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Enhancing Interprofessional Community Engagement through Community-Based Participatory Research Strategies: Care Transitions for Patients Experiencing Housing Instability

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Abstract

Background.

Transitions of care are high-risk periods for adverse outcomes, especially for people experiencing homelessness due to unstable housing, limited care access, and fragmented support. Medical respite care provides a safe and stable environment to recover from post-hospitalization and connections to essential medical and social services. At one large midwestern university, there is a strong commitment to community health improvement and engagement of health professional students in community-based interprofessional practice and education. This setting provides an opportunity to work collaboratively with the medical respite care, health systems and clients, to assess health-related needs using the community-based participatory research (CBPR) framework in authentic learning environments.

Aim.

To determine the facilitators and barriers to medical respite care transitions for people experiencing housing instability using CBPR-informed community health needs assessment (CHNA) approach.

Methods

. CBPR involves six phases: partnership, assessment, planning, implementation, evaluation, and dissemination. The CHNA includes ten steps: designing the assessment plan, building relationships, creating the community profile, assessing health equity, prioritizing community assets and needs, planning an equity strategy, developing an action plan, implementation, evaluation, and dissemination. We began with the partnership phase of CBPR by incorporating relationship building and assessment plan development. *Design*. A qualitative prospective study using one-on-one key informant interviewing. *Participants*. Collaborators who work with medical respite care in both client care and referral capacities. *Data collection.* A semi-structured interview guide was used to collect information virtually. *Data Analysis.* The audio recorded interviews were de-identified, transcribed, coded, and analyzed by thematic analysis.

Results.

Thirteen collaborators comprised of physicians, nurses, and social workers participated in the study. Five major themes emerged including structural and system-level factors (e.g. policy-practice gaps, human and infrastructure resources); care access and continuity (e.g. point of care entry, interprofessional practice and education); social determinants of health (e.g. housing, transportation and communication); interorganizational collaboration and community partnerships (e.g. community engagement and awareness, institutional collaborations); and population health trend (e.g. patient experience and engagement, morbidity and multimorbidity).

Conclusion.

Medical respite care programs significantly improve health outcomes for people experiencing housing instability; however, persistent system, community, and individual barriers remain and require coordinated, collaborative solutions.

Introduction

Transitions of care are widely recognized as periods of heightened vulnerability, during which failures in coordination, communication, and follow-up contribute to adverse outcomes, avoidable hospital readmissions, and excess health system costs (1–3). For individuals who are unhoused or experiencing homelessness, these risks are exacerbated by housing instability, limited access to primary care, and fragmented connections to social services (4, 5). Standard discharge planning processes are poorly aligned with the realities of homelessness, frequently resulting in discharge to shelters or the street, which are settings ill-equipped to support recovery, medication management, or continuity of care, thereby perpetuating cycles of acute care use and health inequity (6, 7).

Medical respite care has emerged as a critical intervention to address gaps in care transitions for individuals experiencing housing instability by providing short-term, post-acute residential care for those who are medically stable but too ill to recover in congregate shelters or unsheltered settings (8, 9). Evidence indicates that medical respite care is associated with reduced hospital length of stay, decreased readmissions, improved linkage to primary care, and enhanced engagement with social and housing services (7, 10). By serving as a bridge between inpatient care and the community, medical respite programs support safer, more equitable care transitions while creating opportunities to address social determinants of health that are often overlooked during hospitalization. Medical respite care is also known as recuperative care and both words are used interchangeably in this paper.

Despite the benefits demonstrated, transitions from hospitals to medical respite care remain inconsistent and are frequently undermined by delayed referrals, limited capacity, and inadequate alignment with community needs (11, 12). Community-based participatory research (CBPR), particularly when integrated with Community Health Needs Assessments (CHNAs), offers a promising approach to strengthening these transitions by centering lived experience, fostering cross-sector collaboration, and tailoring interventions to local contexts (13–15). Applying CBPR-informed CHNAs to health systems research on care transitions can enhance the relevance, effectiveness, and sustainability of medical respite care referral pathways, addressing persistent inequities in post-acute care for people experiencing housing instability (7, 16–18).

One Center for Interprofessional Practice and Education (CIPE) at a large midwestern university is committed to community health improvement while engaging health professional students in community-engaged interprofessional practice and education (IPE). The CIPE is working collaboratively with the medical respite care partners to assess the community's health needs using the CBPR

framework. CBPR is a collaborative and iterative approach to research that equitably involves all partners in the research process while recognizing the strengths that each possesses. CBPR involves six phases: partnership, assessment, planning, implementation, evaluation, and dissemination (15). CHNA includes ten steps as follows: designing the assessment plan, building relationships, creating the community profile, assessing health equity, prioritizing community assets and needs, planning an equity strategy, developing an action plan, plan implementation, evaluation, and dissemination (19). We started with the partnership phase of CBPR incorporating relationship building, assessment planning, and community health needs assessment implementation.

The objective of this study was to collaboratively work with the medical respite care community, including healthcare providers and clients, to determine the facilitators and barriers to medical respite care transitions for people experieicing housing instability using CBPR-informed CHNA approach. This paper reports the results from the voices of healthcare providers who serve in direct care or referral capacity in medical respite care.

Methods

Design

The study was a prospective qualitative study using one-on-one key informant interviewing. The consolidated criteria for reporting qualitative research (COREQ) were followed (20). The study was approved by the institutional review board (HUM00270897).

Study Setting and Participants

This was a single-center study at a large academic health institution. Study participants were collaborators who work with medical respite care in both client care and referral capacities. Collaborators were invited from the medical respite care, private hospitals, academic medical centers, federally qualified health centers, and shelter associations. Invitation to participate in the study was sent through email messages to prospective participants. Non-participants received three additional messages on three different days after which we did not contact them again. Those who responded to the email message invitation were recruited and scheduled for an interview at their convenience. Snowball recruitment method was used. We continued recruitment until data saturation was reached.

Data Collection and Analysis

The qualitative data was collected through an in-depth interview using Zoom®. The semi-structured interview guide (Additional file 1) was co-developed by the CIPE and the medical respite care team. The interview guide was initially piloted with three key informants, after which recommended revisions were incorporated. The guide subsequently underwent expert review to establish face validity. Each interview lasted about 45 minutes and was audio recorded. The interviews were transcribed verbatim using Dropbox® transcription software and verified manually. The transcripts were analyzed by thematic

analysis. NVivo 15 software was used for analysis. Two study team members, CEE and GMRF, coded the transcripts independently and then met to discuss discrepancies and come to agreement on the codes. Themes and subthemes were generated from the codes by consensus.

Results

Thirteen collaborators comprised of physicians, nurses, and social workers participated in the study. The thematic data analysis identified five major themes and twenty-five subthemes. The major themes included structural and system-level factors, care access and continuity, social determinants of health (SDoH), interorganizational collaboration and community partnerships, and population health trends. The themes can be categorized into system-, community-, and individual-level factors (Fig. 1). Care access and continuity cuts across all three levels. SDoH and population health trends are primarily system- and community-level factors. The discussion of the themes and subthemes are focused on facilitators and barriers to healthcare among unhoused populations in medical respite care as reported by the participants. All participants contributed to the five major themes.

Theme 1: Structural and System-level Factors.

These are macro-level health systems characteristics including policies, regulations, and incentives that shape local delivery of care to people. The sub-themes include policy-practice factors, healthcare financing and sustainability, human and infrastructure resources, and health system navigation. The facilitators and barriers to healthcare among populations experiencing housing instability in medical respite care within each sub-theme are discussed below.

