ChinaRxiv 中X

AI translation · View original & related papers at
chinarxiv.org/items/chinaxiv-202602.00161

Exploration and Reflection on a Nurse-led Multidisciplinary Collaborative Service Model for Palliative Care: A Case Study of the Geriatrics Center at West China Hospital (Postprint)

Authors: Zheng Ji, Xie Lingling, Wu Yu, Gao Yueshan, Jiang Yan, Chen Xi, Chen Xi

Date: 2026-02-13T09:09:15+00:00

Abstract

Background Hospice care is an important practice of healthy aging in healthcare services for terminally ill patients. With the continuous development of hospice care research and the advancement of pilot policies, the holistic care service model for hospice care in tertiary public hospitals has become an important component of the service system for improving patients' quality of life, reducing treatment burden, and optimizing resource allocation.

Objective Based on the practice of the Geriatrics Center of West China Hospital, to establish and evaluate a nurse-led multidisciplinary collaborative hospice care service model, aiming to improve the quality of holistic care and end-of-life dignity for terminally ill patients.

Methods A case study design was adopted. Through systematic literature analysis (searching Chinese and English databases, with 56 core literatures finally included) and expert consultation method (inviting 13 senior experts for structured discussion), a service model centered on the "4S" (physical, psychological, social, spiritual) holistic care concept was constructed, and the multidisciplinary team structure, graded training system, and practice pathway were defined. The study implemented interventions for 227 terminally ill elderly patients from 2017 to 2023, and comprehensively evaluated the model' s effectiveness through electronic medical record data, satisfaction surveys, and multidisciplinary collaboration efficiency indicators.

Results The constructed nurse-led West China hospice care multidisciplinary collaborative service model mainly features nurses as core coordinators, adopts a "core layer-execution layer-support layer" three-level multidisciplinary team

as the collaboration model, and has formed systematic assessment tools, training mechanisms, and standardized service pathways. After implementing the nurse-led West China hospice care multidisciplinary collaborative service model, symptom control such as pain was effectively improved, and family satisfaction reached 98.5-99.7 points. From 2017 to 2023, compared with another general ward in the Geriatrics Center of West China Hospital, the hospice care ward showed a certain reduction in ICU transfer rate [0.44% (1/227) vs. 2.93% (6/205), P=0.066], but without statistical significance. Team response speed and collaboration efficiency were significantly improved.

Conclusion The West China hospice care multidisciplinary collaborative model, by highlighting nurse leadership and holistic care concepts, effectively integrates medical and humanistic service resources, significantly improving the care quality and dignified quality of life for terminally ill patients. This model provides a practical paradigm and scientific basis for the development of hospice care services in China' s hospital system. In the future, it is necessary to further expand resource coverage and improve community linkage mechanisms.

Full Text

Exploration and Reflections on the Nurse-Led Multidisciplinary Collaborative Service Model for Hospice Care: A Case Study of the Geriatrics Center at West China Hospital

Abstract

Background: Hospice care represents a critical practice of healthy aging in the healthcare of terminally ill patients. As research on hospice care continues to evolve and pilot policies advance, holistic hospice care service models in tertiary public hospitals have become essential components for improving patient quality of life, reducing treatment burden, and optimizing healthcare resource allocation.

Objective: Based on the practice of the Geriatrics Center at West China Hospital, this study aimed to develop and evaluate a nurse-led, multidisciplinary collaborative hospice care service model to enhance whole-person care quality and preserve end-of-life dignity for terminally ill patients.

Methods: Using a case study design, we constructed a service model centered on the "4S" (Somatic, Sentiment, Social, and Spirit) whole-person care concept through systematic literature analysis (retrieving 56 core publications from Chinese and English databases) and structured expert consultations (inviting 13 senior specialists for structured discussions). The model defined a multidisciplinary team architecture, tiered training system, and implementation pathways. Between 2017 and 2023, the intervention was implemented for 227 terminally ill elderly patients, and model effectiveness was evaluated through electronic med-

ical records, satisfaction surveys, and multidisciplinary collaboration efficiency indicators.

Results: The constructed nurse-led Huaxi Multidisciplinary Hospice Care Service Model positioned nurses as core coordinators within a three-tier collaborative team structure comprising "core, execution, and support" layers, accompanied by systematic assessment tools, training mechanisms, and standardized service pathways. Following implementation, patient symptom control (e.g., pain management) improved significantly, and family satisfaction scores reached 98.5–99.7 points. From 2017 to 2023, the hospice care ward at West China Hospital' s Geriatrics Center demonstrated a lower ICU transfer rate compared to a general ward in the same center [0.44% (1/227) vs. 2.93% (6/205), $P = 0.066$], though the difference was not statistically significant (absolute risk difference ARD = -2.49%; $RR = 0.15$, 95% CI = 0.02–1.21). Team response speed and collaboration efficiency improved markedly.

