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Exploration and Practice of Medical and Prevention Integration Work in Grassroots Hospitals under the Construction of Healthy China Strategy

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Abstract: The Healthy China strategy has promoted primary health services to shift from disease treatment to full life cycle health management. The integration of medical and prevention has become an effective way for primary hospitals to focus on prevention. This article uses the methods of policy analysis, process review, and practical induction to study the connection mechanism between diagnosis and treatment business and basic public health services. After research, it was found that there are problems such as process separation, insufficient information utilization, lack of personnel comprehensive capabilities, and weak performance synergy in the integration of grassroots medical and prevention. Therefore, a closed-loop path is formed that connects risk identification and clinical diagnosis and treatment, extending to follow-up management, and incorporates referral collaboration and quality evaluation. The study believes that grassroots hospitals should take residents' health outcomes as the common goal, use the family doctor team as the carrier, and use information collaboration and performance linkage as the support to make medical services and preventive services continue.

Keywords: Healthy China strategy; Grassroots hospitals; Medical and prevention integration; Family doctors; Health management

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1. Introduction

The report of the 20th National Congress of the Communist Party of China pointed out that it is necessary to innovate medical and prevention coordination and medical and prevention integration mechanisms, improve the public health system, and strengthen the major epidemic prevention and treatment system and emergency response capacity building. The integration of medical and prevention means combining treatment and prevention, that is, medical treatment and prevention interpenetrate and integrate into one. Through the

effective connection, simultaneous provision, and mutual coordination of medical services and preventive services, it can minimize the occurrence of health problems, control the deterioration of health problems in a targeted manner, improve the suitability and effectiveness of medical and health services, and achieve the goal of "health-centered". At present, grassroots hospitals have formed two business systems: clinical diagnosis and treatment and public health. However, there is a certain separation in personnel arrangements and information systems, causing difficulties in the connection between service processes and assessment standards. Patients with hypertension or diabetes will undergo public health follow-up after outpatient diagnosis and treatment. Clinical information and health records cannot be connected in a timely manner, resulting in duplication of services and management omissions. This article mainly analyzes the internal mechanisms of grassroots hospitals, analyzes the contradictions in the integrated operation of medical and prevention, provides a plan for process reshaping and team collaboration, strengthens information support, and improves performance, providing a reference for the formation of a collaborative model of prevention, treatment, and management.

2. Functional positioning of medical and prevention integration in grassroots hospitals under the Healthy China strategy

The main function of medical and prevention integration in grassroots hospitals is to connect residents' medical treatment and risk screening, and then integrate subsequent follow-up into the same health management chain. Hospital managers determine service priorities based on the health needs of their jurisdictions, clinicians identify chronic disease risks simultaneously during diagnosis and treatment, public health personnel change follow-up frequency and intervention content based on diagnosis and treatment results, and family doctor teams assume the important task of integrating information and continuous tracking. The hospital must also embed the county medical community's support capabilities into the chain of responsibility so that grassroots teams can receive timely specialist guidance for complex conditions [1]. This model connects disease treatment and risk control with the same resident as a unit, while carrying out rehabilitation guidance and health education. It also provides a basis for health management for primary diagnosis and hierarchical referral at the grassroots level.

3. Key contradictions in the integrated operation of medical and prevention in primary hospitals

3.1. Insufficient connection between diagnosis and treatment process and public health process

The clinical outpatient clinics of primary hospitals mainly carry out work around the processing of chief complaints, examination and judgment, and then complete diagnosis and medication. Basic public health services arrange tasks according to population categories and follow-up periods. The triggering conditions of the two types of processes are different. After patients complete outpatient treatment, conditions such as abnormal blood pressure or reduced medication compliance will remain in the medical record, and the risk of complications cannot be communicated to public health personnel in a timely manner, resulting in the delay of subsequent intervention. Some follow-up records are not used in the next outpatient clinic, which will affect the decision-making of treatment. Process misalignment causes repeated circulation of health problems

and increases the risk of service interruptions. The hospital should find process breakpoints, turn outpatient risks into follow-up tasks, and allow timely feedback of abnormalities in follow-up to clinicians, so that the results of diagnosis and treatment become the beginning of health management, and the results of follow-up also enter into the next diagnosis and treatment decision.

3.2. Dispersion of health information affects continuous management

The information system of primary hospitals generally keeps outpatient medical records and test results separately. Health files and follow-up records will also be kept separately. Different data fields and update frequencies are also different. Family doctors cannot immediately see the patient's latest follow-up records when receiving a diagnosis, and public health personnel also lack the latest medication adjustments and examination results, resulting in delayed risk judgment. Duplicate entry of information increases the burden on frontline personnel and reduces the team's willingness to actively use health records [2]. Information fragmentation will weaken trend judgment and affect the team's identification of disease changes. The hospital information management department should create a unified index around residents, add changes in blood pressure and blood sugar to a continuous timeline, correlate weight status and major diagnoses, plus changes in medication and referral information, set up abnormal reminders, and allow important data to enter the team's common work interface, thereby strengthening the real-time nature of medical and prevention collaboration.