Policy-practice factors

Participants opined that policies that positively impact health practice delivery facilitate improved health outcomes. For instance, a participant noted that the policy to expand community mental health was a laudable one - “So, you know, I mean, if you look at what the County did, right, we expanded CMH, we paid for expanded CMH coverage, which paid for the CARES Act” (Participant #1)

However, policies that negatively impact practice are barriers to improving health. Health policies are usually made with good intentions, but sometimes there are policy-practice gaps that negate the intended outcome as noted by a participant who was discussing how out of touch some policies can be - "So, you know, you feel like you got the higher ups making these decisions and they don't really get the reality. So, I think, yeah, that's one of the most challenging types of our work" (Participant #2). These policies thereby constitute structural and legal barriers to achieving better health outcomes especially for less resourced populations. Other example quotes from participants include:

They require prior authorizations; they require too many hurdles and hoops and so those clients give up they give up. It's I don't I don't have the time to sit here and argue with an insurance company for three days to get my medication. (Participant #10)

I think one barrier that comes up a lot is like everything is still so siloed like we understand health care to be integrated, we understand the research shows that of course your physical health and your social health and your mental health all impact one another, but in terms of actual service delivery models, these are still very siloed. (Participant #4)

Healthcare financing and sustainability

The importance of funding for healthcare services cannot be overemphasized. Mechanisms of healthcare payment and coverage could enable or constrain services delivery. Participants reported that availability of funds facilitates improved health outcomes among people experiencing housing instability. The health insurance expansion and COVID-19 funds were notable examples.

I would say Obamacare was the single best thing to happen to the unhoused population because it expanded Medicaid and most of the many of these people were able to get expanded Medicaid coverage. Now as we look and then COVID while it was very difficult for people, it did improve many of my clients um medical problems because many of them got housed at a hotel. (Participant #1)

I feel like when we expanded Medicaid years ago, decades ago, right? Everybody was able to actually have health care. (Participant #7)

Participants noted that limited financial resources, insurance coverage challenges, and loss of federal funding constitute barriers to healthcare delivery, especially among individuals experiencing housing instability.

And so, some of the unique barriers is the payer source for Medicaid is very limited. (Participant #10)

I would definitely say the number one [barrier] is the cutting in funding to all these programs, like [a program], which is a substance use treatment program, had cutting in funding. (Participant #8)

Human and infrastructure resources

Participants applauded the existence of community resources including the medical respite care program, shelters, healthcare facilities, and healthcare providers who play significant roles in improving the health of those experiencing housing instability.

I do think that my perception is that being located in [this community], I think that our shelter association is better resourced than many other shelter associations across the state. So, you know, having access to something like recuperative care is certainly a benefit that I think most counties don't have access to. So, I think that is, you know, going well. (Participant #4)

So we're working well in regard to like recuperative care is like having that resource available for patients after their hospitalization. I think that works well. (Participant #8)

We're lucky in this community… I've never seen a community that is this robust with resources… I think it's amazing what people move here, like when they have nothing, they'll come to our shelter because they know that we'll connect to them with supports because we do tend to have a bit more and we have such a great community. (Participant #9)

However, there is still room for improvement in human and infrastructure resources to reach more people. Participants lamented limited community resources including limited bed spaces in the recuperative care facilities, limited provider availability, limited patient contact time, few medical respite care facilities, few shelters, and migration of people who are experiencing housing instability from outside the county further stretching the available resources.

I think recuperative care is a great program when we can get people there. I think, you know, I think the main barriers I see with it is just that there's a lack, like I said, lack of not enough beds and not enough, you know, if I think if they had more staffing there and were able to staff at 24 /7, that would allow for even more patients to take advantage of their program. (Participant #12)

I think our community is really not well equipped to handle the unhoused health issue crisis that we have in our community. There is just, the need is overwhelming and I just don't think that we have the supports in place or the systems in place in our community to be able to really deal with that. (Participant #13)

Health System Navigation

Having simple navigation processes for patients in the healthcare system facilitates easy access to health resources, health providers, and improvement in health outcomes. However, complex navigation processes and poor discharge planning constitute barriers to health especially among those experiencing housing instability.

Our clients tend to feel so overwhelmed. A lot of the clients that we see at [the medical respite program], when they come to us like the first week, some of them have like three or four appointments. And they're like, well, why do I have to go to this appointment? What's this appointment for? Why is that doctor saying this? So that kind of shuts some people down where they are a little bit resistant of like, I don't know, that seems like a lot. Do I actually need to go to that appointment? What are the appointments I absolutely need? (Participant #6)

I think one thing that's really important is discharge planning at the hospitals… sometimes, things that aren't, like really taken into account for for people who are experiencing homelessness. I think a lot of times providers, like, especially when I start following up with a specialist, they're surprised they have no idea that the client is experiencing homelessness. And I really think it affects their plan of care sometimes (Participant #5)

Theme 2: Care Access and Continuity

People experiencing homelessness face persistent barriers to accessing and maintaining continuous healthcare, resulting in fragmented, crisis-driven care. Improving access and continuity of care is essential to reducing avoidable health complications and advancing health equity for this population. The sub-themes include point of care entry, continuity and transitions, communication and connectivity, person-centered care, and interprofessional practice and education.

Point of care entry

Availability and usability of entry points to preventative, primary, and urgent care are essential for health improvement. The medical respite care programs, aside from providing a safe haven for people experiencing housing instability to recuperate, also serve as a bridge connecting these individuals to primary care providers and support them in navigating the complex health system. However, care access challenges persist. Participants wish more could be done to enhance access to care for those experiencing housing instability.

And then as you know, like access to medical care is really challenging too, like there's huge weights here. So just getting in for a visit can be difficult. And then if you have to miss it because of some situation, re-scheduling you're like three four months down the line so and then to be told to call every day for cancellation is just not feasible for many of our patients (Participant #9)

I think if we had more primary care, more like in community care, you know, there are like the FQHC's help of the world that go to people's apartment complexes and stuff…I think we just need more access. (Participant #7)

Continuity and transitions

Processes supporting seamless care across settings and during discharge and hand-off are critical to maintaining optimum health. Nevertheless, challenges to continuity of care among people experiencing housing instability could result from poor hospital discharge planning, provider's hesitation in accepting chronic diseases management because of impact uncertainty, patients' life or behavior challenges, and the delicate balance of patients' autonomy with the offered support. The following are excerpts from the participants

I know things like move so fast and so quickly and you're not really able to maybe acknowledge all of people's concerns, but I do feel like a lot of people are not set up for success when they leave, maybe whether it be something like even like wound care supplies. (Participant #5)

The dialysis is a huge one that we just really struggle at. Um, you know, we get referrals, you know, connecting this client, you know, requesting that we connect them to, you know, dialysis. And then it's like, well, we connect them, but then what, you know, and then a month later, they're going to fall off because their car broke down… every time we get a referral, and we get them frequently for that type of thing. We struggle as to whether to accept it or not because just like, can we really make an impact... (Participant #2)

I've had complicated conversations with some of the patients that I've engaged with, maybe before they were getting into recuperative care, but they were still struggling with housing, like either living in their car or tent camping. And when you're in the cancer center, and then if you're going there for infusion, sometimes you're there for like eight to 10 hours, just sitting there. And some of the folks that I've worked with have expressed a lot of reservation about even going because like my clothes aren't clean. And or like I haven't been to a dentist in years, I can't brush my teeth and I like I don't have many of my teeth or there's a lot of worry about like I'm gonna be around suddenly a lot of people that tend to be much better resourced and like there's a factor of embarrassment. And then we manage for control for that or figure out what you need to be able to access to feel comfortable doing all of this… to figure out what is the appropriate way to support that person, acknowledge their autonomy, and also get them treatment such that they can also take care of themselves physically, is a balance that is impossible (Participant #3)

