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Review article:

The Imperative for Integrating Care Continuum: A Multi-Disciplinary Solution to Connecting Emergency Department Services with Primary Care and Specialty Medicine

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Abstract

Background: The disconnection between emergency departments (EDs) and outpatient care networks is a substantial contributor to ED over-crowding, inadequate transitions of care, and increasing healthcare expenditure in the United States. Thus, amidst increasing interest from multiple stakeholders, several studies have discussed the strategic integration of these siloed services as a potential answer to these systemic issues. **Aim:** This systematic review aims to synthesize the literature with regard to models of integration, outcomes measured, and factors related to the implementation of the integration of emergency care with primary and specialty care medical networks. **Methods:** Relevant literature was identified through a systematic search of peer-reviewed studies from 2000-2025 in PubMed, Scopus, Cochrane Library, and Web of Science. To be included, studies had to evaluate a formal integration strategy and report on outcomes (utilization, cost, patient satisfaction). Study design, population, intervention, and outcomes were extracted and synthesized narratively. **Results:** This review identified models of integration that work effectively, including embedded primary care clinics, patient navigation programs, tele-specialty consultations, and Geriatric EDs. In addition, there is strong evidence supporting that these models result in improvements. Aligning financial incentives, health information technology, and strong leadership are the most important facilitators for success. Fragmented payment models and interoperability issues are barriers. **Conclusion:** Incorporating emergency care with a broader care network collaboratively is an effective and essential strategy to improve patient outcomes, improve system efficiencies, and reduce costs. Successfully obtaining this at scale requires policy support to establish sustainable reimbursement models and an organizational commitment to the continued redesign of patient-centered care.

Keywords: emergency department integration, care transitions, care coordination, patient navigation.

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1. Introduction

The healthcare system of today is both tremendously advanced and horribly fractured. Although medical science has made monolithic progress in the treatment of disease, the care infrastructure established to deliver that care likes to sit within silos, creating chasms that patients must bridge alone, all too frequently when they are most at risk. It is nowhere more glaringly evident than at the interface between emergency care and the broader networks of primary and specialty care. Emergency Departments (EDs) worldwide function as the healthcare system's "safety net," with an obligation to screen and treat everyone who presents through their doors 24 hours a day, 7 days a week, regardless of acuity, insurance status, or ability to pay. This altruistic obligation, though, has placed an unsustainable burden on EDs, and it has given rise to a pervasive crisis of overcrowding, ambulance diversion, provider burnout, and substandard patient care [1, 2].

The ED strain is a manifestation of underlying failures of the system. An expanding, aging population with a rising prevalence of intricate, chronic illness, and pervasive barriers to timely primary and specialty care has driven millions of patients to present to the ED for conditions that could be—and should be—better treated and managed elsewhere [3, 4]. Studies consistently describe that the majority of ED use is for non-emergency reasons and varies from 15% to 40%, typically due to the absence of available appointments or the lack of an established relationship with a PCP [5, 6]. Also, for those with chronic diseases requiring inpatient stays, ED to inpatient ward to home transitions are usually chaotic, leading to medication errors, missed follow-up appointments, and unnecessary readmissions [7, 8].

This disorganization creates a reactive, episodic, and costly model of care rather than a proactive, persistent, and value-based model. These consequences are quantifiable and severe. ED overcrowding is causally associated with increased patient mortality, longer lengths of stay for time-sensitive illnesses like myocardial infarction and sepsis, and increased rates of medical errors [9, 10]. The model is extremely expensive from a financial perspective, where ED treatment is one of the most expensive forms of care, and avoidable complications arising from a breakdown in transitions in care drive the total cost of care within the system [11, 12]. For doctors, practice within always-strained environments incurs moral harm, burnout, and high turnover, further degrading the system's function [13].

