

MARYLAND ACCESS POINT HOSPITAL TRANSITION PROGRAM REPORT

September 10th , 2025

Executive Summary:

The Maryland Access Point Hospital Transition Program is an evidence-based program developed by the Maryland Department of Aging (MDOA) in partnership with Area Agencies on Aging (AAA) to support older adults and adults with disabilities in successfully transitioning from hospital settings back into the community. It offers care coordination services that bridge the hospital and community through providing person-centered assessments, streamlined access to community resources, and 120 days of follow-up to support a successful transition and reduce the risk of rehospitalization or institutionalization. The program assists participants by assessing their needs, connecting them with appropriate services, and helping them to develop care plans. Previous evaluations have shown that the program achieved a return on investment (ROI) and reduced hospital utilization and healthcare costs. This report synthesizes findings from REDCap intake and follow-up forms completed between March 2023 and June 2025, alongside aggregate Chesapeake Regional Information System for our Patients (CRISP) hospital utilization data for participants with complete three-month pre- and post-enrollment information between August 2023 and April 2025. The REDCap data collection forms were iteratively developed with extensive input from MAC Inc.'s Living Well Center for Excellence staff as they were the only active site at the inception of the evaluation. These datasets were used to assess service delivery patterns and estimate the program's overall ROI.

PROGRAM PARTICIPANTS:

- MAC Inc.'s Living Well Center for Excellence (MAC Living Well)
- 211 Maryland
- Worcester County Health Department Maryland Access Point (Worcester MAP)

SERVICE DELIVERY AND COSTS: Between March 2023 and June 2025, a total of 3,088 service units, at a cost of \$92,886.22, were delivered to Hospital Transition Program participants. MAC Living Well's program accounted for the majority of service delivery, providing 65.4% (n = 2,019) of total units and 60.3% (n = \$55,987.64) of total costs. The most frequently used service category across all three sites was Overall

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Care Management, which made up 57.4% (n = 1,722) of service units and 78.2% (n = \$72,652) of total costs. Notably, 866 instances of Overall Care Management services were recorded as being delivered on the same day as program referral, indicating a zero-day wait time. However, data on wait times for other services was inconsistently recorded, which limited the ability to assess timeliness of other service deliveries.

ROI RESULTS: Among 100 participants with complete CRISP data, the program generated an estimated net benefit of \$4,078.88 per member per month (PMPM). The program achieved a 2081% ROI, indicating a \$20.81 reduction in hospital-related costs for every \$1 spent on services. While these results are encouraging, they should be interpreted with caution due to limitations in data completeness and generalizability.

CONCLUSION: Findings from the Maryland Access Point Hospital Transition Program suggest that continued implementation may reduce hospital utilization and costs, with a potentially positive return on investment. To strengthen future evaluations and enhance program effectiveness in supporting Maryland's aging population, it will be important to improve data completeness and consistency in reporting service wait times while addressing other identified challenges.

Participant Overview

Participant data were directly entered into REDCap by staff members at Hospital Transition Program sites. This section summarizes data recorded between March 2023 and June 2025. Staff used the intake form to log participant enrollment, demographics, other characteristics, and additional variables relevant to program evaluation that will be discussed later in this report.

PARTICIPANT ENROLLMENT: MAC Living Well enrolled the highest number of participants, accounting for nearly half of all enrollments (n = 111, 49.6%; see Figure 1 and Table 1). 211 Maryland followed with 65 participants (29.0%), and Worcester MAP enrolled 48 participants (21.4%).

PARTICIPANT DEMOGRAPHICS: Slightly more than half of all participants identified as White (n = 125, 55.8%; see Figure 1 and Table 1), and 42.9% (n = 96) identified as Black or African American. Fewer than 2% of participants were Asian (n = 2, 0.9%) or reported another race (n = 1, 0.4%). Most participants identified as female (n = 128, 57.1%), while 42.9% (n = 96) identified as male. The largest age group was those aged between 66 and 75 years old, representing 36.9% (n = 80) of the total. This was followed by participants aged 76-85 (n = 59, 27.2%) and those aged 56-65 (n = 44, 20.3%).

