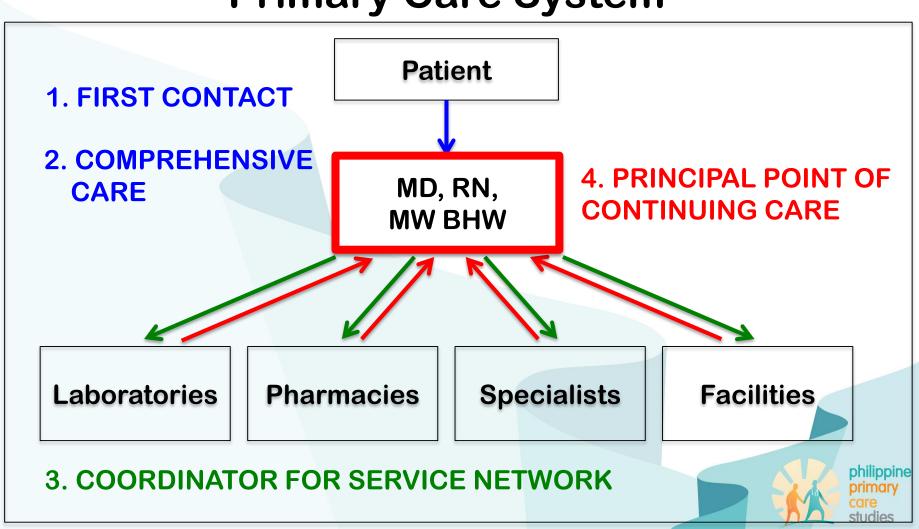
What is Primary Care?

Primary Care is a *system* where patients access healthcare, with *4 main functions*:

Primary Care System



	STRATEGY	OBJECTIVES
RECRUIT	Motivational workshops Fees for services	(New hires) HCW satisfaction
RETRAIN	Lectures Workshops	HCW Knowledge Quality of Care
RETAIN	Motivational Workshops Fees for services	(Quit rates) HCW satisfaction
REGULATE	Require use of EMR, ICD and Formulary meds, SDN	% Compliance
REASSESS	Survey Instruments	Utilization OOP Payments Hospitalization Costing
REACH OUT	Brochures, ads, videos Meetings w people/leaders	Patient satisfaction

KEY PLA	YER: BHW PROPOSED OVERALL RO	DLE: Bridge between community and health system (health coach)	
PRIMARY CARE FUNCTION	PROPOSED COMPETENCIES REQUIRED	Proposed Training Objectives	
I. FIRST CONTACT	distinguish between sick and well (health screening) recognize emergencies and deliver first aid / BCLS/conduct to ER develop communication skills and nurture patient trust (*also for IV. CONTINUING CARE)	distinguish between sick and well (health screening) recognize emergencies and deliver	
II. COMPREHENSIVE CARE	1. perform basic Hx & PE, including non-lab health screening 2. perform and teach household remedies for common conditions 3. counsel patients on general disease prevention and health promotion	first aid / BCLS/conduct to ER 3. develop communication skills and nurture patient trust (*also for IV. CONTINUING CARE)	
III. COORDINATED CARE	inform patients of available meds, tests, services in RHU & SDN communicate freely and effectively with the rest of the team assist patients with logistics for commonly occuring health needs in the community recognize need for MW, RN or MD	 To proactively identify and utilize methods and opportunities for educating the community on primary care servi 3a. To select the proper communication channel, person to communicate with, and information required for communication To describe the options that patients can use for accessing care, as appropriate for a given condition or situation To distinguish with reasonable judgment if a case needs referral to other primary care team members, and which 	mon situations
IV. CONTINUING CARE	1. Knowledge and skills to render monitoring rehab counselling or continuing care under supervision of MD, RN or MW 2. (*As above, cultivating trust for ongoing therapeutic relationship)	 1a. To properly interpret orders from other team members on the patients' charts 1b. To use different options for reaching out to patients 1c. To exercise all necessary community-based clinical skills for carrying out orders 1d. To make relevant, accurate observations in the course of providing care and record / report them appropriately 2. (* Training objectives apply as above for communicating and nurturing trust) 	

Key player: BHW Proposed overall role: Bridge between community and health system (health coach)

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PRIMA CARE FUNCT		PROPOSED COMPETENCIES REQUIRED	PROPOSED TRAINING OBJECTIVES
FIRST	ACT	distinguish between sick and well (health screening) recognize emergencies and deliver	1a, 2a. To identify common signs and symptoms including those for emergency cases1b. To exercise relevant communication techniques for patients for first-contact care in the community setting
E	Ž	first aid / BCLS/conduct to ER 3. develop communication skills and	2b. To demonstrate proper procedures for first aid and BLS 2c. To safely perform the necessary steps in conducting patients to the ER
<u>-</u> (<u>წ</u>	nurture patient trust (*also for IV. CONTINUING CARE)	To use the most appropriate verbal and nonverbal techniques when speaking with and listening to patients

- 1a, 2a. To identify common signs and symptoms including those for emergency cases
- 1b. To exercise relevant communication techniques for patients for first-contact care in the community setting
- 2b. To demonstrate proper procedures for first aid and BLS
- 2c. To safely perform the necessary steps in conducting patients to the ER

3. To use the most appropriate verbal and nonverbal techniques when speaking with and listening to patients

ATE	2. communicate freely and effectively	16. To proactively identity and delize methods and opportunities for educating the community on primary care services
N N	with the rest of the team	2, 3a. To select the proper communication channel, person to communicate with, and information required for common situations
COORDIN	assist patients with logistics for commonly occuring health needs in	that need coordination
8	the community	3b. To describe the options that patients can use for accessing care, as appropriate for a given condition or situation
≝	recognize need for MW, RN or MD	
		4. To distinguish with reasonable judgment if a case needs referral to other primary care team members, and which one
	1. Knowledge and skills to reader	1a. To properly interpret orders from other team members on the patients' charts
/D	 Knowledge and skills to render 	1a. To properly interpret orders from other team members on the patients charts
NG	monitoring	1b. To use different options for reaching out to patients
MUING	_	
TINUING	monitoring	1b. To use different options for reaching out to patients
ONTINUING	monitoring rehab	1b. To use different options for reaching out to patients1c. To exercise all necessary community-based clinical skills for carrying out orders1d. To make relevant, accurate observations in the course of providing care and record / report them appropriately
CONTINUING CARE	monitoring rehab counselling or continuing care under supervision of MD, RN or MW	1b. To use different options for reaching out to patients 1c. To exercise all necessary community-based clinical skills for carrying out orders
IV. CONTINUING CARE	monitoring rehab counselling or continuing care	1b. To use different options for reaching out to patients1c. To exercise all necessary community-based clinical skills for carrying out orders1d. To make relevant, accurate observations in the course of providing care and record / report them appropriately

