Reducing Readmissions, Cutting Costs, Restoring Independence

Evidence from Maryland's Hospital Transitions Program

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Executive Summary

The Hospital Transitions Program (HTP), sponsored by the Maryland Department of Aging (MDoA) and the University of Maryland School of Medicine, was a 1-year pilot with Maryland Information Network to reduce preventable hospital readmissions among Medicaid- and Medicare-eligible older adults and adults with disabilities. These populations experience disproportionately high hospital utilization and face major barriers in accessing community-based supports. Maryland Information Network, administrator of the 211system, was selected to implement the program based on its unique role as a single digital access point for statewide hospital referrals, its breadth of community resource data, and its data-sharing capabilities.

HTP enrolled 62 participants, delivering intensive, person-centered support for 120 days after hospital discharge. Care coordinators guided patients through waiver enrollment, paperwork, insurance navigation, and access to essential services. Analysis through data sharing with Chesapeake Regional Information System for our Patients (CRISP) showed a 23 percent reduction in hospital visits within the first month and a 5 percent reduction at three months. While the declines in visits may appear modest, they translated into a 73 percent and 56 percent reduction in total medical costs, respectively, demonstrating a measurable return on investment for both hospitals and public payers. However, without sustained engagement these gains diminished with utilization and costs rising once program supports ended. This pattern demonstrates that hospital-to-community transition supports cannot be limited to a short intervention window. Additionally, the improved dignity and independence for participants proved that targeted community stabilization can both save money and change lives.

Introduction

The Hospital Transitions Program (HTP) was designed to address one of the most pressing challenges facing Maryland's health and human services system: reducing preventable hospital readmissions among older adults and adults with disabilities who are dually eligible for Medicaid and Medicare. The program exclusively served individuals aged 60 and older, as well as adults aged 18 and older living with disabilities, recognizing that these populations experience disproportionately high rates of hospital utilization and encounter significant barriers in navigating community-based supports.

Across its implementation, HTP enrolled 62 participants, the majority of whom identified as Black, were over the age of 60, concentrated in the Baltimore metropolitan region, and heavily represented

within the Medicare fee-for-service system. This enrollment profile demonstrates strong alignment with the priorities of the Older Americans Act and highlights the program's focus on equity and on the populations most likely to experience both complex health needs and social vulnerability.

The program model combined a person-centered approach with structured Social Determinants of Health (SDOH) screenings, motivational interviewing techniques, and individualized care planning. Care coordinators often engaged with participants multiple times per week to assist with paperwork, insurance navigation, waiver enrollment, and access to medical supplies and in-home supports. This intensive, hands-on engagement later proved to be critical in preventing unnecessary readmissions.

