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Continuity of Palliative Nursing without a Stable Home Address: A Conceptual Service Model for Relational Responsibility across Shelters, Outreach Services, and Temporary Accommodation

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Abstract

To examine how palliative nursing continuity can be sustained when a stable residential address cannot function as the organizing point for follow-up, information exchange, responsibility, and recontact. Original non-empirical service-model development informed by critically selected scholarship on homelessness, palliative and end-of-life care, outreach nursing, service navigation, discharge, integrated care, and continuity. Peer-reviewed evidence published from 2017 to 2025 was selected for direct relevance to homelessness and palliative care or for a clearly bounded contribution concerning nursing access, navigation, transitions, coordination, trauma-informed services, or organizational implementation. The analysis identifies a recurrent mismatch between place-dependent service organization and the mobility, uncertainty, fragmented service use, and relational vulnerability experienced by people without stable accommodation. Continuity therefore requires mechanisms that remain functional when a person moves between shelters, temporary accommodation, hospitals, outreach settings, or periods in which no reliable residential contact point exists. The proposed service logic treats continuity as a distributed organizational responsibility rather than an attribute automatically produced by repeated attendance at one service. Palliative nursing for people experiencing homelessness requires continuity arrangements that can survive changes in place, service, and contact route. Address-independent continuity should protect relational knowledge, clinically relevant information, responsibility, and the possibility of renewed contact while remaining voluntary, privacy-respecting, and adaptable to local service structures.

Keywords: Homelessness, Palliative nursing, Continuity of care, Outreach nursing, Care transitions, Health equity

Introduction

People experiencing homelessness encounter palliative and end-of-life care within health systems that commonly assume a stable place of residence, a reliable means of contact, and predictable movement between services. Contemporary evidence shows persistent barriers to palliative-care access among homeless populations, including difficulties created by service organization, professional uncertainty, fragmented pathways, and the practical conditions in which care must be delivered [1]. These problems occur within a broader pattern of severe health inequity. People experiencing homelessness and other highly excluded populations experience markedly elevated morbidity and mortality compared with general populations [2]. Recent longitudinal work also shows the importance of better identifying and tracking deaths among people who have experienced homelessness, because premature mortality can remain poorly visible within ordinary service systems [3].

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The problem is not adequately described by service availability alone. What matters to people experiencing homelessness when they seek healthcare includes timely access, dignity, compassion, responsiveness, and care that recognizes the individual rather than reducing the encounter to housing status [4]. Community–institutional partnerships have consequently been proposed as one means of reducing disparities where conventional services function poorly across organizational boundaries [5]. Nursing is particularly important in this space because nurse-led services for people experiencing homelessness frequently combine clinical assessment with relationship building, advocacy, navigation, and flexible access [6].

For palliative nursing, these findings create a distinctive continuity problem. Continuity is commonly supported by repeated encounters with the same organization, stable contact information, routine referral pathways, scheduled follow-up, and records that move predictably between known providers. Housing instability weakens each of these assumptions. A person may move among shelters, hospitals, outreach locations, temporary accommodation, informal arrangements, or periods of rough sleeping while serious illness continues. A service model organized primarily around residence may therefore lose continuity precisely when illness and vulnerability increase.

This article develops an address-independent account of palliative nursing continuity. Its purpose is not to substitute a new label for established outreach practice. The analytical task is to determine which continuity functions must remain intact when place changes, which service relationships can carry those functions, and where organizational responsibility is most likely to become unclear.

Background

Palliative-care access for people experiencing homelessness is shaped by clinical complexity and by the conditions of everyday survival. Qualitative research has described barriers arising from fragmented services, uncertainty about responsibilities, difficulties recognizing when palliative care should begin, and limited fit between conventional care arrangements and the circumstances of homelessness [7]. Conversations about deterioration and future care are also affected by uncertainty. Some individuals may prioritize immediate concerns over future planning, while professionals can hesitate to initiate palliative discussions when trajectories are difficult to predict [8]. A systematic review similarly identified the need for flexible, low-threshold, respectful palliative services capable of responding to complex physical, psychological, social, and practical circumstances [9].

Timing is therefore central. In a multiple-case study of seriously ill homeless people, palliative needs occurred within complex and often unpredictable trajectories, and access could be late or difficult to organize [10]. A continuity system that activates only when a person reaches a clearly defined residentially based service pathway may miss periods when deterioration is already occurring. Yet earlier involvement cannot legitimately become compulsory advance-care planning or persistent contact against a person's wishes. The continuity problem concerns maintaining the possibility of care while preserving choice.

