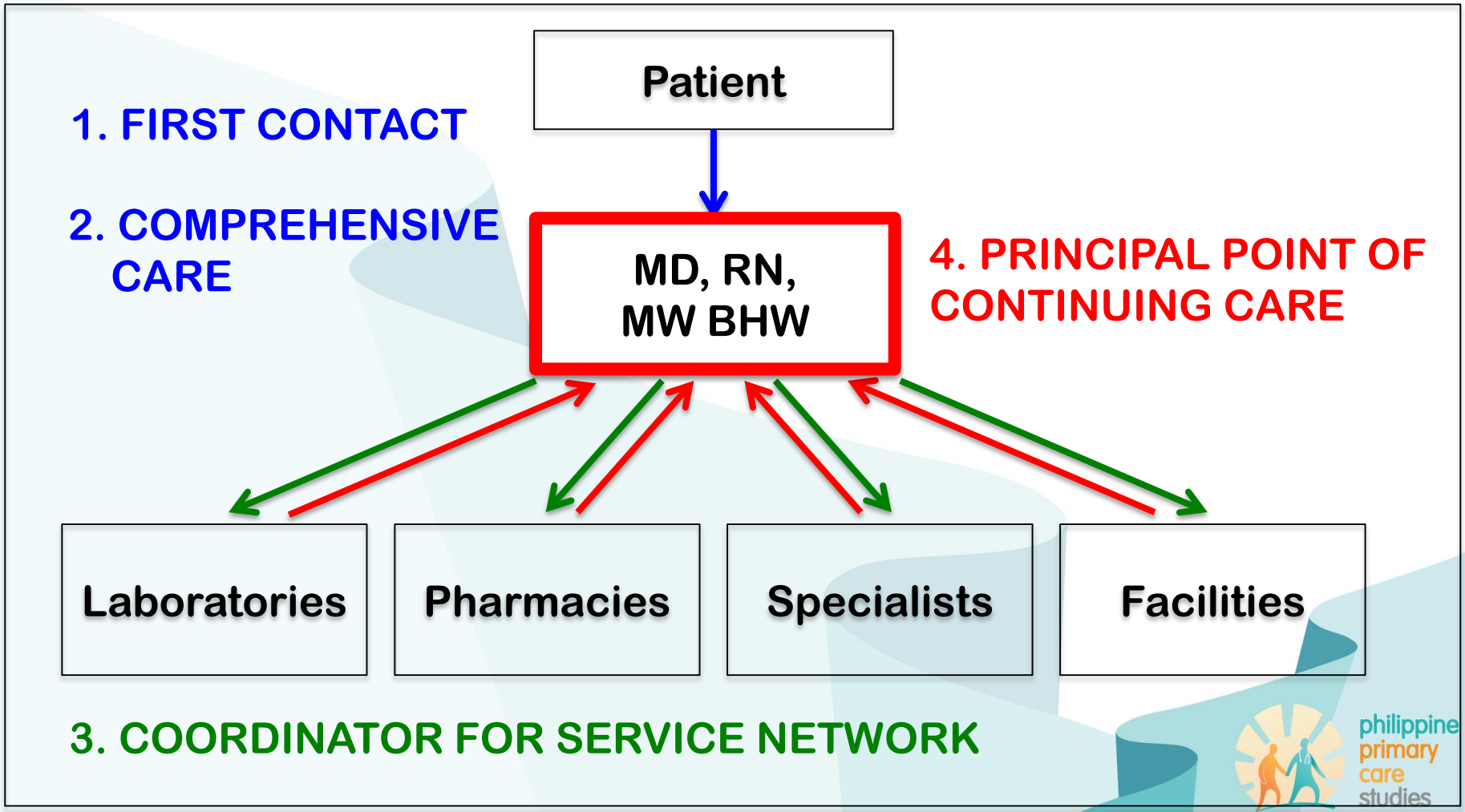
What is Primary Care?

