Impact of the "Five Unifications" Policy on Nursing Quality in Integrated Medical Consortiums: A Longitudinal Study

Authors:

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Abstract

Objective: To systematically review the theory and practice of nursing management in tightly-integrated medical consortia at home and abroad, address current challenges, and explore the development of an innovative model and implementation pathway under the "Five Unifications" policy framework to promote the integration of county-level nursing resources and enhance service capacity.

Methods: Content analysis was employed to examine the evolution of relevant theories, typical models, implementation outcomes, and existing problems both domestically and internationally, thereby summarizing and constructing a nursing management model and implementation pathway for medical consortia.

Results: China has developed models such as multidisciplinary collaboration and standardized management, which have improved nursing quality, yet still faces challenges including imbalanced human resources and information silos. International models of digital integration and team collaboration offer valuable insights. This study proposes a "Five Chains Integration" pathway based on the "Five Unifications" policy—integrating talent, process, information, quality, and resource chains—to achieve systematic synergy.

Conclusion: The "Five Unifications" policy is crucial for overcoming management bottlenecks. The "Five Chains Integration" can effectively activate human resources, redesign workflows, dismantle information barriers, optimize resource allocation, and leverage DRG/DIP reforms to monetize nursing value. This provides a theoretical and practical blueprint for a new paradigm of nursing management in tightly-integrated medical consortia, with significant strategic implications for advancing tiered diagnosis and treatment and the "Healthy China" initiative.

Full Text

Exploration of Nursing Management Models in Compact Medical Communities under the Five Unifications Policy

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Abstract

Objective: To systematically review the theory and practice of nursing management in compact medical communities both domestically and internationally, identify existing challenges, and explore an innovative model and implementation pathway under the "Five Unifications" policy framework to promote the integration of county-level nursing resources and enhance service capacity.

Methods: Content analysis was employed to examine the evolution of relevant theories, typical models, implementation outcomes, and existing problems at home and abroad, thereby summarizing and constructing a nursing management model and implementation pathway for medical communities.

Results: Domestic models such as multidisciplinary collaboration and homogenous management have improved nursing quality, yet challenges persist including uneven human resource distribution and information silos. Foreign models of digital integration and team collaboration offer valuable insights. This study proposes a "Five Chains Integration" pathway grounded in the "Five Unifications" —integrating talent chains, process chains, information chains, quality chains, and resource chains—to achieve systematic synergy.

Conclusion: The "Five Unifications" policy is key to resolving management bottlenecks. "Five Chains Integration" can effectively activate human resources, reshape processes, break down information barriers, optimize resource allocation, and promote the monetization of nursing value through reforms such as DRG/DIP, providing a theoretical and practical blueprint for a new paradigm of compact medical community nursing management with strategic significance for advancing tiered diagnosis and treatment and the "Healthy China" initiative.

Keywords: Five Unifications; Medical Community; Nursing Management; Literature Review

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Against the strategic backdrop of deepening medical and health system reforms, compact county-level medical and health communities (hereinafter referred to as "medical communities") have emerged as a critical vehicle for implementing tiered diagnosis and treatment systems and optimizing primary healthcare

resource allocation, representing an essential pathway toward achieving the "Healthy China 2030" goals. In December 2023, the National Health Commission issued the "Guiding Opinions on Comprehensively Promoting the Construction of Compact County-Level Medical and Health Communities," explicitly identifying medical community development as a core initiative for enhancing the systematic, coordinated, and efficient delivery of county-level medical services [1]. Various regions have actively responded by exploring diverse practical models; for instance, Pujiang County in Chengdu has achieved remarkable results in resource integration and service coordination through its "Four Threes" mechanism of "integrated management, collaborative development, homogeneous services, and joint health governance" [2].

Nursing management serves as a crucial support system for medical community operations, and its model innovation directly impacts overall service effectiveness and health outcomes. In recent years, domestic scholars have conducted numerous explorations into nursing management within medical communities. Cao Rong et al. [3] constructed a compact medical community nursing management program that integrated resources and refined guidance and assessment mechanisms, significantly improving regional nursing management homogenization. Fei Yijun et al. [4] proposed a nursing alliance structure that strengthened service continuity and resource utilization efficiency within medical consortia through unified training, quality control, and information platform construction.

