OPEN ACCESS MODEL EVALUATION

DECEMBER 2025

BHRT
The Behavioral Health Resources & Technical Assistance Program

University of Maryland Baltimore

Prepared by:

Fadia Shaya, Ph.D., MPH
Distinguished University Professor and Executive Director

Nicole Sealfon, MPH
Associate Director

Rana Karslioglu
Public Health Research Specialist

Md Fitrat Hossain, PhD
Post Doctoral Fellow

L. Yesenia Rodriguez Tanta, PharmD, MSc
PhD Student

Taraneh Mousavi, PharmD
PhD Student

University of Maryland Baltimore

BHRT
The Behavioral Health Resources & Technical Assistance Program

Table of Contents

Background

Summary of the Open Access Model

Through the Health Service Cost Review Commission's Regional Partnership Catalyst Program funding, Behavioral Health System Baltimore provided one-year seed funding to outpatient behavioral health programs to support the adoption of the Open Access model. The Open Access model provides flexible scheduling for same-day or next-day appointments for clinicians to see individuals who have an urgent behavioral health need. The array of services includes counseling, screening, de-escalation and stabilization support, assessment, prescribing if appropriate, and facilitating engagement in ongoing treatment.

There were three cohorts of outpatient clinics that received seed funding to implement the Open Access model:

1) Cohort 1: 5 clinics from April 2022 - March 2023
2) Cohort 2: 13 clinics from September 2022 – August 2023
3) Cohort 3: 17 clinics from January 2024 - December 2024

The goal of the Open Access model is to give consumers more control and convenience over their behavioral health services while increasing system capacity to address behavioral health emergencies in a community setting. Open Access appointments are available to anyone who presents with an urgent behavioral health need. The 988 Helpline, which provides free 24/7 emotional support by trained counselors, also refers consumers to the Open Access appointments through a secure portal.

Evaluation Results of the Open Access Model

The Open Access model evaluation explored whether the Open Access model improved access to care, quality of services provided, and whether the model is self-sustaining or needs additional resources for sustainability. The evaluation assessed the consumer experience, staff experience, access and referral intake, revenue, and overall sustainability of the model.

Methods

Staff Experience

Members of the Behavioral Health Resources and Technical Assistance (BHRT) Program at the University of Maryland Baltimore conducted key informant interviews (KII) with staff from the participating clinics who have adopted the Open Access model. Behavioral Health System Baltimore (BHSB) provided the contact list of the 37 clinics that participated. BHRT recruited participants via email and scheduled interviews with staff. BHRT interviewed staff from 33 of the 37 clinics. Interviewees consisted of the owners of the clinics, psychiatrist/psychologist/therapist, nurse practitioners and nurses, and administrators and support staff that were employed during the time of the program.

During the data analysis, BHRT focused on identifying recurring and significant themes to identify patterns that describe the content of the individual interviews. The interviews assessed the participants' overall experience with the Open Access model, and recommendations for the program.

Wait times and Consumer Satisfaction

The clinics who received seed funding worked with a consultant, CMAG & Associates, on implementation and data collection. CMAG collected the data on wait times and centralized it in a project documentation repository. Wait times data were updated monthly and quarterly and submitted by medical center representatives. We created a database to consolidate all wait time entries from the health facilities. Data were extracted, cleaned, and organized into a unified structure by health facility, cohort, and county. This dataset served as the sole source for analysis. We describe the wait times across five sub-activities: referral to intake (I), intake to assessment (A), assessment to the first clinician appointment (CA1), CA1 to second clinician appointment (CA2), and assessment to prescriber appointment (PA). Additionally, CMAG obtained information about consumer satisfaction from some of the clinics. Consumer satisfaction was assessed by representatives using a scale with a maximum score of 5 points, with higher scores indicating greater satisfaction.

Access and Referrals

Data about consumers who were referred by the 988 helpline were collected from January to December for the year 2024 and from January to March for the year 2025. These data are related to the number of referrals which were approved or rejected and the reasons for rejection. It also included data related to no shows to the appointments and the number of consumers who completed their appointments and are in ongoing treatment.

Data regarding consumers who called the clinics directly were collected for Cohort 1, Cohort 2, and Cohort 3. These were related to the total number and average number of consumers served per week. In Cohort 1, there were five facilities with data from January 2023 to March 2023. For Cohort 2, it included the facilities from Cohort 1 in addition 13 facilities and data were collected from January 2023 to August 2023. In Cohort 3, there were 14 facilities with data available from July 2024 to December 2024.

Descriptive summary statistics were used. No statistical inferences were made.

