Journal of Integrative Nursing and Palliative Care (JINPC)

Original Article

Volume 6 | Issue 2 | Page 308-313

Palliative Care Provision for Patients Experiencing Homelessness: Provider Perspectives during COVID-19

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Abstract

Homeless individuals typically suffer from elevated levels of medical complexity, multiple co-existing conditions, and increased mortality risks. They also confront major obstacles when seeking palliative care. Among structurally disadvantaged groups needing end-of-life support, these obstacles intensify, creating significant challenges for patients and clinicians alike and carrying notable consequences for health equity.
This study examined firsthand accounts of palliative care clinicians who supported homeless patients during the COVID-19 pandemic. The focus was on uncovering the obstacles they encountered while delivering care and the elements that contributed to their teams' effectiveness. Seven healthcare professionals from two Canadian palliative outreach teams responsible for providing end-of-life care to homeless patients during the COVID-19 pandemic joined audio-recorded videoconference interviews, which were subsequently transcribed. Data examination relied on generic descriptive thematic analysis.
Five primary themes surfaced: (1) factors negatively impacting patient health, (2) use of technology, (3) care provider emotions, (4) care provider education and advocacy, and (5) outreach team factors. Challenges noted during the pandemic included the exacerbation of patients' pre-existing vulnerabilities and difficulties integrating technology into care provision. Clinicians dealt with a heavier emotional toll marked by higher workloads, elevated stress, heightened fear, and greater grief. Still, various supportive factors enabled teams to deliver excellent care to this at-risk population, including robust team backing, cross-professional teamwork, and efforts centered on advocacy and education. The outreach approach also emerged as an exceptionally adaptable, durable, and flexible framework for delivering care amid the COVID-19 pandemic.

Keywords: COVID-19, Health care providers, Homeless, Interviews, Palliative care, Underserved populations

Introduction

People living without stable housing show higher rates of medical complexity, co-morbidities, and death, in addition to facing numerous hurdles in obtaining palliative care services [1]. Such hurdles encompass unstable housing situations, scarce social supports, prior unfavorable interactions with medical staff, and pervasive stigma throughout the healthcare system [1-4]. Concurrent mental health conditions or substance use issues compound the difficulty of entering palliative care programs [1-4]. Conventional palliative care models are rarely constructed to accommodate these issues and generally presuppose the availability of secure accommodation and an involved support network that permits patients to remain in their usual setting until death [3, 4]. Moreover, a substantial number of healthcare practitioners possess minimal training concerning the specific needs of homeless patients, such as harm reduction strategies and trauma-informed approaches [3-5]. Staff in shelters are likewise frequently unprepared to manage patients with terminal illnesses owing to insufficient preparation and understaffing [4, 5].
Over the last several years, various organizations across Canada have established dedicated palliative outreach initiatives tailored to the needs of people experiencing homelessness. These outreach initiatives represent care

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Received: 02 August 2025; **Accepted:** 24 November 2025; **Published:** 20 December 2025

How to Cite This Article: Walker J, Harris O. Palliative Care Provision for Patients Experiencing Homelessness: Provider Perspectives during COVID-19. J Integr Nurs Palliat Care. 2025;6(2):308-13. https://doi.org/10.51847/SR9DfWfU8e

models that prioritize expanding access to medical treatment and linking individuals with community-based social assistance in the environments where patients reside or receive services [6]. Outreach teams are generally interdisciplinary, bringing together roles such as nurses, social workers, and doctors who jointly address the multifaceted demands of patients who find it hard to participate in standard outpatient or home-based care arrangements [6]. Through such initiatives, services can be offered inside shelters, at drop-in facilities, or directly on the streets when necessary, enabling providers to engage patients in their current locations.

The COVID-19 pandemic aggravated pre-existing inequities in healthcare access. It generated fresh difficulties that hit vulnerable communities especially hard, given their greater susceptibility to infection and serious complications from the virus [7]. At the height of the outbreak, Ontarians with a recent experience of homelessness faced over 20 times the likelihood of hospital admission for COVID-19, more than 10 times the chance of needing intensive care, and over 5 times the risk of dying within 21 days following their initial positive test [8]. Overcrowded conditions, rapid resident movement, and shortages of isolation areas and personnel in shelters created serious impediments to outbreak management [7, 9]. A large proportion of community programs serving homeless populations were compelled to close [7]. Palliative care personnel additionally struggled with limited supplies and inadequate personal protective equipment [10].