3.3. The structure is difficult to support composite services

The integration of medicine and prevention means that grassroots doctors must be able to deal with common and chronic diseases, as well as identify high-risk factors and conduct behavioral intervention. Public health personnel must also understand commonly used drugs and changes in disease conditions, and master referral indications. In actual work, clinical personnel know better about diagnosis, treatment and treatment, while public health personnel know better about project specifications. There is a boundary between the two. Although some teams have implemented joint contracting, there is no training in case collaborative decision-making between various positions for the same patient. The existence of capability boundaries will increase job dependence and reduce team collaboration efficiency. Primary hospitals should choose common chronic diseases as training sites, conduct joint case discussions and outpatient teaching, and review follow-up visits, so that clinicians can master risk stratification methods and public health personnel can master abnormal identification standards, and gradually form composite capabilities through team management of the same patient.

3.4. Dispersion weakens synergy dynamics

The current assessment method in grassroots hospitals generally separates outpatient workload and public health task completion rate. Doctors lack incentives to pay attention to follow-up results after completing diagnosis and treatment. After public health personnel complete the number of follow-up visits, the effect of disease control will also be reduced. Decentralized evaluation will cause team members to work around their own indicators, resulting in resident service continuity not being included in performance results [3]. The evaluation goals have no common direction, and job collaboration is easily replaced by task completion. Managers should include blood pressure and blood sugar control conditions in the evaluation scope, examine

the standardization of follow-up and the closed loop of abnormal referrals, and then combine them with the contracted service satisfaction to form a common performance indicator, so that team members bear the same responsibility for the same health results.

4. Practical path of medical and prevention integration in grassroots hospitals under China's strategic guidance

4.1. Health responsibility unit

4.1.1. Hierarchical management

The family doctor team needs to integrate health records, outpatient diagnosis information, test results, lifestyle risks, etc., and then use this information to divide residents in the jurisdiction into general groups and key groups of concern, and finally identify high-risk groups. The general population mainly receives health education and periodic screening, while key groups increase indicator monitoring and lifestyle intervention. For high-risk groups, family doctors determine the frequency of follow-up and establish referral plans. The team reclassified the stratified list every month based on new diagnostic information, abnormal test results, and changes in follow-up, and proactively contacted those who were continuously lost to follow-up. The stratified results should be adjusted in a timely manner according to changes in conditions and examinations to ensure that limited human resources serve residents with high risks and obvious intervention effects first.

4.1.2. Health responsibility

Primary hospitals should incorporate family doctors and nurses into responsible units, and at the same time attract public health personnel and cooperating doctors from higher-level hospitals to participate. Family doctors make diagnosis and treatment decisions and health management plans, nurses do indicator monitoring and medication guidance, public health personnel do follow-up organization and health education, and superior collaborating doctors do complex case consultation and referral support [4]. The hospital allocates responsibilities according to fixed jurisdictions or fixed contract groups, and establishes a responsibility replacement system to ensure that services are not interrupted during vacations or job adjustments. After the team continues to understand changes in residents' health, it will reduce the cost of patients repeatedly explaining their conditions between various positions, and will also increase the responsibility for tracking abnormal conditions.

4.2. Reshape the continuous service process before, during, and after diagnosis

4.2.1. Risk identification of forward outpatient clinics

Primary hospitals should access residents' health records when registering or waiting for treatment. The system will prompt chronic medical history and past abnormal indicators, and will also remind patients of due follow-up tasks. After the nurse completes basic checks such as blood pressure and weight, she sends the abnormal results to the treating doctor. For residents who have not created a file or whose information has not been updated for a long time, the front desk will simultaneously mark the need to supplement the file and complete the necessary information collection during this visit. Doctors can know the patient's recent risk changes before entering the consulting room, and then decide whether necessary examinations and health interventions are needed. This process embeds public health information into the outpatient preparation process, which can reduce the probability of repeated inquiries and missed investigations.

4.2.2. Integrate diagnosis, treatment and health intervention content

After the treating doctor completes the disease diagnosis and treatment plan, he or she must simultaneously generate a health management prescription based on risk stratification. The prescription should indicate the review time and indicator targets, as well as medication precautions and lifestyle requirements. The system automatically converts prescriptions into team tasks, and nurses and public health personnel carry out follow-up guidance based on this. For residents who experience abnormal blood pressure or blood sugar for the first time, doctors should immediately start retesting and diagnosis evaluation, and at the same time carry out health education to prevent management gaps from occurring after the residents leave the hospital. Patients can receive treatment and prevention information in one visit, and the team can provide services around the same plan, reducing the deviation between clinical treatment and public health guidance.

