A missing piece of the puzzle: Health care providers’ experiences supporting older homeless adults in outreach settings

by

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Author's Declaration

I hereby declare that I am the sole author of this thesis. This is a true copy of the thesis, including any final required revisions, as accepted by my examiners.

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Abstract

Background: The older homeless population in Canada is on the rise. Older homeless adults often face multiple health and social challenges, as well as have distinct service needs. While more research is emerging on the characteristics and experiences of older homeless adults, there is limited information on the experiences of health care providers working closely with this population.

Objectives: The purpose of this study was to gain a better understanding of the experiences of frontline health care providers who support older homeless adults (defined as homeless adults aged 50 or older) in outreach settings. This study specifically investigated how they work in their roles with older homeless persons, as well as the challenges and rewards associated with supporting this unique population.

Methods: This qualitative research followed an interpretive description approach. The study consisted of in-depth, semi-structured interviews with a diverse sample of 10 health care providers who support older homeless adults in outreach settings in a mid-sized metropolitan area located in southern Ontario. Concurrent data collection and analysis, along with an iterative approach, were used to conceptualize patterns and key themes in the data.

Findings/Discussion: Four key themes emerged from data analysis, including: 1) the client-provider relationship as an essential building block; 2) progression of care that acknowledges the 'whole person'; 3) collaboration as integral to providers' work; and 4) system navigation. These themes demonstrated that health care providers offer more than clinical services to their clients. They provide social and health support, are collaborators, system navigators, advocates, and educators. Through their multifaceted roles, health providers encounter individual and systems-level challenges, the latter of which posed the most barriers to delivering optimal care to clients.

Some prominent systems-level challenges in their work were: limited funding, insufficient resources and supports tailored to an older homeless population, coordinating care with different sectors, the cyclical nature of homelessness, and stigmatization. Nonetheless, providers also highlighted the rewarding aspects of their roles. They attained personal and professional fulfillment through witnessing their clients' resilience, celebrating the small wins, having strong interprofessional relationships with colleagues, and having substantial flexibility in their work. Conclusion: Facilitating a greater understanding of these health care workers' experiences can be used to identify strategies on how to further support providers in their roles. Furthermore, findings from this study may assist in informing how service provision can be improved to better meet the needs of older homeless individuals. In line with interpretive description's emphasis on producing practical knowledge for practitioners, a series of proposed recommendations for practice, policy and future research were outlined.

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Chapter 1: Introduction

1.1 Introduction on Homelessness

Since the 1980s, homelessness has been acknowledged as a crisis within Canada, impacting individuals from many communities and walks of life (Piat et al., 2015; Gaetz, 2010). Constructing a definition of homelessness is imperative in establishing a better understanding of what the term encompasses to determine its underlying causes, who it impacts, and how it can be appropriately addressed. While some debate still exists on how to accurately define homelessness (The Homeless Hub, 2009; Hulchanski, 2009), I will be using the Canadian Observatory on Homelessness (COH) definition to inform my understanding of homelessness within the scope of my research. This definition captures the heterogeneity of the homeless population which contains a variety of individuals and families encountering diverse circumstances and challenges (see Glossary).

Homelessness is described as falling on a continuum; at one end are individuals without any shelter, while on the opposite end are the insecurely housed (Gaetz et al., 2012). Since homelessness includes a variety of living and physical situations, a typology was developed to organize the range of accommodations that persons lacking appropriate, stable and permanent housing may be confronted with (Gaetz et al., 2012). This typology comprises individuals who are (1) unsheltered or absolutely homeless, (2) emergency sheltered, (3) provisionally accommodated, and (4) at risk of homelessness (Gaetz et al., 2012). It is important to emphasize that for most individuals, homelessness is a fluid experience as opposed to a static state (Gaetz et al., 2012). This is because a person's shelter circumstances can shift significantly and repeatedly (Gaetz et al., 2012), resulting in ongoing movement between the stages outlined above.

The homeless population can also be differentiated according to the duration and severity of experience, including the chronically homeless, episodically homeless, and transitionally homeless (Gaetz et al., 2014). Distinguishing between the extent and type of homelessness is important, as the episodically and chronically homeless are disproportionately impacted by the severity of their personal struggles (Gaetz et al., 2014). Furthermore, while the episodically and chronically homeless comprise less than 15% of the homeless population in Canada, they use more than half the resources available in the homelessness system, such as day programs and emergency shelter beds (Gaetz et al., 2014).

The homelessness crisis in Canada has expanded from an issue predominantly affecting single men to a problem encompassing a diverse group of men, women, and families (Piat et al., 2015; Gaetz, 2010). Within the homeless population, there is a growing number of older adults over the age of 50 (Stergiopoulos & Herrmann, 2003; Edmonston & Fong, 2011). This trend can be attributed to global population aging, declining wages, reduced benefits (pensions and social assistance), and a limited amount of affordable housing (Ploeg et al., 2008; Gaetz et al., 2014). Older adults are especially vulnerable to the negative consequences of being homeless, including institutionalization and premature death (Ploeg et al., 2008). While there is some literature that captures the characteristics and experiences of older homeless adults, there is still a limited body of research on their service needs and the types of health supports required by this sub-population (McDonald et al., 2007; Canham et al., 2019). Providers, such as health care workers, who work closely with older homeless adults in the community are poised to offer a better understanding of the health and social supports needed by their clients. However, to date, providers' experiences working with older homeless adults are not well-represented in the literature.

This qualitative project guided by interpretive description, aimed to understand the experiences of health care providers who work with older homeless adults in outreach settings, which is one of the most prevalent locations where older adults experiencing homelessness access care (McDonald et al., 2007; Chung et al., 2018). Using semi-structured interviews, health care providers spanning multiple disciplines were asked about how they work in their roles with older homeless adults, as well as the challenges and rewards encountered in their work. There are three central purposes of providing insight into these health care providers' perspectives and accounts: 1) we can determine how to better support health care providers who work with older homeless adults in outreach settings, such as through additional resources and training; 2) in turn, we can plan for better care and services for older homeless adults; and 3) we can provide relevant information for other providers considering working with this population.

Chapter 2: Background and Literature Review

In this chapter, pertinent literature on the current state of homelessness in Canada will be reviewed. Next, homelessness in older adults will be explored, with a specific focus on the "invisibility" of older homelessness, population aging and changing age structures, challenges faced by older adults, differences in homeless trajectories, and risk factors and pathways of older homelessness. Lastly, studies exploring providers' experiences working with homeless populations, and more specifically, older homeless adults will be presented.

2.1 Overview of the Causes of Homelessness

A brief exploration of some of the prevalent causes of homelessness will allow for a better contextual understanding of how this multifaceted issue is engrained in structural factors, individual situations, and systems failures (Gaetz et al., 2013). At the structural level there are economic and societal issues that impact an individual's opportunities and social environments (Gaetz et al., 2013). Some structural factors identified in the literature are: elevated housing costs, inadequate income resulting in poverty, conditions in the labour market, lower public benefits, and experiencing racism and/or discrimination (O'Flaherty, 1996; Schwartz & Carpenter, 1999; Gaetz et al., 2013; Toro, 2007). Canada's rapid urbanization is also playing a substantial role in the homelessness crisis, as affordable housing in large urban centres is limited (Frankish et al., 2005; Woodward et al., 2002).

Individual and relational factors pertain to a homeless individual's personal circumstances, such as: traumatic events; challenges with mental health and addictions; adverse childhood experiences; low educational attainment and insufficient job skills; and domestic violence (Koegal et al., 1995; Herman et al., 1997; Morell-Bellai et al., 2000; Gaetz et al., 2013).

Systems failures happen when other mainstream care and support systems are inadequate, leading vulnerable individuals to rely on the homelessness sector (Gaetz et al., 2013). Some examples of systems failures include insufficient discharge planning for persons transitioning out of hospitals, as well as corrections and mental health/addictions facilities (Gaetz et al., 2013; Canham et al., 2017).

Since homelessness is usually the result of numerous compounding factors (some of which are listed above), it is imperative that research, policies, and programs take into consideration the multiple pathways to homelessness that exist. A qualitative study conducted by Piat et al. (2015) demonstrated how individual and structural factors interact with each other in pathways to homelessness. This supports the concept that homelessness is a process, as opposed to the result of one precipitating event (Martijn & Sharpe, 2006).

2.2 Homelessness in Canada

Due to the lack of reliable and comprehensive data, enumerating homelessness in Canada has been a point of contention with estimations of homelessness being primarily drawn from shelter data (Peressini et al., 1996; Gaetz et al., 2016; Gaetz et al., 2013). As discussed above, defining homelessness has been challenging, resulting in the use of inconsistent definitions to inform data collection (Begin et al., 1999; Bentley, 1995). Other issues that limit a clear picture of the extent of homelessness in Canada involve: the transient characteristics of homelessness, difficulties identifying who is homeless, maintaining communication with this population, and the absence of participation from local agencies (Begin et al., 1995; Bentley, 1995).

The *State of Homelessness in Canada 2016* report suggests that at least 235,000 Canadians experience homelessness throughout a given year (Gaetz et al., 2016). It is imperative to highlight that the actual number of persons facing homelessness in Canada is likely significantly higher (Gaetz et al., 2016; Trypuc & Robinson, 2009). Furthermore, it is estimated that homelessness costs the Canadian economy approximately $7 billion dollars per year (Gaetz et al., 2013). This figure takes into consideration the cost of emergency shelters, along with health care, social services, and corrections (Gaetz et al., 2013). The expenses surrounding homelessness have been widely attributed to people cycling through costly public systems and emergency service systems that are not coordinated (Gaetz et al., 2013).

The homeless population is not homogenous; rather, homelessness is experienced by people from many walks of life, ages, ethno-racial backgrounds, and genders (Frankish et al., 2005; Gaetz et al., 2013). However, current data show that certain groups have a higher likelihood of being homeless (Segeart, 2012; Gaetz et al., 2013). Adult single males between 25 and 55 years of age account for 47% of the Canadian homeless population (Segeart, 2012). Other sub-populations are also confronted with certain risks and/or experience special circumstances, such as: youth, women, and families (Gaetz et al., 2013). In addition, Indigenous persons, LGBTQ individuals and immigrants are disproportionately represented in Canada's homeless population (Grenier et al., 2016a). Findings from Peressini's (2009) study reiterate that appropriate interventions should keep in mind the distinctive needs of these groups.

2.3 Homelessness in Older Adults: An Emerging "Invisible" Issue

Population aging paired with other compounding socio-economic issues, such as the lack of affordable housing, is expected to increase the number of older adults facing homelessness in Canada (Edmonston & Fong, 2011; McDonald et al., 2004; Crane & Warnes, 2001). The literature suggests that 'older' homeless adults include persons who are 50 years of age and over.

This is because homeless individuals in their fifties usually begin exhibiting age-related health impairments that usually occur a decade later in the general population, paired with this population's lower life expectancy (McDonald et al., 2007; Hahn et al., 2006; Crane & Warnes, 2001). Therefore, within the scope of this study, the phrase 'older homeless adults' will encompass individuals who are 50 years old and above. Five central themes were emphasized in the literature on aging and homelessness: (1) the 'invisibility' of older homelessness; (2) population aging and its impact on changing age structures within society, including those who are homeless; (3) the distinct challenges experienced by older homeless adults, which differ from their younger counterparts; (4) the differences in homeless trajectories; and (5) the risk factors and pathways of older homelessness. These key themes will be explored in greater depth.

(1) The "invisibility" of older homelessness

Despite the increasing numbers of older homeless adults in Canada and internationally, this sub-population remains largely overlooked (Barken & Grenier, 2014). While more research is beginning to explore older age homelessness, most studies on homelessness are still centred around earlier periods of the life course (McDonald et al., 2007; Crane & Warnes, 2005). In fact, most research and interventions have been targeted at homeless youth, as well as families with young children (Crane & Warnes, 2010; Gonyea et al., 2010; Culhane et al., 2013). This may be partly explained by collected data on homelessness. For example, a 2001 report indicates that in major urban centres like Toronto and Ottawa, youth and families with young children are the most rapidly growing group of homeless persons (Eberle et al., 2001). Meanwhile, in some Canadian cities older adults are still a minority among homeless people (Grenier et al., 2016a;

Grenier et al., 2016b). However, this trend is starting shift due to population aging and will be explained further below.

Moreover, the literature suggests that the invisibility of homeless older adults may reflect underlying societal viewpoints and assumptions (Gonyea et al., 2010). Gonyea et al. (2010) point to society's reluctance to admit that aging family members may be struggling with poverty, addictions and/or mental illness and finding themselves in precarious living situations. The authors also suggest that the general inattention to homelessness in older age shows the societal perception that the older population is managing well, especially in comparison to younger populations (Gonyea et al., 2010).

(2) Population aging and changing age structures

A 2016 literature review on homelessness among older people revealed that while older adults are still a minority in homeless populations within certain Canadian cities and regions, population aging is shifting current age structures (Grenier et al., 2016b). In 2014, it was estimated that about 14% of homeless persons in Metro Vancouver were in the 55-64 age range, and 4% were 65 years of age and over (Greater Vancouver Regional Steering Committee on Homelessness, 2014). Although the percentage of adults 55 years of age and older indicated appears small, the report reiterates that according to service providers the data underestimate the true extent of homelessness in Vancouver (Greater Vancouver Regional Steering Committee on Homelessness, 2014). This may especially be the case for older adults who are often disconnected from community services and who avoid shelters (Stergiopoulos & Herrmann, 2003; Cohen et al., 1988). The 2013 homeless count in Toronto reported a larger proportion of older homeless adults, with 29% of the homeless population counted as over 51 years old (City of Toronto, 2013). On the other hand, the 2015 count in Montreal noted that individuals aged 50+ made up the largest group of the homeless population (41%), even though Montreal has a smaller homeless population than both Vancouver or Toronto (Latimer et al., 2015). Increasing numbers of older homeless adults in Canada echoes the importance of addressing this population's distinct challenges.

(3) Challenges faced by older homeless adults

A reoccurring theme in the literature is the unique social and health challenges experienced by older homeless adults. While less than 10% of shelter users in Canada are 55 years of age and older, numerous studies show that they normally have longer shelter stays than their younger counterparts (Segaert, 2012; Serge & Gnaedinger, 2003). However, shelters are not typically designed with an older adult population in mind, meaning that they are often inaccessible and/or not adequately equipped to meet the needs of older individuals (Serge & Gnaedinger, 2003). Within shelters and on the streets, older adults are also more susceptible to violence and threats to their safety, as they are often viewed as easy targets (Lee & Schreck, 2005; Dietz & Write, 2005).

For the most part, older homeless adults have smaller social networks that also differ in their composition than the general older population (Cohen, 1999; McDonald et al., 2004). The social networks of older homeless persons usually include individuals from institutions and agencies, such as service providers, and they normally have fewer intimate ties to family than the general population (McDonald et al., 2004). In comparison to their younger counterparts, older homeless individuals experience more social isolation; they are not as likely to interact with other homeless people on the streets, do not have extensive contact with their family, and do not readily seek help from family members (McDonald et al., 2004).

It has been well-established in the literature that older homeless adults face more physical and mental health disadvantages than their younger counterparts (Bottomley, 2001; Garibaldi et al., 2005; Gonyea et al., 2010; Lipmann, 2009). Some frequently reported health issues include vision, dental and back problems, as well as arthritis (McDonald et al., 2004). Based on the findings from a Toronto study, women are more likely to report having problems with bladder control and arthritis (McDonald et al., 2004). Meanwhile, men are more likely to experience skin and back problems (McDonald et al., 2004).

In many cases, older homeless adults have a variety of chronic conditions and complex care needs (Håkanson, & Öhlén, 2016; Hahn et al., 2006; Garibaldi et al., 2005). In comparison to younger homeless adults, it is estimated that older homeless individuals are over 3 times more likely to experience a chronic medical comorbidity (Garibaldi et al., 2005). Common chronic medical conditions amongst the older homeless population include musculoskeletal disorders, chronic obstructive pulmonary disease and seizures (Crowe & Hardill, 1993). Managing diabetes and hypertension is particularly difficult for individuals experiencing homelessness (Hwang & Bugeja, 2000; Kinchen & Wright, 1991). Some contributing factors, highlighted in the literature, that prevent older homeless adults from managing their chronic conditions are the inability to make dietary choices and coordinating taking medication with meals (Hwang & Bugeja, 2000).

The prevalence of geriatric syndromes, which are connected to higher rates of mortality, disability, and utilization of acute care services, are also significantly elevated among older homeless adults in comparison to the general population (Tschanz et al., 2004; Tinetti et al., 1993; Mor et al., 1994; Brown et al., 2012). Amongst the geriatric syndromes are mental health problems, cognitive impairments, and frailty (Brown et al., 2012). For example, a study conducted by Kim et al. (2010) discovered that the probability of having mental health issues doubles for homeless persons over forty-two years of age. In Stergiopoulos and Hermann's (2003) overview of studies, they identified psychosis, depression, and cognitive impairment as the most frequently cited psychiatric disorders within the older homeless population. Due to the elevated burden of disabilities and disease in older homeless adults, this vulnerable population is at an increased risk of frailty (Kushel, 2011). Frailty is defined as an increased state of vulnerability to stressors and decreased reserve (Fulop et al., 2010; Rodríguez-Mañas et al., 2012). Older homeless adults may be placed at a greater risk of frailty due to a myriad of factors, such as adverse life events (Hamilton et al., 2011), substance abuse (Fountain et al., 2003), incarceration (Greenberg & Rosenheck, 2008), as well as mental and physical conditions impacting their health (Nyamithi et al., 2011).

In addition to the social and health challenges faced by the older homeless population, this group faces problems accessing services and shelters (McDonald et al., 2007; Crane, 1996). McDonald et al. (2004) interviewed older adults who were homeless or at risk of homelessness in Toronto. They discovered that one of the barriers to accessing social services is not having the necessary knowledge, as older homeless adults may not be cognizant of the services that can assist them (McDonald et al., 2004). Older homeless people are also confronted with barriers accessing health services, including: mistrust and fear of health care professionals, fear of their illness and/or not recognizing its severity, not possessing a health card, and the price of medications (McDonald et al. 2004; McDonald et al., 2007; Daily Bread Food Bank, 2001). The myriad of distinct challenges encountered by older homeless persons supports the idea that services and programs should be designed to address the specific needs of this population (McDonald et al., 2004).

(4) Differences in homeless trajectories

The literature on homelessness among older homeless persons underscores two distinct trajectories: 1) persons who are homeless throughout the course of their lives and continue following this pattern into older age (chronic or episodic homelessness), or 2) individuals who face homelessness for the first time later in life (late life homelessness) (Grenier et al., 2016b). While the literature has largely emphasized the chronic category, which is likely attributed to its 'human and societal costs', more recent research is pointing to the second pathway's growing prevalence on an international scale (Brown et al., 2013; Grenier et al., 2016b). For example, findings from a 3-nation study on homelessness in later life taking place in the United States, Australia, and England revealed that two-thirds of the older adult participants interviewed had not experienced homelessness during earlier periods of their lives (Crane et al., 2005). Furthermore, older adults who experience homelessness later in life are at a higher risk of staying homeless on a more long-term basis (Caton et al., 2005). Therefore, it is necessary to explore the reasons why and how older people can become homeless later in life.

(5) Risk factors and pathways of older homelessness

The literature on pathways into homelessness later in life is not as clearly presented as that on pathways into homelessness earlier in life (Grenier et al., 2016a). However, research suggests that progressive declines and 'trigger events', along with numerous individual and structural factors, play a part in homelessness within the older population (Grenier et al., 2016a;

Gonyea et al., 2010). Grenier et al.'s (2016a) literature review indicates that macro-level forces can place certain groups of older adults at a disadvantage, which may increase their risk of homelessness. Some structural issues that are commonly associated with homelessness in older persons consist of: insufficient affordable housing, employment difficulties reinforced by ageism, and policies that restrict some people from accessing disability, health and pension benefits (Grenier et al., 2016a; Gaetz et al., 2013; Ng et al., 2013; Vance, 1995; Lee et al., 2010).

In addition to the macro-level conditions listed above, are individual factors that can lead older persons to face a gradual decline into being homeless (Grenier et al., 2016a). Some of these individual factors involve: waning finances resulting in poverty, poor physical and/or mental health, diminishing social connections, alcoholism, lower education levels, and a history of incarceration (Morris et al., 2005; Shinn et al., 2007; Dietz, 2009; Grenier et al., 2016a). Individuals who are subjected to these situations may not possess the required skills or resources to cope with crises, and this may trigger homelessness (Grenier et al., 2016a; Crane & Warnes, 2005). Trigger events encompass: the death of a family member or close friend who may have been a care provider, loss of housing or accommodation, family breakdown, and/or domestic violence (Crane & Warnes, 2005; Gonyea et al., 2010).

