AAVBC

American Academy
of Value Based Care

Emergency Room (ED) Utilization Reduction

Quick Reference Guide

2025

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1. FINANCIAL IMPACT SNAPSHOT

Cost Crisis: Approximately 1 out of every 5 U.S. adults utilize the ED for health care. Up to 37%of ED return visits within 72 hours are potentially avoidable[1-3]

Volume: 155 million ED visits in 2022; 47 visits per 100 people; ED visit rate for Black or African-American non-Hispanic people (91) was the highest among the selected racial and ethnic groups; 17.8 million admissions (11.5% of visits); 3.1 million critical care admission[1]

Avoidable Visits: 13 - 37% of ED visits could be handled in primary care, urgent care, or retail settings,a 2024 study found 24% of adult ED visits were non-urgent[2, 3]

Cost Differential: ED treatment costs nearly 12x more than physician office and can be10x more than urgent care[2]

Savings Potential: $1,500+ per diverted non-emergency case translates to$4.4 billion in nationwide savings annually[2]

Per-Visit Cost Comparison[2, 4, 5]

Care Setting	Average Cost	Cost differential (vs. ED)	Appropriate For
Emergency Department (low-acuity)	$1,716	—	True emergencies(MI, stroke, trauma, AMS)
Same-Day Primary Care	$75-150	Up to $1,641(96%)	Urgent primary care treatable (UTI, mild asthma, minor infection)
Urgent Care Center	$178	$1,538(89%)	Minor injuries (sutures, sprains, simple fracture check), X-ray, basic lab work
Telehealth/Virtual Care	$87	$1,629 (95%)	Stable follow-ups, minor acute symptoms (e.g., cold, mild rash), medication refills, routine chronic condition checks
Retail Clinic	$49	$1,667 (97%)	Minor acute conditions (e.g., vaccination, strep throat test, minor skin irritation)

2. New York University (NYU) ED ALGORITHM CLASSIFICATION SYSTEM

Reducing unnecessary Emergency Department (ED) use depends on knowing which visits are truly emergent versus potentially avoidable. The NYU ED Algorithm classifies ED encounters into four categories (Non-Emergent, Primary Care Treatable, Preventable/Avoidable, and Not Preventable) based on

discharge diagnosis.[6] This evidence-based framework helps organizations quantify avoidable utilization, guide triage and chronic-care interventions, and track performance under NCQA's Emergency Department Utilization (EDU) measure.[7]

Evidence-Based ED Visit Categories[6]

The NYU ED Algorithm is a probabilistic, discharge-diagnosis–based classifier developed from ~5,700 ED records; it assigns probabilities that a visit falls into one of several categories

Caveat: The algorithm uses discharge diagnoses; it does not replace clinical triage based on presenting symptoms (it is not a triage tool and does not determine payment appropriateness).

1. **Non-Emergent** (No 12-hour urgency)
   - **Definition:** The patient's initial complaint, presenting symptoms, vital signs, medical history, and age indicated that immediate medical attention was not necessary within 12hrs and could be evaluated/managed non-urgently outside the ED
   - **Examples:** upper respiratory virus; medication refills
   - **Appropriate settings:** Retail clinic, telehealth, routine primary care

2. **Emergent—Primary Care Treatable** (12-hour window, PC capable)
   - **Definition:** Conditions requiring prompt care but feasible in primary care/office. Did not require continuous observation, and no procedures were performed or resources used that are not available in a primary care setting
   - **Examples:** Uncomplicated urinary tract infection, pharyngitis
   - **Appropriate settings:** Same-day primary care, urgent care

3. **Emergent—Preventable/Avoidable** (Chronic disease failures)
   - **Definition:** Conditions requiring ED resources now, but the episode was potentially preventable/avoidable if timely and effective ambulatory care had been received during the episode of illness
   - **Examples (typical):** Diabetes-related complications (e.g., hyperglycemic crises), COPD/asthma exacerbations, CHF decompensation
   - **Appropriate strategy:** Population health and disease-management programs; timely access and adherence interventions

4. **Emergent—Not Preventable** (True emergencies)
   - **Definition:** Acute, severe conditions where ED-level diagnostics/interventions are necessary and prevention is not generally feasible at the episode level
   - **Examples:** Acute myocardial infarction (AMI); major trauma; acute stroke

Implementation Example:

Step	Action	Operational Focus	Notes
1. Algorithm Integration	Apply NYU or JHU-Expanded Algorithm to ED discharge diagnoses (ICD-10). Exclude trauma, MH/SUD, obstetric, and injury codes not classifiable by the tool	Data analytics / Claims team	Creates baseline view of avoidable vs. unavoidable ED utilization.
2. Risk Stratification	Quantify visit distribution: Non-Emergent, Primary-Care Treatable, Preventable/Avoidable, Not Preventable. Overlay with ACSC and HEDIS EDU metrics	Quality / UM / Population Health	Identifies high-cost, high-frequency segments for targeted intervention
3. Targeted Intervention Design	Non-Emergent → Retail / telehealth access PC-Treatable → Same-day scheduling, nurse triage Preventable → Chronic disease outreach (COPD, CHF, diabetes) Not Preventable → Maintain rapid ED response protocols	Care coordination / Operations	Drives reduction in avoidable ED use, boosts EDU and Star Ratings outcomes

3. CMS AMBULATORY CARE SENSITIVE CONDITIONS (ACSCs)

The CMS and the Agency for Healthcare Research and Quality (AHRQ) use ACSCs as indicators of primary care effectiveness and system access.[1, 2] Through the AHRQ Prevention Quality Indicators (PQIs), ACSC rates measure potentially preventable ED visits and hospitalizations. These metrics directly inform Utilization Management (UM) and Value-Based Care (VBC) frameworks by identifying high-cost, avoidable encounters, guiding targeted interventions, and linking performance to quality incentives and shared savings in CMS programs[8-10]

ACSC rates: A measure of Access and Quality
High rates of ED visits or hospitalizations for ACSCs signal breakdowns in primary and preventive care, as it often reflects gaps in access, chronic-disease control, or follow-up.[1, 2] Reducing these avoidable episodes is central to ED utilization management (UM) and value-based care, as many ACSC-related ED encounters can be prevented or redirected through improved chronic-care programs and same-day primary-care access.[3, 8]

Common contributing factors include:
- Limited access to routine or after-hours primary care
- Poor management of chronic diseases (e.g., COPD, diabetes)
- Delayed response to early symptom escalation

Monitoring ACSC rates enables systems to identify high-impact areas for proactive management, expanded clinic hours, open access scheduling and patient self-management education.

How PQIs and ACSC Rates Influence Value-Based Care Frameworks

Quality Measurement: PQIs serve as federal benchmarks for avoidable ED and inpatient utilization, directly influencing CMS quality scores and Medicare Advantage Star Ratings.[9, 10]

Performance Incentives: Lower ACSC rates improve shared savings and capitation outcomes in ACO REACH, MSSP, and other value-based payment models.[3]

Care Coordination: ACSC metrics (PQI) align with NCQA EDU, FUA, and FUM measures, emphasizing timely follow-up and care continuity after acute events

Cost Containment and ROI: Reducing ACSC-related ED visits lowers per-member per-year (PMPY) costs and improves Medical Loss Ratio (MLR) performance[5]

Population Health Insight: Stratifying ACSC data identifies high-risk populations and guides targeted chronic disease and access-to-care interventions[9]

Chronic Conditions (35–40% of ACSC visits)[12, 13]

- Diabetes complications: Hypoglycemia, acidosis
- COPD exacerbations
- Adult asthma exacerbations
- Congestive heart failure
- Uncontrolled hypertension
- CKD complications

Acute Conditions (60–65% of ACSC visits)[12, 13]

- Dehydration
- Bacterial pneumonia
- Urinary tract infections
- Cellulitis
- Gastroenteritis
- Dental conditions

Key Finding: Among adult ED patients aged 16–44 years, 77.8 % of acute ACSC visits were discharged, compared with 53.1 % for chronic ACSC visits—demonstrating significant opportunity for ED diversion and ambulatory management.[12]

4. CLINICAL OUTCOMES FROM ER DIVERSION

Effective emergency department (ED) diversion improves more than cost metrics—it enhances clinical outcomes, care continuity, and chronic-disease control.[1] [2] Programs that redirect stable or low-acuity patients to primary care, urgent care, or telehealth have demonstrated reductions in repeat ED visits, preventable hospitalizations, and acute exacerbations of chronic conditions such as COPD, diabetes, and heart failure.[3]

Primary and Urgent care triage, open access and extended hours

- **Active Triage and Call-First Protocols:** "Call Before You Go to the ER" programs using nurse or provider triage can safely redirect 20–30% of low-acuity visits to outpatient care, reducing unnecessary ED use while maintaining continuity[14, 15]

- **Flexible Appointment Options:** Offering same-day, morning, and afternoon appointments prevents escalation of chronic conditions such as COPD and diabetes. Expanded access can lower ACSC admissions by 10–15% and improve Star Rating satisfaction domains[14, 16]
- **After-Hours and Weekend Coverage:**
  Practices with evening or weekend hours experience fewer non-urgent ED visits, particularly among working-age and Medicaid populations[14. 16]
- **Predictive Modeling and Data Analytics:**
  Using EHR-based risk flags and predictive tools identifies high-risk patients early, reducing repeat ED and supporting targeted VBC care coordination[14-16]

Virtual care utilization impact:

Integrating virtual care and robust diversion protocols yields measurable improvements in utilization and cost, directly supporting Value-Based Care goals by shifting care to the most appropriate, lower-acuity setting.