Place also has relational meaning. Ethnographic evidence from people experiencing structural vulnerability at the end of life shows that hospitals, clinics, and palliative-care settings can be experienced through existing relations of power, safety, exclusion, and belonging [11]. Formal services remain clinically essential, but physical entry into a healthcare setting does not guarantee relational continuity. If staff do not know the person's history, preferred ways of communicating, important relationships, or previous experiences of harm, transfer can produce a clinical connection without a corresponding sense of continuity.

Embedding specialist palliative expertise within homelessness services offers one response. Experience from London hostels indicates that relationships between palliative-care teams and hostel staff can support learning, improve professional connections, and strengthen recognition of palliative concerns [12]. Such models nevertheless depend on time, workforce capacity, interprofessional trust, and access to wider primary and specialist services. Specialist presence cannot by itself resolve every discontinuity created by movement between settings.

These findings suggest several recurrent mechanisms through which continuity may be lost. **Table 1** organizes those mechanisms as service problems rather than patient deficits.

Table 1. Service discontinuity mechanisms when palliative nursing depends on a stable residential anchor

Discontinuity mechanism	Trigger in unstable accommodation	Consequence for palliative nursing continuity	Why a fixed-address assumption becomes unsafe	Required service capability
Unstable contact point	Shelter move, temporary placement, loss of telephone access, or return to rough sleeping	Planned follow-up may fail despite continuing need	The service may interpret failed contact as disengagement although the contact route has disappeared	More than one voluntary route for recontact

Uncertain illness trajectory	Deterioration occurs without a predictable terminal phase	Referral or palliative discussion may occur late	Eligibility based on a clearly recognized transition may not fit fluctuating illness and competing priorities	Repeated opportunity for reassessment and parallel planning
Loss of relational knowledge	Movement introduces unfamiliar teams and settings	Preferences, prior concerns, and trusted relationships may become invisible	Clinical records alone may not contain the relational context needed to sustain care	Deliberate preservation of relevant person-specific knowledge
Organizational handoff	Responsibility moves between hospital, homelessness, primary, outreach, and palliative services	Each service may assume another team is coordinating care	Formal referral does not necessarily establish continuing ownership	Explicit handoff and responsibility confirmation
Specialist–frontline separation	Palliative expertise and everyday homelessness support sit in different organizations	Early concerns may not reach specialist care; specialist advice may not follow the person	Expertise is present but disconnected from the setting in which change is first noticed	Ongoing consultative links across organizational boundaries

Data sources

The evidence base for this service-model development was assembled as a critically selected scholarly corpus rather than as a systematic review. Direct evidence concerning homelessness and palliative or end-of-life care was given the highest interpretive weight. Evidence from homelessness nursing, navigation, discharge, integrated care, and service coordination was included only where it illuminated a continuity mechanism relevant to the present question. Quantitative effects from non-palliative interventions were not transferred into palliative-care claims.

Recent qualitative evidence from Aotearoa New Zealand highlights the importance of housing key workers in supporting healthcare interactions for people experiencing homelessness. Key workers may hold detailed knowledge of the person, accompany healthcare interactions, and help interpret needs across sectors, while simultaneously encountering limits in professional recognition and role authority [13]. Similar findings from UK hostel support workers show that workers frequently navigate disconnected healthcare and homelessness systems, with collaboration and in-reach helping in some circumstances but remaining difficult to sustain where sectors are poorly connected [14].

The contemporary palliative-care landscape remains organizationally uneven. A UK exploratory study of homelessness and palliative-care initiatives described active attempts to improve relationships and care, while also identifying resource constraints, stigma, and variable organizational capacity [15]. Methodologically, lived-experience involvement is also important. The TIFFIN recommendations developed through work with people who have experienced homelessness emphasize that palliative and end-of-life research in this population requires careful attention to co-production, power, safety, and the practical conditions under which participation occurs [16].

Broader homelessness-service research contributes cautiously transferable mechanisms. A community drop-in hub evaluation found that service coordination depends on more than co-location; consistency, flexibility, and trusted relationships were important to how coordinated care was experienced and delivered [17]. Likewise, qualitative mapping of emergency-department discharge for people experiencing homelessness demonstrated that shelter placement and post-discharge transitions depend on information flows, eligibility processes, communication, and the ability of organizations to coordinate across boundaries [18].

Experimental evidence also shows why active navigation deserves attention, although its outcomes cannot be imported into palliative care. In a randomized trial conducted through a Health Care for the Homeless program, patient navigation substantially increased completion of a lung-cancer screening pathway [19]. Its relevance here lies in the mechanism: maintaining a difficult care pathway may require active coordination and repeated support rather than passive referral. A scoping review of cardiovascular care for people experiencing homelessness reaches a compatible service-level conclusion, showing that effective delivery frequently requires adaptation at patient, clinic, and system levels [20].

