Special Topic on Interdisciplinary Collaboration

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Abstract

Background Under the transformation toward the "biopsychosocial" medical model, medical social work is regarded as an important force in improving the primary healthcare service system. However, the core role expectations theoretically placed on medical social workers often encounter dilemmas of professional marginalization and functional ambiguity in practice, revealing significant tension between theoretical role expectations and real-world operation. Objective Taking Yulin Community Health Service Center in Wuhou District, Chengdu as a case, this paper systematically analyzes the functional positioning and operational mechanisms of medical social workers in primary multidisciplinary team (MDT) practice, and distills an integration pathway that balances feasibility and effectiveness. Methods From April to July 2025, Yulin Community Health Service Center in Wuhou District, Chengdu was selected as the research setting. A qualitative research method was adopted, and the study participants included stakeholders involved in primary multidisciplinary collaboration, such as family doctor team members, medical social workers, medical institution managers, and patients. In the first stage, focus group interviews (n=14) were conducted to construct and optimize the collaboration mechanism between family doctor teams and medical social workers. In the second stage, semi-structured interviews (n=19) were conducted with multiple stakeholders, including managers, medical staff, medical social workers, and patients, focusing on the role positioning, mechanisms of action, and practical outcomes of medical social workers in MDT. Results The study found that the Yulin model did not pursue professional equality, but strategically positioned medical social workers as a "support team" and achieved effective integration through three major mechanisms: (1) organizational embedding: transforming medical social workers from external collaborators into internal members through institutionalized pathways; (2) process integration: systematically embedding medical social workers into the full-service process of "pre-consultation—in-consultation—post-consultation," enabling a shift from passive response to proactive management; (3) effectiveness verification: the involvement of medical social workers produced quantifiable improvements in multiple aspects, such as patient satisfaction and health management efficiency, making their professional value explicitly visible. Conclusion The key to the effective integration of primary medical social workers lies in abandoning idealized role assumptions and instead adopting a pragmatic integration strategy oriented toward value output. This pathway begins by responding to the core concerns of the medical system, demonstrates its value through quantifiable outcomes, and promotes the transformation of medical social work from project-based cooperation to institutionalized embedding. The progressive collaboration model proposed in this study provides locally grounded experience with practical operability for addressing the practical dilemmas of primary medical social work, and helps promote the improvement of China' s primary healthcare service system.

Full Text

Special Topic on Interdisciplinary Collaboration

Balancing Feasibility and Effectiveness: Role Reshaping and Pathway Realization of Primary Care Medical Social Workers in Multidisciplinary Collaboration

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Abstract Background Against the backdrop of the transition toward the "bio-psycho-social" medical model, medical social work is regarded as an important force for improving the primary healthcare service system. However, although medical social workers are theoretically expected to assume important core roles, in practice they often face professional marginalization and functional ambiguity; a significant tension exists between theoretical role expectations and actual operation. **Objective** Taking the Yulin Community Health Service Center in Wuhou District, Chengdu, as a case, this paper systematically analyzes the functional positioning and operating mechanisms of medical social workers in primary multidisciplinary team (MDT) collaboration, and distills an integration pathway that balances feasibility and effectiveness. **Methods** From April to July 2025, a qualitative research approach was adopted at the Yulin Community Health Service Center in Wuhou District, Chengdu. Study participants included family doctor team members, medical social workers, medical institution administrators, patients, and other stakeholders involved in primary multidisciplinary collaboration. In the first stage, focus group interviews (n=14) were conducted to construct and optimize the collaboration mechanism between family doctor teams and medical social workers. In the second stage, semi-structured interviews (n=19) were conducted with multiple stakeholders, including administrators, medical and nursing staff, medical social workers, and patients, focusing on the role positioning, mechanisms of action, and practical outcomes of medical social workers in MDTs. **Results** The study found that the Yulin model does not pursue professional equality; instead, it strategically positions medical social workers as a "support team" and achieves effective integration through three major mechanisms: (1) **organizational embedding**: transforming medical social workers from external collaborators into internal members through

institutionalized pathways; (2) **process integration**: systematically embedding medical social workers into the full-service process of "pre-consultation—consultation—post-consultation," thereby realizing a shift from passive response to proactive management; and (3) **effectiveness validation**: the involvement of medical social workers produced quantifiable improvements in patient satisfaction, health management efficiency, and other aspects, making their professional value more explicit. **Conclusion** The key to effective integration of primary care medical social workers lies in abandoning idealized role settings and instead adopting a pragmatic integration strategy oriented toward value output. This pathway begins by responding to the core concerns of the medical system, validates the value of medical social workers through quantifiable outcomes, and promotes their transition from project-based cooperation to institutionalized embedding. The progressive collaboration model proposed in this study provides locally grounded experience with practical operability for addressing the dilemmas faced by primary care medical social workers, and may help advance the improvement of China' s primary healthcare service system.