Communication and connectivity

Clear, high-quality bidirectional communication, coupled with explicit role clarity during patient-provider encounters, facilitates improvement in health outcomes. Access to functioning technology devices such as a phone and having the appropriate skills to use technology is crucial in every facet of care management. Phones are needed to access services like electronic patient portal, clinic appointment scheduling and follow-up messages, virtual visits, transportation to clinic appointments, and insurance coverage follow-up. Some individuals may have phone communication anxiety, and this hampers their ability to reach out for health services through phone. Phone technology access and use barriers can isolate individuals, reducing their ability to seek help, stay informed, and engage in ongoing care, thereby significantly hampering healthcare management and outcomes. Here are some of what participants had to say regarding communication barriers

So, I think from the hospital end, we could do a better job of like, saying like, hey, here's your point person for this person's particular care. Like this is the social worker that you can have direct communication with. Like this is a number. I think that would really improve and smooth a lot of gears to make things move. (Participant #3)

Now we're coming into where we used to have access to order cell phones for our people. That's no longer the case. You can get a SIM card now, but if you don't have a cell phone, that's not very helpful. And just, you know, with living outside, people are more prone to having items stolen or lost and so you know oftentimes we have folks who don't have phones; and so just contacting their doctor's office, calling for a ride to get to their doctor's office, connecting to their portal they can't do, getting you know like callbacks from the doctor's office is very difficult, you know, even if they are able to, you know, while they're here, you know, I make a lot of phone calls. They, you know, like, I get updates for people's appointments on my phone because they don't have a phone. My number is tied to their account. But when they're in the community, they may not have that or before they come to us, they may not have that.

So, I think that's another big barrier, access to telephones, there aren't pay phones anymore. (Participant #5)

Person-centered care

Care that honors patient's values, preferences, and self-determination facilitates improvement in health outcomes. Participants upheld the importance of engaging and empowering patients to be part of their care, and respecting patients' autonomy and prioritization of their concerns. Nevertheless, sometimes there could be a challenge in balancing appropriate care with patients' autonomy. Below are excerpts from the participants on patient-centered care

So, I think that's actually one of our strong suits at complex care is that we do take a person-centered approach. So, we look at each person as a unique individual. Some programs you get the same thing no matter what and that's not how we work because each person is so different and they have such various needs. (Participant #9)

I am all about self-sufficiency, so I'm always trying to work with the team on, hey, let's for like the first two to three weeks really lean in, do what we can to support the client and scheduling through their insurance, but then we need to at some point instill and empower them to schedule insurance on their own, because when they leave the program, I would like them to feel familiar and equipped with that process so they feel they can continue to easily access transportation. So, I'm constantly trying to remind the team of that because it does take a little bit of work, you know, to empower the client. (Participant #6)

Just the constant, um, like reinforcing needed almost like, and it goes back to this behavior change and people wanting to help, you know, and kind of coming to terms that like we can't help everyone and if they don't want it or aren't open to change or not willing to work with us. (Participant #2)

Interprofessional practice and education

Collaborative team-based care models are beneficial for improving patient health outcomes. Integrating diverse clinical expertise enables more comprehensive, coordinated, and evidence-based care, leading to better clinical outcomes, and cost-effectiveness (21). Structured interprofessional collaboration promotes information sharing, mutual accountability, and safer care delivery. Interprofessional practice and education promotes ongoing professional development, keeping healthcare professionals in tune with current care delivery strategies. Participants expressed the importance of interprofessional practice and education.

Yeah, and there's some coordination that happens. So, the first one is trying to get them connected to [clinic]. And our medical team there can make a referral as well. As long as there is one of those overflow beds, because again, with our health system contracts, there are allocated beds. At times, [we are] creative of going, you know, has this patient been working with medical center? Because if so, then we'll reach out to the social work team and see if they can make a referral for that medical center bed. So, it's

definitely a lot of coordinating when that happens, but in the long run, we're usually able to make that work. (Participant #6)

But then we also have patients who are like who have sickle cell disease and they have untreated pain, and they're in the ED a lot. And we work on training our ED to like know how to help support the patients, not stigmatize the pain and provide the support, but also provide like safe care. (Participant #9)

Theme 3: Social Determinants of Health

Social determinants of health play a critical role in shaping health outcomes among people experiencing housing instability. Limited access to stable housing, income, nutritious food, transportation, and healthcare increases exposure to chronic stress, illness, and preventable health conditions. Addressing these upstream social and structural factors is essential for improving health equity and outcomes in this vulnerable population. The sub-themes include housing, transportation and communication, financial security, food and nutrition security, social support, stigma and trust, health literacy, and environmental factors.

Housing

Housing profoundly influences multiple aspects of an individual's life, including access to medical care, susceptibility to mental health conditions, substance use, exposure to violence, alcohol-related disorders, hospital admissions, overutilization of ER, and access to clean water and sanitation. The availability, stability, and quality of housing resources significantly shape care management and overall health outcomes. Consequently, the importance of adequate housing cannot be overstated. For individuals experiencing housing instability, securing safe and stable housing often takes precedence over addressing health concerns. In recognition of its impact on well-being, inadequate housing is classified as a health-related issue and is represented by various codes within the ICD system.

Participants acknowledged ongoing efforts at the county and state levels to expand housing access; however, they emphasized that the scope of the challenge remains substantial. There is a critical need for increased availability of safe, stable, and affordable housing, as this would play a pivotal role in mitigating the wide range of health issues faced by individuals experiencing housing instability. Below are selected excerpts from the participants:

I still think almost every client we see would say number one health concern is they want to get housed. The longer people are unhoused, the less healthy they are. In terms of continuing to try to make more affordable housing, I think [the county] continues to try to push for that. Unfortunately, it's, it's sort of small little pieces here and there. Meanwhile, the entire market is going up massively. And then you have these small divots of we're gonna carve out this spot with 120 apartments. We're gonna carve out this with 44. So it's still sort of very piecemeal. (Participant #1)

I see housing as a health issue. You know, I mean it's, well, and actually sometimes it is a diagnosis. There is an ICD code, right? So you can plug that in. (Participant #4)

Also housing that is like affordable is oftentimes not well maintained. And that is the contributing factor to people presenting, you know, where it has no air conditioning in the hallways, and so it's incredibly hot…I've had people come in who felt like they had strokes because their blood pressure was so high from the heat, little stuff like that I don't know if that's how it happened, but you know being overheated, I'm sure it does not help you. (Participant #7)

Transportation and communication

Participants stressed that reliable transportation and effective communication systems play a critical role in improving health outcomes by enabling individuals to access medical care, attend appointments, and receive timely health information. For people experiencing housing instability, access to transportation can mean the difference between consistent care and missed treatments or delayed diagnoses. Communication tools, such as phones are usually tied to transportation access. Lack of a functioning phone could mean lack of transportation access. Conversely, the lack of transportation can limit access to clinics, pharmacies, and support services, exacerbating existing health conditions. Here are some excerpts from the participants

I think also access to transportation [is a challenge], while people can get transportation to and from medical appointments, it’s not reliable. Oftentimes we'll have a transportation schedule through their insurance, and they [the transportation] just don't show up. They don't answer the phone. (Participant #5)

I think that the transportation [is a challenge], You know, they could ride the bus. They could. They would need the half fare token or full fare token. But then to get on the bus, like let's say you have an 8am appointment, so you're going to have to get on the bus quite early in the morning to make that. So it's doable, it's possible, but maybe for our folks that are dealing with more medical vulnerability, like we've had some folks that are trying to navigate the bus with wheelchairs and walkers and to make the bus on time is a challenge. (Participant #6)

Not having cell phones. I have a lot of patients who have no, they'll have Medicaid, so they'll have that transportation benefit that their insurance offers, but they don't have a phone to get contacted or to connect with the transportation. (Participant #11)

Financial security

Participants opined that financial security plays a critical role in shaping health outcomes among individuals experiencing housing instability, as it determines their ability to meet basic needs, access healthcare, and maintain continuity of care. Adequate financial resources can facilitate access to stable housing, nutritious food, medications, transportation, and preventive services, all of which contribute to improved physical and mental health.