Research also reflects the differences in pathways between men and women (Grenier et al., 2016a). Homelessness in older men is usually related to mental health issues, addiction, or loss of employment. Homelessness in women later in life is often connected to a trigger event resulting in being homeless for the first time (Toro, 2007; Shinn et al., 2007). Grenier et al. (2016a) state that two issues pertaining to older women's pathways to homelessness are highlighted in the literature: poverty due to family situations as well as the pension system's structure (Rahder, 2006), and experiencing abuse (Toro, 2007). It is clear that there is no single pathway into homelessness later in life, and that these pathways can significantly differ between genders.

2.4 Provider Perspectives and Experiences

As evidenced in the literature, we know that as the population of older homeless adults continues to rise in Canada, it is imperative that services and programs are tailored to meet the unique needs of this heterogenous and particularly vulnerable population. More research is starting to explore the characteristics and experiences of older homeless persons (Brown et al., 2019; Stergiopoulos & Herrmann, 2003; Kisor & Kendal-Wilson, 2002; Grenier et al., 2016b). However, the experiences of frontline providers working closely with this population remains understudied.

Why does eliciting the experiences of providers matter within this context? First of all, frontline service providers supporting older homeless persons witness firsthand the health and social challenges faced by this sub-population. Thus, they can provide valuable input on how services and programs can better support older homeless adults. Secondly, due to the relatively small social networks of this marginalized population, providers often form a key component of their reduced social support networks (McDonald et al., 2004). By speaking with providers, we can also learn how to strengthen support systems for providers. This is critical because working with older homeless persons can often be difficult as a result of systemic barriers (McDonald et al., 2004). A brief summary of the literature on service providers' experiences will be outlined, followed by a discussion on how my research will attempt to address certain gaps in knowledge.

Providers' experiences working with homeless individuals

Presently, there is a small body of research on service providers' experiences working with homeless populations internationally, and even less in Canada (Kerman et al., 2017). However, a pervasive theme within both international and Canadian literature is the barriers that social service and health providers encounter preventing them from better meeting the needs of homeless persons (Kerman et al., 2017). A study by Salem et al. (2018) looked at the perspectives of homeless service providers who work with homeless women. Their sample included participants with a range of occupations (i.e., case managers, social workers, an administrator, and a person working in mental outreach). Homeless service providers spoke about structural and individual-level challenges navigating systems, such as insufficient resources, issues with documentation and shelter accommodations (Salem et al., 2018). Recommendations for programs and targeted outreach approaches were discussed, such as culturally competent training for providers and facilities for women (Salem et al., 2018). The providers also brought up age-related needs specific to older homeless women and the importance of therapeutic relationships rooted in trust (Salem et al., 2018).

Another study guided by the principles of phenomenology captured nurse practitioners' experiences providing care to those that are homeless (Seiler & Moss, 2012). The participants described their experiences working with this population as rewarding, but also discussed the challenges and emotional demands that accompanied their role (Seiler & Moss, 2012). The nurse practitioners touched upon the importance of developing reciprocal relationships with homeless patients (Seiler & Moss, 2012). Through the studies presented, it is evident that providers' insights may allow for a deeper understanding of the complexities surrounding homelessness, the challenges associated with supporting this population and the areas of need for certain sub-populations.

Providers' experiences working with older homeless adults

To date, few studies have specifically explored providers' experiences working with older homeless adults. Providers' perspectives and experiences form "an important piece of the puzzle" to gaining a more comprehensive understanding of the unique needs of this population (Watson, 2010, p. 30). Watson (2010) interviewed staff from different agencies that support older homeless clients in Chicago. The purpose of this research was to acquire provider perceptions on service provision issues related to an older homeless population, and the differences between older homeless persons and clients belonging to other age groups (Watson, 2010). The three main issues impacting service provision for older homeless persons that were discussed by the providers included mental health, physical health, and housing (Watson, 2010). This work emphasized the need for particular therapeutic techniques that consider aging and novel forms of engagement and outreach specifically designed for older adults (Watson, 2010). A study based in Toronto interviewed both older homeless adults and staff/service providers who deal directly with homeless persons (McDonald et al., 2004). Findings from this research pointed to a lack of services and programs that explicitly target the needs of the older homeless population, as well as sub-groups falling in this category like the long-term and newly homeless (McDonald et al., 2004). The participants also echoed the need for service coordination and partnerships especially between the geriatric and homeless service sectors (McDonald et al., 2004).

An area that remains significantly unexplored is the experiences of health care providers who work with older homeless adults. In general, the perspectives and roles of providers have not been at the forefront in health services research, even though they are vital pieces of the puzzle in all forms of health service delivery (Shelton, 2001). Due to the plethora of health disadvantages faced by older homeless persons which are compounded by the barriers they encounter when accessing health care (Grenier et al., 2016a), it is imperative that health care providers are appropriately supported (e.g., with resources and/or training opportunities) so that they can better meet the needs of this population. In order to develop strategies on how health care providers can be further supported, as well as how programs and services can be strengthened to better meet this population's needs, we need to "be able to see the world through the providers' eyes and understand them better" (Shelton, 2001, p. 152).

In summary, we know that older adults experiencing homelessness form a heterogenous group that encounter a unique set of health and social challenges. While the literature on homelessness in older age is expanding, further exploration is needed on the services and types of health supports required by this sub-population. The relationships between providers and older homeless adults is critical, since providers are 'gatekeepers' of health and social services (Biederman & Nichols, 2014; Salem et al., 2018). However, there is a need for more research that incorporates the perceptions of providers, particularly health care providers who support older homeless adults in the community.

Chapter 3: Study Aims

3.1 Study Rationale

My exploratory study aimed to fill this current gap in knowledge by exploring health care providers' experiences supporting older homeless adults. More specifically, my research focused on the experiences of health care providers supporting older homeless adults in outreach settings, which included drop-in clinics operating in shelters and homeless service centres (i.e., soup kitchens). Since homeless persons may struggle accessing and obtaining care in conventional health care settings, such as emergency rooms, hospitals, and clinics open to the general public, other outreach models have been recommended to make health care services more accessible to homeless individuals in the community (Hwang et al., 2000; Elvy, 1985; Jego et al., 2018). Learning from health care providers who work in these alternative models of care is important as they may be the first point of contact for older homeless persons with complex health and social challenges. Although I initially considered gathering the perspectives of both providers and older homeless adults, it was determined that this approach would not be feasible or appropriate for the purposes of a Master's project. Older homeless adults are an especially vulnerable and marginalized group and it is important that as a researcher, I was mindful of the time required to build a trusting relationship with research participants.

Furthermore, health care providers working in a mid-sized metropolitan area situated in southern Ontario were interviewed for this study. Currently, a large portion of homelessness research is focused on large metropolitan areas, such as Toronto, Vancouver, and Montreal. Nonetheless, homelessness and population aging are social issues prevalent in Canadian mid-sized metropolitan areas. Thus, acquiring the perspectives of providers working with homeless older adults in a mid-sized city was warranted.

3.2 Research Questions

This research investigated the central research question and sub-questions:

1. What are health care providers' experiences supporting older homeless adults in outreach settings in a mid-sized metropolitan area located in southern Ontario?
    a) How do health care providers work in their roles to meet the complex needs of older homeless persons in outreach settings?
    b) According to these health care providers, what are the challenges of working with homeless older adults and what further resources or supports might assist them in addressing these challenges?
    c) What are the rewards of working with homeless older adults in outreach settings?

To answer these research questions, it is important to define the terms 'health care providers' and 'homeless older adults' within the scope of this study. The term 'health care provider' incorporates a broad range of providers who deliver care in varying capacities. Some examples include nurses, nurse practitioners, physicians, social workers and chiropodists. These health care providers may interact with clients that fall anywhere along the homeless continuum in outreach settings, from being unsheltered to insecurely housed. Thus, the phrase 'homeless older adults' encompasses persons 50 years of age or older who fall anywhere along the homeless continuum described earlier. In addition, during interviews with providers, individuals referred to the older adults they worked with as "clients", "patients", and/or "participants." For the purposes of this study, the word "clients" was used to convey the providers' relationships with the older adults that they support. This decision was made since "clients" was the most frequently used term by the study participants, but it is still critical to acknowledge the diversity in terms used by the providers that were interviewed.

The overall goal of this study was to expand our understanding of the experiences of health care providers who work with older homeless adults in outreach settings located in a mid-sized metropolitan area in southern Ontario. By asking providers about their work with homeless older adults (roles, challenges and rewards), findings from this research can be used to inform practice, policy and educational strategies pertaining to how we can better support health care providers in their work with older homeless persons.

Chapter 4: Methods

4.1 Research Design and Approach

The experiences of health care providers supporting older homeless persons in outreach settings were explored using an interpretive description approach (Thorne, 2008; Thorne, Kirkham, & O'Flynn-Magee, 2004). Interpretive description is an analytical, inductive approach that is aimed at generating ways of understanding aspects of individuals' health and illness experiences from an applied health standpoint (Thorne, 2008; Thorne et al., 1997). This recently developed non-categorical approach "align[s] with a constructivist and naturalistic orientation to inquiry" (Hunt, 2009, p. 1284), in that realities are fundamentally subjective, as well as contextual and constructed (Thorne, 2008; Thorne et al., 2004). Interpretive description recognizes that commonalities may exist between people with similar experiences, but also acknowledges "the individual expressions of variance" (Thorne, 2008, p.74).

One of the hallmark elements of interpretive description is creating meaningful knowledge that can be applied within practice and clinical contexts (Thorne, 2008). As interpretive description is situated within "the applied disciplinary domain," it does not necessarily emphasize theorizing (Thorne, 2008, p.68). Thus, a theoretical framework was not adopted for the purposes of this study. Instead, my thesis was grounded in describing and interpreting "patterns of experience, action, or expression" (Thorne, 2008, p.68). Interpretive description was selected to address the proposed research questions as it allows for both a description and interpretation of health care providers' shared experiences of supporting older homeless adults in outreach settings. It also facilitated an understanding that upholds the unique perspectives of each health care provider, which supports interpretive description's emphasis on subjective and contextual constructions of experiences. In addition, one of the goals of this research was to generate knowledge that will be relevant and applicable to health care providers who work with older homeless persons.

4.2 Participants, Recruitment and Data Collection

Setting and sampling strategies

This study was conducted in southern Ontario, Canada in a middle-sized metropolitan area. As much as possible, I aimed to recruit a diverse sample of health care providers who work with homeless individuals in differing capacities with varying years of experience working in their roles. My sample consisted of 10 health care providers who had firsthand experience working with older homeless adults in outreach settings. Of the 10 participants, 50% had a background in nursing and 2 providers were allied health professionals (see Table 1). As noted in Table 1, of the total sample, 1 health care provider was retired, and the remaining were currently practicing. The total participant sample consisted of 7 females and 3 males. The years of experience working in outreach with homeless persons was fairly balanced with 60% of the participants having 0-5 years and the remaining 40% having 6+ years (see Table 2). The total years of experience working in the health care field were also recorded, with 4 providers having 16+ years in their respective disciplines (see Table 3).

Table 1: Participant roles

Participant roles	# of participants
Nurse Practitioner (NP)	2
Family Physician (MD)	2*
Psychiatrist (MD)	1
Chiropodist	1
Registered Nurse (RN)	2
Registered Social Worker (RSW)	1
Shelter Manager of Mental Health & Housing (background in outreach nursing)	1

*one of the family physicians was retired

Table 2: Number of years of experience in outreach

Years of experience in outreach	# of participants
0-1	3
2-5	3
6-10	2
11+	2

Table 3: Number of years of experience in health care field

Years of experience in health care field	# of participants
0-5	2
6-10	3
11-15	1
16+	4

Purposeful sampling was used to develop a deeper understanding of health care providers' experiences supporting older homeless adults in outreach settings. This sampling technique is "widely used in qualitative research for the identification and selection of information-rich cases for the most effective use of limited resources" (Palinkas, 2015, p. 534). Within this study, purposeful sampling allowed me to identify health care providers who had firsthand experience working with older homeless adults in outreach settings and could articulate their thoughts. Therefore, participants were eligible for inclusion if they were a practicing or former health care provider, had firsthand experience working with older homeless adults (individuals aged 50 years and older) in outreach settings, and were fluent in English. I attempted to capture a full range of perspectives by intentionally recruiting a diverse group of knowledgeable providers, including allied health professionals. Due to the relatively small pool of potential participants, a snowball approach was used to recruit more providers from current participants' personal networks (Patrick et al., 1998). These personal networks often involved a diverse group of health care providers since all participants worked on interdisciplinary teams.

Recruitment and data collection

A key stakeholder, who is the Director of Housing for a men's shelter in the region, was contacted. The importance and relevance of the study was explained to the key stakeholder, and study procedures were outlined (see Appendix A1). Upon approval from the key stakeholder, the recruitment email was forwarded (Appendix B1) to health care providers in her professional network who work in outreach settings. The key stakeholder was also sent the study's recruitment poster (Appendix C1) that could be placed in staff or meeting rooms at her organization's site. As mentioned previously, snowball sampling further supported recruitment. In-person interviews took place prior to the onset of the COVID-19 pandemic, however recruitment and data collection were eventually modified to include only telephone interviews with participants (see Appendices A2, B2, & C2).

Health care providers, who expressed interest in participating in the study, were invited to schedule in-person (n=8) or telephone interviews (n=2) at a time and location that was most convenient for them. Prior to commencing the interview, I reviewed the study's letter of information (Appendices F1 or F2) with each participant. I ensured that the participants were made aware that being involved in this study was completely voluntary, and that if they chose to withdraw from the study, their data would be immediately destroyed. After answering any questions that the participants had, I obtained written consent for in-person interviews (Appendix

G). Verbal consent was obtained for telephone interviews (Appendix H) and recorded using a verbal consent log (Appendix I).

In-depth semi-structured interviews were used as the data collection method for this study. Thorne (2008) posits that individual interviews can establish a useful basis when generating knowledge pertaining to issues within clinical/applied health settings. Individual interviews were especially required in this context since little is known about the experiences of health care providers who work with older homeless adults in outreach settings. Thus, interviews facilitated a rich understanding of the thoughts, challenges and rewards surrounding their roles and work with this complex population. In line with the underlying principles of semi-structured interviews, the prepared interview guide (Appendix D) included open-ended questions and probes that were used to follow up on participants' responses (Roulston, 2010).

Before data collection began, I piloted my interview guide with a nurse practitioner who had been working on an outreach primary care team with homeless persons for more than a year. This ensured that the language used in the interview guide was clear and appropriate, as well as provided me with the opportunity to practice timing and question delivery. Any necessary adjustments were made to the interview guide prior to conducting the other interviews. Interviews lasted between 30 to 90 minutes and broadly explored health care providers' experiences supporting older homeless adults in outreach settings. Health care providers were first asked some general background information questions, such as what their position was and years of experience in their field. Afterwards, I asked participants about how they work in their role to meet the complex needs of older homeless persons. We also discussed the challenges of working with this population and what additional resources or supports would be useful in addressing these challenges, as well as the rewards of working with older homeless persons.

I wrote supplementary field notes during and after the interviews, which were recorded in a journal. The notes taken involved any specific points mentioned by the participant that I wanted to follow-up on, interesting observations that could not be captured through the audio recording, thoughts, feelings, and ideas. Concurrent data collection and analysis, guided by reflective and iterative processes, were employed throughout the study (Thorne, 2008). At the end of each interview, health care providers received a feedback letter (Appendix J) and remuneration through a $10 gift card. Participants were also asked whether they would like to participate in a follow-up discussion (Appendix E) to further explore or challenge developing conceptualizations. Seeking participants' input prior to finalizing the study's analysis is a strategy proposed by Thorne et al. (1997) to enhance rigor within interpretive description.

4.3 Data Analysis

Data analysis followed an inductive approach, consisting of working with the data to derive concepts, explanations or themes related to the phenomenon (Thorne, 2008; Thomas, 2006). While interpretive description can draw upon a range of qualitative approaches to guide the analytic process, the researcher should be dedicated to "comprehending data, synthesizing meanings, theorizing relationships, and recontextualizing data into findings" (Thorne et al., 2004, p. 6; Morse, 1994). Ongoing immersion in the data before commencing coding, classifying, or establishing linkages is encouraged (Thorne et al., 1997; Thorne, 2008). As previously mentioned, immersion in the data began during and following each interview by means of written field notes and journaling. I then transcribed the audio recordings verbatim, which allowed me to continuously engage with the data, as well as support the creation of brief synopses of each interview (Thorne, 2008). Similarly, Hunt (2009) wrote synopses so that he could continuously refer to them throughout the analytic process and keep in mind each participant’s entire narrative and its idiosyncratic elements. Please reference Appendix K for an example of a participant synopsis. Following the transcription of each interview, I completed a close reading of each transcript to further facilitate immersion in the data (Thorne, 2008). This involved jotting down initial thoughts, points of interest and questions in the transcript margins. All transcriptions were uploaded and managed in NVivo 12, a qualitative data analysis computer software.

Next, I created a preliminary broad-based coding scheme. Rather than focusing on precision within my codes, I attempted to group data with similar properties together and considered how they related to other groupings (Thorne, 2008). The initial coding strategy allowed me to draw together “a group of data bits” that may have been thematically related and reflect upon what the relationships might look like (Thorne, 2008, p.146). For example, ‘building trust’, ‘encouraging client choice’ and ‘adopting central support roles’ were grouped together during early stages of data analysis. Over time, it became clear that these approaches adopted by providers were elements of the client-provider relationship, a major theme explored in this thesis. Engaging with the data holistically facilitated an understanding of the larger picture, which is an important feature of fostering more comprehensible analytic frameworks for interpretive description (Hunt, 2009; Thorne, 2008). This was accomplished by asking questions such as, “what is happening here?” and “what am I learning about this?” (Thorne et al., 1997). Alongside coding, I engaged in memoing to capture my ideas on early patterns, lingering questions about health care providers’ experiences, and how excerpts relate to other participants’ transcripts.

Hallmark aspects of interpretive description are “constant comparison, iterative analysis and reciprocal approaches to data making and analysis” (Hunt 2009, p.1288). Since data collection and analysis occurred concurrently, preliminary codes were adjusted as interviews and immersion in the data continued (Thorne, 2008). Analysis was also driven by constant comparison, which involved juxtaposing data to search for similarities and differences that existed across and between participants' experiences working with older homeless persons in outreach settings (Thorne, 2008). During this process, I frequently returned to the participant synopses to be mindful of individual cases, while seeking to recognize commonalities among participants' experiences (Hunt, 2009). Concept mapping is a visual tool that was used to assist in conceptualizing patterns in the data and the eventual development of themes (Hunt, 2009; Thorne et al., 2004). Before sharing preliminary findings with participants, the initial codes and emerging themes were reviewed with a second researcher. Prior to finalizing the analysis, participants were invited to provide feedback on evolving themes in the data, as well as comment on the list of drafted recommendations for practice, policy, and research. Feedback was provided informally through email and served to refine the analytic process, by giving me the opportunity to think about how the participants' perspectives supported or challenged my initial analysis.

A journal, in the form of a blank notebook, was used to document analytic thinking from the project's conception to the end stages of analysis. The journal outlined my analytical reasoning and decisions, recorded my thought processes and personal reflections (Thorne, 2008), as well as served as an audit trail (Birks et al., 2008; Lincoln & Guba, 1985). For example, during data analysis, the journal was used to highlight components of the data that were surprising or confusing to me, and concepts that required further probing. Throughout the study's duration, the journal also recorded field notes, memos, and concept maps. Journaling was one of the approaches used to enhance qualitative rigor in this study. Please see Table 4 in Appendix L for strategies adopted in this study to ensure methodological rigor.

4.4 Considerations

Reflexivity

Within qualitative research, reflexivity is imperative throughout the research process, from the creation of research questions to drawing conclusions (Guillemin & Gillam, 2004). Reflexivity is rooted in critical reflection on the types of knowledge generated from research and how that knowledge is produced (Guillemin & Gillam, 2004). A reflexive researcher is able to critically look at their role in the research process and recognize the factors shaping their construction of knowledge (Guillemin & Gillam, 2004). Another aspect of reflexivity is critically investigating the overall purpose of the research and interpersonal aspects related to the researcher and participants (Guillemin & Gillam, 2004). Being reflexive allows for an understanding of the limitations of the knowledge that is developed and possible ethical issues (Guillemin & Gillam, 2004). Thus, an ongoing effort was made to integrate reflexive practices into how I approached and conducted my study. For example, l engaged in reflexive exercises that fostered self-reflection and introspection, such as writing a positionality statement (below). This statement discussed personal characteristics about myself and my motivations for conducting this type of research (Guillemin & Gillam, 2004; Bradbury-Jones, 2007).