[**Keywords**] quality assurance, health care; primary care; medical social work; multidisciplinary collaboration; community health service center; case study

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Balancing Feasibility and Effectiveness: Role Reshaping and Pathways of Primary Care Social Workers in Multidisciplinary Collaboration

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Abstract Background Under the bio-psycho-social medical model, medical social work is expected to play an integral role in primary healthcare, yet in practice medical social workers often face role ambiguity and marginalization. **Objective** This study examines how medical social workers are functionally positioned and operationally integrated within multidisciplinary teams (MDTs) in primary care, drawing on a case study from Chengdu, China. **Methods** A qualitative study was conducted between April and July 2025 at a community health service center. Data were generated through focus group interviews (n=14) and semi-structured interviews (n=19) with family doctor team members, medical

social workers, administrators, and patients. **Results** Findings show that effective integration does not rely on formal professional equality. Instead, medical social workers

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are embedded as a supporting team through three mechanisms: organizational embedding into internal service structures, process integration across pre-, during-, and post-consultation stages, and outcome validation through observable improvements in patient satisfaction and care efficiency. **Conclusion** A pragmatic, value-oriented integration strategy enables medical social work to move from peripheral participation to institutionalized embedding in primary care. This study provides an empirically grounded pathway for strengthening MDT collaboration in primary healthcare settings.

[Key words]Quality assurance, health care; Primary healthcare; Medical social work; Multidisciplinary team collaboration; Community health service center; Case study

Against the backdrop of the continued advancement of the Healthy China strategy, prioritizing the primary level has become an important component of healthcare work in the new era[1]. Strengthening the service capacity of primary healthcare institutions, promoting their transformation, and effectively involving medical social workers have become important issues of scholarly concern[2-3]. On the one hand, owing to the complexity of disease treatment—for example, head and neck cancers require multidisciplinary team (MDT) care, in which professionals collaborate on diagnosis, staging, treatment planning, management, and support for patients[4]. On the other hand, as patients' health awareness increases, their expectations of healthcare services are no longer limited to curing the disease itself; psychological needs are also growing[5]. Cutting-edge medical technologies and advanced medical equipment alone can hardly meet patients' multifaceted needs[6], while the important role of social work in primary healthcare settings has been repeatedly confirmed abroad[7-8]. For example, compared with traditional hospitalization models, the MDT model in countries such as Israel has been relatively successful. Under the community-based home hospitalization (CBHH) model developed for acute and chronic, rehabilitation, and end-of-life medical conditions, patients report high satisfaction with dignity, team attitudes, and nursing care[9], highlighting the effectiveness and importance of community services in the health system[10]. However, the success

of MDT models abroad relies to a considerable extent on financial incentives, and universal healthcare coverage is a key factor in successful chronic disease management[11]. For instance, the home hospitalization model imposes relatively high requirements on medical supply, professionals, and venues, and its sustainability also depends heavily on continuous financial investment. Yet the growth in China' s medical-resource supply has slowed markedly over the past two decades[12]. Compared with developed countries and regions, China has not yet achieved full national policy funding coverage for primary healthcare. In addition, factors such as a large population, vast territory, and uneven levels of economic development and education between eastern and western regions all impose high demands on China' s healthcare service system[13]. Therefore, there is currently a lack of in-depth domestic discussion, from the perspective of local cases, of the role of medical social workers in primary healthcare services[14]. In fact, care and coordination have always been part of social work, but little is known about the role they play in primary care for patients with complex health backgrounds and needs[14], and the role of social workers remains unclear[7]. Against this background, as China' s healthcare services shift from "treating illness" to "health management," there is an urgent need for medical social workers to compensate for the shortcomings of traditional medicine in psychological and social support[15].

Existing studies indicate that medical social workers play diverse roles in primary healthcare services, and that these roles occupy a core position. Specifically, medical social workers mainly undertake three categories of functions: first, as patient supporters, such as in behavioral intervention, care coordination, and assessment[16–17]; second, as collaborators with medical and nursing staff[18]; third, as advocates, promoting interprofessional cooperation in areas such as social equity and the protection of human rights[8]. In terms of scope, their functions are not limited to mental health support, but extend further into broader areas such as preventive healthcare, health promotion, and even palliative care[19]. In an ideal MDT model, medical social workers and medical/nursing staff are not in a superior–subordinate or primary–secondary relationship; rather, they are partners with equal voice within their respective professional domains[17]. Researchers believe that social workers have the potential to play a leadership role in interprofessional collaboration[20]. However, there is a significant tension and gap between this ideal positioning and the realities of practice. In reality, under multiple constraints such as resources, staffing quotas, and professional recognition, the role of medical social workers in primary healthcare institutions is often placed in a supplementary position rather than the core position advocated by theory. Insufficient role consensus between medical social workers and medical/nursing staff remains a central bottleneck in interprofessional collaboration[21]. Second, medical social work started relatively late in China, and people' s understanding of its social value remains vague[22]. Third, traditional concepts of medical care generally emphasize "treating the body" while neglecting "healing the mind." This cognition directly leads to a pronounced inequality in professional discourse power be-

tween medical teams centered on clinical diagnosis and treatment and medical social work teams responsible for psychosocial support: medical decision-making often carries absolute authority, and medical social workers are regarded in hospitals as a dispensable presence within the administrative system[22]. Moreover, patients' family members often substitute for professional social workers in rehabilitation care[23], further weakening the influence of social work teams. Overall, previous studies have mostly depicted the macro-level role framework of medical social workers, but micro-level practical issues—such as how they become embedded and exert effects in specific MDTs, and how they overcome dilemmas of positioning—still require deeper exploration.

Based on this, this article takes Yulin Community Health Service Center in Wuhou District, Chengdu, Sichuan Province, which has carried out pioneering exploration in the involvement of medical social workers in the primary healthcare system, as a case study. Focusing on the collaborative practice between family doctor teams and medical social workers, it aims to answer: (1) What are the operable roles of medical social workers in primary-level MDTs? (2) How do they become embedded in organizations and processes to unleash effectiveness? (3) What pathway can be both feasible and effective within the local institutional context? The study adopts a two-stage qualitative design. On the basis of presenting role positioning and practical outcomes, it proposes a pragmatic collaboration model that promotes institutionalized embedding through the visualization of contributions.