Figure 1: Participant Enrollment

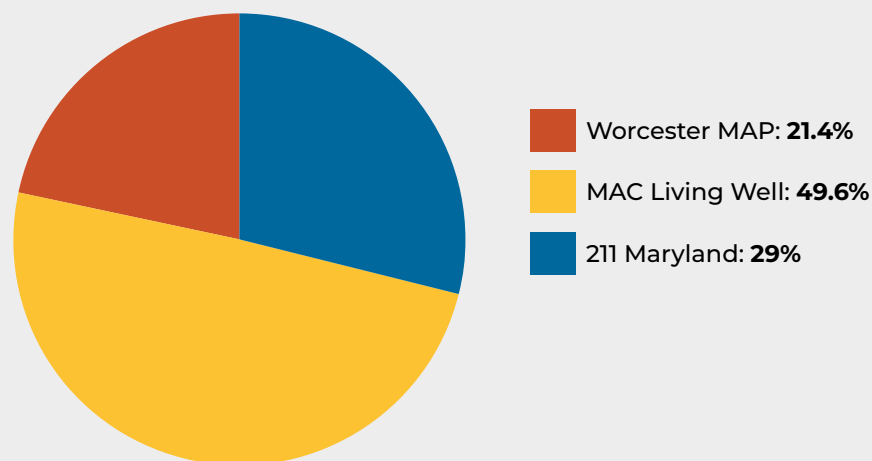


Table 1. Participant Enrollment Count and Demographics

Participant Demographics	Amount (%)
Site:	
MAC Living Well	111 (49.6)
Worcester MAP	48 (21.4)
211 Maryland	65 (29.0)
Race:	
White	125 (55.8)
Black/African American	96 (42.9)
Asian	2 (0.9)
Other	1 (0.4)
Ethnicity:	
Non-Hispanic/Latino	222 (99.1)
Hispanic/Latino	2 (0.9)
Gender:	
Female	128 (57.1)
Male	96 (42.9)
Age Group:	
18-39	1 (0.5)
40-55	8 (3.7)
56-65	44 (20.3)
66-75	80 (36.9)
76-85	59 (27.2)
85+	25 (11.5)
Missing	7 (3.1)

PARTICIPANT CHARACTERISTICS AT INTAKE: Other participant characteristics collected at intake included insurance type, Medicaid eligibility, under age 60 with a disability, veteran status, housing status, and living status. More than half of all participants were insured through Medicare with a supplemental plan (n = 71, 31.7%; see Table 2) or Medicare only (n = 52, 23.2%). Participants who were insured through Fully Dual Eligible (Community MA) (n = 26, 11.6%) or Medicaid (n = 22, 9.8%), followed. A similar proportion of participants (n = 22, 9.8%) were Partially Dual Eligible (QMB/SLMB). Fewer participants were covered by private insurance (n = 3, 1.3%), TriCare (n = 2, 0.9%), or Veterans Health Benefits (n = 1, 0.4%). Approximately 11.2% (n = 25) of participants reported having other insurance plans that were not listed on the form, which included: Humana Medicare Advantage, Humana Medicare, Medicare Advantage, CareFirst BCBS Advantage, Johns Hopkins Medicare Advantage, Medicare Part A only, Aetna Medicare Advantage, UHC Medicare Advantage, Alterwood Medicare Advantage, and employer-sponsored health coverage. Fewer than one-third of participants were eligible for Medicaid (n = 69, 30.8%).

Only 8.5% (n = 19) of participants were under age 60 with a disability and 5.4% (n = 12) identified as veterans. Regarding housing status, approximately one-third of participants rented (n = 76, 33.9%) or outright owned their home (n = 74, 33.0%). Additionally, 17.4% (n = 19) reported living in no-cost housing. The remaining participants owned their homes with a mortgage (n = 19, 8.5%), were without housing (n = 12, 5.4%) or lived in a rehabilitation or nursing home (n = 4, 1.8%). Nearly half of all participants (n = 107, 47.8%) reported living alone.

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Others lived with a spouse or partner (n = 43, 19.2%) or with their children (n = 38, 17.0%). The remaining 16.1% lived with either roommates (n = 21, 9.4%) or siblings (n = 15, 6.7%).