KEY PLAY	YER: BHW PROPOSED OVERALL RO	DLE: Bridge between community and health system (health coach)	
PRIMARY CARE FUNCTION	PROPOSED COMPETENCIES REQUIRED	PROPOSED TRAINING OBJECTIVES	
I. FIRST CONTACT	distinguish between sick and well (health screening) recognize emergencies and deliver first aid / BCLS/conduct to ER develop communication skills and nurture patient trust (*also for IV. CONTINUING CARE)	 1a, 2a. To identify common signs and symptoms including those for emergency cases 1b. To exercise relevant communication techniques for patients for first-contact care in the community setting 2b. To demonstrate proper procedures for first aid and BLS 2c. To safely perform the necessary steps in conducting patients to the ER 3. To use the most appropriate verbal and nonverbal techniques when speaking with and listening to patients 	
II. COMPREHENSIVE CARE	1. perform basic Hx & PE, including non- lab health screening 2. perform and teach household remedies for common conditions 3. counsel patients on general disease prevention and health promotion	 perform basic Hx & PE, including non- lab health screening perform and teach household remedies for common conditions 	g
III. COORDINATED CARE	inform patients of available meds, tests, services in RHU & SDN communicate freely and effectively with the rest of the team assist patients with logistics for commonly occuring health needs in the community	Counsel patients on general disease prevention and health promotion 4. To distinguish with reasonable judgment if a case needs referral to other primary care team members, and whice the primary care team members.	ences rvices mmon situations on
IV. CONTINUING CARE	Knowledge and skills to render monitoring rehab counselling or continuing care under supervision of MD, RN or MW (*As above, cultivating trust for ongoing therapeutic relationship)	 1a. To properly interpret orders from other team members on the patients' charts 1b. To use different options for reaching out to patients 1c. To exercise all necessary community-based clinical skills for carrying out orders 1d. To make relevant, accurate observations in the course of providing care and record / report them appropriatel 2. (* Training objectives apply as above for communicating and nurturing trust) 	ly

KEY PLAYER: BHW PROPOSED OVERALL ROLE: Bridge between community and health system (health coach)

PRIMARY CARE FUNCTION	PROPOSED COMPETENCIES REQUIRED	PROPOSED TRAINING OBJECTIVES
	 distinguish between sick and well 	1a, 2a. To identify common signs and symptoms including those for emergency cases
	(health screening)	1b. To exercise relevant communication techniques for patients for first-contact care in the community setting
FIRST	recognize emergencies and deliver	
# 5	first aid / BCLS/conduct to ER	2b. To demonstrate proper procedures for first aid and BLS
- 5	develop communication skills and	2c. To safely perform the necessary steps in conducting patients to the ER
0	nurture nationt trust (*also for IV	

- 1a. To distinguish among various common signs and symptoms
- 1b. To obtain routine measurements such as vital signs and anthropometrics (BP, WHR, BMI, HR, RR, etc.)
- 1c. To describe common signs and symptoms in terms of onset, severity, and other aspects
- 1d. To record and report findings
- 2a. To match various home remedies to their correct indication(s)
- 2b. To enumerate the steps and materials needed for common home remedies
- 2c. To advise patients with the right information about home remedies, such as when, how, and why to use them

3a. To identify common types of patients or situations that may warrant preventive or health promotive counseling 3b. To explain essential points of health promotion

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E. CO	the community 4. recognize need for MW, RN or MD	3b. To describe the options that patients can use for accessing care, as appropriate for a given condition or situation
_	,	4. To distinguish with reasonable judgment if a case needs referral to other primary care team members, and which one
NTINUING	Knowledge and skills to render monitoring rehab counselling or continuing care	 1a. To properly interpret orders from other team members on the patients' charts 1b. To use different options for reaching out to patients 1c. To exercise all necessary community-based clinical skills for carrying out orders 1d. To make relevant, accurate observations in the course of providing care and record / report them appropriately
ĭ. C	under supervision of MD, RN or MW 2. (*As above, cultivating trust for ongoing therapeutic relationship)	2. (* Training objectives apply as above for communicating and nurturing trust)

KEY PLAYER: BHW PROPOSED OVERALL ROLE: Bridge between community and health system (health coach)

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PRIN CARE FUNC		PROPOSED COMPETENCIES REQUIRED	PROPOSED TRAINING OBJECTIVES
H	ե	distinguish between sick and well (health screening) recognize emergencies and deliver	1a, 2a. To identify common signs and symptoms including those for emergency cases1b. To exercise relevant communication techniques for patients for first-contact care in the community setting
I. FIRST	CONTA	first aid / BCLS/conduct to ER 3. develop communication skills and	2b. To demonstrate proper procedures for first aid and BLS2c. To safely perform the necessary steps in conducting patients to the ER
		nurture patient trust (*also for IV. CONTINUING CARE)	3. To use the most appropriate verbal and nonverbal techniques when speaking with and listening to patients

- 1a. To enumerate the medications, tests, and services available within the RHU and SDN, or use appropriate references 1b. To proactively identify and utilize methods and opportunities for educating the community on primary care services
- 2, 3a. To select the proper communication channel, person to communicate with, and information required for common situations that need coordination
- 3b. To describe the options that patients can use for accessing care, as appropriate for a given condition or situation
- 4. To distinguish with reasonable judgment if a case needs referral to other primary care team members, and which one

COORD	assist patients with logistics for commonly occurring health needs in	that need coordination	
<u>=</u>	the community 4. recognize need for MW, RN or MD	3b. To describe the options that patients can use for accessing care, as appropriate for a given condition or situation	
		4. To distinguish with reasonable judgment if a case needs referral to other primary care team members, and which one	
(7)	1. Knowledge and skills to render	1a. To properly interpret orders from other team members on the patients' charts	
INUING	monitoring	1b. To use different options for reaching out to patients	
⊋	rehab	1c. To exercise all necessary community-based clinical skills for carrying out orders	
CONTIN	counselling or continuing care	1d. To make relevant, accurate observations in the course of providing care and record / report them appropriately	
∑	under supervision of MD, RN or MW 2. (*As above, cultivating trust for ongoing therapeutic relationship)	2. (* Training objectives apply as above for communicating and nurturing trust)	
	ongoing the apeatie relationship/		