Taken together, these evidence classes support a bounded inference. Relational mediators, structured handoffs, active navigation, flexible access, and cross-sector coordination are plausible continuity mechanisms. The direct palliative literature establishes the need for such adaptations; the broader homelessness literature clarifies how they may function. The latter does not establish palliative effectiveness.

The evidence developed in this section can be compressed visually only if direct palliative evidence and transferable service evidence remain distinguishable.

Figure 1 maps the evidence-supported dependencies through which palliative nursing continuity may be preserved when location changes, while keeping direct palliative evidence separate from transferable service mechanisms.

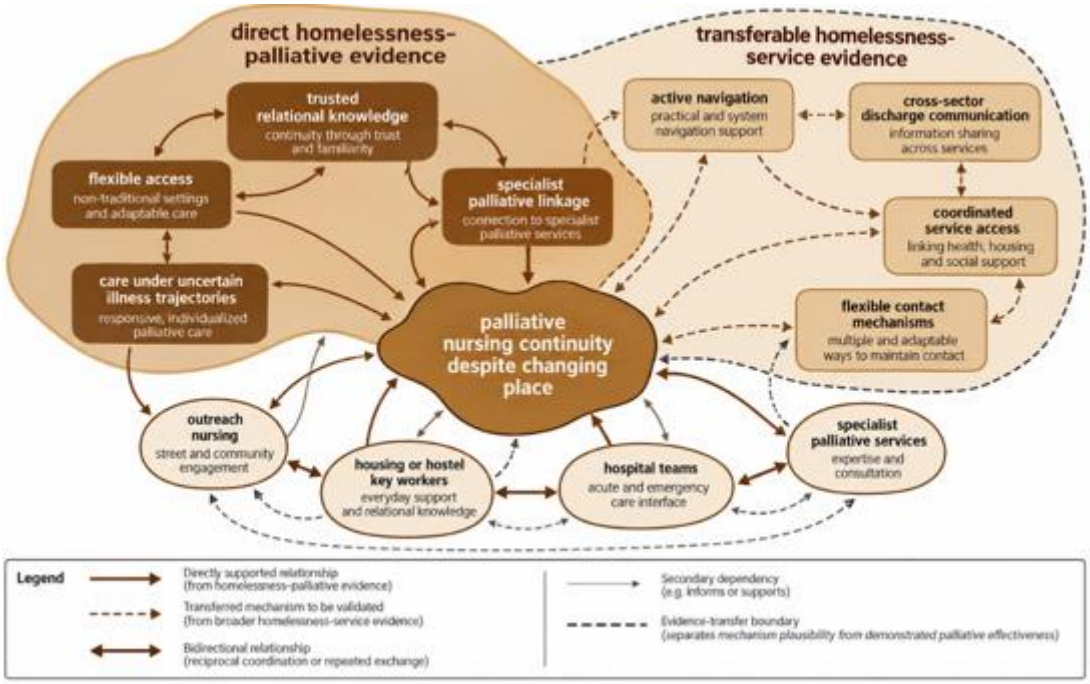


Figure 1. Evidence-supported dependencies for palliative nursing continuity when residential location is unstable

Overview of the issues

Continuity problems become most visible at transitions. Integrated-care experience among people experiencing homelessness suggests that coordinated medical, behavioral-health, and community services can reduce some manifestations of fragmentation, although small observational evaluations cannot establish a general causal model for palliative care [21]. Hospital-based navigation research similarly shows that maintaining continuity after admission requires flexibility, sustained relationship building, stakeholder support, and deliberate linkage to community services [22]. The implication for palliative nursing is organizational: a discharge instruction can transfer information without ensuring that another person or service has actually assumed continuing responsibility.

Relational continuity is also conditioned by previous experiences of trauma and by the organization in which professionals work. A mixed-method evaluation of trauma-informed practice across services for people experiencing multiple disadvantage found that implementation required sustained organizational support and psychologically safer working environments; measurable organizational change was not automatically produced within a short implementation period [23]. At a wider structural level, forced displacement and policies that repeatedly move people from one place to another can themselves disrupt safety, access, and continuity [24]. Stable contact therefore cannot be treated solely as an individual behavioral responsibility when the surrounding environment repeatedly destabilizes place.