Table 2. Participant Characteristics at Intake

Key Characteristics	Amount (%)
Insurance Type:	
Medicare and Supplemental	71 (31.7)
Medicare Only	52 (23.2)
Fully Dual Eligible (Community MA)	26 (11.6)
Medicaid	22 (9.8)
Partially Dual Eligible (QMB/SLMB)	18 (8.0)
Privately Insured	3 (1.3)
Uninsured	3 (1.3)
TriCare	2 (0.9)
Veterans Health Benefits (VA)	1 (0.4)
Other	25 (11.2)
Unknown	1 (0.4)
Eligible for Medicaid:	
Yes	69 (30.8)
No	155 (69.2)
Under Age 60 with a Disability:	
Yes	19 (8.5)
No	205 (91.5)
Veteran:	
Yes	12 (5.4)
No	212 (94.6)
Housing Status:	
Rent	76 (33.9)
Own outright	74 (33.0)
No cost housing	39 (17.4)
Own with mortgage or loan	19 (8.5)
Homeless	12 (5.4)
Rehabilitation/nursing home	4 (1.8)
Living Status:	
Live alone	107 (47.8)
Live with spouse	43 (19.2)
Live with child/children	38 (17.0)
Live with roommate(s)	21 (9.4)
Live with sibling(s)	15 (6.7)

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REFERRAL SOURCE: Program sites used the REDCap intake form to document how participants were referred to the Hospital Transitions Program. Almost all participants were referred through a hospital (n = 219, 97.8%; see Table 3). A small number of participants were referred by a physician (n = 2, 0.9%) or through other sources (n = 3, 1.3%).

EARLY WITHDRAWAL: Program sites were instructed to record whether participants withdrew from the program prior to completing 120 days. Participant withdrawal status was assessed at each follow-up interval (30, 60, 90, and 120 days). A total of 76 participants withdrew early. Among these, the most common reasons were that participants were unresponsive (n = 31) or voluntarily opted out of the program (n = 20). Additional reasons included participants who passed away (n = 10), entered long-term care (n = 8), or were referred to services that were no longer available (n = 1). Four withdrawals were due to other reasons, including two participants who moved out of the state and two responses that were unclear.

Table 3. Referral and Early Withdrawal

Referral Source and Withdrawal Status	Amount (%)
Referral Source:	
Hospital	219 (97.8)
Other	3 (1.3)
Physician Referral	2 (0.9)
Early Withdrawal (multiple selections allowed) *:	
No	595
Yes	76
<i>Enrollee unresponsive</i>	31
<i>Enrollee choice</i>	20
<i>Enrollee expired</i>	10
<i>Enrollee entered LTC</i>	8
<i>Services referred unavailable</i>	1
<i>Other</i>	4
<i>Missing</i>	2

*Sites were asked at each follow-up interval (30, 60, 90, and 120 days) to report whether the participant had withdrawn from the program.

DAYS SPENT IN A COMMUNITY OR NON-INSTITUTIONAL SETTING: Sites also tracked the number of days each participant spent in a community or non-institutional setting.

- **MAC Living Well** recorded the highest total, with participants spending 14,692 days in non-institutional settings. Individual days ranged from 0 to 233, with an average of 134.8 days.
- **211 Maryland** followed with a total of 9,684 days. Individual days ranged from 30 to 312 days, with an average of 151.3 days.
- **Worcester MAP** recorded a total of 4,207 days. Individual days ranged from 0 to 315 days, with an average of 102.6 days.

Service Delivery and Costs

PROGRAM SERVICES OVERVIEW: The Hospital Transition Program offered 23 services to participants. These services were grouped into the categories below for analysis purposes. Categories were determined

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using data specific to the State of Maryland from the Older Americans Act Title III Total Expenditures by Total Service Units and other relevant materials provided by the program coordinator.

- **Nutritional Support (\$5 per meal):** Home-delivered meals
- **Transportation (\$70 per trip):** One-way transportation trips
- **Home Modifications (\$765.83 per project):** Minor home modifications
- **Housing (\$28.70 per day):** Housing (cost per day)
- **Counseling (\$40.06 per session):** Counseling services (including dietary), person-centered options counseling, National Family Caregiver Support Program, chronic disease self-management, and falls prevention classes
- **Overall Care Management (\$41 per visit):** Personal care services, skilled home health, information, referral, assistance, Community First Choice, waiver, Senior Care, Community for Life, Medicare-related benefits, counseling and subsidies, and in-home aide services
- **Other Services (\$18 per hour):** Chore services, medical alert services, and durable medical equipment