KEY PLAY	YER: BHW PROPOSED OVERAL	ROLE: Bridge between community and health system (health coach)	
PRIMARY CARE FUNCTION	PROPOSED COMPETENCIES REQUIRED	Proposed Training Objectives	
I. FIRST CONTACT	CONTINUING CARE)	1a, 2a. To identify common signs and symptoms including those for emergency cases 1b. To exercise relevant communication techniques for patients for first-contact care in the component of the c	ommunity setting ning to patients
II. COMPREHENSIVE CARE	2. perform and teach hous remedies for common c 3. counsel patients on gen prevention and health p	nonitoring ehab counselling or continuing care	IR, RR, etc.) nd why to use them promotive counseling
III. COORDINATED CARE	tests, services in RHU & 2. communicate freely and with the rest of the tean	Inder supervision of MD, RN or MW *As above, cultivating trust for ingoing therapeutic relationship) 4. To distinguish with reasonable judgment if a case needs referral to other primary care tear	se appropriate references y on primary care services ation required for common situations condition or situation m members, and which one
IV. CONTINUING CARE	1. Knowledge and skills to render monitoring rehab counselling or continuing care under supervision of MD, RN or MV 2. (*As above, cultivating trust for ongoing therapeutic relationship)	 1a. To properly interpret orders from other team members on the patients' charts 1b. To use different options for reaching out to patients 1c. To exercise all necessary community-based clinical skills for carrying out orders 1d. To make relevant, accurate observations in the course of providing care and record / report 2. (* Training objectives apply as above for communicating and nurturing trust) 	ort them appropriately

KEY PLAYER: BHW Proposed overall role: Bridge between community and health system (health coach)

PRIMARY CARE FUNCTION	PROPOSED COMPETENCIES REQUIRED	Proposed Training Objectives
I. FIRST CONTACT	1. distinguish between sick and well (health screening) 2. recognize emergencies and deliver first aid / BCLS/conduct to ER 3. develop communication skills and nurture patient trust (*also for IV. CONTINUING CARE)	 1a, 2a. To identify common signs and symptoms including those for emergency cases 1b. To exercise relevant communication techniques for patients for first-contact care in the community setting 2b. To demonstrate proper procedures for first aid and BLS 2c. To safely perform the necessary steps in conducting patients to the ER 3. To use the most appropriate verbal and nonverbal techniques when speaking with and listening to patients
ц	 perform basic Hx & PE, including non- lab health screening 	 To distinguish among various common signs and symptoms To obtain routine measurements such as vital signs and anthropometrics (BP, WHR, BMI, HR, RR, etc.)

- 1a. To properly interpret orders from other team members on the patients' charts
- 1b. To use different options for reaching out to patients
- 1c. To exercise all necessary community-based clinical skills for carrying out orders
- 1d. To make relevant, accurate observations in the course of providing care and record / report them appropriately

2. (* Training objectives apply as above for communicating and nurturing trust)

II. COORDINAT CARE	communicate freely and effectively with the rest of the team assist patients with logistics for commonly occuring health needs in the community recognize need for MW, RN or MD	2, 3a. To select the proper communication channel, person to communicate with, and information required for common situations that need coordination3b. To describe the options that patients can use for accessing care, as appropriate for a given condition or situation
_	,	4. To distinguish with reasonable judgment if a case needs referral to other primary care team members, and which one
ONTINUING	Knowledge and skills to render monitoring rehab counselling or continuing care	 1a. To properly interpret orders from other team members on the patients' charts 1b. To use different options for reaching out to patients 1c. To exercise all necessary community-based clinical skills for carrying out orders 1d. To make relevant, accurate observations in the course of providing care and record / report them appropriately
S	under supervision of MD, RN or MW 2. (*As above, cultivating trust for ongoing therapeutic relationship)	2. (* Training objectives apply as above for communicating and nurturing trust)



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ongoing therapeutic relationship)

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PRIMARY CARE	PROPOSED COMPET	ENCIES PROPOSED TRAINING OBJECTIVES	
FUNCTION	REQUIRED		
FIRST CONTACT	distinguish between si (health screening) treat and render preve certain conditions in h	distinguish between sick and well	ight have, if any e) motion
100	community and clinic s	(health screening)	motion
I. FIRS	MCH 3. recognize emergencies first aid / BLS / conduc	2. treat and render preventive care for	
EHE CARE	1. perform basic Hx & PE non-lab health screeni	certain conditions in home /	iR, RR, etc.)
II. COMPREHE NSIVE CARE	perform and teach hot remedies for common counsel patients on ge	community and clinic setting esp	
	prevention and health 1. inform patients of avaitests, services in RHU (MCH	e appropriate references
COORDINATED CARE	communicate freely ar with the rest of the tea	recognize emergencies and deliver	H priority programs, including PHIC
CARE	 assist patients with log commonly occurring he the community 	first aid / BLS / conduct to ER	on primary care services tion required for common situations
≡	4. attend to MCH 5. recognize need for RN	4. develop communication skills and	tion required for common situations
CARE	Knowledge and skills to monitoring rehab	nurture patient trust (*also for IV.	
UINGC	counselling or continuing care	CONTINUING CARE)	rt them appropriately
/. CONTINUING	under supervision of Me 2. Render continuing MCH specialist consult or adm 3. (*As above, cultivating tr	ission 2b. To identify conditions that would need continuing patient care, including but not only in	maternal, neonatal, and child care (<u>ex</u>

3. (* Training objectives apply as above for communicating and nurturing trust)

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	PRIMARY CARE FUNCTION	PROPOSED COMPETENCIES REQUIRED	Proposed Training Objectives
	CT	distinguish between sick and well	1. To name the possible new illnesses or new symptoms of existing conditions that patients might have, if any

- 1. To name the possible new illnesses or new symptoms of existing conditions that patients might have, if any
- 2a. To perform proper procedures for common clinical conditions (esp. maternal and child care)2b. To advise patients and BHWs on common home remedies, preventive care,and health promotion
- 3a. To describe how emergency conditions would usually appear
- 3b. To demonstrate basic first aid and BLS procedures
- 3c. To safely perform the necessary steps in conducting patients to the ER
- 4. To use the most appropriate verbal and nonverbal techniques when speaking with and listening to patients

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- or continuing care under supervision of MD or RN
- Render continuing MCH after RN, specialist consult or admission
- (*As above, cultivating trust for ongoing therapeutic relationship)
- 1e. To contribute suggestions to the management plan
- 2a. To perform routine 'rounds' in the community for maternal, neonatal, and child care
- 2b. To identify conditions that would need continuing patient care, including but not only in maternal, neonatal, and child care (ex. breastfeeding management)
- (* Training objectives apply as above for communicating and nurturing trust)