4.2.3. Form a closed loop of post-diagnosis follow-up and referral

Public health personnel should follow health management prescriptions for telephone or outpatient follow-up. They can also conduct door-to-door follow-up visits as needed, and timely feedback abnormal indicators to family doctors. Family doctors will adjust medication or arrange follow-up consultations according to changes, and initiate county coordinated referral for patients who meet the referral criteria. The grassroots team also needs to record the reason for the referral, the institution receiving the treatment and the time of the appointment to prevent just transferring out the registration. After the diagnosis and treatment at the higher-level hospital, the diagnosis results and treatment plans are fed back to the grassroots team, and the family doctor continues to be responsible for the management of the recovery and stable periods. Primary hospitals rely on this closed loop to maintain the continuity of patient information between various service levels, and also clearly identify the responsible persons at each stage.

4.3. Build a closed loop of shareable health information

4.3.1. Unified resident health information view

The information management department of primary hospitals should associate electronic health records with key fields of outpatient information, centrally display recent diagnoses and main indicators on the family doctor's work interface, and also reflect medication plans, follow-up status, and referral results. The system displays changing trends in chronological order and maintains information on responsible personnel and processing situations [5]. For repeatedly entered fields, the system should first use the existing valid data, and then modify it after confirmation by the person in charge, thereby reducing repetitive filling. The unified view allows doctors to quickly judge the control effect, and also enables public health personnel to accurately implement intervention plans, improves the consistency of information in team collaboration, and provides a reliable source of data for quarterly quality evaluations.

4.3.2. Set up risk warning and task dispatch mechanism

Hospitals should formulate early warning rules based on changes in blood pressure and blood sugar, and judge whether follow-up visits are normal based on weight changes and long-term absences. When a certain indicator reaches a set threshold, the system will automatically assign tasks to the corresponding groups and set the completion time according to the risk level. High-risk tasks are pushed by family doctors, and ordinary follow-up reminders are completed by nurses or public health personnel, who are triaged according to different positions. The team closes this task after contacting, reviewing or referring residents, and stores

the relevant location tracks into the system. For overdue tasks, the department head immediately urges them to handle them, forming a traceable chain from the occurrence to handling of abnormal risks.

4.4. Build a health outcome-oriented performance evaluation mechanism

4.4.1. Establish quantitative indicators that pay equal attention to process and results

Grassroots hospitals should take prevention and continuous health management as the direction, incorporate risk identification and standardized follow-up into process evaluation, and include disease control and referral closed-loop into outcome evaluation. Indicators should take into account the controllability of the team and the health outcomes of residents, and set specific target values. The management department should unify the time and denominator range of data extraction, and also stipulate the elimination criteria for abnormal situations to ensure comparability among various teams. The hospital can monitor core indicators on a quarterly basis, compare data with the same caliber to identify weak links in the process, and feed the results back to the responsible team. (**Table 1**)

Table 1. Suggested thresholds for core indicators of medical and prevention integration in primary hospitals

Indicator name	Calculate caliber	Recommended target value
Risk stratification coverage of key groups	Number of people who have completed risk stratification/number of people who should be stratified × 100%	≥ 95%
24-hour push rate of outpatient abnormal information	Number of abnormal cases pushed within 24 hours/Total number of abnormal outpatient cases × 100%	≥ 90%
Hypertension standard management rate	Number of people under standardized management/number of people included in management of hypertension × 100%	≥ 90%
Diabetes standard management rate	Number of people under standardized management/number of people with diabetes included in management × 100%	≥ 90%
Abnormal task closed-loop completion rate	Number of completed disposal tasks/total number of abnormal tasks × 100%	≥ 95%
Two-way referral information return rate	The number of people who have completed the result return / the actual number of referrals × 100%	≥ 90%

4.4.2. Strengthen the performance application of evaluation results

Hospital managers should directly link indicator results with team performance, and arrange training and process improvement based on the results. Teams that meet the goals in quarterly evaluations receive corresponding performance incentives, and teams whose individual indicators continue to be low enter a special review. The management department distinguishes personnel capabilities and information system problems based on the reasons, identifies process design flaws, and sets a rectification deadline. If the indicators have not been improved in two consecutive evaluation cycles, the hospital management should re-examine the indicator settings and resource allocation, and adjust job tasks if necessary. The hospital's annual evaluation should also pay attention to the trend of improvement in chronic disease control and changes in residents' service experience, so as to continuously revise the index weights and ensure that the performance mechanism always supports medical and prevention collaboration.

5. Conclusion

The Healthy China strategy points out the path from disease treatment to full-cycle health management

for the integration of medicine and prevention in grassroots hospitals. Primary hospitals should reorganize services around the same residents and health goals, with the same responsibility team, combine outpatient diagnosis and treatment with risk screening, and then connect health intervention and follow-up management to two-way referrals to form a continuous service chain. The key to practice is to establish a health responsibility unit, use information systems to support task flow, use composite teams to undertake continuous services, and use quantified performance to form stable incentives. Primary hospitals should change the risk stratification criteria and service focus according to the disease spectrum and residents' needs in the jurisdiction, so that the integration of medical and prevention becomes a normalized operating system. After the hospital continues to feedback health results to process improvement and performance evaluation, it can promote the integration of medical and prevention to form a stable closed loop, improve grassroots health gatekeeping capabilities and residents' sense of gain in health management.

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Disclosure statement

The author declares no conflict of interest.

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