This research is the initial effort to examine the distinctive difficulties experienced by palliative care clinicians caring for homeless patients during the COVID-19 pandemic. Its objective is to illuminate the specific care obstacles that surfaced and to pinpoint the supportive elements that helped teams surmount these issues while striving for equitable service delivery. The insights gained may help other healthcare groups serving disadvantaged communities refine their care approaches.

Materials and Methods

Setting and participants

This qualitative project used purposive sampling to select participants from two Canadian outreach teams dedicated to meeting the palliative care requirements of marginally housed individuals. Recruitment proceeded on a rolling basis and continued until thematic saturation was achieved. The two teams were located in separate Canadian provinces, and one team was about twice the size of the other. Both teams had a comparable composition of professional roles, including social workers, nurses, and physicians. All selected participants had been actively delivering palliative care to people experiencing homelessness throughout the COVID-19 pandemic. Approval from the Unity Health Research Ethics Board was obtained before commencing the study.

To be eligible for participation, individuals needed to:

- Be healthcare staff who are allocated at least one half-day per week to provide palliative care for those experiencing homelessness, for a minimum period of six months during the COVID-19 pandemic,
- Be employed at one of the two specified Canadian research sites, and
- Possess strong English language proficiency.

Data collection

Interviews lasting 20-40 minutes were conducted via a secure videoconferencing system in October and November 2021. Verbal consent was collected from each participant immediately before the session began. A semistructured interview guide was used to investigate supportive factors, clinical and organizational hurdles, and health-related behaviors that shaped the delivery of palliative care during the COVID-19 outbreak. The guide underwent minor iterative refinements as interviewing continued. All sessions were audio-recorded digitally, transcribed verbatim, and then de-identified. The original audio recordings were permanently deleted following transcription.

Data analysis

Descriptive thematic analysis was applied to examine the interview content [11]. The entire analysis process was conducted by the coinvestigators under the supervision of an experienced qualitative methods expert. An iterative, emergent coding strategy was followed, allowing themes to emerge organically from the raw data rather than relying on a prior theoretical framework. The two coinvestigators performed independent coding, after which any disagreements were addressed and reconciled through joint discussion.

Individual coded excerpts were then clustered into broader groupings based on their underlying meaning. Domains, themes, and recurring patterns were established with direct reference to the central research question. Emerging insights were repeatedly verified against earlier data using an ongoing constant comparison technique [12].

Results and Discussion

In total, seven participants took part in the interviews. The group consisted of four physicians, two nurses, and one social worker. Five themes emerged.

Theme 1: Factors negatively impacting patient health

Without stable housing, participants observed that patients faced elevated risks of catching COVID-19 inside shelters and developing serious complications. They mentioned that shelter hotel programs, introduced by various regions as a pandemic measure, provided short-term relief for patients. Nevertheless, moving patients to hotels led to unforeseen drawbacks, such as greater social isolation and a rise in overdose fatalities.

Mismatches between available healthcare resources, existing policies, and this population's actual needs were found to deter patients from seeking care. Specific examples included the absence of harm reduction options in palliative settings (such as safe opioid supply programs), lack of health insurance coverage, failure to acknowledge patients' street families, and restrictions on visitor access.

Participants explained that COVID-19 further weakened an already shaky social safety net for these individuals by shutting down community resources like drop-in centers, harm reduction programs, and dedicated healthcare teams.

Theme 2: Use of technology

Participants noted that the expanded reliance on technology in healthcare during the COVID-19 period created obstacles for patients without access to phones or other communication tools. To address this, teams supplied phones and tablets so patients could join virtual appointments with specialists; these devices were frequently secured through charitable donations. Difficulties in building meaningful therapeutic connections were highlighted. Some patients struggled to participate in online platforms because of mental health issues, physical disabilities, trauma histories, and similar factors. One team developed a protocol to assess patients' medical stability and comfort with technology before deciding whether virtual care was suitable.

Despite these hurdles, when virtual care was made fairly available, it helped eliminate transportation challenges, allowed teams to see more patients overall, and provided simpler pathways for patients to receive medical attention.

Theme 3: Provider emotions

Participants described facing heightened emotional pressures linked to the pandemic, such as fear of contracting COVID-19, feelings of grief, burnout, and moral distress. Rising patient numbers, staff shortages, frequent unexpected deaths, and multiple overlapping health emergencies intensified these pressures. To support their well-being and resilience, providers adopted various coping strategies, including team debriefing sessions and structured grief circles.