Positionality statement

Research guided by qualitative approaches, in this case interpretive description, is not an unbiased process. The researcher's individual worldviews and life experiences ultimately shape the research process, beginning with the selection of a research topic and culminating in the interpretation of study findings. My personal interest in aging and homelessness was a result of my undergraduate thesis work. In this study, I interviewed both persons with Parkinson's and their caregivers about their illness experiences. Participants spoke about their struggles navigating a complex and fragmented health care system. The majority of the study participants were part of Canada's middle-class and had substantial social supports. This observation led me to start thinking about low-income, precariously housed, and homeless older adults. I began wondering a critical question: *"If older middle-class adults with chronic conditions are struggling, then how are older homeless adults managing?"* Upon exploring the literature, I came to the striking realization that the already limited body of homelessness literature does not adequately capture the realities and service needs of specific sub-groups, like older homeless adults. As a white, educated, and middle-class woman who has never faced housing insecurity, I am also aware that my social position affords me significant privilege.

Part of this reflexive process is acknowledging that as a graduate student with no clinical training, I am an 'outsider' conducting research with a group of health care providers who share their own culture and identity. Morse (2010) discusses her stance on outsiders doing qualitative health research; outsiders are investigators conducting qualitative health research who are not health care professionals and do not have a care provider role. Morse (2010) raises some disadvantages associated with outsiders conducting qualitative health research. For example, investigators with a health background are able to interpret the data appropriately as they are more familiar with health and medical literature and can link their findings to other research in their field (Morse, 2010). However, Morse (2010) also points out that conducting research from an outside perspective can be advantageous. As an outsider, I entered the field with a naïve outlook; a care provider who is conducting research in a very familiar setting, may overlook particular details that an outsider will view as important (Morse, 2010). As part of my reflexive practice, I strove to examine how my role as an outsider influenced the research process over the study’s duration. For example, after interviews, critical self-reflection was assisted through journaling by analyzing how my own background and assumptions might be influencing my interpretation and understanding of the collected data.

Ethical considerations

This study gained ethics clearance from the University of Waterloo’s Office of Research Ethics (ORE# 41210). To view the ORE approval certificate, refer to Appendix M. Please note that ethics protocol amendments have been submitted and approved since the study’s initial approval date. Prior to data collection, each participant was randomly assigned a participant ID number for identification purposes. This number was recorded on the bottom of consent forms to ensure that collected data were de-identified as soon as possible. The list that links participants' ID numbers with their names and consent forms was stored on a password protected computer at the University of Waterloo. The file containing this information is saved on the UW server, and is password protected with an encryption system. Participants’ names will not appear in any report or publication resulting from this study.

Chapter 5: Findings

Conversations with health care providers working in outreach settings revealed the following key themes: 1) the client-provider relationship as an essential building block; 2) progression of care that acknowledges the 'whole person'; 3) collaboration as integral to providers' work; and 4) system navigation. Health care providers also discussed both challenges and rewards that relate to each theme identified above. In this chapter, the listed themes and their appropriate subthemes will be explored by drawing upon excerpts and quotes from participant interviews. For a representation of major themes, subthemes and key ideas, in table format please reference Table 4 (Appendix N).

5.1 The Client-Provider Relationship as an Essential Building Block

All participants stressed the importance of relationship building in their work with older homeless adults. These client-provider relationships can be further examined through three subthemes: (a) building trust; (b) encouraging client choice; and (c) adopting central support roles.

5.1.1 Building trust

Fostering relationships rooted in trust were described as an imperative component of health care providers' work with older homeless adults. Some providers discussed how their initial visits with new older adult clients primarily revolved around establishing trust. For example, one participant said, *"I mean really if you want to talk about what do my first visits look like, I spend many visits just trying to build trust with folks, right?"* Trust building in client-provider encounters involved validating older adults' experiences and providing them with the opportunity to be heard:

> *So I think a lot of it just in the beginning is trying to get people to trust you and unfortunately sometimes that piece gets... it's undervalued I think sometimes the importance of it. Because they won't come back if they don't feel like they can trust you or understand you if you're not validating their experiences. So, I think that's a large part of it with older adults, is trying to validate what they've been through, letting them be heard. (P01, Nurse Practitioner)*

As stated by the participant above, for older adults facing homelessness, lack of trust can act as a deterrent to seeking care from the provider. On the other hand, fostering a trusting and non-judgmental relationship where a client feels comfortable sharing their experiences, may allow the provider to maintain an ongoing rapport with the older adult and eventually begin addressing other health and social needs. This concept is highlighted by the providers below:

> *It's more just always remaining really non-judgmental and just listening to their stories and all the challenges that they've had in their life. And, once that openness and that safe space is created, and they can share more things that have happened for them, then I feel like I can kind of start to do the counseling piece. (P07, Registered Social Worker)*
>
> *It's really interesting that adrenaline will just take you through many, many illnesses that they're not really recognizing. So once that relationship is established, you can interrupt that process and say, "You're only using three sentences before you're taking a lot of deep breaths. Is there something wrong with your breathing today?" And if you have that relationship, they might be willing to talk to you about that. (P05, Registered Nurse)*

While all providers pointed to the role that building trust plays in their day-to-day work with clients, many of them also recognized that forming trusting client-provider relationships requires significant time. Unlike other health care settings where patients already possess a certain degree of trust, providers working with this population usually need to devote many visits, and sometimes years, establishing trust:

> *And the big thing I had to deal with the first year or two there was gaining their trust because most of my clientele were very distrustful of the medical profession and it took a while for me to prove I had no ulterior motive for this, I just wanted to help where I could and I had to prove that. So that was a big barrier that you don't have to deal with in*

> *family medicine, you assume you have the trust, that wasn't an assumption you can make with our clientele. So, it was a totally different clientele. (P10, Retired Family Physician)*

Providers emphasized that gaining trust with older adult clients is especially time demanding because of their accumulated negative health care experiences. As opposed to younger clients, older adults are more likely to be *"a little less trusting"* of their health care providers, and as a result attaining a trusting relationship takes time:

> *And it does take a long time for the older guys and girls to trust because they've already been through that healthcare system for how many years, like four years plus. Having people turning them away or judging them or they feel less than. So, I'd say a lot of the comments that I'll get is... I got one just recently and it was from an older person and they said something like, "Thanks for making me feel like a person." Something like that and it kind of blew me away…and so, I think those are all barriers… it's like they have zero trust in the system. (Participant 4, Nurse Practitioner)*

Providers, such as the one above, spoke about older adults' distrust in the health care system shaped by prior encounters that left them feeling dehumanized. Consequently, health care providers needed to consider how previous negative healthcare experiences may influence an older client's ability to build trust, but providers focused on *"trying to find that common ground of just the human experience."* Focusing on building trust with clients and creating non-judgmental spaces where they felt respected also required an understanding of trauma. For health care workers, engaging in client-provider relationships with older adults revolved around acknowledging the impact of past and recent trauma. Providers affirmed that building relationships with older homeless adults and delivering care requires an understanding of the interconnectedness of trauma, mental health, and addiction. Some providers, such as the nurse practitioner below, expanded on this concept:

> *But, that's the other thing with this population is there's a big trauma component or whether their addiction...circles back to some mental health generally, something traumatic has happened to them. (P04, Nurse Practitioner)*

In order to collaborate with clients in developing possible pathways towards recovery, providers approached their work with this population through a trauma lens. As evidenced in this subtheme, building trust is an essential first step in the client-provider relationship. Furthermore, through maintaining trust with older homeless adults and recognizing the role of trauma, health care workers were able to initiate further support for clients' other health and social needs.

5.1.2 Encouraging client choice

A reoccurring sentiment expressed amongst providers was promoting a relationship where clients felt a sense of personal control and responsibility over their own health. One provider explained why giving older homeless adults control over their healthcare decisions guides her work with this population:

> *I like to give them control because then a lot of times what we see is they don't have a lot of control over certain aspects of their life. So, if they can at least make some healthcare decisions, it gives them some responsibility, some accountability. It makes them feel good and that that's a sense of control that they have, and it also makes my job easier because if they're saying, yeah, this is really important, they will also be more motivated to work towards it. (P04, Nurse Practitioner)*

To this provider, her reasoning for ensuring that older homeless clients feel a sense of control over their health is multifaceted. In recognizing that individuals navigating homelessness often lack control in other areas of their lives, this health care provider seeks to instill self-agency by enabling clients to lead their own health care decisions. She also mentioned that giving clients control over their health care as opposed to *"just telling them what to do"* will encourage them to work towards addressing the issues that are most meaningful to them. Phrases such as, *"I have a tendency to always take my cue from the clients,"* and *"it's all just geared on what that person finds to be most important to them"* reflect that health care providers in outreach settings prioritize older homeless adults' goals and readiness to engage in care. One health care provider commented:

> *I think the thing is we might not make huge changes in their health outcomes but if we can treat the issues that are important to them…they might not be the issues that I think are the most important, but if they're the issues that are important to them and it makes them just a little bit more comfortable in their world, then that's what I want to do. (P01, Nurse Practitioner)*

As demonstrated by this health care worker, the emphasis in providers' work with older homeless adults is placed on their clients' goals as opposed to making drastic changes in health outcomes. At times, providers must put aside their own beliefs about which issues are most important to address and take direction from their clients in their care. To conclude, the client-provider relationship in outreach settings is grounded in promoting client choice in how health care providers work with older homeless adults.

5.1.3 Adopting central support roles

A pervasive sub-theme spanning multiple interviews was health care providers taking on central support roles when working with older homeless adults in outreach. Providers spoke about the isolation that their clients experience and the overall lack of social support. One family physician that was interviewed has a separate primary care practice, in addition to her outreach work with the interdisciplinary primary care team. She compared the social support networks that older adults usually have in her primary care practice to older homeless clients' small circles of support:

> *I guess one of the other challenges in the older people is sort of lack of family support and other social supports, which in my primary care practice, I certainly see people who generally have social connections, be it neighbors or even care providers that they've been attached with for a while. Whereas people who don't have any fixed address don't really have that stability of support surrounding them. (P02, Family Physician)*

Unlike other older adults, older homeless clients are frequently estranged from their families and friends, in part due to their precarious living situations and struggles with mental health and addiction. Providers also reported on the immense loss *"of loved ones and dear friends"* and that many older homeless adults are *"now starting to see all their friends pass away,"* which also contributes to their reduced social networks. As a result, health care providers working with this population often assume central support roles for their clients. However, the nature of these supporting roles varies between providers, with some participants describing how they fill in for missing family members:

> *I know I become this person's niece or granddaughter or little sister or older sister, depending on who you're working with. There is a bond that forms, while you maintain your professionalism, I would say that relationship, it has boundaries. But that's very joyful. Knowing that somewhere this person has a family, but they can't be together and it's sacred to be a stand-in for a family member. It's a sacred thing.*
> *(P05, Registered Nurse)*

The aforementioned quote reflects how this provider is a family member figure to her clients within the professional boundaries of her role as a health care worker. Similarly, another provider spoke about the duality of his role supporting older clients as both a parental figure and nurse. When asked how he describes his role to the older adults that he works with, the provider stated "*And I say, I'm going to parent you and I'm going to nurse you. But that's my job and that's my nature."* Providers also took charge of responsibilities usually belonging to family members or caregivers, like helping clients keep track of appointments, arranging transportation to appointments, and managing medications. Even after an older homeless adult has died, providers who worked closely with the individual may still stand in place of family members, such as being documented as next of kin and/or attending memorial services. One health care provider mentioned that some of the older clients that she works with have identified her as next of kin; however, this has implications for older adults wishing to be cremated:

> *Because you can't cremate someone with me as the next of kin because I'm not next of kin. So [the administrative assistant], she will be the next of kin for some people because [her] and I operate in very similar ways. And that's because they're so estranged from family. Like, family haven't seen them for 20, 30 years, right? (P06, Registered Nurse)*

The same provider also described attending a burial service for an older homeless adult whose next of kin could not be contacted. Therefore, it is clear that the central support roles that providers possess, can in some cases extend beyond the older adult's life:

> *So yeah, now, one of the next of kin that this woman put down, he died last year, and they couldn't find his next of kin. So we went to the funeral, and they just buried him in this unnamed plot. And [name of funeral home] will just take ODSP money for that month and bury them for nothing…they had a couple of the interns from the funeral home. So they all do this great service, and nobody knows that; they just do it. So we just try and have some representation there to acknowledge that. (P06, Registered Nurse)*

Other health care workers offered more indirect social support, by linking older clients with providers, such as outreach workers, who could then provide more individualized social support. For instance, one nurse practitioner explained:

> *So, outreach is really big because we want them to feel connected to the community. That is so important because there's always, especially with the older population, like social isolation. They are very much by themselves and if they don't have any family around or people that they would identify as family, we try and help them to feel connected. So again, that's not so much my role. But, it would maybe be, if I felt they were at risk for social isolation or didn't really have too much connection in terms of that community, I would try and connect them with a social worker or an outreach worker so that they can try and start that. (P04, Nurse Practitioner)*

Health care providers conceded that a key element of supporting older adults was connecting them to the community, which is why linking older clients to outreach workers who could better facilitate these connections is vital. For socially isolated older homeless adults, being connected to the community, namely through community programs and volunteer opportunities, was a way for them to regain *"that sense of purpose."* Altogether, this section highlights that one aspect of the client-provider relationship entails health care workers adopting central support roles for the older homeless adults that they work with.

5.1.4 Challenges and rewards

Emotionally demanding nature of roles

Providers discussed the challenges and rewards associated with building trusting relationships that promoted client choice and taking on central support roles with older homeless adults. The most significant challenge mentioned by health care providers was how emotionally demanding their roles could be and the impact their work had on their mental well-being. Participants noted that in comparison to their younger counterparts, older adults are more likely to anticipate failure and be in a state of hopelessness, which can be *"emotionally hard to see."* A few providers referred to the guilt that they felt:

> *I think when I first started it was, you almost feel a little bit guilty, to be honest, that was something. So personally, I feel that it's not fair that at the end of the day I get to go home to a nice warm bed and they don't. So, that's been a little bit hard I guess on my own mental health. (P0 1, Nurse Practitioner)*

> *So well and it's hard because we drive up in our cars and we park, and they see us. We have this whole other life and we can't even begin to imagine what their life has been like or is like. So, you know, you pull up in your car and I drive an 11-year-old car, so it's nothing fancy. But, still I have a car, I have a house, I get to sleep at night, and have a shower, and so you're instantly already worlds apart. (P07, Registered Social Worker)*

These quotes reveal that health care providers felt guilty about the division between their lives and their clients' realities. Furthermore, by forming close relationships with older clients where they felt comfortable sharing information about their lives, providers listened to some very painful stories. One provider reflected on the difficulties that she encountered being entrusted with clients' stories: *"What's hard is listening to their stories, of course, because it's years of intergenerational trauma, and complex trauma, and some pretty horrific things that people have endured."* She continued to explain that listening to clients' experiences and life stories was particularly challenging when she started working with homeless individuals in her current role:

> *I think initially more so because I don't think I was adequately prepared to really hear. Not that you can ever be. The volume of stuff and the similarities between their childhoods and things that happened to them. And, then you kind of get to a point where it's almost normalized, which I'm not sure it's healthy either, but it definitely is easier for me as a person to deal with it when I leave there. (P07, Registered Social Worker)*

This provider spoke about how she coped with hearing older homeless adults' life experiences and reaching a point where these stories filled with trauma were 'almost normalized.' Due to the emotionally demanding and exhausting aspects of their work, health care providers elaborated on the strategies that they used to look after their own mental health and avoid burnout. According to one provider, she attends counseling sessions and allocates some time outside of work to enjoy activities that bring her happiness:

> *It takes a toll on your own mental health. You have to have a good outlet on what brings you back to the job every day. So recently I thought it would be really important to talk to somebody outside of work. So, you can always bounce ideas off your colleagues at work. But in terms of how you manage the day-to-day stress of seeing people so disadvantaged, so you seek counseling …that's what I do. I see a counselor. But then it's also you find other ways to help manage all that stress that you're feeling. So I do a lot of stuff outside of work. You find things that you love to do because that kind of also helps to take your mind off of it. So, whether it's traveling or doing puzzles or anything just to help kind of take a break from it, so that you can return and do your job. (P04, Nurse Practitioner)*

According to numerous providers, maintaining a good work-life balance was important in taking care of their mental health. For some providers, such as the nurse practitioner above, they strove to achieve work-life balance through hobbies, as well as remaining connected to their family and friends. To further illustrate this point, a provider spoke about how she avoids burnout and remains grounded: *"I have a wonderful partner and I ride horses about four to six times a week and I ride and train them. So, that keeps me very grounded and present."* Regardless of what strategies providers used to maintain a good work-life balance and avoid burnout, it was clear that coping with the emotionally demanding nature of their work is a prevalent challenge.

Storytelling, witnessing strength and healing

Although listening to older homeless adults' life stories, which usually contained a history of trauma and pain, was very challenging for many providers, a few participants also described how rewarding it was hearing about their clients' journeys. Learning more about older adults' stories and how they arrived in their present circumstances, was described by the following provider:

> *I loved just sitting down with people and hearing their story, because everybody's got a story. And some older gentlemen walked around our parking lot. Wasn't always an old guy walking on the parking lot. He was a schoolteacher, he was married. He had kids, he had a cottage, he had a boat. So, I love hearing these stories of how did he get here? How can we get you back to where you want to be?*
> *(P09, Shelter Manager of Mental Health & Housing)*

Through the client-provider relationships formed, participants spoke about witnessing older homeless adults' strength and resilience as a rewarding component of their work. The health care provider below summarized this idea:

> *So, what I love about it is the resilience that you see in our patients. You'll see somebody who is homeless and really struggling, but then just... I don't know how to describe it. It's the way they are. They're strong and you can see that. So, they've been through so much and yet they're still sitting there, we're talking about their healthcare. That's the part I think I love about it is just to see the strength that those individuals have.*
> *(P04, Nurse Practitioner)*

Observing clients' resilience and ability to adapt under difficult conditions led some health care providers to reflect on their own lives. One provider spoke about how working in outreach with homeless individuals has facilitated a deeper appreciation for her life: *"It's just a reminder every time I'm there of how wonderful my own life is and how blessed I've been."* Meanwhile, a different participant postulated that working in this setting supported healing for providers who had difficult upbringings and pasts:

> *It's a place of healing our own stuff, I think. A lot of people that work in this environment have come from a struggle, some kind of a struggle, usually as a child. And that's across*

> *the board you find that. It's amazing. But whereas a child you had anger that you had to live that life, as an adult, when you think you can't do it, it heals all those wounds. It's fascinating to watch that. It really is…I can say that almost across the board, really. So there's great satisfaction in that. (P06, Registered Nurse).*

Overall, the client-provider relationship formed the basis, or ‘building block’ of health care providers’ work with older homeless adults. Within their relationships with elderly clients, providers incorporated strategies grounded in building trust and promoting client choice. Assuming central support roles for older homeless individuals, who usually had limited or non-existent support networks, was also identified as a pivotal aspect of their work with this population. Once providers had developed a strong rapport with clients, they could begin working towards tackling health and social issues impacting the ‘whole person.’

5.2 Progression of Care that Acknowledges the ‘Whole Person’

When supporting older homeless adults in outreach settings, health care providers approached their work holistically by considering the ‘whole person.’ This approach, which was often stepwise and dynamic, will be explored through two subthemes: (a) addressing the immediate crisis; and (b) care evolving to incorporate chronic health, mental health, and addiction.