SERVICE UNITS AND COSTS: Between March 2023 and June 2025, a total of 3,088 units of service were recorded in REDCap as delivered to Hospital Transition Program participants, totaling \$92,886.22 in service costs. MAC Living Well's program accounted for the majority by delivering 2,019 units (65.4%) at a cost of \$55,987.64 (60.3%) (see Table 4). Worcester MAP delivered 737 units (23.9%) at a cost of \$21,458.89 (23.1%) while 211 Maryland provided 332 units (10.8%) totaling \$15,439.69 (16.6%). Across all sites, the most frequently utilized service category was Overall Care Management, with 1,722 units (57.4%) delivered at a total cost of \$72,652 (78.2%) (see Figures 2 and 3). The second most utilized service overall was Nutritional Support, with 1,112 units (36.0%) provided at a total cost of \$5,560.00 (6.0%). Transportation services were the next most used service by participants at 211 Maryland (n = 53 units, 16.0%; \$3,710, 24.0%) and Worcester MAP (n = 44 units, 6.0%; \$3,080, 14.4%) (see Table 5). MAC Living Well Counseling services were the next most utilized, with 38 units (1.9%) delivered at a cost of \$1,531.66 (2.7%). Counseling also represented 2.8% (n = 21) of services delivered to Worcester MAP participants (\$841.26, 3.9%), while no Counseling services were used by 211 Maryland participants. Few participants across all sites used Other Services (n = 30 units, 1.0%; \$540.00, 0.6%), Housing (n = 11, 0.4%, \$315.70, 0.3%), and Home Modifications (n = 6, 0.2%; \$4,594.98, 4.9%) (see Figures 2 and 3).

Figure 2: Total Units of Services Delivered Across All Sites (as a %)

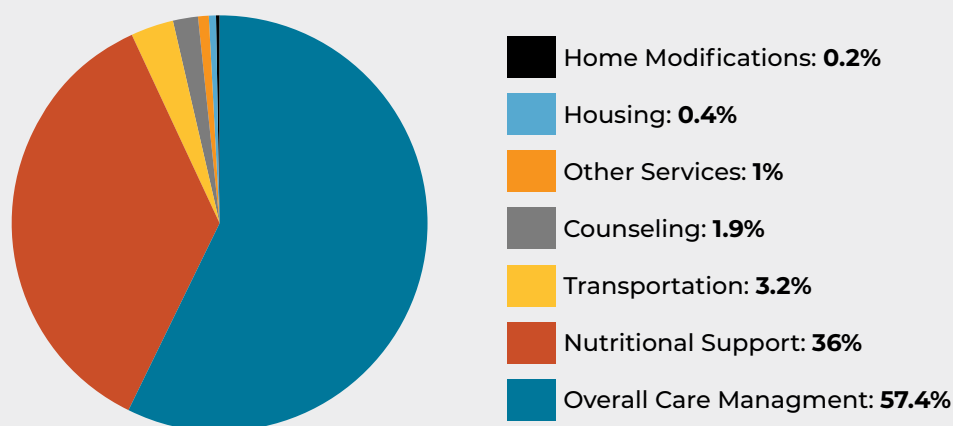


Table 4. Total Units of Services Delivered by Site

Sites and Services	Amount (%)
MAC Living Well	2,019 (65.4)
Overall Care Management	1,188 (58.8)
Nutritional Support	775 (38.4)
Transportation	1 (0.0)
Home Modifications	2 (0.1)
Housing	1 (0.0)
Counseling	38 (1.9)
Other Services	14 (0.7)
Worcester MAP	737 (23.9)
Overall Care Management	365 (49.5)
Nutritional Support	288 (39.1)
Transportation	44 (6.0)
Home Modifications	1 (0.1)
Housing	4 (0.5)
Counseling	21 (2.8)
Other Services	14 (1.9)
211 Maryland	332 (10.7)
Overall Care Management	219 (66.0)
Nutritional Support	49 (14.7)
Transportation	53 (16.0)
Home Modifications	3 (0.9)
Housing	6 (1.8)
Counseling	0 (0.0)
Other Services	2 (0.6)

