Development of a Competency Certification Framework for Primary Care Providers in the Context of Universal Health Care in the Philippines

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<td>AO</td>
<td>Administrative Order</td>
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<tr>
<td>BEmONC</td>
<td>Basic Emergency Obstetrics and Newborn Care</td>
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<td>BLS</td>
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<td>CEmONC</td>
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<td>CHED</td>
<td>Commission on Higher Education</td>
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<td>CPD</td>
<td>Continuing Professional Development</td>
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<td>DOH</td>
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<td>EMR</td>
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<td>HHRDB</td>
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<td>ITR</td>
<td>Individual Treatment Record</td>
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<tr>
<td>KSA</td>
<td>Knowledge, skills, attitudes</td>
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<td>LGU</td>
<td>Local Government Unit</td>
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<td>MD</td>
<td>Medical Doctor</td>
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<td>MDG</td>
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<td>MMR</td>
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<td>MOV</td>
<td>Means of verification</td>
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<td>NCD</td>
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<td>Out-patient Department</td>
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<td>PCP</td>
<td>Primary Care Provider</td>
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<td>PCF</td>
<td>Primary Care Facility</td>
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<td>PHC</td>
<td>Primary Health Care</td>
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<td>PHN</td>
<td>Public Health Nurse</td>
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<td>PRC</td>
<td>Philippine Regulatory Commission</td>
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<td>Philhealth</td>
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<td>RA</td>
<td>Republic Act</td>
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<td>RHM</td>
<td>Rural Health Midwife</td>
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<td>RM</td>
<td>Registered Midwife</td>
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<td>RN</td>
<td>Registered Nurse</td>
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<td>TA</td>
<td>Technical Assistance</td>
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<td>UHC</td>
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DEFINITION OF TERMS

**Accreditation** is a process whereby the qualifications and capabilities of healthcare providers are verified in accordance with the guidelines, standards, and procedures set by Philhealth (Philhealth, nd)

**Certification of Primary Care Provider** is a process by which the DOH awards a certificate to an individual who has demonstrated competence in a specialty area beyond the minimum requirements set for licensure, have additional education and training mechanisms to practice primary care (Rooney and van Ostenberg, 1999; UHC Act, 2019). The certification process is DOH-supervised, with performance criteria, and assessment processes established and accepted as standard across all DOH-hospitals

**Competency** entails having and demonstrating the “knowledge, skills, abilities, and traits” to successfully and effectively deliver high-quality services (Kak, 2000). It is also having “a cluster of related knowledge, skills, and attitudes (KSA) that affects a major part of one’s job (a role or a responsibility), that correlated with performance on the job, that 1) can be measured against well-accepted standards, and that 2) can be improved via training and development.” (Parry, 1996)

**Licensing** of health professionals refers to the process of individual licensing by PRC to ensure professional competence. A certificate of registration/ professional license shall be issued to an applicant who passes the examination upon payment of the prescribed fees (RA 2382, RA 9173, RA 7392)

**Primary care** refers to initial-contact, accessible, continuous, comprehensive and coordinated care that is accessible at the time of need including a range of services for all presenting conditions , and the ability to coordinate referrals to other health care providers in the health care delivery system, when necessary (RA 11223)

**Primary care provider** refers to a health worker, with defined competencies, who has received certification in primary care as determined by the DOH or any health institution that is licensed and certified by the DOH (RA 11223)

**Primary care worker** refers to a health worker, who may be a health professional or community health worker/volunteer, certified by DOH to provide primary care services (IRR of RA 11223)
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EXECUTIVE SUMMARY

The Universal Health Care (UHC) Act emphasizes the provision of quality primary care for all Filipinos. This mandates that each Filipino will be afforded a primary care provider that would act as the navigator, coordinator, and initial and continuing point of contact in the healthcare delivery system.

In order to achieve this, there is a need to understand the state of primary care in the Philippines, to tailor primary care practices according to the local context, to identify the core competencies of a primary care provider, and to determine how primary care providers can be certified according to these competencies.

Since the Alma Ata declaration 40 years ago until today, primary care for all Filipinos has not yet been achieved. There are several challenges in achieving this, such as the fragmentation of health service provision and governance as a result of the local government code, maldistribution of health human resources, and lack of service coverage despite population coverage through the national health insurance.

In an attempt to improve the provision of primary care in the country, primary care practices can be imagined as models characterized by six identified elements:

- Population reach
- Scope of services
- Organizational type
- Team composition and scope of work
- Care pathway
- Governance

Breaking down primary care models into elements allow for flexibility of design according to varying local contexts (i.e. urban areas, rural areas, geographically isolated and disadvantaged areas (GIDA), conflict areas, and disaster-prone areas). It is valuable to define these models because it can be used as benchmark for leveling up of primary care facilities as well determining the appropriate complement of primary care providers in these facilities. These six elements of a primary care model serve as input to the Department of Health’s Administrative Order Philippine Primary Care Agenda, which will set the direction and provide guidance in the development and implementation of policies, plans, and programs relevant to primary care. Further, defining the primary care model is necessary as it is the setting in which the primary care providers perform their competencies.

The competencies of primary care providers were culled out from existing documents from the Department of Health and complemented by current data from literature. These were validated among different health professionals from both the public and private sector. Seven core competencies in primary care are identified:

1. Providing first-contact care
2. Providing comprehensive care
3. Providing continuing care
4. Coordinating care
5. Managing patient records
6. Promoting health
7. Implementing public health functions

A competency assessment tool was subsequently developed based on the validated core competencies. The tool is a formative evaluation of the behavioral manifestations that are to be observed in a health worker.

Five key recommendations were formulated based on the five-step certification framework:

- **Recommendation 1: Orient health education and professional licensing towards primary care**
  
  While elements of primary care already exist in current curricula and programs of care providers, these training programs and outcomes can be reviewed to determine how they can be further aligned to the goals of universal health care, particularly in primary care.

- **Recommendation 2: Consider different post-graduate primary care training and education options.**
  
  Various training designs can be explored and should be developed to cover for competency gaps. These can be 2 days to week-long trainings to be developed by the DOH in collaboration with experts. Further, elevating primary care as a post-graduate degree can be discussed as it serves several advantages in terms of improving quality of training and attractiveness of the profession.

- **Recommendation 3: Build DOH capacity to manage competency assessors and evaluate competency assessment methods**
  
  A task force specifically designated to issue certifications, and recruit, set the criteria for, orient, and manage assessors must be created within the Department of Health. Further, they will be in charge of regularly evaluating the competency list and assessment methods for further refinement.

- **Recommendation 4: Implement gradually and evaluate the certification process**
  
  It is acknowledged that certification will require several years before each Filipino is afforded a primary care provider as mandated in the law. Thus, each facility may begin with at least one primary care provider in the first five years before certification of all basic primary care team members is required.

- **Recommendation 5: Link the maintenance of certification with continuing professional development (CPD) requirements**
  
  In order to reduce complexity of the re-certification process, linking requirements for primary care re-certification with CPD unit requirements for renewal of professional license by the PRC every three years can be explored.