Results/Findings

Clinic Staff Experience of the Open Access model

Workflow Integration and Improvement

Across all cohorts, clinics consistently reported the importance of integrating the Open Access model into their existing operations rather than building a new workflow. Early in implementation, many clinics experienced temporary interruption as they adjusted scheduling, intake, and documentation processes to meet same-day or access expectations. Cohort 1 clinics, particularly in Carroll and Howard counties, described these adjustments as inconvenient and initially confusing, stating that staff needed extra time to merge Open Access with existing intake systems. Cohort 2 clinics showed gradual improvement as staff learned to manage the new pace and developed structured appointment scheduling procedures. By Cohort 3, most clinics, especially Baltimore City and Baltimore County, reported that Open Access had become a part of their normal operations. They cited smoother scheduling, better task completion, and fewer workflow interruptions. Baltimore City clinics reported the heaviest client flow and difficulty maintaining pace. Overall, participants agreed that once integrated, the Open Access model improved efficiency and client access, though maintaining consistent documentation and follow-up procedures required ongoing coordination.

Integration with Existing Systems

"Integrated Open Access model into workflow without creating a new one."

"It wasn't a separate process—we built it into what we were already doing, just faster."

Early Workflow Distributions

"While the workflow initially caused some inconvenience, systems were eventually merged and staff had enough time to complete tasks."

"It was hard in the beginning because you're changing how everyone schedules and documents, but after a few months, it evened out."

Scheduling and Task Completion

"Our approach was to schedule appointments within one to two days, with multiple follow-up calls if unsuccessful, and use the EHR system to document interactions."

"We set the expectation that clients would be contacted within 48 hours and documented that in the system—it helped keep everyone accountable."

Onboarding and Client Flow

"Onboarding changed. Whether walk-in, prior clients, or new clients, all were identified as Open Access clients after adapting the model."

"Having a clear intake process for Open Access made things easier because we didn't have to guess how to categorize someone."

Improvements Over Time

"By the time we got through the first few months, it was just part of how we worked—it wasn't new anymore."

"Eventually, everything ran smoothly. The model had been operationalized and worked well with our existing systems."

Balancing Volume and Pace

"The Open Access model accelerated client access to services, though staff sometimes struggled with the increased pace."

"The pace was intense at first, but once we reorganized scheduling and documentation, it became manageable."

Positive Impact on Efficiency

"Once everything was in place, the workflow improved. Clients were seen faster and follow-ups were done on time."

"After integration, it made our system more efficient overall—we were getting people in faster and reducing no-shows."

Overall Experience

A recurring theme when asked about overall experience among participants was that Open Access is a good framework/concept/system. Many sites were already implementing similar concepts, and the seed funding provided additional support and collaboration. The negative attitudes were around the challenges with the 988 call center, lack of response from consumers, slow influx of referrals from 988, and improvements to the portal system.

Positive Attitudes toward Open Access Model

"I think that the concept is absolutely phenomenal, especially for people who are looking to get into services quickly. While we haven't gotten referrals [from 988], we still do have the availability to accommodate people that are looking for Open Access."

"I would say positive the Open Access model for us as a system was not new, so we had a general understanding conceptually, and kind of a framework and staffing. What I thought was very helpful is we had not ever done it at Park Heights, so, always having startup funds or grant funds to give us the opportunity to kind of like develop a new program or service without the concern or the risk of expense, and overhead is always a huge advantage for programs. The involvement of CMAG was really beneficial. So just having them as an additional resource, and then also I think accountability was great, you know. We can get turned around with a lot of shifting priorities. But we, you know, had scheduled cadences and reporting which kept us on track or more on track."

"So the system itself... the experience has been pretty good. It's a pretty simple, straightforward system."

"Okay, the system, the concept is, it's a really good concept. It's a really good system. It's almost. I think I've mentioned this in previous meeting it kind of mirrors, you know the acute the acute managed care primary care model in terms of urgent, or, you know, appointments for mental health as opposed to primary care or acute medical appointments. So, I like that, you know, and as it relates to access to care. The concept and providing those types of appointments, you know, which are more urgent as opposed to something that that a client might need, like a you know, like a 30-day, 90 day follow up, you know, in a traditional mental health setting..."

"We basically already had the model in operation because of what we do. So, for us it was a very small lift. It was more about data and 988. Cause we already had the goal to get people in within 48 hours of referral or call within our urgent care program. We already have walk-ins when you would come in and see a clinician, so we already kind of met all the criteria for it, so that was simple enough."

"Overall, I think it was a good experience. I think that it was a learn as we go kind of thing... So I think that, you know, there were a lot of kinks that we had to kind of work through, you know, with the different aspects of the grant...So, it took a little longer to kind of launch... And we were able to accomplish, you know, some pretty good numbers as a result of the grant."

Challenges and Barriers to Open Access Model

"Things didn't go exactly the way that I thought they would go, as far as the influx of clients that we would have received, like from 988."

"We didn't get anyone to come in [from the 988 referrals]. It was hard to get in touch with people. We would call as soon as we got the referral. If they didn't answer, we would send a text message. I would say about 1/4 of the people called us back. There were times where we weren't sure if they went somewhere else or if somebody else contacted them because it says something on there, but just to make sure, we would call them anyway because we didn't want anybody to slip through the cracks, you know. It may have been the case where they had already gone somewhere and had, you know, or had spoken to somebody, had an appointment to come."