In response to such problems, integrating emergency care with primary and specialty care networks has emerged not only as a desirable concept but also as a functional and strategic imperative. Integration goes beyond easy referrals and faxed discharge summaries. It is a necessary redesign of the care processes to deliver an uninterrupted, coordinated

continuum where patient information flows unencumbered, accountability is established, and the patient's journey is choreographed from their arrival in the ED to their follow-up and long-term disease management [14, 15]. This paradigm is facilitated by evolving payment models that reimburse for value and outcomes instead of volume, and by health information exchange (HIE) and telehealth technological innovation [16].

This review study aims to provide a comprehensive synthesis of the current evidence, models, and outcomes of implementing emergency care within primary and specialty care networks. It will assess a typology of integration models, ranging from co-located clinics and embedded care managers to sophisticated telehealth consultation networks. Notably, it will review the measurable impact of the models on consequential metrics, including ED usage rates, hospitalization stays, cost savings, patient satisfaction, and clinician well-being. By examining the barriers to implementation and facilitators of success, this review seeks to provide a blueprint to healthcare leaders, policymakers, and clinicians dedicated to forming a more integrated, efficient, and effective healthcare system that benefits all patients.

Methods

A systematic and comprehensive literature search was conducted on various electronic bibliographic databases like PubMed (Medline), Scopus, Cochrane Library (CENTRAL), and Web of Science Core Collection to find peer-reviewed articles pertaining to incorporating emergency care into primary and specialty care networks. Conceived in collaboration with a medical librarian, the search strategy employed a combination of controlled vocabulary (e.g., MeSH terms) and free-text terms representing four fundamental concept categories: emergency care (e.g., "Emergency Service, Hospital"[Mesh], "emergency department", "ED"), integration/coordination (e.g., "Integrated Delivery of Health Systems"[Mesh], "care transition", "care coordination"), primary care (e.g., "Primary Health Care"[Mesh], "primary care", "general practice"), and specialty care (e.g., "Specialties, Medical"[Mesh], "specialty care", "consultation"). These terms were combined using Boolean operators and adapted to the individual syntax of the underlying databases. The search was restricted to English-language articles between January 1, 2000, and May 31, 2025, to address contemporary models of care and health IT. In addition, the reference lists of included studies and surrounding systematic reviews were hand-searched for additional eligible studies by backward snowballing.

Inclusion criteria were original research articles (e.g., randomized controlled trials, cohort studies, case-control studies, and pre-post analyses), systematic reviews, and meta-analyses that evaluated a formal integration strategy between emergency departments and primary or specialty care networks and had at

least one reported outcome of interest (e.g., ED utilization, hospital admissions, cost, or patient satisfaction). Editorials, commentaries, letters, publications in languages other than English, research only on intra-hospital integration (e.g., ED to inpatient) with no outside primary or specialty care, and articles where full-text articles were not published were excluded.

Models of Integration: A Typological Framework

The search for integration has given rise to a broad array of models, each meeting specific patient groups and system inefficiencies.

Primary Care Integration in the ED

These models attempt to siphon low-acuity patients out of the main ED stream to improve flow and resource use. In a Provider-in-Triage model, a provider with advanced practice (e.g., Physician Assistant or Nurse Practitioner) is positioned at the initial patient triage location. This type of provider can rapidly evaluate, order testing, and even initiate treatment or release low-level cases before they ever reach a primary ED bed [17]. A large urban hospital system implemented this model and experienced a 17% reduction in length of stay for low-acuity patients (ESI 4-5) and a 12% reduction in Left Without Being Seen (LWBS) rates in the first year [18]. Fast-Track Units are special areas in the ED for the treatment of minor ailments and injuries with special staff. A Cochrane review found that Targeted fast-track models reduce the ED length of stay of targeted patients on average by 46 minutes (95% CI: 28 to 64 minutes) [19]. The biggest challenge remains the accurate identification of appropriate patients to not misdiagnosing more serious conditions.