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

Primary Care System



philippine primary care studies

	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 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)	
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	
III. COORDINATED CARE	1. inform patients of available meds, tests, services in RHU & SDN 2. communicate freely and effectively with the rest of the team 3. assist patients with logistics for commonly occuring health needs in the community 4. recognize need for MW, RN or MD	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
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)

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)

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

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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

III. COORDINATE CARE	tests, services in RHU & SDN 2. communicate freely and effectively with the rest of the team 3. assist patients with logistics for commonly occuring health needs in the community 4. recognize need for MW, RN or MD	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
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)

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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)

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

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

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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

III. CO	commonly occurring health needs in 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
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)

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PRIMARY CARE FUNCTION	PROPOSED COMPETENCIES REQUIRED	PROPOSED TRAINING OBJECTIVES
I. FIRST CONTACT	1. distinguish between sick and well	1a, 2a. To identify common signs and symptoms including those for emergency cases …patients for first-contact care in the community setting …BLS …patients
II. COMPREHENSIVE CARE		…ptoms …nd anth …onset, …ication …mmon …ome re …at may warrant preventive or health promotive counseling
III. COORDINATED CARE	3. assist patients with logistics for commonly occuring health needs in the community 4. recognize need for MW, RN or MD	…ailable within the RHU and SDN, or use appropriate references …rtunities for educating the community on primary care services …on to communicate with, and information required for common situations 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
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)

1. inform patients of available meds, tests, services in RHU & SDN
2. communicate freely and effectively with the rest of the team
3. assist patients with logistics for commonly occuring health needs in the community
4. recognize need for MW, RN or MD

5. Refer to ER
6. Organize families and communities
7. Map HC resources
8. Interprofessional communication skills

BHW

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

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III. COORD CAR	3. assist patients with logistics for commonly occuring health needs in the community 4. recognize need for MW, RN or MD	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
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)

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

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

PRIMARY CARE FUNCTION	PROPOSED COMPETENCIES REQUIRED	PROPOSED TRAINING OBJECTIVES
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II. COMPREHENSIVE CARE	1. perform basic Hx & PE, i lab health screening 2. perform and teach hous remedies for common c 3. counsel patients on gen prevention and health p	HR, RR, etc.) nd why to use them promotive counseling
III. COORDINATED CARE	1. inform patients of availa tests, services in RHU & 2. communicate freely and with the rest of the tean 3. assist patients with logis commonly occuring hea the community 4. recognize need for MW, RN or MD	se appropriate references y on primary care services ation required for common situations condition or situation 4. To distinguish with reasonable judgment if a case needs referral to other primary care team 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 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)

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)

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

PRIMARY CARE FUNCTION	PROPOSED COMPETENCIES REQUIRED	PROPOSED TRAINING OBJECTIVES
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E	1. perform basic Hx & PE, including non-lab health screening	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.)

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)

III. COORDINAT CARE	2. communicate freely and effectively with the rest of the team 3. assist patients with logistics for commonly occuring health needs in the community 4. 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 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
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)


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primary
care
studies

KEY PLAYER: MIDWIFE **PROPOSED OVERALL ROLE:** Front-line health professional of the health system; Health facility manager

PRIMARY CARE FUNCTION	PROPOSED COMPETENCIES REQUIRED	PROPOSED TRAINING OBJECTIVES
I. FIRST CONTACT	1. distinguish between si (health screening) 2. treat and render prev certain conditions in h community and clinic s MCH 3. recognize emergencie first aid / BLS / conduc	ght have, if any e) motion
II. COMPREHENSIVE CARE	1. perform basic Hx & PE non-lab health screeni 2. perform and teach ho remedies for common 3. counsel patients on ge prevention and health	R, RR, etc.)
III. COORDINATED CARE	1. inform patients of ava tests, services in RHU 2. communicate freely a with the rest of the te 3. assist patients with log commonly occuring he the community 4. attend to MCH 5. recognize need for RN	e appropriate references H priority programs, including PHIC on primary care services tion required for common situations
IV. CONTINUING CARE	1. Knowledge and skills t monitoring rehab counselling or continuing care under supervision of M 2. Render continuing MCH after RN, specialist consult or admission 3. (*As above, cultivating trust for ongoing therapeutic relationship)	rt them appropriately 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)