Conclusion: The Huaxi multidisciplinary hospice care model effectively integrates medical and humanistic service resources by emphasizing nurse leadership and whole-person care concepts, significantly improving care quality and dignity for terminally ill patients. This model provides a practical paradigm and scientific foundation for developing hospice care services within China' s hospital system. Future efforts should expand resource coverage and refine community linkage mechanisms.

Keywords: Hospice care; Multidisciplinary collaboration; Whole-person care; Service model

---

As China' s population aging accelerates [1,2] and the proportion of disabled and terminally ill patients increases significantly [3], public awareness of death quality has grown, yet China's current death quality ranking stands at only 53rd globally [4]. Traditional end-of-life treatments emphasize aggressive rescue while neglecting patient dignity, whereas hospice care emphasizes whole-person care that maintains dignity and improves quality of life, resulting in surging demand [5]. In China, hospice care practice centers on terminally ill patients and their families, providing holistic care—including physical symptom control (e.g., pain, dyspnea), psychosocial support, and personalized medical decision assistance—through multidisciplinary collaboration, aiming to achieve whole-person, whole-family, whole-process, and whole-team care while respecting patient autonomy [6].

Currently, less than 10% of the eligible population in China receives hospice care services. Since the gradual rollout of hospice care pilot policies and standards in 2017, service models have continued to evolve; however, tertiary hospitals still face multiple systemic challenges [7–9]: (1) imperfect multidisciplinary collaboration mechanisms; (2) insufficient precision training for hospice care professionals; (3) lack of assessment and intervention tools; and (4) unclear content and implementation pathways for hospice care service models. Nevertheless,

how to construct and systematically implement a nurse-led hospice care service model, and what impact such a model has on patient outcomes and care quality, remains lacking in systematic practical evidence and effectiveness verification. Therefore, this study focuses on two research questions: (1) How can a nurse-led, multidisciplinary collaborative hospice care service model be constructed? and (2) What are the implementation effects of this model regarding symptom control, psychological support, and family satisfaction for terminally ill patients? The aim is to contribute to establishing a systematic and standardized whole-person hospice care model.

This study employs a project case study design, taking the hospice care service model at West China Hospital' s Geriatrics Center as a typical case to deeply analyze its establishment process, organizational and functional structure, implementation pathways, and effectiveness evaluation. Using literature review and expert consultation methods, we systematically explored and constructed a nurse-led multidisciplinary collaborative hospice care service model. This paper introduces the practice at the Geriatrics Center of Sichuan University West China Hospital as a case study.

1.2 Literature Analysis

To establish a scientific and standardized intervention protocol, this study strictly followed evidence-based integration pathways, systematically conducting literature retrieval and evidence synthesis. First, two researchers trained in systematic evidence-based methodology conducted comprehensive searches of Chinese and English databases including CNKI, Wanfang Data, PubMed, and Web of Science. Search keywords included: "hospice care," "palliative care," "nurse-led," "multidisciplinary team," "service model," and their Chinese equivalents. Inclusion criteria focused on empirical research, systematic reviews, and policy documents addressing care models for terminally ill patients, multidisciplinary team construction, nursing roles, and service pathways. Ultimately, 56 core publications were selected to construct the preliminary theoretical framework and element pool for the service model.

1.3 Expert Consultation Method

Based on the literature retrieval results, a preliminary draft of the nurse-led multidisciplinary collaborative hospice care service model was developed (including team architecture, training protocols, service pathways, and evaluation indicators). The expert consultation method was used to conduct two rounds of review: 13 experts engaged in hospice care clinical practice, nursing management, geriatrics, and social work were invited—all with more than 10 years of relevant experience and associate professor rank or above. One structured seminar was organized, lasting 3 hours, employing a structured discussion process including protocol presentation, group discussion, centralized review, and consensus formation. Experts conducted in-depth discussions on the importance (using a 5-point Likert scale) and operability of model elements, providing modification

suggestions. The overall authority coefficient of the experts was 0.838, significantly > 0.7, indicating good expert authority. The expert meeting ultimately confirmed the national policy *Practice Guidelines for Hospice Care (Trial)* [10] and the WHO' s global development strategy *Quality Health Services and Palliative Care: Policy, Strategy and Practice Support Resource Guide* [11], conducting multidisciplinary team organization and service model exploration based on the 4S model (Somatic, Sentiment, Social, Spirit) and establishing a hospice care management group emphasizing the collaborative integration of organizational structure, staffing, service content, and system management.