Palliative-care-specific implementation research reaches a compatible conclusion. A process evaluation of a multicomponent intervention for people experiencing homelessness demonstrated that improvement depends on implementation across several levels rather than on the mere existence of specialist palliative expertise [25]. Observational evidence from hospitalized veterans with heart failure further indicates that homelessness or housing instability is relevant to patterns of palliative and hospice utilization [26]. These findings should not be read as evidence that one housing category causes one utilization pattern in every health system. They establish that housing circumstances intersect with how serious-illness care is reached and used.

The person requiring care may also have needs that do not fit a single clinical pathway. Qualitative research with older homeless adults describes simultaneous physical, psychological, social, and existential concerns [27]. A focus-group study involving seriously ill homeless people and healthcare professionals likewise identified barriers to palliative care and interest in accessible specialist consultation [28]. Continuity therefore has to preserve clinical responsiveness without assuming that all individuals prioritize the same symptoms, conversations, or service relationships.

Across these transitions, several responsibility points recur: someone must know that the person has moved; clinically relevant information must remain available; a receiving service must know what it is expected to do; and there must be a feasible route for renewed contact if the planned pathway breaks. Failure at any one of these points can occur even when every individual professional acts reasonably within the boundaries of their own service.

Table 2 locates these responsibility problems at concrete service transitions rather than assigning them to a single profession.

Table 2. Responsibility points at transitions relevant to address-independent palliative nursing

Transition situation	Principal continuity risk	Responsibility that must remain explicit	Information requirement	Contact requirement	Necessary flexibility
Hospital to shelter or temporary accommodation	Discharge occurs before receiving services understand ongoing serious-illness needs	Named confirmation that follow-up responsibility has been accepted	Current care priorities, medication or symptom concerns, agreed plans, relevant preferences	A route that does not depend solely on one address or telephone number	Ability to revise destination and follow-up arrangements when placement changes
Shelter or hostel to hospital	Relational knowledge held by homelessness staff may be absent from the clinical encounter	Mechanism for appropriate communication between frontline support and clinical teams	Information relevant to current care, communication preferences, existing support relationships	Ability for trusted workers to remain involved with consent	Recognition that non-clinical workers may hold valuable contextual knowledge without assuming clinical authority
Outreach contact to specialist palliative service	Referral is made but engagement is lost before specialist assessment	Continued ownership until a workable connection is established	Reason for referral, urgency, prior engagement conditions, barriers already known	Multiple voluntary ways to reconnect	Specialist access that can adapt to outreach or non-clinic settings where feasible
Move between shelters or temporary accommodation	Care plan remains tied to the previous location	Explicit review of who now coordinates follow-up	Portable, current, minimum-necessary information	Recontact route that can survive another move	Plans updated without requiring the person to restart the entire pathway
No stable placement or intermittent contact	Services may interpret absence as refusal or closure	Agreed conditions for continued availability and re-entry	Sufficient information to resume care safely if contact returns	Low-threshold re-entry without punitive assumptions	Episodic engagement permitted when clinically and ethically appropriate
Parallel involvement of several services	Shared care becomes diffuse responsibility	Clear distinction between consultation, coordination, and continuing clinical responsibility	Source-attributed information and current role allocation	Cross-service communication with consent	Responsibility can be redistributed as needs and setting change

This transition analysis establishes the problem that the conceptual model must solve. Address-independent palliative nursing cannot be reduced to mobility of records, outreach availability, or a single coordinating role. The next section therefore develops how continuity of the person, information, responsibility, and contact pathways can be treated as distinct but interacting service functions.

Conceptual findings

The evidence supports an address-independent model only if continuity is treated as several interacting functions rather than as repeated contact with one organization. Continuity of persons means preserving recognition of preferences, relational history, communication needs, symptom priorities, and trusted support relationships when setting changes. Preferences around discussions of dying show why this matters: engagement may be welcome in some circumstances and unsafe or unwanted in others [29]. Stigma across healthcare and support systems further means that recognition cannot be reduced to a diagnosis or homelessness label [30].

Continuity of information means that clinically relevant information remains usable across hospital, shelter, temporary accommodation, outreach, or periods without stable placement. Portability alone is insufficient. Information must be current, source-attributed, proportionate to need, and governed by consent and confidentiality.

Continuity of responsibility means that referral does not automatically equal transfer. Consultation, coordination, and continuing clinical responsibility are distinct. Nurse-led outreach can improve perceived access and person-centredness, while housing and service trajectories remain variable [31]. Relational workers may also carry substantial grief when supporting structurally vulnerable people through deterioration and death [32]. Responsibility therefore cannot depend on unlimited informal labour.