The DOH-HHRDB may consider these recommendations in their organization efforts. It may consider strengthening the DOH Academy as an external unit which will streamline the recruitment of assessors, assessment activities and certification.
I INTRODUCTION

Primary care is a level of healthcare that serves as an entry point of individuals in the health system. Its functions include care provision that is characterized as accessible, comprehensive, continuous, and accountable (IOM, 1978). In the Philippines, primary care is delivered at rural health units (RHUs) and Barangay Health Stations (BHS) in the government sector. These serve as the first contact of care for communities. On the other hand, patients may also opt to seek primary care from the private sector through private clinics, mall-based clinics, and outpatient departments of private hospitals. It is reported that more patients seek consult at public facilities compared to private facilities across the archipelago (Dayrit, 2018). Typically, RHUs and BHS are staffed by primary care providers – physicians, nurses and midwives – who provide both clinical care and public health functions in the community.

As the Republic Act 11223 or the Universal Health Care Act was signed into law, primary care providers are required to have a set of defined competencies to receive certification. It is also mandated in the law that the Department of Health (DOH) and the local government units (LGUs) shall endeavor to provide a health care delivery system that will afford every Filipino a primary care provider that would act as the navigator, coordinator, and initial and continuing point of contact in the healthcare delivery system.

Certification is a process by which the DOH awards a certificate to individuals that received additional education or training and demonstrated competence in a specialty area beyond the minimum requirements set for licensure, and training mechanisms to practice primary care. The certification of the primary care provider has implications in the scheme of licensing primary care facilities and subsequent contracting by Philhealth in the primary care provider network. Hence, the competent mix of health care workers in the facilities is only one of the many components in the operationalization of UHC. Through certification, it is envisioned that competent primary care providers will enable improvement in the responsiveness of the health system and prevent individuals from illnesses by health promotion. These are all aligned with the aims of UHC for every Filipino to achieve improved health outcomes and is guaranteed protection against financial risk.

As the national technical authority for health, the DOH through the Health Human Resource Development Bureau (DOH-HHRDB) will provide the guidelines for defining the competencies of primary care workers. In support of UHC and DOH, the World Health Organization contracted ThinkWell LLC, Philippines to provide technical assistance to the DOH-HHRDB in developing the competency certification framework for primary care providers. This technical assistance addresses the need to identify the competencies of primary care health workers and the development of a competency framework in alignment with the UHC law provisions.

OBJECTIVES

The overall objective of this technical assistance (TA) is to develop a competency certification framework for primary care health workers. Specifically, this TA aims to:

1. Map out the current state and set the goals of primary care provision in the Philippines, informed by international, national and local agenda frameworks,
grounded on authentic voices from multiple stakeholders at various levels within and beyond the health sector

2. Develop models of primary care provision for the Philippines based on best practices of primary care around the world that are [a] aligned with identified PC goals and [b] grounded on existing realities, standards and regulations in the Philippine setting

3. Develop, validate, and pilot test a competency assessment tool for primary care providers in the selected models

4. Develop and validate a framework for certification of primary care providers and its partner institutions

II METHODS

To complete the deliverables of this report, four phases of work were planned at the inception state. The four phases of work are as follows:

Phase 1: Documents Review and Consultations
– Desk review on setup of primary care provision in the Philippines; national and sectoral development agenda, local and international standards, existing policies and operational frameworks; and goals, guarantees and features of primary care provision in the Philippines
– Interviews on primary care provision in the Philippine setting

Phase 2: Development of Primary Care Models
– Desk review on existing primary care models in the Philippines, and models and scenarios of primary care provision in various setups, contexts and team composition
– Stakeholder consultations on the feasibility of the developed models

Phase 3: Development of Primary Care Competencies and Prototyping
– Desk review on existing primary care competencies locally and abroad
– Consultative workshops on primary care competencies
– Key informant interviews on development of competency assessment tools and its applicability
– Focused group discussions to validate the competency assessment tool

Phase 4: Development of Primary Care Certification Framework
– Desk review on the certification frameworks for health workers locally and abroad
– Consultative workshop on the feasibility of the developed certification framework

PHASE 2: DEVELOPMENT OF PRIMARY CARE MODELS

Desk Review
Desk review on primary care models and best practices was conducted through various databases and included systematic reviews, meta-analysis, case studies and series, grey literature, reports, and even primary sources. The literature was critically appraised, and then findings were synthesized by collating and organizing the data. The elements of a primary care model were determined by comparing the data and extracting relevant themes
Preliminary Analysis
A preliminary analysis of the technical, legal, and operational feasibility of the model was done by reviewing applicable laws or mandates relating to primary care facilities and provider roles. This included a careful review of the UHC law followed by the implementing rules and regulations to assess the applicability of the results in the Philippine setting.

Stakeholder Consultations
The desk review and preliminary analysis resulted in the identification of essential elements of primary care models, as no one model can be prescribed for the varied contexts within the Philippines. These were then presented in a consultative meeting attended by representatives from both public and private sectors. These included professional societies and organizations of medical doctors, nurses, midwives, and dentists. Feedback on the technical and operational feasibility of the results were collated, utilized to refine the results, and incorporated as important considerations when adapting the elements of the model in the local setting.

Phase 3: Development of Primary Care Competencies and Tools
Extracting the core competencies
Consultations with DOH-HHRDB was conducted to map out the existing documents on primary care provider competencies. It is recognized that the DOH-HHRDB has put in a lot of effort in identifying standards for all positions in the DOH since 2005. A more recently updated Competency Standards was adapted by the bureau in 2017 (Pick, 2017). Furthermore, the bureau recently produced a Learning & Development Framework for RHUs (MHO, PHN and RHM) that provides the tasks and competencies expected from these three cadres (DOH-HHRDB, 2018).

Aside from existing documents in DOH, more recent researches were retrieved from the academe (Dans, 2019; Dayrit, 2019). The expected roles and competencies of the health professionals were then culled out from these documents. In addition, international competency frameworks were reviewed for each health professional.

Thematic analysis was then conducted to identify the core competencies for the selected health professionals.

On consultations with DOH-HHRDB, core primary care competencies that are generally applicable to the doctor, nurse, and midwife should be used as basis to certify primary care providers in the immediate future as mandated by the UHC law. For this purpose, it was necessary to define competencies that were general enough to be applied to the different cadres, but still specific enough to ensure quality of primary care. The competencies were thus filtered through the following criteria:

- Can each cadre perform the competency on the basis of how they are and should be trained?
- Should all three cadres (doctor, nurse, midwife) have the competency?
- Are there no legal mandates that prohibit the specific primary care provider to perform this competency?

The mapped competencies were further reviewed and refined by:
Carving out specific competencies that required emphasis based on the law, such as management of patient records and health promotion, and identifying them as core competencies instead
Reclassifying specific competencies to the appropriate core competencies
Reviewing the competencies vis-a-vis the expectations of the UHC law from primary care providers

Developing the tool

The mapped competencies were then translated into a competency assessment tool that can be used by assessors to certify primary care providers. There were several considerations in the development of the tool:

- There is an urgent need for the Department of Health to certify primary care providers as stipulated in the UHC Law. While the purpose of certification is to ensure quality of primary care provision, competencies must be reasonable and achievable in order to ensure a sufficient supply of primary care providers in the short-term.
- Resources to certify primary care providers are limited (i.e. number of qualified assessors). Thus, in the short-term only medical doctors, nurses, and midwives will be certified by the Department of Health. The process of assessment should be straightforward and easily accomplished without compromising rigour and the purpose of certification.

With these considerations in mind, it was decided that the most practical means of verification that can be used in the short-term are (1) documents review and (2) on-site observation.

