|---|---|---|
| **Learning and growth** | Mixed methods<br>-Indigenous knowledge translation (storytelling, expressive arts and metaphor)<br>-qualitative (interviews, sharing circles, direct observations/site visits)<br>-quantitative (surveys, document/file review) | Nominal, ordinal | **Nominal**<br>Examples of promising or wise practices arising from the IEAPC-funded project with regards to enhancing the quality of palliative approaches to care<br>Examples for how the IEAPC-funded project is using the Palliative Care Competency Framework<br>**Ordinal**<br>Level of agreement or satisfaction with IEAPC-funded project human resources (includes organizational capacity building and professional development) with the relationship between identified quality care IEAPC-funded project activities and corresponding outcomes<br>The extent to which IEAPC-funded project team used the Palliative Care Competency Framework | Quarterly and annual |

## *Other evaluation considerations*

- **Recognize and address social determinants of health and Indigenous-specific social determinants of health**. To what extent are IEAPC-funded initiatives recognizing and addressing some or all of the social determinants of health and Indigenous-specific social determinants of health?

  For example, how are IEAPC-funded initiatives recognizing and addressing housing, basic amenities and the environment? People experiencing homelessness or vulnerable housing often lack the necessary housing, basic amenities and environment to access equitable healthcare supports such as home and community care.

- **Use of proxies.** Proxies such as frontline workers at shelters, an unhoused person's chosen family or related allies/advocates seek to understand and have empathy for people and groups who experience marginalization, discrimination and oppression through deep listening and acknowledgement of their lived experiences. Proxies may seek to promote and empower but not to speak for marginalized people and groups. Proxies can commit to action to correct injustices and promote balance through respect, cultural humility and inclusion.

  Consider if or how proxies may be used in the IEAPC-funded project evaluation on behalf of people experiencing homelessness or vulnerable housing who are accessing palliative approaches to care. For example, suitable proxies would have knowledge, experience and empathy in (1) understanding homelessness and (2) seeking or needing palliative approaches to care.

- **Assess sustainability.** IEAPC-funded initiatives are time-limited in nature. Therefore, assessing the sustainability of IEAPC-funded initiatives aids project teams in creating a business case or related rationale for these initiatives to continue now and into the future. The Long Term Success Tool and The Program Sustainability Assessment Tool are examples of resources that can be used, adapted, scaled and customized to individual IEAPC-funded initiatives to articulate the project team's state of readiness and related efforts for long term impact in supporting people experiencing homelessness or vulnerable housing who are accessing palliative approaches to care.

# Appendix D: About Healthcare Excellence Canada and the Canadian Partnership Against Cancer

Healthcare Excellence Canada
Excellence en santé Canada

CANADIAN PARTNERSHIP AGAINST CANCER
PARTENARIAT CANADIEN CONTRE LE CANCER

## Healthcare Excellence Canada

Launched in 2021, Healthcare Excellence Canada (HEC) brings together the Canadian Patient Safety Institute and Canadian Foundation for Healthcare Improvement. HEC is an independent, not-for-profit charity funded primarily by Health Canada. Through collaboration with patients, caregivers and people working in healthcare, HEC turns proven innovations into lasting improvements in all dimensions of healthcare excellence.

HEC focuses on improving care of older adults, bringing care closer to home with safe transitions, and supporting pandemic recovery and resilience – with safety and quality embedded across all of HEC's efforts. It is committed to fostering inclusive and equitable care through meaningful partnerships with different groups, including patients and caregivers, First Nations, Inuit and Métis, healthcare providers and more. Learn more about HEC.

## Canadian Partnership Against Cancer

As the steward of the Canadian Strategy for Cancer Control (the Strategy), the Canadian Partnership Against Cancer (the Partnership) works to implement the Strategy to reduce the burden of cancer on Canadians. The partner network – cancer agencies, health system leaders and experts and people affected by cancer – brings a wide variety of expertise to every aspect of our work. The federal government created the Partnership in 2006 to move the Strategy into action, and the Partnership receives ongoing funding from Health Canada to continue supporting partners from across Canada. With over 15 years of collaboration, the Partnership is accelerating work that improves the effectiveness and efficiency of the cancer control system, aligning shared priorities and mobilizing positive change across the cancer continuum.

The Partnership continues to support the work of the collective cancer community in achieving its shared 30-year goals: a future in which people in Canada have equitable access to high-quality cancer care, fewer people get cancer, more people survive cancer and those living with the disease have a better quality of life. Learn more about the Partnership.

Since its formation in 2006, the Partnership has been working with partners from across the country to advance action on the cancer care priorities of First Nations, Inuit and Métis Peoples. The Partnership supports self-determined, Peoples-specific solutions for sustainable system change across cancer care that benefit all First Nations, Inuit and Métis Peoples, their families and communities. Learn more about this work.

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# CO-CREATING COMMUNITIES

Healthcare Excellence Canada
Excellence en santé Canada

CANADIAN PARTNERSHIP AGAINST CANCER
PARTENARIAT CANADIEN CONTRE LE CANCER