5.2.1 Addressing the immediate crisis

Health care workers’ first interactions with older homeless adults were usually centred around providing acute care and support pertaining to basic necessities (i.e., housing, food, and income). When asked how she supports and provides care to older adults, a registered nurse simply asserted, “w*e have to start very basic ... with food.”* A few participants outlined what providers' initial encounters with older clients look like:

> *I would say often individuals first get connected to the primary care clinic for physical health needs. So, sometimes it's because someone has a bad cough or an infection of some kind, or maybe they have a wound that they want looked at. And so, that's often their first entry into that clinic. (P08, Psychiatrist)*
>
> *And that usually starts very small with simple things like wound care, giving people socks, a warm coat, very simple things, providing them with their daily necessities that might really have not anything to do with what people think of as traditional healthcare but think about how hard it would be to get well if you have frostbite and your feet are freezing cold. (P01, Nurse Practitioner)*

Treating foot conditions formed a big part of providing wound care for older homeless adults. Foot-related concerns predominantly stemmed from improperly fitting shoes, prolonged exposure to the elements and insufficient foot hygiene practices. A chiropodist discussed his work with homeless individuals:

> *But a lot of times I'm getting people with, "I was out all weekend in a rainstorm, and I've developed these lesions on my feet. They really hurt. I can't walk. What can you do for me?" So we're doing basically wound care, changing their socks, educating them, keep your feet dry if you can have extra socks on hand, good shoes, that sort of thing. (P03, Chiropodist)*

Beyond treating foot wounds, the chiropodist's visits with this clientele base involved fixing shoes and giving clients dry socks. It was evident through interviews with providers that their work with older homeless adults requires more than offering 'traditional' clinical services. As explained by a health care provider, *"even though I'm a nurse practitioner, the medical history almost takes a back burner because you have all these other things that you're trying to accomplish first."* Within a care setting where people's basic needs are not being appropriately met, the boundaries of providers' roles and responsibilities are expanded: *"So when we look at even like the Maslow's hierarchy of needs, your number one thing is looking at their housing, their finances, social supports. So, that's our go to right then and there."* As illustrated through this quote, addressing social determinants of health was intertwined with health care providers' work with older clients in outreach. In conjunction with providing acute care, assisting older adults in finding stable housing was prioritized:

> *When I see somebody in a homeless shelter is dealing with anything that's acute obviously. Any acute medical illnesses, which we can deal with. And obviously if somebody needs intense acute care, then we arrange that as well. But barring that, the next most important thing is who's helping you find somewhere stable to live.*
> *(P02, Physician)*

During our conversation, this provider later explained the intrinsic links between housing and health.

> *I think housing is the biggest thing for people because if you don't have housing, you don't have health. And people are in itinerant housing and shelters and homeless and living on the street. I mean their health outcomes are totally different from health outcomes of people who do have housing because you're not going to sit and talk to somebody about smoking cessation, even if they have COPD, if they're living on a park bench it's just not appropriate. (P02, Physician)*

Health care providers echoed this participant's perspective on housing and health. A common thread amongst most participant interviews was the profound impacts that poor housing conditions had on both short-term and long-term health. Without stable housing, providers noted that it would be very difficult for clients to attain better health outcomes or make progress in other areas:

> *Because many of them would want, I could think a list of things they'd want to change, but if they're not housed, it's very hard to do anything else, but focus on your housing. So, I'll offer them support around the housing piece, as well. Generally, people there know all the options available to them. They're either at [name of local shelter] or they're couch surfing or using the shelter system in some regard.*
> *(P07, Registered Social Worker)*

As one provider eloquently stated, *"housing is number one and it always comes back to that."* Besides housing, providers assisted older adult clients with obtaining ID, finances, and income support. A few providers spoke about connecting older homeless adults without proper identification to an ID worker, which was imperative in accessing medication and other medical services in the community. During their visits, health care workers asked older clients questions surrounding their income situations. For example, a few participants touched upon working with clients to submit their OW (Ontario Works) and ODSP (Ontario Disability Support Program) applications:

> *So, a lot of them, if they're not on OW, we get them onto OW right away. And then, I will start to get to know them so that we can work towards ODSP because there's such a big difference between OW allowance and ODSP allowance. So those are our kind of…that's where we start. (P04, Nurse Practitioner)*
>
> *And I have to do them. They didn't get done by themselves. And the ODSPs would give them about $1000 a month, whereas the OW cheque would be about $550 to $600 a month. So if they had a disability and I could legitimately prove that, they would get $1050 to $1100 as opposed to $650, that made a difference initially anyway of going from a boarding house to a single apartment. Nothing fancy, nothing very nice. But if you went from a boarding house, you went from a place where if you put something in fridge, in the boarding house, you're not going to find it there in the morning.*
> *(P10, Retired Family Physician)*

Evidently, during their initial interactions with clients, providers focused their attention on 'addressing the immediate crises', which usually included support around basic necessities and acute care. The excerpts showcased in this section demonstrate how health care providers address their older clients' most pressing issues, which differ significantly from the immediate health needs of older adults not experiencing housing insecurity.

5.2.2 Care evolving to incorporate chronic health, mental health, and addiction

After working with an older adult client for a period of time and creating rapport, health care providers spoke about integrating other aspects of care into their work with the individual. The majority of health workers mentioned that taking a slow approach in care progression was vital in preventing an older adult from feeling overwhelmed:

> *Blood work, x-rays, go fill a prescription, referral to a specialist, that becomes very overwhelming but if I can break it into small parts and say, "You know what, let's get*

> *your foot fixed up. I'm worried about it. Come back and see me tomorrow so I can see it again and then maybe we can talk about the fact that you're not sleeping well or the fact that you're feeling more anxious or that you're feeling more depressed or you're worried about your substance use." (P01, Nurse Practitioner)*

The provider above also indicated that her work with older homeless adults *"has a tendency to evolve into more chronic disease management, support around mental health and addiction."* When working with an older population, health care providers noted that managing a variety of chronic conditions was common:

> *So, when I say I provide primary care that can mean a whole bunch of different things. So, it can mean chronic disease management. So, working with individuals who have the whole range of chronic disease from high blood pressure to diabetes to dementia. (P04, Nurse Practitioner)*
>
> *Generally, what I expect when I meet someone, unfortunately who is 50 or older, I'm going to expect them to have some of the disease conditions or process that somebody much older would have because they're aging prematurely. So, we see congestive heart failure sooner, we can see COPD much sooner, arthritis, endocarditis sooner, diabetes sooner. Any geriatric type of difficulty or illness you might expect, you can see really see in somebody 50 to 55. (P05, Registered Nurse)*

As reflected in the quote above, health care providers witnessed accelerated aging processes in this population, with chronic conditions emerging in clients' fifties and sometimes even in their forties. Within this context, providers heavily supported older adults in managing chronic physical and mental health conditions. In fact, mental health issues were one of the most prevalent health concerns that providers encountered in their work with older clients. One participant commented that mental health challenges impact both older adults who are newly homeless and the chronic homeless:

> *The ones that have been homeless all their lives usually have mental health issues… The other ones who have become homeless out of conditions that have happened in their lives and nothing to do with mental health or alcoholism, just poverty, that's huge. Those are the guys that are severe risk of suicide, right? (P05, Registered Nurse)*

Older adults' mental health, along with cognitive impairment, had widespread implications on ability to access services. For this reason, one of the primary care teams that operated at a medical outreach clinic, worked regularly with a psychiatrist. Below, the psychiatrist explained how the primary care team involves her in addressing older adults' mental health needs, as well as the barriers arising from untreated mental health issues:

> *And then as the primary care team with the nurses and nurse practitioners and family doctors get to know them, if they have concerns about memory or mood or anxiety or psychosis, then they'll often get me involved to try to do a consultation, to help with some assessment and treatment planning, and often, because if there are kind of untreated areas of mental health needs, then those can be significant barriers to trying to support that person to be more stable, or even just to navigate other services that they can be a barrier to trying to get the ID that they need ,for example, or trying to get a health card replaced and so, we work together on problem-solving based on what that person's own are needs are. (P08, Psychiatrist)*

For some older adults facing homelessness, progression of care also included addiction management. While older clients for the most part were not IV drug users like many of their younger counterparts, providers still supported this group with substance abuse issues, specifically related to alcohol. Harm reduction techniques were underlined as *"the only useful way"* that providers could assist clients in managing their addictions. For example, a social worker spoke about supporting older homeless adults in their struggles with addiction guided by harm reduction strategies. Her approach recognizes that an older adult's surroundings, like their contacts, significantly impact their addiction and even their housing:

> *So generally the ones that I can think of off the top of my head do have either they have their own addictions that they've been dealing with for years so they've been in and out of treatment programs…A lot of that work is helping them try to manage their addiction in a way that is a harm reduction approach, but tries to keep them away from the people who get them into trouble and then they lose their housing. So, I have a couple of guys that I work with right now and generally that work is with a team of outreach workers from [name of housing support organization], for example, who are housing supporters. (P07, Social Worker)*

Between participants, there was variation in their levels of prior training and experience in mental health and addiction, with one family physician saying*: "So I joined the clinic as a family* *doctor, offering medical care and I offered whatever skill I had and the level of addiction and mental health, which initially was very, very poor to almost nil in terms of addiction."* To build a stronger knowledge base around these areas, this participant looked for sources online. On the other hand, some health care providers indicated that through prior work and volunteer opportunities, they had already developed skills that were needed to support individuals with mental health and addiction issues.

To conclude, this subtheme depicts that providers were actively involved at different points of a client's care journey, while taking into consideration the person's needs in a holistic manner. Beginning with acute care and offering support around basic necessities, health care providers' roles with older adults evolved to incorporate managing chronic conditions and addictions. Throughout the client's care journey, health care providers proceeded one step at a time, ensuring that the older adult was comfortable with the pace of their care and did not feel overwhelmed.

5.2.3 Challenges and rewards

Older clients' health going unchecked

Health care workers spoke about challenges and rewards associated with providing holistic care to older homeless adults that encompassed a variety of health and social needs. According to providers, a major challenge was older homeless adults seeking care after years of their health going unchecked. Providers found it difficult to address older adults' accumulated health conditions that were usually severe by the time the client sought care:

> *And it's challenging because if you would've seen them maybe 15 years ago, you could have maybe helped them with an orthotic or referred to physio or OT, but they just have powered through it and it becomes a chronic problem and you can only do so much at that stage. (P03, Chiropodist)*

> *I still do have some that are over 50, but by the time they get to that stage, they are quite frail. They have a lot of medical issues that haven't been addressed. Things really starting to deteriorate so that's really sad. (P04, Nurse Practitioner)*

> *Health needs are profound, actually, because they often won't come to you until they're at last stages of heart disease or cirrhosis, or they've been on the street and in the winter. We've had gangrene resulting in amputation, resulting in death, diabetes that hasn't been controlled. So, you got blind issues, lots of things like that. (P06, Registered Nurse)*

Providers explained that older adults' hesitation to seek care until *"they can no longer function,"* circles back to a few factors, with one being previous adverse health care experiences leading to distrust in health professionals. The subtle progression of health conditions that *"become the new normal everyday"* can also delay seeking treatment, as well as older homeless adults' overall fear of knowing their health status.

Issues with follow-up and adherence

A second challenge identified by health care providers was follow-up with clients and treatment adherence. Providers noted that older homeless adults' transience, due to lack of stable housing and changing life situations, was a barrier in scheduling follow-up appointments. The excerpts below shed light on health care providers' perspectives pertaining to challenges with follow-up:

> *It's trying to optimize health outcomes for that. So it's referrals, it's different diagnostics, it's investigations, but then one of the challenges is follow-up, right? Because if they're itinerant and they don't have a fixed address, then sometimes you get a result and it's hard to follow up. (P02, Family Physician)*

> *I do find it more challenging working with people who are struggling with homelessness and it's because I can go into somebody's home on Monday and Tuesday, look at their medications, assess them in their home. When they are not housed, it's more difficult because they often lose their medications or they're really hard sometimes to track down and it can be all dependent on where they stayed that night. (P04, Nurse Practitioner)*

Due to the reasons stated above, maintaining continuity of care was difficult for health care providers. Additionally, underlying mental health conditions compounded the challenges providers encountered with follow-up and fostering continuity of care. One provider described this predicament:

> *There's been situations where I've booked clients to come here [community health centre] to see me because I have more resources here. So, it's more complex cases and more often than not it's a no show just because there's no way of calling them to remind them about their appointment, the cards get lost. A lot of times there's mental health issues as well, which makes it even harder for them to stay on a schedule and follow up and meet me here. (P03, Chiropodist)*

This provider continued to explain that issues with older clients' mental health and addiction contribute to challenges revolving around treatment plan adherence. He indicated that not consistently seeing results can be a frustrating aspect of his work:

> *Yeah, and I know how to fix it, but I can't control that person's life. I can't follow them out of the work environment and make sure that they're following those instructions. And like you said, a lot of addiction, a lot of mental health issues too, which went untreated. Obviously following a simple treatment plan is very difficult for some people. So it can be frustrating in that sense that we don't often see or always see results. (P03, Chiropodist)*

The provider offered another perspective on his work with this population and seeing results. He found it rewarding that he was able to offer services that immediately provided the client with relief:

> *If somebody comes in, let's say with a really deep painful corn from walking around town for a month, I'm able to completely take that off right there. They stand up and they go, "Oh my God, I feel so much better. It's like nothing was there." And then they're ready to go. So, job satisfaction, certainly seeing results like that is good. And I know I said one of the challenges was seeing people and not seeing change. So, there's two sides of the coin. But yeah, it gives me the opportunity to do something right there for someone and have them feel better. (P03, Chiropodist)*

While follow-up with older clients and treatment adherence made it difficult for providers to see consistent results, some health care workers expressed the personal significance of being able to make even small improvements in older adults' health and well-being.

“Small wins”

In their roles with older homeless adults, providers celebrated the *“small wins.”* One of the most rewarding *“small wins”* was when a client decided to reconnect with a provider. In other settings, the significance of a client returning to seek care from a provider may seem minimal, but participants explained the magnitude of this step:

> *To me, the most rewarding thing is when people come back, where I've never met them before, they meet me in the shelter, they meet me at [name of community organization], whatever and they come back to see me the following week or two weeks later. To me, that's really the most rewarding thing and that's what keeps me doing it, is that someone who hasn't been connected is finding their way to become reconnected again and I think that's kind of what keeps me going. (P01, Nurse Practitioner)*

> *And so, we have our first appointment, I feel like nothing's accomplished. But then, they show back up in a week and it's like the best feeling because I'm like, okay, this is that tiny little bit. They know that, one, if they're coming back, I think they must feel that we care. And, we care about them and we want the best for them. So when they come back, it's a good feeling. (P04, Nurse Practitioner)*

On many occasions, providers working in outreach were the first point of contact for older homeless adults with the health care system, and at times even the social services sector. Health care workers found this aspect of their work rewarding because as the first point of contact, they were able to connect older adults to other health and social supports in the community.

> *We've had cases where I am the first person that they see in the health care system. They come in with frostbite on their toe. We'll see that, we'll treat it and then I will say this person's having trouble with the elements, no housing, no shelter. And then that person will set them up with a shelter. They are able to go to the shelter. And to me that I was the first person to help them through that is rewarding to me for sure. Get them out of the elements and into a more comfortable setting. And a lot of people will come back and thank me for it. Which just seeing that reward too is it's a lot of satisfaction.*
> *(P03, Chiropodist)*

The “small wins” that participants witnessed reminded them that *“recovery is possible”*, even if the path is slow and gradual. Overall, the broad theme of providing care that acknowledges the ‘whole person’ reflects the many dimensions of care incorporated in providers’ work with older homeless adults. Offering clinical services represents just one component of health care providers' everyday interactions with older clients. At the forefront of their work is addressing the fundamental social determinants of health, such as older adults' living environments, economic situations, and social contexts.

5.3 Collaboration as Integral to Providers' Work

A persistent theme underpinning interviews with providers was the necessity of ongoing collaboration with an array of providers. To further examine how health providers worked collaboratively in outreach settings, two subthemes will be described: (a) collaboration with providers on the same team; and (b) collaboration with community partners.

5.3.1 Collaboration with providers on the same team

Health care workers spoke very positively about their experiences collaborating with other providers on their interprofessional teams and relied heavily on each other to support older adult clients. Collaboration with colleagues was described as *"a team effort"*, with one participant stating, *"you're one person and a member of team, and that whole team provides wraparound supports to the clients."* Within the collaborative care model described by providers, outreach workers and allied health professionals were well-integrated, as well as played an important role in bridging persisting social and health gaps that interfered with care. For instance, a physician explained:

> *I probably wouldn't be able to do this job if I didn't have a social worker and patient support worker because it would be just too much to do sort of primary care stuff and identify… sort of ongoing health issues and also support people because it's getting them to appointments, getting them to get blood work done, getting their medications, all those pieces. That if you're just seeing somebody in an office and you say, "Okay, I'm going to get this CAT scan done and I'm going to prescribe this med." Well, if they have no means to get to the hospital and have it done, they don't have drug cards, they have no money,*

> *they can't buy the medication, or they don't have their card because they haven't gone through all the steps to get a card. If you didn't have that support, then I think it probably would be pretty useless what you're doing. (P02, Family Physician)*
>
> *It's a vicious cycle. And the outreach workers are an essential part of the program and we have usually anywhere from seven to nine outreach workers at any one time and they're the ones that do the real work in this program. We couldn't offer care to the homeless if we didn't have an outreach program. If the outreach workers weren't available, the people that we need to help would have no one else to assist them in getting around to get to appointments or helping apply for housing somewhere. (P10, Retired Family Physician)*

Building on this idea, an allied health worker spoke about the strengths of being on an interprofessional team in outreach settings:

> *I see a lot of, like, there's been a whole initiative in [name of region] around the interprofessional program that's developed to try and coordinate resources instead of duplicating. Because we have so many people trying to do the same thing. So, trying to streamline that and have a coordinated effort, although it's not really working a hundred percent yet. To just see people trying is great. I'm very fortunate working at the [outreach clinic] and that the colleagues that I work with, I kind of rely on them for the referrals. So they might see somebody who comes in for a broken hand and then that person will just naturally start talking about their life or "oh, I'm having sleep problems too." And, then I get a referral for working with somebody to help their sleep improve. So, it's a very cohesive team and a very respectful team, so they respect what I do. I respect what they do. (P07, Registered Social Worker)*

Working cohesively as a team allowed for more efficient resource coordination and ensured that older clients were being appropriately linked to providers. Within their interprofessional teams, allied health professionals expressed that they felt valued and respected. Due to older homeless adults' complex health situations, a few providers mentioned that they relied on their colleagues' unique areas of expertise to help them navigate uncertain territory:

> *Yeah, I need those additional supports. So just because of the complexity of their health. Like I said, most of these individuals are quite unwell and so as a nurse practitioner, I have to be mindful of my scope of practice. So, I need people that I can consult with on specific things and we've tried to do stuff. When I talk about not being risk averse, some of it, I mean you're doing things you might not normally do, but you want to do it with the best research and evidence kind of behind you. So I rely on the expertise from my colleagues to help me make those clinical decisions and what am I watching for and those kinds of things. (P01, Nurse Practitioner)*

The care provider above talked about not being *“risk averse working in this world,”* explaining that outreach work could be unpredictable with *“lots of ebbs and flows.”* This sentiment was shared by most participants, and some discussed how the unpredictable nature of their work impacted their safety in the workplace. Within outreach settings with a diverse group of clienteles facing various mental health and substance abuse issues, aggressive behaviours were not uncommon. Therefore, health care providers worked as a team to support one another and de-escalate situations. As shown, providers openly communicated any safety concerns with their team members who were always in close proximity during their visits with clients:

> *So typically, if something like that were to occur, we are in a very close setting with other practitioners there and also people that work on the floor there. So if I have any concerns, like I might practice with the door open, I might give a heads up to one of the other colleagues, "Hey, this person is really agitated, I'm going to see them, but just know that we might need to deescalate the situation." (P03, Chiropodist)*

The showcased participant perspectives reiterate how providers on the same interprofessional team benefitted from collaborating with each other. By contributing their unique strengths and areas of expertise, health workers stated that they were able to coordinate care more efficiently and better support their clients’ complex needs. Although the nature of their work environments and clients could be unpredictable, providers worked as a team to manage difficult situations.

5.3.2 Collaboration with community partners

Health care providers’ work with older homeless adults required substantial ongoing collaboration with community agencies, organizations, and consultants (health care professionals in specialized fields like psychiatry or dentistry). Networking with community partners enabled providers to support clients more adequately as they transitioned between care settings and systems:

> *90% of what we do is networking. I'll call Julia over at [name of community organization] and she'll give us, "Hey, where is this person on the housing list?" Or, this person needs to spit out, and I'll call Mark my housing worker, "Mark, can you get this guy spit out?" But I think most of what we do is call in somebody who knows. So, I don't ever profess to know all the answers. I would rather get involved with an agency who does. So, if it's family doctors or nurse practitioners, if they need healthcare. The housing piece, we typically would go to [name of community organization] for the long-term housing…all that stuff that we need somebody to go up the ladder of chronicity or whatever to get them housed. But yeah, I think working with all of the agencies is a huge part of whether they're seniors, adults, or youth is, we can't do this alone.*
> *(P09, Shelter Manager of Mental Health & Housing)*

Health care workers appreciated opportunities to engage with different community partners to work towards improved outcomes for their clients. A participant described an existing collaborative initiative that she found helpful:

> *We have something in our community called 'Connectivity Table' where people who are really struggling out in the community, their names are kind of brought forward. All the support people in the community, a lot of them sit around that table….from like police, hospital, shelters, specialized outreach services (SOS), lots of people sit around that table and talk about how we're going to support a certain individual. So, there are resources available in the community and that happen very frequently, and you do see good outcomes for individuals that these practices can work. (P01, Nurse Practitioner)*

When providers had the opportunity to work with community partners both informally and through organized initiatives, they felt better equipped to help their clients more smoothly navigate available services and resources. Regardless of their client's age, pulling community partners into their circle of care was necessary. Due to older homeless adults' distinct health and social service needs, fostering productive community partnerships with agencies, organizations, and consultants formed a critical aspect of providers' work with this population.