However, current nursing management practices in medical communities still face numerous challenges. Most studies have focused on integrating single resources such as personnel or equipment, without systematically establishing a multi-chain coordination mechanism encompassing talent cultivation, process optimization, information connectivity, quality control, and resource allocation. Issues such as non-uniform performance incentives and quality evaluation standards, low platform interoperability, and insufficient dynamic resource allocation response have hindered the realization of a "monitoring-feedback-optimization" closed loop. Additionally, significant regional disparities in resource allocation and development stages have limited the scalability of existing models.

To address these dilemmas, Hubei Province pioneered the "Five Unifications" policy framework—unified standards and processes, unified position management, unified information platforms, unified performance assessment, and unified resource allocation—providing institutional safeguards for nursing management. Against this backdrop, this study innovatively proposes the "Five Chains Integration" development pathway. Grounded in the "Five Unifications" as the institutional cornerstone, this approach achieves deep coupling of talent chains, process chains, information chains, quality chains, and resource chains to construct a closed-loop management system covering the entire service cycle. The aim is to form a replicable and scalable new paradigm for county-level medical community nursing management, providing theoretical support and practical

reference for high-quality implementation of tiered diagnosis and treatment.

1. Evolution of Nursing Management Theory in Compact Medical Communities

The theoretical development of nursing management in compact medical communities fundamentally represents the evolution of systematic solutions addressing fragmented medical resources and disrupted service chains. This development rests upon two major theoretical frameworks.

Holistic governance theory, proposed by Perri 6 in 1997, advocates for a citizen-centric approach that leverages information technology and coordination, integration, and accountability mechanisms to consolidate dispersed resources into a unified platform, thereby providing one-stop services and enhancing government governance [5]. In recent years, researchers have applied this theory to compact medical community construction and pathway optimization, enabling effective interconnectivity of dispersed medical resources across policy, funding, and talent dimensions, thereby improving overall service effectiveness and resident health security [6-7].

Collaborative governance theory, emerging in the 1990s from the combination of Hermann Haken' s synergetics concept and governance theory, calls for joint responses to social issues by governments, non-governmental organizations, enterprises, and citizens through collaborative efforts and complementary advantages. This approach aims to achieve whole-system benefits exceeding the sum of individual parts, constructing a comprehensive, multi-level governance system that promotes social harmony and stability [8]. Liu Yaqing et al. [9], in a practical study in Gongyi City, noted that through government leadership, inter-agency collaboration, and institutional and economic support, compact medical community construction achieved improvements in medical service quality and resident health levels. Cui Zhaohan et al. [10] found through empirical research that administrative mechanisms form the foundation of organizational synergy, while relational mechanisms (such as doctor-patient trust and community participation) significantly enhance the continuity of primary healthcare services.

Overall, current domestic research has explored the internal mechanisms and practical models of county-level compact medical communities from two distinct perspectives: holistic governance and collaborative governance. Holistic governance theory emphasizes resource integration, process reengineering, and cross-departmental collaboration under systematic thinking, focusing on constructing a unified, coordinated, and sustainable governance system. Collaborative governance theory, conversely, stresses flexible and efficient coordination mechanisms among various stakeholders, validating the decisive role of government guidance and multi-actor collaboration in improving medical community operational efficiency. Existing research has provided rich theoretical and empirical support for medical community construction.

2.1 Main Domestic Models and Effectiveness of Compact Medical Community Nursing Management

Domestic compact medical community nursing management has adopted several primary models:

1. **Multidisciplinary collaborative management model**: This approach integrates nursing, medical, rehabilitation, and psychological resources through medical community information platforms, establishing patient databases to implement standardized, individualized nursing interventions. Emphasizing data-driven decision-making and team collaboration, this model is commonly applied in chronic disease management and pressure injury prevention [11-13].
2. **Homogenous management model**: This model promotes unified nursing quality standards, training systems, and assessment mechanisms within medical communities, achieving standardization and normalization of nursing services across all levels of healthcare institutions. Common practices include rotating nursing staff training, skills assessment, and joint quality control system construction [14-16].
3. **Extended nursing service model**: Leveraging medical community platforms, this model extends inpatient services into communities and homes, particularly suitable for chronic disease, postoperative rehabilitation, and geriatric care scenarios. This approach often integrates "Internet+Nursing" technologies to achieve integrated online assessment, offline service, and remote guidance [17-20].
4. **Target management and performance incentive model**: Grounded in target management theory, this model establishes clear nursing quality objectives and drives improvement through regular assessments and incentive mechanisms, commonly applied in primary healthcare facility capacity building [21].
5. **Traditional Chinese medicine nursing appropriate technology promotion model**: This model systematically promotes TCM nursing techniques within medical communities through methods such as "downward dispatch and upward research" and "layered training," enhancing primary TCM nursing service capacity [22].