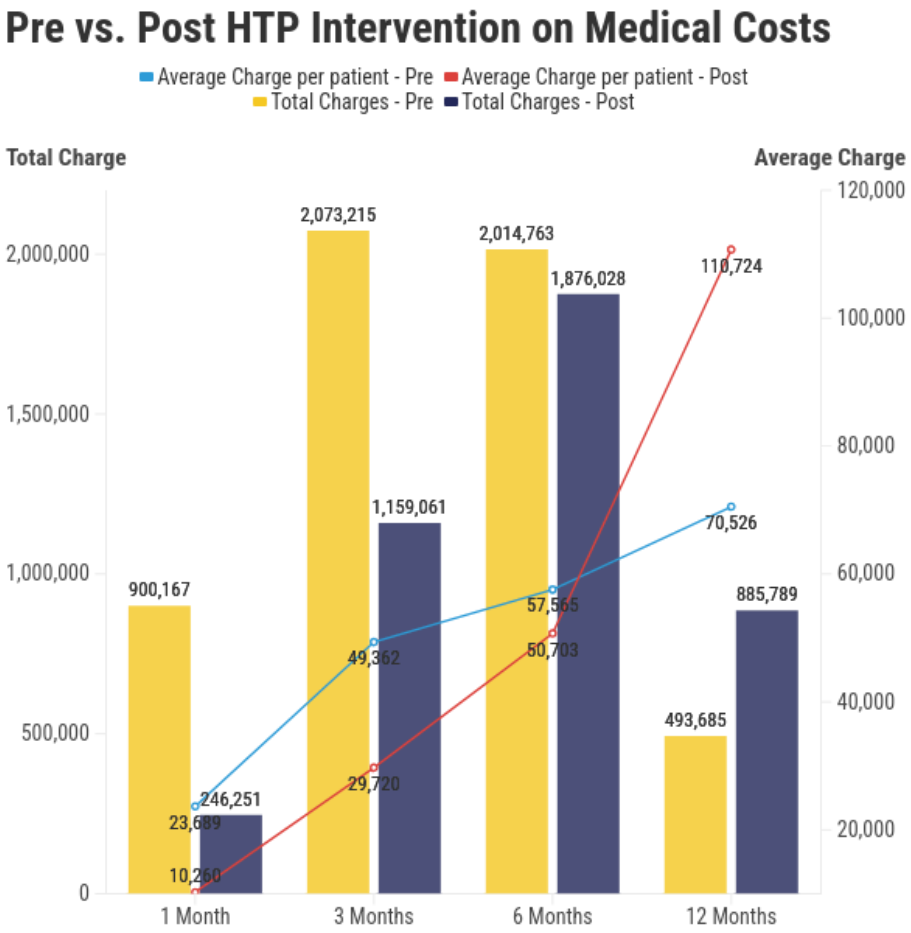
Program Participants and Demographics

The Hospital Transitions Program (HTP) served 62 participants, all of whom were Medicaid- or Medicare-eligible older adults (60+) or adults with disabilities (18+). This population represents those at highest risk for hospital readmission and most in need of coordinated community supports. More than 70 percent of participants were 60 and older, with the majority over 65. Among those with reported data, 62 percent were female and nearly two-thirds identified as Black/African American. Geographically, the program was concentrated in the Baltimore metropolitan area, with Baltimore County, Baltimore City, and Anne Arundel County accounting for nearly three-quarters of enrollees.

These demographics illustrate HTP's focus on a high-need, high-cost population where effective transition supports can produce meaningful improvements in both health outcomes and cost savings.

Cost Impact and Return on Investment

Hospital utilization data revealed significant cost implications. In the first month after enrollment, average charges per patient fell from $23,689 pre-enrollment to $10,260 post-enrollment, reflecting $13,428 in avoided costs per patient. At three months, the pattern continued, with charges dropping from an average of $49,362 pre-enrollment to $29,720 post-enrollment. Across the panel of participants, these reductions represented thousands of dollars in avoided hospital charges during the most vulnerable post-discharge period. At six months, just two months after program supports ended, cost savings slowed with average savings per patient reduced to $6,861. These savings are particularly meaningful given that all participants were Medicaid- or Medicare-eligible. By lowering preventable readmissions, HTP directly reduced costs for public payers and relieved financial pressure on hospitals subject to readmission penalties.



Net Return on Investment. With a total program cost of $220,000, the prorated cost for the 120-day period was approximately $73,333. Subtracting this investment from approximately $1.6 million in gross savings yields a **net savings of more than $1.5 million.** This translates to an **ROI of 22:1**, meaning every dollar invested in HTP returned twenty-two dollars in avoided hospital costs. The short-term cost impact demonstrates that early, intensive community stabilization is not only clinically effective but also fiscally responsible.

1.6M	1.5M+	22:1
Total Avoided Charges (120 days)	Net Savings (120 days)	Return on Investment

However, the data also showed that these gains did not sustain long after program supports ended. At twelve months, charges per patient post-intervention had risen to $110,724 on average, reflecting negative savings of $40,197 compared to pre-program levels. This sharp rebound underscores a critical reality: programs like HTP must extend well beyond the initial 120-day window if long-term cost savings and patient stability are to be preserved.

It should be noted that participants entered the Hospital Transitions Program on a rolling basis for eight months. As a result, early data points (1–3 months) reflect outcomes for the full cohort of participants, while later data points (6–12 months) reflect only those who had entered the program early enough for measurement. The strongest ROI findings therefore come from the first 120 days, when the full cohort was engaged and over $1.5 million in avoided charges were achieved.

The financial analysis validates hospital-to-community transitions as a high-value intervention. When patients were supported through the critical first 3 months, the program significantly reduced hospital charges. Sustained investment in extended transition supports could translate these short-term cost savings into lasting system-wide impact.

"On The Ground"

While data offers critical evidence of program effectiveness, the day-to-day experience of the Hospital Transitions Program (HTP) was defined by direct, personal engagement with participants. The care coordinator's perspective provides valuable insight into how the program's design translated into meaningful change for vulnerable individuals.

The HTP model emphasized motivational interviewing, person-centered planning, and Social Determinants of Health (SDOH) screenings. These approaches allowed participants to identify their own priorities while giving the coordinator a framework for tailoring care plans. A central lesson from implementation was that the first thirty days following hospital discharge require decisiveness. During this "bridge period," participants often needed intensive, hands-on support, sometimes requiring multiple touch points each week. Assistance ranged from completing insurance paperwork and navigating state waiver applications to coordinating medical supplies and arranging in-home supports. This early engagement proved critical in preventing unnecessary readmissions and setting a foundation for longer-term stability.

The program produced numerous success stories that illustrate both health impact and restored independence. One recurring achievement involved helping participants secure long-delayed approvals for the state waiver program. Many participants had begun the application process months earlier but became stuck in paperwork or lacked the support to navigate multiple agencies. HTP stepped in to expedite those applications, often moving them from "pending" to "approved" in a matter of weeks. These approvals unlocked in-home supports that allowed participants to remain safe at home, directly preventing unnecessary returns to the hospital.

Regaining Independence

One HTP client, living with HIV and coping with an amputation, was discharged home to unsafe conditions. Without grab bars, he risked falling every time he entered the bathroom. Chronic wounds were left untreated, creating the likelihood of another hospital stay. He had no dentures, leaving him unable to eat properly, and the combination of poor health and isolation drained his confidence.

As the care coordinator, I intervened on several fronts. I persuaded his property management company to install grab bars, stabilizing his home environment.