- **Reduced ED Visits & Hospitalizations:** Telehealth and virtual care users are associated with fewer non-emergent ED visits and lower escalation to ED in several settings[17-19]
- **Successful Diversion Rate:** Preventing more costly care; When patients call with a symptom-based complaint, those who receive a tele-emergency consultation with a physician are significantly less likely to make an in-person ED visit within 7 days[17-19]
- **Resolution in Virtual Setting:** For acute, non-emergent conditions, most concerns can be resolved in a single virtual visit[16-18]
- **Reduced costs:** cost of a direct-to-consumer telehealth visit is significantly lower than an ED visit for an acute illness, often costing as little as **5% of an ED visit**[4, 5, 17]
- **Greater Transitional Care Management:** Embedding post-discharge virtual check-ins within 48–72 hours lowers readmissions and supports Transitional Care Management (TCM) requirements under CMS value-based programs[20]
- **Lower Skilled Nursing Facility (SNF) Transfers:** Use of telehealth in SNFs, especially virtual physician assessments, reduces unnecessary hospital transfers by 10–15%**,** improving patient safety and cutting high-cost readmission penalties[20]

California Primary Care Continuity Study[19]

Design: Retrospective cohort analysis of ~49,000 adult Medi-Cal (California Medicaid) beneficiaries with at least one primary-care visit between 2008 and 2010.

Objective: To evaluate whether continuity of primary care (seeing the same provider consistently) was associated with differences in emergency-department (ED) utilization and hospitalization rates.

Key Findings:
- Patients with **high continuity of care** (≥ 50 % of visits with the same primary-care provider) had:
  - **2.0 percentage-point higher probability of having zero ED visits** during the study year compared with those with no continuity.
  - **Fewer hospitalizations** and lower rates of **ambulatory-care–sensitive condition (ACSC)** admissions.

- Benefits were most pronounced among patients with **chronic illnesses** (e.g., diabetes, COPD, heart failure).
- Associations remained significant after adjustment for demographics, comorbidities, and access factors.

Takeaways:

Strengthening **longitudinal primary-care relationships** reduces preventable acute utilization. Embedding continuity metrics within **ED diversion**, **UM**, and **value-based care (VBC)** frameworks can lower costs while improving chronic-disease outcomes.

Financial Outcomes

- **Monthly cost reduction:** Telehealth adopters have~$500-$700 lower monthly expenditures[21]
- **Per-visit savings**: Studies of virtual urgent care and telemedicine show net savings of ~$80 per visit compared with in-person encounters, largely through avoided ED and urgent-care utilization[17]
- **Medicare and Patient Travel Savings:** The CMS Office of the Actuary and Taskforce on Telehealth Policy (2021–2024) estimated ~$60 million annually in travel-related cost savings for Medicare beneficiaries, projected to exceed $170 million by 2029 as adoption scales[20, 22]

5. RAPID TRIAGE DECISION FRAMEWORK

A standardized, rapid-assessment framework helps clinicians and care coordinators determine the safest, most cost-appropriate care setting within minutes. It supports ED utilization management (UM) by differentiating true emergencies from conditions manageable via same-day primary care or telehealth, reducing avoidable ED visits without compromising safety.[1, 9]

5-Minute Emergency Assessment Protocol[23]

Step	Time limit	Operational Focus	Notes
1. Chief Complaint	60 sec	Identify severity based on presenting symptoms	Red Flag: Chest pain, shortness of breath, altered mental status, severe pain, or fever ≥ 102 °F → Send to ED (ACEP 2023) Yellow Flag: Moderate symptoms → Same-day/urgent care Green Flag: Mild or chronic concerns → Telehealth/routine care
2. Vital Signs	90 sec	Detect physiologic instability	BP ≥ 180/110 mm Hg or < 90/60 mm Hg → ED (CDC/ACEP) HR > 120 or < 50 bpm, O_2 sat < 95 %, Temp ≥ 101.5 °F → Evaluate urgently or refer to ED depending on context
3. Focused History Review	120 sec	Assess risk factors & recent events	Recent hospitalization (< 30 days), medication changes, or unstable chronic conditions → higher risk; consider ED referral
4. Alternative Pathway Decision	60 sec	Match condition to safest care setting	Confirm same-day availability; if clinically stable, redirect to urgent care or telehealth. Escalate if symptoms progress.
5. Safety Net & Documentation	30 sec	Close the loop on care plan	Provide clear follow-up instructions, return precautions, and complete MEAT-level documentation for UM audit compliance.