Content Validity and Feasibility

Specific observable behaviors and a list of documents that may be used for verification were then determined for each competency. Once completed, its content validity and feasibility were tested.

Content Validity

Content validity was determined both quantitatively and qualitatively. Quantitatively, each competency was subjected to a survey of whether or not these were essential in providing good primary care, useful but not essential, or not essential at all. The content validity ratio was then computed to determine which competencies were valid. These results were complemented with qualitative data which provided depth in understanding each competency and which revealed barriers to performing them.

Feasibility

The operational feasibility was also tested by asking a total of 22 experienced MHOs, nurses, midwives, and development management officers (DMO) to use the tool on-site in RHUs identified by DOH-CHD 6. Informed consent was solicited from doctors, nurses and midwives who were observed during the validation.

After using the tool, the following dimensions on feasibility were reviewed:

- Time required to administer the tool
- Understandability of instructions
- Availability of means of verification in the facility
- Applicability of means of verification to the competency
- Space required to administer the tool
Costs involved in administering the tool

After the results of the validity and feasibility tests were determined, each competency was again reviewed and adjusted as necessary. Further the specific detail for means of verification was reviewed. Many of them were not applicable and unclear, and thus required revisions.

**PHASE 4: DEVELOPMENT OF CERTIFICATION FRAMEWORK**

**Desk review** was done to synthesize existing certification processes from systematic reviews, grey literature, reports, and primary sources. Alignment with existing laws, particularly the Universal Health Care Law and the Continuing Professional Development Law, were essential in providing the operational and legal context for certification. Finally, comparison with current certification processes by the Department of Health and international frameworks was done to identify the general steps for certification.

**Stakeholder Consultations.** Results from the desk review generated the general steps for certification. These were then presented in consultative meetings attended by representatives from both the public and private sectors. These included professional societies and organizations of medical doctors, nurses, midwives, and dentists. Participants’ responses provided insights towards refining the steps of the certification process and its feasibility.

**LIMITATIONS**

The proposed competencies are developed based on existing documents that are believed to be based on the process of task analysis, development of performance quality standards, and identification of skills, knowledge and values required for quality performance. The working group also recognized that the DOH-HHRDB had existing competencies for health workers at the primary care level and these competencies were culled out in alignment with the UHC law. To complement the existing competencies from the DOH, additional local studies on primary care workers were also considered in the identification of competencies. Hence, the generated initial competencies were not based on primary data collection but on secondary data. The working group made a conscious effort to validate these competencies by consultations in local settings and from experts from various health professions.

In addition, the developed competencies do not detail clinical technical competencies for each health professional. The developed competencies were rather presented as a set of core competencies that is expected from any primary care provider, regardless of profession. Furthermore, it was agreed that a “blanket set” of competencies relevant to these select health professionals will be developed. In the long term, primary care competencies are expected to be included in the curricula of key health professionals.
III RESULTS

PRIMARY CARE IN THE PHILIPPINES

Health Status in the Philippines
The Philippine health system faces challenges in providing adequate health care in the present decade. While Filipinos tend to live longer with life expectancy increases from 62 years in 1980 to 69 years in 2016, there is also a shift of premature mortality due to non-communicable diseases (NCDs) (Dayrit, 2018). On the other hand, the country still struggles with communicable diseases such as pneumonia and tuberculosis as the leading causes of death among Filipinos. Furthermore, deaths due to accidents and injuries are increasing and is contributing to major causes of deaths in the Philippines (IHME, 2019). This epidemiological transition, which is known as the triple burden of disease, plagues the country with a combination of chronic lifestyle diseases, infectious diseases, and deaths or injuries due to globalization. These conditions place greater challenge in the delivery of primary care services.

The country also failed to meet some of the national targets for the Millenium Development Goals (MDGs) that are indicative of primary care services. The maternal mortality ratio (MMR) remained high at 114 deaths per 100,000 live births in 2015 and the proportion of births attended by a skilled health personnel is only at 87%. Despite these failed targets, there were marked improvements in the under-five mortality rate (27.1) and infant mortality rate (21.5) in 2016 in comparison to the previous decades. On the other hand, other infant and child indicators remain lagging with a high prevalence of stunting (33.5) among children ages 0-60 months. Furthermore, vaccination rates remain low, with only 62% of children aged 12-23 months being fully immunized (Dayrit, 2018).

Communicable diseases continue to be a health challenge in the country and may be attributed to lack of access to health services or lack of advances in the management of these conditions. Despite the steady improvement of TB treatment success rates and case detection rate over the years, tuberculosis continues to account for a considerable portion of disability-adjusted life years (DALYs) in the country.

These health conditions from communicable and NCDs should be addressed primarily at the primary care level. However, the provision of primary care in the country remains to be inadequate despite several health reforms enacted over the decades.

Provision of primary care in the Philippines

Following the Alma-Ata Declaration in the 1970s, the primary health care approach was adopted as a national policy in the Philippines. Despite more than 40 years since its declaration, primary health care for all has not been achieved in the Philippines. This is due to the fragmentation of the healthcare system in all aspects: service delivery, governance, health policy, and financing.

This fragmentation can be traced back even prior to the devolution of the healthcare system. In 1991, The Local Government Code (LGC) was responsible for the devolution of the healthcare system from the national government to the local government. It envisioned a more responsive approach to the health needs of its people.
Under the LGC, the provision of primary health care is under the mandate of the municipal and city governments. Barangay health stations are maintained by barangay and municipal governments. The Department of Health (DOH), on the other hand, is mandated to set the national policy agenda, technical standards, and guidelines on health. It also retains its mandate over specialized and tertiary-level care. It is noteworthy, however, that the additional national government allocation to the LGU was not commensurate to the functions that were transferred to the local governments (Abrigo, 2017).

Individual health services can either be provided by the public or the private sectors, that overlap across the various levels of care in a free-market model. Hence, there are no gatekeepers in the system and a Filipino may choose to access any level of care depending on their perceived needs, preferences and willingness to pay. Bypassing of primary care facilities is common, and patients cite dissatisfaction with the quality of care or lack of supplies at public facilities as important factors in their decision to consult with higher levels of care (Romualdez, 2011). Basic equipment necessary to deliver primary care, such as vaccine refrigerator, blood pressure apparatus and nebulizers, are unavailable in some RHUs (Dayrit, 2018).

Financing primary care is also an issue. Albeit slow, outpatient benefits have been developed for primary care settings, including primary care benefit, maternal care package, newborn care package and TB package. The utilization of these benefits has been increasing over the years, mainly due to the large increase in public and private birthing facilities. However, the utilization of these health services has lagged, and the benefit package remains narrow due to inadequate coverage of primary care benefits.

Health human resources for primary care are lacking in numbers and competencies related to primary care. The distribution in terms of place of work is hospital-centric and is curative in nature. Ninety-one percent of doctors work in hospitals, and 9% in non-hospital and primary care settings. In addition, majority of nurses (74%) and almost half of midwives (41%) are employed in hospitals. This reflects the hospital-centric model of the health system which is contrary from a model of care in which primary care is the first contact of care. Furthermore, although RHUs and BHS are conveniently located, these facilities are underutilized due to (1) unavailability of workers and (2) the notion that they are least competent among government health workers (World Bank, 2001). In addition, doctors, nurses and midwives in RHUs were identified to need continuing health education and refresher courses for various clinical skills. Likewise, BHWs lack primary care skills which compromises the quality of health services delivered (ZFF, 2011). Hence, certification of primary care providers serves to address this need to assure quality in primary care provision.