2 Results

2.1 Theoretical Basis of the Nurse-Led Huaxi Multidisciplinary Collaborative Hospice Care Service Model

The nurse-led Huaxi Multidisciplinary Collaborative Hospice Care Service Model is built upon a multidimensional, interdisciplinary theoretical foundation, integrating international advanced hospice care concepts with localized practical needs to form a scientific and systematic theoretical framework. First, the model takes the whole-person care concept as its core theoretical basis, encompassing holistic concern for the physical (Somatic), psychological (Sentiment), social (Social), and spiritual (Spirit) dimensions of terminally ill elderly patients with chronic diseases—the "4S" care model [12]. This model not only echoes the WHO definition of hospice care but also reflects the deep application of the bio-psycho-social medical model in modern geriatrics and palliative medicine.

Second, the model draws upon the Chronic Care Model (CCM) [13] and team science theory [14] to construct multidisciplinary collaboration mechanisms. According to the hospice care practice guidelines published by the American Society of Clinical Oncology (ASCO) [15], and in collaboration with the geriatric palliative medicine team at Saint Louis University in the United States, the model establishes nurses as core coordinators. Nurses in the team perform case management, symptom control, psychosocial support, and communication hub functions—a design rooted in evidence-based practice and consistent with international trends emphasizing the value of nursing professionalism, stressing the establishment of collaborative therapeutic relationships among patients, families, and medical teams. Finally, the model relies on structured nursing theory and competency frameworks [16] to establish tiered nurse training and competency evaluation systems, ensuring nurses possess core competencies in symptom management, grief counseling, communication skills, and spiritual care, thereby guaranteeing the operability and quality sustainability of the service model. In summary, the theoretical basis of this service model includes not only macro-care concepts and international guideline consensus but also integrates multidisciplinary team operation mechanisms and nursing role theory, jointly supporting the scientific validity and advancement of the "nurse-led, multidisciplinary collaborative" high-quality hospice care service system.

Figure 1

Figure 1: Figure 1

2.2 Establishing the Nurse-Led Multidisciplinary Collaborative Hospice Care Team Based on the 4S Framework

Based on preliminary research and needs analysis, this study constructed a multidisciplinary collaborative service model led by hospice care specialist nurses. The model uses the 4S whole-person care concept as its framework, covering comprehensive services across physical, psychological, social, and spiritual dimensions, and forming a clearly hierarchical, orderly collaborative team architecture and standardized processes. The core characteristics of the model are manifested in a three-tier team structure of "Core Layer—Execution Layer—Support Layer" (

).

The Core Layer comprises hospice care specialist nurses, "Sunshine Angels" (psychological counselors), and medical social workers, responsible for formulating, coordinating, and continuously evaluating holistic care plans. The Execution Layer includes physicians, nutritionists, rehabilitation therapists, psychological counselors, pharmacists, and traditional Chinese medicine practitioners, who provide specialized interventions based on Core Layer assessment results. The Support Layer consists of volunteers and primary caregivers, implementing social support and daily life assistance services under Core Layer guidance.

The model establishes systematic collaborative workflows: First, specialist nurses conduct preliminary comprehensive assessments to identify patient needs across the 4S dimensions; based on assessment results, they collaborate with Core Layer members to formulate preliminary care goals and activate corresponding Execution Layer professionals for in-depth assessment and intervention as needed, such as requesting medical evaluations from physicians or nutritional plans from dietitians; Execution Layer intervention results feed back to the Core Layer, where specialist nurses coordinate plan adjustments, and Sunshine Angels or medical social workers implement corresponding psychosocial support. In this process, medical social workers serve dual roles: in the Core Layer, they are responsible for assessing and coordinating social and spiritual needs; in the Support Layer, they primarily organize volunteers and community resources to provide non-medical support. This design ensures social workers' core position in team decision-making while leveraging their resource integration capabilities.

Through these processes and role definitions, the model achieves a dynamic division of labor and response mechanism oriented toward patient and family needs, clarifying collaborative interfaces and information flow pathways at each stage, providing systematic support for the standardization of hospice care services and whole-person care goals. The core team architecture and division of labor

are shown in .