Takeaway

Effective emergency triage is not limited to physicians: best practice requires that **all patient-facing team members** understand the key terms, symptom "red flags," and most common ED emergencies. Educating medical assistants, nurses, front office/call-center staff, and care coordinators in this framework ensures that every patient encounter, whether in person or virtual, supports safe, timely decision-making and prevents unnecessary ED use.

6. CONDITION-SPECIFIC DIVERSION OPPORTUNITIES

Condition-level targeting enables practices to focus diversion strategies where the highest preventable ED utilization occurs.[1] [2] Redirecting these encounters to primary care, urgent care, or telehealth produces substantial cost savings and quality-metric gains under value-based contracts.

Top treat-and-release ED visits with the highest proportion of potentially avoidable ED cases: [1, 2, 6, 24]

Respiratory Conditions (~85% avoidable)
- **Acute upper respiratory infection & other upper respiratory infections:** 5.87M ED visits per year
- **Respiratory signs and symptoms:** 2.65M ED visits
- Typically mild; manageable via primary care, urgent care, or telehealth. NYU algorithm classifies ≥90 % as *non-emergent*
- Estimated savings per diverted case: $1,140
- Estimated annual savings per 1000 members: $36,970

Gastrointestinal Symptoms (~60-70% avoidable)
- **Abdominal pain, diarrhea, and other digestive disorders:** 6.45M ED visits per year
- High-frequency, low-severity GI complaints; majority require only basic diagnostics.
- Estimated savings per diverted case: $1,140
- Estimated annual savings per 1000 members: $28,933

Minor Injuries (~70% avoidable)
- **Musculoskeletal pain / strains / sprains / superficial injuries:** 15M+ ED visits per year
- Common low-acuity visits; often appropriate for urgent care or PCP management
- Estimated savings per diverted case: $1,150
- Estimated annual savings per 1000 members: $21,996

Skin Infections (~50–65 % avoidable)
- **Skin and subcutaneous tissue infections:** 2.8M ED visits per year
- Mild cellulitis/abscess cases can usually be treated outpatient with oral antibiotics
- Estimated savings per diverted case: $1,140
- Estimated annual savings per 1000 members: $19,289

Minor Infections (~>80 % avoidable)
- **Otitis media / viral infection:1.75M ED visits** per year
- Urinary tract infections (UTI): 3.25M ED visits per year

- Highly treatable outpatient; high proportion of pediatric visits

Minor Pain (~70 % avoidable)
- **Headache / migraine (nontraumatic):** 3M+ ED visits per year
- Most cases non-emergent; red flags easily triaged

Targeting high-frequency, low-acuity conditions offers the greatest opportunity to reduce avoidable ED use. Condition-specific diversion not only lowers costs but also drives measurable gains in quality, access, and value-based performance.

7. IMPLEMENTATION STRATEGIES BY NYU CATEGORY

The NYU ED Algorithm enables organizations to operationalize ED utilization reduction by tailoring interventions to each visit category—Non-Emergent, Primary Care Treatable, and Preventable/Avoidable.

Aligning these strategies with NCQA EDU/FUA/FUM measures and CMS value-based care programs ensures that diversion efforts translate into measurable quality gains and financial performance.

NYU Category	Time limit	Implementation Strategies	VBC / UM Impact
Non-Emergent Conditions	Mild, low-acuity issues (e.g., medication refills, URI, minor rashes)	• Partner with **retail clinics** for walk-in availability [2, 5] • Integrate **telehealth protocols** for refills and follow-ups[17, 18] • Provide **extended office hours** to reduce after-hours ED visits[16] • Distribute **patient education materials** on "Call Before You Go to the ER" [15]	• Lowers NCQA EDU rates[3, 7] • Improves CMS Star Ratings "Getting Care Quickly" [10]
Primary Care Treatable	Urgent but stable (UTI, mild asthma, minor injury)	• Guarantee **same-day appointments** for acute complaints [14, 16] • Use **nurse triage** and standing protocols to redirect non-urgent calls[14] • Expand **point-of-care testing** (strep, flu, UTI)[14] • Create **direct ED-PCP consult lines** for real-time diversion[15]	• Reduces low-acuity ED approvals in UM workflows[9] • Improves ACSC and PQI performance[9, 10]
Preventable / Avoidable	Chronic-disease–driven ED use (COPD, CHF, diabetes)	• Implement **disease-specific management programs** (e.g., COPD, diabetes)[8, 19] • Deploy **home BP and glucose monitoring** with virtual follow-up. [20, 22] • Establish **asthma/COPD action plans** and **medication-adherence outreach**[9]	• Improves PQI 05 (COPD) and PQI 01 (Diabetes) metrics[9] • Supports shared-savings and readmission-reduction goals. [10]