The implementation of domestic compact medical community nursing management has yielded several notable effectiveness outcomes. **Patient outcomes have improved**, evidenced by reduced pressure injury incidence, enhanced self-management capabilities among chronic disease patients, fewer complications, and improved quality of life [11-12]. **Resource integration and efficiency optimization** have been achieved through vertical management, resource sharing, and information connectivity, enabling rational allocation and efficient utilization of nursing human resources [15,23]. **Primary care capacity has been strengthened**, with standardized training, technology dissemination, and spe-

cialist nurse cultivation effectively enhancing professional capabilities and service levels among primary care nursing staff [24-25]. Improvements have been observed in primary care quality scores, emergency response capabilities, and documentation standardization [16,26]. **Nursing satisfaction has increased**, with patient satisfaction with nursing services generally improving, particularly in extended and specialized nursing services [27-28].

2.2 Problems and Challenges in Domestic Implementation

Despite these achievements, several problems persist in domestic compact medical community nursing management implementation:

- **Human resource allocation remains uneven**, with primary healthcare institutions suffering from insufficient nursing staff, irrational structural composition, and inconsistent professional capabilities that hinder full compliance with homogenous management requirements [22,29].
- **Information platform construction remains incomplete**, as some medical community information management systems have not achieved full integration, impeding data sharing and affecting multidisciplinary collaboration and continuity of care implementation [19].
- **Cultural integration and management coordination prove difficult**, as original management systems and cultural atmospheres vary significantly among member units, generating resistance or execution deviations during integration [16].
- **Performance assessment and incentive mechanisms remain inadequate**, lacking scientific, unified nursing performance evaluation systems that effectively motivate nursing staff to actively participate in medical community construction [28].

2.3 Foreign Models and Effectiveness of Integrated Healthcare System Nursing Management

Foreign integrated healthcare systems have developed several nursing management models with demonstrated effectiveness:

1. **Digital integrated care model**: This approach employs AI prediction tools, remote monitoring platforms, and cross-institutional electronic health records to achieve care coordination. Guo' s hierarchical management model significantly improved nursing quality and patient satisfaction, suggesting it should be promoted as an effective strategy for optimizing nursing services [30]. The Dutch Buurtzorg community nursing model, utilizing an APP-based scheduling system, reduced nurses' administrative burden and increased home visit efficiency, resulting in decreased per capita medical expenditure and saving approximately $1,200 per person annually in emergency care costs [31].
2. **Interprofessional team-based care model**: This model features nurse-

led multidisciplinary teams integrating social workers, pharmacists, and community resources. Canada' s "Health Links" program, coordinated by nurse case managers, increased rural elderly vaccination rates by 40% through weekly virtual team meetings that developed personalized care plans [32]. Germany' s Integrated Care Centers (ICCs) incorporated community nurses into hospital discharge planning, reducing readmission rates by 18% [33].

3. **Value-based payment model**: This approach links insurance payments to nursing-sensitive indicators (such as fall incidence and patient self-management capabilities), with nursing teams earning performance bonuses through quality achievement. In the US CMS "BPCI-A" program, participating hospital nurses reduced joint replacement patient rehabilitation cycles by five days [34].

These foreign practices emphasize professional nursing leadership, standardized processes, cross-sector collaboration mechanisms, and deep IT empowerment. Their core principle involves empowering nurses, clarifying their value, and supporting their role through institutional and technological frameworks—offering important lessons for China' s medical community construction under the "Five Unifications." Beyond administrative integration, greater emphasis should be placed on stimulating the intrinsic vitality and professional value of the nursing workforce through scientifically designed roles, responsibilities, incentives, and support systems that position nursing staff as key drivers for medical communities to achieve "people-centered health" goals.