2.3 Tiered and Domain-Specific Precision Training for the Multidisciplinary Hospice Care Team

The training system strictly corresponds to the three-tier "Core-Execution-Support" architecture, ensuring that training content closely matches each role' s functions:

(1) Core Layer Training (led by hospice care specialist nurses): Addressing the need for multidisciplinary integration and complex symptom control capability enhancement, this layer' s training aims to strengthen leadership, coordination, and decision-making capabilities. Under the specialized guidance of the Geriatrics Center and Saint Louis University expert teams (2–4 times/month), training content includes: completing theoretical foundations through the "Huaxi Cloud Classroom" *Standardized Curriculum for Geriatric Hospice Care*; continuously updating global hospice care progress and symptom control technologies (e.g., precision medication management, aromatherapy, music therapy, and other non-pharmacological interventions); and focusing on enhancing core skills such as family meeting organization, bad news delivery, end-of-life comfort care (position management, dyspnea relief), comprehensive geriatric assessment (CGA), and advance care planning (ACP) through case discussions and workshops. Simulation experiences and role-exchange mechanisms are also introduced to enhance team empathy and communication skills.

(2) Collaborative Execution Layer Training (physicians, nutritionists, rehabilitation therapists, psychological counselors, pharmacists, traditional Chinese medicine practitioners, etc.): Centering on their professional collaborative roles within the multidisciplinary team, this training emphasizes "domain refinement," focusing on integrating professional skills with hospice care goals. Training content includes understanding collaborative workflows and role positioning; learning how to respond to Core Layer assessment results and provide professional interventions; and mastering specialized skill updates for terminally ill patients, such as nutritional support protocols for advanced patients, rehabilitation function maintenance, psychological counseling techniques, and rational medication reduction.

(3) Auxiliary Support Layer Training (medical social workers, volunteers, and caregivers): Addressing issues such as service homogenization and insufficient grief support skills, this training focuses on empathetic communication, grief counseling theory, and practical operations. Social workers additionally learn resource linking and case management processes; volunteers and caregivers focus on basic daily care skills, psychological support boundaries, and service safety protocols.

Multidisciplinary team assessment and evaluation are conducted through tiered theoretical and practical assessments: Medical teams complete online testing for the *Standardized Curriculum for Geriatric Hospice Care* (full score system,

$\geq$ 90 points to pass), are required to complete hospice care science popularization tasks in teams (videos, manuals, PowerPoints, etc.), and participate in multidisciplinary consultations and case sharing; social workers are required to complete 5 case managements per month, conduct 1 group activity, and share 1 professional literature item on hospice care or medical social work; volunteers are required to participate in at least 3 ward service activities per semester. The team regularly conducts service quality tracking, combining patient family satisfaction, symptom control, and multidisciplinary collaboration efficiency for dynamic optimization.

2.4 Innovation in Hospice Care Practice Tools

Addressing the late start of hospice care in China and the lack of localized assessment and intervention tools, our team developed a series of assessment and intervention tools based on clinical practice. Regarding assessment tools, the team independently developed an end-of-life quality of life scale for elderly patients with chronic diseases [17], with a verified Cronbach' s α coefficient of 0.927, providing a specialized end-of-life quality of life measurement tool for elderly patients with chronic non-malignant diseases. This holds significant importance for clinically emphasizing and improving the quality of life for this elderly population and has currently been promoted for application. Regarding intervention tools, the team has developed dignity conversation checklists [18], "Qingxin Shuyuan" and other dignity intervention tools, and assessment and treatment communication whiteboards, focusing on and enhancing patient dignity and effective communication with medical staff. Video decision aids based on advance care planning [19] have been applied in the care of terminally ill elderly patients; these humanized intervention pathways deepen patient understanding of hospice care, providing support for patients to make end-of-life medical decisions consistent with personal wishes.

2.5 Implementation Pathway of the Nurse-Led Huaxi Multidisciplinary Collaborative Model

Compared with multidisciplinary collaboration models abroad where nurses and medical social workers collaborate equally [20], medical social work in China remains in the preliminary stage of development, while nurses serve as the connecting subject between medical teams and social services, fully capable of coordinating multidisciplinary collaborative work in hospice care. Based on this, relying on the multidisciplinary platform of a comprehensive hospital and led by nurses coordinating clinical staff, medical social workers, and student volunteers, the standardized operation of the nurse-led multidisciplinary collaborative hospice care model is completed collectively.

(1) Nurse-Coordinated Assessment and Planning Stage: Physicians and hospice care specialist nurses jointly complete patient admission assessments. Nurses integrate multidisciplinary team (MDT) consultation opinions (including disease prognosis, symptom spectrum, functional status, and patient needs),

leading the formulation of whole-person care plans centered on the "4S" framework to ensure synergy between medical interventions and humanistic care.