1 Objects and Methods

1.1 Study Objects

From April to July 2025, based on the definition of stakeholders, this study defined its study objects as the institutions, groups, and individuals related to the MDT model of primary healthcare services in Yulin Community that could, to a certain extent, influence the implementation effects of the MDT model and the improvement of primary healthcare service quality. Inclusion criteria: [[unclear: text continues beyond the visible page after "particip···"]]

stakeholders in the primary health-care MDT service model, including members of family doctor teams, managers of primary medical and health institutions, community residents, community neighborhood committees, medical social workers, medical personnel from public health departments, medical management research institutes, Beijing hospital management departments, pharmacists, and severe mental disorder management teams. The above professionals all had 3 years or more of relevant collaboration experience; the service recipients (patients and residents) had all received relevant services and were able to clearly recall their service experiences. Exclusion criteria were: (1) individuals who had never been exposed to work related to the primary health-care MDT service model or had never received related services; (2) relevant persons who had language-expression or communication barriers, could not communi-

cate fluently, or could not accurately express their views. The study followed the principles of voluntariness and informed consent. All participants signed written informed consent before the start of the study and were informed that they could withdraw unconditionally at any stage without affecting previous or subsequent services. To protect privacy, quotations in the text are uniformly identified by "type–number." The study was approved by the Ethics Committee of the Institute for Social Development, Southwestern University of Finance and Economics (ethics approval No.: LL-20250412-XF08). All research data were anonymized strictly in accordance with the requirements of the ethics review committee and were accessible only to designated researchers.

1.2 Research Content

(1) The organizational structure and work process in the MDT model: the specific work and responsibilities of the family doctor team and medical social workers before consultation, during diagnosis, and after the consultation. (2) The role and functional boundaries of social workers in the MDT: clarifying the mechanisms through which they serve as a bridge in doctor–patient communication, integrate volunteer service resources, and complement the advantages of traditional medical services. (3) Review of the practical effectiveness of medical social work: scientific evaluation using multidimensional indicators, such as patient satisfaction and health-management efficiency. (4) Discussion of future sustainable-development strategies: exploring improvement pathways in areas such as talent cultivation and institutional optimization.

1.3 Data Collection

1.3.1 First Stage: Focus Group Interviews This stage aimed to systematically evaluate and optimize the organizational structure and work process of the MDT model initially constructed on the basis of actual community needs and preliminary practical exploration, with a focus on analyzing the rationality and operability of the MDT work process so as to improve the practicality and feasibility of this mechanism in community practice. This stage adopted the focus group discussion method and was conducted from April to May 2025. The participants consisted of 14 members, specifically including 4 managers of medical institutions, 2 managers of medical social work institutions, 2 medical social workers, 2 general practitioners, 2 scholars of medical social work, and 2 scholars of general practice.

The two focus group discussions were conducted via online video meetings, lasting approximately 120 min and 150 min, respectively. All meeting content was audio-recorded and transcribed into text, and thematic analysis was used to form the collaborative work process between the family doctor team and medical social workers, as shown in Table 1.

1.3.2 Second Stage: Semi-Structured Interviews Face-to-face or telephone interviews were conducted mainly around two core questions: (1) in current primary medical and health institutions, the specific roles and functional positioning of medical social workers in scenarios such as MDT team collaboration, doctor–patient communication, and resource integration; (2) the specific service content provided by medical social workers in MDT practice, its value manifestation, and relevant benefit indicators. The research team developed an interview outline according to the research objectives and literature review. Although there was a preset framework of core questions, interviewers were allowed to flexibly follow up or adjust the order of questions according to respondents' answers, balancing systematicity and openness. The interviewees consisted of 19 members; their basic information is detailed in Table 2. Interview Topic 1 (collaborative process research) used purposive sampling to select key roles directly involved in MDT services, covering the full range of scenarios in which social workers assist medical and nursing teams. Interview Topic 2 (functional positioning and effectiveness evaluation research) used snowball sampling, with the aim of expanding the sampling scope and covering multidimensional stakeholders in effectiveness evaluation. Each interview lasted 20–30 min. The entire process was audio-recorded and transcribed into textual materials. Data analysis used thematic analysis; through continuous comparison, classification, and abstraction, core themes were extracted. To ensure a comprehensive perspective, the distillation of each theme drew on respondents with different identities.

The two rounds of data collection were implemented by two researchers who had received systematic qualitative training: Researcher 1 (WM), with a background in sociology, more than 2 years of experience in MDT and medical social work research, systematic training in qualitative interviewing and analysis, and multiple successful experiences in conducting quantitative questionnaire data collection and qualitative interview information collection; Researcher 2 (JX), with 20 years of work experience in primary community health service centers, including 13 years of management experience, and multiple training experiences in qualitative interviewing and analysis. To reduce positional bias that might arise from dual identities, this study adopted: (1) role reflection: recording preset viewpoints and important decisions in research journals; (2) triangulation: multi-source comparison among managers, medical and nursing staff, social workers, and patients; (3) two-person independent coding,

Table 1 Collaboration process between Yulin family doctor team and medical social workers

