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The Impact of Medical Respite Care on Healthcare Costs and Outcomes for Homeless Populations: A Literature Review

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Abstract

National homelessness rates are steadily rising, posing challenges in health care. Homelessness exacerbates health conditions, increasing chronic mental and medical diagnoses, while reducing traditional treatment efficacy Research highlights medical respite care as an effective intervention, improving post-hospitalization outcomes and reducing Emergency Department utilization, hospital stays, and readmissions. This literature review examines various medical respite models and their impact on clinical outcomes, patient experience, and healthcare costs. Different funding approaches are explored, ultimately advocating for shared financial responsibility among multiple stakeholders to ensure sustainable support for these programs.

Keywords: Medical Respite Care, Transitional Care for Homeless, Recuperative Care, Homelessness, Transitions of Care.

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Homelessness has been steadily rising in the U.S. since 2017, with 771,480 people experiencing homelessness in 2024 (U.S. HUD, 2024). Almost 50% of the homeless live with some type of disability or health comorbidity, including hypertension (44.2%), diabetes

(19.2%%), chronic obstructive pulmonary disease (36.8%), and hepatitis (18.1%) (Bensken et al., 2021; Smith et al., 2021; U.S. HUD, 2022). Without stable housing, individuals struggle with medication access, nutrition, and rest, leading to increased Emergency Department (ED) visits (Holmes, et al., 2020). In Los Angeles, despite comprising less than 0.8% of the population, homeless individuals accounted for 10% of EMS calls and 13% of ED transports, utilizing EMS services up to 19 times more than housed populations. This resulted in high hospital readmission rates, with 24.5% readmitted within 30 days and 48% within a year (Abramson, Sanko, & Eckstein, 2021).

Healthcare providers face challenges in continuity of care due to patients' lack of permanent addresses, phone access, and transportation (Hauff, 2014; Leggio, et al., 2020). Hospitals also bear significant financial burdens, as many homeless patients rely on Medicaid or require uncompensated care. A study of 8,400 Medicaid enrollees in New Jersey found that homeless individuals had 73% higher ED spending and 47% higher inpatient costs than housed individuals. However, housing support programs led to a 27% per-person cost savings (Cantor et al. 2020). While permanent housing solutions remain complex, even transitional medical respite care can reduce healthcare costs and improve outcomes by providing stable environments for recovery.

Methods

This integrative literature review examines peer-reviewed and grey literature from national databases on medical respite care, linking research on health system utilization, health outcomes, and costs for homeless populations within the United States. It also evaluates patient experiences and explores government policies affecting medical respite care and reimbursement.

Research Aims

This review addresses: (1) Patterns of healthcare utilization among homeless individuals. (2) Medical respite as an intervention for acute care utilization. (3) Cost implications of medical respite programs for payors and providers.

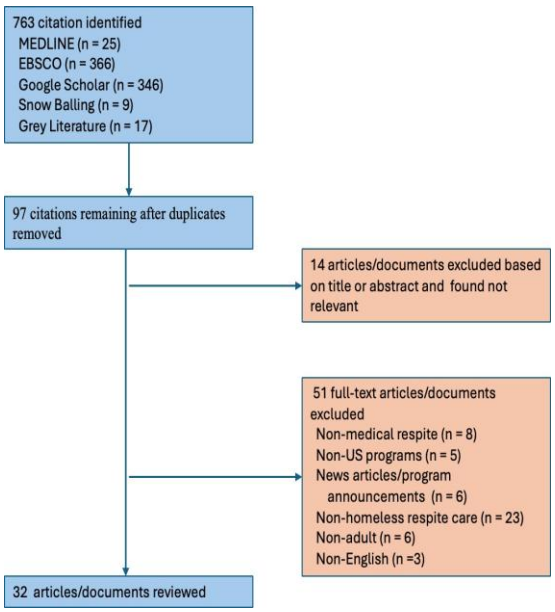
Search Strategy

In January of 2025, MEDLINE, EBSCO, Google Scholar were searched (2009 to 2025) using the following key words: ("Medical Respite Care") AND (Homelessness or Homeless). The search strings were used consistently across all the databases that were searched, and no truncations were used. Review articles were searched for additional relevant citations. No authors were contacted. Subsequently, research librarians provided additional recommendations in February 2025, incorporating grey literature. Additionally, Centers for Medicare & Medicaid Service (CMS) policy outlines were analyzed for cost impacts, given the high Medicaid enrollment among homeless individuals.