3. (* Training objectives apply as above for communicating and nurturing trust)



MIDWIVES

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+‡+	KEY F	PLAYER	MIDWIFE	1a. To distinguish among various common signs and symptoms
Ī	PRIMA	IRY	PROPOSED COM	1b. To obtain routine measurements such as vital signs and anthropometrics
	CARE FUNCT	ION	Require	(BP, WHR, BMI, HR, RR, etc.)
l	FUNCI			1c. To describe common signs and symptoms in terms of onset, severity, and other aspects
	Å CT	:	 distinguish between: (health screening) 	1d. To record and report findings
	Ľ	2	2. treat and render prev	•
	I. FIRST CONTACT		certain conditions in community and clinic	2a. To match various home remedies to their correct indication(s)
	IRS1		MCH	2b. To enumerate the steps and materials needed for common home remedies
	Ξ.		recognize emergenci first aid / BLS / condu	·
		п ш :	1. perform basic Hx & P	2c. To advise patients and BHWs with the right information about home remedies,
	į	AR	non-lab health screer	such as when, how, and why to use them
	= 5	COMP	perform and teach he remedies for commo	
	Ş		3. counsel patients on g	3a. To identify common types of patients or situations that may warrant preventive or
			prevention and healt	health promotive counseling
	Q	:	 inform patients of av tests, services in RHU 	3b. To explain to patients and BHWs the essential points of disease prevention and h
	III. COORDINATED		2. communicate freely	ealth promotion
	NO.	SAR I	with the rest of the to 3. assist patients with k	Promotion
	90	3	commonly occuring h	40. To identify health needs in motornal negative and shild care that are within the scene
	8		the community 4. attend to MCH	4a. To identify health needs in maternal, neonatal and child care that are within the scope
	=		5. recognize need for RI	of work of MWs
		:	 Knowledge and skills 	4b. To demonstrate maneuvers and procedures in basic maternal and child care
	ARE		monitoring rehab	4c. To instruct patients on basic maternal and child care
	0 0		counselling	1d. To make relevant, accurate observations in the course of providing care and record / report them appropriately
	5		or continuing care under supervision of I	1e. To contribute suggestions to the management plan
	<u>Z</u>		2. Render continuing M	
	IV. CONTINUING CARE		specialist consult or a	
	≥.		(*As above, cultivatin ongoing therapeutic r	
				3. (* Training objectives apply as above for communicating and nurturing trust)

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attend to MCH

recognize need for RN or MD

arrying out orders viding care and record / report them appropriately

under supervision of MD or RN

V. CONTINUING CARE

- Render continuing MCH after RN, specialist consult or admission
- (*As above, cultivating trust for ongoing therapeutic relationship)
- 2a. To perform routine 'rounds' in the community for maternal, neonatal, and child care
- 2b. To identify conditions that would need continuing patient care, including but not only in maternal, neonatal, and child care (ex. breastfeeding management)
- (* Training objectives apply as above for communicating and nurturing trust)



	KEY PLAYE	R: MIDWIFE PROPOSED OVI	ERALL ROLE: Front-line health professional of the health system; Health facility manager
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	PRIMARY	PROPOSED COMPETENCIES	Proposed Training Objectives
	CARE	REQUIRED	

- 1a. To enumerate the medications, tests, and services available within the RHU and SDN, or use appropriate references
- 1b. To identify the referral centers or referral clinics, laboratory and pharmacy in the areas.
- 1c. To explain the qualifications and mechanics for the enrolment / inclusion of patients in DOH priority programs, including PHIC benefits
- 1d. To proactively identify and utilize methods and opportunities for educating the community on primary care services
- 2, 3a. To select the proper communication channel, person to communicate with, and information required for common situations that need coordination
- 3b. To describe the options that patients can use for accessing care, as appropriate for a given condition or situation
- 4. To demonstrate knowledge and skills in all aspects of basic maternal, neonatal and child care 5a. To distinguish with reasonable judgment if a case needs referral to other primary care team members, and which one
- 5b. To describe how conditions that need referral to the RN or MD would usually appear

under supervision of MD or RN

2. Render continuing MCH after RN,
specialist consult or admission

(*As above, cultivating trust for ongoing therapeutic relationship)

- 2a. To perform routine 'rounds' in the community for maternal, neonatal, and child care
- 2b. To identify conditions that would need continuing patient care, including but not only in maternal, neonatal, and child care (ex. breastfeeding management)
- (* Training objectives apply as above for communicating and nurturing trust)



Primary Care Function	PROPOSED COMPETENCIES REQUIRED	Proposed Training Objectives	
D II. I. FIRST CONTACT COMPREHE NSIVE CARE	certain conditions in h community and clinics MCH 3. recognize emergencies first aid / BLS / conduc 1. perform basic Hx & PE non-lab health screeni 2. perform and teach hor remedies for common 3. counsel patients on ge prevention and health 1. inform patients of ava	nowledge and skills to render nonitoring ehab ounselling or continuing care and skills to render	ght have, if any e) motion IR, RR, etc.) e appropriate references
III. COORDINATED CARE	2. communicate freely ar with the rest of the tea 3. assist patients with log commonly occurring he the community 4. attend to MCH	Render continuing MCH after RN, pecialist consult or admission *As above, cultivating trust for	H priority programs, including PHIC on primary care services tion required for common situations
IV. CONTINUING CARE	 Knowledge and skills t 	2a. To perform routine 'rounds' in the community for maternal, neonatal, and child care 2b. To identify conditions that would need continuing patient care, including but not only in breastfeeding management)	t them appropriately maternal, neonatal, and child care (ex

3. (* Training objectives apply as above for communicating and nurturing trust)

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	PRIMARY CARE FUNCTION	PROPOSED COMPETENCIES REQUIRED	PROPOSED TRAINING OBJECTIVES
	CT	distinguish between sick and well (booth serencies)	1. To name the possible new illnesses or new symptoms of existing conditions that patients might have, if any

- 1a. To properly interpret orders from other team members on the patients' charts
- 1b. To use different options for reaching out to patients
- 1c. To exercise all necessary community-based clinical skills for carrying out orders
- 1d. To make relevant, accurate observations in the course of providing care and record / report them appropriately
- 1e. To contribute suggestions to the management plan
- 2a. To perform routine 'rounds' in the community for maternal, neonatal, and child care 2b. To identify conditions that would need continuing patient care, including but not only in maternal, neonatal, and child care (ex breastfeeding management)
- 3. (* Training objectives apply as above for communicating and nurturing trust)