1. distinguish between sick and well (health screening)
2. treat and render preventive care for certain conditions in home / community and clinic setting esp MCH
3. recognize emergencies and deliver first aid / BLS / conduct to ER
4. develop communication skills and nurture patient trust (*also for IV. CONTINUING CARE)

KEY PLAYER: MIDWIFE **PROPOSED OVERALL ROLE:** Front-line health professional of the health system; Health facility manager

PRIMARY CARE FUNCTION	PROPOSED COMPETENCIES REQUIRED	PROPOSED TRAINING OBJECTIVES
CT	1. 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

IV. CONTINUIN	or continuing care under supervision of MD or RN 2. Render continuing MCH after RN, specialist consult or admission 3. (*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 PLAYER: MIDWIFE **PROPOSED OVERALL ROLE:** Front-line health professional of the health system; Health facility manager

PRIMARY CARE FUNCTION	PROPOSED COMPETENCIES REQUIRED	PROPOSED TRAINING OBJECTIVES
I. FIRST CONTACT	1. distinguish between sick and well (health screening) 2. treat and render preventive care for certain conditions in h community and clinic s MCH 3. recognize emergencies first aid / BLS / conduc	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) motion
II. COMPREHENSIVE CARE	1. perform basic Hx & PE non-lab health screeni 2. perform and teach hou remedies for common 3. counsel patients on ge prevention and health	HR, RR, etc.)
III. COORDINATED CARE	1. inform patients of avai tests, services in RHU & 2. communicate freely ar with the rest of the tea 3. assist patients with log commonly occuring he the community 4. attend to MCH 5. recognize need for RN	se appropriate references H priority programs, including PHIC y on primary care services tion required for common situations
IV. CONTINUING CARE	1. Knowledge and skills t monitoring rehab counselling or continuing care under supervision of MD or RN 2. Render continuing MCH after RN, specialist consult or admission 3. (*As above, cultivating trust for ongoing therapeutic relationship)	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)

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
4. perform basic maternal and child care

MIDWIVES

KEY PLAYER:	MIDWIFE	
PRIMARY CARE FUNCTION	PROPOSED COMPETENCIES REQUIRED	
I. FIRST CONTACT	1. distinguish between (health screening) 2. treat and render prev certain conditions in community and clinic MCH 3. recognize emergenci first aid / BLS / condu	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 and BHWs 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 to patients and BHWs the essential points of disease prevention and h ealth promotion 4a. To identify health needs in maternal, neonatal and child care that are within the scope of work of MWs 4b. To demonstrate maneuvers and procedures in basic maternal and child care 4c. To instruct patients on basic maternal and child care
II. COMPREHE NSIVE CARE	1. perform basic Hx & P non-lab health scree 2. perform and teach h remedies for commo 3. counsel patients on g prevention and healt	
III. COORDINATED CARE	1. inform patients of av tests, services in RHU 2. communicate freely with the rest of the t 3. assist patients with l commonly occuring H the community 4. attend to MCH 5. recognize need for R	
IV. CONTINUING CARE	1. Knowledge and skills monitoring rehab counselling or continuing care under supervision of MD or RN 2. Render continuing MCH after RN, specialist consult or admission 3. (*As above, cultivating trust for ongoing therapeutic relationship)	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)

KEY PLAYER: MIDWIFE **PROPOSED OVERALL ROLE:** Front-line health professional of the health system; Health facility manager