Inclusion & Exclusion Criteria

After a large number of duplicates were removed, 96 articles/documents were further reviewed. Subsequently, the titles and abstracts of the remaining article/documents were examined for relevancy and an additional 14 were excluded. Finally, article/documents were excluded if they focused on non-medical respite care, non-U.S. based programs, news announcements, non-homeless respite care, non-adult programs, or were non-English. The 31 remaining articles were then examined and read for this literature review (see Figure 1).

Figure 1. Study selection



Findings

Medical respite care programs were first begun in Europe and only relatively recently been developed in the United States. Furthermore, due to the slow development of such programs, it has only been in the last 15 years that outcome and impact studies could be conducted on different multiple sites and patterns can be discerned.

Medical respite care programs originated with Barbara McInnis House Boston and Christ House in Washington, D.C. in 1985, resulting in a 50% reduction in 90-day readmissions among complex patients (Belardo, 2022; Boston Health Care for the Homeless Program, 2023; Kertesz et al., 2009). Nonetheless, some subsequent studies showed mixed results with higher initial costs and readmission rates compared to self-care patients; however, adjusting for clinical complexity, medical respite could yield $1.81 in savings per dollar invested (Doran, 2013; Kertesz et al., 2009; NIMRC, 2021b). The following is an overview of findings looking at different aspects of medical respite and medical care utilization.

Hospital Readmissions

Reducing admissions is crucial, particularly for homeless populations with high rates of chronic conditions (Wang et al., 2021, Walton, 2024). Homeless individuals face readmission rates of 27.3% versus 17.5% for housed patients and are 57.2% more likely to visit the ED (Miyawaki et al., 2020). Medical respite referral further cuts hospital admissions by 49% (Buchanan, 2006). Long-term, the National Institute for Medical Respite Care (NIMRC, 2021a) reported that several studies that they reviewed showed an approximate 24% reduction in hospital admissions within a year post-respite, at just 5–10% of a hospital day's cost.

Length of Stay

Hospitals struggle with prolonged stays for homeless patients due to inadequate discharge options, affecting capacity and costs (Baek et al., 2018; Dirmyer, 2016). California mandates transitional care plans for homeless patients, creating logistical challenges (Young, 2020). Medical respite reduces hospital length of stay and follow-up admission stays from 8.3 to 3.7 days (Buchanan, 2006), helping alleviate these burdens.

Patient Experience

Homeless patients face post-discharge challenges, including poor hospital-community coordination, inadequate shelter support for medical needs, medication management barriers, and lack of transportation (Hadenfeldt, Todd, & Hamzhie, 2023; Leggio et al., 2020; Park et al., 2017; Zur, Linton, Mead, 2016). Medical respite addresses these by providing onsite care, case management, and stable recovery environments, improving patient outcomes and engagement.

Medical respite facilitates connections to community resources, increasing outpatient utilization threefold (Biederman, Modarai et al., 2019) and ensuring long-term care while reducing system- wide costs (NIMRC, 2021b).

Pilot studies show promising cost efficacy even with limited resources. In the VA's Hospital to Housing (H2H) program, staff received basic clinical training to support low-acuity patients, reducing ED and inpatient utilization by 67% and increasing primary care visits by 45% (Kinczewski, 2023). Similarly, a Durham, NC study found that among 29 patients, medical respite reduced hospital admissions by 37%, inpatient days by 70%, and overall care costs by 48.6% (Biederman, Gamble et al., 2019).

Impact on Quality Ratings

Centers for Medicare & Medicaid Service (CMS) ratings, hospital performance metrics, and financial incentives are influenced by utilization patterns (CMS, 2022; Kim et al., 2020).

High ED and readmission rates among homeless patients skew these metrics, risking reputational and financial penalties, while lower readmission rates correlated with higher operating margins and financial stability (Enumah, Resnick & Chang, 2022). Therefore, investing in transitional care solutions like medical respite can improve hospital quality scores and financial health (NIMRC, 2021b).