(2) Nurse-Led Implementation Stage: Physical Care: Nurses coordinate the implementation of personalized symptom interventions (e.g., delirium management, sleep disorder management, nutritional support protocols, oral care, acupuncture treatment) based on medical assessment results and medical team functional assignments; they interface with non-pharmacological therapies (e.g., aromatherapy, essential oil touch, small fans to improve dyspnea), achieving integration of medical technology and comfort care. **Bidirectional Linkage of Psycho-Social Care:** Nurses serve as cross-team collaboration hubs, dynamically monitoring patient psychological states and promptly contacting Sunshine Angels and psychological counselors for intervention when psychological issues arise; simultaneously, they collaborate with the hospital Youth League Committee/Social Work Office to plan social activities (intangible cultural heritage paper-cutting, wheelchair garden tours, etc.), ensuring activity designs comply with patient physical grading; they promptly identify patients needing social support and collaborate with medical social workers to link resources.
Multidisciplinary Collaboration for Spiritual Care: Nurses collaborate with physicians to provide end-of-life medical decision support (such as advance care planning); addressing the neglect of elderly patients' spiritual needs, they collaborate with social workers to carry out dignity therapy and "Smart Health Care" based life education activities for the elderly, including life health education and life meaning reflection themes, aiming to shape correct life-and-death views for patients in the final stages of life and maintain their dignity and autonomy.

(3) Implementation Conclusion and Summary Stage: Team members discuss opinions on implementation protocols or content requiring further discussion; Conduct implementation effectiveness evaluations for team members, patients, and families; Nurses lead multidisciplinary meetings for phase summaries and next-step planning.

(4) Extended Service Stage: Community extension services are led by the nursing team of West China Hospital' s Geriatrics Center, collaborating with medical social workers and allied community institutions to establish a "Three-Level Follow-Up Network" : First, regular community clinics and health education are conducted, where multidisciplinary members provide home symptom management guidance and life education popularization; second, continuous care is carried out through home visits for discharged patients after symptom control; third, using information platforms, follow-up reminders are automatically pushed to discharged patients after symptom control and to families of deceased patients, dynamically assessing psychological states and grief intervention needs. This practice pathway exploration also confirms the significance and value of hospital-community collaboration forming whole-process management [21,22].

[FIGURE:2]

2.6 Application Effects of the Huaxi Multidisciplinary Collaborative Hospice Care Service Model

For 227 terminally ill elderly patients (age $\geq$ 60 years) admitted between 2017 and 2023 who received multidisciplinary collaborative hospice care services—with case records indicating "death," primary diagnoses of advanced chronic non-communicable diseases (including end-stage heart/kidney/liver/respiratory failure and metastatic malignant tumors), hospitalization time $\geq$ 48 hours, and medical decision-making exercised by relatives—the nurse-led Huaxi multidisciplinary collaborative hospice care service model effectively controlled patient pain and other uncomfortable symptoms, provided comfort care and psychological humanistic services, improved self-care related knowledge for elderly patients and their caregivers, and enhanced end-of-life decision-making related knowledge. Through symptom control such as pain and dyspnea, the model improved end-of-life quality of life for elderly patients and increased family satisfaction for deceased patients.

According to inpatient satisfaction surveys, patient and family satisfaction scores for the geriatric hospice care unit between 2017 and 2024 reached 98.5–99.7 points. Data extracted from the electronic medical record system showed that from 2017 to 2023, the hospice care ward at West China Hospital' s Geriatrics Center demonstrated a lower ICU transfer rate compared to another general ward in the same center [0.44% (1/227) vs. 2.93% (6/205); absolute risk difference ARD = −2.49%]. Due to the small number of events, Fisher' s exact test was used ($P = 0.066$), and the difference between the two groups did not reach statistical significance ($RR = 0.15$, 95% CI = 0.02–1.21). This model, by implementing 4S-based hospice care services following patient wishes, can to a certain extent avoid invasive treatments that do not benefit quality of life while optimizing critical care medical resource utilization. However, the current small sample size and few events may result in insufficient statistical power, failing to detect potential true differences. This trend is consistent with the core goal of hospice care to reduce unnecessary aggressive interventions and focus on symptom management and comfort care. Future larger-scale prospective studies are needed to further verify these results with adequate sample sizes and clarify the underlying clinical decision pathways and influencing factors.