5.3.3 Challenges and rewards

Access to and sharing information

Numerous participants identified information sharing as a challenge that they experienced in their work. Although a few participants commented that access to medical records and information sharing in outreach have improved throughout the years, there still appears to be some enduring gaps. A couple of the providers said that they have a common electronic medical record (EMR) system on their immediate teams, which facilitates information sharing between health care workers on the same team:

> *So, we're all on the same electric medical records, same EMR. And so allied health put notes on the patient's chart, same as I do. And then we can message each other. You can go in and somebody messaged me, "Saw this person that day." (P02, Family Physician)*

However, health care providers were restricted in their ability to easily share information between different teams and organizations supporting homeless individuals in the community. The participants below explained why this is challenging:

> *One of our major challenges is we don't have a universal chart. So I'd say that's a major barrier. So I might see an individual one day. The next day, it's the nurse practitioner from [name of community organization]. The next day it's a nurse practitioner. It doesn't matter, but we don't have a way of accessing that same chart and with these folks that they might not remember what medication they were prescribed, they don't really remember what they were supposed to do for follow-up. There's a lot of time spent calling people, trying to figure out what was done. It's been a barrier for us to try and have a universal chart because these people access care wherever is most convenient for them and that's... I mean I understand why they would do that. We as health care people need to figure out a better way to share information that's confidential within the confines of the legislation but it's a barrier for us. (P01, Nurse Practitioner)*
>
> *Not connected with other organizations. So, outside of the team. And that's a barrier, right? Because we don't know particularly where the person is on the housing list because housing is managed by somebody else. So, then it takes somebody making that phone call, making the contact, and trying to see. But the barriers there is we're dealing with personal health information that you have to be very careful as to who has access to that. And it would be great if we could be more connected electronically.*
> *(P02, Family Physician)*

A few observations arise from these excerpts. First of all, not having a streamlined approach for sharing information between providers in different community settings is a major barrier. Often, this results in health care workers dedicating a large portion of their time to following up with other providers and partners outside of their teams. Within this very challenging context where clients are seeking services based on convenience, one of the providers above highlighted the advantages of implementing ‘a universal chart.’ Lastly, generating information sharing tools or approaches is difficult territory, especially because of concerns surrounding client privacy. Nonetheless, providers were optimistic about exploring new ways to connect providers and community members with one another to promote better client outcomes.

Challenging encounters with other providers

Although health care workers spoke very positively overall about collaborating with other providers, a couple of participants described challenging experiences with other workers. For example, a physician discussed a dilemma pertaining to support workers and prescribing medications for older adults:

> *Some people will have, say, support people, accompany them to an appointment, which is fine if they need a second set of ears or if they need somebody to give you some additional history. But sometimes the support workers unfortunately don't understand the whole system. Don't understand the underlying medical health issue, like people who have a substance use disorder and are in chronic pain. Well, unfortunately a lot of people as they get older will be in chronic pain and they don't really understand the balance between how you manage chronic pain in an older person who also has a substance misuse disorder. And for their safety, for society's safety, you have to be very careful with what you do. And sometimes I think support workers just think that it's very easy for me to just write a prescription, say here you go, problem solved. (P02, Family Physician)*

This health care professional’s perspective conveys a clash between differing provider perspectives and training. In the scenario described, the physician’s medical training shapes her perspective on appropriately prescribing medication within the context of chronic pain and substance misuse. On the other hand, the support worker’s primary role is to advocate for the client’s needs, similar to that of a family member. Another challenge raised by a provider was interacting with workers who were less persistent in their approaches and exhibited defeatist attitudes:

> *I think so because I think, again, just like people who are homeless, I think there's workers who become jaded as well, and who have maybe been doing their job too long and, "Well, they don't want help, then we're not going to help them. Why even bother trying?" This is what I get. I get this from a lot of physicians, in this role, in my previous role, "Well, we've been trying to help this guy for five years. He doesn't want the help." I'm like, "So we just quit? We just stop? No, I can't do that." I think it is challenging with some specific people. As far as specific types of workers, I don't think I can say I have a tough time working with all housing workers or with all nurse practitioners. I think it's very individualized, very specific. (P09, Shelter Manager of Mental Health & Housing)*

Generally, providers spoke very highly about their colleagues' enthusiasm and dedication to their work. Nonetheless, it is equally important to recognize that interprofessional collaboration in outreach settings is not without its challenges and that there are still areas for improvement.

Shared experiences

Providers reflected on some of the rewarding aspects of working in a collaborative environment, such as being able to *"learn from lots of other disciplines."* As opposed to other health care settings where interprofessional collaboration is not consistently adopted, providers worked alongside each other when making care decisions:

> *Personally, I love working here for that reason because the collaboration is so good. Someone in my role, typically a chiropodist is in a private practice, so they're on their own completely by themselves. So if I ever had to order an x-ray for someone, I would have to write a letter to the doctor, send it to the doctor, the patient would have to go make an appointment with the doctor, hope that the doctor agrees with me, send them for an x-ray, x-ray results go back to the doctor, patient has to go back to the doctor and then bring it back to me. So it's this huge roadblock in terms of continuity of care. But here, like I said, I walk next door and I say, "Hey, we've both seen this client, we can discuss the client. This is what I think we need. Do you have any other recommendations? Can we do anything else?" So it's not only for me from my work life or work balance, it's a lot less stressful on me to just be able to do that. And then for the client too. They don't have to worry about making several appointments to get that x-ray. (P03, Chiropodist)*

As illustrated in the quote above, there was consensus amongst providers that collaboration is advantageous in reducing their workload and improving outcomes for clients. Two health care workers referred to the sense of camaraderie they felt, with one provider saying she dealt with difficulties in her role *"knowing that I'm on the team and that I'm not alone trying to face this and I'm with a team who's constantly working to improve that for the folks that we're supporting."* A second health care worker had a similar outlook:

> *I think, just the camaraderie and the shared experience with other health care workers, whether it be on the community ward team or at [name of soup kitchen with a medical clinic]. Just being able to vent with each other, but yeah… So, I think, it's just having good people around you that you work with that are all trying to do the same thing, have the same goal. Yeah. It's like just shared experience really.*
> *(P07, Registered Social Worker)*

In summary, ongoing collaboration with other providers and community partners formed an integral part of their work in outreach. Despite some of the challenges presented, interprofessional collaboration offered numerous benefits to both the providers and their clients. Without collaborative partnerships in this setting, it would be impossible to address older adults' complex health and social issues, as well as navigate the broader system.

5.4 System Navigation

The final theme emerging from conversations with providers was system navigation in their everyday work, which can be deconstructed into the following two subthemes: (a) community transitions; and (b) different policies and guidelines.

5.4.1 Community transitions

Health care providers discussed supporting their older clients through three main community transitions: 1) correctional facilities into the community, 2) hospital into the community, and 3) community/hospital into long-term care (LTC). Providers indicated that navigating these transitions was multifaceted and involved many moving pieces. For instance, a nurse practitioner spoke about the current state of transitions for clients from correctional facilities or hospital into the community:

> *I wish there was better transitions for individuals from jail into the community, from hospital into the community. So sometimes they stabilize really well in jail or they stabilize really well in the hospital. But the transition doesn't happen and so then they come back to community, they come back to the street, we don't know what medication they were on, what they were taking when they were there, what supports were in place and they just kind of show up on your doorstep and you're starting all over from scratch. It's an incredible waste of time and resources. So, I think the systems all just need to kind of pull together a little bit better that we see more seamless transitions, that if people are being discharged to street from hospital or from jail, there needs to be a discharge plan for all of those individuals between the institutions and the community providers that are going to provide support for them. (P01, Nurse Practitioner)*

The provider’s perception of these transitions reflects that there are significant gaps surrounding discharge planning from institutional settings into the community for homeless individuals. She continued to explain that discharge meetings between community providers and the institutions only happen under *“really fortunate circumstances.”* Building on this concept, insufficient discharge planning has significant implications for older homeless adults who have chronic conditions and limited social support networks. A participant shared a story about a client and the concerns surrounding his discharge from hospital:

> *We have another guy, he's probably about 50, close to 50, if not over. And, he's one where he's going to have to go for a spinal surgery coming up in the near future. And so, it's coordinating with, and again precariously housed and what do we do with this guy after he has spinal surgery? We don't want him to get an infection. So, we're coordinating with the neurosurgeon or spinal surgeon in [city name]. We have outreach workers that are meeting with this person. We will have to try and get respite involved. (P04, Nurse Practitioner)*

As showed above, coordinating adequate services for older adults leaving hospital after having undergone procedures is crucial in promoting recovery. An example provided was a community organization that frequently assists in booking hotel rooms for homeless individuals being discharged from hospital. Otherwise, these clients are *"being discharged to homelessness,"* which is not conducive to healing and puts them at risk of being trapped in an ongoing cycle:

> *So, the other gentlemen, again, same thing. Very, very, very mentally unwell that we are trying to house. He's going through the cycle of going in the hospital, getting medicated, being well, coming out, landing in shelter, getting unwell, going back to hospital. (P09, Shelter Manager of Mental Health & Housing)*

Health care workers were also involved in coordinating transitions from the community into LTC. A registered nurse explained that a major barrier to entering LTC was a history of substance abuse, which would automatically flag the older clients' application. However, even once an older adult was admitted to LTC, adjusting to a new environment was difficult especially for older adults who had experienced chronic homelessness:

> *And if you've been homeless most of your life, how do you use a bed, and use a room, and go to the dining room, and eat at a table with three other people when you've been alone most of your life? So, some people fall into that, and some people struggle into that. Some people refuse to do that. So, they want to sleep outside, outside the front door of the... you know? So those things don't work for people. (P06, Registered Nurse)*
>
> *Some folks don't necessarily want to sleep in a bed when they come in off the street. So that was very hard for folks in long-term care to have somebody, "They don't sleep in the bed. They have a beautiful bed." Yes, it's beautiful, and thank you but he or she won't come out of the closet, literally, until they acclimatize, and it could take a little while. (P05, Registered Nurse)*

While one of the registered nurses above mentioned that some clients who were usually in their fifties liked the sense of community fostered in LTC, they felt out of place because the majority of other residents were in their seventies or older. During these transitions, providers advocated on behalf of their clients and combatted stigma, often educating staff working in institutions about the experiences and needs of homeless individuals.

5.4.2 Different policies and guidelines

When describing their work in outreach settings, providers commented on the looser structure, with one health care worker saying it was a lot less *"data driven"* than her role at the community health centre. Within this model, there was a lot more flexibility in relation to policies and guidelines:

> *In the environment that I am in, because there's a lot less structure, I might not have to adhere to the same kind of clinic policies and guidelines and forms and data collection and service agreements to the ministry. It may just look a little bit different, like I don't have to really prove that I'm doing paps and mammograms and colorectal screening on this population the way I do in the community health centre. (P01, Nurse Practitioner)*

Due to the flexibility within their roles, providers attempted to be as accommodating as possible with their clients. Weekly drop-in clinics that do not require appointments or health care cards to access services were offered in the community, such as at shelters or homeless service settings:

> *Just because nobody makes appointments, tends to be the last thing on somebody's mind is getting to appointments. So, if they know I'm always there Tuesdays from 10 to 1, there's a good chance that they're going to keep coming back because they're already there anyways for meals. (P03, Chiropodist)*

As evidenced by the providers above, their work environments in outreach were more unstructured than other care settings. This flexibility was advantageous for both clients seeking care and health workers, something which will be expanded upon in greater detail in the next section.

5.4.3 Challenges and rewards

Paperwork and timing

Providers stressed that navigating the system could be very frustrating and time consuming. A few providers spoke about having to complete large amounts of paperwork for clients, especially for financial support. A retired family physician reflected on the substantial volume of paperwork that he needed to fill out for clients in comparison to his previous family medicine practice:

> *The other frustrating part really took up a lot of my time is I had to do an enormous amount of paperwork for these guys. I thought when I went through my general family practice where I did insurance for them forever, I said "At least I'll get rid of all that paperwork junk." I had more paperwork junk than I saw…they needed letters for the lawyers, they need letters for the probation officers, they need letters for the housing people, they need letters for all kinds of stuff and they also needed forms signed for their Ontario Works support and their ODSD's. (P10, Retired Physician)*

However, completing paperwork was identified as just one piece of the complex puzzle and oftentimes, clients were left waiting for the different pieces to be assembled. One provider indicated that this can be very challenging for clients who are feeling motivated and seeking help:

> *There are so many hoops to jump through to get things for individuals. So many phone calls that need to be made. So many case conferences that need to happen, names that need to be on different lists to make things happen for individuals and to try and keep them engaged while they're just waiting. There's a lot of time spent waiting for things to happen, waiting to get into specialists, waiting to get housing, waiting to get treatment and that can be really hard for individuals because they're at a place where they're reaching out and they're motivated and then the services that they need aren't there for them, housing isn't there for them. (P01, Nurse Practitioner)*

Therefore, providers' ability to assist clients was limited by system constraints and as a health care worker reiterated, there are many *"hoops you have to jump through to make things happen for individuals and the amount of time that it takes…so I think that's the hardest part."*

Limited resources

Another significant system constraint was inadequate resources, ranging from limited housing options and treatment facilities to a need for more outreach workers. The health care providers below outlined how limited resources can impact their work with homeless individuals:

> *I don't have much to offer except kindness and some medical knowledge that I hope to bestow on somebody, but I don't have any housing to offer someone. I don't have an infirmary because that would be wonderful. We do have hospitality house where people will come in, if they're convalescing or senior. But there's only so many beds. (P05, Registered Nurse)*

> *The difficult part was accessing resources, that used to get us not only frustrated but angry and there are lots of barriers. Our clienteles often don't have telephones or are hard to reach. They often missed appointments that we arranged for them for x-rays or tests, consultations and that was hard. If you arranged a consultation and they didn't show, then the person we consulted is ticked off and so we wasted an hour. Those things were very frustrating and annoying and the fact that many of the things we wanted to do for them couldn't be done because there's no funds to pull it off. (P10, Family Physician)*

To navigate the systems challenges identified above, like lack of consistent funding, providers had to find creative approaches to *"make things work in a grassroots way."* Before receiving support for wound care, a health care provider who had been working in outreach for many years spoke about repurposing common household ingredients in the past to treat wounds. Evidently, systems constraints present challenging and frustrating situations for providers and their clients, which are addressed, if possible, with innovative approaches.

Flexibility and autonomy

As described earlier in this section, health care providers' work in outreach is quite unstructured, therefore lending providers autonomy. Participants appreciated the flexibility in their work environments, as they were able to tailor their days according to client needs. A registered nurse who works predominantly with precariously housed and homeless clients on the streets noted the benefits of this flexibility:

> *Certainly. The flexibility is incredible. I know that being governed by the nursing college and my nursing practice within my scope, there's so much flexibility when the policy is actually flexible governing your work. So I know that I can move my schedule myself to accommodate the needs that I'm finding on the street. And I know that it all leads back to flexibility (P05, Registered Nurse)*

When asked to expand on what flexibility in her work looks like throughout a typical day, she explained:

> *I know that if I can shift things to my teammates, and if I need to, I can spend extra time with one person and I also can move to find where people might be. I can actually go out on foot or with a partner in a car and go searching for someone. So that's what that looks like. Also, with other typical, similar situations, you might have to ... You're only allotted so much time with one person, with flexibility I could spend half a day with one person and half with another, so see two people all day. Although that's quite a luxury. I think that I'm really getting at, is I'm not worried about someone asking me, how does she spend her day? I have an assigned caseload and there's trust that I will see those individuals as frequently and as much as possible. (P05, Registered Nurse)*

In fact, a few providers indicated their personal preferences for working in unstructured settings, and consequently welcomed the flexibility that their roles afforded them.

In conclusion, conversations with providers exhibited a pervasive theme relating to system navigation, including supporting older adults through community transitions and relocations. A secondary aspect of system navigation involved different policies and guidelines that dictated the looser structure of their work, although providers generally liked the flexibility it offered them. Challenges surrounding the many ‘hoops’ health care providers needed to overcome and limited resources were also discussed.

Chapter 6: Discussion

6.1 Key Findings

The primary aim of this study was to gain a deeper understanding of health care providers' experiences working with older homeless adults in outreach settings. To facilitate a rich understanding of providers' experiences, I was interested in exploring how providers worked in their roles to deliver care to this population, as well as the challenges and rewards associated with their roles. A key overarching finding that emanated from the collected qualitative data, subsequent analyses and presentation of major themes is that the interviewed group of *health care providers wear many 'hats.'* As exemplified in Figure 1, working in outreach settings with older adults requires more than delivering clinical services. Each of these 'hats'/roles will be expanded upon in greater detail and compared against the literature, along with the associated challenges and rewards.

Figure 1: Health care providers' hats

Social support

Health care providers offered **social support** to older homeless adults through relationship building, which involved establishing trust and encouraging client choice. These aspects of the client-provider dynamic described by participants align with the guiding principles of therapeutic alliance, also referred to as the therapeutic relationship (Bonin et al., 2010; Salem et al., 2018; Tsai et al., 2013). Characteristics of therapeutic relationship building with homeless populations include establishing trust, client-centred care and trauma-informed care (Bonin et al., 2010; Salem et al., 2018).

Previous studies have looked at trust building between homeless individuals and providers (Salem et al., 2018; Biederman & Nichols, 2014; Bharel, 2015). One particular study discussed therapeutic relationships between homeless women and providers (Salem et al., 2018). The authors stated that establishing trust required time but was necessary to create rapport between the provider and client (Salem et al., 2018). Conversations with participants revealed that developing trusting therapeutic relationships between older clients and health care providers is especially important due to this population's prior histories and adverse experiences. As demonstrated jointly in health care providers' interactions with older clientele and the literature, older individuals who have endured chronic homelessness are generally more mistrusting of the health care system (McDonald et al., 2004).

Providers engaging in therapeutic relationships with older adults also incorporated a trauma-informed approach to care. The premise of trauma-informed care is an assumption that "homelessness is a traumatic experience, which for many homeless people is compounded by serious medical and behavioral health problems and/or histories of abuse and neglect from which they still suffer" (Bonin et al., 2010, p. 24). Trauma-informed care is vital within homeless populations, as they endure high levels of traumatic stress. Health care providers asserted that older homeless adults may be especially susceptible to traumatic stress, resulting from threats to their safety, complex health issues and years of accumulated trauma (Hopper et al, 2010).

Across all interviews, providers also stressed giving older adults control over their own care and involving them in decision-making processes, which is a tenet of person-centred care. This approach to care underscores a partnership between both the recipient and heath care provider that encourages client self-determination and choice (Bonin et al., 2010). Within this partnership, the recipient decides the focus and progression of treatment, as well as determines outcomes in line with their personal capacities and supports that are available (Bonin et al., 2010). Adopting person-centred care approaches between providers and clients facing homelessness is supported in the literature. For example, a study involving eight European countries, investigated how social service providers working with homeless persons describe the principles and objectives of their services (Gaboardi et al., 2019). A central principle guiding their work was incorporating a person-centred approach, where the client's individual choices and goals are prioritized (Gaboardi et al., 2019). Health care providers explained that empowering clients to be in control of their care, especially individuals with many years of accumulated negative health care experiences and trauma, motivated them to begin working towards addressing more serious health issues. Ultimately, the information presented may be helpful to providers who are interested in working with older homeless persons, in which establishing therapeutic relationships will likely underpin their work.

Furthermore, many health care providers assumed central support roles for their older clients, many of whom had limited or non-existent ties with friends and family (McDonald et al., 2004). While the specific nature of these support roles varied between providers, a few health workers mentioned that they assumed family figure roles. A surprising finding is that some providers maintained their familial roles even after a client's death, such as attending memorial services. With older homeless adults' social networks often being predominantly comprised of providers and individuals from agencies, health care workers are uniquely positioned to offer valuable assistance surrounding end-of-life planning and decision-making (Ko et al., 2015). Thus, health care providers working in outreach who attempt to build longitudinal trusting relationships with their clients, may be poised to offer older homeless adults culturally competent end-of-life care, such as through relevant discussions and documentation. This is an area that warrants further investigation in future studies, as highlighted in the recommendations section. By providing social and even emotional support to their clients, health care providers hear a variety of life experiences and difficult stories. As a result, it is equally important that providers practice self-care and look after their own mental health to avoid burnout (Salem et al., 2018).