Continuity of contact pathways means preserving voluntary ways to reconnect when an address changes, a telephone is lost, or engagement becomes intermittent. Routes may include agreed alternative contacts, outreach locations, trusted intermediaries, or low-threshold re-entry. Their purpose is continued availability, not surveillance.

The model also avoids equating continuity with uninterrupted attendance. Intermittent engagement can coexist with continuity when the service retains enough relational and clinical context to resume care safely without requiring the person to reconstruct the entire pathway. Continuity is therefore judged by recoverability of care across disruption, not by perfect adherence to appointments or continuous presence within one service.

In operational terms, the model does not require one organization to retain every function at all times. A nurse may carry current clinical responsibility while a hostel worker retains relational knowledge and a specialist team provides consultation. What matters is that the configuration is visible and that movement between configurations is deliberate. This distinction prevents "shared care" from becoming an undefined space in which several services are involved but none can say who will act if the person deteriorates, misses an appointment, or appears in a different setting.

The four functions are interdependent. Information without responsibility may not produce action; responsibility without contact may become nominal; contact without recognition may become intrusive. The model therefore treats continuity as a distributed service property spanning nursing, palliative, primary-care, hospital, homelessness, housing, and outreach services. Policy separation can make such accountability structurally invisible: Canadian analysis found limited integration between homelessness and palliative-care policy domains [33]. This supports the need to make responsibility explicit, without assuming that the Canadian pattern is universal.

Results and Discussion

Palliative nursing continuity cannot rest solely on individual professional commitment. Homelessness–palliative initiatives show that staffing, funding, stigma, and organizational capacity constrain what committed practitioners can sustain [15]. Broader chronic-care evidence likewise indicates that care for people experiencing homelessness often requires adaptation at patient, clinic, and system levels [20]. Address-independent continuity should therefore be an organizational responsibility supported by nursing practice.

Interagency coordination must distinguish handoff from abandonment. Housing or hostel workers may hold valuable relational knowledge [13]; discharge transitions may depend on information, eligibility, and communication processes [18]; and navigator programs show that post-discharge continuity requires active linkage [22]. Services should make visible who currently holds coordination responsibility, whether the receiving service has accepted transfer, and what happens if connection fails.

This governance approach also separates flexibility from informality. Flexible arrangements may legitimately change appointment location, contact route, or which professional leads a particular episode. Informality becomes unsafe when those adaptations are undocumented, dependent on personal goodwill, or unavailable when a familiar worker is absent. The proposed model therefore values relational continuity while requiring organizational memory around agreed responsibilities. That is especially important where staff turnover, shift patterns, service eligibility rules, or short accommodation placements make person-to-person continuity difficult.

Flexibility must also preserve equity. Formal services can reproduce experiences of exclusion [11], while displacement can further destabilize health and access [24]. Address-independent pathways should expand routes into equivalent-quality palliative care, not establish a clinically thinner parallel system. Feasibility also depends on workforce support. Embedded specialist expertise can strengthen relationships [12], but trauma-informed implementation requires organizational conditions [23], and relational workers may experience compounded grief [32].

Table 3 converts these implications into bounded governance requirements rather than validated practice standards.

Table 3. Implementation and governance requirements for address-independent palliative nursing continuity

Governance function	Minimum organizational requirement	Patient-protective boundary	Validation question
Continuity ownership	A named service or role holds current coordination responsibility during transitions	Responsibility may move but should not disappear	Can current responsibility be identified at each transition?
Information portability	Current, clinically relevant, source-attributed information can cross settings lawfully	Share only necessary information under applicable consent and privacy rules	Does information arrive in a usable form?
Contact continuity	More than one voluntary recontact route can be agreed	No coercive tracking or surveillance	Can patients reconnect after unplanned disruption?
Interagency handoff	Sending and receiving services confirm defined responsibilities	Non-clinical workers are not assigned duties beyond role competence	Are handoffs completed rather than merely initiated?
Specialist access	Palliative expertise can support frontline services across settings where feasible	Specialist input should complement trusted relationships	Which arrangements are feasible locally?
Workforce sustainability	Relational and coordination labour is recognized and supported	Continuity must not require unlimited worker availability	What support conditions sustain the model?
Equity oversight	Flexible pathways are compared with equivalent standards of care	Homelessness must not reduce entitlement to mainstream or specialist care	Does flexibility improve access without lowering quality?

Relational responsibility must remain visible when place changes. **Figure 2** represents responsibility as transferable and shareable, but not disposable.