Conversely, financial insecurity can act as a significant barrier, forcing individuals to prioritize immediate survival needs such as shelter and food over healthcare, often leading to delayed treatment, worsening chronic conditions, and increased reliance on emergency services. Limited financial means may also restrict access to communication tools and insurance coverage, further hindering engagement with healthcare systems. Ultimately, financial instability compounds existing vulnerabilities, making it more difficult for individuals experiencing housing instability to achieve and sustain positive health outcomes.

One participant captured it this way “But the main problem they have is they're unhoused and they're poor, Mm -hmm, and why are they unhoused? because they're poor.” (Participant #1)

Other participants said: “you know a lot of our folks don't have income when when they're out on the street and so they can't afford even simple things like a bottle of Tylenol right or something that like you would you always have it in your cupboard at home. You don't even think about it. But these folks can't just go out and purchase that, you know. So I think those are the main things” (Participant #13)

“Um, I feel like by not having resources and, you know, um, available to you, I just feel like it's just so many things like you're not, you maybe don't have like medically necessary food that you need, that you must eat for like to control your diabetes. You may not have the proper financial resources to pay for, you know, their prescriptions. You may not have the proper insurance.” (Participant #8)

Another participant bemoaned the cuts in federal funding for healthcare programs; “I think then like also like changes in funding and resources so like there's just and I think it's just gonna get worse right with the reduction in our supports for grant monies and those types of things so limited more limited access to food and transportation and housing really” (Participant #9)

Food and nutrition security

Participants expressed that food and nutrition security are essential determinants of overall health outcomes among people experiencing housing instability by influencing both physiological resilience and the ability to manage chronic conditions. Reliable access to affordable, nutritious food can support immune function, stabilize conditions such as diabetes or hypertension, and reduce stress associated with food scarcity, thereby improving overall health and healthcare engagement. Conversely, food insecurity, often marked by reliance on low-cost, energy-dense but nutrient-poor foods can exacerbate malnutrition, worsen chronic disease outcomes, and increase vulnerability to infections and mental health challenges. Additionally, the instability of housing can limit food storage, preparation, and access to consistent meals, compounding the negative effects. Thus, without integrated efforts to address both housing and nutrition needs, food insecurity can act as a barrier, while improved food access can serve as a key facilitator of better health outcomes in this population. Some excerpts from the participants include

If you don't have food or you don't have a way to get food or don't have a way to cook, that's also going to cause malnourishment. And that can, wounds can be more common when you're malnourished. You

know, then your body's struggling a little bit more. So that can cause a lot of unhealthiness. (#12)

Just you know, like the nutrition aspect of everything, you know wound healing, just having access to healthy foods, just yeah, it's just incredible what a difference that can make. (Participant #2)

I would say, you know, now we [the medical respite center] have access luckily, our previous environment, we didn't have a kitchen in our, in the rooms. Now they have like a small kitchenette, which does open up some doors. Lack of access to kitchens is huge for meal prep. A lot of times you end up with processed shelf -stable foods that are high in sodium, just very, very unhealthy and they tend to be the most affordable. There are some really good food pantries in the area, but some of those items, unless you have a home to cook them in to have the healthier foods, it does limit you. (Participant #5)

Social support

Participants expressed that individuals experiencing housing instability persistently report loneliness and lack of support system. Positive social support such as emotional encouragement, financial assistance, help navigating healthcare, or access to safe temporary housing can buffer stress, improve medication adherence, facilitate continuity of care, and promote healthier behaviors among people experiencing housing instability. On the other hand, limited, inconsistent, or negative social ties (e.g., networks that normalize substance use, interpersonal conflict, or exploitation) can exacerbate stress, hinder access to resources, disrupt treatment, and reinforce harmful coping strategies. Thus, the quality, stability, and context of social support systems are critical determinants of whether such networks act as protective factors or barriers to improved health in this vulnerable population. Below are some excerpts from the participants

I do acknowledge that a lot of our clients just don't have support family, friends, you know, they say their emergency contact is like their neighbor down the street who they see, you know, once a month walking around the block. It's just like they just have no one. And so I can only imagine how that would affect the overall health. (Participant #2)

Their support systems are so small. We are not a village, we are a barrier, a country of me, of like me, not we. So these people, their support systems are so incredibly small that they are just like out in the ether by themselves. You know, like, I have a patient today. I literally had to go to her apartment to get something for her. So she can go to a nursing facility because she had no one. She has no emergency contacts listed. She has no set next of kin. She has nobody. (Participant #7)

So if they had good medical care or if they had good psychosocial supports, then they would be able to manage their care differently. They may often have very limited social supports, so there's really nobody. They've maybe burnt all their bridges or they don't have a lot of supports due to mental health diagnoses or whatnot (Participant #9)

Stigma and trust

Participants identified stigmatization as a significant barrier to improving health among people experiencing housing instability. Fear of being judged or treated poorly can lead individuals to delay or avoid seeking medical care, even when they are facing serious health challenges.

I think I was mentioning earlier about a lot of the stigma. I think there's a lot of folks that I've worked with over the years and not necessarily specific to cancer care, that have delayed care or declined or like not gone in for preventative things, dental visits, well visits, whatever it is because like they don't want to be judged and like they don't want to go in for a doctor to tell them like well find some housing and then actually not offer any kind of solution. So I think there's a lot of folks like why the hell would I do that, if like I feel terrible like there's not a whole lot that happens, maybe I have a chronic health condition but like I can live with it until it's a crisis. I see that as a very large barrier (Participant #3)

Stigmatization undermines trust, yet trust is fundamental to effective patient–provider relationships and better health outcomes.

If you belong to communities that have been victimized by medicine or healthcare as an institution, you're less likely to try and seek that care. I think so trust can be low. (Participant #4)

Yeah, they barely trust, like it's very hard to have trust with someone here, at the hospital, just from their interactions with, I think previous providers or some discrimination or a different hospital that should do them one way or they get kicked out. (Participant #7)

Trust in the health system can significantly improve health outcomes for people experiencing housing instability by encouraging timely care-seeking, openness in communication, and adherence to treatment plans. When individuals feel respected, safe, and free from judgment, they are more likely to engage consistently with healthcare providers, disclose relevant health and social challenges, and follow medical advice. Trust also strengthens continuity of care, improves coordination of services, and fosters willingness to use preventive and supportive resources, all of which are critical for managing chronic conditions and reducing avoidable complications in this vulnerable population. Trust in the health system can be actively cultivated, as noted by this Participant: “Sometimes there also is a distrust of the health system. I think that has improved over the years. I recall like back in 2019, us identifying that as one of our goals and outcomes of increasing trust and reliance on, you know, primary care and attending to appointments because people just felt like I don't need that and they don't know what they're talking about and they diagnosed me with this and I don't trust it. I have seen a slight increase in that over the years, thankfully, where more people are willing to access care and are building that trust.” (Participant #6)

Health literacy

Health literacy serves as a key facilitator of improved health outcomes among people experiencing housing instability by enabling individuals to understand health information, navigate healthcare systems, communicate effectively with providers, and make informed decisions about prevention and

treatment. Individuals with adequate health literacy are more likely to engage in timely care, adhere to medications, and utilize available support services. In contrast, limited health literacy acts as a significant barrier, as difficulty understanding medical instructions, insurance processes, or available resources can lead to delayed care, poor adherence, increased emergency service use, and worse overall health outcomes.