I connected him to wound care that promoted healing and prevented readmission. Through advocacy with partner agencies, I secured dentures at no cost, restoring his ability to eat and improving his nutrition. With these basics in place, I was able to help him apply for work, leading to employment at Walmart.

In just a few months, my client moved from daily risk and dependence to stability, income, and renewed dignity. My client's success proves the impact targeted support can have to break the cycle of hospital readmission and transform lives. – Care Coordinator, Hospital Transitions Program

Other participants benefited from home modifications, enrollment in waiver programs, and access to therapeutic services. For many, the consistent social contact provided by the program reduced isolation and promoted emotional well-being. By reducing loneliness and ensuring participants stayed engaged with care plans, HTP lowered the risk that unmanaged conditions would escalate into hospital visits. In fact, participants frequently expressed disappointment when the program ended, underscoring how important continuity and social connection were to their overall stability.

Despite these challenges, the coordinator's reflections reveal a program that delivered far more than transactional services. Sometimes the greatest intervention was simply being present in conversation reminding participants they were not alone. This human connection, combined with structured assessments and persistent advocacy, created tangible health benefits and meaningful improvements in dignity and independence.

At the same time, several barriers challenged service delivery. Family members were often the source of referrals, and while participants provided consent, the perspectives of adult children, spouses, or powers of attorney did not always align with participant preferences. This required careful navigation to keep services person-centered. Reporting systems also created challenges. The REDCap platform's fields did not allow coordinators to capture advocacy efforts, incremental progress, or avoided emergency department visits. Similarly, CRISP data delays meant that measurable return-on-investment (ROI) evidence was not available in real time, even when participant outcomes clearly demonstrated success.

Barriers, Lessons Learned and Recommendations

The Hospital Transitions Program highlighted not just program-specific challenges, but larger system barriers that shape outcomes for Medicaid- and Medicare-eligible older adults and adults with disabilities. Addressing these barriers at the state and community level is essential for reducing preventable hospital readmissions and supporting long-term stability.

Barriers

- **Fragmented Service Access:** participants often waited weeks or months for waiver approvals, home modifications, or medical equipment. These gaps left them vulnerable during recovery. Without faster access to stabilizing supports, hospitals bear the cost of preventable readmissions that could otherwise be avoided through timely community-based interventions.
- **Rigid Data Systems:** The designated platform used for reporting restricted capture of the full scope of case management activities. Checkboxes did not reflect process milestones such as "application pending," advocacy efforts, or avoided hospitalizations. This understates the breath of impact, creating limited visibility to policymakers and program designers seeking to identify and scale what works.
- **CRISP Panels:** Technical issues delayed access to hospital utilization data. Initial runs returned far fewer patients than expected, limiting the ability to produce timely return-on-investment (ROI) data for external evaluation.
- **Program Duration:** HTP services were designed as a time-limited intervention. While highly effective in the first 30–90 days, outcomes diminished once support ended, leaving many participants vulnerable to readmission after six to twelve months. Gains achieved early in the

program eroded without sustained engagement, driving higher long-term costs to Medicare and Medicaid.
- **Family vs. Participant Priorities:** Family members or powers of attorney were often deeply involved in care planning. At times, family expectations conflicted with the participant's expressed goals, requiring careful navigation to keep care plans person-centered and prevent conflict from triangulation. Without structures that center participant choice while constructively engaging families, care planning can be destabilized, undermining outcomes and risking readmission.

Lessons Learned

- **The first thirty days after discharge are critical.** Intensive engagement during this bridge period prevented readmissions and set a foundation for stability.
- **Narrative outcomes matter.** Building trust, reducing isolation, and resolving systemic barriers such as waiver delays were as critical as securing a specific service. These outcomes must be better captured in reporting systems.
- **Interoperability is essential.** Without seamless data integration between hospital and community systems, or a defined intermediary, it is difficult to quantify and respond to impact in real time.
- **Consistency is valuable**. Many expressed disappointment when the program ended, underscoring the importance of consistent community support for sustained health outcomes.

Recommendations

1. **Formalize a 30-Day Bridge Protocol:** Build an intensive engagement model for the first month post-discharge, with structured check-ins multiple times per week.
2. **Extend Program Duration:** Extend services beyond the initial 120-day intervention window to preserve the gains achieved during the transition period and prevent the resurgence of readmissions at the 6–12 month mark.
3. **Strengthen Interoperability:** Centralize reporting tools or develop interoperability to reduce multiple system use by coordinators and improve timely ROI evidence.
4. **Sustain Through Funding Alignment:** Pursue Medicaid/Medicare reimbursement and hospital cost-sharing models to secure financial sustainability.

Conclusion

The Hospital Transitions Program demonstrated that intensive, person-centered interventions during the first thirty days post-discharge can significantly reduce readmissions and associated costs for Medicaid- and Medicare-eligible older adults and adults with disabilities. The evidence points to the need for continued investment and expansion, ensuring that Maryland can build on these proven short-term gains and deliver sustainable, long-term improvements in health outcomes and system costs. The challenge now is how to extend and sustain it. With targeted investment, Maryland can transform these short-term gains into long-term system savings and improved quality of life for some of its most vulnerable residents.