**National local & sectoral leadership agenda**

To address the need to shift the current system to healthcare rooted in a strong foundation in primary health care, Republic Act No. 11223 known as the Universal Health Care Act (UHC law) was signed in 2019 to achieve the SDG of Universal Health Coverage. The law stresses the need for a more responsive healthcare system that addresses inefficiencies and inequities by strengthening primary health care. By assigning a primary care provider to every Filipino, thus guaranteeing every Filipino’s right to health.
There are existing national and international health agenda that support the aims of the UHC law even before it was signed. These health agendas and policies highlight the need to improve primary care services delivery.

The most recent health agenda of the Department of Health, the DOH Administrative Order (AO) 2018-0014 Strategic Framework and Implementing Guidelines for FOURmula One Plus for Health (F1+) provides the overall policy direction of the DOH to prioritize activities that will respond to attaining health goals. These goals were built on health-related outcomes in the Philippine Development Plan 2017-2022, Ambisyon Natin 2040, and the Sustainable Development Goals. In this medium-term strategy framework, primary care is envisioned to improve through reforms in the service delivery pillar. These reforms include: (1) increasing access to quality essential health products and services through a comprehensive essential health package for all ages, (2) ensuring equitable access through updating of health facilities, and (3) engaging service delivery networks (SDNs) to deliver a comprehensive package of health services through gatekeeping mechanisms, assignment of individuals and families to a primary care provider, and two-way referral systems at all levels of SDN.

Furthermore, Philhealth, the national health insurance agency, continues to expand the range of services in the outpatient setting. It has evolved from outpatient benefits for the sponsored program only in year 2000, to further inclusion of maternity care package (2003), TB-DOTS (2003), neonatal care package (2006), malaria treatment (2008), HIV/AIDS treatment (2009), and animal bite (2010). In the recent decade, it has also included insertion of intrauterine device (2014), noncommunicable disease drugs (2014), and other primary care services to the sponsored program only (2015).

By 2017, the DOH released the AO 2017-0012 or the Guidelines on the Adoption of Baseline Primary Health Care Guarantees for All Filipino, which states that there are health guarantees or benefit packages per life stage of the individual, be it individual-based or population-based health care. This guided the expansion of the primary care benefit package by PhilHealth. As of 2018, the primary care benefit package was expanded to cover all members, including those from the formal economy, lifetime members and senior citizens.

In the country’s long-term vision of Ambisyon Natin 2040 through Executive Order (EO) No.5, s.2016, health is given a priority in one of its pillars. Through this EO, strategic development plans that have implications in primary care provision are stated through the Philippine Development Plan 2017-2022. The government envisions strategies that will improve nutrition and health including: (1) guaranteeing care through quality nutrition and healthcare interventions at all life stages; (2) ensuring access through functional service delivery which ensures functional and efficient networks of health care providers and upgrading and equipping of health facilities, and improving health workers; and (3) sustaining health financing by expanding health insurance coverage and improving benefit packages.

**International operational frameworks**

Globally, it is recognized that primary care has been oversimplified in resource-constrained settings. While in well-resourced contexts primary care is understood with reference to
physicians with specialization in family medicine or general practice, low-resource settings may restrict primary care to a narrow range of health problems, an isolated community health worker, or curative care for common ailments. Hence, the World Health Report (2008) recommended reforms that reorganize health services as primary care so that these will be more responsive to the changing world while producing better outcomes. Service delivery reforms are meant to transform conventional healthcare delivery into primary care due to its robust evidence on effectiveness and efficiency. While different variations of people-centered primary care exist, its main features include person-centeredness, comprehensiveness and integration, continuity of care, and participation of patients, families and communities.

To facilitate primary care, arrangements for transformation of conventional care into local networks of primary care is recommended. This is expected to bring care closer to the people, give primary care providers the responsibility for the health of a defined population, and strengthen the primary care providers’ role as coordinators of inputs of other levels of care. A UHC law, with its potential to ensure accessibility without undue reliance on out of pocket payments, is also a pre-condition to facilitate this.

Efforts to orient health systems towards primary health care among countries is reinforced in The Declaration of Astana on Primary Health Care and the accompanying Vision for Primary Health Care in the 21st Century. While this is mainly on primary health care (PHC), one of its components is primary care and essential public health functions as core of integrated health services. The primary care component of PHC is further described as meeting people’s health needs through comprehensive promotive, protective, preventive, curative, rehabilitative and palliative care through the life course, strategically prioritizing key health services aimed at individuals and families through primary care and the population, with essential public health functions as the central elements of integrated health services.

The operational framework for PHC proposed a set of levers that would help countries make progress across the three components of PHC. The PHC levers are grouped as either functions at the policy level or functions at the operational level. Hence, there are two levels of levers: (1) governance, policy and finance levers, and (2) operational levers. These levers are interdependent, and most levers have elements that are policy and elements that are operational.

Monitoring of primary care requires all elements on both the governance, policy and finance levers and operational levers. Political commitment and leadership, governance and policy frameworks, and adequate funding and equitable allocation of resources is necessary from the first group of levers. On the other hand, the operational lever requires all of the following: (1) engagement of community and other stakeholders to jointly define problems and solutions and prioritize actions, (2) models of care that prioritize primary care and public health functions, (3) ensuring the delivery of high quality and safe health services, (4) engagement with private sector providers, (5) adequate quantity, competency levels, and distribution of a multidisciplinary PHC health workforce, (6) physical infrastructure and appropriate medicines, products and technologies, (7), digital technologies for health information and communication, (8) purchasing and payment systems that promote PHC and integration across the health system, (9) PHC-oriented research and knowledge management, and (10) monitoring and evaluation.
Hence, for primary care to function in the health system, all the previously mentioned elements should be addressed. While this technical assistance will mainly focus on the primary care health workers’ competencies, a review of models of care was also conducted to identify the existing models of care and provide recommendations on possible models to be developed in the Philippine setup.

ELEMENTS OF PRIMARY CARE MODELS

In the context of the Universal Health Care Law (RA 11223), the practice of primary care exists within a healthcare provider network, within which primary care providers operate. Thus, in defining the competencies of a primary care provider, there is value in describing the context that demands these competencies to be performed.

In order to systematically describe this context, six essential elements of a primary care practice are identified:

**Figure 1. Six essential elements of a primary care model**

Breaking down the primary care model into these six elements allows for some malleability and applicability in specific contexts and needs. As each element can be modified, the overall model can be casted to be responsive and feasible depending on the potential and existing financial, structural, and health human resources and local population needs.

**A. Population Reach**

*Principle: Primary care services should be accessible to the whole population – small enough for personal care, large enough for impact. (NHS, 2018)*

There are several ways to identify population reach. Some methods are preferred over others on the basis of which method is less arbitrary, which best considers accessibility to the population, and the available data from the field.

**Facility: Population Ratio**

This method is most commonly used in defining the catchment population of each facility. For example, in Thailand, one Tambon (sub-district facility) serves a population of 5,000 (WHO, 2017). In the UK, experience has shown that the optimal population size served by one GP practice is 30,000 to 50,000 (BMA, 2019).