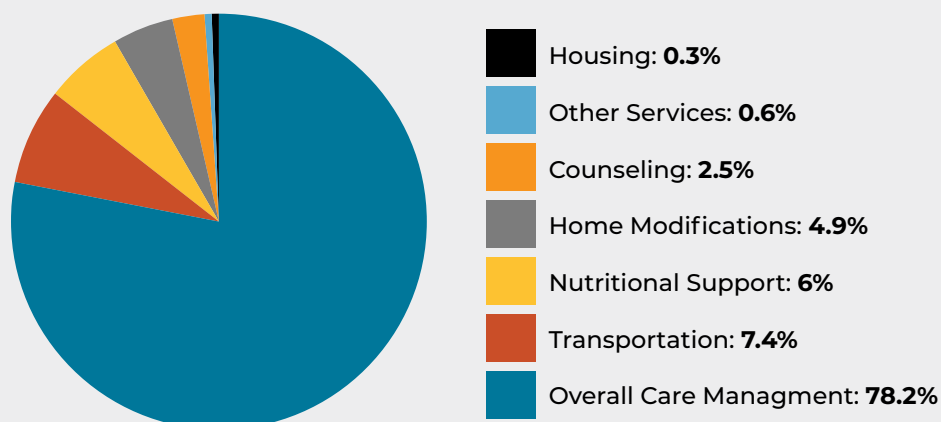
Figure 3: Total Costs of Services Delivered Across All Sites (as a %)


Table 5. Total Cost of Services Delivered by Site

Sites and Services	Amount (%)
MAC Living Well	\$55,987.64 (60.3)
Overall Care Management	\$48,708.00 (87.0)
Nutritional Support	\$3,875.00 (6.9)
Transportation	\$70.00 (0.1)
Home Modifications	\$1,531.66 (2.7)
Housing (cost per day)	\$28.70 (0.1)
Counseling	\$1,522.28 (2.7)
Other Services	\$252.00 (0.5)
Worcester MAP	\$21,458.89 (23.1)
Overall Care Management	\$14,965.00 (69.7)
Nutritional Support	\$1,440.00 (6.7)
Transportation	\$3,080.00 (14.4)
Home Modifications	\$765.83 (3.6)
Housing (cost per day)	\$114.80 (0.5)
Counseling	\$841.26 (3.9)
Other Services	\$252.00 (1.1)
211 Maryland	\$15,439.69 (16.6)
Overall Care Management	\$8,979.00 (58.2)
Nutritional Support	\$245.00 (1.6)
Transportation	\$3,710.00 (24.0)
Home Modifications	\$2,297.00 (14.9)
Housing (cost per day)	\$172.20 (1.1)
Counseling	\$0 (0.0)
Other Services	\$36.00 (0.2)

SERVICE WAIT TIMES: Wait times between service referrals and start dates were calculated using data recorded in the REDCap forms. However, services that should have been entered as newly started with referral and start dates were instead logged as continuing services, or the date fields were missing data. As a result, the available data offers a partial snapshot of wait times.

- **Overall Care Management:** There were 866 instances in which service began on the same day as referral (0-day wait). Other documented wait times included 2, 5 (two instances), 7, 12, 21, 29, and 30 days. Thirty-five instances were missing a service start date, and seven additional instances were excluded due to inconsistent data.
- **Nutritional Support:** Three instances of service began on the same day as the referral. The remaining documented wait times were 7, 9, 14, 33, 51, and 60 days. Twenty-three referrals were missing a service start date.
- **Transportation:** Two instances began on the same day as referral. Other wait times included 1, 16, and 21 days. Eleven referrals lacked a corresponding start date.
- **Home Modifications:** Wait times were 0, 18, and 41 days across three service instances. Four instances were missing a service start date.

- **Housing:** Eight instances of service began on the same day as referral. Five instances lacked service start dates.
- **Counseling:** Nineteen instances began on the same day as referral. Other wait times included 29 and 31 days. Fourteen referrals were missing start dates.
- **Other Services:** Nine instances began on the same day as referral. Additional wait times were 1, 17, 22, and 41 days. Twelve instances of referrals lacked start dates.

Hospital Utilization and Return on Investment

Program sites were asked to submit CRISP data on participants' aggregate hospital utilization and associated costs. Hospital utilization data was provided by MAC Living Well and Worcester MAP after obtaining consent from participants to be included in the panel results. 211 Maryland did not provide any hospital utilization data therefore their participants' data are not included in the following analysis. Service units and costs were used in addition to aggregate hospital utilization data to determine the ROI. Results were generated using the Commonwealth Fund's ROI Calculator for Healthcare Partnerships to Address Social Needs which are presented and discussed in this report. Cumulative totals were manually calculated by summing and averaging hospital utilization and cost data across all relevant categories, and cross checked using the ROI calculator. MAC Living Well submitted five usable CRISP panels for analysis that cover time periods for participants with available hospital utilization data that allowed for a full three-month pre- and post-enrollment analysis between August 2023 and April 2025. Worcester MAP submitted one usable CRISP panel with a three-month pre- and post-analysis timeframe between October 2024 and April 2024.