Stage	Process	Family doctor team (core team)	Medical social workers (support team)
Before consultation	Registration and contracting	Establish a multi-party contracted payment mechanism; clarify the service team; determine the contractual service relationship; make patient consultation appointments	Provide door-to-door services to obtain residents' information; identify and manage high-risk populations; collect residents' willingness to sign contracts; remotely complete registration and contracting
Before consultation	Information collection	Screen patients under team management; integrate residents' health information; form a complete health profile	Conduct door-to-door health information collection for residents (including contracted and non-contracted patients) (basic information, blood glucose and blood pressure measurements, etc.); feed back residents' health information to the family doctor team

Stage	Process	Family doctor team (core team)	Medical social workers (support team)
During consultation	Health assessment	Initial consultation and referral; conduct health-risk stratification; determine key health concerns; communicate assessment results with residents	Notify residents or their family members door-to-door to go to the community health service center to communicate assessment results
During consultation	Service provision	Conduct routine consultations, issue prescriptions and labora-tory/examination orders; formulate and adjust treatment plans; arrange appointment services and collaborative services; implement and follow up health plans	Provide residents with health-knowledge publicity and education; introduce contracted service package items to residents; guide residents to seek medical care; provide basic health education to residents
After consultation	Evaluation and feedback	Explain test results to patients; monitor the current status and trends of relevant indicators	Provide post-consultation follow-up for residents; feed follow-up information back to the family doctor team

consensus merging; (4) member checking: some interviewees were invited to verify the accuracy of the thematic summaries.

In addition to qualitative data, some of the quantitative indicators involved in the results of Tables 3 and 4 were derived from annual management statistics

and information-system export data from the institutions where the interviewees worked (time range: 2023-01-01—2024-12-31; populations: contracted residents, patients under chronic-disease management, and the entire population served by the center), and authorization was obtained from each center for academic research.

Table 2 Basic information of interviewees *(n=19)*

Indicator	Composition ratio [persons (%)]
Gender	
Male	8 (42.11)
Female	11 (57.89)
Region	
Chengdu, Sichuan Province, and surrounding cities	11 (57.89)
Beijing	3 (15.79)
Shanghai	3 (15.79)
Guangdong Province	2 (10.53)
Personnel type and code	
Managers of medical institutions (H1–H5)	5 (26.32)
Managers of medical social-work institutions (M1, M2)	2 (10.53)
Medical social workers (S1–S3)	3 (15.79)
Members of family-doctor teams (F1–F5)	5 (26.32)
Community- and patient-related parties (C1–C4)	4 (21.05)

Note: Medical social workers = medical social work practitioners.

2 Results

2.1 Organizational structure and workflow of the primary-level MDT model

(1) Organizational restructuring promotes transformation of the service model. The Yulin Center innovatively adopted an organizational structure of "three beams and nine pillars, with vertical and horizontal management." The "three beams" mean that the center is divided into the Business Office, the Medical Education Office, and the Administrative Office; the "nine pillars" refer to nine departments, including the General Practice Department, Community Nursing Department, and Preventive Health Care Department. This has formed a service model that extends from traditional single-disease diagnosis and treatment to integrated health management. (2) A three-level service network of "center–station–family" was built to achieve full service coverage. As the core hub, the community health service center undertakes important responsibilities such as technical guidance and resource allocation; community health service stations serve as intermediate links, providing residents with

convenient basic medical care and public health services; and families are the terminal end of services, relying on contracted family-doctor services, with medical personnel regularly providing household health services. (3) Multimorbidity management is implemented to improve service precision. For key groups, especially older adults, children, and persons with disabilities or living in hardship, multimorbidity management is implemented under the MDT framework. (4) The concept of general practice is upheld to create a proactive health-management service model. Comprehensive care for patients is emphasized: attention is paid not only to disease treatment, but also to patients' psychological, social, and other needs, thereby providing continuous health services covering the whole life cycle. In summary, structurally, the center is oriented toward service needs and has built a three-tier service system with the family-doctor team as the core, other professional and technical personnel as the auxiliary force, and social workers, community volunteers, and others as support. This clarifies the responsibilities, work processes, and quality standards of medical social workers; realizes the connection and implementation of primary-level health services at the levels of "community–courtyard–family–individual" ; and facilitates the integration of medical treatment and prevention. As shown in Figure 1.

From the perspective of whole-process management, medical social workers have effectively improved the efficiency of family-doctor teams. For example, in the pre-visit registration and contracting stage, family-doctor teams establish the contracted-payment mechanism and arrange patients' appointment scheduling; medical social workers go door to door to obtain residents' information, collect willingness to sign contracts, and complete contracting remotely. In the service-provision stage during visits, family-doctor teams conduct routine consultations, issue prescriptions and laboratory-test orders, and dynamically adjust treatment plans; medical social workers carry out health-knowledge publicity and popularization, introduce contracted service packages, guide residents in seeking care, and provide health education. In the post-visit evaluation and feedback stage, family-doctor teams explain test results to patients and continuously monitor health indicators; medical social workers provide post-visit follow-up and feed follow-up information back to the family-doctor team. As shown in Table 1.

2.2 Roles and functional positioning of social workers in MDTs

According to feedback from semi-structured interviews, the current positioning of medical social workers is to reduce burdens and empower the core family-doctor team, enabling it to focus more on professional medical diagnosis and treatment services and thereby achieve team effectiveness in which "1+1>2." Specific responsibilities include: (1) team-collaboration support: medical social workers assist family teams and undertake non-medical health-management tasks; (2) a bridge for doctor–patient communication: they alleviate information gaps between doctors and patients and reduce medical disputes and complaints;

(3) integration of social resources: they link community volunteers, charitable organizations, and psychological and legal resources to provide patients with more continuous services; (4) management of key groups: for older adults, people with chronic diseases, and other key populations, they provide personalized health management and psychological support, helping reduce the hospitalization or rehospitalization rates of key groups or patients; (5) extension of health services: they participate in preventive services such as community baseline surveys, improving residents' awareness of health knowledge; (6) interdisciplinary collaborative innovation: they participate in joint case discussions and optimize diagnostic and treatment plans. As shown in Table 3.