V. CONTINUIN

- or continuing care under supervision of MD or RN
- Render continuing MCH after RN, specialist consult or admission
- (*As above, cultivating trust for ongoing therapeutic relationship)
- 1e. To contribute suggestions to the management plan
- 2a. To perform routine 'rounds' in the community for maternal, neonatal, and child care
- 2b. To identify conditions that would need continuing patient care, including but not only in maternal, neonatal, and child care (ex. breastfeeding management)
- 3. (* Training objectives apply as above for communicating and nurturing trust)





KEY PLA	KEY PLAYER: NURSE PROPOSED OVERALL ROLE: Overall manager for patient care				
PRIMARY CARE FUNCTION	PROPOSED COMPETENCIES REQUIRED	Proposed Training Objectives			
I. FIRST CONTACT	distinguish between sick and well (health screening) treat and render preventive care for certain conditions in home / community and clinic setting incl MCH	1. To name the patient's condition that may require medical attention, if any 2a. To perform proper procedures for common clinical conditions (for all ages) 2b. To advise patients and MWs on home remedies, preventive care, and health promo 3a. To describe how emergency conditions would usually appear 2b. To demonstrate basic first aid and RLS procedures.	tion		
II. COMPREHENSIVE	perform basic Hx & PE, including health screening w or wo labs perform and teach household remedies for common medical conditions counsel patients on general diseaprevention and health promotion	distinguish between sick and well (health screening) treat and render preventive care for certain conditions in home /	urine etc) everity, and other aspects th as when, how, and why to use them		
III. COORDINATED	inform patients of available med tests, services in RHU & SDN communicate freely and effective with the rest of the team assist patients with logistics for overall health needs recognize need for MD	for certain conditions in home / community and clinic setting incl MCH	or use appropriate references rea rity programs, and PHIC benefits (navigation) s & resources prmation required for common situations		
CONTINUING CARE	1. Knowledge and skills for specific parts of care for a. Chronic conditions b. Post-discharge, post-op/post intervention patients, including postpartum and neonatal care c. Administration of parenteral medications, either in the clinic or at home 2. Tap MWs and BHWs to maximize	 1a. To properly interpret MD orders and the overall management plan 1b. To effectively reach out to patients, directly or through the MW/BHW network 1c. To apply community-based and clinic based knowledge and skills for carrying out ord 1d. To make relevant, accurate observations in the course of providing care and record 1e. To contribute suggestions to the management plan 1f. To identify conditions that would need further continuing care, the MD's attention, or 2a. To supervise MWs and BHWs in understanding and carrying out management plans, 3. (* Training objectives apply as above for communicating and nurturing trust) 	report them appropriately		

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ongoing management of patients in

the community setting



	KEY PLA	YER: NURSE PROPOSED O	overall role: Overall manager for patient care
‡+			
	PRIMARY CARE FUNCTION	PROPOSED COMPETENCIES REQUIRED	Proposed Training Objectives

I. FIRST

distinguish between sick and well (health screening)
 treat and render preventive care for certain conditions in home / community and clinic setting incl MCH

1. To name the patient's condition that may require medical attention, if any

2a. To perform proper procedures for common clinical conditions (for all ages)

2b. To advise patients and MWs on home remedies, preventive care, and health promotion

3a. To describe how emergency conditions would usually appear

b. To domente basis first aid and DIC messadores

1. To name the patient's condition that may require medical attention, if any

2a. To perform proper procedures for common clinical conditions (for all ages)

2b. To advise patients and MWs on home remedies, preventive care, and health promotion

3a. To describe how emergency conditions would usually appear

3b. To demonstrate basic first aid and BLS procedures

	4. recognize need for MiD	tnat need coordination
	1. Knowledge and skills for specific	1a. To properly interpret MD orders and the overall management plan
	parts of care for	1b. To effectively reach out to patients, directly or through the MW/BHW network
문	a. Chronic conditions	1c. To apply community-based and clinic based knowledge and skills for carrying out orders
8	b. Post-discharge, post-op/post	1d. To make relevant, accurate observations in the course of providing care and record / report them appropriately
IV. CONTINUING (intervention patients, including	1e. To contribute suggestions to the management plan
	postpartum and neonatal care	1f. To identify conditions that would need further continuing care, the MD's attention, or a new consultation
	c. Administration of parenteral	
	medications, either in the clinic	2a. To supervise MWs and BHWs in understanding and carrying out management plans, through BHS and community rounds
	or at home	
	2. Tap MWs and BHWs to maximize	3. (* Training objectives apply as above for communicating and nurturing trust)
	ongoing management of patients in	
	the community setting	



ongoing management of patients in

the community setting



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	PRIMARY CARE FUNCTION	PROPOSED COMPETENCIES REQUIRED	PROPOSED TRAINING OBJECTIVES
LEIRST	—	 distinguish between sick and well (health screening) 	1. To name the patient's condition that may require medical attention, if any
	ST	2. treat and render preventive care	2a. To perform proper procedures for common clinical conditions (for all ages)
	I. FIRST CONTACT	for certain conditions in home / community and clinic setting incl	2b. To advise patients and MWs on home remedies, preventive care, and health promotion
	0	МСН	3a. To describe how emergency conditions would usually appear
			3b. To demonstrate basic first aid and BLS procedures
		1 perform basic Hx & PF including	1a. To distinguish among various common signs, symptoms, and diagnostic test findings

- 1a. To distinguish among various common signs, symptoms, and diagnostic test findings
- 1b. To obtain routine measurements and specimens (vital signs, anthropometrics, blood, urine etc)
- 1c. To describe common signs, symptoms, and diagnostic test findings in terms of onset, severity, and other aspects
- 1d. To record and report findings that are adequate for the patient's condition(s)
- 2a. To match various home remedies to their correct indication(s)
- 2b. To enumerate the steps and materials needed for common home remedies
- 2c. To advise patients and midwives with the right information about home remedies, such as when, how, and why to use them

000	overall health needs 4. recognize need for MD	2, 3b. To select the proper communication channel, person to communicate with, and information required for common situations that need coordination
TINUING CARE	1. Knowledge and skills for specific parts of care for a. Chronic conditions b. Post-discharge, post-op/post intervention patients, including postpartum and neonatal care c. Administration of parenteral medications, either in the clinic	1a. To properly interpret MD orders and the overall management plan 1b. To effectively reach out to patients, directly or through the MW/BHW network 1c. To apply community-based and clinic based knowledge and skills for carrying out orders 1d. To make relevant, accurate observations in the course of providing care and record / report them appropriately 1e. To contribute suggestions to the management plan 1f. To identify conditions that would need further continuing care, the MD's attention, or a new consultation 2a. To supervise MWs and BHWs in understanding and carrying out management plans, through BHS and community rounds
IV. CONT	or at home 2. Tap MWs and BHWs to maximize ongoing management of patients in the community setting	3. (* Training objectives apply as above for communicating and nurturing trust)