They're not consistent with PCP, right? I think there's also sometimes like a cultural thing. I don't know if it's just like in the homeless community or people in general, but that everything is an emergency, nothing is a PCP. And so like a lot of different you know, like people need to differentiate like what's the emergency and you do the emergency versus what is something that I can get from my primary care doctor. (Participant #7)

Alongside efforts to improve health literacy among individuals experiencing housing instability, there should also be increased awareness within the broader community of available homelessness and health resources.

Like if you're asking about generally, county residents in general, I don't think they understand the severity of homelessness or the lack of access to resources. I think there's need for education, in a sense, to the general community and then implement more resources. (Participant #12)

Strengthening health literacy, therefore, is essential for empowering this population to better manage their health and access appropriate care.

Environmental factors

Environmental factors are critical social determinants of health, encompassing the physical, social, and built environments in which people live, work, and interact. Conditions such as housing quality, neighborhood safety, exposure to pollutants, access to clean water and nutritious food, and availability of green spaces can significantly influence health behaviors and outcomes. For individuals experiencing housing instability, adverse environmental conditions such as overcrowding, unsanitary shelters, or exposure to extreme weather can increase the risk of infectious diseases, chronic illness, and mental health challenges. One Participant noted the unpredictability of the state weather "Um, temperature, I mean, extreme temperatures and, and, you know, the, the, the fact that our climate is, you know, we're in a place that has four seasons and the four seasons are unpredictable and the weather is unpredictable" (Participant #10)

Conversely, access to safe, stable, and resource-rich environments can promote well-being, support healthier lifestyles, and reduce health disparities. This dynamic has contributed to the migration of individuals experiencing housing instability to areas with greater access to resources that can improve their circumstances. However, such migration often places strain on existing systems, resulting in limited resources due to the increased demand and growing number of individuals in need of services.

I think [the city], as a more well-resourced left-leaning space, I think does try and contribute support to their shelter association. And I feel like that I hear about shelter associations and other parts of the state that are trying to send folks over here because we're gonna have more more access here than they would and where they're at right, so that kind of causes you know access problems too as I know that the wait list right now for a shelter bed is enormous right, so the sort of the need vastly outweighs sort of the the access. So, to me, it just seems like the problem has just continued to grow. It is going to continue to grow. (Participant #4)

Theme 4: Interorganizational Collaboration and Community Partnerships

Interorganizational collaborations and community partnerships can improve health outcomes for people experiencing housing instability by coordinating healthcare, social services, and housing support to address complex, overlapping needs and enhance trust and accessibility through community engagement. In contrast, their absence can fragment care, leaving services siloed, disrupting continuity, and limiting access to essential support, ultimately undermining trust and worsening health outcomes. The subthemes include community organizations and institutions, cross-sector partnerships, community resources and community engagement.

Community organizations and institutions

Participants identified a range of organizations and institutions in the community, including federally qualified health centers, large medical centers, educational institutions, shelter associations, housing commissions, medical respite centers, food pantries, and public kitchens. These entities play essential and evolving roles in improving the health of people experiencing housing instability by delivering healthcare, social services, and advocacy tailored to this population’s needs. Participants shared the following perspectives on the roles of these organizations within the community

We do have an outpatient complex care management team too. So me and my work partner do the inpatient but on the flip side of that there is a much larger group who does the outpatient and they are incredibly skilled at getting people housing. They're on like the housing commission committees. (Participant #7)

Yeah, so for one, having Clinic on site twice a week gives access where a client could present for a meal and just share with our staff like I've been feeling really under the weather, I haven't been able to get a hold of my medications, I know that I need insulin and I've been without for quite some time and so we can say oh well this afternoon we have clinic we really want you to get upstairs you can do a walk -in, you don't even have to schedule an appointment, and they can see you before 5 p .m. today. And so that access has been great for our clients because, you know, transportation is available, but it does discourage individuals to going across the town. So it's just upstairs, and I feel nice. (Participant #6)

I am very proud also of the advocacy work that we do at [the clinic], especially, you know, given the current climate, just the continued push that everyone deserves equal care and equal health in the community. So whether that be going to [the capital] and having conversations with, you know, appropriate people or, you know reaching out via various media to really get the word out and advocate for everyone. (Participant #2)

Cross-sector partnerships

Cross-sector partnerships are vital for improving health outcomes among people experiencing housing instability because they align healthcare, housing, and social services to address interconnected needs through coordinated, person-centered approaches. By leveraging shared expertise, resources, and community trust, these collaborations enhance access to comprehensive care, reduce service gaps, and support continuity across systems. Participants reported on several beneficial cross-sector collaborations.

So we spend a lot of time at complex care building our community relationships. So we get to know our partners in the community. So we build relationships with like [hospital]. We work closely with their complex care management program. So we have a lot of patients who go between the health system so we can work with them. We've built relationships with FQHC. We tried to coordinate with the shelters so we know a lot of the caseworkers with the housing commission, with community mental health, with we are part of barrier busters. (Participant #9)

I think that we're looking to build that community collaborative with the health systems and saying we all are partners in this that, you know, we are integrated, you know, when we first were learning about recuperative care, they call it an integrated health system. And, you know, it does involve obviously FQHC, us the shelter and the both health systems of meeting this community need and trying to address the health outcomes with common goals of reducing like ED visits, reducing inpatient stays, self -sufficiency of managing their own chronic conditions, access to healthcare, access to transportation, like all of it kind of goes hand in hand in this integrated model. And we all benefit from it, right? (Participant #6)

Another Participant emphasized the pivotal role of research in driving health improvements, particularly when supported by strong collaboration between healthcare systems and community-based organizations.

I wholeheartedly support, you know, the research you're trying to get, garner and what you're trying to kind of, you know, ascertain from these interviews. I think it's important, you know, to understand that a hospital can cure and do, but their limitations stop. And so our community partners have to be able to pick that up in the community and continue to run with it. You know, we're limited. (Participant #10)

In contrast, the absence of such partnerships leads to fragmented, siloed services that hinder coordination, limit access to essential supports, and ultimately contribute to poorer health outcomes and persistent inequities. Participants highlighted key areas of mutually beneficial collaboration between

medical respite programs and interprofessional learners, faculty, and staff, while also noting challenges associated with sustaining these partnerships.