ROI CALCULATOR SETUP: The first step in using the Commonwealth Fund ROI calculator was to input all services delivered by the program, categorized as Nutritional Support, Transportation, Home Modifications, Housing, Counseling, Overall Care Management, and Other. To account for the expected impact of these services on medical utilization, hospital admissions was the selected domain. While other options such as hospital readmissions, skilled nursing/rehab facility admissions, emergency department visits, falls, and outpatient visits were available to choose from, hospital admissions were the only metric available for the analysis. All medical utilization values were taken from CRISP panels and reflected hospital use at three months pre- and post- enrollment. Each panel included a relatively small sample size, ranging from 8 to 27 participants; therefore, hospital admissions were scaled to represent a rate of one year per 100 members. The average length of stay per hospital admission was entered as 5.5 days, based on 2021 estimates for community-dwelling adults aged 65+ who were not Medicare beneficiaries.¹ The average cost per hospital day was calculated using pre-enrollment total hospital charges from CRISP data and converted to a PMPM value. The estimated high-need, high-cost population was set at 1,500, which represents the number of individuals MDOA aims to serve through this program. Service unit and cost data were taken from data recorded in REDCap and scaled to PMPM values for entry into the calculator. Finally, expected changes in hospital admissions and cost per admission were used to calculate the overall percent reduction in utilization and medical costs.

HOSPITAL UTILIZATION DATA: A summary of hospital utilization across both program sites is presented in Table 6. Across both program sites, a total of 100 members hospital utilization data were included in CRISP panels with 228 pre-enrollment hospital visits, 146 post-enrollment hospital visits, \$2,187,583 pre-enrollment charges, and \$905,130 post-enrollment charges recorded. While each site's panel showed reductions in hospital visits post-enrollment, the magnitude of this change varied. These aggregate values were scaled to a PMPM basis when appropriate to meet input requirements of the ROI calculator.

¹ Medicare Payment Advisory Commission. Report to the Congress: Medicare payment policy (Chapter 3: Hospital inpatient and outpatient services). Washington, DC: MedPAC, March 2024. https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch3_MedPAC_Report_To_Congress_SEC-1.pdf

Table 6: Hospital Utilization Data, CRISP Pre/Post Analysis

Site and Time Period	Member Count	Visits (pre)	Visits (post)	Charges (pre)	Charges (post)
MAC Living Well					
Aug 23 – Feb 24	27	80	44	\$750,891	\$281,463
Nov 23 – May 24	23	61	39	\$502,888	\$193,575
Jan 24 – Jul 24	10	24	16	\$251,960	\$69,400
May 24 – Nov 24	8	13	8	\$152,501	\$30,738
Oct 24 – Apr 25	23	22	21	\$304,611	\$238,874
Worcester MAP					
Oct 24 – Apr 25	9	28	18	\$224,732	\$91,080
Total	100	228	146	\$2,187,583	\$905,130

ROI RESULTS: Hospital utilization data were collected for 100 participants using CRISP panels, which included three months pre-enrollment and three months post-enrollment data. These values were scaled to calculate estimates of annual PMPM hospital charges and service delivery costs. Based on these estimates, the cost of delivering social services to 100 participants was estimated at \$195.96 PMPM (see Table 7). Pre-enrollment hospital charges averaged \$7,291.94 PMPM and post-enrollment charges decreased to \$3,017.10 PMPM. After accounting for the cost of services, this resulted in a total reduction of \$4,274.84 PMPM. A net benefit of \$4,078.88 PMPM was calculated by subtracting the cost of services from the reduction in hospital charges. This yields a ROI of 2081%, which indicates that for every \$1 spent on delivering services, there was a \$20.81 reduction in costs related to hospital utilization charges.