Aligning clinical interventions with NYU ED Algorithm categories transforms ED diversion into a measurable quality-improvement strategy—lowering avoidable ED use, improving patient access, and driving value-based performance.

8. VALUE-BASED CONTRACT IMPACT

Reducing avoidable ED utilization has measurable downstream effects on value-based care (VBC) performance, driving improvements across HEDIS measures, CMS Star Ratings, and shared-savings outcomes. Lowering non-emergent ED use strengthens preventive care engagement, care coordination, and cost-efficiency; key levers in both **Medicare Advantage (MA)** and **Accountable Care Organization (ACO)** contracts.[2, 3, 10, 11, 15]

HEDIS and Quality-Measure Impact[3,10, 15-17, 19]

High rate indicates poor care management or inadequate access to care

Measure Domain	What your ED-reduction program changes	Value-Based Effect (how it shows up)
ED Utilization (AMB-ED / EDU)	Divert stable complaints to PCP/UC/telehealth; extend hours; call-first triage	Fewer low-acuity ED encounters → improved EDU rate and member experience
FUM (Follow-Up after ED for Mental Illness) / FUA (SUD)	Scheduled tele-follow-up within 7 days; warm handoffs from ED	Higher follow-up completion → better FUM/FUA scores (quality & care coordination)
CDC (Diabetes) & CBP (Blood Pressure Control)	Continuity, home monitoring, rapid access to primary care	Fewer ACSC events (PQIs) and better control rates → boosts quality and lowers acute spend. Reduces PQI 01 events (diabetes complications), Enhances Star measure *Blood Pressure Control* and PQI 07 prevention

Medicare Advantage Star Ratings – What Improves[9, 11, 15, 16, 19]

Star Domain	ED-reduction lever	How it influences Stars
Access/Experience (e.g., *Getting Care Quickly*)	Same-day visits, after-hours access, telehealth entry points	Better CAHPS access responses; supports star-level thresholds
Care Coordination	Closed-loop follow-up after ED, transitions protocols	Higher care-coordination performance; aligns with FUM/FUA completion[11 15]
Intermediate Outcomes (CBP, diabetes control)	RPM + continuity + rapid titration clinics	Better control rates; fewer PQI-flagged events

Shared- Savings and ROI Modeling:

Parameter	Example scenario (per 1000 members)	Notes
Baseline ED Rate	340 ED visits / 1,000 members / year	Current unmanaged utilization
Target Reduction	25 % (≈ 85 visits avoided)	Aligns with CMS avoidable-ED benchmarks
Estimated Gross Savings	**≈ $100,000 per 1,000 beneficiaries** based on HCUP & HCCI cost differentials.	Direct medical-cost reduction

Practice Share (50 %)	≈ $50,000 net annual gain	Reinforces sustainability of VBC participation

ED diversion, timely follow-up, and chronic-care access are the shortest path to measurable gains in HEDIS, Stars, and shared savings—convert clinical reliability into financial reliability.

9. PATIENT COMMUNICATION SCRIPTS

Initial Triage

"I want to make sure you get the right care in the right place. Let me ask a few quick questions about your symptoms."

"Based on what you've told me, it sounds like we can safely treat you through [primary care / urgent care / telehealth]. This saves you time and helps avoid unnecessary costs—an average ER visit is about $1,400, while a primary-care visit is around $160 and an urgent-care visit about $260."

"If anything changes—like new chest pain, trouble breathing, or confusion—please go to the ER immediately."

Takeaways:
- Reinforces safety first, then cost awareness.
- Positions staff as care navigators, not gatekeepers.
- Fulfills CMS "right site of care" and patient-education expectations

Cost Discussion

"Your ER copay is typically around $250–$500 depending on your plan, while a primary-care visit is about $25–$50. Some insurers may not fully cover ER visits for non-emergencies, which could leave you with a larger bill."

"Choosing an alternative site not only saves money but also helps your care team follow up more quickly and coordinate next steps."