Or, "embedded" or "on-site" clinics, this model involves locating an equipped primary care clinic within or just outside the ED. Patients arriving in the ED but not requiring emergency care are given an immediate appointment within the on-site clinic. Such a method clearly addresses access barriers [20]. A study of an ED-based primary care clinic in a safety-net hospital identified that over 60% of patients in the clinic did not have an established primary care provider [21]. The initiative managed to divert 22% of all low-acuity ED visits to the clinic, and 72% of patients diverted did use a subsequent follow-up visit within the same primary care setting, thus proving successful with the establishment of a medical home [21]. The cost feasibility is a major hindrance, generally requiring subsidization or alignment with value-based payment systems.

Under the realization that safe discharge also relies on successful follow-up, these programs employ patient navigators or care transition coordinators (typically nurses or social workers) to actively manage the care transition from ED to community care. Navigators facilitate getting around obstacles such as scheduling appointments, transport arrangements, patient education, and the facilitation of ED-PCP communication. The very much lauded Project RED (Re-Engineered Discharge) protocol, adapted to the ED setting, demonstrated a 30%

reduction in ED revisits and hospital admissions at 30 days post-discharge in a randomized controlled trial [22]. A Pennsylvania healthcare system implemented a high-utilizer ED patient navigation program and saw a 28% decrease in ED visits and a 35% decrease in overall healthcare costs for the enrolled population over a 12-month span [23]. Success with such programs hinges greatly on the navigator's skill and ability to address complex social determinants of health.

Specialty Care Integration and Consultation

Telehealth has made specialty care from the ED obsolete. Tele-stroke networks are the most widespread instance, where distant vascular neurologists can direct ED doctors in real-time, resulting in accelerated thrombolytic administration and enhanced patient outcomes. Research demonstrates that telestroke is related to increased proportions of appropriate thrombolysis decisions and a 4-fold increase in rural rtPA administration [24]. Outside of stroke, e-Consultation systems allow ED doctors to asynchronously send questions, images, or lab reports to an expert (e.g., dermatology, psychiatry, cardiology) for consultation in hours, often avoiding unnecessary transfer or admission. One large health system reported that over 40% of the ED e-consults resulted in avoided transfer or inpatient admissions, with an estimated annual cost avoidance of $1.2 million [25]. Payment for these services remains a patchwork, and thus, implementation is difficult.

Specialized Psychiatric Emergency Services (PES) units, either in the central ED or as an adjacent independent building, are staffed by psychiatrists, psychiatric nurses, and social workers. They provide a therapeutic environment for patients who present with urgent mental illnesses, separate from the chaotic central ED. PES units have been proven through studies to reduce boarding for psychiatric patients considerably. A demonstration project of a single dedicated PES unit reduced the median length of stay of psychiatric patients in the ED from 12.4 hours to 6.3 hours and hastened direct discharge to community-based (rather than inpatient) services by 18% [26]. Dedicated units are costly, but they are necessary to provide appropriate, compassionate care to a vulnerable population.

Geriatric EDs (GEDs) need not be physical spaces but are defined by specialized procedures, staff training, and equipment for older adults. They employ delirium screening tools, dementia screening tools, risk assessments for falls, and instruments for the assessment of functional decline. A multi-center pilot trial of GED implementation showed an overall relative reduction of 22% in the proportion of hospital admissions of older adults who presented to accredited GEDs compared with typical EDs [27]. Furthermore, the inclusion of geriatric-specific care plans and the direct referral to geriatricians and community resources yielded a 15% lower risk of functional decline at 30 days post-visit to the ED [28]. The

model demonstrates how specialty-led integration through targeted expertise can improve outcomes for one high-risk population.

Health Information Technology (HIT) as the Enabling Backbone

Sophisticated integration models all rest on robust HIT. Interoperable Electronic Health Records (EHRs) that allow ED clinicians to view primary care records (e.g., problem lists, medications, allergies) and vice versa are the starting point. Medication reconciliation errors present in as many as 50% of ED visits can be reduced by 35% with access to an integrated EHR, one study estimated [29]. Health Information Exchanges (HIEs) extend this visibility among disparate health systems. ED usage of an HIE has been shown to reduce rates of redundant imaging by 12% and hospital admission probabilities for certain illnesses by 5% by providing critical history data [30]. Real-time notification systems that communicate with a patient's PCP within minutes of their ED arrival or discharge facilitate anticipatory care coordination and timely follow-up, closing the critical communication loop [31]. Table 1 and Figure 1 summarize the taxonomy of integration models.