These numbers are however arbitrary. In comparison to other methods, this places the least emphasis on the geographical accessibility of the facilities to the population. It also does
not adjust for the size or capacity of each facility, as a standard ratio is often prescribed or
determined for all facilities regardless of capacity.

**Effective Catchment Population (patient origin analysis)**

This method is preferred and is less arbitrary as it computes for the underutilization and
overutilization of a facility. The effective catchment population defines the actual
population that the facility provides services for. Below is the equation to determine this
number:

\[ N = N_c \frac{U}{U_c} \]

\( U \) = # of consultations dispensed at facility overall and by place of residence of patients
\( U_c \) = # of consultations by patients living within theoretical facility catchment
\( N_c \) = Total population in the theoretical catchment of the facility (i.e. towns that “belong” to the facility)

‘\( N \)’ provides the effective catchment population of the facility. By comparing the effective
catchment population to the theoretical catchment population, over- or underutilization of
a facility can be determined.

Knowing the effective catchment population of the facility provides basis for a facility to
increase or reduce its service capacity in order to maximize efficiency.

While this method is rigorous and produces valuable information for the primary care
practice or facility, historical data is necessary. This data may not be readily available in
existing primary care practices.

**Theoretical or Geographical Catchment Population**

The geographic catchment population can be determined through (a) straight-line distance
or (b) travel time.

Straight line distance measures the population within a circle whose radius is an arbitrary
number, with the primary care facility as the middle of that circle. Because this method does
not consider geographical barriers such as landscapes which significantly affects physical
access, travel time is usually preferred.

Travel time method includes the population covered within a certain travel time regardless
of physical distance.

While no standard straight-line distance and travel time has been determined as standard
for primary care facilities, the WHO makes some recommendations for BEmONC and
CEmONC facilities: 5-kilometer straight-line distance or 1-hour travel time from the facility
(WHO, 2009).

**B. Scope of Services**

*Principle: A network should be able to provide access to comprehensive primary care services
(versus individual facilities)*
In the Philippines, there are two bases for evaluating the comprehensiveness of primary care services:

1. The Primary Health Care Guarantees for All Filipinos (Administrative Order 2017-0012). These guarantees, as defined by the administrative order, is a “package of services the state commits to providing all Filipinos.”
2. Anticipated health needs of the population

Where resources are limited, local epidemiological data is crucial in nuancing the health needs of the population. An understanding of the local health needs aids in strategizing for prioritization of resources.

In practice, the scope of services actually offered among primary care facilities may vary significantly (Pineault et al., 2008). In the Philippines, although public primary care facilities, such as the rural health units and barangay health centers are mandated to deliver national DOH programs and the primary health care guarantees, comprehensiveness of care may vary or may even be suboptimal due to varying factors — lack of appropriate HRH, ill-equipped facilities, geographical isolation, unique local health needs. Because the scope of services varies depending on the facility, it is important to first perform an exercise of evaluating the comprehensiveness of the services currently provided by each facility.

Comprehensiveness has two important dimensions: (1) complexity and (2) range of health needs (Contandriopoulos et al., 2018).

**Figure 2. Conceptualization of care comprehensiveness.**

The comprehensiveness of services, by evaluating service coverage relative to care complexity and the range of health needs, can be mapped and illustrated in the primary care box in Figure 2.

For example, a specific health facility is able to provide services for a certain range of health needs for less complex cases. Ideally, by forming a network, a facility is able to expand the comprehensiveness of the services it can provide, as shown in Figure 3.
Figure 3. Example of mapping of comprehensiveness of primary care services provided by a health facility before and after forming a network.

This mapping exercise will help identify which services fall on the unfilled portions of the box. It can aid in determining and prioritizing which services or facilities primary care practices network with and what additional roles of the health care team are to be added.

C. Organizational Type

Principle: Coordinated care and access to a wider range of care must be provided effectively and cost-efficiently

As mandated in the UHC law, the primary care facility should be part of the network. At the primary care level, the facility can be part of a primary care provider network—a network of primary care facilities providing primary care services. Multiple organizational types exist for primary care provider networks. The three simplified types are described below.

Figure 4. Three organizational types of polyclinics in primary care.

Adapted from Under One Roof (2008). King’s Fund.
In same-site polyclinics (retained separate practices and merged practices), doctors convene in the same building as an attempt for multi-professionals to connect without the need for coordinated referrals across geographical distances. These polyclinics are used in countries such as Singapore, Brazil, Australia, and Chile. It must be noted however that putting practices within one location does not assume integration. In Cuba, this lack of integration despite being under one roof was addressed by introducing joint consultations (Imison, 2008).

In networked polyclinics, existing primary care facilities link and coordinate with other facilities to increase the diversity of services. In this organization type, primary care practices are not relocated to one location. Linkage between services and facilities are not necessarily 1:1 so as to take advantage of the economy of scale in networks. This type has been adopted in some GP practices in London and has been found to be suitable in areas where the population is relatively spread out (Imison, 2008).

D. Team Composition and Scope of Work

*Principle: The team should provide services collectively to meet the needs of the population.*

As of December 2017, the top three categories of health professionals in the Philippines working in health institutions are nurses (90,308), doctors (40,775), and midwives (43,044). Institution-based doctors are affiliated between public and private institutions equally at 50%. Unlike doctors, more nurses (61%), midwives (91%), and medical technologists (53%) work in public institutions. (*Dayrit, 2018*) Considering these top three categories, including the primary care physician, nurse, and midwife to the basic health care team may be feasible.

The World Health Assembly, through multiple resolutions, has also urged the strengthening of nursing and midwifery, recognising their role in providing comprehensive primary health care services. Aside from being involved in treatment, prevention, and promotion, nursing/midwifery personnel possess the necessary managerial, supervisory and teaching skills from which may be drawn teachers and supervisors of primary health care workers; They also are able to organise communities to provide population-based services (i.e. vaccination programs).

![Figure 5. Basic and Additional Members of the Primary Care Team](image)

Analysis of the literature suggests, not surprisingly, that expanding the scope of primary care services, increasing accessibility, and maintaining or improving efficiency call for greater use of multi-professional teams (*Laurant et al., 2005*). The other categories of health workers existing in the Philippines are medical technologists, pharmacists, dentists, nutritionists, radiology technicians, physical therapists, occupational therapists, X-ray technicians, sanitary inspectors, barangay or community health workers, among others.
The scope of the work of the health team members can be imagined using the same graph used to evaluate service comprehensiveness. In order to optimize the roles of the health team members, it is important to map their contributions to the services provided.

Figure 6 shows examples of models that optimize the roles of different members of the health team.

Figure 6. Mapped Roles of primary care team members according to roles and services


This mapping exercise allows for some exploration of new roles that the health team may need, such as the Primary Health Care Nurse Practitioner (PHCNP) which may be able to manage more complex and a wider range of health needs. However, it is important to consider that redefining roles will require additional skills and resources for training and development (Contandriopoulos et al, 2018).

Before redefining roles, there is a need to review the present roles of primary care providers in primary care facilities. These roles may not be completely standardized across all public primary care facilities such as rural health units, as the local chief executives and medical doctors, who are often seen as the primary care team leader, are given leeway to manage the human resources within the facilities. It is prudent to evaluate whether or not primary care providers are overburdened with too many roles. It is also important to consider that providers within a cadre may perform different roles. For example, at present, some RHU nurses act as Public Health Nurses and perform managerial functions, while some perform clinical functions.

