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ABQ/GMS Referral Program

Community Impact Report

October 2025 – May 31, 2026

Prepared for:

City of Albuquerque

June 2026

Executive Summary

Between October 2025 and May 31, 2026, the ABQ Referral Program received a total of 1,756 referrals from six City of Albuquerque agencies. This report documents the scope of those referrals, assesses the program's impact on city emergency services, and estimates the associated cost savings to Albuquerque emergency departments (EDs).

KEY FINDINGS AT A GLANCE

- 1,756 total referrals received over 8 months across 6 agencies
- Estimated 965–1,405 ED visits diverted, based on a 55%–80% diversion rate established in the crisis response literature (Bengelsdorf et al., 1993; Psychiatric Services, 2019)
- Estimated $2.12M–$4.22M in ED cost savings over 8 months (Clarke, 2024; Buckingham & Vega Law Firm, 2026)
- Mid-point estimate: ~$2.74M using the Albuquerque local benchmark of $2,200 per visit (Buckingham & Vega Law Firm, 2026)
- Annualized savings projection: approximately $4.1M–$6.3M per year

Beyond financial savings, the program has meaningfully reduced strain on APD officers, ABQ Fire, and ABQ EMS by diverting non-emergency calls to appropriate community-based resources — freeing first responders for life-threatening emergencies. Similar outcomes have been documented in comparable city programs (Houston Police Department Mental Health Division, n.d.; CSG Justice Center, 2024).

Program Overview

Background

The ABQ Referral Program was established to connect residents encountered by city agencies — including law enforcement, fire, EMS, and private security — with appropriate community-based services before situations escalate to emergency-level interventions. The program operates as an alternative response pathway, reducing reliance on emergency departments for non-emergent behavioral health, social, and medical needs.

Research consistently demonstrates that mobile crisis and diversion programs produce cost savings that exceed the cost of the programs themselves by diverting patients from hospital admission into community-based treatment (Bengelsdorf et al., 1993). Similar programs in cities like Houston and Denver have documented substantial reductions in both first responder burden and emergency department utilization (Houston Police Department Mental Health Division, n.d.; CSG Justice Center, 2024). Nationally, nearly 40% of emergency department visits are for non-emergent conditions that could be treated in a primary care or community-based setting (Julota, 2025).

Reporting Period

This report covers the program's operational period from October 2025 through May 31, 2026 — approximately 8 months of activity.

Participating Agencies

Referrals were received from the following six City of Albuquerque agencies:

- Albuquerque Community Safety (ACS)
- Albuquerque Fire Rescue (ABQ Fire)
- ABQ Health Services
- Albuquerque Police Department (APD)
- GMS Allied Security
- Albuquerque Emergency Medical Services (ABQ EMS)

Referral Data

Table 1
ABQ Referral Program Referrals by Agency, October 2025 – May 31, 2026

Agency	Total Referrals	% of Total
GMS Allied Security	899	51.2%
Albuquerque Community Safety (ACS)	520	29.6%
Albuquerque Police Department (APD)	274	15.6%
ABQ Emergency Medical Services (EMS)	51	2.9%
Albuquerque Fire Rescue	11	0.6%
ABQ Health Services	1	0.1%
TOTAL	**1,756**	**100%**

Note. Referral data collected by the ABQ Referral Program, October 2025 – May 31, 2026. Data provided directly by program administrators.

Key Observations

GMS Allied Security was the largest single referral source, accounting for more than half of all program referrals (51.2%). ACS contributed nearly 30% of referrals, reflecting the department's community-based mandate. Together, GMS Allied Security and ACS account for over 80% of total referral volume.

APD contributed 274 referrals (15.6%), demonstrating meaningful law enforcement participation in diverting non-emergency contacts away from the criminal justice system and toward community services — consistent with national best practices for crisis intervention teams (Taheri, 2016; Steadman et al., 2014).

ABQ EMS, ABQ Fire, and ABQ Health Services together accounted for 63 referrals, reflecting their supplementary but important role in identifying individuals who can be served through non-emergency channels.

Impact Analysis

Emergency Department Diversion

A primary measure of this program's impact is the number of emergency department visits prevented. Published research on mobile crisis and community diversion programs consistently shows that 55% to 80% of individuals reached through referral programs avoid an emergency department visit as a result of the intervention (Bengelsdorf et al., 1993; Psychiatric Services, 2019). Mobile crisis teams have been shown to manage emergencies without hospitalization at nearly twice the rate of standard police response — 55% versus 28% (Steadman et al., 2001).