KEY PLAYER: NURSE

the community setting

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PRIM CARE FUNC		PROPOSED COMPETENCIES REQUIRED	Propose	d Training Objectives
1. distinguish between sick and well (health screening) 2. treat and render preventive care for certain conditions in home / community and clinic setting incl		(health screening) 2. treat and render preventive care for certain conditions in home / community and clinic setting incl	To name the patient's condition that may require medical contains a second	nditions (for all ages) ntive care, and health promotion
	COORDINATED COMPREHENSIVE	tests, services 2. communication with the res	ents of available meds, ces in RHU & SDN ate freely and effectively st of the team ants with logistics for othereds	5. Manage MWs General tion(s non h ion a able within the RHU and SDN, or use appropriate references tories and pharmacies in the area imary care services, DOH priority programs, and PHIC benefits (navigation) ity about these health services & resources
	00 C	4. recognize n		to communicate with, and information required for common situations
IV. CONTINUING CARE		1. Knowledge and skills for specific parts of care for a. Chronic conditions b. Post-discharge, post-op/post intervention patients, including postpartum and neonatal care c. Administration of parenteral medications, either in the clinic or at home 2. Tap MWs and BHWs to maximize ongoing management of patients in	1a. To properly interpret MD orders and the overall manage 1b. To effectively reach out to patients, directly or through 1c. To apply community-based and clinic based knowledge 1d. To make relevant, accurate observations in the course 1e. To contribute suggestions to the management plan 1f. To identify conditions that would need further continuit 2a. To supervise MWs and BHWs in understanding and car 3. (* Training objectives apply as above for communicating parts of the communicating supervise MWs and BHWs in understanding and car 3.	the MW/BHW network and skills for carrying out orders of providing care and record / report them appropriately ing care, the MD's attention, or a new consultation rying out management plans, through BHS and community rounds



PROPOSED COMPETENCIES REQUIRED 1. distinguish between sick and well (health screening) 2. treat and render preventive care for certain conditions in home / community and clinic setting incl MCH 1. To name the patient's condition that may require medical attention, if any 2a. To perform proper procedures for common clinical conditions (for all ages) 2b. To advise patients and MWs on home remedies, preventive care, and health promotion 3a. To describe how emergency conditions would usually appear 3b. To demonstrate basic first aid and BLS procedures			
(health screening) 2. treat and render preventive care for certain conditions in home / community and clinic setting incl MCH 2a. To perform proper procedures for common clinical conditions (for all ages) 2b. To advise patients and MWs on home remedies, preventive care, and health promotion 3a. To describe how emergency conditions would usually appear	ARE	Proupen	Proposed Training Objectives
	I. FIRST CONTACT	(health screening) 2. treat and render preventive care for certain conditions in home / community and clinic setting incl	 2a. To perform proper procedures for common clinical conditions (for all ages) 2b. To advise patients and MWs on home remedies, preventive care, and health promotion 3a. To describe how emergency conditions would usually appear

- 1a. To enumerate the medications, tests, and services available within the RHU and SDN, or use appropriate references 1b. To identify the referral centers or referral clinics, laboratories and pharmacies in the area
- 1c, 3a. To assist patients in understanding and availing of primary care services, DOH priority programs, and PHIC benefits (navigation)
- 1d. To direct midwives and BHWs in educating the community about these health services & resources

2, 3b. To select the proper communication channel, person to communicate with, and information required for common situations that need coordination

8	overall health needs 4. recognize need for MD	2, 3b. To select the proper communication channel, person to communicate with, and information required for common situations that need coordination
IV. CONTINUING CARE	1. Knowledge and skills for specific parts of care for a. Chronic conditions b. Post-discharge, post-op/post intervention patients, including postpartum and neonatal care c. Administration of parenteral medications, either in the clinic or at home 2. Tap MWs and BHWs to maximize ongoing management of patients in the community setting	1a. To properly interpret MD orders and the overall management plan 1b. To effectively reach out to patients, directly or through the MW/BHW network 1c. To apply community-based and clinic based knowledge and skills for carrying out orders 1d. To make relevant, accurate observations in the course of providing care and record / report them appropriately 1e. To contribute suggestions to the management plan 1f. To identify conditions that would need further continuing care, the MD's attention, or a new consultation 2a. To supervise MWs and BHWs in understanding and carrying out management plans, through BHS and community rounds 3. (* Training objectives apply as above for communicating and nurturing trust)



(* Training objectives apply as above for communicating and nurturing trust)

Tap MWs and BHWs to maximize ongoing management of patients in

the community setting



- 1a. To properly interpret MD orders and the overall management plan
- 1b. To effectively reach out to patients, directly or through the MW/BHW network
- 1c. To apply community-based and clinic based knowledge and skills for carrying out orders
- 1d. To make relevant, accurate observations in the course of providing care and record / report them appropriately
- 1e. To contribute suggestions to the management plan
- 1f. To identify conditions that would need further continuing care, the MD's attention, or a new consultation
- 2a. To supervise MWs and BHWs in understanding and carrying out management plans, through BHS and community rounds
- 3. (* Training objectives apply as above for communicating and nurturing trust)

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5	 b. Post-discharge, post-op/post 	1d. To make relevant, accurate observations in the course of providing care and record / report them appropriately
Ü	intervention patients, including	1e. To contribute suggestions to the management plan
Z	postpartum and neonatal care	1f. To identify conditions that would need further continuing care, the MD's attention, or a new consultation
₹	c. Administration of parenteral	
Ē	medications, either in the clinic	2a. To supervise MWs and BHWs in understanding and carrying out management plans, through BHS and community rounds
6	or at home	
Ö	Tap MWs and BHWs to maximize	3. (* Training objectives apply as above for communicating and nurturing trust)
≥	ongoing management of patients in	
	the community setting	







	REFFERENCE DOCTOR I ROPOSED OVERALE ROLL. OVER ALL ROLL OF BULIEFIE RATE (REY decision maker)		
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PRIMARY CARE FUNCTIO	PROPOSED COMPETENCIES	PROPOSED TRAINING OBJECTIVES	
ONTACT	lead overall patient care on first contact diagnose and initiate treatment and prevention plans for common	1a. To stay well informed and updated on health, disease, and treatment concerns relevant to the community1b. To advise patients and health staff about common health conditions, suggested treatment plans, and current health policies2a. To diagnose the patient's new conditions and update existing conditions, if any	