E. Care Pathway

*Principle: Quality care must be provided sustainably by the human health resources available*

Determining a patient’s care pathway within a primary care facility is necessary so that each team member can perform their roles sustainably. Otherwise, there is a tendency for certain team members to be overburdened by too many roles.
Below are examples of care pathways in the presence and absence of a primary care physician.

**Figure 7. Care pathways in primary care facilities with the presence or absence of a primary care physician.**


In the first sample care pathway, the patients are first seen by the primary care physician who then refers to the other team members as necessary, depending on the management plan.

On the other hand, in the second sample care pathway, patients can be first seen by a primary care specialized nurse, such as a primary health care nurse practitioner. This nurse determines the diagnosis and the treatment plan and refers the patient to the appropriate primary care provider. For more complex cases that require specific treatment or diagnostic tests, the nurse refers the patient to the physician (Contandriopoulos et al, 2018). It may be important to note that no difference in “health outcomes for patients, process of care, resource utilization, and cost” have been demonstrated between care pathways with physicians and nurses as the core professional. (Laurant et al, 2005).

Figure 7 shows sample care pathways that have been used for facilities providing care for individual patients. However, primary care providers in public facilities also perform public health functions, and thus are responsible for populations as well. These public health roles must be kept in mind when designing the care pathway so that providers are not overloaded with work.

**F. Governance**

*Principle: The components of the network must be strategically managed to provide integrated care to the local population*

The Department of Health (DOH), as the national authority on health, provides policies and general plans for the devolved health units. Because of this devolved set-up, the local government units (i.e. provincial, city, and municipal governments) are responsible for managing and implementing local health programs and services.

In order to provide some technical guidance to the local government units, local health boards chaired by the local chief executive (governor or mayor) are present. They serve as
the health systems advisory body to the executives. The region, on the other hand is represented by the DOH representative within the DOH Regional Health Office.

Because the provincial health board, city health board, and municipal health board function as separate boards, there is little room to collaborate and align provincial, city, and municipal health goals. In the context of the UHC law where a recentralization of some governance functions to the level of the province occurs, a restructuring of the health board to convene both the provincial and municipal chief executives within one board may be useful.

Further, the value of a dedicated network manager to oversee primary care provider networks must be explored. In the UK where Primary Care Networks have been rolled out for the past 2 years, new strategic leadership and managerial positions have been opened. Their roles include producing an operating plan, lead on implementing of services and initiatives, and assisting in investigations into serious incidents, among others (Serkle, 2019).

It is foreseen that the operational roles of the network manager include liaising with members of the network to integrate services, liaising with other stakeholders (i.e. the provincial health board, purchaser), data management for continuous medical records, and quality assurance to provide comprehensive, continuous, and coordinated care. Financing roles may include liaising with the purchaser for the disbursement of funds and the provision of claims.

**Tailoring Primary Care Models for Specific Contexts**

The array of factors to consider when deciding the features of the primary care model is vast. Contexts are variable and change often. However, it is possible to generally classify contexts into the following categories: urban, rural, geographically isolated and disadvantaged area (GIDA), conflict areas, and disaster-prone areas. Some postulations and recommendations on specific elements of the model can be made on this basis of these categories.

In highly urbanized areas, such as those classified as independent cities of the country, where populations are denser, using geographic catchment population methods may overestimate facility’s capacity. Where data is available, it is recommended that the effective catchment population of the primary care facility be measured and adjusted according to the facility’s actual capacity. Also because of a denser population of primary care providers, it may be easier to establish same-site polyclinics in this setting as compared to the rural areas. In the same way, a wider team composition may be considered, and the scope of work may be mapped so that the doctor, nurse, and midwife are not overburdened with work. Care pathways can explore assigning specific cases to additional members of the team (i.e. physical therapist, occupational therapist, specialized nurses) when available.

In rural and GIDA areas, the use of the straight-line method in determining the catchment population may underestimate the facility’s capacity. If a geographic catchment population method were to be used, travel time or distance method may be more appropriate where transit from a patient’s home to a facility may be a long way or may require travel by foot or unpredictable access to transportation. Further, in these areas where primary care providers are scarce, travel is inconvenient, and patients’ residences are scattered in difficult-to-reach areas, a networked polyclinic organization type may be more favorable
than a same-site organizational type. The team composition may be small, and thus the scope of work and care pathway must be re-evaluated to increase efficiency. The patient may not have to be seen by multiple primary care providers within the team, but only by those most appropriate for his/her case. It is also important to consider that many indigenous populations reside in these GIDA areas. Cultural norms and sensitivities may have specific effects in the provision of primary care to these populations.

In disaster-prone areas, additional considerations include building the capacity to provide immediate disaster response and relief at the primary care level. Majority of the victims of disasters are the poor who live in unsafe areas and vulnerable homes. Above immediate relief, the primary care system must be able to prepare for and withstand health risks as an effect of the disasters. For example, flooding can lead to a leptospirosis epidemic. (World Bank, 2011) Considering these, an ad hoc care pathway utilizing available team members may need to be established in preparation for disasters.

In conflict areas, there are unique travel and time considerations. Travel of both patients and providers may be limited to ensure safety. Time-curfews may also be present in certain military-occupied locations. Because of these limitations, a specific care pathway may have to be devised and negotiated with stakeholders beyond the care team in order to reach patients isolated due to surrounding conflict. In the same way as the GIDA areas, where transport of goods and services is a challenge, provision of the entire range and complexity of primary care services may not be realistic. The scope of services of these facilities should be re-explored, and an exercise of prioritizing services may be done.

There are many other factors unique to localities. Thus, to ensure that the adopted primary care models are appropriate and effective, it is best that these are discussed and designed by local providers, technical persons, and authorities themselves.

**Primary Care Provider Competencies**

Eight core competencies were initially culled out from literature review. The initial extracted competencies include: (1) providing first-contact care, (2) providing comprehensive care, (3) providing continuing care, (4) coordinating care, (5) navigating for patients, (6) managing patient records, (7) promoting health, and (8) implementing public health functions. The results of the initial review were presented to DOH-HHRDB and were supported for the next phase of validation.

Quantitative and qualitative data from key informant interviews, focused group discussions were triangulated to scrutinize each core competency and its behavioral manifestations. The summary of all comments and suggestions on the competencies are shown in Table 1 and the detailed contents of interviews and workshops are in Annex 2. The main themes from the interviews and discussions were also extracted and these were used to revise the competencies and/or its behavioral indicators (Table 2). One major change for example, is subsuming navigating for patients under coordinating care as it was assessed to overlap with coordinated care and implementation of public health functions.
Table 1. Feedback from Validation Interviews, FGDs and Workshops, October – November 2019