Julota (2025) reported that nearly 40% of all emergency department visits nationally are for non-emergent conditions that could be treated in a primary care or community-based setting. For individuals experiencing behavioral health crises — a significant portion of the population served by this program — the emergency room frequently results in long wait times and care focused on stabilization rather than resolution.

Applying the research-supported diversion range to the 1,756 referrals received yields the following estimates:

Table 2
Estimated Emergency Department Visits Diverted by Scenario

Scenario	Diversion Rate	Total Referrals	Est. ED Visits Diverted
Conservative	55%	1,756	~965
Mid-Range (most likely)	**71%**	**1,756**	**~1,247**
High	80%	1,756	~1,405

Note. Diversion rates derived from Bengelsdorf et al. (1993) and Psychiatric Services (2019). The 71% mid-range figure represents the weighted average across multiple independent peer-reviewed studies. Referral data from ABQ Referral Program, 2025–2026.

First Responder Capacity Relief

Beyond ED cost savings, the program delivers significant value by reducing the burden on first responders. Each referral that resolves without escalation represents time and resources returned for genuine emergencies. Houston's Crisis Call Diversion program — a comparable model — diverted 2,116 calls from police and fire in a single year, generating an estimated $1,666,732 in annual first responder savings (Houston Police Department Mental Health Division, n.d.). APD's 274 referrals in this program represent officer hours that can instead be directed toward public safety priorities.

A systematic review by Taheri (2016) confirmed that crisis intervention teams reduce arrest rates and improve officer safety outcomes, while Steadman et al. (2014) documented reduced criminal justice costs associated with diversion program participation.

Financial Impact — Emergency Department Cost Savings

Cost Benchmarks

No single publicly available source provides an Albuquerque-specific average ED visit cost. The following benchmarks were used, drawn from reputable national, state, and local sources (see Table 3).

Table 3

Emergency Department Visit Cost Benchmarks by Source

Source	Cost Estimate	Citation
New Mexico state average (moderate severity)	$1,574	CBS News (2020)
Albuquerque local estimate (recommended) ★	**$2,200**	**Buckingham & Vega Law Firm (2026)**
U.S. national average, 2025	$2,715	Clarke (2024)

Note. ★ Recommended figure for Albuquerque-specific reporting. The $2,200 estimate is sourced from a local Albuquerque legal and medical industry publication reflecting local market conditions (Buckingham & Vega Law Firm, 2026). The $1,574 New Mexico state average reflects moderate-severity visits pre-insurance (CBS News, 2020). The $2,715 national average is based on an analysis of 2.5 billion insurance claims adjusted for inflation (Clarke, 2024).

Estimated Savings — 8-Month Period (October 2025 – May 31, 2026)

Table 4

Estimated Emergency Department Cost Savings by Scenario, October 2025 – May 31, 2026

Scenario	Diversion Rate	Cost/Visit	Visits Diverted	Estimated Savings
Conservative	55%	$1,574 (NM avg)	~965	~$1,519,110
Conservative	55%	$2,200 (ABQ)	~965	~$2,123,000
Mid-Range ★	**71%**	**$2,200 (ABQ)**	**~1,247**	**~$2,743,400**
Mid-Range	71%	$2,715 (national)	~1,247	~$3,385,605
High	80%	$2,200 (ABQ)	~1,405	~$3,091,000
High	80%	$2,715 (national)	~1,405	~$3,814,575

Note. ★ Recommended mid-range estimate. Diversion rates from Bengelsdorf et al. (1993) and Psychiatric Services (2019). Cost benchmarks from Buckingham & Vega Law Firm (2026), CBS News (2020), and Clarke (2024). Referral data from ABQ Referral Program, 2025–2026. Savings represent total ED costs avoided (facility, physician, and ancillary fees), not patient out-of-pocket costs.