"The downside to it is just not having enough information to reach individuals and/or them not being responsive to actually connect with the service."

Recommendation of Open Access Model

Open Access model participants ranked their likelihood to recommend the Open Access model to other providers. On a scale of 1-10, the average score was 8.8. There was consensus that Open Access is a good model. While most providers recommend the model to other providers, some providers stated that the model would be hard for a smaller organization and in particular if the organization did not have enough staff to support the operational changes needed to implement and sustain new processes. There were also some comments around minor difficulties navigating the portal.

Recommendation of Open Access

"It is a wonderful thing. Having a portal to be able to get referrals out is important in Baltimore."

"I would recommend especially for providers who are seeking referrals. I think it would be a good opportunity to help bridge the gap between mental health services and the community. I hear a lot of people say it's hard to find or connect to mental health services or get a response from an agency, so I think it's a win-win for both sides if it's done correctly, I think people will have easier access to treatment, so I would highly recommend it."

"The process itself is quite easy to maneuver through and it also helps to connect people in the community who may not otherwise know where to go and get assistance."

"Should be implemented in every primary care or any type of outpatient behavioral settings."

Continuation of Implementation of Open Access Model

All clinics reported continuing the Open Access model. Some reported they already had a similar model prior to the seed funding and others share they will continue as it fits their clinic's needs and capacity. Others reported they have continued with adaptations to best fit their clinics and workflow and adjustments to improve implementation post seed funding.

Positive Response to Continue Open Access Model

"Because we still use it. A big change is more staff oriented and having a rotation of intake persons, so initially we had the idea of having one intake person and that became too overwhelming, so we have dates and times available for actually almost every provider. It gave us a wide range of availability. Prior to Open Access we had walk ins, but it was at random like who's available or what time, and now we have solid availability, and everyone's electronic schedule is up to date."

"Still use the model, still track the data. Overall model adapted."

"We have been continuing the models as it fits us. Will probably continue implementing for at least another year and will decide. "

"I would definitely say a 10 because even though we don't have people flooding our phones, I think it is something that I would want to remain in the event that somebody does need it. The main thing that has changed is that we identify a few staff and block off time on their schedule, specifically for when we offer the Open Access time. So, if someone does happen to call, they're able to get them scheduled quickly."

"Our CEO is very happy with it, and I would say that we're going to stick with it. I can't imagine it going away anytime soon. This is something that we are still currently doing in our clinic."

"It is absolutely something that we are continuing because I think it's a great model. At first, I wasn't giving all the forms and paperwork to clients to complete to make the intake process faster, but we learned that when people want to be seen, they'll do what it takes. We changed and started collecting all of the information up front like we would for any other client. Our hours stayed consistent throughout the grant like we never changed them. Once the hours were set, it's just really working harder to advertise it."

Unsure on Continuation of Open Access Model

"One clinic had the contract, don't know if it would be beneficial to continue because we skip both internal agency referrals and then also external through some of like our peers. Since we have other referral sources, hard to accommodate those super immediate ones from Open Access."

Ease of Implementation

Open Access participants ranked the ease of implementation of the Open Access model in their clinic. Ease of implementation ranged among clinics with an average score of 7.8. When the scores were lower, they represented more difficulties with implementation, with those clinics reporting struggles with staffing, training and clinic buy-in. Most clinic staff reporting easier implementation had experience with similar models or components of Open Access.

Staffing Issues

"Challenge was staffing, had a little challenge early on to hire for the position."

"Had to bring in a new therapist for staffing. Process and system were easy to navigate."

Training

"Wasn't that easy, had to get everyone trained, clinician buy-in and then training the clinicians."

Workflow

"Had to come up with process, plans and procedures to make sure workflow wasn't disrupted. Had to make sure they needed to accommodate language barriers."

"I would say probably an 8. Just kind of reorienting the front office probably was the most challenging part because they were used to doing it a certain way and they weren't in all the meetings and may not even share the same passion for walking. They kind of were comfortable with their structure, but the group that I had to go on the Open Access team was very passionate about same day next day, service crisis management. So. I would say that would make it an 8."

"I feel like that's multifaceted because the actual workflow of it wasn't that hard, but having everything we need to make sure it flows smoothly with a little bit more challenging."

Previous Experience

"Not difficult, run into glitches. Model was already set up this way, had experience with a walk-in clinic prior."

"I mean, it was fairly simple. We were sort of already doing some of it. It was fairly easy."

"Already would take clients that are same day clients."

"I would say ours was pretty easy outside of like the parameters but like thinking about the concept of Open Access, I feel we were able to do that because we were already kind of doing it. It wasn't exactly 24 or 48 hours, but we were able to onboard people within a timely fashion. We've always kind of been with that model, especially with the availability of staff. The walk-in portion was new."