2.3 Evaluation of the effects after social workers joined MDTs

Foreign studies have found that, after the introduction of social workers, indicators related to emergency care showed significant optimization

. By comparison, discussions of benefit evaluation after social workers participate in primary-level medical and health institutions in China remain relatively scarce. This section summarizes evaluations, from the perspectives of different participating actors' posts and roles, of the effects after medical social workers joined MDTs, covering the service-demand side

Figure 1 Schematic diagram of the organizational structure of the Yulin MDT model

Text shown in the diagram: support team; auxiliary team; core team; patient. The support team consists of community grid workers, social workers, social sports instructors, care workers, volunteers, and others. The auxiliary team consists of pharmacists, psychological counselors, exercise-prescription specialists, rehabilitation therapists, traditional Chinese medicine physicians, and others. The core team consists of family doctors, physician assistants, and health-promotion specialists. Service content of the family-doctor team: provision of comprehensive and continuous public health, basic medical, and health-management services.

Table 3 The functional positioning of social workers in MDT

Theme dimension	Functional positioning	Interview quotations
Team collaboration support	Optimize the structure of family doctor teams; undertake non-medical health management tasks	(1) Family doctor -F1: "The medical social workers helped us complete home-based contract signing and health-record collation for about 60 community residents who were key targets of assistance and concern, allowing doctors to focus on consultations." (2) Nurse -F2: "In the past, home follow-up visits took 1-2 hours per person, and sometimes residents were unwilling to let us visit. Now social workers communicate with residents in advance, collect data, increase efficiency by 30%, and reduce the work pressure on family doctors."

Theme dimension	Functional positioning	Interview quotations
Doctor–patient communication bridge	Alleviate information asymmetry between doctors and patients; promote patients' understanding of and adherence to diagnosis and treatment plans; mediate potential doctor–patient conflicts	(1) Patient' s family member –C1: "The medical social worker often came to communicate with the elderly person at home and learn about the elderly person' s situation; in the end, the elderly person became willing to take medicine as instructed." (2) Director of a community residents' committee –C2: "Medical dispute complaints decreased by half last year; social workers participated in the mediation of five consultation-related cases."

Theme dimension	Functional positioning	Interview quotations
Integration of social resources	Link community volunteers, public-welfare organizations, etc.; build a "medical + social" support network	(1) Medical social worker –S1: "We actively applied for public-welfare venture-philanthropy projects and established 'one person, one file' health records and one-to-one plans with family doctor teams for 80 persons with mental disorders under weak guardianship, providing case-management services." (2) Manager of a social-work organization –M1: "Medical social workers, working together with family doctor teams, can help establish a healthier social-work service system."

Theme dimension	Functional positioning	Interview quotations
Management of key populations	Provide individualized health management and psychological support for older adults, people with chronic diseases, and persons with disability or loss of self-care ability	(1) Homebound resident with disability and cognitive impairment –C3: "The medical social worker comes every month to ask about my health status; if there are changes or control is poor, they contact the family doctor to come and examine me." (2) Institute of Medical Management –H1: "After medical social workers joined, medical care moved from the original basic medical disease treatment to present-day whole-person care, especially in the management of chronic diseases among older adults."

Theme dimension	Functional positioning	Interview quotations
Extension of health services	Conduct community baseline surveys and preventive services such as health education; assist medical teams in extending health services from institutions to communities and families, and promote the integration of medical treatment and prevention	(1) Community director –C2: "Family doctor teams and medical social workers jointly carried out community health education activities; residents' participation improved markedly, and the organization became more orderly and the activities more professional. Ordinary people gained more." (2) Family doctor –F3: "After medical social workers joined, the frequency of community health activities increased from once per month to 2–3 times per month."

Theme dimension	Functional positioning	Interview quotations
Cross-disciplinary collaborative innovation	Participate in joint case discussions; provide social-psychological assessments; optimize diagnosis and treatment plans	(1) Family doctor -F3: "The social worker found that a patient with diabetes had mood problems that were causing fluctuations in blood glucose, and promptly gave us feedback, helping us adjust the patient' s chronic-disease management plan." (2) Head of the public health department -H5: "After cooperating with medical social workers, for some complex medical problems, medical social workers helped coordinate psychological aspects, and work efficiency improved noticeably."

Table 4 Effect evaluation of social workers' participation in MDT

Evaluation dimension	Specific indicators	Interview quotations
Patient satisfaction	Increased satisfaction; increased patient adherence	(1) Community patient -C4: "Now, after signing up, with social workers participating, I can find someone whenever there is a problem. It is much more convenient than before, and I can see social workers right in the community." (2) Beijing medical administration department -H2: "Medical social workers assist family doctors and patients in establishing trust···After community health service centers introduced medical social workers, patients' adherence to health guidance increased by about 30%. The satisfaction rate of patients served by family doctor teams with medical social workers increased to 92% from a baseline of 78%; this is inseparable from the increased communication time and personalized services after medical social workers joined."