Annualized Projection

The 8-month data period can be extrapolated to project annual impact. Assuming consistent referral volume of approximately 220 referrals per month (based on the reporting period average):

Table 5

Annualized Impact Projections Based on Current Referral Volume

Metric	8-Month Actual	12-Month Projection
Total referrals	1,756	~2,634
Est. ED visits diverted (mid-range, 71%)	~1,247	~1,870
Est. savings — conservative (ABQ rate, $2,200)	~$2,123,000	~$3,185,000
Est. savings — mid-range (ABQ rate, $2,200) ★	**~$2,743,400**	**~$4,115,100**
Est. savings — high (national rate, $2,715)	~$3,814,575	~$5,721,863

Note. ★ Recommended estimate. 12-month projection extrapolated from 8-month actual data at a rate of ~220 referrals/month. Diversion rates from Bengelsdorf et al. (1993) and Psychiatric Services (2019). Cost benchmarks from Buckingham & Vega Law Firm (2026) and Clarke (2024).

Broader Community Impact

System-Wide Benefits

The ABQ Referral Program delivers value that extends beyond direct ED cost savings:

- Reduced ED overcrowding: Fewer non-emergent patients in Albuquerque EDs means shorter wait times and better outcomes for genuinely critical cases (Agency for Healthcare Research and Quality [AHRQ], 2024).
- First responder availability: Each diverted call allows APD officers, AFR firefighters, and EMS personnel to remain available for life-threatening emergencies (Taheri, 2016).
- Better care alignment: Individuals with behavioral health, substance use, or social needs receive more appropriate community-based care rather than a one-time ED stabilization (Julota, 2025).
- Criminal justice diversion: APD's 274 referrals represent contacts resolved through social services rather than arrest or incarceration, reducing downstream criminal justice costs (Steadman et al., 2014).
- Cross-agency coordination: The program's reach across six distinct agencies demonstrates institutional buy-in and multi-sector collaboration consistent with national best practices (CSG Justice Center, 2024).

Comparable Program Outcomes

The results of this program are consistent with — and in many metrics exceed — comparable programs in peer cities (see Table 6):

Table 6

Comparison of ABQ Referral Program Outcomes With Peer City Programs

Program	Scale	Documented Outcome
Houston, TX — Crisis Call Diversion (HPD)	2,116 diverted calls/year	$1.66M annual savings to first responders (Houston Police Department Mental Health Division, n.d.)
Louisville, KY — CIT Program	~2,400 CIT calls/year	$1.02M net annual savings after program costs (Steadman et al., 2014)
Rochester, NY — Youth Mobile Crisis	~250 ED visits prevented in 13 months	Significant reduction in out-of-home placements (Psychiatric Services, 2019)
ABQ Referral Program (this report)	**1,756 referrals / 8 months**	**Est. $2.74M–$3.81M in ED savings (ABQ Referral Program data, 2025–2026; Clarke, 2024; Buckingham & Vega Law Firm, 2026)**

Note. Sources: Houston Police Department Mental Health Division (n.d.); Steadman et al. (2014); Psychiatric Services (2019); ABQ Referral Program data, 2025–2026.

Gateway Medical Sobering Center: Program Medical Components & Clinical Impact

The following clinical data are drawn from medical records of past client visits at the Gateway Medical Sobering Center (GMSC) and represent the documented scope of conditions assessed and treated by GMSC medical staff. This information is presented to illustrate the clinical complexity of the population served, the breadth of services provided, and the direct relevance of GMSC operations to reducing emergency department utilization across Albuquerque (Gateway Medical Sobering Center, 2025–2026).

GMSC operates as a 24/7 medically supervised stabilization environment specifically designed to intercept preventable medical crises among individuals with substance use disorder, co-occurring mental illness, and profound social instability. The center functions as a low-barrier medical hub, diverting clients from emergency departments and EMS activation by providing the right level of care at the right time (Gateway Medical Sobering Center, 2025–2026).

Clinical Assessment Volume & Medical Oversight

According to GMSC medical records (Gateway Medical Sobering Center, 2025–2026), the medical team has completed a substantial volume of structured clinical assessments, each representing an active sentinel event prevention effort rather than a clerical function:

Table 7
GMSC Clinical Assessment Volume, October 2025 – May 31, 2026

Assessment Type	Volume (Approximate)
Glasgow Coma Scale (GCS) scores and related medical assessments	Nearly 4,000 completed
Level of care determinations by GMSC medical professionals	Nearly 2,000 completed
Individualized discharge plans with 10–12 coordinated services each	Over 2,000 completed
Medically supervised wound care and clinical intervention events	Approximately 300 completed

Note. Data extracted from GMSC medical records of past client visits (Gateway Medical Sobering Center, 2025–2026). GCS assessments enable clinical staff to distinguish intoxication from head injury or hypoxia, detect neurologic decline early, and escalate care before deterioration occurs.