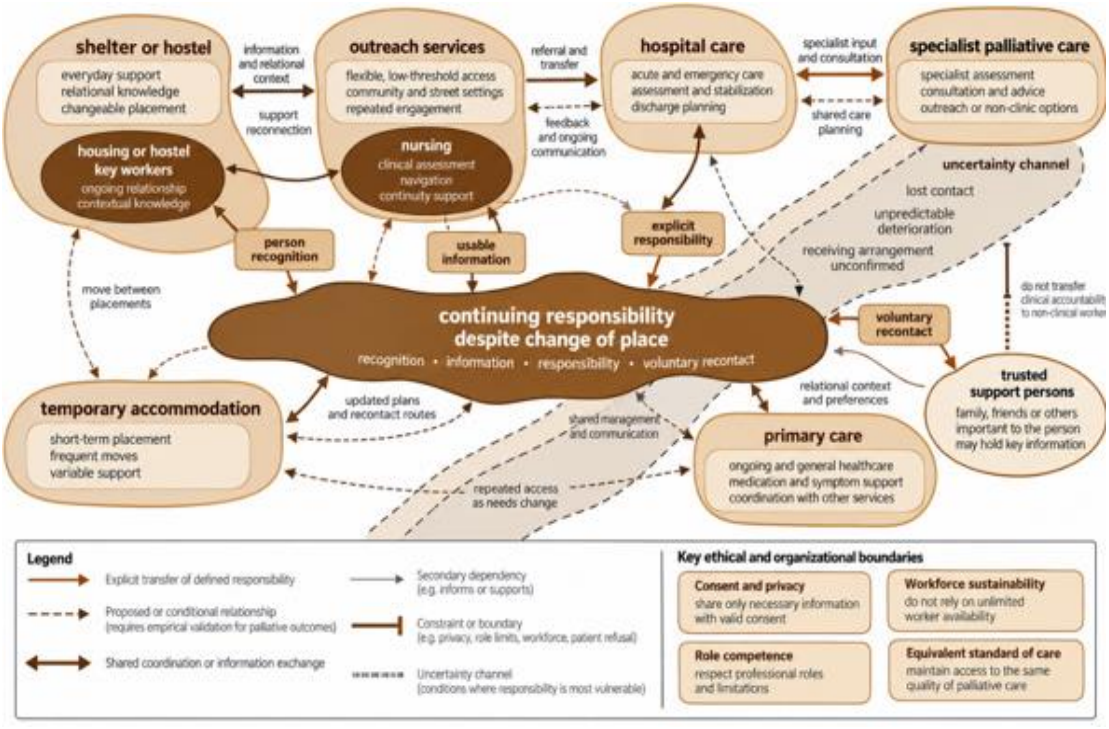


Figure 2. Relational responsibility across unstable accommodation and service transitions

Existing evidence is heterogeneous in population, jurisdiction, service configuration, and method. Direct palliative studies are largely qualitative or implementation-focused, while several mechanisms in this synthesis come from broader homelessness healthcare. Process evaluation also shows that palliative interventions depend on local adoption and implementation [25]. The model therefore requires prospective testing rather than assumption of effectiveness.

Validation should assess whether patients find the four continuity functions useful and non-intrusive; whether responsibility can be identified reliably across transitions; whether information portability protects privacy; whether flexible re-entry improves reconnection; and what effects occur on patient-defined continuity, symptom support, dignity, workforce burden, and equitable access.

Research should also test failure conditions. A continuity arrangement may be technically available yet unacceptable because a person distrusts information sharing, does not want an intermediary contacted, or prioritizes other needs. Services may lack interoperable records, outreach capacity, or a receiving organization willing to accept responsibility. These are not deviations to be hidden in evaluation; they are central tests of whether address-independent continuity can operate ethically under real service constraints.

Address independence is not a substitute for housing. Its purpose is to prevent residential instability from becoming an additional barrier to palliative care while efforts to secure safe housing continue.

Conclusion

Palliative nursing continuity without a stable home address requires preservation of four connected functions: recognition of the person, clinically usable information, explicit responsibility, and a voluntary route back into care. These functions may be distributed across several services, but distribution should not make accountability invisible.

The proposed model therefore asks what must remain continuous when place does not. Its answer is relational and organizational rather than residential: care should remain reachable, informed, accountable, and person-sensitive without making a fixed address the condition for continuity. Empirical validation across health systems and patient-defined priorities is now required.