Purpose:
- Promotes financial transparency without deterring true emergencies
- Supports Star-Rating domains for *Care Coordination* and *Getting Needed Care Quickly*
- Demonstrates compliance with CMS patient-education and cost-communication best practice

Tips

- Train all call-center and front-desk staff in script use; update quarterly with current local cost data
- Pair scripts with decision trees (ex. Section 5) to ensure consistent red-flag screening
- Document each redirected encounter under MEAT (Monitor / Evaluate / Assess / Treat)

Consistent, empathetic cost and triage scripting turns patient conversations into quality interventions while reducing avoidable ED visits, improving satisfaction, and strengthening value-based performance metrics

10. ROI Calculation Examples

A. Practice with 1,000 Patients

Parameter	Assumption
ED visits per 1,000 patients / year	340 ED visits
Avoidable ED share / Target Reduction	25 % (≈ 85 visits avoided)
Alt-site cost (PCP / UC mix)	$180 avg
Net saving per diverted visit	≈ $1,170
Shared-savings split	% payer / 50 % practice (Typical ACO/MA contract)

B. Base Case Calculation – 2,000 Patients

Category	Formula	Value
Baseline avoidable visits	(2,000 × 340 / 1,000) × 0.25	≈ 170 visits
Diverted visits (50 % success rate)	170 × 0.5	≈ 85 visits
Gross cost savings	85 × $1,170	≈ $99,450
Total financial benefit (Y1)	Savings + bonus	≈ $100 K–$165 K
Total investment (Y1)	Setup $45 K + Ops $28 K	$73 K
Net benefit (Y1)	Benefit – Investment	≈ $27 K – $92 K
ROI (Y1)	Net ÷ Investment	37 % – 126 %
ROI (Ongoing)	Benefit ÷ Annual Ops ($28 K)	250 % – 590 %

Once implementation costs are absorbed, annualized ROI can exceed 2.5–5× operating spend through sustained ED-avoidance and quality-bonus revenue.This example assumes that organizations are in high standing across Value Based framework metrics.

11. Quality Assurance Recommendations

Maintaining rigorous quality and safety oversight ensures that ED-diversion programs deliver clinical, regulatory, and contractual integrity. Oversight must confirm that every redirected patient receives medically appropriate, documented, and follow-up-supported care.

Embedding standardized protocols, physician review, and structured documentation aligns diversion programs with NCQA, CMS, and ACEP quality requirements that protect patients while sustaining Utilization-Management (UM) and Value-Based Care (VBC) performance metrics.

Safety Standards[3, 7, 9, 15, 23]

Requirement	Implementation
Board-Certified Physician Oversight	A medical director or supervising physician must review and sign off on triage algorithms, standing orders, and escalation criteria at least annually
Standardized Clinical Protocols	Evidence-based triage and follow-up templates for respiratory, GI, musculoskeletal, and dermatologic complaints; updated every 12 months
Regular Case Review & Audit	Monthly peer review of ≥10 % of diverted encounters to assess decision accuracy, outcomes, and documentation completeness
Adverse Event Reporting System	Any unplanned ED return, hospitalization, or safety event within 7 days triggers root-cause review and reporting within 72 hours
Zero-Tolerance Policy	Ongoing diversion is contingent on *zero safety events directly linked to inappropriate triage*. Immediate retraining or suspension if event occurs.

Documentation Requirements[3, 7, 15]

Element	Notes	Audit / Compliance Link
Triage Decision Rationale	Capture symptom severity, vital-sign thresholds, and decision logic supporting diversion	Required for UM audit and NCQA EDU validation
Alternative Pathway Selection	Identify selected site (PCP, UC, telehealth) and clinician responsible	Demonstrates "right site of care" compliance
Patient Education Provided	Document that the patient received written or verbal instructions on alternative-site care and red-flag symptoms	Satisfies CMS patient-communication standards
Adverse Event Reporting System	Explicit return precautions, escalation triggers, and 24/7 contact line	ACEP Triage Safety Standards
Safety-Net Instructions	Scheduled appointment or tele-check within 48–72 hours; note provider and modality	Improves FUM/FUA measure completion

Continuous Quality Improvement Process

- Conduct quarterly performance reviews on diverted-case outcomes (readmissions, satisfaction, EDU/FUM metrics).

- Maintain annual policy attestation signed by medical leadership verifying adherence to ACEP and CMS standards.
- Integrate findings into staff education and triage-protocol updates.

Quality assurance is the backbone of any successful medical practice, it is critical for providers to encourage safe and responsible ED diversion.

12. DISPARITIES REQUIRING TARGETED INTERVENTION

Addressing disparities in ED utilization is essential. Lower-income, transportation-limited, and digitally disconnected populations experience 2–3× higher rates of preventable ED visits, even after adjusting for comorbidities and access barriers. Reducing these disparities strengthens both clinical outcomes and contractual quality metrics such as EDU, FUA, and ACSC/PQI indicators.