3 Discussion

3.1 The Nurse-Led Multidisciplinary Collaborative Hospice Care Service Model

Nurses' dominant position in the multidisciplinary hospice care team fundamentally stems from their irreplaceability as dual-dimensional hubs connecting medical and humanistic collaboration: On one hand, they rely on professional medical knowledge (such as comprehensive hospice care assessment) to actively cooperate with medical teams in implementing physical and mental care; on the other hand, as key collaborators with medical social workers, they promptly

identify patient psychosocial needs (such as financial pressure, spiritual distress), accurately referring non-medical issues such as family conflicts and grief warnings to the social work team, achieving synchronous intervention for symptom control and humanistic care. This role fits deeply with China' s current medical resource situation—the positive trend in registered nursing workforce advantages [23]—providing continuous service to patients clinically. This study indicates that the nurse-led hub mechanism promotes timely symptom control and improves the timeliness of social work intervention, both stemming from nurses' frontline screening of implicit issues, ultimately constructing the nurse-led multidisciplinary collaborative hospice care service model.

3.2 Division of Labor and Overall Collaboration Efficiency in the Multidisciplinary Hospice Care Team

The Huaxi model reconstructs multidisciplinary team divisions based on the "whole-person care" concept, breaking through traditional physician-led linear collaboration frameworks. By clarifying role function boundaries, a dynamic division of labor mechanism is established: Nurses serve as leaders responsible for all aspects of whole-person care; geriatricians collaborate with nutritionists, rehabilitation therapists, traditional Chinese medicine practitioners, and pharmacists to responsible for physical care and symptom control; Sunshine Angels and psychological counselors provide phased psychological support. The systematic involvement of medical social work teams and student volunteers supplements humanistic care resources, providing social support and spiritual care. This study preliminarily shows that this model may bring positive outcomes: multidisciplinary consultation response times are shortened, care plan formulation and implementation are smoother, and pathways for initiating interventions based on assessment results are clearer and more direct, further improving hospice care quality, though its effectiveness awaits verification through more rigorous prospective controlled studies in the future. Additionally, the improvement in team collaboration efficiency mainly stems from team dynamics, primarily related to reward mechanisms, team atmosphere, management personnel coordination and division of labor, and member relationships [24].

Based on literature review and the response to the practical needs of hospice care for "active aging," the "Huaxi Hospice Care Model" uses the whole-person care concept as its foundation, establishing a hospice care multidisciplinary team to provide scientific ideas for improving hospice care professionalism in China' s hospital-centered system.

3.3 The Multidisciplinary Collaborative Hospice Care Service Model Effectively Improves Service Quality

This study systematically improved end-of-life patient care quality by constructing a multidisciplinary collaborative hospice care service model. Intervention protocols based on the 4S principle achieved organic unification of symptom management, psychological adjustment, and social support by integrating med-

ical technology goals with humanistic service needs. This model breaks through the limitations of "emphasizing technology over humanity" in traditional medical models, effectively responding to patients' multi-dimensional needs across physical, psychological, social, and spiritual dimensions through dynamic collaboration of multidisciplinary teams, embodying the core value of whole-person care.

Compared with conventional medical models, this model significantly optimizes patient and family care experiences through early integration of social support resources (such as family participation, community linkage). Family involvement in the care process not only enhances the continuity of home care but also strengthens family coping capabilities through empowerment mechanisms, highly consistent with the "family-team collaboration" concept in Australia' s *National Palliative Care Strategy 2018* [25]. Simultaneously, the proactive intervention by the multidisciplinary team in the psychosocial needs of patients and their family members (such as dignity therapy, life review) effectively improves patient emotional states, consistent with the United Kingdom' s *End of Life Care Strategy* emphasizing attention to patient and family psychosocial needs [26]. Research confirms that this model can systematically improve hospice care service quality, providing a practical paradigm for constructing a full-cycle hospice care system in China. Its successful experience demonstrates that the nurse-led multidisciplinary collaborative model is key to solving the fragmentation of end-of-life patient care and achieving the humanistic transformation of medical services.

3.4 The Important Role of Medical Social Workers in Cross-System Integration

In the Huaxi multidisciplinary hospice care team, social workers effectively respond to the multi-dimensional needs of terminally ill patients and their families across psychological, social, and spiritual dimensions through systematic, structured services. Specifically, this includes: providing professional psychological support to alleviate patient anxiety and depression regarding the death process; integrating civil affairs, medical insurance, charity, and community resources to construct social support networks and assist in achieving home hospice care referrals; helping patients formulate advance care plans to maintain their medical autonomy; and coordinating multi-party resources to achieve patients' end-of-life wishes (such as family reunions). Regarding family support, social workers conduct care skills training and organize support groups (typically 8–12 people) to reduce family care burden, and implement full-process grief support from anticipatory grief counseling during the terminal phase to bereavement counseling after death, preventing complicated grief disorders.