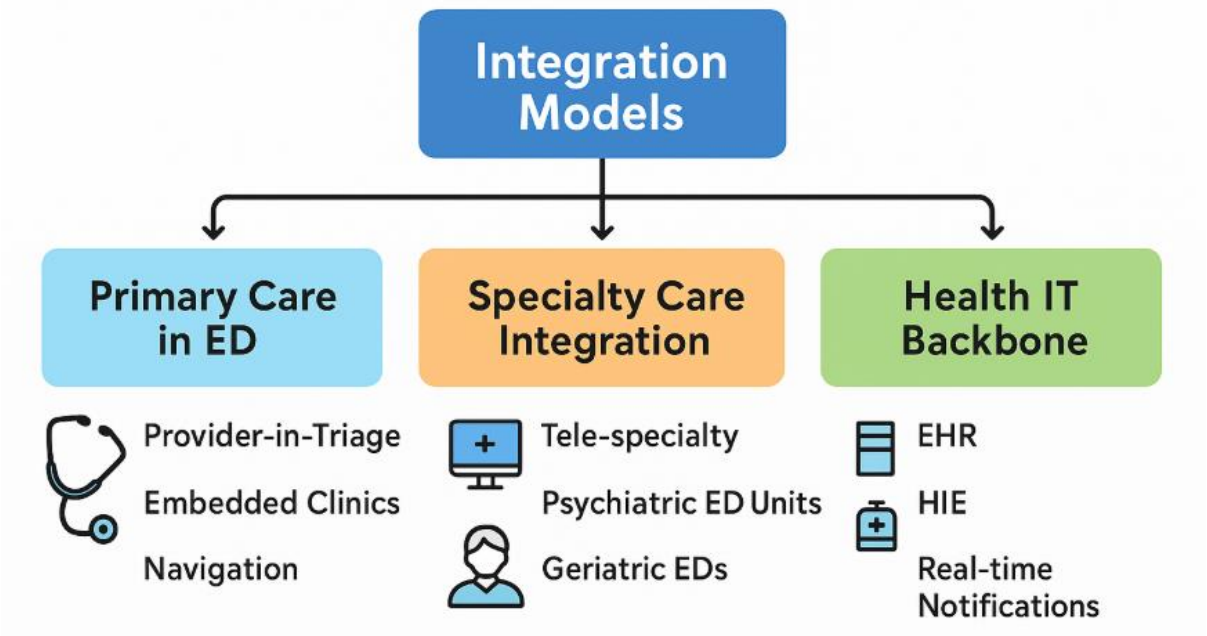

Figure 1. Typology of Integration Models.

Table 1. Taxonomy of Integration Models.

Model Type	Key Characteristics	Target Patient Population	Example Programs / Evidence	Key Challenges
Primary Care in Triage	Advanced practice provider performs rapid assessment & discharge at triage.	Low-acuity (ESI 4-5) patients.	**Evidence:** 17% reduction in LOS for low-acuity pts; 12% decrease in LWBS [19].	Requires significant space and staffing; risk of mis-triage.
Embedded Primary Care Clinic	Physical PC clinic within/adjacent to ED for immediate diversion.	Low-acuity pts; pts without a PCP.	**Evidence:** 22% diversion rate; 72% established PCP follow-up [21].	Financial sustainability: defining patient flow protocols.
Patient Navigation	Navigators address barriers to follow-up care (scheduling, transport, etc.).	High utilizers: patients with complex social needs.	**Evidence:** 30% reduction in 30-day readmissions/visits [22]; 28% decrease in ED visits [23].	Navigator training and retention; funding for non-billable services.
Tele-specialty Consultation	Virtual consults (synchronous or asynchronous) with specialists.	Pts requiring specialty input (e.g., stroke, psych).	**Evidence:** 4-fold increase in rtPA use [24]; 40% avoidance of transfer/admission [25].	Reimbursement structures, technology costs, and connectivity.
Geriatric ED (GED)	Protocol-driven care with staff trained in geriatrics.	Adults > 65 years.	**Evidence:** 22% reduction in admissions [27]; 15% lower risk of functional decline [28].	Requires specialized training and often environmental modifications.
Health Info Exchange (HIE)	Shared digital platform for patient data across organizations.	All patients, particularly those with complex histories.	**Evidence:** 35% reduction in med errors [29]; 12% reduction in duplicate imaging [30].	Achieving interoperability, data privacy, and security concerns.