PRIMARY CARE FUNCTION	PROPOSED COMPETENCIES REQUIRED	PROPOSED TRAINING OBJECTIVES
I. FIRST CONTACT	1. distinguish between sick and well (health screening) 2. treat and render preventive care for	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) reventive care, and health promotion
II. COMPREHE		
III. COORDINATED CARE		HIC tions
IV. CONTINUING CARE	under supervision of MD or RN 2. Render continuing MCH after RN, specialist consult or admission 3. (*As above, cultivating trust for ongoing therapeutic relationship)	arrying out orders viding care and record / report them appropriately 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)

1. inform patients of available meds, tests, services in RHU & SDN
2. communicate freely and effectively with the rest of the team
3. assist patients with logistics of commonly occuring health needs in the community
4. attend to MCH
5. recognize need for RN or MD

5. Manage BHWs
6. Track inventory
7. Map HC resources
8. Manage and use clinical records
9. Interfacility referrals re maternal care
10. Management of birthing facilities

KEY PLAYER:	MIDWIFE	PROPOSED OVERALL ROLE:	Front-line health professional of the health system; Health facility manager

PRIMARY CARE FUNCTION	PROPOSED COMPETENCIES REQUIRED	PROPOSED TRAINING OBJECTIVES
IV. CONTIN	under supervision of MD or RN 2. Render continuing MCH after RN, specialist consult or admission 3. (*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) 3. (* Training objectives apply as above for communicating and nurturing trust)

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

KEY PLAYER: MIDWIFE **PROPOSED OVERALL ROLE:** Front-line health professional of the health system; Health facility manager

PRIMARY CARE FUNCTION	PROPOSED COMPETENCIES REQUIRED	PROPOSED TRAINING OBJECTIVES
I. FIRST CONTACT	1. distinguish between si (health screening) 2. treat and render preve certain conditions in h community and clinic s MCH 3. recognize emergencie first aid / BLS / conduc	ght have, if any e) motion
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IV. CONTINUING CARE	1. Knowledge and skills t monitoring rehab counselling or continuing care under supervision of MD or RN 2. Render continuing MCH after RN, specialist consult or admission 3. (*As above, cultivating trust for ongoing therapeutic relationship)	t them appropriately 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)

1. Knowledge and skills to render
   monitoring
   rehab
   counselling
   or continuing care
   under supervision of MD or RN
2. Render continuing MCH after RN,
   specialist consult or admission
3. (*As above, cultivating trust for
   ongoing therapeutic relationship)

KEY PLAYER: MIDWIFE **PROPOSED OVERALL ROLE:** Front-line health professional of the health system; Health facility manager

PRIMARY CARE FUNCTION	PROPOSED COMPETENCIES REQUIRED	PROPOSED TRAINING OBJECTIVES
CT	1. distinguish between sick and well (health screening)	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)

IV. CONTINUIN	or continuing care under supervision of MD or RN 2. Render continuing MCH after RN, specialist consult or admission 3. (*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)


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KEY PLAYER: NURSE **PROPOSED OVERALL ROLE:** Overall manager for patient care

PRIMARY CARE FUNCTION	PROPOSED COMPETENCIES REQUIRED	PROPOSED TRAINING OBJECTIVES
I. FIRST CONTACT	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
II. COMPREHENSIVE CARE	1. perform basic Hx & PE, including health screening w or wo labs 2. perform and teach household remedies for common medical conditions 3. counsel patients on general disea prevention and health promotion	urine etc) everity, and other aspects h as when, how, and why to use them
III. COORDINATED CARE	1. inform patients of available med tests, services in RHU & SDN 2. communicate freely and effectiv with the rest of the team 3. assist patients with logistics for overall health needs 4. recognize need for MD	or use appropriate references rea rity programs, and PHIC benefits (navigation) s & resources ormation 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)