Evaluation dimension	Specific indicators	Interview quotations
Health management efficiency	Increased patient visit rate, health examination rate, and hypertension control rate	(1) Family doctor –F3: "Medical social workers participated in some non-medical services of the team; the home-visit rate for patients with chronic diseases increased, and the health examination rate rose by about 10%." (2) Community director –C2: "The control rate among patients with hypertension rose from 63% to 72%; the sustained follow-up visits by medical social workers were indispensable."
Resource integration efficacy	Increased utilization rate of community resources; increased number of public-welfare cooperation projects	(1) Administrator of a primary medical and health institution –H3: "Medical social workers can screen high-risk families, help allocate resources precisely, and give priority to vulnerable groups." (2) Manager of a social-work organization –M2: "Together with the community health service center, we applied for two public-welfare support projects; this year we raised 100,000 yuan, covering 140 disadvantaged and specially concerned individuals in the jurisdiction."

Evaluation dimension	Specific indicators	Interview quotations
Team collaboration efficacy	Improved response time to social needs referred by general practitioners; improved efficiency in formulating joint intervention plans; improved management outcomes for patients with severe mental illness	(1) Medical social worker –S2: "Now the response time to social needs referred by doctors does not exceed 3 hours, and team collaboration is smoother." (2) Pharmacist –F4: "After medical social workers joined, the accuracy of our medication plans improved by nearly 30%." (3) Severe mental illness management group –F5: "With the assistance of medical social workers, we have a better handle on managing patients with severe mental illness under weak guardianship. Together with medical social workers, according to the different project service targets, we established three special-service WeChat work groups: health monitoring for people in difficulty, family care for severe mental illness, and disability/dementia support."

Evaluation dimension	Specific indicators	Interview quotations
Community health level	Increased coverage of residents' health activities and increased awareness of health knowledge	(1) Community patient -C4: "The health-courtyard activities organized by the social-work organization taught me how to measure my own blood pressure and emergency-response skills." (2) Head of the public health department -H4: "Medical social workers are responsible for integrating community resources and designing health education activities. After they joined, the coverage rate of community health activities increased from 60% to 85%, and awareness of health knowledge increased from 80% to 90%."
Economic benefits	Reduced unnecessary health-care expenditures among residents and reduced incidence of complications	(1) Community patient -C4: "After participating in the health education activities organized by the community, I buy fewer health products and no longer spend money recklessly." (2) Family doctor -F3: "For some residents, because adherence improved, they take medication and attend follow-ups regularly, and complications decreased."

(such as community residents and patients) and the supply side (medical social workers or administrators, etc.), together with subjective evaluations and objective data indicators. The evaluation content included improvements in six indicators: patient satisfaction, health management efficiency, resource integration efficacy, team collaboration efficacy, community health level, and economic benefits, as shown in Table 4.

2.4 Collaborative Model and Directions for Improvement

2.4.1 Collaborative model

The above results jointly reveal the action logic and outcome pathways of medical social workers in primary-level multidisciplinary collaboration. Table 3 shows that the functions of social workers are mainly reflected in six dimensions: collaborative empowerment, communication bridging, resource integration, key-population management, service extension, and cross-disciplinary innovation. These correspond to the key needs of the medical system at different stages and form the empirical basis for the first two links of "identifying concerns" and "precise intervention." The quantitative results shown in Table 4 further verify the significant improvements after social-worker intervention in patient satisfaction, health management efficiency, resource integration efficacy, and community health level; these measurable outcomes provided a basis for the subsequent links of "effectiveness verification" and "institutionalized embedding"

real-world basis. Accordingly, the study constructs a progressive pragmatic collaborative model that combines feasibility and effectiveness, as shown in Figure 2.

The core logic of the pragmatic collaborative model is as follows. First, by identifying key concerns, it begins with the priorities of the medical team, which holds the dominant voice; the medical social work team proactively communicates with medical management to clarify its core performance indicators. Second, targeted intervention is carried out: the specific duties of social workers are designed around KPIs. For example, to improve patient satisfaction, medical social workers can conduct thorough pre-consultation communication and provide post-consultation emotional support and follow-up; to reduce doctor–patient conflicts, medical social workers can serve as neutral third parties for communication and mediation. Third, by quantifying outcomes, the value of social work is made visible: the effectiveness of collaboration must be presented through data recognized by the medical system. By tracking changes in the above indicators, the added value brought by social work intervention can be demonstrated intuitively, thereby transforming social workers from a cost center into a value center. Finally, cooperation is deepened and moves toward institutional embedding: on the basis of recognized value, and using actual benefits as evidence, the future goal is to gradually promote the inclusion of social workers in routine team configurations, clarify job responsibilities, and ultimately

achieve the transition from project-based cooperation to institutionalized integration.

Therefore, the successful integration of grassroots medical social workers is a dynamic evolutionary process from "marginality" toward "integration." First, in terms of role positioning, it moves from role parallelism to structural embedding. Previous studies have mostly defined the role of medical social workers in a parallel manner, while how they collaborate at the organizational level has remained relatively vague. The Yulin model, however, clearly positions medical social workers within the support team and establishes an institutionalized mechanism of division of labor and collaboration with the core team composed of family physicians. As a result, medical social workers are no longer abstract collaborators, but systematic and operational participants with a clear position in the organizational structure and clear process relationships; the performance of their functions thus has a solid organizational guarantee. Second, in terms of working mode, it moves from passive response to process integration. Previous descriptions of medical social work intervention often implied a passive, referral-based model dominated by the medical team

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. By contrast, the Yulin model demonstrates the proactive integration of medical social workers into the full process of medical services: before, during, and after consultation, the work of social workers is proactively and systematically woven into the entire service chain. Unlike the diagnosis-and-treatment orientation in previous studies, it represents a paradigm shift from after-the-fact remediation to prior prevention and whole-process management, significantly improving the continuity and proactivity of services. Third, in terms of value realization, it moves from value advocacy to evidence-based efficacy. Existing studies have emphasized the value-advocacy role of medical social workers in areas such as social justice and medical humanities

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. Although important, these roles are difficult to measure intuitively in practice because of their abstract nature. This study, through concrete practice data, makes the value of medical social workers explicit and quantitatively demonstrable, strongly proving that their professional intervention can be directly translated into improvements in medical quality, management efficiency, and economic benefits. This has practical significance for promoting professional recognition and institutional acceptance of medical social work.