High-Risk Populations and Drivers[1, 2, 9, 13, 20, 22]

Population / Barrier	Relative Risk	Potential Underlying Factors
Lower-income individuals	~2.5× more preventable ED visits	Limited primary-care access, insurance instability, deferred care due to cost
No personal vehicle	~2.5× higher overall ED use	Transportation barriers to same-day primary or urgent care
No internet / digital access	~2× more preventable ED visits	Inability to use telehealth or patient portals; poor follow-up continuity
Medicaid beneficiaries	Highest ED utilization rates nationally	Limited after-hours care, higher chronic burden, fragmented networks

Targeted Solutions

Intervention	Focus	Expected Impact
Transportation Partnerships	Collaborate with organizations and health plan benefits to offer rideshare, or non-emergency medical transportation (NEMT) providers.	To ensure same-day access to primary and urgent care. Reduces missed appointments and ED reliance for low-acuity issues.
Technology Access Programs	Provide loaner tablets, Wi-Fi vouchers, or public-site telehealth booths for patients without internet access.	Expands digital inclusion and improves telehealth reach
Enhanced Health Literacy Support	Integrate visual and language-appropriate materials explaining when to use PCP, urgent care, or ED.	Improves patient confidence and self-triage accuracy
Culturally Appropriate Materials	Co-design outreach with community groups to ensure language, tone, and imagery resonate with diverse populations	Increases trust, adherence, and satisfaction, improving *CAHPS* and *Star* measures

Implementation into VBC framework

- **UM Teams:** Flag social risk codes (use IC10 coding ex. Z-codes) to identify members needing transportation or digital-access support.
- **Quality Programs:** Track EDU, FUA, and ACSC rates stratified by income, insurance, and digital-access indicators.

- **Population Health Managers:** Integrate these disparity metrics into VBC dashboards and ACO equity benchmarks (per CMS 2024 guidance)[10]

Reducing avoidable ED use requires equity-driven design to ensure that diversion strategies succeed for every population, not just those with easy access to care.

Conclusion and Takeaways

Reducing avoidable ED utilization is both a clinical imperative and a strategic priority for value-based organizations.[15] When implemented with standardized triage, timely access, and robust telehealth integration, diversion programs deliver measurable gains in patient safety, cost savings, and quality performance.[3, 6, 9]

The NYU ED Algorithm offers an evidence-based foundation for risk stratification and triage decisions, while alignment with NCQA EDU/FUA/FUM and CMS ACSC measures ensures financial return and regulatory compliance.[3 9 10]

Systematic intervention can prevent up to one-third of ED visits, translating to $1,200–$1,500 savings per diverted encounter and roughly $100,000 annual savings per 1,000 members.[4,5] In practice, organizations realize ROI exceeding 150% in the first year through lower acute-care costs, shared-savings participation, and enhanced Star-Rating performance. These gains are achievable without compromising safety, programs operating under ACEP and CMS quality standards report zero adverse events from diverted care when clinical oversight and follow-up protocols are followed.[23]

Takeaways

1. **Up to 37% of ED visits** are potentially avoidable with systematic intervention
2. **$1,500 savings** per diverted visit creates compelling, repeatable ROI
3. **NYU Algorithm** provides an evidence-based framework for triage decisions
4. **~60-65% % of acute ACSCs** don't require admission - prime diversion targets
5. **Telehealth reduces** ED visits by 2-3% with very high single-visit resolution
6. **Same-day access and extended hours** is critical for successful sustainable diversion
7. **Possible 10:1 ROI** in first year makes this a priority investment for VBC organizations
8. **HEDIS improvements** greatly enhance value-based performance
9. **Zero safety events** are achievable with protocolized triage, documentation, and oversight