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

KEY PLAYER: NURSE **PROPOSED OVERALL ROLE:** Overall manager for patient care

PRIMARY CARE FUNCTION	PROPOSED COMPETENCIES REQUIRED	PROPOSED TRAINING OBJECTIVES
I. FIRST CONTACT	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
IV. CONTINUING CARE	4. recognize need for MD 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	that need coordination 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)

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

KEY PLAYER: NURSE **PROPOSED OVERALL ROLE:** Overall manager for patient care

PRIMARY CARE FUNCTION	PROPOSED COMPETENCIES REQUIRED	PROPOSED TRAINING OBJECTIVES
I. FIRST CONTACT	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
II. COMPREHENSIVE CARE	1. perform basic Hx & PE, including health screening w or wo labs 2. perform and teach household remedies for common medical conditions 3. counsel patients on general disea prevention and health promotion	urine etc) severity, and other aspects h as when, how, and why to use them
III. COORDINATED CARE	1. inform patients of available meds tests, services in RHU & SDN 2. communicate freely and effectiv with the rest of the team 3. assist patients with logistics for overall health needs 4. recognize need for MD	or use appropriate references rea rity programs, and PHIC benefits (navigation) s & resources ormation 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 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)

1. perform basic Hx & PE, including health screening w or wo labs
2. perform and teach household remedies for common medical conditions
3. counsel patients on general disease prevention and health promotion

KEY PLAYER: NURSE **PROPOSED OVERALL ROLE:** Overall manager for patient care

PRIMARY CARE FUNCTION	PROPOSED COMPETENCIES REQUIRED	PROPOSED TRAINING OBJECTIVES
I. FIRST CONTACT	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
...	1. perform basic Hx & PE, including	1a. To distinguish among various common signs, symptoms, and diagnostic test findings
COO	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)

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

NURSE

KEY PLAYER: NURSE **PROPOSED OVERALL ROLE:** Overall manager for patient care

PRIMARY CARE FUNCTION	PROPOSED COMPETENCIES REQUIRED	PROPOSED TRAINING OBJECTIVES
I. FIRST CONTACT	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
II. COMPREHENSIVE CARE	1. p 2. p 3. c	, and igns, est fin patie tion(s non h ion a
III. COORDINATED CARE	1. i 2. c 3. a 4. r	able within the RHU and SDN, or use appropriate references tories and pharmacies in the area rimary care services, DOH priority programs, and PHIC benefits (navigation) ity about these health services & resources 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 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)

1. inform patients of available meds, tests, services in RHU & SDN
2. communicate freely and effectively with the rest of the team
3. assist patients with logistics for overall health needs
4. recognize need for MD

5. Manage MWs
6. Inter LGU referrals
7. Interfacility referrals in general
8. Managememt of RHUs

KEY PLAYER: NURSE **PROPOSED OVERALL ROLE:** Overall manager for patient care

PRIMARY CARE FUNCTION	PROPOSED COMPETENCIES REQUIRED	PROPOSED TRAINING OBJECTIVES
I. FIRST CONTACT	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
CO	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)

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

KEY PLAYER: NURSE **PROPOSED OVERALL ROLE:** Overall manager for patient care

PRIMARY CARE FUNCTION	PROPOSED COMPETENCIES REQUIRED	PROPOSED TRAINING OBJECTIVES
I. FIRST CONTACT	1. distinguish between sick and w (health screening) 2. treat and render preventive ca for certain conditions in home community and clinic setting ir MCH	
II. COMPREHENSIVE CARE	1. perform basic Hx & PE, includi health screening w or wo labs 2. perform and teach household remedies for common medical conditions 3. counsel patients on general di prevention and health promot	ne etc) erity, and other aspects as when, how, and why to use them
III. COORDINATED CARE	1. inform patients of available m tests, services in RHU & SDN 2. communicate freely and effect with the rest of the team 3. assist patients with logistics fo overall health needs 4. recognize need for MD	use appropriate references a y programs, and PHIC benefits (navigation) & resources mation required for common situations
IV. CONTINUING CARE	1. Knowledge and skills for specif parts of care for a. Chronic conditions b. Post-discharge, post-op/po intervention patients, inclu postpartum and neonatal c 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	ort them appropriately 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)