Theme 4: Care provider education and advocacy

Exchanging knowledge with fellow healthcare professionals enhanced skills in delivering fair and equitable palliative care. Additional helpful activities included grief workshops, grief circles involving providers, and the adoption of advanced care planning tools tailored for the COVID-19 context. Speaking up on behalf of patients when dealing with shelters, COVID hotels, and hospital-based teams proved essential for relocating patients to safer environments. These clinicians also pushed for better health policies at the provincial level, such as prioritizing access to COVID-19 vaccines for people living in shelters. Raising public understanding of their patients' circumstances by sharing real-life stories through opinion pieces, media interviews, and other outlets emerged as an effective form of advocacy.

Theme 5: Outreach team factors

Essential elements of the outreach care model that supported continued delivery of palliative services to patients included the ability to work across varied locations and environments with patients, the multidisciplinary and complementary expertise of team members, and a collective dedication to maintaining face-to-face care whenever possible.

These clinicians also reported collaborating within their teams to create innovative approaches to care delivery and to assist the efforts of other healthcare and social service groups. Through this process, the teams broadened their responsibilities during the pandemic and forged new collaborations with charitable groups, volunteer networks, community agencies, and hospital personnel. As one participant noted, "It did bring a lot of people together. It gave us a common enemy: COVID."

Overall, participants characterized the outreach team model as highly adaptable and robust throughout the pandemic. This approach played a central role in enabling them to sustain excellent standards of patient care.

Outreach team members directly observed the numerous obstacles confronting individuals experiencing homelessness who required palliative care during the COVID-19 pandemic. These healthcare professionals emphasized longstanding barriers to care documented in earlier systematic reviews, such as the absence of harm-reduction strategies within conventional palliative programs and the lack of recognition of patients' street families [1, 4, 5]. They also expressed concern about the fragility of the social safety nets these patients depend on for everyday survival and about how rapidly such services vanished amid the pandemic.

Adverse consequences involved diminished service availability, declining patient health and quality of life, higher rates of overdose fatalities, increased social isolation, and relocation to unfamiliar parts of the city. These observations align with prior research demonstrating the unequal burden of pandemics on structurally disadvantaged groups [7], with an even more pronounced effect on palliative care patients who often manage extensive medical complexity and significant disabilities. Our findings indicate that COVID-19 exerted a particularly severe negative influence on the health of palliative care patients experiencing homelessness and underscore the urgent requirement for enhanced medical and social assistance to meet the intricate needs of this group.

Greater reliance on technology for healthcare delivery emerged as standard practice during the pandemic. Previous studies have identified advantages of virtual palliative care, such as broadening service reach, scaling up service capacity, enabling patients to see facial expressions without masks, and lowering the chance of virus spread [13, 14]. At the same time, concerns regarding weak therapeutic connections, inappropriate application of virtual tools, and limited accessibility for disadvantaged patients have also been raised [14, 15]. These issues were clearly evident in our research; many patients lacked access to phones or computers. To address this gap, both teams partnered with charitable organizations to supply phones and tablets. Expanding technological availability brought several advantages, including fewer transportation difficulties for patients, smoother connections to specialists, and more patient consultations. Our results imply that improving equitable access to technology for certain palliative care patients experiencing homelessness could help lower obstacles to receiving palliative services.

Our findings further emphasize that virtual care does not work effectively for every patient. Individuals dealing with certain mental health challenges, cognitive limitations, or sensory impairments may find it difficult or impossible to participate meaningfully in virtual appointments [14]. Providers stressed the critical value of establishing direct, in-person relationships with patients. Given that many individuals in this population have had prior unfavorable encounters with the healthcare system, developing trust often required face-to-face interactions. Consequently, while greater technological access can offer important benefits, in-person care continues to be essential for delivering high-quality palliative support to patients experiencing homelessness and should be preserved even during public health emergencies.