PROPOSED OVERALL ROLE: Overall leader for natient kare (key decision maker)

- 1a. To stay well informed and updated on health, disease, and treatment concerns relevant to the community
- 1b. To advise patients and health staff about common health conditions, suggested treatment plans, and current health policies
- 2a. To diagnose the patient's new conditions and update existing conditions, if any
- 2b. To formulate management plans for patients
- 2c. To perform proper procedures for all common clinical conditions (for all ages)
- 2d. To advise patients and health staff on medical plans, home remedies, preventive care, and health promotion
- 3a. To identify emergency cases for various conditions
- 3b. To demonstrate basic first aid and BLS procedures

V. CONTINUING CARE

- 4. To identify conditions that require referral to specialists
- 5. To use the most appropriate verbal and nonverbal techniques when speaking with and listening to patients

1. Following up specialist care	1. To integrate specialist advice and interventions within the patient's overall management plan and individual context
2. Communication and planning	
Knowledge and skills for planning and	2b. To clearly communicate the management plan through specific orders for specific health workers
providing continuing care for	2a. To effectively reach out to patients, directly or through the RN/MW/BHW network
a. Chronic conditions	2c. To supervise RNs, MWs and BHWs in understanding and carrying out management plans
 b. Post-discharge, post-op/post- 	2d. To consider suggestions to the management plan from primary care team members and specialists
intervention patients	
(*As above, cultivating trust for	3a. To directly provide essential follow up care including but not only monitoring, wound care, rehabilitation, early detection of
ongoing therapeutic relationship)	complications, and liaising with specialists



K ÷	EY PLA	YER: DOCTOR PROPOSED	OVERALL ROLE: Overall leader for patient kare (key decision maker)	
c	RIMARY ARE UNCTION	PROPOSED COMPETENCIES REQUIRED	PROPOSED TRAINING OBJECTIVES	
-	CARE COMPREHENSI	emergencies 1. perform a good Hx & PE, includ health screening 2. perform and teach household remedies 3. diagnose, treat and institute preventive measures for comm medical conditions 1. inform patients of available me tests, services in RHU & SDN 2. communicate freely and effecti with the rest of the team 3. assist patients with logistics for overall health needs. 4. recognize need for specialty ca admission 5. co-manage patients during adn and specialty referral	1. perform a good Hx & PE, including health screening 2. perform and teach household remedies 3. diagnose, treat and institute preventive measures for common medical conditions 4. perform minor surgical procedures	, and health promotion Indings in primary care Ing how, when, and why to use them (EBM) Or use appropriate references Irea Irity programs, and PHIC benefits Ires & resources Ormation required for common situations Is of the health system
	IV. CON IIN DING CARE	1. Following up specialist care 2. Communication and planning 3. Knowledge and skills for planning a providing continuing care for a. Chronic conditions b. Post-discharge, post-op/post-intervention patients 4. (*As above, cultivating trust for ongoing therapeutic relationship)	1. To integrate specialist advice and interventions within the patient's overall management 2b. To clearly communicate the management plan through specific orders for specific h 2a. To effectively reach out to patients, directly or through the RN/MW/BHW network 2c. To supervise RNs, MWs and BHWs in understanding and carrying out management 2d. To consider suggestions to the management plan from primary care team members 3a. To directly provide essential follow up care including but not only monitoring, woun complications, and liaising with specialists	ealth workers plans and specialists

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	PRIMARY CARE FUNCTION	PROPOSED COMPETENCIES REQUIRED	PROPOSED TRAINING OBJECTIVES		
	NTACT	lead overall patient care on first contact diagnose and initiate treatment and	 To stay well informed and updated on health, disease, and treatment concerns relevant to the community To advise patients and health staff about common health conditions, suggested treatment plans, and current health policies 		

Proposed Overall Leader for national kare (key decision maker)

- 1a. To thoroughly assess the full range of common signs, symptoms, and diagnostic test findings in primary care
- 1b. To accurately record all clinically significant findings for each patient
- 2a. To demonstrate proper use of common household remedies

DOCTOR

- 2b. To properly instruct patients and health workers on common home remedies, including how, when, and why to use them (EBM included)
- 3a. To identify all health needs, both present and anticipated (Overall Risk Approach; Health Screening), of patients in all age groups
- 3b. To formulate diagnostic and therapeutic plans that are appropriate, adequate, and evidence based
- 3b-1. To proactively take steps that promote good health, prevent anticipated conditions, and detect and treat ongoing illnesses
- 3b-2. To incorporate medical, surgical, and other (i.e. lifestyle related) approaches as appropriate
- 3b-3. To incorporate input and feedback from patients and health workers about the treatment plan
- 3b-4. To find, appraise, and apply scientific evidence for guiding the above clinical decisions
- 3c. To explain to patients and health workers the essentials of illness prevention, health promotion, and treatment options
- 3d, 4. To demonstrate common clinical and surgical maneuvers and procedures in primary care

3u, 4. i	o demonstrate common chinic	and surgical maneuvers and procedures in primary care
RE	Following up specialist care Communication and planning	1. To integrate specialist advice and interventions within the patient's overall management plan and individual context
IV. CONTINUING CA		2b. To clearly communicate the management plan through specific orders for specific health workers 2a. To effectively reach out to patients, directly or through the RN/MW/BHW network 2c. To supervise RNs, MWs and BHWs in understanding and carrying out management plans 2d. To consider suggestions to the management plan from primary care team members and specialists
	intervention patients 4. (*As above, cultivating trust for ongoing therapeutic relationship)	To directly provide essential follow up care including but not only monitoring, wound care, rehabilitation, early detection of complications, and liaising with specialists



Proposed overall pole. Overall leader for national kare (key decision maker)

KEY PLA	YER: DOCTOR PROPOSED OV	ERALL ROLE: Overall leader for patient ka	re (key decision maker)
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PRIMARY CARE FUNCTION	PROPOSED COMPETENCIES REQUIRED	Prop	OSED TRAINING OBJECTIVES
NTACT	lead overall patient care on first contact diagnose and initiate treatment and		ease, and treatment concerns relevant to the community n health conditions, suggested treatment plans, and current health policies
I. FIRST CONTACT	tests, services	ts of available meds, in RHU & SDN	e existing conditions, if any 5. Specialty referrals hor 6. Manage team size
II. COMPREHENSI	with the rest of 3. assist patients	with logistics for	7. Healthcare integration 8. Refer for or order elective admissions 9. Population Health
ORDINATED	overall health 4. recognize nee admission	needs. d for specialty care,	Assessment 10. Coordination with LGU