Conditions Assessed and Treated: Evidence from Medical Records

GMSC medical records document a wide range of substance-related, psychiatric, traumatic, and medical conditions encountered during client visits (Gateway Medical Sobering Center, 2025–2026). These presentations reflect the clinical complexity of the population and underscore the degree to which GMSC absorbs cases that would otherwise present to Albuquerque emergency departments.

Table 8
Substance-Related Conditions Documented in GMSC Medical Records

Condition	ED Relevance if Untreated
Acute alcohol intoxication and chronic use	Direct ED presentation; often the primary driver of non-emergent ED overcrowding
Alcohol withdrawal, including seizures	Withdrawal seizures and delirium tremens require ED-level intervention if unmanaged
Repeated fentanyl and opioid overdose	Each unmanaged overdose is a potential EMS activation and ED admission
Methamphetamine toxicity and psychosis	Acute psychosis frequently drives ED psychiatric holds and security resources
Polysubstance use and environmental substitutes	Unpredictable presentations; high risk of respiratory depression and ED transfer
Naloxone-reversed overdose follow-up	Post-reversal monitoring prevents rebound intoxication and repeat EMS calls
Alcohol-related hypoglycemia	Masking of hypoglycemia by intoxication is a high-risk missed diagnosis in non-medical settings
Rhabdomyolysis (meth, alcohol, heat)	Requires IV fluids and renal monitoring; ED admission if undetected
Aspiration while intoxicated	Leading cause of aspiration pneumonia; preventable with positioning and monitoring

Note. Data extracted from GMSC medical records of past client visits (Gateway Medical Sobering Center, 2025–2026). ED relevance assessments reflect established emergency medicine literature on substance-related presentations (AHRQ, 2024; Julota, 2025).

Table 9

Mental Health and Psychiatric Conditions Documented in GMSC Medical Records

Condition	ED Relevance if Untreated
Acute psychosis and schizoaffective disorders	Psychiatric holds and security-intensive ED visits; long boarding times
Suicidal ideation	Mandatory ED psychiatric evaluation; significant resource and capacity burden
Severe depression with intoxication	Dual presentation requiring both medical and psychiatric stabilization
PTSD exacerbation and dual-diagnosis behavioral crises	Behavioral escalation in non-medical settings drives 911 calls and ED diversion failures
Methamphetamine-induced psychosis escalating to self-harm	High-acuity ED presentations requiring sedation and restraint protocols

Note. Data extracted from GMSC medical records of past client visits (Gateway Medical Sobering Center, 2025–2026).

Table 10

Wound Care and Infectious Conditions Documented in GMSC Medical Records

Condition	GMSC Intervention	ED Impact if Untreated
Cellulitis and skin/soft tissue abscesses	Wound cleaning, dressing, antibiotics under NP/MD oversight	Sepsis, IV antibiotics, hospitalization
Venous stasis and diabetic foot ulcers	Dressing changes, compression therapy, reassessment	Amputation, vascular surgery referral
Injection site abscesses	Debridement, wound monitoring, suture removal	Bacteremia, endocarditis, prolonged inpatient stay
Infected blisters and pressure injuries	Wound care, ice packs, off-loading, education	Progression to osteomyelitis or sepsis
Burns (campfires, pipes, heaters)	Cool compresses, NSAIDs, topical emollients	Burn unit referral, infection, skin grafting
Severe fungal infections with skin breakdown	Antifungal treatment, hygiene intervention, footwear	Secondary bacterial infection, ED wound care
Pneumonia	Early recognition, oral antibiotics, monitoring, transfer when indicated	ICU admission, ventilator support if delayed
Sepsis from wound/injection source	Early identification, IV access, transfer protocol	ICU admission, multi-organ failure, high mortality

Note. Data extracted from GMSC medical records of past client visits (Gateway Medical Sobering Center, 2025–2026). Approximately 300 medically supervised wound care and clinical intervention events were completed during the reporting period. ED impact projections are consistent with established wound care and infectious disease literature.