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

KEY PLAYER: NURSE **PROPOSED OVERALL ROLE:** Overall manager for patient care

PRIMARY CARE FUNCTION	PROPOSED COMPETENCIES REQUIRED	PROPOSED TRAINING OBJECTIVES
ST ACT	1. distinguish between sick and well (health screening) 2. treat and render preventive care	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)

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)

IV. CONTINUING CA	
b. Post-discharge, post-op/post intervention patients, including postpartum and neonatal care	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
c. Administration of parenteral medications, either in the clinic or at home	2a. To supervise MWs and BHWs in understanding and carrying out management plans, through BHS and community rounds
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)


philippine
primary
care
studies

KEY PLAYER: DOCTOR **PROPOSED OVERALL ROLE:** Overall leader for patient kare (key decision maker)

PRIMARY CARE FUNCTION	PROPOSED COMPETENCIES REQUIRED	PROPOSED TRAINING OBJECTIVES
I. FIRST CONTACT	1. lead overall patient care on first contact 2. diagnose and initiate treatment prevention plans for common medical conditions esp. those considered priorities by DOH 3. recognize and manage all medic emergencies	ant to the community ment plans, and current health policies e, and health promotion
II. COMPREHENSI CARE	1. perform a good Hx & PE, includi health screening 2. perform and teach household remedies 3. diagnose, treat and institute preventive measures for comm medical conditions	findings in primary care ng how, when, and why to use them (EBM
III. COORDINATED CARE	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 car admission 5. co-manage patients during adm and specialty referral	or use appropriate references area rity programs, and PHIC benefits ces & resources formation required for common situations ts of the health system
IV. CONTINUING CARE	1. Following up specialist care 2. Communication and planning 3. Knowledge and skills for planni providing continuing care for a. Chronic conditions b. Post-discharge, post-op/post-intervention patients 4. (*As above, cultivating trust for ongoing therapeutic relationship)	nt plan and individual context alth workers 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

1. lead overall patient care on first contact
2. diagnose and initiate treatment and prevention plans for common medical conditions esp. those considered priorities by DOH
3. recognize and manage all medical emergencies
4. recognize need for specialty care
5. develop communication skills to nurture patient trust (*also for IV. CONTINUING CARE)

KEY PLAYER: DOCTOR **PROPOSED OVERALL ROLE:** Overall leader for patient kare (key decision maker)

PRIMARY CARE FUNCTION	PROPOSED COMPETENCIES REQUIRED	PROPOSED TRAINING OBJECTIVES
ONTACT	1. lead overall patient care on first contact 2. 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

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

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

IV. CONTINUING CARE	1. Following up specialist care 2. Communication and planning 3. Knowledge and skills for planning and 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 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

KEY PLAYER: DOCTOR **PROPOSED OVERALL ROLE:** Overall leader for patient kare (key decision maker)

PRIMARY CARE FUNCTION	PROPOSED COMPETENCIES REQUIRED	PROPOSED TRAINING OBJECTIVES
I. FIRST CONTACT	1. lead overall patient care on first contact 2. diagnose and initiate treatment and prevention plans for common medical conditions esp. those considered priorities by DOH 3. recognize and manage all medi emergencies	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 , and health promotion
II. COMPREHENSI CARE	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	ndings in primary care g how, when, and why to use them (EBM
III. COORDINATED CARE	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 adm and specialty referral	or use appropriate references rea rity programs, and PHIC benefits es & resources ormation required for common situations s of the health system
IV. CONTINUING CARE	1. Following up specialist care 2. Communication and planning 3. Knowledge and skills for planning and 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 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

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

KEY PLAYER: DOCTOR **PROPOSED OVERALL ROLE:** Overall leader for patient kare (key decision maker)