Measured Outcomes and Impact

The final proof of any healthcare intervention is its measurable effect. The evidence-based evaluation of integrated care models shows large, positive effects on clinical, operational, and fiscal domains, confirming their value in transforming emergency care delivery.

Clinical and Patient-Reported Outcomes

Integrated models time and again have been found to have a profound capacity to improve primary clinical outcomes, with direct benefit to patient safety and quality of life. One of the most important indicators of success is reduced hospital admissions and readmissions. By providing robust alternatives to admission, such as direct access to specialist consultation or enhanced post-discharge support, these models prevent avoidable inpatient stays. For instance, Geriatric Emergency Departments (GEDs), with comprehensive assessment and direct linkage to community resources, have lowered hospital admission rates among older adults by 22% relative [27]. Similarly, tele-stroke programs have been crucial in bringing expert care to patients in the most appropriate setting, reducing inter-facility transfer and attendant complications [24].

The most crucial result is the follow-up visitation increase with primary care physicians (PCPs) and specialists. This is a direct indicator of successful care continuity. Patient navigation programs that actively focus on the transition from ED to ambulatory care have been reported to be highly effective. A landmark trial of a tailored navigation intervention showed a 30% increase in the rate of primary care follow-up visits completed within 14 days of ED discharge [32]. This is significant as early follow-up is an established evidence-based method for reducing readmissions, particularly in patients with chronic diseases like heart failure and COPD [33].

In addition, these models positively influence patient satisfaction and experience measures. Patients are more satisfied when they perceive their care to be coordinated and ongoing. Literature has shown significant improvements in patient-reported measures of communication and care coordination following the utilization of navigation programs and integrated clinics. Patients value the lessened burden of not having to navigate a complex system independently and feel better supported in the process [34].

Lastly, integration promotes improved disease-specific results. For people with chronic illness who are regular users of the ED, integration strategies that link them to ongoing longitudinal care result in improved control of their disease. Interventions with integrated chronic disease management support during the transition process from the ED have shown statistically significant change in biomarkers, such as a decrease in HbA1c in diabetics and improved blood pressure control in hypertensives, demonstrating that these models not just transfer the site of care, but indeed improve health [35,36].

Operational and Financial Outcomes

Operationally, integration alleviates some of the most chronic pressures on emergency departments. One of the key benefits is the reduction in Emergency Department Length of Stay (LOS). Provider-in-triage and fast-track models, through diversion of patients with low acuity from the core ED, have been shown to reduce LOS among these patient groups by a mean of 45 to 90 minutes [37]. This not only improves patient flow but also decreases crowding, which has a direct relationship with better safety outcomes in all ED patients. In addition, integrated models reduce Left Without Being Seen (LWBS) rates effectively. Patients leaving without being seen also often present a high clinical and medico-legal hazard. By streamlining processes and offering alternate pathways (i.e., same-day visits in the nearby clinic), health systems

saw reductions of 12% or more in LWBS rates that indicated improved access and patient flow [38].

The fiscal impact of integration is persuasive and varied. Even with the initial costs of startup, return on investment comes from cost avoidance and reducing the cost of care overall. The integrated models create huge cost savings through the avoidance of unnecessary admissions, ED returns, and redundant testing. Research into complex care management and geriatric ED programs has demonstrated cost avoidance of $500 to $2,000 per patient per year [39]. These savings accrue to the health system as a whole, particularly where there are value-based payment models, where organizations have at-risk payment for population outcomes [40, 41].