Figure 2 A pragmatic collaborative model for integrating medical social workers into grassroots MDT

- **(1) Identifying concerns: targeted services**
  Proactively connect with medical management and identify its core performance indicators (KPIs) and service concerns, such as patient satisfaction and doctor–patient conflicts.

- **(2) Targeted intervention: addressing pain points**
  Design specific social-work responsibilities around KPIs, such as improving satisfaction through pre-consultation communication, reducing conflicts through neutral mediation, and providing precise services.
- **Value-driven institutional embedding**
- **(3) Evidence of efficacy: making value visible**
  Through data recognized by the medical system, quantify outcomes and intuitively demonstrate the added value brought by social work intervention.
- **(4) Institutional embedding: deepening integration**
  After value has been demonstrated, promote the institutionalization of positions, responsibilities, and processes, achieving the transition from project-based cooperation to routine team configuration.

2.4.2 Future Directions for Improvement

The current new model of medical services has gradually tended toward reliance on community-based settings, yet communities remain at the margins of the medical service system

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. In primary health care, the actual roles played by social workers encompass a broader range of services that contribute to individual health and well-being beyond their assigned responsibilities; in some institutions, they even provide group appointment services related to health behaviors and self-management

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. Based on interviewees' feedback, social workers in the current grassroots medical system face similar difficulties: although in practice they have already assumed some functions of medical social workers, from the perspective of institutional and professional systems, medical social work has not yet been formally and systematically incorporated into the service framework. Therefore, fully incorporating medical social workers into the community health service system is an important direction for improving the community medical service model. As members of family physician teams noted, the overall degree of cooperation and integration between medical social workers and family physicians is low. As interviewee H2 stated: "At present, medical social workers are still not sufficiently involved in the actual work of family physicians. They simply work together because of the project; they have not truly been integrated into the team, so work integration is somewhat difficult." Meanwhile, in the view of managers of medical social work institutions, insufficient funding guarantees and the absence of position settings are also current difficulties faced by medical social workers. M2 said: "When the project ends, funding cannot be guaranteed, and cooperation [continuing with family doctors] becomes a fleeting thing. Moreover, grassroots medical and health institutions currently do not have the position of medical

social worker. In other words, even if we want to recruit a medical social worker, even as temporary staff, there is no such position, so we cannot apply to higher-level departments." In addition to mechanism building, interviewees offered the following suggestions for the future development of medical social workers in grassroots medical and health institutions: (1) capacity training. It is necessary both to strengthen family physicians' understanding of the concept of medical social work and to improve medical social workers' basic medical knowledge. (2) Shared information and support platforms. Health records should be shared, and interprofessional communication platforms should be established.

3 Discussion

3.1 Pathways for Reshaping the Role of Grassroots Medical Social Workers

3.1.1 The Practical Logic of an Auxiliary Role Equal collaboration is an expression of the professional values of social work, but in the medical field dominated by biomedicine, its realization faces practical challenges. First, in terms of knowledge systems and professional authority, physicians possess the authority to diagnose diseases and prescribe treatment, which occupies an absolutely dominant position in medical services whose primary goal is curing disease. Second, from the perspective of patients' hierarchy of needs, the restoration of physical health is their foremost and most urgent concern, while needs such as psychological adjustment and social support often come afterward. Therefore, the Yulin model positions medical social workers as a support team rather than a core team, and does not insist on formal

···equality, but rather to explore functional complementarity, thereby laying a foundation for the feasibility of collaboration.

3.1.2 Context-led predominance beyond assistance

However, the role of medical social workers is dynamic and complex, and goes far beyond the passive execution of medical orders. First, in specific disease-management contexts (such as hypertension and diabetes), social workers can play a leading and even decisive role. The long-term outcomes of such diseases depend heavily on patients' self-health management, lifestyle changes, and medication adherence. The effect of physicians' prescribing authority is limited, whereas social workers' professional interventions in health-behavior promotion, family support-system building, and patient psychological counseling become key to determining the success or failure of health management. H1: "The participation of medical social workers has moved primary-level medical care from the original disease treatment to today' s whole-person care, especially in chronic disease management among older adults" ; this is precisely the embodiment of social workers' shift from an auxiliary role to a leading one. Second, social workers play the roles of advocates and resource linkers that are difficult for the medical team to replace. For example, for families unable to bear

medical expenses because of poverty, for patients requiring scarce resources such as organ-transplant links, or for special groups needing policy support, the advocacy function of medical social workers is of paramount importance. S1: "Medical social workers actively apply for public-welfare venture-philanthropy projects to establish health records for people with severe mental disorders"; this goes far beyond the scope of auxiliary diagnosis and treatment. Because medical staff are busy and constrained by their professional domains, it is difficult for them to effectively link social-policy and public-welfare resources outside the hospital; this is precisely where the core advantage of medical social workers lies.