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Comments</th>
</tr>
</thead>
</table>
| Positive Feedback | – The competencies are aligned with the supposed tasks of primary care  
| | – All these competencies can be done by the health professionals if given proper training |
| Challenges | – Majority of health workers require training on information systems. Aging health workers shift away from using technology  
| | – There are some midwives who require training in interpersonal skills and use of EMRs  
| | – “not sure about DMD (dentists) at the moment, my understanding is they don’t do much population care”  
| | – Midwives and dentists need further capacity building  
| | – Can nurses give medications when doctors cannot be reached? |
| Suggestions and recommendations | – Technical clinical skills on first-contact care and comprehensive care should be guided by the assumption that they are working within their scope of practice  
| | – There is overlap of some core competencies: navigation and coordination can be the same thing, health promotion can be under comprehensive care, and managing patient records can be under coordinated care  
| | – Remove implementing public health functions as a competency as this will compete with primary care functions  
| | – Be inclusive and consider a setup with specialist doing primary care  
| | – Have a 2-3-day workshop to re-orient on primary care  
| | – There is a need for training of health systems management  
| | – Other competencies that can be considered may include transition management (multi-tier protocols or referral pathways) and clinical governance  
| | – Quality assurance should be considered as a core competency  
<p>| | – Public health specialists are necessary for health promotion and epidemiology |</p>
<table>
<thead>
<tr>
<th>Theme</th>
<th>Effect on the results</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 The performance of competencies depends on the scope of practice</td>
<td>The competencies are phrased generally so that they are applicable to different cadres Assumption: assessor should know scope of practice of the provider</td>
</tr>
<tr>
<td>2 Primary care providers may possess the competency, but external factors prevent performance of these</td>
<td>Standards were maintained but allowed some flexibility (i.e. competency on managing records did not restrict to EMRs alone)</td>
</tr>
<tr>
<td>3 Some competencies overlapped with each other (i.e. coordinating care and navigating patients)</td>
<td>Some competencies were combined, while ensuring crucial content was not lost; Some competencies remained separate on the basis of size of scope</td>
</tr>
<tr>
<td>4 There were queries if private providers should perform public health functions/competencies</td>
<td>Public health competencies were retained due to current existing roles especially in the public sector</td>
</tr>
<tr>
<td>5 The competencies can be acquired and performed if given the proper training</td>
<td>Recommend development of trainings to cover for these competencies and aid in certification in short-term.</td>
</tr>
<tr>
<td>6 Some competencies can be done by other health workers beyond the doctor, nurse, midwife</td>
<td>Recommendations include expanding certification in the long-term</td>
</tr>
</tbody>
</table>

**FINAL RECOMMENDED PRIMARY CARE PROVIDER COMPETENCIES**

Seven core competencies for primary care providers were considered after the literature search and conduct of validation. These core competencies are as follows:

- Providing first-contact care
- Providing comprehensive care
- Providing continuing care
- Coordinating care
- Managing patient records
- Promoting health
- Implementing public health functions
A competency model is provided for each of these competencies. The competency model is “a collection of the specific behaviors that effective individuals exhibit to achieve success in a particular role or group of roles.” (Root, 2018) In contrast to a job analysis or job description which only describes the functions to be performed, competency models describe actual job behaviors. The elements of the competency model include the following:

1. **The competency title and name:** this is the name or title of the competency being described.
2. **The competency definition:** this is a brief description of the competency to aid readers to understand the type of behavior expected of this competency.
3. **The behavioral indicators:** these are statements of what can be observed from individuals who possesses the competencies and shows what effective performance looks like.

**Core Competency Models**

1. **Providing first contact care**
   - **Definition:** the ability to provide health services within a time frame appropriate to the urgency of the health problem (Starfield, 2007)
   - **Behavioral indicators:**
     - Establishes an effective partnership with patients
     - Assesses and manages patient’s clinical condition within the scope of profession (i.e. midwife assesses and manages maternal and child health cases)
     - Administers appropriate initial treatment within the scope of the profession (i.e. nurse manages cases of diarrhea initially with oral rehydration solution)
     - Recognizes patients who require higher levels of care (within and outside of primary care facility)

2. **Providing comprehensive care**
   - **Definition:** the ability to provide a wide range of health services that meet the common needs across all life stages (Starfield, 2007)
   - **Behavioral indicators:**
     - Considers the patient's context in planning for care management (using the biopsychosocial approach)
     - Implements individual and population healthcare including health screening, diagnostic, therapeutic, and preventive measures within the scope of the profession
     - Counsels patients on general disease prevention and health promotion, including household remedies

3. **Providing continuing care**
   - **Definition:** the ability to provide a sustained partnership with the patient in the management of his/her condition (Starfield, 2007)
   - **Behavioral indicators:**
     - Sustains a harmonious and continuing relationship with patients and clients, especially those with chronic and persistent health challenges that can be managed at the primary care level
     - Plans for continuing care for patients with chronic conditions, post-discharge, and those referred back to primary care
4. Coordinating care
   *Definition:* The ability to transfer and share responsibility across disciplines and levels of care (Starfield, 2007)
   
   *Behavioral indicators:*
   - Refers to specialty care and higher levels of care as necessary
   - Guides patients in conduct of referrals for medications, diagnostic tests and services in the network
   - Participates in multi-disciplinary care and inter-professional care teams for patients when necessary
   - Communicates effectively with care providers within the facility and the health care provider network
   - Assists patients in navigating through other agencies and resources in the community

5. Managing patient records
   *Definition:* The ability to ensure coordination of care through accurate and timely integration of medical records in the healthcare provider network (RA 11223)
   
   *Behavioral indicators:*
   - Ensures quality of patient care records in terms of accuracy, completeness, reliability and timeliness using standard protocols
   - Maintains privacy and security of data
   - Demonstrates familiarity with the use of existing and mandated health information systems

6. Promoting health
   *Definition:* The ability to identify, describe, and implement programs, policies, and other health promotion interventions that are empowering, participatory, holistic, intersectoral, equitable, sustainable, and multi-strategic in nature, which aim to improve health (WHO, n.d.)
   
   *Behavioral indicators:*
   - Understands fundamental concepts of health promotion and disease prevention within the scope of the profession, including national and international health goals
   - Effectively communicates with patients, families and communities on practices that promote health by contextualizing the health information to their needs
   - Implements strategies that promote inclusivity to identified vulnerable groups, and improves their access to primary care, considering their unique health needs

7. Implementing public health functions
   *Definition:* The ability to implement public health/population health services as mandated by the Department of Health (RA 11223)
   
   *Behavioral indicators:*
   - Demonstrates knowledge on the basic concepts of public health surveillance and applies them appropriately on the health concerns of the community
   - Implements public health functions, measures their progress and results, and effectuates a feedback mechanism
   - Engages community leaders and stakeholders in the implementation of programs
The first five competencies are expected to be performed by individuals. However, the last two competencies on promoting health and implementing public health functions are expected to be performed by a health team usually consisting of a physician, nurse and midwife. For example, doctors or nurses may take on more technical skills such as data analysis of epidemiologic data, which is not expected from midwives.

**COMPETENCY TOOL**

The competency assessment tool (Annex 3) is a checklist which details the key behaviors that must be observed or verified through records during assessment. The tool has a part for identifying data and the checklist for the indicators required for the competency. The tool is intended to be formative in focus and provides the candidate information on competency gaps that may be addressed through learning and development interventions. **Two means of verification (MOV) –** either through (1) **direct observation** or through (2) **records review** will be used to verify the behaviors from each health worker. An affirmative check on either MOV implies that the behavior is manifested by the primary care health worker.

Observation of the health worker with patients can be done in 30 minutes to an hour. About 5-7 patients can be seen by a health professional during that period and that number will suffice for observing competencies related to first-contact care, comprehensive care, continuing care, coordinated care, health promotion for individuals, and managing patient records. However, it is best to conduct records review on activity reports for health promotion for communities and for implementing public health functions.