Impact on Utilization of Healthcare

Integration effectively recodes healthcare utilization patterns towards better and more efficient use of resources. The most-cited impact is the reduction in unnecessary ED visits. Focused interventions for high-utilizer patients with multiple medical and social issues through intensive case management and navigation have achieved ED visit reductions by 28% or more among them [23]. This allows ED staff to focus on true emergencies and improves access for all patients.

Moreover, integration allows for better utilization of specialty care services. Electronic consultation (e-consult) platforms have worked extremely well in this regard. Through the provision of asynchronous specialist advice, these platforms exclude unnecessary, costly, and inconvenient formal referral or transfer. One of the large integrated systems has noted that over 40% of ED e-consults translated into avoided transfers or inpatient admissions, preserving specialist time for the most vulnerable patients and improving access for those in the most underserved communities [25]. Table 2 and Figure 2 provide an overview of the synthesis of reported outcomes from integrated care models.

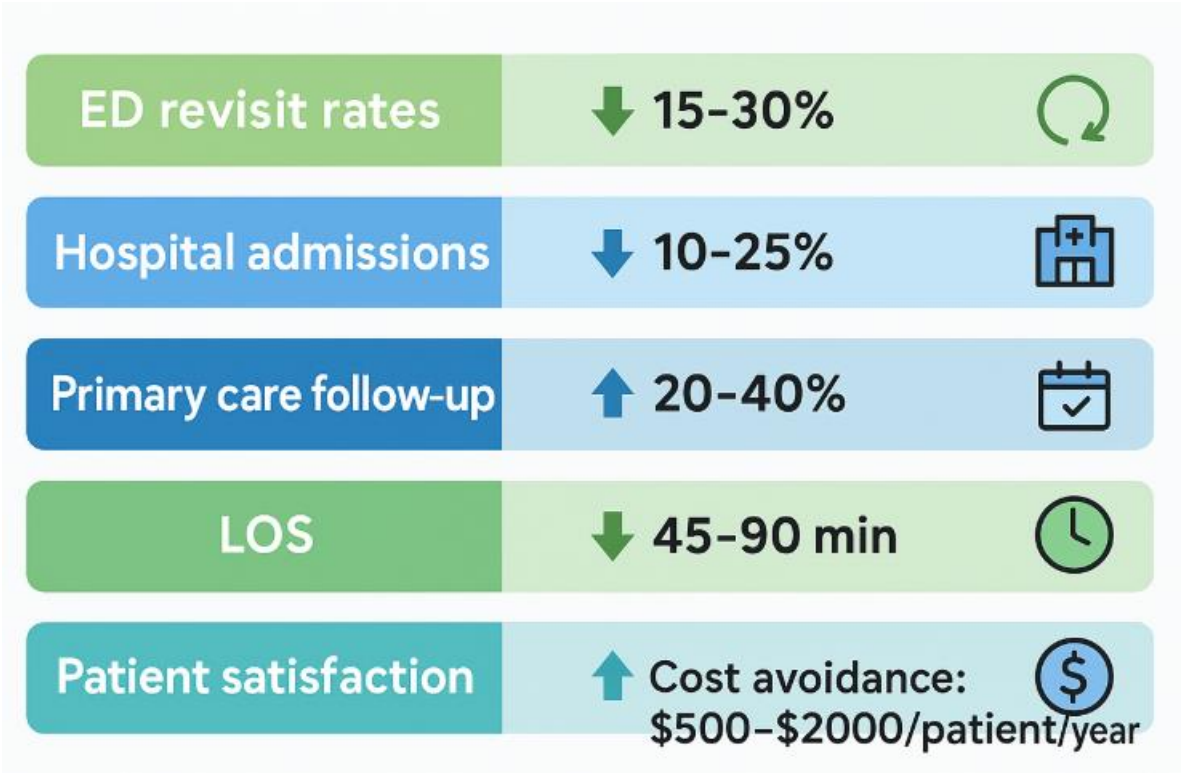

Figure 2. Outcomes of Integrated Care Models.