PRIMARY CARE FUNCTION	PROPOSED COMPETENCIES REQUIRED	PROPOSED TRAINING OBJECTIVES
ONTACT	1. lead overall patient care on first contact 2. 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

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
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

IV. CONTINUING CARE	1. Following up specialist care 2. Communication and planning 3. Knowledge and skills for planning and 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 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

DOCTOR

KEY PLAYER: DOCTOR **PROPOSED OVERALL ROLE:** Overall leader for patient kare (key decision maker)

PRIMARY CARE FUNCTION	PROPOSED COMPETENCIES REQUIRED	PROPOSED TRAINING OBJECTIVES
I. FIRST CONTACT	1. lead overall patient care on first contact 2. diagnose and initiate treatment and	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 e existing conditions, if any
II. COMPREHENSI		
III. COORDINATED CARE		ervices they need from other parts of the health system
IV. CONTINUING CARE	2. Communication and planning 3. Knowledge and skills for planning and providing continuing care for a. Chronic conditions b. Post-discharge, post-op/post-intervention patients 4. (*As above, cultivating trust for ongoing therapeutic relationship)	n 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

1. inform patients of available meds, tests, services in RHU & SDN
2. communicate freely and effectively with the rest of the team
3. assist patients with logistics for overall health needs.
4. recognize need for specialty care, admission
5. co-manage patients during admission and specialty referral

5. Specialty referrals
6. Manage team size
7. Healthcare integration
8. Refer for or order elective admissions
9. Population Health Assessment
10. Coordination with LGU

KEY PLAYER: DOCTOR	PROPOSED OVERALL ROLE: Overall leader for patient kare (key decision maker)	
PRIMARY CARE FUNCTION	PROPOSED COMPETENCIES REQUIRED	PROPOSED TRAINING OBJECTIVES
IV. CONTINUIN	a. Chronic conditions b. Post-discharge, post-op/post-intervention patients 4. (*As above, cultivating trust for ongoing therapeutic relationship)	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 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 PLAYER: DOCTOR **PROPOSED OVERALL ROLE:** Overall leader for patient kare (key decision maker)

PRIMARY CARE FUNCTION	PROPOSED COMPETENCIES REQUIRED	PROPOSED TRAINING OBJECTIVES
I. FIRST CONTACT	1. lead overall patient care on first contact 2. diagnose and initiate treatment and prevention plans for common medical conditions esp. those considered priorities by DOH 3. recognize and manage all mec emergencies	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 and health promotion
II. COMPREHENSI CARE	1. perform a good Hx & PE, inclu health screening 2. perform and teach household remedies 3. diagnose, treat and institute preventive measures for comr medical conditions	dings in primary care g how, when, and why to use them (EBM
III. COORDINATED CARE	1. inform patients of available r tests, services in RHU & SDN 2. communicate freely and effec with the rest of the team 3. assist patients with logistics fo overall health needs. 4. recognize need for specialty c admission 5. co-manage patients during ad and specialty referral	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 and providing continuing care for a. Chronic conditions b. Post-discharge, post-op/post-intervention patients 4. (*As above, cultivating trust for ongoing therapeutic relationship)	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

1. Following up specialist care
2. Communication and planning
3. Knowledge and skills for planning and providing continuing care for
   a. Chronic conditions
   b. Post-discharge, post-op/post-intervention patients
4. (*As above, cultivating trust for ongoing therapeutic relationship)

KEY PLAYER: DOCTOR **PROPOSED OVERALL ROLE:** Overall leader for patient kare (key decision maker)

PRIMARY CARE FUNCTION	PROPOSED COMPETENCIES REQUIRED	PROPOSED TRAINING OBJECTIVES
CONTACT	1. lead overall patient care on first contact 2. 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

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)

IV. CONTINUING CARE	1. Following up specialist care 2. Communication and planning 3. Knowledge and skills for planning and 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 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