3.1.3 Constructing a feasible and effective collaborative model

At this point in the discussion, the ultimate question returns to how to build a collaborative model that is both feasible and effective. Effectiveness has been demonstrated, but feasibility is the key bottleneck for wider promotion, involving such real-world difficulties as professional boundaries, the motivation for collaboration, and especially conflicts in performance assessment between different systems (such as medical care and social work). In order to translate the ideal of "effectiveness" into universal "feasibility," medical social workers should, in the early stage of integration, first focus on solving the most pressing problems within the medical system, thereby proving their own value and laying the foundation for deeper cooperation. In summary, this study proposes a progressive and pragmatic collaborative model: through a value-driven embedded strategy of exchanging actual contributions for status, it identifies a feasible and effective practical pathway for medical social workers within real-world power structures. However, while the pathway of "exchanging contribution for status" improves feasibility, it may also bring three kinds of tension. First, value deviation: in the pursuit of KPIs, social workers may become excessively instrumentalized and deviate from their core professional values such as "social justice" and "empowerment." Second, the reproduction of dominance: a medicine-dominated performance framework may solidify discourse asymmetry. Third, sustainability: when external resources shrink or projects terminate, the benefits may be difficult to maintain steadily. Therefore, this study recommends adopting a balanced scorecard at the organizational level: in addition to outcome indicators (satisfaction, control rates), process and justice indicators should be incorporated (such as coverage of disadvantaged groups, timeliness of referral, success rate of dispute mediation, etc.), and a dual-channel performance evaluation should be established (in which both medical teams/family doctors and social workers share responsibility and benefits). At the same time, regular joint case conferences and cross-professional review should be used to correct role drift and alleviate structural asymmetry.

3.2 Structural evolution of the ideal of equal collaboration

As shown in Figure 3, from the perspective of structural hierarchy, the real-world health service system still presents a vertical hierarchical structure. Not only is there a divide in knowledge and power between patients and professionals; within professional groups there are also disciplinary hierarchies. This vertical structure reinforces professional boundaries and power inequality. In the ideal state, however, collaborative relationships should present a concentric-circle horizontal structure: all professions should coordinate around the common goal of "health," each performing its own duties and supporting one another across different rings. In this structure, the realization of each party' s function requires finding, within the network structure, a functional positioning and interaction mechanism that fit with the parent system: in the inner circle close to the clinical front line, physician dominance is unavoidable; in the outer circle that connects community support and expands social influence, the resource-linking and behavior-change capacities of social workers are more leading. In this case, recognizing differences, leveraging complementarity, and supplementing them with visible contributions instead won social workers a more stable position.

The evolution from reality to the ideal is still in an initial stage and is constrained by multiple real-world factors. First, differences in standards for recognizing the performance of medicine and social work make it difficult to measure the outcomes of interprofessional collaboration in a unified way. Second, compared with physicians, the professional education system and practical experience of social workers remain relatively weak, and the degree of professionalization is still insufficient. Third, knowledge barriers and trust gaps between doctors and patients remain. Even though the rise of new media and health communication has improved information asymmetry to a certain extent, it has not yet fundamentally eliminated this structural divide. All of the above constitute obstacles to the evolution from a real-world vertical hierarchy toward an ideal concentric network, and social workers are reshaping their own roles in the intermediate zone of the current collaborative structure.

4 Conclusion

The key to the effective integration of primary-level medical social work into the medical system lies not in taking an idealized role orientation of equal partnership as the premise, but in supporting organizational status through measurable professional contributions as an integrative pathway. This study finds that by accurately positioning themselves as a support team serving the core goals of medicine, and by closely linking professional services with the core performance indicators of medical teams, medical social workers can not only be systematically embedded throughout the entire diagnosis-and-treatment process, but, more importantly···

Visible text in Figure 3:

- Real-world vertical hierarchy

- In positive evolution
- Real-world obstacles
- Ideal concentric-circle dimension
- Medical experts, managers
- (General/family) physicians; nurses; medical technicians
- Medical social work
- Patients and families
- Professional boundaries, disciplinary inequality, inequality in doctor-patient power
- Community and social support layer (people-centered)
- Integrated care layer (chronic disease management, rehabilitation)
- Clinical correction layer (diagnosis, prescription)
- Health of patients and families
- Medical social work, community volunteers, non-governmental organizations, etc.
- Gradual progress
- Equal collaboration; beyond an auxiliary positioning

Figure 3 Structural evolution and role reshaping of the health service system

what is needed is to present their work outcomes by converting them into visualized data recognized by the healthcare system. This shift from value advocacy to effectiveness presentation provides practical evidence for medical social workers to obtain professional recognition and to explore pathways for institutionalized embedding.

Limitations of the study: First, limitations of context. This study is based on a single case; its explanatory power is influenced by contextual factors such as specific policy support, leadership, and resource endowment, and its external transferability to other community contexts is limited. Second, limitations of data sources. The quantitative indicators came from the institution' s existing management statistics and information system. Although multiple sources of data were compared, discussed, and checked, they may still be affected by caliber differences; future studies should use standardized scales and control designs for verification. In the future, multi-site comparative embedded case studies and mixed-methods research should be conducted to test the model's generalizability and boundary conditions in regions with differing resource endowments, and to further summarize and verify relevant theories and hypotheses concerning the collaboration mechanism between medical social work and general practice.

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