Staffing and Role Adjustment

Staffing appeared as both a success and an ongoing challenge across all cohorts, with possible opportunities for growth, given more time. Many clinics expanded their teams to meet the increased client volume; others maintained their staffing and redistributed roles. Cohort 1 and 2 clinics reported limited staffing, often relying on a single therapist or shared administrative staff, in early implementation. Some clinics became flexible with staff, while others hired nurse practitioners, intake specialists, or additional therapists. New staff were able to handle walk-ins and same day appointments. By Cohort 3, several clinics successfully restructured teams for more effective intakes, documentation, and follow-ups. This was seen particularly in Baltimore County and Baltimore City, where larger infrastructures allowed for smoother expansion. Howard and Carroll Counties experienced slower adaptation due to smaller program sizes. Participants agreed that staffing adjustments were essential to sustaining access, improving workflow, and preventing burnout.

Staffing Growth and Expansion

"Our staffing model changed from one therapist to three therapists once we implemented Open Access."

"We hired NPs and some people to help with walk-in clients. The volume increased, and we needed more hands."

"Staffing grew over time. At first, it was just one person handling everything, but eventually, we brought in more clinicians."

Staffing Stability and Role Redistribution

"Staffing model remained unchanged, but we shifted roles so that intake staff handled the front end and clinicians focused on follow-ups."

"We didn't hire new people, but we divided responsibilities differently—our existing staff just got better at managing flow."

"We made it work with the same number of staff, but that required constant communication and flexibility."

Staffing Challenges and Workload Strain

"Staffing challenges were real, but we overcame them by cross-training existing staff. Everyone had to wear multiple hats at the start."

"It was tough because turnover happened right when demand increased. We had to shuffle people around just to keep up."

"Sometimes we had the clients, but not enough clinicians available for same-day assessments."

Impact on Workflow and Efficiency

"Once we had enough staff, everything moved smoother—clients were seen faster, documentation was caught up, and follow-ups didn't pile up."

"The additional hires made it possible to schedule within 24–48 hours, which made a huge difference."

"When it was just one or two people, it was overwhelming. Once we brought on an extra clinician, things balanced out."

Adaptation and Team Collaboration

"Our team adapted quickly. We learned each other's roles and stepped in when someone was out—it became a team effort."

"Even when short-staffed, our group worked well together, which kept things stable."

"The staffing model reinforced access-to-care goals through designated staff and a new system that improved coordination."

Access Data: Summary of Appointments and Referrals

Referrals to Open Access from the 988 Helpline

The referrals data from 988 helpline were available from January to December 2024 and from January to March 2025. When a consumer calls the 988 helpline, the counselor can refer the consumer to Open Access clinics through a secure portal. The Open Access clinics are then able to accept or reject the referrals. Within the secure portal, a referral is marked "accepted" when the clinic is able to reach the consumer to schedule an appointment. A referral is marked as "rejected" within the portal for a variety of reasons that are described below, with the majority of referrals being rejected because the clinic was not able make contact with the consumer.
In 2024, 37 Open Access clinics received referrals from the 988 Helpline. In 2024, the least common reason for rejecting a referral was that no clinician was available. However, in 2025, the individual received services from the provider and could not come back.

Approved Referrals for 2024

There were 404 approved referrals from January to December 2024 across all 37 facilities. The maximum number of approved referrals was 70 with a median 6 (IQR: 2-10). On average, there were 11 referrals approved/preapproved by each facility in 2024.

Total Approved Referrals	Average Approved Referrals per Clinic	Maximum Approved Referrals in 2024	Median Approved Referrals
404	11	70	6

Outcomes of Accepted Referrals

Three distinct outcomes emerged among accepted referrals:

1. *The consumers attended and completed the intake process.*
2. *The consumers completed the intake process and proceeded to ongoing treatment.*
3. *The consumers did not attend the scheduled intake appointment.*

No Shows for Approved Referrals

There were 54 No Shows among the approved referrals in 2024. This means that 13% of approved appointments were missed due to different reasons. That percentage is below typical no show rates in community clinics. It was also noted that with the appointments being given immediately, some clients were not able to arrange their schedules with such short notice. One study from 2019 mentioned that the missing appointments in community clinics for behavioral health is around 20%. The maximum number of no shows is 22 and the median is 2.5 (IQR: 2-7). There were 10 facilities with an average of 5 no shows for approved referrals.

Completed Intake for Approved Referrals

Among the approved referrals, there were 13 who completed intake. The maximum number of completed intake was 3 and the median was 2.5.

Completed Intake and Ongoing Treatment for Approved Referrals

In 2024, there were 44 approved referrals with completed intake and ongoing treatment. The maximum number was 12 and the median was 2 (IQR: 1-8). On average, there were 5 approved referrals with ongoing treatment per facility.