Well, I know that we have been always interested in having students come and do things with the clients whether be like, it's that something that could be done like you guys come and like do an educational session for you know a group of clients that have similar illnesses or you know come out and inform us on on some stuff or maybe help us collaborate. (Participant #13)

The constraints of medicine, you know, you can't do anything without liability insurance. You can't do anything with all of those things. I mean, the community outreach needs to work two ways. I mean, yes, we open the doors to anyone and everyone, but not anyone and everyone can get to those through those doors. The job is hard enough as it is. I don't want to throw some poor student under the bus. (Participant #10)

Community resources and Community engagement

Participants recognized a diverse network of community resources that support health outcomes for individuals experiencing housing instability, including state-funded community programs, county health plans, food pantries, transportation services, private food providers, shelters, medical respite programs, large hospital systems, nonprofit organizations, and drop-in clinics. However, they emphasized the critical need to improve access and connectivity to these resources, while also advocating for the expansion of available services, given the substantial health and social challenges faced by this population.

Well, resources such as your, such as the recuperative care program for one, also the County has really, you know, has multiple like resources for, I feel like for food, for, you know, material needs for like, I, you know with the homeless population that I work with like they know like a lot of them know about local resources they know where to go for a hot meal they know where to go for A, B and C like I feel like that's really great about the County and Yeah, I think that's what we're doing really well in this area is even though I feel like it could still be better. I feel like for the amount of resources we do have, it's good to know that at least like people are getting a hot meal, they're getting a shower, they know where to go for these various things. (Participant #8)

Participants underscored the importance of programs that enhance community engagement. Increasing public awareness of homelessness and available support resources may help catalyze collective action, counteracting the sense of passivity noted among community members.

I do think that [the state community program], that's a really neat program. A lot of the major institutions in the area are involved and it's a great place for people to be able to kind of like swap resources, swap ideas for patient needs. They meet fairly regularly and I think at least like once a month and the different organizations… they will present cases on folks that are maybe running into issues in the community and everyone kind of puts their minds together to say, well, have you tried tapping into this? Have you tried

tapping into that? And I've seen people, clients be able to access transportation benefits through that organization, to be able to access connecting with a little bit more like supportive housing. And so that's a very beneficial program. (Participant #5)

I think the community always wants to do something different. I just don't think people understand the nature of the issues. Like if you're asking about generally county residents in general, I don't think they understand the severity of homelessness or the lack of access to resources. I think there needs to for education, in a sense, to the general community and then implement more resources. I think the agencies that do the work are aware of the resources, but I think anyone else, you know, the residents or anyone else, doesn't always aware you know, of what's missing or what's needed. I think there needs to be more education. (Participant #12)

Theme 5: Population Health Trends

Population health trends among people experiencing housing instability reflect a disproportionate burden of chronic disease, mental health conditions, and unmet social needs, driven by systemic inequities in housing, income, and access to care. This population often exhibits higher rates of conditions such as hypertension, diabetes, substance use disorders, and infectious diseases, alongside increased healthcare utilization, particularly emergency services, due to fragmented and episodic care. Concurrently, trends toward aging populations and urban housing shortages further intensify vulnerability, while limited access to preventive services, stable nutrition, and continuity of care perpetuates poor outcomes. Although emerging models like integrated care and community-based interventions show promise, persistent structural barriers continue to shape adverse population health patterns for those without stable housing. The subthemes include morbidity and multimorbidity, pandemic effects, and patient experience and engagement.

Morbidity and multimorbidity

Participants highlighted a substantial burden of morbidity and multimorbidity among individuals experiencing housing instability, noting the frequent presence of multiple concurrent chronic conditions. They emphasized a concerning trend of younger individuals presenting with serious illnesses such as cancer.

I think of things in like sort of simple numbers. I sort of tend to view it as two thirds, two thirds, two thirds, which is two -thirds of the shelter people have mental health problems, two -thirds have substance use, two -thirds have big chronic health conditions, and there's this trifecta in the middle which has all three, but there are lots of people at the shelter who do not use any substances, there are lots of people at the shelter who do not have chronic conditions, and there's lots of people at the shelter who do not have any mental health problems, and that same goes with [the medical respite center] but they do have more of those problems than the general population does. (Participant #1)

I don't know why we're seeing the increase in the cancer diagnoses. It is a bit concerning. And there have been, you know, younger folks that are coming across our program that are, you know, with late-stage cancer stuff. So I don't know why that's, it's happening, but it's definitely a trend. (Participant #13)

They also noted an increasing number of patients with highly complex health profiles alongside those at imminent risk of progressing into medical complexity.

I will say we've had an increase of people like I said who are kind of riding the line, like they're not quite sick enough, they're not quite psychosocially complex enough, but they're going to be. And so without supports to keep them stable, they'll become one of our [complex] patients. (Participant #9)

Participants expressed varied perspectives on the trajectory of population health trends among individuals experiencing housing instability. While some perceived a clear deterioration in health outcomes, others believed conditions have remained largely unchanged, and still others characterized the trend as mixed, reflecting both areas of decline and pockets of stability or improvement.

I think negatively, you know, the housing crisis has only gotten worse. Um, and from my understanding, it may get even worse. you know, we see We see the hospital, our census is always very high and a lot of those issues are social issues. A lot of people don't have insurance and they don't qualify for Medicaid. So I feel like social issues are just getting worse and worse, which leads to health issues getting worse and worse. (Participant #11)

I would say probably negatively. Just the patients we see that come into our building are a lot more complex than they were. You know, even four years ago, people that came in were a little less complicated, had a little bit less going on, and then now, I think, following COVID, I think a lot of resources closed or just funding got cut or just different changes the government has made it harder. I also think, you know, if I think there's – I would say they definitely are getting sicker, or at least more complicated, if they're not secure, there's more social issues at play (Participant #12)

So that, but there's part of me that feels like it's [population health trend] gotten a little, like a touch worse. I don't know, maybe a little better, a little but worse because a lot more communicable diseases, you know, the COVIDs that turn into pneumonia, that noroviruses that run rampant, especially shelters that just take people out. Then there's also a little better because there are programs that can help a little better, a little more, like the source, recuperative cares that have been more involved with these populations. So it's a mixed bag. (Participant #7)

Pandemic effects

Participants underscored the multifaceted impact of the COVID-19 pandemic on healthcare access, morbidity, and service delivery for individuals experiencing housing instability. They noted that the pandemic produced both beneficial and adverse effects on health outcomes within this population. On the positive side, it catalyzed the mobilization of federal funding and emergency resources, which expanded access to housing and healthcare services for people experiencing homelessness.

…and then COVID while it was very difficult for people, it did improve many of my clients um medical problems because many of them got housed at a hotel. Um and that was including much of the unhoused population, right? That was not even in the shelter, so many of them got housed at the hotel (Participant #1)

And I will say it's a weird, you know, it was really weird during the pandemic where we were kind of like flooded with money, right? Yeah, we got all this, and it was like, whoa, (Participant #2)

On the negative side, the pandemic resulted in the suspension of the medical respite program and contributed to the worsening of chronic disease management among this population.

And then unfortunately when the pandemic hit us, March of 2020, we were advised by Public Health to close the [medical respite care] program. They shared that because the majority of those clients were coming from the hospitals that was too high of a risk, given that they might have been exposed to COVID. So that was really unfortunate. (Participant #6)

I think the biggest thing is, you know, the pandemic really exacerbated a lot of our chronic disease issues with a lot of our patients who might have already, you know, kind of been lost to follow up or not great at following up. And then, and then for obvious reasons didn't come in. So we are kind of still playing catch up with a lot of that. (Participant #2)

However, the shelter partnership remained robust throughout the pandemic, and the medical respite program has since resumed operations, with clients currently accommodated in hotel settings. Despite these gains, concerns persist regarding the program's long-term sustainability and potential for expansion in the face of post-pandemic funding constraints.