Health support

Secondly, providers offered **health support** that integrated the full spectrum of physical, mental, and social determinants of health. Past research has shown that a holistic and integrated care approach is more likely to be effective for homeless persons (Cabán-Alemán et al., 2020). Meeting the older client's most basic necessities was usually the first step in the care journey, followed by managing chronic diseases, mental health conditions and addictions. In outreach settings, health care providers were often confronted with "tri-morbidity," in which low physical health is further complicated by the co-occurrence of mental health and substance abuse issues (Hewett et al., 2012). An interesting observation noted during provider interviews was the variation in their perceived level of preparedness for supporting a population with intertwined mental health and addiction issues. While some health care providers had previously worked in positions that equipped them with the necessary skills, other providers learned on the job and/or used online sources to build a stronger knowledge base. Regardless of their previous experiences related to managing mental health and addiction issues, providers reiterated the necessity of using harm reduction techniques in their work. A harm reduction approach aims to minimize the health and social harms connected to substance use and addiction (Thomas, 2005). However, at the core of harm reduction is giving individuals a choice of how they will reduce harms, without requiring that they abstain or stop using substances (CMHA, n.d.).

While providers spoke about the prevalent physical and mental health conditions in older clients that align with findings from other studies (Garibaldi et al., 2005; Gonyea et al., 2010; McDonad et al., 2004), participants elaborated on the impact of social determinants, like housing, on health. Without stable and affordable housing options for older homeless adults, providers asserted that it would be challenging for clients to achieve improved health outcomes. Health care providers raised the need for more housing options that specifically target the diverse needs of homeless older adults, which is consistent with the homelessness literature (McGhie et al., 2013). Generally, shelters are not ideal housing alternatives for older adults, especially since they are usually more tailored towards a younger population (McGhie et al., 2013). Due to Canada's pervasive lack of affordable housing, more subsidized housing that offers support services for older adults' health and social needs is required (McGhie et al., 2013; Brown et al., 2013). Keeping in mind the heterogeneity that exists even with the older homeless population, it is critical that supports are flexible and can be adapted to accommodate the older adult's individual needs.

Collaborators

When working with older homeless adults in outreach settings, health care providers were **collaborators** that worked in interprofessional teams, and they frequently interacted with community partners. Overall, health care workers spoke very positively about their experiences collaborating with other providers and expressed the numerous advantages associated with working in a team-based environment. The benefits of interprofessional collaboration, such as improved client outcomes and efficient use of resources, are echoed within other health care settings (Bridges et al., 2011; Sargeant et al., 2008). Due to the complexity of health and social circumstances faced by homeless individuals, especially older clientele, interprofessional collaboration that effectively engages different disciplines is necessary (Moskowitz et al., 2016). Within the collaborative outreach model described by providers, allied health professionals were meaningfully integrated and felt respected by their colleagues. This fostered strong professional relationships between providers on the same team, where they relied on each other's strengths and maintained ongoing communication with their colleagues, such as expressing safety concerns. Although providers networked extensively with community partners, it was clear that information sharing between different teams and organizations was a prominent gap. In order to foster better continuity of care for older homeless adults, these findings solidify the need for resources and/or tools that facilitate timely, safe and confidential ways of sharing client information between different institutions and organizations.

System navigators

Next, health care providers were **system navigators** that supported older homeless adults during difficult community transitions. Insights from providers revealed the absence of standardized discharge protocols for older homeless individuals leaving institutions, such as hospitals, which builds upon the limited research in this area. A few recent Canadian studies have explored transitions for homeless persons from hospital into the community (Canham et al., 2017; Canham et al., 2020). Canham et al.'s (2017) scoping review broadly investigated the health supports needed by homeless individuals transitioning from hospital. The authors suggest the need for coordination between service systems, including hospitals and shelter/housing, to enhance transitions for homeless clients from hospital (Canham et al., 2017). Health care providers' dialogues surrounding after-care supports as pivotal in preventing readmission, such as an appropriate place to recover, were substantiated by this study's claims (Canham et al., 2017). Another study narrowed in on older homeless adults' specific health and psychosocial needs post-discharge (Canham et al., 2020). In that study, a group of health and service providers from Metro Vancouver were interviewed. They were directly involved in the provision of services related to transitioning individuals experiencing homeless from hospital into the community (Canham et al., 2020). Adding to the health care providers' perspectives showcased in this thesis, the researchers discovered the lack of appropriate housing options for older adults upon hospital discharge and the inadequate community support to assist older adults with complex and chronic conditions (Canham et al., 2020)

Health care providers also reflected on older homeless adults' transitions into LTC, a theme that remains relatively unexplored. One qualitative study gathered the perspectives of service providers who support older homeless adults' relocations to LTC (Sussman et al., 2020). The study's central findings included the need for more housing options for older homeless individuals with minor functional limitations, such as requiring assistance with activities of daily living (Sussman et al., 2020). This would prevent premature relocation to LTC and allow older homeless adults to age in place for a longer duration (Sussman et al., 2020; Jego et al., 2018). According to the service providers in Sussman et al.'s (2020) study, intersectoral collaboration between hospital and community supports would allow for the most appropriate selection of LTC facilities for older homeless adults. Participants interviewed for this thesis corroborated other findings from Sussman et al.'s (2020) study, such as the need for harm reduction models in LTC homes and heightened flexibility around rules and regulations in LTC, to facilitate more positive relocation experiences for older homeless adults. A unique point raised by health care providers in this thesis was the alienation that some older homeless adults may feel when entering LTC, as they are usually significantly younger than other residents. Additional research on how to foster a sense of community and belonging for older homeless adults in LTC is necessary. Addressing the LTC sector's limited awareness of issues pertaining to homelessness and underlying prejudices through training sessions should also be prioritized (Sussman et al., 2020).

Advocates and educators

Lastly, health care providers were **advocates** and **educators**, with both roles frequently overlapping. Providers worked tirelessly to advocate for their clients' needs and combat stigma in the health care system and even in their wider communities. Many older homeless persons experience stigmatization and exclusion, in which being both 'old' and 'homeless' can be regarded as a form of 'double jeopardy' (Rich et al., 1995). The double burden of stigmatization can have significant ramifications on older clients' ability to seek and receive care (Woolrych et al., 2015). Therefore, providers working in outreach recounted numerous instances where they educated other health care workers, such as community consultants and LTC staff, about their clients' needs and life circumstances. In doing so, providers were able to challenge other health care workers' preconceived assumptions that were barriers to accessing care for this population. While many of the providers built a knowledge base according to firsthand experiences and seeking out resources on their own, they also indicated their interest in additional training and educational opportunities related to caring for the older homeless population.

Systems-level challenges

Through their roles providing health and social support, collaborating, navigating systems, as well as advocating and educating, health care providers encountered a variety of challenges in their work. While providers mentioned some individual-level challenges, like coping with the emotionally demanding nature of their work and difficult interactions with other providers, the majority of the challenges that they encountered were systems-level issues. Health care workers were most frustrated by systems-level challenges that imposed multiple barriers to delivering optimal care to their clients. Some of these challenges encompassed: limited funding; inadequate resources and supports tailored to an older homeless population (i.e., housing options, rehab programs and treatment centres, and community supports that promote aging in place); coordinating care with different sectors; the cyclical nature of homelessness, with individuals constantly filtering in between institutions; and stigmatization. A key takeaway from my conversations with providers was that without beginning to address these deeply engrained systems-level issues, it is very difficult to make huge strides in improving health outcomes for older homeless adults.

Personal and professional fulfillment

Health care providers described many rewarding aspects of their roles that led to personal and professional fulfillment. Among the rewarding aspects of their work was bearing witness to the strength and resilience demonstrated by their clients, who often endured years of hardships and trauma. By being entrusted with older homeless adults' often difficult life stories, some health care workers described gaining a new perspective on their own lives. In a care setting where system constraints and structural inequities that reinforce homelessness can be demoralizing, health care providers focused on the small victories. Whether this be a client returning for a follow-up visit or alleviating pain from a wound, providers found motivation in these seemingly small wins. By collaborating with other providers, health care workers gained shared experiences with their colleagues and were able to learn from a variety of disciplines. Their roles also afforded them significant flexibility, which many providers appreciated and allowed them to better adapt their care for their clients' specific needs. What stood out to me most during interviews with this group of providers, was their passion and dedication to improving their clients' well-being and quality of life.

6.2 Recommendations

In line with interpretive description's focus on producing practical and applicable results for practitioners in applied health fields, a series of easily digestible recommendations for practice, policy, and research were drafted. Providers working with older homeless adults are encouraged to use the following recommendations to strengthen current practices and advocate for additional resources, training, and research. It is imperative to note that while health care providers' experiences formed the basis of this study, their perspectives touched upon resources and supports that would better assist their older clients, as well as themselves. Therefore, the proposed recommendations relate to both health care providers and the older clients they support. These recommendations were informed by health care providers' dialogues and key themes in the literature:

Practice

1. Additional training and educational opportunities, specifically related to geriatrics and addictions, for health care providers working with older homeless adults
    - Workshops and further training may be helpful for new health care providers who possess limited experience working with older homeless persons
    - Incorporate more learning opportunities in health professional programs for students interested in working with at risk and homeless populations
        - Curriculum should emphasize therapeutic relationship building, interprofessional collaboration, harm reduction approaches, mental health, and adequate knowledge regarding addictions management
        - One specific example is offering specialized training opportunities in family residency programs that offer the necessary knowledge base and practical skills for working in outreach settings
2. Cultural competency training on homelessness and aging for staff members who interface with older homeless adults, especially where care transitions occur in the community, such as hospital, correctional facilities and LTC

3. Co-development of tools/resources aimed at enhancing streamlined and timely approaches to safely share important client information between health teams, social services, agencies, and institutions that support older homeless adults
    - These resources will facilitate cross-sectoral collaboration, especially during care transitions for older adults with complex health issues and minimal social support networks
4. Implementation of discharge protocols and/or care planning for community transitions (i.e., correctional facilities→ community; hospital→ community; community/hospital→ long-term care)
5. Increased collaborations between primary care teams working in outreach and consultants (e.g., geriatricians)

Policy

1. Increased accessible, affordable, and safe housing options for low-income and homeless older adults that support aging in place
    - More available senior-specific subsidized housing tailored to meet the fluctuating needs of a heterogenous group of older adults (containing appropriate environmental modifications, support workers and programs that support community connections)
2. Adoption of more flexible rules and regulations that incorporate a harm reduction approach in LTC settings
3. Expanded funding for after-care supports that assist older homeless adults' recovery post-hospital discharge

    - Safe locations for individuals leaving hospital to heal (i.e. respite)
    - Medication management and subacute medical care, along with support for clothing, dietary needs, and transportation
4. Rehab facilities and programs that are tailored to accommodate the distinct needs of older homeless adults
5. Enhanced outreach services, including more outreach workers that meet older homeless adults where they are in the community and link them to services and supports (this recommendation is especially timely with the COVID-19 pandemic)

Research

1. Explore how health care providers working closely with older homeless adults can be involved in end-of-life planning and decision-making
2. Co-develop discharge planning protocols/tools and conduct a mixed methods evaluation that incorporates the perspectives of providers and older homeless adults
3. Additional studies that integrate the perspectives of health and social service providers, as well as older homeless adults (i.e. older homeless adults' perceptions of transitions and relocations into LTC)

6.3 Limitations

My thesis findings should be viewed in light of some limitations. First of all, a fairly small sample of health care providers working in outreach settings situated within one mid-sized urban metropolitan area in southern Ontario were recruited for this study. These specific circumstances limit the overall transferability of study findings to other health care providers working in different jurisdictions. Although the sample size was relatively small, a diverse participant group, comprised of different health care providers with varying roles and years of experience, was recruited. Moreover, providers offered in-depth accounts of their experiences working with older homeless adults that produced rich data. In line with Thorne and colleagues' (2008) justification for the usefulness of studies with smaller sample sizes, interpretive description can still produce important knowledge and identify areas that require further investigation.

Second of all, health care providers indicated that they rarely encountered older homeless women in their work, therefore most of their experiences with the older homeless population were based off of interactions with men. This means that while the findings shed considerable light on the experiences of older homeless adults as revealed through discussions with providers, they predominantly related to older homeless men. However, as conveyed in the literature, pathways into homelessness and prevalent health conditions for men and women are not uniform (McDonald et al., 2004). In addition, my thesis findings were solely derived from provider interviews. I suggest that further research be conducted that jointly investigates the experiences of providers and homeless older adults, especially sub-groups within this population (e.g. different ethno-cultural groups and LGBTQ2+ older adults).

To avoid research that overemphasizes qualitative interviews and neglects "the material world", studies that employ interpretive description approaches capitalize on several data collection strategies to provide a more comprehensive interpretation of a phenomenon (Thorne et al., 2004, p.3). However, only one-on-one interviews were conducted, accompanied by field notes taken during and after interviews. Although participant observations were initially considered as a method of obtaining valuable contextual information on health care providers' work with older homeless adults, it was decided that observations were not feasible within the scope of this study. The primary reasons for this are the ethical challenges related to maintaining practitioner-patient confidentiality and the time constraints of a Master's program.

The possibility of using other data sources, such as collateral documentary sources (e.g., practice guidelines or media reports), were explored. In interpretive description, including documentary sources is regarded optimistically as a way of enhancing the breadth of the inquiry (Thorne et al., 1997). However, collateral documentary sources were ultimately not used because participant interviews produced sufficiently rich data for the purposes of a Master's thesis. Even though using multiple data sources is encouraged, Thorne (2008) realizes that due to time and resource constraints in smaller qualitative health research, studies with one source of data still play a role in developing meaningful results. Within these studies, it is imperative that the researcher continuously reflects on the limitations of using that single source when analyzing the data and forming conclusions (Thorne, 2008).

Lastly, interpretive description is a fairly novel qualitative approach and there are limited resources on this methodological framework (Hunt, 2009). When searching the literature, it was evident that there are a limited number of articles and texts to reference in comparison to other qualitative methodologies. This can lead to some ambiguities about interpretive description's research design and how to apply it in a study. To overcome this limitation, I predominantly consulted Thorne and colleagues' texts which are comprehensive and accessible (Thorne et al., 1997; Thorne et al., 2004; Thorne, 2008). I was also mentored by my thesis committee members who have experience using interpretive description.

6.4 Contributions

By exploring health care providers’ experiences supporting older homeless adults in outreach settings, this study’s findings addressed a significant gap in the current literature and established a knowledge base for future studies in this area. My thesis also contributes to the limited body of literature on interpretive description. Beyond presenting findings on a significant gap in the homelessness and methodological literature, this study is aimed at generating knowledge that is relevant and applicable to health care providers who work with homeless older adults in outreach settings.

Through gaining a better understanding of health care providers’ experiences working with a complex sub-population, we can begin developing strategies on how to better support this group of providers. Asking health care providers about the challenges that they encounter in their work served to inform a list of recommendations on what further resources, programs and/or training opportunities health care providers require to better meet the health and social needs of older homeless persons. Learning how health care providers work in their roles to support older homeless persons facilitated a deeper understanding of how service provision can be improved to target this population’s distinct needs. Due to the difficult nature of their work, I also wanted to learn about health care providers’ perceived rewards of working with older homeless persons. These findings may inform future recommendations on how to incentivize other health care providers to work with marginalized and complex populations. Lastly, on a wider scale, understanding the experiences of health care providers who work with a complex population can also assist in informing policy and educational strategies related to improving services and care for complex populations.

6.5 Conclusion

My thesis sought to understand the experiences of health care providers supporting older homeless adults in outreach settings. An in-depth exploration of providers' experiences was captured by asking providers how they work in their roles to meet the needs of older homeless adults, along with perceived challenges and rewards. Key themes revealed that providers' roles working with older homeless adults were multifaceted and extended beyond delivering clinical services. Rather, health care providers offered ongoing social and health support to their clients, collaborated within their teams and broader communities, navigated complex systems, and were avid advocates and educators. Within their roles, health care providers faced individual and systems-level challenges. Health care workers expressed the most frustration surrounding systems-level challenges that limited their ability to make drastic and sustainable changes in their clients' health outcomes. Despite these difficulties, providers found their work personally and professionally rewarding. In accordance with interpretive description's focus on generating relevant and meaningful information to the applied practice context, findings from this study informed the creation of a list outlining recommendations for practice, policy and research. While this study contributes valuable insights to an underexplored area, namely health care providers' experiences working with older homeless adults, further research is needed that integrates both provider and client perspectives.

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Appendix A1: Recruitment Telephone Script (In-person Interviews)

Exploring the experiences of health care providers supporting older homeless adults in homeless service and outreach settings

P = Director
I = Student Researcher (Veronica Sacco)

I - May I please speak to [name of Director]?

P - Hello, [name of Director] speaking. How may I help you?

I - My name is Veronica Sacco and I am a Master's Student under the supervision of Dr. Paul Stolee in the School of Public Health & Health Systems at the University of Waterloo. I am reaching out to you to discuss a research opportunity that you may be interested in. We are looking for participants to take part in one-on-one interviews to support our project on health care providers who work with homeless persons. More specifically, our study will explore the experiences of health care providers who support older homeless adults in homeless service and outreach settings. This research will hopefully allow for a better understanding of how health care providers work in their roles to meet the complex health and social needs of this population. By asking health care providers about the challenges and rewards of working with older homeless persons, we can also determine what further resources and supports would enable service providers to better meet the needs of homeless older adults.

Is this a convenient time to give you further information about the interviews?

P - No, could you call back later (agree on a more convenient time to call person back). OR

P - Yes, could you provide me with some more information regarding the interviews you will be conducting?

I - Background Information:

- The interviews will be in-person one-on-one interviews with health care providers. As much as possible, we are aiming to recruit a diverse sample of health care providers that work with homeless individuals in differing capacities with varying years of experience working in their roles. We expect that this sample will include individuals such as: nurses, nurse practitioners, psychiatrists, social workers, and physicians (this list is not exhaustive). Participants must meet all the following inclusion criteria:

  1) Are a current or former health care provider who works/has worked with homeless persons in the community
  2) Have firsthand experience working with older homeless adults (individuals who are 50 years of age and older)
  3) Are fluent in English

- The interviews will last about 45 minutes-1 hour at a date/time that is most convenient to the participant. The interview will take place at a mutually agreed upon location between the researcher and the participant (i.e. a confidential space/meeting room at the participants' place of work, coffee shop or other public space).
- Involvement in the one-on-one interviews is entirely voluntary and there are no known or anticipated risks to participation in this study.
- Participants will receive remuneration through a $10 gift card of their choice to either Starbucks, Tim Hortons or Indigo to thank them for their time.
- Participants will be asked to read the study's Letter of Information and consent forms, which will also ask if they would like to be contacted to participate in future discussions related to the study.
- During the interviews, the participants will be asked questions related to their roles as health care providers and experiences supporting older homeless adults in the community.
- Participants may decline to answer any of the questions they do not wish to answer and may withdraw from the study at any time. With the participants' permission, the interviews will be audio-recorded to facilitate collection of information, and later transcribed for analysis.
- Any information provided by participants will be grouped with responses from other participants. Furthermore, participants will not be identified by name in any report or publication resulting from this study.
- The data collected will be kept in a secure location and disposed of in 7 years.
- If health care providers at [insert name of organization] have any questions regarding this study, or would like additional information to assist them in reaching a decision about participation, they will be can to contact **Veronica Sacco** (MSc candidate) at xxx-xxx-xxxx, or **Dr. Paul Stolee** (Associate Professor) at 519-888-4567, Ext. 38982.
- I would like to assure you that this study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee. However, the final decision about being a part of the study is the participant's.
- If health providers at [insert name of organization] that meet the inclusion criteria are interested in participating in the study, they can contact the primary researchers (Veronica Sacco or Dr. Paul Stolee) for the study's letter of information.
- Would you be interested in forwarding a recruitment email that outlines the details of this study to health care providers working at [insert name of organization]?

P - No thank you. OR

P - Sure (researcher will then send participant recruitment email).

I - Thank you very much for your time. Once again, if you have any questions or concerns please do not hesitate to contact me at xxx-xxx-xxxx.

P - Good-bye.

I - Good-bye.

Appendix A2: Recruitment Telephone Script (Telephone Interviews)

Exploring the experiences of health care providers supporting older homeless adults in homeless service and outreach settings

P = Director
I = Student Researcher (Veronica Sacco)

I - May I please speak to [name of Director]?

P - Hello, [name of Director] speaking. How may I help you?