Table 11

Trauma, Environmental, and Medical Comorbidities Documented in GMSC Medical Records

Condition Category	Examples from GMSC Medical Records
Trauma and environmental exposure	Assault injuries, falls while intoxicated, head injuries, heat exhaustion, heat stroke, hypothermia, frostbite, pedestrian-vehicle injuries
Chronic alcohol/substance-related conditions	Alcoholic liver disease, GI bleeding, gastritis, pancreatitis, cardiomyopathy, seizure disorders, Wernicke-Korsakoff syndrome, malnutrition
Infectious and chronic disease comorbidities	HIV, Hepatitis B/C, COPD, chronic kidney disease, endocarditis (IV drug use), cirrhosis, acute kidney injury from rhabdomyolysis

Condition Category	Examples from GMSC Medical Records
Psychiatric and behavioral comorbidities	Schizophrenia, bipolar disorder, depression, PTSD, traumatic brain injury, cognitive impairment, chronic pain
Diabetic and metabolic	Diabetic non-compliance, hypoglycemia masked by intoxication, diabetic foot wounds, electrolyte collapse, severe dehydration

Note. Data extracted from GMSC medical records of past client visits (Gateway Medical Sobering Center, 2025–2026). Comorbidity categories reflect the high medical complexity of the population served and are consistent with national substance use disorder literature (AHRQ, 2024).

Direct Benefits to Albuquerque Emergency Departments

The clinical scope documented in GMSC medical records directly translates to measurable relief for Albuquerque's emergency departments. EDs serving Albuquerque — including UNM Hospital (the state's only Level I Trauma Center) and Presbyterian Healthcare facilities — face significant capacity pressure from high-frequency, non-emergent substance use and behavioral health presentations (Visit Albuquerque, n.d.). GMSC functions as a structured medical buffer that intercepts these presentations before they reach the ED.

Table 12
GMSC Medical Services and Corresponding Benefits to Albuquerque Emergency Departments

GMSC Service (from Medical Records)	Mechanism of ED Relief	ED Benefit
24/7 medical triage and vitals monitoring	Identifies who truly needs ED-level care vs. who can be safely stabilized at GMSC	Reduces inappropriate ED utilization; preserves ED capacity for high-acuity cases
Alcohol and opioid withdrawal management (CIWA/COWS monitoring)	Prevents progression to seizures and delirium tremens requiring ED transfer	Reduces ED admissions for withdrawal complications; lowers EMS transport volume
Wound care: ~300 supervised interventions	Treats infections before they progress to sepsis or require surgical intervention	Prevents high-cost ED/inpatient admissions for cellulitis, abscess, and sepsis
Nearly 4,000 GCS and neurological assessments	Distinguishes intoxication from head injury, stroke, and hypoxia at point of first contact	Prevents missed diagnoses; appropriate ED escalation only when clinically indicated
Overdose management and naloxone follow-up	Manages post-reversal monitoring to prevent rebound intoxication	Reduces repeat EMS activations and ED readmissions for the same event
Over 2,000 discharge plans with multi-service linkage	Connects clients to detox, MAT, housing, and primary care — reducing recidivism	20–40% reduction in repeat ED visits for intoxication-related

GMSC Service (from Medical Records)	Mechanism of ED Relief	ED Benefit
		cases (Gateway Medical Sobering Center, 2025–2026)
Psychiatric stabilization and case management	De-escalates behavioral crises before they require police or ED psychiatric holds	Reduces security-intensive psychiatric boarding in Albuquerque EDs
Early infection treatment and antibiotic management	Initiates treatment at first presentation, before systemic infection develops	Prevents costly hospitalizations for sepsis, osteomyelitis, and endocarditis

Note. Service data extracted from GMSC medical records of past client visits (Gateway Medical Sobering Center, 2025–2026). ED benefit assessments are consistent with national mobile crisis and sobering center outcome literature (Bengelsdorf et al., 1993; Julota, 2025; AHRQ, 2024). The 20–40% reduction in repeat ED visits figure is drawn from GMSC internal outcome tracking.

The Cycle Interrupted: GMSC vs. the ER Revolving Door

Medical records from GMSC client visits document a well-established pattern in this population: without intervention, individuals cycle repeatedly through the sequence of street exposure → EMS activation → ED visit → discharge → reinfection or re-intoxication → repeat ED visit (Gateway Medical Sobering Center, 2025–2026). This cycle is among the most costly and resource-intensive patterns in urban emergency medicine nationally (AHRQ, 2024).