Case Study of Potential Savings: Catholic Charities & Providence Sacred Heart

In Spokane, WA, where 13.4% of residents live in poverty, Catholic Charities and Providence Health Care launched a single medical respite bed at a homeless shelter in 2012 (Robert Wood Johnson Foundation, 2017). The $7.28/night bed reduced costly hospital stays ($3,200/night). Some homeless individuals previously made 60–100 ER visits annually, prompting Providence to expand to 20 beds, saving $16 million in the first year (R. McCann, personal communication, 2023). Chronic homeless individuals in Spokane cost $50,000–$250,000 per year in public services, demonstrating respite's economic benefits (Sadowski, 2019).

The Need for Stable Funding

Despite proven benefits, medical respite lacks consistent funding. Medicaid covers medical care but not lodging, food, or transportation, necessitating private and grant funding (NIMRC, 2021). Often, local governments fund respite care programs, recognizing its cost- saving potential for EMS and emergency services (McAuliffe et al., 2022). For instance, Baltimore subsidizes 25% of its 25-bed respite program, with hospital partnerships (50%), grants (13%), and Medicaid (12%) covering the rest (NIMRC, 2021; NHCHC, 2017). Hospitals remain key funding sources, as respite frees beds, reduces costs, and meets nonprofit hospitals' Community Needs Assessment obligations (Cantor, 2020; NHCHC, 2017). With 59% of respite programs relying on hospitals for funding, securing a share of hospital cost savings could stabilize respite programs despite fluctuating Medicaid policies (NHCHC, 2017).

Medical respite programs typically require diverse funding sources, as only 23% operate from a single source, while 57% rely on three or more (NHCHC, 2017). Given their broad impact, diversified funding is logical. The NIMRC (2021) suggests that a collaborative, multi- stakeholder funding model can support larger, sustainable programs by sharing financial responsibility across communities.

Emotional Impact on Recipients

Medical respite care provides a safe environment for recovery, allowing patients to

focus on their health without worrying about basic needs like shelter and food. This stability improves their overall well-being and quality of life (National Health Care for the Homeless Council, 2022). A broader benefit of respite care is that it provides social support and companionship, which are essential for emotional well-being and improving the lived lives of the patients (Wu et al., 2022).

Improvement in Patient Trust

Medical respite care programs offer patients more autonomy in medical decision-making and engage them as partners in their care. Physicians report that this approach establishes greater dignity and trust with their patients (NHCHC, 2022). The trust gained through medical respite care leads to higher patient satisfaction and better health outcomes (Birkhäuer et al., 2017).

Conclusions

This literature review highlights the significant clinical and social benefits associated with medical respite care for the homeless. For instance, in regard to medical cost implications, numerous studies demonstrate significant cost savings of up to 50% as a result of significant reductions in ED visits, hospital admissions, length of stay, and readmissions among the homeless. For example, in a 20-bed program with Catholic Charities in Spokane, Washington, the acute care utilization decreases resulted in $16 million in healthcare saving during the first year. Additionally, there was a corresponding improvement in both hospital quality scores and financial health. Finally, the utilization changes in acute and inpatient care had significant impact on homeless individuals' healthcare behaviors. In particular, by providing shelter support for medical needs, medication management, transportation, patients became more compliant and shifted more to outpatient services. Consequently, these programs improve patient emotional well-being, trust with their medical providers, connection to community resources, and patient satisfaction. All of these benefits led to better health outcomes.

Stable funding remains a major challenge, especially during economic downturns. However, small-scale respite programs within existing resources have proven effective. Recognizing and utilizing the broad range of stakeholders—including hospitals, Medicaid/ Medicare, and emergency services—can help distribute financial responsibility and ensure sustained support for medical respite programs, improving healthcare for the homeless.

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Dr. Patrick Panos, MPH is an Associate Professor of Social Work at the University of Utah. With over 35 years of healthcare experience, he brings a strong foundation of community based participatory action research shaped by a commitment to social justice rooted in Jesuit educational values. In addition to direct care, he has played a key role in mentoring and training case managers, equipping them with the skills and compassion needed to navigate complex systems and provide client-centered support. His community efforts reflect a deep dedication to service, advocacy, and transformative care.