Rejected Referrals for 2024

In total, 1,114 referrals were noted as rejected in 2024. The maximum number of referrals rejected by a facility was 125 and the median was 27.50 (IQR: 7-43). However, it is important to qualify “rejected” most often, meaning the individual could not be reached (see Fig 1 and Fig 2).

Accepted and Rejected Referrals for 2025

For 2025, referrals data is available for January, February, and March. The records were available for 39 facilities.

There were 85 approved referrals. The maximum number of total approved referrals in 2025 was 16 and median was 1 (IQR: 1-3). There were total 20 approved referrals with no shows. There were total 18 approved referrals with complete intake and on-going treatment.

On the other hand, there were 421 rejected referrals. The maximum number of rejected referrals was 43 and median 6 (IQR: 2-15).

Reasons for Referrals Rejections in 2024 and 2025

The reasons for rejecting referrals were similar in 2024 and 2025. Both in 2024 and 2025, the most common reasons for rejecting referrals were not being able to contact individual (Fig 1 and Fig 2). In 2024, the least common reason for rejecting a referral was that no clinician was available. However, in 2025, the individual received services from the provider and could not come back.

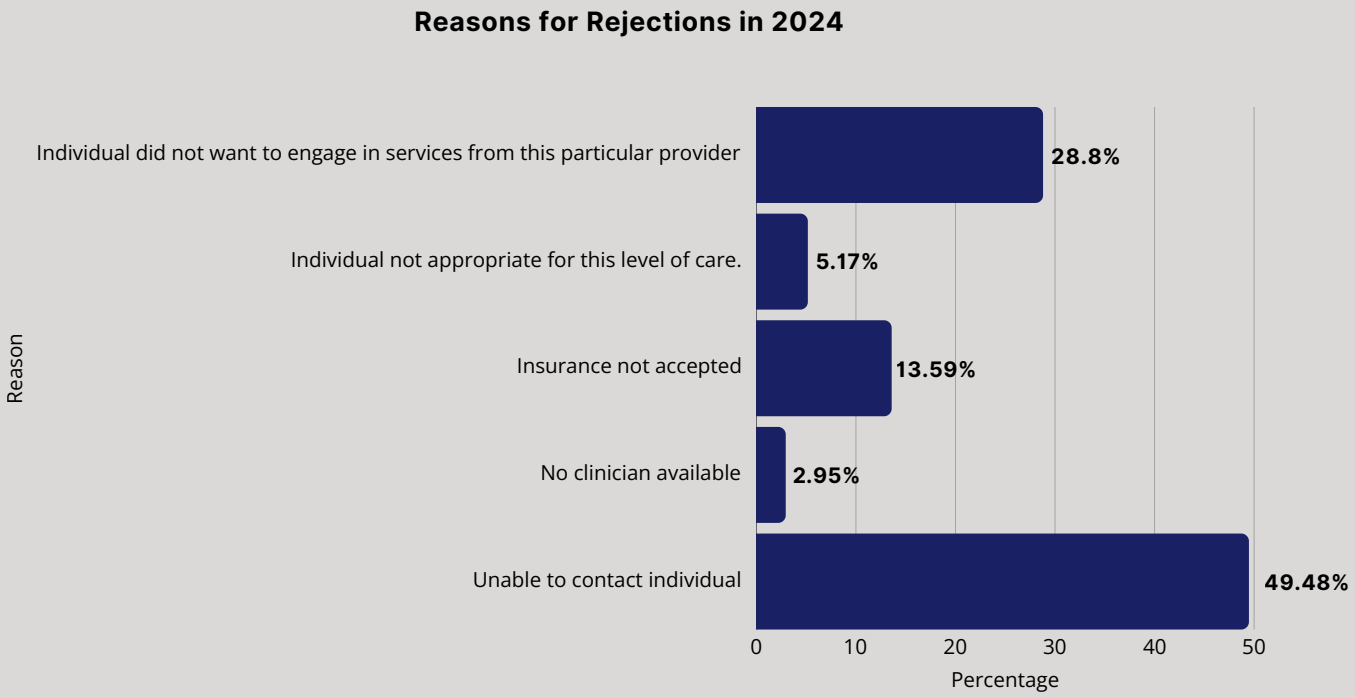


Figure 1: Distribution of Reasons for Rejected Referrals Across All Facilities Combined in 2024