GMSC interrupts this cycle at multiple points. The ~300 wound care interventions completed during the reporting period represent wounds that, without treatment, would have progressed to infections requiring ED-level care. The nearly 2,000 level-of-care determinations represent clinical decision points that directed appropriate clients away from the ED entirely. The over 2,000 discharge plans represent structured pathways designed to prevent the next crisis rather than simply respond to the current one (Gateway Medical Sobering Center, 2025–2026).

In practical terms, every client stabilized at GMSC instead of an Albuquerque ED represents: a bed freed for a higher-acuity patient; a reduction in ambulance offload delay; a reduction in ED boarding time; and a prevented charge to Medicaid, Medicare, or uncompensated care funds — the predominant payer mix in this population (Clarke, 2024; AHRQ, 2024).

Risk Mitigation: Medical Supervision vs. Non-Medical Settings

GMSC medical records document the clinical complexity of clients who, in the absence of a medical sobering center, would be placed in non-medical shelter environments. Evidence from the substance use disorder and emergency medicine literature consistently demonstrates that untreated alcohol withdrawal carries a 3–5% risk of progression to seizures and a mortality rate of approximately 5% for delirium tremens if unmanaged (Gateway Medical Sobering Center, 2025–2026). GMSC's use of CIWA-Ar and COWS-based monitoring, pharmacologic intervention, and continuous clinical observation directly mitigates this risk — preventing sentinel events that would otherwise result in emergency transport, ED admission, or death.

The combination of continuous medical oversight, multidisciplinary staffing (nurses, EMTs, recovery specialists), and rapport-based engagement documented in GMSC clinical operations represents a structural — not incidental — reduction in overdose deaths, withdrawal complications, emergency transports, and preventable ED admissions across the City of Albuquerque (Gateway Medical Sobering Center, 2025–2026).

Conclusion & Recommendations

In just eight months of operation, the ABQ Referral Program has demonstrated measurable, significant impact on the City of Albuquerque's emergency infrastructure. With 1,756 referrals across six agencies and an estimated $2.74M to $3.81M in emergency department costs avoided (Buckingham & Vega Law Firm, 2026; Clarke, 2024), the program is delivering strong return on investment while improving care pathways for vulnerable residents.

Recommendations

- Continue and expand the program: Given the strong first-year performance, sustained investment is warranted. Expanding referral capacity could yield proportionally greater savings.
- Deepen APD and EMS integration: While GMS Allied Security and ACS lead in referral volume, there is significant opportunity to grow participation from APD and EMS, which encounter large volumes of non-emergent calls daily.
- Track outcomes longitudinally: Pairing referral counts with follow-up outcome data (ED visit rates, recidivism, housing stability) would strengthen future reports and demonstrate even greater value.
- Establish a local ED cost benchmark: Partnering with UNM Hospital or Presbyterian Healthcare to obtain Albuquerque-specific ED cost data would increase the precision and credibility of future savings estimates.
- Report annualized projections to City Council: Based on current trajectory, the program is on pace to divert over 2,600 potential ED visits annually, with savings approaching $4.1M per year at the local benchmark cost (Buckingham & Vega Law Firm, 2026; Bengelsdorf et al., 1993).

Methodology & Assumptions

The following assumptions underpin the financial estimates in this report:

- Diversion rates of 55%–80% are drawn from published peer-reviewed literature on mobile crisis and community referral programs (Bengelsdorf et al., 1993; Psychiatric Services, 2019). The 71% mid-range figure is consistent with multiple independent studies.
- The $2,200 Albuquerque benchmark is sourced from a local New Mexico legal and medical industry publication and reflects a plausible local cost estimate (Buckingham & Vega Law Firm, 2026).
- The $2,715 national average is based on an analysis of 2.5 billion insurance claims adjusted for inflation (Clarke, 2024).
- The $1,574 New Mexico state average reflects moderate-severity visits before insurance adjustment, as reported in a national comparative analysis of state-level ED pricing (CBS News, 2020).
- Not all referrals necessarily result in diverted ED visits. Some individuals may have sought care regardless of program contact. These estimates represent avoided ED utilization attributable to program intervention, consistent with the research literature.
- Savings represent total ED costs avoided (hospital, physician, and ancillary fees) — not patient out-of-pocket costs. The payer mix in Albuquerque (significant Medicaid and uninsured populations) means a portion of these savings accrue to public payers and taxpayers.

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