2.4 Challenges in Foreign Integrated Healthcare Nursing Management Implementation

Foreign integrated healthcare nursing management implementation also faces significant challenges:

- **Nursing human resource system adaptation disconnects**: Nurses must assume integration and coordination responsibilities, yet 80% lack cross-institutional decision-making authority (such as resource allocation), creating a power-responsibility imbalance [35]; only 35% of community nurses can proficiently use AI triage tools, exacerbating workload burdens [36]. US ACO nurses spend an average of 17.9 hours per week on administrative tasks due to multi-system data entry, with turnover rates climbing to 31% [30].
- **Technology integration barriers**: Interoperability rates among hospital, community, and home care systems remain below 20%, requiring nurses to manually re-enter 68% of data fields [37].
- **Payment and incentive misalignment**: Nursing quality indicators (such as pressure ulcer prevention) require increased staffing investment, yet payment models mandate 15% cost reductions, creating goal conflicts [38]. In UK Primary Care Networks (PCNs), nurse-led health screenings

account for only 12% of payment weights, with funding dependent on temporary project support [39].

These challenges serve as warnings for "Five Unifications" policy implementation: beyond institutional unification, explicit authority for nurse-led cross-institutional coordination must be established within regional medical community systems, unified nursing information platforms must be constructed, and every nursing professional must be ensured proficient operation capabilities.

3. Future Innovation Pathways for Compact Medical Community Nursing Management Models

Future innovations in compact medical community nursing management models can focus on four key dimensions:

1. **Institutional innovation** to break systemic bottlenecks: Establish county-level nursing resource allocation centers with unified budgeting and quality control [40-41]; implement "county-managed township-used" flexible staffing pools with position allowances and professional title preferences [17-18]; and adopt DRG/DIP nursing value add-ons that incorporate nursing quality outcome indicators into payment assessments [11].
2. **Service restructuring** to create a three-level integration chain: County hospitals establish specialist nursing alliances to provide guidance on critical care, complex wounds, and intravenous therapy complications through online or on-site consultation [42-43]; township hospitals establish nursing-public health fusion stations responsible for chronic disease management and medical-preventive care integration [12,44]; and village clinics establish smart health kiosks for chronic disease risk screening and emergency referral [19].
3. **Technology empowerment** through primary care-adapted smart solutions: Break information silos via county nursing data centers and cross-institutional automated data capture [11].
4. **Talent revolution** through new nursing workforce cultivation: Establish practical training bases in county hospitals, implement a "dual-teacher" talent program, appoint medical community lead unit head nurses as primary care nursing directors, and integrate village doctors into the nursing continuing education system [27].

To construct a new paradigm of compact medical community nursing management with Chinese characteristics, the core lies in comprehensively implementing the "Five Unifications" policy through five key pathways. First, **unified management systems** break the "multiple management heads" dilemma by establishing county nursing resource allocation centers that vertically manage personnel, finances, and materials to improve resource utilization efficiency [15]. Second, **unified personnel deployment** activates human resource potential

through "county-managed township-used" staffing pools and dual employment systems, expanding the scale of registered personnel under record-filing systems and implementing primary care service incentive policies linked to professional title promotion [16]. Data show this model has covered 73% of pilot areas, extending average nursing staff primary care service duration by 3.2 years [26]. Third, **unified medical services** reconstruct the three-level service chain by establishing an integrated nursing service network with county hospitals as leaders, township hospitals as hubs, and village clinics as foundations, achieving effective integration of specialist, general, and home-based nursing services [12]. Fourth, **unified information platforms** break data silos by constructing county nursing information hubs that support cross-institutional data sharing and business collaboration, providing technical support for homogenous quality control and closed-loop management [19]. Fifth, **unified resource allocation** optimizes the service supply side by innovatively implementing DRG/DIP nursing value add-on mechanisms that incorporate 12 nursing-sensitive indicators including pressure injury incidence and patient satisfaction into payment assessments, driving the monetization of nursing value [13].

Under the traction of the "Five Unifications" policy, China' s compact medical community nursing management model is undergoing a historic transition from "fragmented exploration" to "systematic innovation." Through institutional restructuring that activates human resource value, technology empowerment that reshapes service processes, and integrated Chinese-Western medicine approaches that create distinctive pathways, China is not only constructing a more efficient nursing service network for 280 million domestic chronic disease patients but also contributing an "Eastern solution" to global integrated healthcare that is "primary care-based and nursing-centered." Future breakthroughs must continue in payment reform depth, digital inclusion breadth, and standard export height to ultimately achieve the leap from "county nursing communities" to the "Healthy China collaborative network."

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Note: Figure translations are in progress. See original paper for figures.