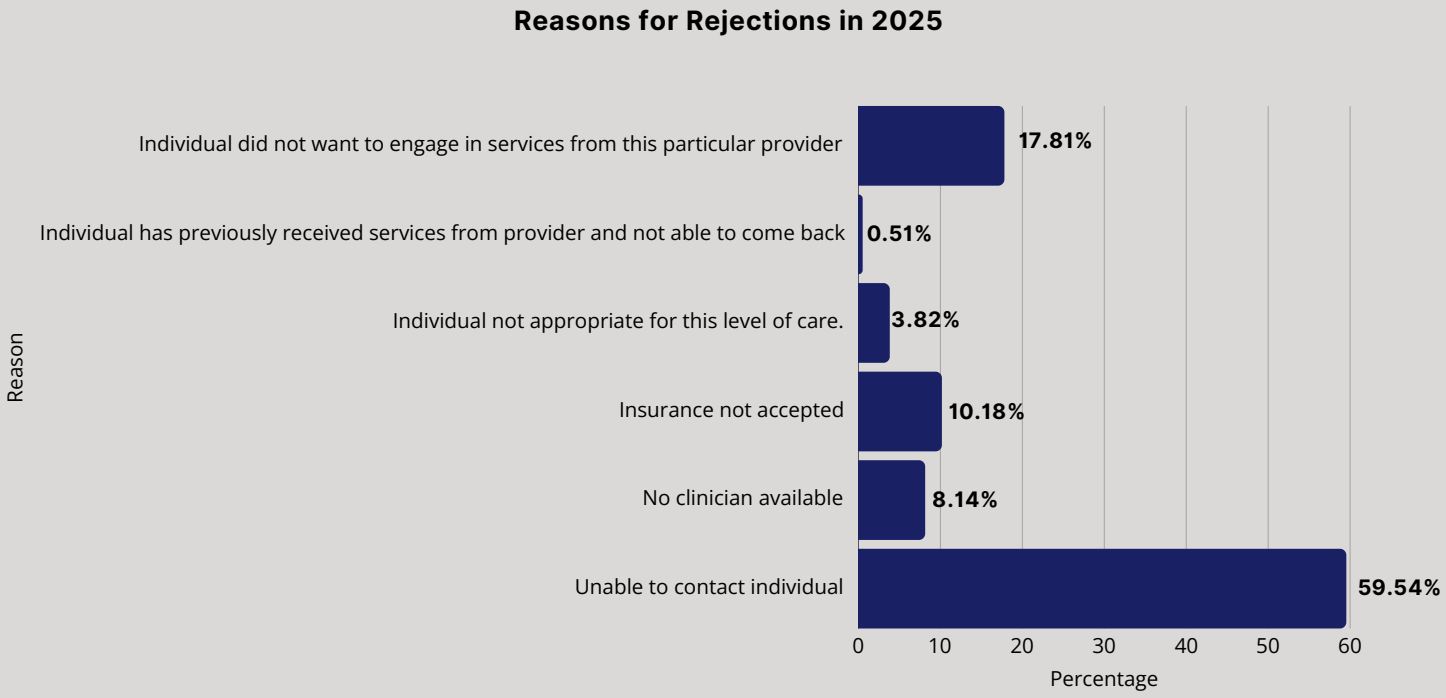


Figure 2: Distribution of Reasons for Rejected Referrals Across All Facilities Combined in 2025

Consumers Who Contacted the Open Access Clinics Directly

Most of the Open Access appointments were made from direct calls by consumers to the clinics. The appointments data for referrals that came from consumers directly to the clinics were collected for Cohort 1 and Cohort 2. These were related to the total number and average number of consumers served per week. In Cohort 1, there were five facilities in four different locations with data from January 2023 to March 2023. In Cohort 2, same facilities from Cohort 1 were included in addition to 13 more which included data from January 2023 to August 2023. In Cohort 3, there were 14 facilities with data available from July 2024 to December 2024.

Total Open Access Appointments Scheduled

In total, 1561 consumers received assistance from the clinics using the Open Access model across all cohorts. Among them, 1,105 consumers were served in cohort 1 and cohort 2. A majority of consumers receiving care (874) were from Baltimore city. The remaining 456 consumers were from cohort 3. A majority of consumers receiving care (305) from cohort 3 were from Baltimore County.

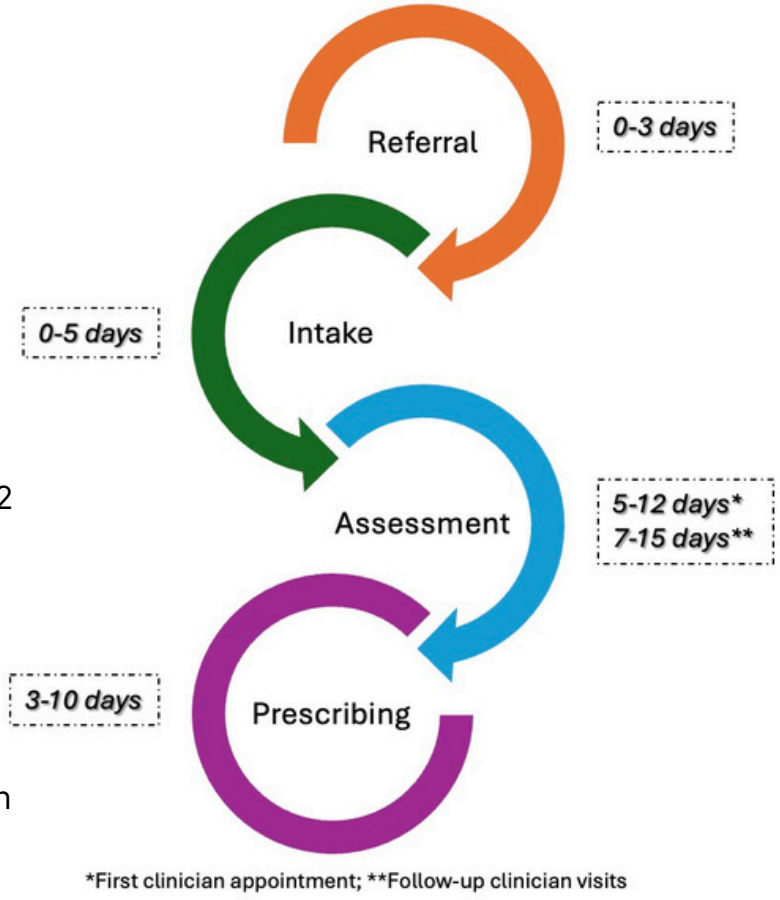
Table 1: New Consumers Served at Open Access (OA) by Each Cohort.