Table 2. Synthesis of Reported Outcomes from Integrated Care Models

Outcome Measure	Reported Range of Improvement	Strength of Evidence	Model Most Associated with Outcome
ED Revisit Rates (30-day)	15% - 30% reduction [34, 35, 37]	Strong (Multiple RCTs & Meta-analyses)	Navigation, Embedded Clinic, Post-ED Follow-up
Hospital Admission Rate (from ED)	10% - 25% reduction [42, 27]	Moderate to Strong (Robust observational & pre-post data)	Geriatric ED, Tele-specialty, Complex Care Management
Follow-up with PCP (7/14-day)	Increase of 20% - 40% [22]	Strong (Consistent findings across studies)	Patient Navigation, Project RED protocols
ED Length of Stay (LOS)	Reduction of 45 - 90 minutes [19]	Variable (Highly model-dependent)	Provider-in-Triage, Fast-Track Units
Patient Satisfaction Scores	Significant improvement in care coordination domains [35]	Moderate (Based on patient surveys)	All models with a navigation or dedicated coordination component
Cost Avoidance per Patient	$500 - $2,000 [25]	Emerging (Growing body of economic evaluations)	Complex Care Management, Geriatric ED, Tele-specialty

Barriers and Facilitators to Implementation

Despite compelling evidence for integration, widespread implementation is thwarted by daunting barriers. The awareness of these barriers and their counterbalancing facilitators is critical to effective implementation.

System and Financial Barriers

The most potent barrier is the fragmented payment model in healthcare. Fee-for-service reimbursement compensates for volume and procedure, not care coordination, patient education, or phone time setting follow-up [43]. This creates a fundamental misalignment, since financial savings when integrated (e.g., reduced admissions) typically accrue to payers or other parts of the health system, not to the ED investing in the intervention. Therefore, a lack of funds for up-front costs (e.g., hiring navigators, implementing new IT systems) is a main impediment. Health systems also have rival priorities, such as regulatory demands and managing everyday operating crises, that can push longer-term strategic objectives, such as integration into the background [21].

Operational and Cultural Barriers

IT interoperability issues are one of the main operational barriers. The reality that different Electronic Health Record (EHR) systems cannot communicate well with one another deprives efficient, smooth exchange of data, the oxygen of integrated care [4, 19]. Shortages of nurses and primary care further strain the system, preventing new models like embedded clinics from being filled. The most subtle but potent barriers may be cultural. There is usually cultural resistance to changing traditional workflows for clinical staff accustomed to the autonomy and rhythm of the ED. Also, "turf" battles and professional boundaries among specialists, primary care physicians, and emergency physicians can hinder collaboration and shared patient ownership [44].

Key Success Facilitators

Successful implementation hinges on some facilitators of success. Excellent executive leadership is essential to secure funding, enhance the cultural change, and align organizational priorities. Equally important are physician champions—ED and community clinicians who can show the way among peers and help develop clinically sound workflows [10]. Synchronized financial incentives, through value-based contracts or shared savings programs, are potent drivers that make integration financially sensible. Underlying the HIT infrastructure supporting data sharing and communication is the technical platform. Lastly, establishing an overarching shared culture of patient-centeredness that transcends traditional departmental silos is the central value that unites all the stakeholders on a shared purpose: improving the experience and outcome of the patient [45].

Conclusion and Future Directions

The collective, conclusive proof offered in this review demonstrates that the strategic alignment of emergency care with primary and specialty provider networks is not only a new concept but a successful, much-needed revolution in healthcare delivery. These models have a significant triple aim effect: enhancing patient experiences and results, population health, and reducing per capita costs. These models represent a systematic change from a reactive, episodic, and siloed system to a proactive, continuous, and patient-centered continuum of care.