Regarding service processes, social workers' case work strictly follows six standardized stages of "intake—assessment—planning—intervention—evaluation—termination," with dynamic adjustment of intervention strategies; group work designs activity schemes according to different functional orientations such as sup-

port, education, or therapy, implementing dual-track evaluation of process and outcomes.

However, social workers currently face multiple challenges in practice: First, the absence of dedicated positions leads to fragmented services; second, the lack of systematic and continuous professional training mechanisms limits further improvement of service capabilities; third, the continuity and accessibility of grief support services (especially during the bereavement period) remain insufficient; fourth, the promotion of advance care planning still faces dual obstacles of limited social awareness and insufficient legal protection; fifth, group work faces operational difficulties such as low patient participation and inadequate activity design adaptability; sixth, culturally sensitive intervention tools and standardized assessment systems remain to be developed and improved. These challenges stem from both external environmental constraints such as macro policies, resource allocation, and social culture, and are closely related to insufficient internal professional capacity building and support mechanisms within the social work service system.

3.5 Limitations and Future Development

Although the "Huaxi Model" constructed in this study has shown positive effects in practical application, certain limitations remain. First, this model operates within the context of a large tertiary hospital with abundant resources, and its multidisciplinary collaboration mechanism highly depends on the stability of professional talent teams. Although a specialist nurse training system has been established, other professional roles such as psychological counselors, traditional Chinese medicine practitioners, and rehabilitation therapists face insufficient staffing and frequent turnover, potentially affecting service continuity and quality. Second, a systematic payment and dedicated position management mechanism has not yet been formed, resulting in low synergy among "hospital-community-family" tripartite linkages and still-limited multi-party resource integration and operational effectiveness. Furthermore, as an exploratory case study, this conclusion derives from single-center practice summary, and its generalizability requires cautious consideration; model promotion must fully consider differences in resource conditions, cultural backgrounds, and policy supports across different medical institutions.

In the future, relying on the "Key Technologies and Service Model Demonstration Application for Geriatric Hospice Care" project officially launched in 2024, multi-situation, multi-center verification and adaptation research can be conducted through collaboration among multiple alliance hospitals, further exploring hierarchical care pathways and intelligent management platforms adapted to China' s national conditions. Continuously developing localized assessment and intervention tools, promoting the deep integration of nurse-led models with policy guarantees, will help construct a "early identification—precision intervention—tiered management—intelligent monitoring" closed-loop mechanism for full-process hospice care, ultimately improving service accessibility and coverage

levels, assisting China' s hospice care in moving from scattered pilots toward inclusive development.

References

[1] Wang Xinru, Sheng Yu. Progress in the application of advance care planning in cancer patients [J]. Chinese Journal of Nursing, 2019, 54(2): 306-310.

[2] Khatib R, Lee G A, Marques-Sule E, et al. Evaluating the extent of patient-centred care in a selection of ESC guidelines [J]. Eur Heart J Qual Care Clin Outcomes, 2020, 6(1): 55-61. DOI: 10.1093/ehjqcco/qcz025.

[3] Lü Guoying, Zhou Wanli, Wang Chaoqun. Population aging, proximity to death time, and medical expenditure: An empirical analysis based on the Chinese Longitudinal Healthy Longevity Survey [J]. Chinese Journal of Health Policy, 2020, 13(5): 1-9.

[4] Finkelstein E A, Bhadelia A, Goh C, et al. Cross country comparison of expert assessments of the quality of death and dying 2021 [J]. J Pain Symptom Manage, 2022, 63(4): e419-e429. DOI: 10.1016/j.jpainsymman.2021.12.015.

[5] Zeng Yaoxin, Ning Xiaohong, Zheng Ying, et al. Construction of an integrated outpatient palliative care medical-nursing whole-process management model [J]. Acta Academiae Medicinae Sinicae, 2024, 46(2): 210-216.

[6] Yu Ting, Zhou Chuanru, Wang Cong, et al. Concept analysis of hospice care [J]. Chinese Nursing Research, 2025, 39(2): 177-182.

[7] Ji Guangwei, Zhou Mingfei, Zhou Yuxin, et al. Research and evaluation of domestic and international hospice care development models [J]. The Journal of Practical Medicine, 2024, 40(7): 877-886.

[8] Le Yingnan, Yu Xiaoli, Qian Ying. Practice and reflections on "Internet + Hospice Care" under the medical community model [J]. Chinese Nursing Management, 2024, 24(5): 765-768.