	Cohort 1 (October 2022-March 2023)	Cohort 2 (February 2023-August 2023)	Total	
New OA Clients	45	1060	1105	
Total Number of individuals receiving assistance via Open Access by county for Cohort 1 and Cohort 2				
	Baltimore City	**Baltimore County**	**Howard County**	**Carroll County**
New Open Access Clients	874	167	34	30
Cohort 3 July 2024- December 2024				
	Baltimore City	**Baltimore County**	**Howard County**	**Total**
New Open Access Clients	133	305	18	456

Consumer Experience

Wait Times

We found that the early steps of the service process functioned efficiently across most participating locations. On average, consumer experienced 0–3 days from referral to intake and 0–5 days from intake to assessment, indicating that the initial entry points into care are generally timely. As the process moves toward clinical appointments, wait times showed greater variability: the first clinician appointment typically occurred within 5–12 days for most consumers, while follow-up clinician visits ranged from 7–15 days, depending on local workflow and scheduling capacity. Prescriber appointments were generally accessible, with wait times typically 3-10 days, though wait times of months were observed due to temporary operational constraints.

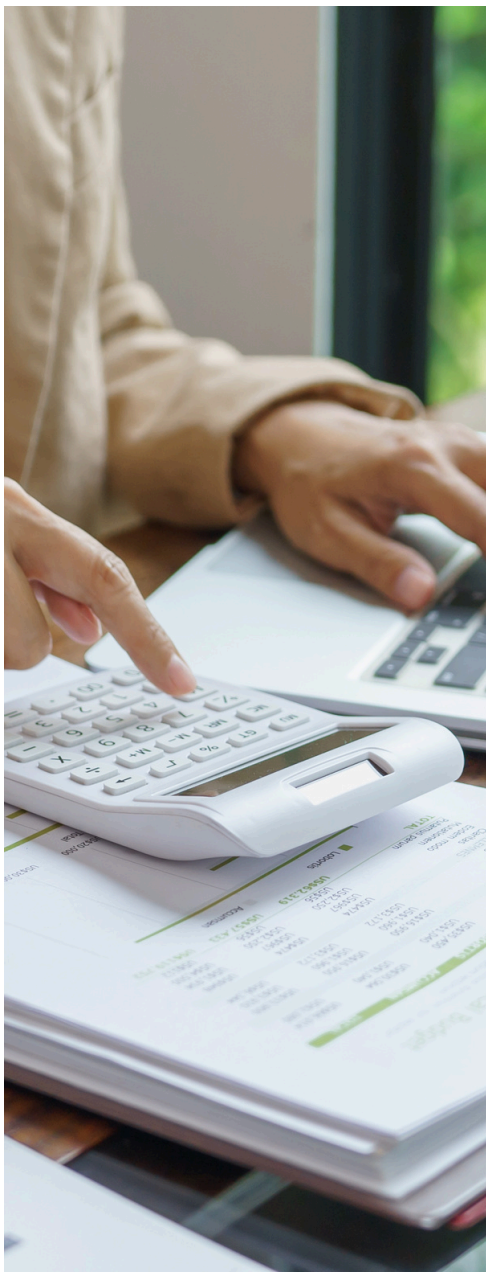


Consumer Satisfaction

Consumer satisfaction data from locations that submitted usable information (257 surveys across 7 clinics) showed average satisfaction scores ranged from 3.5 to 4.8 out of 5, suggesting generally positive experiences with staff, communication, and accessibility. Reporting completeness varied across sites, with one clinic contributing to most surveys, while others had limited months of data.