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References

1. Rodericks-Schulwach A, Gokani R, Martin L. Palliative care access and use among homeless individuals: A scoping review. BMC Palliat Care. 2025;24(1):203. doi:10.1186/s12904-025-01835-x
2. Aldridge RW, Story A, Hwang SW, Nordentoft M, Luchenski SA, Hartwell G, et al. Morbidity and mortality in homeless individuals, prisoners, sex workers, and individuals with substance use disorders in high-income countries: A systematic review and meta-analysis. Lancet. 2018;391(10117):241-50. doi:10.1016/S0140-6736(17)31869-X
3. Tuson M, Vallesi S, Wood L. Tracking deaths of people who have experienced homelessness: A dynamic cohort study in an Australian city. BMJ Open. 2024;14(3). doi:10.1136/bmjopen-2023-081260
4. Miller JP, Hutton J, Doherty C, Vallesi S, Currie J, Rushworth K, et al. A scoping review examining patient experience and what matters to people experiencing homelessness when seeking healthcare. BMC Health Serv Res. 2024;24(1):492. doi:10.1186/s12913-024-10971-8
5. Lee JJ, Jagasia E, Wilson PR. Addressing health disparities of individuals experiencing homelessness in the U.S. with community institutional partnerships: An integrative review. J Adv Nurs. 2023;79(5):1678-90. doi:10.1111/jan.15591
6. McWilliams L, Paisi M, Middleton S, Shawe J, Thornton A, Larkin M, et al. Scoping review: Scope of practice of nurse-led services and access to care for people experiencing homelessness. J Adv Nurs. 2022;78(11):3587-606. doi:10.1111/jan.15387
7. Shulman C, Hudson BF, Low J, Hewett N, Daley J, Kennedy P, et al. End-of-life care for homeless people: A qualitative analysis exploring the challenges to access and provision of palliative care. Palliat Med. 2018;32(1):36-45. doi:10.1177/0269216317717101
8. Hudson BF, Shulman C, Low J, Hewett N, Daley J, Davis S, et al. Challenges to discussing palliative care with people experiencing homelessness: A qualitative study. BMJ Open. 2017;7(11). doi:10.1136/bmjopen-2017-017502
9. Klop HT, de Veer AJE, van Dongen SI, Francke AL, Rietjens JAC, Onwuteaka-Philipsen BD. 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):67. doi:10.1186/s12904-018-0320-6