So, after COVID sort of settled, which would be probably three years into COVID, we started looking at restarting the [medical respite program], which is when we did. And rather than keep them on the second floor at the shelter, we got funding to put them at a hotel. (Participant #1)

And now [post-pandemic] it's kind of like, okay, here's, we're back to reality. And now we're kind of here digging again. So, it's been a weird ebb and flow in that sense, but it's out of our hands, I suppose. (Participant #2)

Patient experience and engagement

Participants emphasized the importance of recognizing patients as active partners in their own care, underscoring the value of patient-centered approaches. They highlighted high levels of patient satisfaction with the medical respite program and identified opportunities to strengthen empowerment and engagement through targeted education, consistent communication, and reassurance.

I don't know of a single person who said, I want to get out of the [medical respite program], I want out of here, I would rather go back to the shelter, or I would rather go back to the street. Not, not a person.

(Participant #1)

I think you know, we're really focusing on client education around some of the changing policy, you know while we're also doing what we can to get our voice out there… So we're trying to take away those barriers to help with that and just yeah being proactive to connecting people to our social workers and some of our advocates. And just to add to that, just saying like this this isn't going to change the care that we provide. So, I think in providing that kind of stability and assuring people that we will continue to because that's our other fear, they lose their coverage and they don't come in and it's like no you can, you know. (Participant #2)

So like my biggest thing I would love to be able to tap into our people with for our people would be like just education. depending on what discipline it is, I mean, there's so many things that could be brought to the table. I feel like having people have a better understanding of what their medications are and their timings and what are their side effects and what are important things to talk to your doctor about. I think about that with like the pharmacy. We get a lot of people um, maybe have multiple prescribers in the community, um, for various reasons, whether or not just really following up and then they have all these pills, but just, you know, making sure that people aren't, you know, having interactions, um, with different medications, um, knowing about access for different programs, one thing I'm seeing now more than I didn't see before. (Participant #5)

Discussion

This CBPR-informed community health needs assessment sought to identify facilitators and barriers to medical respite care transitions for people experiencing homelessness from the perspectives of healthcare providers working within the medical respite care community. Findings revealed five interconnected themes: structural and system-level factors, care access and continuity, social determinants of health, interorganizational collaboration and community partnerships, and population health trends. Together, these themes illustrate that successful medical respite transitions are shaped by factors operating at multiple levels, from broader policy and healthcare systems to individual, social, and organizational contexts. The findings reinforce the growing recognition that medical respite care serves as a critical bridge between acute healthcare settings and community reintegration for those experiencing housing instability (22, 23).

Structural and System-Level Factors

Participants identified structural and system-level barriers as foundational influences on medical respite transitions. Challenges related to funding instability, limited respite bed availability, restrictive eligibility criteria, fragmented policies, and inadequate housing resources frequently hindered effective care transitions. These findings align with previous research demonstrating that individuals experiencing homelessness face significant barriers during hospital discharge and post-acute recovery due to gaps in

transitional care infrastructure, insufficient housing options, and fragmented service delivery systems (24, 25)

The prominence of structural barriers in this study further supports evidence that homelessness is fundamentally shaped by policy, economic, and systemic factors rather than individual behaviors alone. Medical respite programs were originally developed to address the unsafe discharge of medically vulnerable individuals to shelters or the street; however, ongoing limitations in reimbursement mechanisms, affordable housing availability, and workforce capacity continue to constrain program effectiveness (22, 23). These findings suggest that improving respite transitions requires policy-level investments that expand capacity, strengthen reimbursement models, and integrate medical respite services into broader homelessness response systems.

Care Access and Continuity

Care access and continuity emerged as another central theme. Participants described difficulties maintaining follow-up appointments, accessing primary and specialty care, obtaining medications, and navigating fragmented care systems after discharge. Conversely, effective case management, discharge planning, and care coordination were identified as important facilitators.

These findings are consistent with literature demonstrating that continuity of care is essential for reducing rehospitalization and improving recovery among people experiencing homelessness. Medical respite programs have been associated with improved access to health services, reduced emergency department utilization, and enhanced post-acute recovery because they provide a bridge between hospital care and community-based services (16, 23). Similarly, evidence suggests that people experiencing homelessness experience disproportionately poor discharge outcomes when transitional supports and follow-up care are inadequate (22, 24)

Our findings reinforce the importance of person-centered transition planning that begins before discharge and continues throughout respite care. Integrating patient navigators, community health workers, and multidisciplinary care teams may enhance continuity across health care settings and improve long-term outcomes (26, 27).

Social Determinants of Health

The theme of social determinants of health underscored the inseparable relationship between health outcomes and broader social conditions. Participants identified housing instability, transportation barriers, communication barriers, food insecurity, financial hardship, behavioral health needs, and limited social support as major influences on transition success. These findings are well supported by homelessness literature demonstrating that social determinants significantly contribute to health disparities, healthcare utilization, and recovery outcomes among people experiencing homelessness (28, 29).

Participants frequently described situations in which medical stabilization alone was insufficient to support recovery because underlying social needs remained unresolved. This observation aligns with evidence suggesting that medical respite programs are most effective when they integrate clinical care with housing navigation, case management, behavioral health services, and access to community resources. Furthermore, addressing social determinants of health has been recognized as a critical strategy for reducing preventable hospital utilization and promoting long-term stability among those experiencing housing instability (30, 31).

Interorganizational Collaboration and Community Partnerships

Interorganizational collaboration and community partnerships were viewed as essential facilitators of effective medical respite transitions. Participants highlighted the importance of relationships among hospitals, medical respite programs, shelters, housing organizations, social service agencies, and public health entities in supporting coordinated care. Effective communication, shared goals, and strong referral networks were perceived as critical components of successful transitions.

These findings are consistent with previous research emphasizing the importance of cross-sector collaboration in addressing homelessness and improving health outcomes. An integrative review of community-institutional partnerships found that collaborative approaches can improve access to health services while addressing broader social determinants affecting people experiencing homelessness (28). Similarly, emerging frameworks for healthcare system responses to homelessness identify medical respite programs, hospital-community partnerships, and interagency coordination as essential elements of comprehensive homelessness interventions (32).

The findings also support the principles of CBPR, which emphasize shared ownership, community engagement, and collaborative problem-solving (14, 15). Participants' emphasis on partnership suggests that strengthening interorganizational networks may improve referral processes, reduce service fragmentation, and support more person-centered transitions.

Additionally, participants specifically identified the following potential areas of collaboration between the interprofessional academic community and the medical respite care community

- Health science learners could provide clients with an education on nutrition, medications, various diseases and general wellness
- Institutional collaboration to provide more beds and staff for the medical respite program
- Advocacy and community engagement to support more housing resources
- Health science learner's internship at the medical respite program
- Collaborative research to understand community health needs

Population Health Trends

Participants identified broader population health trends that affect medical respite care transitions, including increasing rates of chronic illness, behavioral health conditions, substance use disorders, aging among people experiencing homelessness, and growing medical complexity. These trends were perceived as increasing demand for medical respite services while simultaneously creating greater challenges for care coordination and discharge planning.

These observations are consistent with national reports documenting increasing health acuity among people experiencing homelessness. Research has shown that this population experiences disproportionately high rates of chronic disease, mental illness, and substance use disorders, often requiring extensive care coordination and long-term support services (22, 23). As homelessness continues to rise and demographic patterns evolve, medical respite programs face increasing pressure to accommodate individuals with more complex medical and social needs (32).