[9] Yan Ge, Ning Xiaohong. Co-management model of palliative care for terminally ill patients [J]. Acta Academiae Medicinae Sinicae, 2023, 45(6): 955-960.

[10] National Health Commission Office. Notice of the National Health Commission Office on Issuing the Practice Guidelines for Hospice Care (2025 Edition) [EB/OL]. (2025-08-01) [2025-12-18]. https://www.nhc.gov.cn/yzygj/c100068/202508/77bbbf599f894e40bbeffff9

[11] Rao Qianyi, Bai Ruonan, Luo Jun, et al. Interpretation of the WHO' s *Quality Health Services and Palliative Care: Policy, Strategy and Practice Support Resource Guide* [J]. Journal of Nurses Training, 2023, 38(19): 1795-1798. DOI: 10.16821/j.cnki.hsjx.2023.19.011.

[12] Li Xuying, Chen Yongyi, Shen Boyong, et al. Whole-person care model for hospice care [J]. Chinese Nursing Management, 2018, 18(S1): 69-72.

[13] Yeoh E K, Wong M C S, Wong E L Y, et al. Benefits and limitations of implementing Chronic Care Model (CCM) in primary care programs: a systematic review [J]. Int J Cardiol, 2018, 258: 279-288. DOI: 10.1016/j.ijcard.2017.11.057.

[14] Collaco J M, St Geme J W 3rd, Abman S H, et al. It takes a team to make team science a success: career development within multicenter networks [J]. J Pediatr, 2023, 252: 3-6.e1. DOI: 10.1016/j.jpeds.2022.08.040.

[15] Ferrell B R, Temel J S, Temin S, et al. Integration of palliative care into standard oncology care: ASCO clinical practice guideline update summary [J]. J Oncol Pract, 2017, 13(2): 119-121. DOI: 10.1200/jop.2016.017897.

[16] Stanford P E. How can a competency framework for advanced practice support care? [J]. Br J Nurs, 2016, 25(20): 1117-1122. DOI: 10.12968/bjon.2016.25.20.1117.

[17] Yang Zijing, Wei Dan, Yang Liangqin, et al. Development and reliability and validity testing of the Quality of Life Scale for Elderly Patients with Chronic Non-malignant Diseases at the End of Life [J]. Journal of Chengdu Medical College, 2024, 19(1): 98-104.

[18] Zhou Yulan, Shu Xiao, Yang Zijing, et al. Research progress on dignity therapy for terminally ill patients [J]. Journal of Nurses Training, 2024, 39(22): 2432-2436. DOI: 10.16821/j.cnki.hsjx.2024.22.012.

[19] Shu Xiao, Yang Liangqin, Yang Zijing, et al. Application progress of video decision aids in advance care planning [J]. Chinese Journal of Modern Nursing, 2023(4): 557-560. DOI: 10.3760/cma.j.cn115682-20220310-01110.

[20] Bekelman D B, Feser W, Morgan B, et al. Nurse and social worker palliative telecare team and quality of life in patients with COPD, heart failure, or interstitial lung disease: the ADAPT randomized clinical trial [J]. JAMA, 2024, 331(3): 212-223. DOI: 10.1001/jama.2023.24035.

[21] Huang Zehuan, Xin Mengdong, Qi Lidan, et al. Constituent elements, experience, and promotion significance of the integrated medical-care hospice care model [J]. Chinese Medical Ethics, 2025, 38(7): 914-.

[22] Yang Yilong, Cui Meng, Zhao Xinxin, et al. Stakeholder research on hospice care under the "hospital-community" linkage [J]. Chinese Medical Ethics, 2024, 37(3): 339-346.

[23] Zhou Minghua, Tan Hong, He Sichang. Analysis of structural change trends of health technicians in Sichuan Province [J]. Modern Preventive Medicine, 2022, 49(7): 1259-1263.

[24] Lindesmith A R, Cartwright D, Zander A, et al. Group dynamics: research and theory [M]. Oxford: Row, Peterson, 1953: xiii.

[25] The national palliative care strategy 2018 [R/OL]. [2025-10-10]. https://www.health.gov.au/sites/default/files/the-national-palliative-care-strategy-2018.pdf.

[26] Liu Qian, Fang Chao. Development history and enlightenment of hospice care institutions in the United Kingdom [J]. People' s Tribune, 2024(6): 61-65. DOI: 10.3969/j.issn.1004-3381.2024.06.015.

Source: ChinaXiv —Machine translation. Verify with original.