The estimated benefit per panel varied by time period and site. The highest return was observed among 10 participants from MAC Living Well with hospital utilization data available from January through July 2024, which allowed for a full three-month pre- and post-enrollment analysis. The program spent an estimated \$81.51 PMPM on delivering social services during this period. Hospital charges decreased from \$8,398.67 pre-enrollment to \$2,313.33 PMPM post-enrollment. A net benefit of \$6,003.82 PMPM was calculated by subtracting the cost of services from the reduction in hospital charges. The ROI of 7365% indicates that for every \$1 spent on services, there was a \$73.65 reduction in costs related to hospital utilization charges.

The second highest return was observed among eight participants from MAC Living Well with hospital utilization data from May to November 2024. During this period, the program spent an estimated \$157.58 PMPM on social services. Hospital charges declined from \$6,354.21 pre-enrollment to \$1,280.75 PMPM post-enrollment, yielding a net benefit of \$4,915.88 PMPM. This translates to a 3119% ROI, meaning each \$1 spent corresponded to a \$31.19 reduction in hospital-related costs.

For 27 participants from MAC Living Well with data available between August 2023 and February 2024, the program spent an estimated \$213.14 PMPM on delivering services. Hospital charges dropped from \$9,270.26 to \$3,474.86 PMPM. This resulted in a \$5,582.26 PMPM net benefit and an ROI of 2619%.

Among nine Worcester MAP participants with data from October 2024 to April 2025, service delivery costs averaged \$267.76 PMPM. Hospital charges fell from \$8,323.41 to \$3,737.33 PMPM. This resulted in a net benefit of \$4,682.31 PMPM and a 1748% ROI.

In the November 2023 to May 2024 timeframe, the program spent an estimated average of \$298.14 PMPM on 23 MAC Living Well participants. Hospital charges decreased from \$7,288.23 to \$2,805.43 PMPM. This led to a \$4,184.65 PMPM net benefit and an ROI of 1403%.

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For 23 MAC Living Well participants tracked between October 2024 and April 2025, the program spent an estimated \$108.62 PMPM on service delivery. Hospital charges declined from \$4,414.65 to \$3,461.94 PMPM, yielding a net benefit of \$844.09 PMPM and an ROI of 777%.

Table 7: ROI Results

Site and Time Period	Member Count	Service Cost PMPM	Net Benefit	ROI%*
MAC Living Well				
Aug 23 – Feb 24	27	\$213.14	\$5,582.26	2,619%
Nov 23 – May 24	23	\$298.14	\$4,184.66	1,403%
Jan 24 – Jul 24	10	\$81.51	\$6,003.82	7,365%
May 24 – Nov 24	8	\$157.58	\$4,915.88	3,119%
Oct 24 – Apr 25	23	\$108.62	\$844.09	777%
Worcester MAP				
Oct 24 – Apr 25	9	\$267.76	\$4,682.31	1,748%
Cumulative	100	\$195.96	\$4,078.88	2,081%
*ROI values are expressed as percentages that reflect how many dollars are returned for every \$1 spent. For example, an ROI of 2619% means every \$1 spent returns about \$26.19.				

ACCOUNTING FOR UNCERTAINTY IN THE ROI: The Commonwealth Fund's ROI Calculator for Healthcare Partnerships to Address Social Needs includes an optional tool that simulates financial impacts from two types of uncertainty that organizations may face. The first is cost uncertainty regarding the expenses of providing social services and the second is uncertainty regarding the effectiveness of social services. The accounting for uncertainty tool was unavailable at the time of analysis; therefore, simulations could not be generated.

STRENGTHS AND LIMITATIONS: Comprehensive REDCap data collection provided detailed information on participant demographics, service units, and associated costs. This data allowed for a clear understanding of the magnitude of services delivered across participating sites. Additionally, the inclusion of CRISP data provided the most accurate assessment of hospital utilization and costs for participants across the timeframes examined. At the same time, there were several limitations to this analysis. Wait times between service referral and start were not consistently tracked. Staff turnover during the reporting period likely contributed to variation in data entry practices. Additionally, CRISP data for 211 Maryland participants was unavailable and participant IDs could not be matched for four of the five panels submitted by Worcester MAP, making them unusable for ROI analysis. It is important to interpret these findings with caution. The analyses are based on small samples and relatively short observation periods, which may overstate the financial benefit and limit the ability to draw broader conclusions. Additionally, reductions in hospital utilization may be influenced by factors unrelated to program participation, such as natural improvements in health status. Given the high cost of hospital care for this population, even modest declines in admissions can result in significant savings. While the results are encouraging, they may not reflect the true net benefit under broader or longer-term conditions.