The COVID-19 pandemic placed additional pressure on healthcare teams through rising patient numbers and the need to address service shortfalls. Participants described feeling uncertain about the future course of the pandemic and expressed worries about contracting or spreading COVID-19. This mirrors the emotional load reported by home care staff [16], long-term care personnel [10], and palliative care groups throughout the crisis [17, 18]. However, because they served marginalized groups, our participants also experienced moral distress from recognizing the unequal toll the pandemic would take on their patients, along with compounded grief stemming from unexpected fatalities linked to both COVID-19 and opioid overdoses. These findings underscore the importance of developing effective approaches to identify and support healthcare providers experiencing moral distress during crises, especially those caring for disadvantaged populations.

With the heightened emotional pressures brought on by the pandemic, a key factor supporting team resilience was robust peer support combined with shared team principles, consistent with observations by Cheng and Li Ping Wah-Pun Sin [17] regarding palliative care groups. Many providers in our study emphasized the strength of their team bonds, the value of regular reflection and debriefing sessions, and their common dedication to delivering fair and equitable care. While these strategies existed before the pandemic, they gained greater emphasis as the emotional demands of providing care intensified during the crisis. Our results reinforce the case for building robust support structures within healthcare teams to enhance both individual and collective resilience when facing emergencies.

Participants also identified fresh avenues for advocacy and learning. One significant obstacle to care access stems from insufficient palliative care knowledge among shelter workers, as well as a limited understanding of how to support marginalized groups among general medical staff [1, 2, 5, 10]. Certain palliative care teams have responded by focusing on education to broaden service reach [4, 13]. In our research, one team developed a specialized advanced care planning resource for social service staff to help preserve patient autonomy in defining their care objectives. Providers further raised awareness of their clients' situations by sharing stories on social media to draw public attention to the challenges faced by people experiencing homelessness. Outreach teams possess specialized insight into their patients' palliative care journeys and are ideally situated to serve as advocates and educators, thereby enhancing overall care quality.

Importantly, this research underscores the strengths of outreach-based care models in delivering palliative services to patients experiencing homelessness amid the COVID-19 pandemic. Previous work has recommended outreach and shelter-based palliative approaches for this group because of their relatively modest costs, strong focus on patient preferences, and capacity to engage individuals in their own environments [1, 4, 12, 19]. In the present study, the adaptable nature of the outreach model enabled teams to adjust rapidly to evolving rules and restrictions. They maintained their core operations without major interruptions or changes.

As a result, outreach teams emerged as a vital asset, benefiting not only patients but also other healthcare groups; they were frequently called upon to arrange consultations with additional providers, coordinate care, and address gaps in both medical treatment and social assistance. These teams are inherently multidisciplinary, equipping them to tackle a wide array of complex needs in the shifting pandemic environment. The COVID-19 pandemic brought into sharp focus the essential contributions of such teams in sustaining care for at-risk patients during periods of upheaval. It illustrated how outreach models could deliver an even broader range of services when properly supported.

Several limitations of the study should be acknowledged, along with opportunities for further investigation in this area. First, participation was restricted to members of two Canadian palliative outreach teams, even though interdisciplinary data saturation was achieved. Experiences from comparable teams across Canada or abroad may vary, yet the lessons derived here are expected to remain relevant in different settings. Furthermore, the study focused exclusively on provider viewpoints; incorporating patient voices would represent a valuable direction for subsequent research.

Conclusion

This article examines the lived experiences of interdisciplinary palliative care providers supporting populations experiencing homelessness during the COVID-19 pandemic and sheds light on the distinctive obstacles confronting this patient group. It also identifies key facilitators that enabled these teams to remain resilient amid the global health emergency, such as expanding technological access without abandoning in-person interactions, fostering a strong team culture, pursuing advocacy and educational efforts, and operating within a collaborative, interprofessional framework—all supported by a versatile outreach model. As we look past the immediate COVID-19 context, these observations can guide other healthcare professionals serving socially disadvantaged groups in establishing team priorities and enhancing the quality of care delivery.

Acknowledgments: None

Conflict of interest: None

Financial support: This study was supported by the Department of Family and Community Medicine at the University of Toronto.