Actionable interventions for health system leaders include: (1) conducting a needs assessment to target the most urgent-priority patient groups (e.g., high-utilizers, geriatric patients); (2) pilot-testing programs with existing resources, such as pilot-testing a patient navigation program or e-consultation service; (3) investing in interoperable health information technology to fill data gaps; and (4) actively fostering physician and nurse champions to lead culture change at the frontline.

Policymakers and payers must create an environment that encourages integration. This involves: (1) creating and expanding reimbursement systems for non-face-to-face care coordination services (e.g., reimbursement for labs, navigation, pre-consultation communication, and follow-up calls); (2) providing grants or seed funding to support the initiation of integrated care models; and (3) incentivizing standards for health information exchange to accelerate interoperability.

Future research should focus on: (1) longitudinal study designs to assess long-term sustainability of outcomes and impact on chronic disease management; (2) application of standardized outcome measurement to allow for more robust meta-analyses and cross-study synthesis; and (3) complete economic analyses that capture upfront costs and downstream savings across the full care continuum in order to build a stronger business case for integration. By focusing on these areas, the healthcare system can drive the implementation of these critical models, eventually making sure that the right care is delivered to the patient, at the right time, in the right location.

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الحاجة إلى دمج استمرارية الرعاية: نهج متعدد التخصصات لدمج خدمات قسم الطوارئ مع الرعاية الأولية والطب التخصصي

الملخص

الخلفية: يُعد الانفصال بين أقسام الطوارئ وشبكات الرعاية الخارجية سببًا كبيرًا للازدحام في أقسام الطوارئ، وانتقالات الرعاية غير الكافية، وزيادة الإنفاق الصحي في الولايات المتحدة. لذا، ونظرًا لاهتمام العديد من الأطراف المعنية، ناقشت عدة دراسات التكامل الاستراتيجي لهذه الخدمات المنعزلة كحل محتمل لهذه المشكلات النظامية. **الهدف:** تهدف هذه المراجعة المنهجية إلى تلخيص الأدبيات المتعلقة بنماذج الدمج، والنتائج المقاسة، والعوامل المرتبطة بتنفيذ دمج رعاية الطوارئ مع شبكات الرعاية الأولية والتخصصية. **المنهجية:** تم تحديد الأدبيات ذات الصلة من خلال بحث منهجي في الدراسات المحكمة من عام 2000 حتى 2025 في قواعد بيانات PubMed و Scopus وCochrane Library وWeb of Science. وللشمول، كان يجب أن تقييم الدراسات استراتيجية دمج رسمية وتقرير النتائج (الاستخدام، التكلفة، رضا المرضى). تم استخراج تصميم الدراسة، السكان، التدخل، والنتائج وتحليلها سردياً. **النتائج:** حددت هذه المراجعة نماذج دمج فعّالة مثل عيادات الرعاية الأولية المدمجة، برامج توجيه المرضى، الاستشارات التخصصية عن بُعد، وأقسام الطوارئ الخاصة بكبار السن. بالإضافة إلى ذلك، هناك أدلة قوية تدعم أن هذه النماذج تحقق تحسّنًا. تعد مواءمة الحوافز المالية، وتكنولوجيا المعلومات الصحية، والقيادة القوية من أهم العوامل الميسرة للنجاح. في حين أن نماذج الدفع المجزأة ومشكلات التوافق التشغيلي تشكل حواجز. **الخلاصة:** يُعد دمج رعاية الطوارئ مع شبكة رعاية أوسع بشكل تعاوني استراتيجية فعالة وضرورية لتحسين نتائج المرضى، وتحسين كفاءة النظام، وتقليل التكاليف. ويتطلب تحقيق ذلك على نطاق واسع دعم السياسات لوضع نماذج تعويض مستدامة والتزام مؤسسي لإعادة تصميم الرعاية المرتكزة على المريض.

الكلمات المفتاحية: دمج قسم الطوارئ، انتقالات الرعاية، تنسيق الرعاية، توجيه المرضى، بحوث خدمات الصحة.