Cost Analysis

Based on therapist and prescriber wages plus a 30% overhead factor, the total cost of providing same-day intake capacity in 2024 was approximately $45,613, including both attended appointments and no-shows. Over the same period, completed same-day intakes billed to Medicaid and other payers generated about $54,483 in revenue. This means that, within the data we have, the service essentially “paid for itself” and produced a surplus of roughly $8,870, an estimated return on investment (ROI) of about 19%, or about $1.19 in revenue for every $1.00 spent.



There are limitations to this analysis. First, the analysis is based on a limited set of encounter and billing data for 2024 and does not capture all Open Access-related visits across all sites; many encounters supported by the broader investment were not included in this dataset. Second, we only examined the narrow flow of dollars directly tied to same-day intake visits, without incorporating other clinical services, downstream utilization, or non-billable work such as outreach and care coordination. As a result, the revenue of $54,483 against $45,613 in costs is best interpreted as a conservative snapshot of one clinic-level activity, not as a full economic evaluation of the entire Open Access model. Third, a portion of the cost comes from no-show appointments. When consumers do not attend, the clinic still bears staff and facility costs but receives no revenue, which lowers the observed ROI. We did not have sufficient detail to model how changes in scheduling practices, reminders, or eligibility criteria might improve this.

More importantly, the broader public health impact of models like Open Access is likely to be larger than this simple financial margin suggests.

Evidence from other behavioral-health access initiatives shows that timely outpatient care can reduce emergency department and inpatient use and generate net savings for payers and health systems. For example, a randomized trial of a standardized community health worker program serving adults found that every $1 invested returned $2.47 to Medicaid within a year, primarily by reducing hospitalizations [3]. More recently, an employer-sponsored behavioral health benefit with fast access to psychotherapy and medication management was associated with a 1.9-to-1 return, meaning every $100 invested reduced overall medical claims costs by about $190 [4].

Although we did not link Open Access encounter data to local emergency department or hospitalization records for this preliminary analysis, these studies suggest how same-day access to community-based behavioral health care can create value beyond the clinic budget. As one simple illustration, avoided emergency department (ED) use could increase the value of Open Access model beyond the clinic budget. In 2024, the program served a few hundred consumers. If same-day access prevented even 15-20 mental-health-related ED visits in the subsequent year, this would correspond to approximately $11,000 to $15,000 in avoided ED service costs, using the national average of about $750 per visit in 2021. These avoided costs would be additive to the $8,870 clinic-level surplus estimated here.

Because we lack the local utilization data to confirm exactly how many ED visits were prevented, this should be viewed as an evidence-informed scenario, not a measured effect. Nonetheless, it highlights that the 19% ROI reported above likely underestimates the full public health and system-level return from creating timely access to outpatient behavioral health care.

In summary, with limited 2024 billing data, the same-day outpatient therapy component of the Open Access model appears to generate slightly more revenue than it costs to deliver, even before counting any downstream savings from avoided crises. At the same time, the analysis is constrained by incomplete data on visits, the exclusion of most of the broader program's investment, and the absence of linked outcomes such as ED visits and hospitalizations.

Limitations

The main challenge identified was the lack of standard procedures for collecting and reporting satisfaction data, which limited the ability to obtain a clear, continuous picture of client perceptions across the project. Overall, these findings indicate strong performance in the earliest stages of the service process and identifiable opportunities to improve consistency in scheduling and data reporting for later appointments. Establishing simple, uniform reporting guidelines and clear definitions of each wait-time category would enhance the accuracy of future summaries and help staff identify operational bottlenecks more quickly. These aggregated insights provide practical direction for improving workflow efficiency and strengthening the overall consumer experience for future evaluations of the Open Access model.

There were also some inconsistencies in data recording at some of the clinics. These have resulted in some data not being included in the analysis. As the Open Access model continues, the systems will be in place at all the clinics; thus, making future assessment more comprehensive.

References

1. Biggs, J., Njoku, N., Kurtz, K., & Omar, A. (2022). Decreasing missed appointments at a community health center: a community collaborative project. Journal of Primary Care & Community Health, 13, 21501319221106877.
2. Agency for Healthcare Research and Quality (AHRQ), Healthcare Cost and Utilization Project (HCUP). Statistical Brief #257: Costs of Emergency Department Visits for Mental and Substance Use Disorders in the United States, 2017. Rockville, MD: AHRQ; 2020. https://hcup-us.ahrq.gov/reports/statbriefs/sb257-ED-Costs-Mental-Substance-Use-Disorders-2017.jsp?
3. Kangovi S, Mitra N, Grande D, Long JA, Asch DA. Evidence-Based Community Health Worker Program Addresses Unmet Social Needs And Generates Positive Return On Investment. Health Aff (Millwood). 2020;39(2):207-213. doi:10.1377/hlthaff.2019.00981.
4. Hawrilenko M, Smolka C, Ward E, et al. Return on Investment of Enhanced Behavioral Health Services. JAMA Netw Open. 2025;8(2):e2457834. Published 2025 Feb 3. doi:10.1001/jamanetworkopen.2024.57834.