REFERENCES

1. Centers for Disease Control and Prevention. FastStats: Emergency Department Visits. Updated June 8, 2025. https://www.cdc.gov/nchs/fastats/emergency-department.htm
2. Illustra Health. Reducing Avoidable Emergency Department Utilization in Value-Based Care. Published August 27, 2025. https://illustra.health/blog/reducing-avoidable-emergency-department-utilization-in-value-based-care/
3. National Committee for Quality Assurance. Emergency Department Utilization (EDU). https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/emergency-department-utilization-edu/
4. Roemer M. Costs of Treat-and-Release Emergency Department Visits in the United States, 2021. HCUP Statistical Brief No. 311. Rockville, MD: Agency for Healthcare Research and Quality; September 2024. https://hcup-us.ahrq.gov/reports/statbriefs/sb311-ED-visit-costs-2021.pdf
5. Health Care Cost Institute. 2022 Health Care Cost and Utilization Report. Published April 1, 2024. https://healthcostinstitute.org/images/pdfs/HCCI_2022_Health_Care_Cost_and_Utilization_Report.pdf
6. Billings J. NYU ED Algorithm Background. New York University Robert F. Wagner Graduate School of Public Service; 2024. https://wagner.nyu.edu/faculty/billings/nyued-background
7. National Committee for Quality Assurance. Emergency Department Utilization (EDU) Measure. Updated 2025. https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/emergency-department-utilization-edu/
8. Oh NL, Potter AJ, Sabik LM, Trivedi AN, Wolinsky F, Wright B. The association between primary care use and potentially preventable hospitalization among dual eligibles aged 65 years and older. BMC Health Serv Res. 2022;22(1):1-9. doi:10.1186/s12913-022-08326-2
9. Agency for Healthcare Research and Quality. Prevention Quality Indicators (PQIs): Technical Specifications and Resources. Version 2023. https://qualityindicators.ahrq.gov/modules/pqi_resources.aspx
10. Centers for Medicare & Medicaid Services. Ambulatory Care Sensitive Conditions—Quality and Value-Based Programs Overview. Updated 2024. https://www.cms.gov
11. National Committee for Quality Assurance. Emergency Department Utilization (EDU), FUA, and FUM Measures. Updated 2025. https://www.ncqa.org
12. Parkinson B, Meacock R, Checkland K, Sutton M. Unseen patterns of preventable emergency care: Emergency department visits for ambulatory care sensitive conditions. J Health Serv Res Policy. 2022;27(3):232-241. doi:10.1177/13558196211059128
13. MedPAC (RTI International). Updating Risk-Adjusted Ambulatory Care Sensitive Hospital and ED Use. February 2024. https://www.medpac.gov/wp-content/uploads/2024/06/Feb2024_ACSH_ACSV_report_CONTRACTOR_SEC.pdf
14. Denham A, Hill EL, Raven M, Mendoza M, Raz M, Veazie PJ. Is the emergency department used as a substitute or a complement to primary care in Medicaid? Health Econ Policy Law. 2024;19(1):73-91. doi:10.1017/S1744133123000270
15. Centers for Medicare & Medicaid Services. Reducing Avoidable Emergency Department Visits. Updated 2024. https://www.cms.gov
16. Jerant A, Bertakis KD, Fenton JJ, Franks P. Extended office hours and health care expenditures: a national study. Ann Fam Med. 2012;10(5):388-395. doi:10.1370/afm.1382
17. Nord G, Rising KL, Band RA, Carr BG, Hollander JE. On-demand synchronous audio-video telemedicine visits are cost-effective. Am J Emerg Med. 2019;37(5):890-894. doi:10.1016/j.ajem.2018.08.017
18. Lyles A. The impact of telemedicine on ED costs and utilization: Literature and strategies review. EM Resident. Published December 17, 2020. https://www.emra.org/emresident/article/lit-review-telemedicine/

19. Pourat N, Davis AC, Chen X, Vrungos S, Kominski GF. In California, primary care continuity was associated with reduced emergency department use and fewer hospitalizations. Health Aff (Millwood). 2015;34(7):1113-1120. doi:10.1377/hlthaff.2014.1165

20. Taskforce on Telehealth Policy (NCQA). Findings and Recommendations: Telehealth Effect on Total Cost of Care. 2024. https://www.ncqa.org/programs/data-and-information-technology/telehealth/taskforce-on-telehealth-policy-findings-and-recommendations-telehealth-effect-on-total-cost-of-care

21. Weiner JP, Bandeian S, Hatef E, Lans D, Liu A, Lemke KW. In-person and telehealth ambulatory contacts and costs in a large US insured cohort before and during the COVID-19 pandemic. JAMA Netw Open. 2021;4(3):e212618. doi:10.1001/jamanetworkopen.2021.2618

22. Centers for Medicare & Medicaid Services. Medicare Telehealth Report to Congress, 2024. Updated 2024. https://www.cms.gov

23. American College of Emergency Physicians. Emergency Department Triage Scale and Patient Prioritization Guidelines. 2023. https://www.acep.org

24. Roemer M. Most Frequent Reasons for Treat-and-Release Emergency Department Visits, 2018. HCUP Statistical Brief No. 286. Rockville, MD: Agency for Healthcare Research and Quality; 2021. https://hcup-us.ahrq.gov/reports/statbriefs/sb286-ED-Frequent-Conditions-2018.pdf