10. de Veer AJE, Stringer B, van Meijel B, Verkaik R, Francke AL. Access to palliative care for homeless people: Complex lives, complex care. BMC Palliat Care. 2018;17(1):119. doi:10.1186/s12904-018-0368-3
11. Giesbrecht M, Stajduhar KI, Mollison A, Pauly B, Reimer-Kirkham S, McNeil R, et al. Hospitals, clinics, and palliative care units: Place-based experiences of formal healthcare settings by people experiencing structural vulnerability at the end-of-life. Health Place. 2018;53:43-51. doi:10.1016/j.healthplace.2018.06.005
12. Armstrong M, Shulman C, Hudson B, Brophy N, Daley J, Hewett N, et al. The benefits and challenges of embedding specialist palliative care teams within homeless hostels to enhance support and learning: Perspectives from palliative care teams and hostel staff. Palliat Med. 2021;35(6):1202-14. doi:10.1177/02692163211006318
13. Gott M, Williams L, Wiles J, Black S, Moeke-Maxwell T, Robinson J, et al. The central role of housing key workers in supporting healthcare interactions for people experiencing homelessness and implications for palliative care: A qualitative study. BMC Palliat Care. 2024;23(1):275. doi:10.1186/s12904-024-01598-x
14. Muzafar I, Cunningham O. Hostel support workers' experiences navigating healthcare alongside people experiencing homelessness: A qualitative study in the UK. BMJ Open. 2024;14(9). doi:10.1136/bmjopen-2024-085949
15. Crooks J, Flemming K, Shulman C, Hudson B. Understanding aims, successes and challenges of palliative care and homelessness initiatives across the UK: An exploratory study. BMJ Open. 2024;14(1). doi:10.1136/bmjopen-2023-075498
16. Crooks J, Flemming K, Shulman C, Casey E, Hudson B. Development of the TIFFIN recommendations for co-producing palliative and end-of-life care research with individuals with lived experience of homelessness: A qualitative study. Palliat Med. 2024;38(7):746-54. doi:10.1177/02692163241259667
17. Adams EA, Ramsay SE. Exploring what works well and less well in a community-based drop-in hub providing health and wellbeing services for people experiencing homelessness: A participatory action evaluation of service coordination. BMC Health Serv Res. 2024;24(1):1423. doi:10.1186/s12913-024-11897-x
18. Marcus ER, Carreras Tartak JA, Halasz H, Chen D, Lee J, He S. Discharge process for patients experiencing homelessness in the emergency department: A thematic qualitative study. PLoS One. 2024;19(6). doi:10.1371/journal.pone.0304865
19. Baggett TP, Sporn N, Barbosa Teixeira J, Rodriguez EC, Anandakugan N, Critchley N, et al. Patient navigation for lung cancer screening at a health care for the homeless program: A randomized clinical trial. JAMA Intern Med. 2024;184(8):892-902. doi:10.1001/jamainternmed.2024.1662
20. Macklin J, Samson B, Zsager A, Ross H, Pinto A, Gibson JL. Cardiovascular disease management and healthcare delivery for people experiencing homelessness: A scoping review. BMC Health Serv Res. 2024;24(1):1080. doi:10.1186/s12913-024-11503-0
21. Grove LR, Benzer JK, McNeil MF, Mercer T. Integrated care for people experiencing homelessness: Changes in emergency department use and behavioral health symptom severity. BMC Health Serv Res. 2025;25(1):777. doi:10.1186/s12913-025-12860-0
22. Jenkinson JIR, Moro D, Dada O, Francombe Pridham K, Cygler J, Hwang SW. Implementing a hospital-based case management intervention for people experiencing homelessness: The navigator program. BMC Health Serv Res. 2025;25(1):1006. doi:10.1186/s12913-025-13170-1
23. Farr M, Eyles E, Stone T, Redaniel MT, Traub T, Burrowes J, et al. Implementing trauma-informed practice across services to support people experiencing multiple disadvantage: A mixed method study. BMC Health Serv Res. 2025;25(1):1266. doi:10.1186/s12913-025-13339-8
24. Goldshear JL, Reuter TK, Bluthenthal RN, Borquez A. Displacement, health outcomes, and the human rights of people experiencing homelessness in the USA. Lancet Public Health. 2025;10(10). doi:10.1016/S2468-2667(25)00197-5
25. Klop HT, de Veer AJE, Gootjes JRG, Groot M, Rietjens JAC, Onwuteaka-Philipsen BD. Implementation of a threefold intervention to improve palliative care for persons experiencing homelessness: A process evaluation using the RE-AIM framework. BMC Palliat Care. 2022;21(1):192. doi:10.1186/s12904-022-01083-3
26. Gula AL, Ramos J, Simpson JM, Jiang L, Martin E, Wice M, et al. Utilization of palliative care in veterans admitted with heart failure experiencing homelessness. J Pain Symptom Manage. 2022;64(5):471-7. doi:10.1016/j.jpainsymman.2022.07.010
27. Bazari A, Patanwala M, Kaplan LM, Auerswald CL, Kushel MB. 'The thing that really gets me is the future': Symptomatology in older homeless adults in the HOPE HOME study. J Pain Symptom Manage. 2018;56(2):195-204. doi:10.1016/j.jpainsymman.2018.05.011
28. Klop HT, van Dongen SI, Francke AL, de Veer AJE, Rietjens JAC, Gootjes JRG, et al. The views of homeless people and health care professionals on palliative care and the desirability of setting up a

consultation service: A focus group study. J Pain Symptom Manage. 2018;56(3):327-36. doi:10.1016/j.jpainsymman.2018.05.026
29. Crooks J, Davis G, Pattinson M, Casey E, Shulman C, Flemming K, et al. Exploring perspectives regarding death cafés for people experiencing homelessness: A qualitative study. BMJ Open. 2025;15(6). doi:10.1136/bmjopen-2024-096990
30. Guise A, McCusker M, Adams J, Újhadbor R, Helleren S, Mazhari T, et al. Experiences of stigma and discrimination among people experiencing homelessness: A cross-sectional pilot survey in South London, UK. BMJ Open. 2025;15(10). doi:10.1136/bmjopen-2025-103529
31. Bell L, Whelan M, Lycett D, Fernandez E, Khera-Butler T, Kehal I, et al. Healthcare and housing provision for a UK homeless community: A qualitative service evaluation. Public Health. 2024;229:1-6. doi:10.1016/j.puhe.2024.01.017
32. Giesbrecht M, Mollison A, Whitlock K, Stajduhar KI. "Once you open that door, it's a floodgate": Exploring work-related grief among community service workers providing care for structurally vulnerable populations at the end of life through participatory action research. Palliat Med. 2023;37(4):558-66. doi:10.1177/02692163221139727
33. Walsh JJ, Sussman T, Bosma H, Carter RZ, Cormier É, Canham SL. The intersections of palliative care and homelessness in social policy: A content analysis of Canadian policy documents. BMC Palliat Care. 2025;24(1):229. doi:10.1186/s12904-025-01866-4