I - My name is Veronica Sacco and I am a Master's Student under the supervision of Dr. Paul Stolee in the School of Public Health & Health Systems at the University of Waterloo. I am reaching out to you to discuss a research opportunity that you may be interested in. We are looking for participants to take part in one-on-one telephone interviews to support our project on health care providers who work with homeless persons.

More specifically, our study will explore the experiences of health care providers who support older homeless adults in homeless service and outreach settings. This research will hopefully allow for a better understanding of how health care providers work in their roles to meet the complex health and social needs of this population. By asking health care providers about the challenges and rewards of working with older homeless persons, we can also determine what further resources and supports would enable service providers to better meet the needs of homeless older adults.

Is this a convenient time to give you further information about the interviews?

P - No, could you call back later (agree on a more convenient time to call person back). OR

P - Yes, could you provide me with some more information regarding the interviews you will be conducting?

I - Background Information:

- Telephone interviews with health care providers will be conducted. As much as possible, we are aiming to recruit a diverse sample of health care providers that work with homeless individuals in differing capacities with varying years of experience working in their roles. We expect that this sample will include individuals such as: nurses, nurse practitioners, psychiatrists, social workers, and physicians (this list is not exhaustive). Participants must meet all the following inclusion criteria:

  1) Are a current or former health care provider who works/has worked with homeless persons in the community
  2) Have firsthand experience working with older homeless adults (individuals who are 50 years of age and older)
  3) Are fluent in English

- The phone interviews will last about 45 minutes-1 hour at a date/time that is most convenient to the participant.
- Involvement in the one-on-one interviews is entirely voluntary and there are no known or anticipated risks to participation in this study.
- Participants will receive remuneration through a $10 gift card of their choice to either Starbucks, Tim Hortons or Indigo to thank them for their time.
- Participants will be sent a copy of the study's Letter of Information prior to the phone interview if they would like to review study details. The Letter of Information will also be reviewed by the researcher on the day of the interview and verbal consent will be acquired. This will also involve the researcher asking if the participant would like to be contacted to participate in future discussions related to the study.
- During the interviews, the participants will be asked questions related to their roles as health care providers and experiences supporting older homeless adults in the community.
- Participants may decline to answer any of the questions they do not wish to answer and may withdraw from the study at any time. With the participants' permission, the interviews will be audio-recorded to facilitate collection of information, and later transcribed for analysis.
- Any information provided by participants will be grouped with responses from other participants. Furthermore, participants will not be identified by name in any report or publication resulting from this study.
- The data collected will be kept in a secure location and disposed of in 7 years.
- If health care providers at [insert name of organization] have any questions regarding this study, or would like additional information to assist them in reaching a decision about participation, they will be can to contact **Veronica Sacco** (MSc candidate) at xxx-xxx-xxxx, or **Dr. Paul Stolee** (Associate Professor) at 519-888-4567, Ext. 38982.
- I would like to assure you that this study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee. However, the final decision about being a part of the study is the participant's.
- If health providers at [insert name of organization] that meet the inclusion criteria are interested in participating in the study, they can contact the primary researchers (Veronica Sacco or Dr. Paul Stolee) for the study's letter of information.
- Would you be interested in forwarding a recruitment email that outlines the details of this study to health care providers working at [insert name of organization]?

P - No thank you. OR

P - Sure (researcher will then send participant recruitment email).

I - Thank you very much for your time. Once again, if you have any questions or concerns please do not hesitate to contact me at xxx-xxx-xxxx.

P - Good-bye.

I - Good-bye.

Appendix B1: Recruitment Email (In-person interviews)

Hello,

My name is Veronica Sacco and I am a Master's student working under the supervision of Dr. Paul Stolee in the Geriatric Health Systems Research Group in the School of Public Health & Health Systems at the University of Waterloo. The reason that I am contacting you is that we are conducting a study that explores the experiences of health care providers supporting older homeless adults in homeless service and outreach settings. We are currently seeking health care providers who would be interested in participating in this study and meet **all** the following requirements:

1) Are a current or former health care provider who works/has worked with homeless persons in the community
2) Have firsthand experience working with older homeless adults (individuals who are 50 years of age and older)
3) Are fluent in English

Participation in this study involves participating in an individual in-person interview lasting approximately 45 minutes to 1 hour in length. The interview will be scheduled at a date/time that is most convenient to you. Furthermore, the interview will be conducted at a mutually agreed upon location (i.e. a confidential space/meeting room at your place of work, coffee shop or other public space). The interview will be conversational in nature, with some guiding questions related to your role as a health care provider and experiences supporting older homeless adults in the community. You may decline to respond to any of the questions you do not wish to answer and may withdraw from the study at any time. With your permission, the interview will be audio-recorded to facilitate collection of information, and later transcribed for analysis. You will also be asked if you are interested in participating in future discussions related to the study. Participants will be provided with remuneration through a $10 gift card to either Starbucks, Tim Hortons or Indigo to thank them for their time. I would also like to assure you that the study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee. However, the final decision about participation is yours.

If you are interested in participating and/or would like more information about the study, please contact myself, Veronica Sacco (email address: vsacco@uwaterloo.ca; phone number: xxx-xxx-xxxx) or Dr. Paul Stolee (email address: stolee@uwaterloo.ca; phone number: 519-888-4567 x35879). We are excited about this study and sincerely hope that you will consider participating.

Best wishes,
Veronica Sacco

Appendix B2: Recruitment Email (Telephone Interviews)

Hello,

My name is Veronica Sacco and I am a Master's student working under the supervision of Dr. Paul Stolee in the Geriatric Health Systems Research Group in the School of Public Health & Health Systems at the University of Waterloo. The reason that I am contacting you is that we are conducting a study that explores the experiences of health care providers supporting older homeless adults in homeless service and outreach settings. We are currently seeking health care providers who would be interested in participating in this study and meet **all** the following requirements:

1) Are a current or former health care provider who works/has worked with homeless persons in the community
2) Have firsthand experience working with older homeless adults (individuals who are 50 years of age and older)
3) Are fluent in English

Participation in this study involves participating in a telephone interview lasting approximately 45 minutes to 1 hour in length. The interview will be conversational in nature, with some guiding questions related to your role as a health care provider and experiences supporting older homeless adults in the community. You may decline to respond to any of the questions you do not wish to answer and may withdraw from the study at any time. With your permission, the interview will be audio-recorded to facilitate collection of information, and later transcribed for analysis. You will also be asked if you are interested in participating in future discussions related to the study. Participants will be provided with remuneration through a $10 gift card to either Starbucks, Tim Hortons or Indigo to thank them for their time. I would also like to assure you that the study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee. However, the final decision about participation is yours.

If you are interested in participating and/or would like more information about the study, please contact myself, Veronica Sacco (email address: vsacco@uwaterloo.ca; phone number: xxx-xxx-xxxx) or Dr. Paul Stolee (email address: stolee@uwaterloo.ca; phone number: 519-888-4567 x35879). We are excited about this study and sincerely hope that you will consider participating.

Best wishes,
Veronica Sacco

Appendix C1: Recruitment Poster (In-person interviews)

HEALTH CARE PROVIDERS NEEDED FOR RESEARCH IN HOMELESSNESS IN OLDER ADULTS

Researchers from the University of Waterloo are looking for health care providers to take part in a study exploring:

the experiences of health care providers supporting older homeless adults in homeless service and outreach settings.

As a participant in this study, you would be asked to: participate in one (1) in-person interview that will be approximately 45 minutes-1 hour in length. Participants will be provided with a $10 gift card to thank them for their time.

To be eligible for this study, participants must meet **all** the following requirements:

1) Are a current or former health care provider who works/has worked with homeless persons in the community
2) Have some firsthand experience working with older homeless adults (individuals who are 50 years of age and older)
3) Are fluent in English

For more information about this study, or to volunteer for this study,
please contact:

Veronica Sacco, MSc candidate;
vsacco@uwaterloo.ca; xxx-xxx-xxxx

or

Paul Stolee, Associate Professor, PhD;
stolee@uwaterloo.ca; 519-888-4567 x35879

This study has been reviewed by and received ethics clearance through a University of Waterloo Research Ethics Committee.

Appendix C2: Recruitment Poster (Telephone interviews)

HEALTH CARE PROVIDERS NEEDED FOR RESEARCH IN HOMELESSNESS IN OLDER ADULTS

Researchers from the University of Waterloo are looking for health care providers to take part in a study exploring:

the experiences of health care providers supporting older homeless adults in homeless service and outreach settings.

As a participant in this study, you would be asked to: participate in one (1) telephone interview that will be approximately 45 minutes-1 hour in length. Participants will be provided with a $10 gift card to thank them for their time.

To be eligible for this study, participants must meet **all** the following requirements:

1) Are a current or former health care provider who works/has worked with homeless persons in the community
2) Have some firsthand experience working with older homeless adults (individuals who are 50 years of age and older)
3) Are fluent in English

For more information about this study, or to volunteer for this study, please contact:

Veronica Sacco, MSc candidate;
vsacco@uwaterloo.ca; xxx-xxx-xxxx

or

Paul Stolee, Associate Professor, PhD;
stolee@uwaterloo.ca; 519-888-4567 x35879

This study has been reviewed by and received ethics clearance through a University of Waterloo Research Ethics Committee.

Appendix D: Interview Guide

Exploring the experiences of health care providers supporting older homeless adults in homeless service and outreach settings

Section 1: GENERAL BACKGROND INFORMATION (Adapted from Toscan et al., 2012[1]; Sheiban, 2013[2])

***The purpose of this set of questions is to assist the participant in becoming more comfortable with the interviewer and interviewing environment.*

1. What is your position here at [INSERT LOCATION]?

2. How many years have you been employed in your current position at [INSERT LOCATION]?

3. Overall, how many years of experience do you have working as an [INSERT POSITION]?
    - ➢ **Probe: in other locations/organizations, when did you graduate and/or receive training in your field?

The questions outlined involve probes that are indicated by an arrow symbol. More generalized probes will also be made during the discussion (i.e. asking for clarification, expanding on thoughts, and providing examples).

Section 2: Role(s) of health care providers supporting older homeless persons

1. Can you please describe your role as [INSERT POSITION]?
    - ➢ How did you come to work as [INSERT POSITION]?
    - ➢ What do you like about your role? What do you find difficult?
2. As [INSERT POSITION], how do you work with older homeless adults (individuals 50 years of age and older) in the community?
    - ➢ How do you support and provide care to older homeless adults?
    - ➢ How do you address this population's needs? (i.e. health and social)
3. If I were a new older client/patient that was homeless and we were having our first encounter, what would you say to me? How would you describe your role?
    - ➢ How well do you think these clients/patients understand your role?
4. How are your experiences working with older homeless adults in comparison to homeless individuals from other age groups?
    - ➢ What are the similarities?
        - ▪ **Probe: Causes of homelessness?
        - ▪ **Probe: Challenges that older homeless adults face vs. challenges that homeless individuals from other age groups face?
        - ▪ **Probe: Social and health complexities?

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[1] Toscan, J., Mairs, K., Hinton, S., Stolee, P., & InfoRehab Research Team. (2012). Integrated transitional care: patient, informal caregiver and health care provider perspectives on care transitions for older persons with hip fracture. *International journal of integrated care*, *12*.

[2] Sheiban, L. (2013). Why do you care? Exploring the experiences of health care providers supporting patients with dementia in primary care memory clinics (Published Master's thesis). University of Waterloo, Waterloo, Canada.

    - **Probe: Personal and social circumstances?
    - **Probe: Barriers accessing services?
  - What are the differences?
    - **Probe: Causes of homelessness?
    - **Probe: Challenges that older homeless adults face vs. challenges that homeless individuals from other age groups face?
    - **Probe: Social and health complexities?
    - **Probe: Personal and social circumstances?
    - **Probe: Barriers accessing services?

5. Through your role as [INSERT POSITION], what type of interactions do you have with other health/service providers in the community who also have experiences supporting older homeless persons?
   - Describe interactions; provide example of interactions (if you do not interact with other health/service providers, why is this the case?)

Section 3: Challenges and motivations associated with working with older homeless adults

1. As [INSERT POSITION], can you tell me more about the challenging experiences that you encounter working with older homeless adults?
   - **Probe: Could you provide me with an example of a time that you felt challenged/that it was challenging to work with older homeless adults? How did it make you feel?
   - **Probe: How do you deal with these challenges? Could you provide me with an example of a time that you addressed (a) challenge(s) while working with this population?
   - **Probe: Are there certain resources or supports available to you that assist you in dealing with these challenges?
   - **Probe: What resources or supports do you think have been most helpful to your patients/clients who are 50 years of age and older? What resources or supports have been most helpful to you?
   - **Probe: What resources or supports have been least helpful in caring for older homeless persons?
   - **Probe: Do you think other resources or supports would better assist you in dealing with these challenges?

2. Can you tell me more about the rewarding experiences that you encounter working with older homeless adults?
   - **Probe: Could you provide me with an example? How did it make you feel?
   - **Probe: How do these rewards impact your work with this population? Do they motivate you?

Section 4: Additional Comments or Thoughts

1. Is there something else that you would like to add that was not mentioned in our discussion?

Appendix E: Follow-up Discussion Email

Exploring the experiences of health care providers supporting older homeless adults in homeless service and outreach settings

Participants who agreed to participate in a follow-up discussion, will be emailed a summary of emerging themes and initial key findings from data analysis. They will have the opportunity to comment and provide feedback on the study summary, which will be incorporated in the project's final write-up. Below is the structure for the follow-up emails to be sent to participants:

Dear [participant name],

My name is Veronica Sacco and I am a Master's student working under the supervision of Dr. Paul Stolee in the Geriatric Health Systems Research Group in the School of Public Health & Health Systems at the University of Waterloo. As a reminder, we are conducting a study that explores the experiences of health care providers supporting older homeless adults in outreach settings. During your first interview, we discussed how you work in your role to meet the complex needs of older homeless adults, as well as the perceived challenges and rewards of working with this population.

You indicated on your consent form that you were interested in participating in a follow-up discussion on emerging themes and key findings. Attached to this email is a summary of the themes and findings generated from my initial data analysis. If you are still interested, I would welcome any feedback and/or comments via email once you have reviewed the attached document. Your feedback will be crucial in refining the analytic process, to either support or challenge my initial findings. Below, are some prompts that you may want to consider when reviewing the study's summary:

- What stands out to you about these key themes/ideas?
- Do you agree/disagree with my interpretation of the study's findings?
    - Which parts do you agree/disagree with and why?
    - Are there any areas I overlooked or could have strengthened?

Your identity will be kept confidential and any comments that you provide will not be identified with your name or other personal information in reports. Any feedback is welcome, but it is ultimately your decision if you would like to provide comments on the study's emerging themes and key findings at this time.

Thank you for your consideration,

Veronica Sacco

Appendix F1: Letter of Information (In-person interviews)

Exploring the experiences of health care providers supporting older homeless adults in homeless service and outreach settings

Researchers:
Paul Stolee, PhD
Associate Professor
University of Waterloo
200 University Ave W, Waterloo, ON N2L3G1
Email: stolee@uwaterloo.ca **Phone:** 519-888-4567 x35879

Veronica Sacco, MSc candidate
University of Waterloo
200 University Ave W, Waterloo, ON N2L3G1
Email: vsacco@uwaterloo.ca **Phone:** xxx-xxx-xxxx

A. INTRODUCTION

You are being asked to give your permission to participate in a Master's research study called "Exploring the experiences of health care providers supporting older homeless adults in homeless service and outreach settings" conducted by two researchers: Dr. Paul Stolee (Associate Professor), and Veronica Sacco (MSc Candidate). Your participation in this study is entirely voluntary, so it is up to you to decide whether or not to take part in this study. Before you decide, it is important for you to understand what the research involves. This letter provides you with information about the study. It will explain why the research is being done; what specifically you are being asked to do; and the possible benefits, risks and discomforts.

B. WHAT IS THE PURPOSE OF THIS STUDY?

Demographic shifts are resulting in growing numbers of older adults experiencing homelessness in Canada, although most research and interventions are currently targeted at homeless youth, families, and veterans. In fact, the number of seniors facing homelessness doubled in Toronto between 2011-2014 (Centre for Equality Rights in Accommodation, 2017). The literature suggests that 'older' homeless adults include persons who are above the age of 49, as homeless individuals in their fifties begin exhibiting age-related health impairments that usually occur a decade later in the general population. Older adults may experience homelessness for numerous reasons, such as: insufficient income to pay for housing, deteriorating mental and physical health, being subjected to violence and abuse, and/or the breakdown of a relationship.

In many cases, older homeless adults have a variety of chronic conditions and require complex care needs. The physical, social, and psychological challenges older homeless adults face are compounded by the barriers this population faces accessing health care, such as the discontinuity of care due to their transience. While more research is emerging on the characteristics and experiences of older homeless adults, there is limited information pertaining to the experiences of health care providers working closely with this population. Researchers and policymakers have largely not accessed the knowledge and experiences of service providers, including health care providers. In order to gain a better understanding of the issues surrounding homelessness in older adults and develop strategies to address them, it is imperative that the voices of both providers and older homeless adults are heard. Furthermore, by exploring how health care providers work in their roles, as well as the challenges and rewards of supporting this vulnerable population, we can determine what additional resources, programs and/or training opportunities are required to further support service providers in their work with older homeless adults.

This study will address the critical gap in knowledge pertaining to the experiences of health care providers supporting older homeless adults. The proposed project will attempt to gather the perspectives of a diverse group of health care providers (including: nurses, nurse practitioners, psychiatrists, social workers, physicians etc.) who work in non-traditional health care settings, specifically outreach settings. Understanding the experiences of health care providers who work with a complex sub-population can also assist in informing policy and educational strategies related to improving services and care for complex populations.

C. WHO CAN PARTICIPATE?

We are looking for current health care providers who support individuals in homeless service and outreach settings (i.e. drop-in clinics, shelters, safe consumption sites, and mobile outreach vans) who meet all of the following criteria:

1) Are a current or former health care provider who is working/has worked with homeless persons in the community
2) Have firsthand experience working specifically with older homeless adults (individuals aged 50 years of age and older)
3) Are fluent in English

D. WHAT WILL I BE ASKED TO DO?

In-person Interviews: You are being invited to participate in an interview conducted by Veronica Sacco, which will include an overview of the research project. Afterwards, you will be asked to share your perspectives on your current role and experiences in supporting older homeless adults in the community. Providing insights on your experiences will assist in the understanding of the research topic. This conversation will take place as an individual interview, which will be scheduled at your convenience. The conversation will be led in-person by one researcher and will last for approximately 45 minutes to 1 hour. With your permission, the interview will be audio-recorded. In your consent form, you will be asked whether you would like to participate in a follow-up discussion and provide input on the study's preliminary findings. To thank you for your time, all study participants will receive a $10 gift card to either Tim Hortons, Indigo, or Starbucks. The amount received is taxable. It is your responsibility to report this amount for income tax purposes.

E. WHERE WILL THE STUDY TAKE PLACE AND WHEN?

The study will take place in-person at a location that has been agreed upon between you and the researcher. Some examples include: a confidential space at your place of work (i.e. office or meeting room), coffee shop or other public spaces. At this time, we are asking you to participate in one (1) interview as well as to indicate your interest in participating in a follow-up discussion on the consent form.

F. CAN I CHANGE MY MIND ABOUT PARTICIPATING IN THE STUDY?

Your participation in the study is completely voluntary and you may choose to withdraw from participating at any time. Your decision whether or not to participate has no effect on your employment now or in the future. You can decline to participate in the study without penalty. If you agree to participate, you will be able to talk about whatever you are comfortable with. If there is an interview question you do not want to answer, you may say, “I don’t want to answer that question.” If you wish to withdraw, you can let the interviewer know any time during the interview, or you can contact one of the primary researchers (Dr. Paul Stolee and Veronica Sacco). If you decide to leave the study, all of the data collected from you will be immediately destroyed up until December 30th 2020, as you will not be able to withdraw consent once papers and publications have been submitted to publishers.

G. RISKS AND BENEFITS

There are no known or anticipated risks associated with your participation in the overall project.

H. CONFIDENTIALITY AND DATA SECRUITY

Your identity will be kept confidential and identified by number only. Your name will not appear in any report or publication resulting from this study. Any quotations used in reports from your interview will not be identified with your name or other personal information.You have the right to ask the researchers about the data being collected about you for the study and about the purpose of these data. You also have the right to ask the researchers to let you see your information and make any necessary corrections to it.