Implications for Practice and Policy

The findings have important implications for practice, policy, and healthcare system design. First, interventions aimed at improving medical respite transitions should adopt a multilevel approach that addresses structural barriers while simultaneously enhancing individual-level support services. Expanding medical respite capacity and developing sustainable reimbursement models may improve access and continuity of care (22).

Second, healthcare organizations should prioritize comprehensive discharge planning and care coordination strategies that extend beyond the hospitalization period (16, 33). Embedding case managers, community health workers, and peer navigators within transition processes may facilitate continuity of care and improve patient engagement (26, 27).

Third, findings highlight the need for integrated approaches that address housing, behavioral health, transportation, and other social determinants alongside medical treatment. Because transition outcomes are strongly influenced by social conditions, healthcare and policy interventions must extend beyond traditional biomedical models (23, 26, 28, 32).

Finally, strengthening interprofessional partnerships among healthcare systems, housing organizations, community agencies, and public health entities may create more coordinated systems of care that reduce fragmentation and improve outcomes for people experiencing homelessness (26, 28, 32).

Limitations

Several limitations should be considered. First, the study focused on healthcare providers within a specific medical respite care community, and findings may not be transferable to all geographic regions or program models. Second, because the study relied on qualitative data, findings reflect participants' perceptions and experiences rather than objective measures of transition outcomes. Third, participation was voluntary, creating the possibility of selection bias whereby individuals with particularly strong perspectives on medical respite care were more likely to participate. Finally, although the CBPR-informed

approach enhanced stakeholder engagement and contextual relevance, the findings represent conditions within a specific healthcare and policy environment that may change over time.

Future Research

Our next CBPR study is incorporating the perspectives of individuals with lived experience of homelessness to complement provider perspectives and support the development of more person-centered transition interventions.

Future research should examine the effectiveness of specific strategies for improving transitions, including peer support interventions, housing navigation programs, integrated behavioral health services, and enhanced care coordination models. Longitudinal studies are needed to evaluate how medical respite transitions influence healthcare utilization, housing stability, and health outcomes over time. Additionally, comparative studies across different medical respite programs and healthcare systems could identify best practices and contextual factors associated with successful transitions.

Conclusion

Overall, this study demonstrates that medical respite care transitions for people experiencing homelessness are shaped by a complex interplay of structural, healthcare, social, organizational, and population-level factors. While medical respite programs provide a critical bridge between acute care and community recovery, their success depends on addressing systemic barriers, promoting continuity of care, responding to social determinants of health, strengthening community partnerships, and adapting to evolving population health needs. These findings emphasize the importance of coordinated, multisector, and community-engaged approaches to improving transition experiences and advancing health equity for those experiencing housing instability.

Abbreviations

CBPR
Community-based Participatory Research
CHNA
Community Health Needs Assessment
CMH
Community Mental Health
FQHC
Federally Qualified Health Center
SDoH
Social Determinants of Health

Declarations

Ethics approval and consent to participate

The study was reviewed by the University of Michigan institutional review board, was assigned the approval number HUM00270897, and was conducted in accordance with the Declaration of Helsinki. All participants were duly consented using the informed consent approved by the institutional review board.

Consent for publication

Not applicable.

Availability of data and materials

The datasets generated and/or analysed during the current study are not publicly available to ensure anonymity of participants but are available from the corresponding author on reasonable request.

Competing interests

The authors declare that they have no competing interests

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Authors' contributions

ACB conceived the project idea. CEE wrote the protocol for IRB approval. ACB, CEE and GMRF conducted the interviews. CEE and GMRF analyzed the transcripts. CEE wrote the manuscript. ACB and GMRF reviewed the manuscript. All authors approved the final version of the manuscript.

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Figures

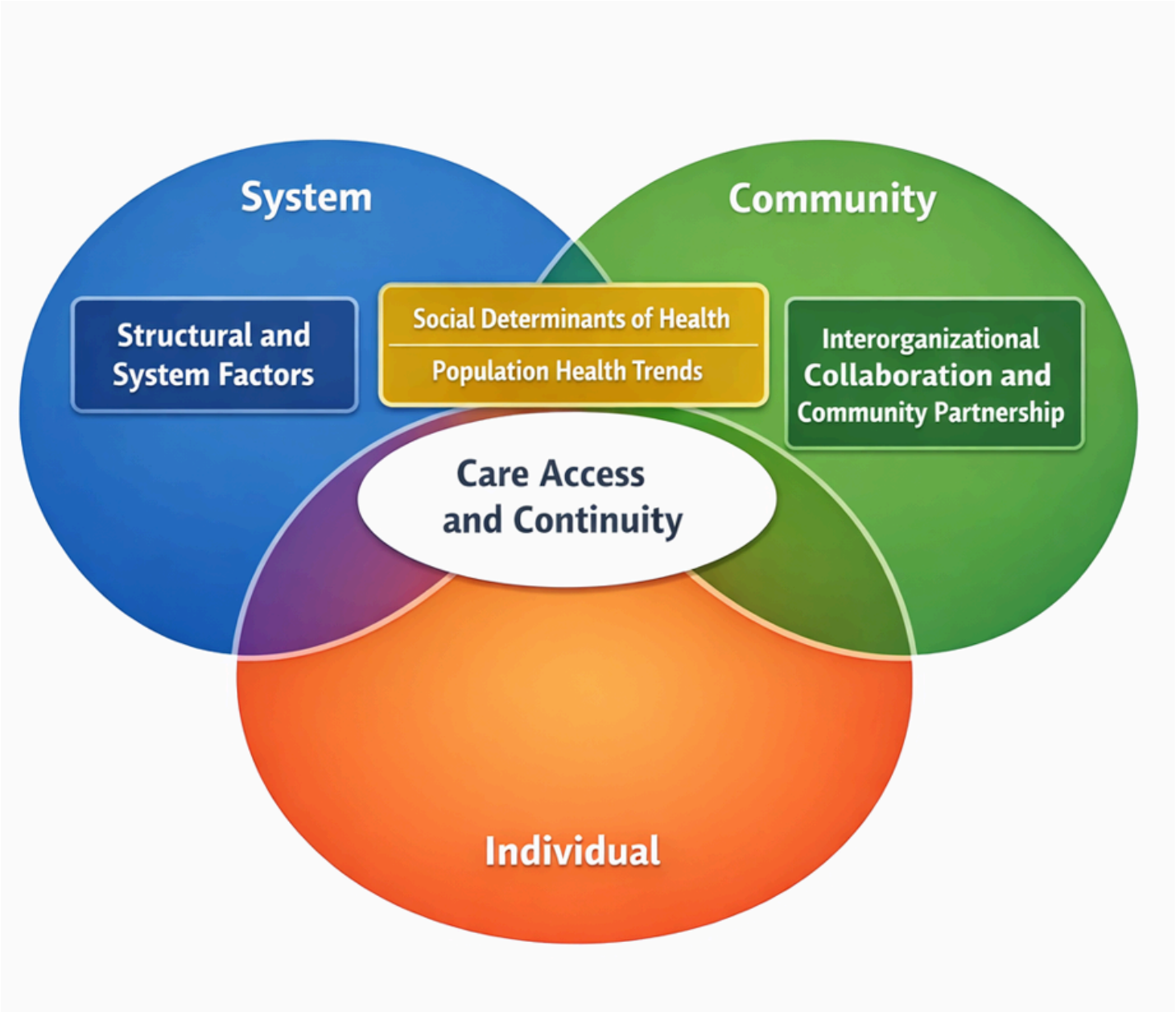


Figure 1

Themes categorization

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