Ethics statement: None

References

1. Klop HT, De Veer AJ, Van Dongen SI, Francke AL, Rietjens JAC, Onwuteaka-Philipsen BD, et al. Palliative care for homeless people: a systematic review of the concerns, care needs and preferences, and the barriers and facilitators for providing palliative care. BMC Palliat Care. 2018;17(1):1–6.
2. Hutt E, Albright K, Dischinger H, Kuntz J, Whelan J, Rosenberg J, et al. Addressing the challenges of palliative care for homeless veterans. Am J Hosp Palliat Care. 2018;35(3):448–55.
3. Stajduhar KI, Mollison A, Giesbrecht M, McNeil R, Dosani N, Hughes J, et al. "Just too busy living in the moment and surviving": barriers to accessing health care for structurally vulnerable populations at end-of-life. BMC Palliat Care. 2019;18(1):1–4.
4. West KJ, Wrobel B, Pallotta S, Tzou P, Black K, Cohen J, et al. Bearing witness: exploring the end-of-life needs of homeless persons and barriers to appropriate care. Omega (Westport). 2020;82(1):63–91.
5. MacKenzie M, Purkey E, Esmail S, McNeil R, Pauly B, Buxton J, et al. Barriers to end-of-life services for persons experiencing homelessness as perceived by health and social service providers. J Am Board Fam Med. 2019;32(6):847–57.
6. Arriagada D, Van Citters BA, Bartels SJ, Desmond M, Smyer MA, Cook BL, et al. A systematic review of the effectiveness of community-based mental health outreach services for older adults. Psychiatr Serv. 2004;55(11):1237–49.
7. Perri M, Dosani N, Hwang SW. COVID-19 and people experiencing homelessness: challenges and mitigation strategies. CMAJ. 2020;192(26):E716–9.
8. Richard L, Booth R, Rayner J, Kothari A, Pottie K, Kendall C, et al. Testing, infection and complication rates of COVID-19 among people with a recent history of homelessness in Ontario, Canada: a retrospective cohort study. CMAJ Open. 2021;9(1):E1–9.

9. Zhu A, Bruketa E, Svoboda T, Gerdtz M, Moffatt S, Tsemberis S, et al. Respiratory infectious disease outbreaks among people experiencing homelessness: a systematic review of prevention and mitigation strategies. Ann Epidemiol. 2022;1047-2797(22)00038-2.
10. Harasym P, Brisbin S, Afzaal M, Sinnarajah A, MacLeod R, Thomas R, et al. Barriers and facilitators to optimal supportive end-of-life palliative care in long-term care facilities: a qualitative descriptive study of community-based and specialist palliative care physicians' experiences, perceptions and perspectives. BMJ Open. 2020;10(8):e037466.
11. Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psychol. 2006;3(2):77–101.
12. Gruenewald DA, Doan D, Poppe A, Johnson A, Kvale EA, Rosenberg AR, et al. "Meet me where I am": removing barriers to end-of-life care for homeless veterans and veterans without stable housing. Am J Hosp Palliat Care. 2018;35(12):1483–9.
13. Blinderman CD, Adelman RD, Kumaraiah D, Khan Z, Mehta A, Gottlieb M, et al. A comprehensive approach to palliative care during the coronavirus pandemic. J Palliat Med. 2021;24(7):1017–22.
14. Cherniwchan HR. Harnessing new and existing virtual platforms to meet the demand for increased inpatient palliative care services during the COVID-19 pandemic: a 5 key themes literature review of the characteristics and barriers of these evolving technologies. Am J Hosp Palliat Care. 2022;39(5):591–7.
15. Kuntz JG, Kavalieratos D, Esper GJ, O'Connor M, Petrillo L, Matlock DD, et al. Feasibility and acceptability of inpatient palliative care e-family meetings during COVID-19 pandemic. J Pain Symptom Manage. 2020;60(3):e28–e32.
16. Sterling MR, Tseng E, Poon A, Cho J, Avgar AC, Kern LM, et al. Experiences of home health care workers in New York City during the coronavirus disease 2019 pandemic: a qualitative analysis. JAMA Intern Med. 2020;180(11):1453–9.
17. Cheng JO, Sin ELPW, Chan CLW, Leung JCS, Lee E, Kwok S, et al. The effects of nonconventional palliative and end-of-life care during COVID-19 pandemic on mental health—junior doctors' perspective. Psychol Trauma. 2020;12(S1):S146.
18. Wallace CL, Wladkowski SP, Gibson A, White P, Wenner L, O'Connor M, et al. Grief during the COVID-19 pandemic: considerations for palliative care providers. J Pain Symptom Manage. 2020;60(1):e70–6.
19. Purkey E, MacKenzie M, MacNeil R, Pauly B, Buxton J, Brown S, et al. Experiences of palliative health care for homeless and vulnerably housed individuals. J Am Board Fam Med. 2019;32(6):858–67.