Data collected will be kept securely stored in a locked office for a period of at least 7 years, and then confidentially destroyed. The answers to the interview will be stored in a locked file cabinet, in a locked office, at the University of Waterloo for a period of at least 7 years. After 7 years, any written notes from the interview will be confidentially shredded and electronic files will be erased after 7 years. Only the project team will have access to entire interviews. With your permission, anonymous quotations may be used in the following way:

- in teaching and demonstration materials,
- in scholarly papers, articles and other publications, and
- in presentations at academic conferences

I. QUESTIONS

This study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee (ORE #41210). If you have questions for the Committee contact the Office of Research Ethics at 1-519-888-4567 ext. 36005 or ore-ceo@uwaterloo.ca

If at any time you have questions about the proposed research, please contact:
Paul Stolee (Associate Professor), PhD, School of Public Health and Health Systems, University of Waterloo, Waterloo, Ontario, 519-888-4567 ext. 35879, stolee@uwaterloo.ca
or
Veronica Sacco (MSc Candidate), School of Public Health and Health Systems, University of Waterloo, Waterloo, Ontario, xxx-xxx-xxxx, vsacco@uwaterloo.ca.

Appendix F2: Letter of Information (Telephone Interviews)

Exploring the experiences of health care providers supporting older homeless adults in homeless service and outreach settings

Researchers:
Paul Stolee, PhD
Associate Professor
University of Waterloo
200 University Ave W, Waterloo, ON N2L3G1
Email: stolee@uwaterloo.ca **Phone:** 519-888-4567 x35879

Veronica Sacco, MSc candidate
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200 University Ave W, Waterloo, ON N2L3G1
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A. INTRODUCTION

You are being asked to give your permission to participate in a Master's research study called "Exploring the experiences of health care providers supporting older homeless adults in homeless service and outreach settings" conducted by two researchers: Dr. Paul Stolee (Associate Professor), and Veronica Sacco (MSc Candidate). Your participation in this study is entirely voluntary, so it is up to you to decide whether or not to take part in this study. Before you decide, it is important for you to understand what the research involves. This letter provides you with information about the study. It will explain why the research is being done; what specifically you are being asked to do; and the possible benefits, risks and discomforts.

B. WHAT IS THE PURPOSE OF THIS STUDY?

Demographic shifts are resulting in growing numbers of older adults experiencing homelessness in Canada, although most research and interventions are currently targeted at homeless youth, families, and veterans. In fact, the number of seniors facing homelessness doubled in Toronto between 2011-2014 (Centre for Equality Rights in Accommodation, 2017). The literature suggests that 'older' homeless adults include persons who are above the age of 49, as homeless individuals in their fifties begin exhibiting age-related health impairments that usually occur a decade later in the general population. Older adults may experience homelessness for numerous reasons, such as: insufficient income to pay for housing, deteriorating mental and physical health, being subjected to violence and abuse, and/or the breakdown of a relationship.

In many cases, older homeless adults have a variety of chronic conditions and require complex care needs. The physical, social, and psychological challenges older homeless adults face are compounded by the barriers this population faces accessing health care, such as the discontinuity of care due to their transience. While more research is emerging on the characteristics and experiences of older homeless adults, there is limited information pertaining to the experiences of health care providers working closely with this population. Researchers and policymakers have largely not accessed the knowledge and experiences of service providers, including health care providers. In order to gain a better understanding of the issues surrounding homelessness in older adults and develop strategies to address them, it is imperative that the voices of both providers and older homeless adults are heard. Furthermore, by exploring how health care providers work in their roles, as well as the challenges and rewards of supporting this vulnerable population, we can determine what additional resources, programs and/or training opportunities are required to further support service providers in their work with older homeless adults.

This study will address the critical gap in knowledge pertaining to the experiences of health care providers supporting older homeless adults. The proposed project will attempt to gather the perspectives of a diverse group of health care providers (including: nurses, nurse practitioners, psychiatrists, social workers, physicians etc.) who work in non-traditional health care settings, specifically outreach settings. Understanding the experiences of health care providers who work with a complex sub-population can also assist in informing policy and educational strategies related to improving services and care for complex populations.

C. WHO CAN PARTICIPATE?

We are looking for current health care providers who support individuals in homeless service and outreach settings (i.e. drop-in clinics, shelters, safe consumption sites, and mobile outreach vans) who meet all of the following criteria:

1) Are a current or former health care provider who is working/has worked with homeless persons in the community
2) Have firsthand experience working specifically with older homeless adults (individuals aged 50 years of age and older)
3) Are fluent in English

D. WHAT WILL I BE ASKED TO DO?

Telephone Interviews: You are being invited to participate in a telephone interview conducted by Veronica Sacco, which will include an overview of the research project. Afterwards, you will be asked to share your perspectives on your current role and experiences in supporting older homeless adults in the community. Providing insights on your experiences will assist in the understanding of the research topic. This conversation will take place as an individual interview, which will be scheduled at your convenience. The conversation will be led by one researcher and will last for approximately 45 minutes to 1 hour. With your permission, the interview will be audio-recorded. When the researcher obtains verbal consent, you will be asked whether you would like to participate in a follow-up discussion and provide input on the study's preliminary findings. To thank you for your time, all study participants will receive a $10 gift card to either Tim Hortons, Indigo, or Starbucks. The amount received is taxable. It is your responsibility to report this amount for income tax purposes.

E. WHERE WILL THE STUDY TAKE PLACE AND WHEN?

The study will take place by phone. At this time, we are asking you to participate in one (1) interview as well as to indicate your interest in participating in a follow-up discussion.

F. CAN I CHANGE MY MIND ABOUT PARTICIPATING IN THE STUDY?

Your participation in the study is completely voluntary and you may choose to withdraw from participating at any time. Your decision whether or not to participate has no effect on your employment now or in the future. You can decline to participate in the study without penalty. If you agree to participate, you will be able to talk about whatever you are comfortable with. If there is an interview question you do not want to answer, you may say, “I don’t want to answer that question.” If you wish to withdraw, you can let the interviewer know any time during the interview, or you can contact one of the primary researchers (Dr. Paul Stolee and Veronica Sacco). If you decide to leave the study, all of the data collected from you will be immediately destroyed up until December 30th 2020, as you will not be able to withdraw consent once papers and publications have been submitted to publishers.

G. RISKS AND BENEFITS

There are no known or anticipated risks associated with your participation in the overall project.

H. CONFIDENTIALITY AND DATA SECRUITY

Your identity will be kept confidential and identified by number only. Your name will not appear in any report or publication resulting from this study. Any quotations used in reports from your interview will not be identified with your name or other personal information. You have the right to ask the researchers about the data being collected about you for the study and about the purpose of these data. You also have the right to ask the researchers to let you see your information and make any necessary corrections to it.

Data collected will be kept securely stored in a locked office for a period of at least 7 years, and then confidentially destroyed. The answers to the interview will be stored in a locked file cabinet, in a locked office, at the University of Waterloo for a period of at least 7 years. After 7 years, any written notes from the interview will be confidentially shredded and electronic files will be erased after 7 years. Only the project team will have access to entire interviews. With your permission, anonymous quotations may be used in the following way:

- in teaching and demonstration materials,
- in scholarly papers, articles and other publications, and
- in presentations at academic conferences

I. QUESTIONS

This study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee (ORE #41210). If you have questions for the Committee contact the Office of Research Ethics at 1-519-888-4567 ext. 36005 or ore-ceo@uwaterloo.ca

If at any time you have questions about the proposed research, please contact:
Paul Stolee (Associate Professor), PhD, School of Public Health and Health Systems, University of Waterloo, Waterloo, Ontario, 519-888-4567 ext. 35879, stolee@uwaterloo.ca
or
Veronica Sacco (MSc Candidate), School of Public Health and Health Systems, University of Waterloo, Waterloo, Ontario, xxx-xxx-xxxx, vsacco@uwaterloo.ca.

Appendix G: Consent to Participate

Exploring the experiences of health care providers supporting older homeless adults in homeless service and outreach settings

I have read the information letter about the study being conducted. I know that the Master's project is being conducted by Dr. Paul Stolee (Associate Professor) and Veronica Sacco (MSc Candidate) in the School of Public Health and Health Systems at the University of Waterloo.

I was informed that you would like my help to better understand my perspective in regards to the experiences of health care providers supporting older homeless adults in homeless service and outreach settings. I was informed that my participation in this study involves one (1) individual interview lasting approximately 45 minutes to 1 hour, with the possibility of participating in a follow-up discussion at a later time if I am interested.

I have decided to participate in the research study based on the information I have received in the discussion with the researcher(s) from the University of Waterloo. I have had the opportunity to ask questions and receive any additional details I wanted about the study. I also understand that I may decline answering any of the questions, if I so choose and I am free to withdraw from the study at any time up until December 30th 2020 by telling the researchers that I no longer wish to continue.

My identity will be held in confidence and I will not be identified in any reports or publications resulting from this research. I was informed that any quotations taken from my interview will be referenced as anonymous in any publications of this research.

Please note, by signing this consent form you are not waiving your legal rights or releasing the investigator(s) or involved institution(s) from their legal and professional responsibilities.

(Check the box or boxes indicating the parts of the study you agree to participate in)

- ☐ I agree to participate in this study
- ☐ I agree to participate in an in-person or telephone interview
- ☐ I give consent for quotations from my interview to be used in thesis or publications where they will be referenced as anonymous.
- ☐ I agree to be audio recorded during the interview

Participant Name:______________________________(Please print)

Participant Signature: ______________________________

Witness Name:__________________________________(Please print)

Witness Signature: ________________________________

Date: ____________________________

Would you be interested in participating in a follow-up interview?

☐ YES, I am interested in participating in a follow-up discussion. My contact information is:

E-mail address:_________________________________

Phone number: _________________________________

☐ NO, I am not interested in participating in a follow-up interview.

When this study is completed, we will write a summary of the results. Would you be interested in receiving a copy?

☐ YES, please e-mail me a summary of the results. My e-mail address is:

____

☐ YES, please mail me a summary of the results. My mailing address is:

☐ NO, I do not wish to receive a summary of results

The research study has been reviewed by and received ethics clearance through a University of Waterloo Research Ethics Committee.

Appendix H: Verbal Consent Script

Exploring the experiences of health care providers supporting older homeless adults in homeless service and outreach settings

Researchers:
Paul Stolee, PhD
Associate Professor
University of Waterloo
200 University Ave W, Waterloo, ON N2L3G1
Email: stolee@uwaterloo.ca **Phone:** 519-888-4567 x35879

Veronica Sacco, MSc candidate
University of Waterloo
200 University Ave W, Waterloo, ON N2L3G1
Email: vsacco@uwaterloo.ca **Phone:** xxx-xxx-xxxx

Note: The student researcher will first review the letter of information with the participant and answer any questions before proceeding to the verbal consent questions below.

Consent questions:

- Do you agree to participate in a telephone interview for this study knowing that you can withdraw at any point with no consequences to you?
  [If yes, begin the interview.]
  [If no, thank the participant for his/her/their time.]

- Do you consent to allowing quotations from your interview to be used in thesis or publications where they will be referenced anonymously?

- Do you agree to be audio recorded during the interview?

- Are you interested in being contacted to possibly participate in a follow-up discussion via email to discuss emerging themes and findings?

- When this study is completed, we will write a summary of the results. Would you be interested in receiving a copy?

*Consent will be recorded in the verbal consent log (Appendix I).

Appendix I: Verbal Consent Log

Exploring the experiences of health care providers supporting older homeless adults in homeless service and outreach settings

Researchers:
Paul Stolee, PhD
Associate Professor
University of Waterloo
200 University Ave W, Waterloo, ON N2L3G1
Email: stolee@uwaterloo.ca **Phone:** 519-888-4567 x35879

Veronica Sacco, MSc candidate
University of Waterloo
200 University Ave W, Waterloo, ON N2L3G1
Email: vsacco@uwaterloo.ca **Phone:** xxx-xxx-xxxx

RESEARCHER'S LOG FOR RECORDING VERBAL CONSENT

Participant's unique ID number	**Participant's name**	**Date**	**Consent to participate in phone interview (Y/N)**	**Consent for anonymous quotes to be used (Y/N)**	**Consent to be audio-recorded (Y/N)**	**Consent to be contacted for follow-up discussion (Y/N)**	**Would like a summary of results (Y/N)**

Appendix J: Feedback Letter for Participants

Exploring the experiences of health care providers supporting older homeless adults in homeless service and outreach settings

Dear [insert participant name],

We would like to thank you for your participation in this study entitled "Exploring the experiences of health care providers supporting older homeless adults in homeless service and outreach settings." As a reminder, the purpose of this study is to explore the experiences of health care providers who work with older homeless adults in the community.

The data collected during interviews will contribute to a better understanding of health care providers' roles and experiences providing care to a complex patient population. Hearing the voices of providers is imperative in strengthening our understanding of the issues surrounding homelessness in older adults. These findings can also help in generating strategies on how to further support health care providers in their work with older homeless adults. This information will be valuable with Canada's aging population, as more older adults are facing homelessness.

Please remember that your identity as a participant will be kept confidential. Once all the data are collected and analyzed for this project, we plan on sharing this information with the research community through seminars, conferences, presentations, and journal articles. If you are interested in receiving a summary of the study results, ensure that you have indicated so on the consent form that you filled out. In the meantime, if you have any questions about the study, please do not hesitate to contact us (Veronica Sacco and Dr. Paul Stolee) by email or telephone.

This study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee (ORE #41210). If you have questions, please contact the Office of Research Ethics, at 1-519-888-4567 ext. 36005 or ore-ceo@uwaterloo.ca.

Sincerely,

Veronica Sacco (MSc Candidate)
University of Waterloo, School of Public Health and Health Systems
Phone: xxx-xxx-xxxx **Email:** vsacco@uwaterloo.ca

Dr. Paul Stolee (Associate Professor)
University of Waterloo, School of Public Health and Health Systems
Phone: 519-888-4567 x35879 **Email:** stolee@uwaterloo.ca

Appendix K: Sample Participant Synopsis

Synopsis- P01

P01 is a current nurse practitioner who has worked at a local community health centre for the past 10 years. The community health centre focuses on providing primary care to marginalized individuals and those who face barriers accessing health care. For the past year, P01 has started a new role as a member of an Interdisciplinary Primary Care team that provides health care to those who are homeless or at risk of homelessness through an outreach approach. P01 has always been passionate about working with homeless individuals, along with addiction and mental health work, using collaborative models. Some challenges P01 highlighted in their work is being a source of primary support for people who are often isolated, the “ebbs and flows” of homelessness, as well as the lack of structure in in the workday. While working with homeless older adults, P01 goes slow and attempts to address the issues that are important to each client. P01 said that the most rewarding aspect of their work is when a client who has been disconnected from the system for many years, decides to seek care and even returns for follow-up visits.

Appendix L: Enhancing Qualitative Rigor

Table 4: Criteria used to assess qualitative rigor

Credibility	**Transferability**	**Dependability**	**Confirmability**
How well do the study's findings align with the participants' experiences?	*What is the extent to which findings generated from this study fit within other contexts?*	*How consistent are the research findings and to what degree is the research process documented to allow for external review and critique?*	*To what extent are the researcher's own viewpoints and motivations influencing the study findings and interpretations?*
• Follow-up discussions with participants, enabling them to comment on emerging themes and initial findings • Review of codes and subsequent themes with second researcher	• Interviews with a diverse sample of providers (varying roles, years of experience, different care teams)	• Creation of an audit trail, achieved through journaling which captured memos, field notes and analytical observations/ideas • In-depth interviews with participants that supported thick descriptive data	• Integrating reflexive practices throughout the research process (i.e. journaling, writing a positionality statement)

The four criteria listed above (credibility, transferability, dependability, and confirmability) are commonly used to assess the rigor of qualitative studies. Shenton (2004)'s discussion on these criteria was used to inform the creation of this table.

Appendix M: ORE Approval

UNIVERSITY OF WATERLOO

Notification of Ethics Clearance to Conduct Research with Human Participants

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Principal Investigator: Paul Stolee (School of Public Health and Health Systems)

Student investigator: Veronica Sacco (School of Public Health and Health Systems)

File #: 41210

Title: Exploring the experiences of service providers supporting older homeless adults in community-based settings

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The Human Research Ethics Committee is pleased to inform you this study has been reviewed and given ethics clearance.

Initial Approval Date: 07/30/19 (m/d/y)

University of Waterloo Research Ethics Committees are composed in accordance with, and carry out their functions and operate in a manner consistent with, the institution's guidelines for research with human participants, the Tri-Council Policy Statement for the Ethical Conduct for Research Involving Humans (TCPS, 2nd edition), International Conference on Harmonization: Good Clinical Practice (ICH-GCP), the Ontario Personal Health Information Protection Act (PHIPA), the applicable laws and regulations of the province of Ontario. Both Committees are registered with the U.S. Department of Health and Human Services under the Federal Wide Assurance, FWA00021410, and IRB registration number IRB00002419 (HREC) and IRB00007409 (CREC).

This study is to be conducted in accordance with the submitted application and the most recently approved versions of all supporting materials.

Expiry Date: 07/31/20 (m/d/y)

Multi-year research must be renewed at least once every 12 months unless a more frequent review has otherwise been specified. Studies will only be renewed if the renewal report is received and approved before the expiry date. Failure to submit renewal reports will result in the investigators being notified ethics clearance has been suspended and Research Finance being notified the ethics clearance is no longer valid.

Level of review: Delegated Review

Signed on behalf of the Human Research Ethics Committee

Joanna Eidse

Joanna Eidse, Research Ethics Officer, jeidse@uwaterloo.ca, 519-888-4567, ext. 37163

This above named study is to be conducted in accordance with the submitted application and the most recently approved versions of all supporting materials.

Documents reviewed and received ethics clearance for use in the study and/or received for information:

file: AppendixATelephoneScript_version2_20190725.docx

file: AppendixBRecruitmentEmail_version1_20190624.pdf

file: AppendixCRecruitmentPoster_version1_20190624.pdf

file: AppendixDInterviewGuide_version1_20190625.pdf

file: AppendixELetterofInformation_version2_20190725.docx

file: AppendixFConsentForm_version2_20190725.docx

file: AppendixGFeedbackLetter_version2_20190725.docx

Approved Protocol Version 2 in Research Ethics System

This is an official document. Retain for your files.

You are responsible for obtaining any additional institutional approvals that might be required to complete this study.

Appendix N: Summary of Main themes, Subthemes and Key ideas

Table 5: Main themes, subthemes and key ideas

Main Theme	Subthemes	Key Ideas
1) The client-provider relationships as an essential building block	(a) Building trust (b) Encouraging client choice (c) Adopting central support roles	• Requires time • Acknowledging trauma • Client control over care • Becoming a family member figure • Connecting clients to the community
	Challenges and rewards	• Emotionally demanding nature of roles • Storytelling, witnessing strength and healing
2) Progression of care that acknowledges the 'whole person'	(a) Addressing the immediate crisis (b) Care evolving to incorporate chronic health, mental health, and addiction	• Acute care • Support around basic necessities • Chronic disease management • Support around mental health and addiction
	Challenges and rewards	• Older clients' health going unchecked • Issues with follow-up and adherence • "Small wins"
3) Collaboration as integral to providers' work	(a) Collaboration with providers on the same team (b) Collaboration with community partners	• Working in an interprofessional team • Safety • Partnering with community agencies, organizations and consultants
	Challenges and rewards	• Access to and sharing information • Challenging encounters with other providers • Shared experiences
4) System navigation	(a) Community transitions (b) Different policies and guidelines	• i) correctional facilities into the community ii) hospital into the community iii) community/hospital into long-term care • Work is more unstructured
	Challenges and rewards	• Paperwork and timing • Limited resources • Flexibility and autonomy

Glossary

At risk of homelessness: while these individuals are not homeless, their “current economic and/or housing situation is precarious or does not meet public health and safety standards” (Gaetz et al., 2012, p. 1)

Chronically homeless: persons who are homelessness for at least a year, usually for long periods of time (Gaetz et al., 2014)

Emergency sheltered: refers to people who are staying at emergency shelters or accessing system supports (Gaetz et al., 2012)

Episodically homeless: individuals who shift in and out of homelessness throughout different periods in their lives (Gaetz et al., 2014)

Homelessness: “describes the situation of an individual, family or community without stable, safe, permanent, appropriate housing, or the immediate prospect, means and ability of acquiring it. It is the result of systemic or societal barriers, a lack of affordable and appropriate housing, the individual/household’s financial, mental, cognitive, behavioural or physical challenges, and/or racism and discrimination” (Gaetz et al., 2012, p. 1)

Provisionally accommodated: individuals who are without permanent shelter and may access temporary housing supported by the government or non-profit sector (Gaetz et al., 2012)

Transitionally homeless: those who have been facing homelessness on a more short-term basis, typically less than a month (Gaetz et al., 2014)

Unsheltered/absolutely homeless: persons who are usually living in spaces not intended for human habitation, such as on the streets (Gaetz et al., 2012)