5. co-manage patients during admission and specialty referral

ervices they need from other parts of the health system

the patient's overall management plan and individual context

- 2. Communication and planning
- 3. Knowledge and skills for planning and providing continuing care for
 - a. Chronic conditions
 - b. Post-discharge, post-op/postintervention patients
- 4. (*As above, cultivating trust for ongoing therapeutic relationship)
- 2b. To clearly communicate the management plan through specific orders for specific health workers
- 2a. To effectively reach out to patients, directly or through the RN/MW/BHW network
- 2c. To supervise RNs, MWs and BHWs in understanding and carrying out management plans
- 2d. To consider suggestions to the management plan from primary care team members and specialists
- 3a. To directly provide essential follow up care including but not only monitoring, wound care, rehabilitation, early detection of complications, and liaising with specialists



- 1a. To enumerate the medications, tests, and services available within the RHU and SDN, or use appropriate references
- 1b. To identify the referral centers or referral clinics, laboratories and pharmacies in the area
- 1c, 3a. To assist patients in understanding and availing of primary care services, DOH priority programs, and PHIC benefits (navigation)
- 1d. To direct RNs, MWs, and BHWs in educating the community about these health services & resources
- 2, 3b. To select the proper communication channel, person to communicate with, and information required for common situations that need coordination
- 3c. To instruct patients step by step on how to get the services they need from other parts of the health system
- 3d, 4a, 5a. (overall concepts) To understand and apply principles of clinical stewardship and the structure of primary care systems/services
- 4b. To distinguish with reasonable judgment if a case needs referral to a specialist or needs hospital admission
- 4c. To describe how conditions that need specialty referral or hospital admission would usually appear
- 4d. To delegate tasks within the treatment plan to the right primary care team member, distinguishing which are best handled by RN, MW, or BHW
- 5b. To make referrals that are truly needed, have clear goals, and are acceptable to patients and colleagues/partners 5c. To access, assess, and contribute to hospital and specialist treatment plans

V. CONTINUIN

- a. Chronic conditions
- Post-discharge, post-op/postintervention patients
- (*As above, cultivating trust for ongoing therapeutic relationship)
- 2c. To supervise RNs, MWs and BHWs in understanding and carrying out management plans
- 2d. To consider suggestions to the management plan from primary care team members and specialists
- 3a. To directly provide essential follow up care including but not only monitoring, wound care, rehabilitation, early detection of complications, and liaising with specialists



	KEY PLA	YER: DOCTOR PROPOS	SED OV	ERALL ROLE: Overall leader for patient kare (key decision maker)	
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	PRIMARY CARE FUNCTION	PROPOSED COMPETENCI REQUIRED		PROPOSED TRAINING OBJECTIVES	
	I. FIRST CONTACT	lead overall patient care on first contact diagnose and initiate treatment prevention plans for common medical conditions esp. those considered priorities by DOH recognize and manage all medemergencies	t and	1a. To stay well informed and updated on health, disease, and treatment concerns releval 1b. To advise patients and health staff about common health conditions, suggested treatment common up specialist care Communication and planning	
	II. COMPREHENSI	perform a good Hx & PE, inclu health screening perform and teach household remedies diagnose, treat and institute preventive measures for commedical conditions		Knowledge and skills for planning and providing continuing care for a. Chronic conditions	dings in primary care g how, when, and why to use them (EBM
	III. COORDINATED CARE	inform patients of available m tests, services in RHU & SDN communicate freely and effect with the rest of the team assist patients with logistics for overall health needs. recognize need for specialty cadmission co-manage patients during ad and specialty referral		b. Post-discharge, post-op/post- intervention patients (*As above, cultivating trust for ongoing therapeutic relationship)	r use appropriate references ea ty programs, and PHIC benefits s & resources rmation required for common situations of the health system
	IV. CONTINUING CARE	1. Following up specialist care 2. Communication and planning 3. Knowledge and skills for planning providing continuing care for a. Chronic conditions b. Post-discharge, post-op/pointervention patients 4. (*As above, cultivating trust for ongoing therapeutic relationships.)	ost-	2b. To clearly communicate the management plan through specific orders for specific hea 2a. To effectively reach out to patients, directly or through the RN/MW/BHW network 2c. To supervise RNs, MWs and BHWs in understanding and carrying out management pla 2d. To consider suggestions to the management plan from primary care team members at 3a. To directly provide essential follow up care including but not only monitoring, wound complications, and liaising with specialists	plan and individual context Ith workers ns nd specialists
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	RET PLATER. DOCTOR PROPOSED OVERALE ROLE. OVER All reader for patient kare (key decision maker)		
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	PRIMARY CARE FUNCTION	PROPOSED COMPETENCIES REQUIRED	PROPOSED TRAINING OBJECTIVES
	ONTACT	lead overall patient care on first contact diagnose and initiate treatment and prevention plans for common	 1a. To stay well informed and updated on health, disease, and treatment concerns relevant to the community 1b. To advise patients and health staff about common health conditions, suggested treatment plans, and current health policies 2a. To diagnose the patient's new conditions and update existing conditions, if any

POSED OVERALL POLE: Overall leader for natient kare (key decision maker)

- 1. To integrate specialist advice and interventions within the patient's overall management plan and individual context
- 2b. To clearly communicate the management plan through specific orders for specific health workers
- 2a. To effectively reach out to patients, directly or through the RN/MW/BHW network
- 2c. To supervise RNs, MWs and BHWs in understanding and carrying out management plans
- 2d. To consider suggestions to the management plan from primary care team members and specialists
- 3a. To directly provide essential follow up care including but not only monitoring, wound care, rehabilitation, early detection of complications, and liaising with specialists
- 3b. To identify conditions that would need further continuing care, or a new consultation
- 3c. To make relevant, accurate observations in the course of providing care and record / share them appropriately
- 4. (* Training objectives apply as above for communicating and nurturing trust)

V. CONTINUING CARE

	1. Following up specialist care	 To integrate specialist advice and interventions within the patient's overall management plan and individual context
2. Communication and planning		
	3. Knowledge and skills for planning and	2b. To clearly communicate the management plan through specific orders for specific health workers
	providing continuing care for	2a. To effectively reach out to patients, directly or through the RN/MW/BHW network
	a. Chronic conditions	2c. To supervise RNs, MWs and BHWs in understanding and carrying out management plans
	 b. Post-discharge, post-op/post- intervention patients 	2d. To consider suggestions to the management plan from primary care team members and specialists
	 (*As above, cultivating trust for ongoing therapeutic relationship) 	3a. To directly provide essential follow up care including but not only monitoring, wound care, rehabilitation, early detection of complications, and liaising with specialists