The records (existing and standard) that were deemed useful include the following:
- Individual treatment record (ITR)
- Electronic medical record (EMR)
- Target Client List (TCL)
- Activity reports
- Logbook of referrals
- Awards
- List of trainings or certificate of trainings

Reviewing records take a longer time at around 1-1.5 hours. It is best that the health workers have prepared these records beforehand to save time. Other documents may provide some information but were deemed not useful during validation such as the Individual Employee Performance and Commitment Review (IPCR). However, it is best to refer to these other records if they are deemed relatable to the identified behaviors. Other records that may be used include feedback reports from clients and through social media, patient feedback surveys, minutes of meetings, co-authored policies or ordinances, learning materials developed by the health worker, technical reports, or published academic worker.

**Assumptions and Limitations**

Factors that must be considered when using records review as a means of verification include the availability of the record and the completeness or accuracy of the record for the identified behavior. On the other hand, observation requires that the health worker and the patients are amenable for observation. In addition, the assessors must be knowledgeable about the standards of the behaviors based on the scope of practice of each profession. Hence, assessors must be knowledgeable of terminologies, best practices, and the technical
knowledge and skills required for the tasks. Furthermore, it is best that the assessor recognizes the language used by the health worker and patients (context and area specific). Finally, the means of verification can be subjective dependent on the standards recognized by the assessor. Hence, this may be prone to bias on the side of the assessor.

During the validation, the study team was unable to determine if any health worker would be able to pass all the items in the checklist as there were competencies that are impossible to observe with just one visit. In addition, although health workers verbalize that they are doing the required behaviors, it was not feasible to objectively confirm these as they were not able to provide the necessary records as evidence of performance.

Ideally, a health worker is certified as a primary care health worker if all of the behavioral indicators are met for all core competencies.

IV. DISCUSSION

PRIMARY CARE MODELS AND PROVIDER COMPETENCIES

Primary care provision in the country remains inadequate due to poor performance of primary care delivery in some LGUs affected by the lack and fragmentation of formal referral and gatekeeping mechanisms, inadequate funding for primary care, and inadequacy of health human resources in numbers and competencies. Certification of primary care providers, as mandated by the UHC law, seeks to address this need to improve the competencies of primary care providers. On the other hand, the primary care models offer flexibility on the types of health professionals to be considered in the network and how care pathways can vary depending on the persons available and the need of the population. Lastly, the recommended competencies for primary care are drawn from existing frameworks and outputs of studies which are currently implemented on a limited pilot basis in selected areas of the country. The suggested tool developed includes some identified means of verification that are based on the content validity and feasibility of applying the competency assessment tool.

The core competencies for primary care health workers were formulated based on previous work done by the DOH-HHRDB. These competencies were supplemented by additional literature and validation from workshops. The identified primary care competencies are (1) providing first-contact care, (2) comprehensive care and (3) continuing care, (4) coordinating care, (5) managing patient records, (6) promoting health, and (7) implementing public health functions. These core competencies are carried out in various degrees of sufficiency particularly in the public sector; however, additional training was deemed necessary in carrying out these competencies. Additional training on basic clinical skills for maternal and child health, computer literacy, information management, and health systems management were noted to be necessary to enable performance of these behaviors. In addition, health workers require additional infrastructure to adequately carry out these competencies. The lack of hardware (computers), EMR and internet connection were consistently identified as chronic problems especially in the remote and rural areas. Hence, the health workers find it difficult to perform the competencies required on managing patient records.

It should be emphasized that the mere availability of health workers is not sufficient. The recommended range of comprehensive primary care services can only be effective and
impactful when health workers possess the necessary knowledge, skills and attributes described under the identified primary care competencies. In addition, a more equitable and rational distribution of the health workforce are important enablers to ensure that these services are available and accessible to the population. These factors contribute to a motivated and empowered workforce to ensure the delivery of quality care adequately supported by the health system (WHO, 2016). Hence, while competencies are only part of assuring that the health worker has the ability to perform the tasks required of the job, other aspects of health human resource and the primary care provider network infrastructure must be monitored to ensure effective delivery of services.

Task shifting in a primary care provider network can potentially address the health workforce crisis. However, task shifting alone is not expected to resolve this dilemma. The recommendations stress that task shifting should be implemented alongside other strategies that are designed to increase the total number of workers in all cadres. Furthermore, if task shifting will be considered in a primary care model, the countries should define the roles and the associated competency levels required for existing cadres who are extending their scope of practice (WHO, 2008).

In preparing the health workforce, the curriculums for the training of health professionals are expected to meet standards that are often defined as core competencies. Beyond this, the curriculums must be responsive to the changing state of knowledge in health and the needs and demands emerging from health systems, including consumers’ expectations (WHO, 2006). In light of the UHC, the health professions curriculums are to be primary-care oriented. While the current CHED memorandum orders for the training of physicians, nurses and midwives includes primary care, the shift towards a more primary-care oriented curricula versus its current hospital-centric nature should be developed and emphasized.

Lastly, it is crucial to encourage health professionals to undertake lifelong learning and develop relevant workplace competencies. New trends in education aim to improve public health by integrating practice-based teaching, problem-based learning, and patient-focused practice (WHO, 2006). These types of training methods ought to be considered in the retraining of existing health professionals as they evolve into the needed primary care providers as mandated by UHC.

**PRIMARY CARE COMPETENCY CERTIFICATION**

In the development of the competency assessment tool, different means of verification provide their own value and drawbacks. Multiple assessment methods were identified including on-site job sample or observation, job simulation, records review, computerized or written test, and performance appraisal, among others (Kak, 2010). Each method varies in terms of replicability, approximation to real life situation, practicability in terms of time and timing, amount of resources required, and potential bias.

For the assessment of primary care competencies, written/computerized tests do not seem appropriate as they only measure knowledge but little of performance and application of knowledge (Jansen et al. 1995; Sloan et al. 1993). On the other hand, while job simulation or OSCE type of examination is ideal, it requires a significant amount of resources and preparation that may not be operationally feasible considering the limitation of time and resources (Colliver and Williams 1993; Elnicki et al. 1993; Stillman et al. 1986). A reasonable alternative for job simulation is on-site observation which still approximates real-life situations. This, however, requires more time for assessment as an opportune time to observe all the behavioral manifestations is necessary.
It is acknowledged that not all situations can be observed in a short amount of time. Thus, records review, despite its inability to approximate real-life situations, is necessary to augment for what cannot be observed at the time of assessment. Records however are also limited considering that behaviors and processes are often not completely documented in records (Franco et al. 1997; Hermida et al. 1996; Norman et al. 1985). In order to address this, primary care providers can be made aware beforehand of the documents they are to prepare for certification. This will allow them time to complete their documents.

As the UHC Law rolls out in the next ten years, it is foreseen that the need for primary care certification will decrease particularly if the recommendations for curricular modifications of the various health professions is carried out. It is hoped that ten years from full implementation of the law, all graduates of health profession courses are sufficiently and satisfactorily trained and educated with a strong focus on primary care delivery within the philosophy and principles of primary health care.

V. RECOMMENDATIONS FOR PRIMARY CARE CERTIFICATION

PROPOSED CERTIFICATION FRAMEWORK

Under the UHC Law, only those who received post-graduate primary care certification from the DOH, and PRC will be considered primary care providers. In the process of certification, there are five essential elements or steps to be considered (Figure 8).

Figure 8. Certification Framework Process.

The succeeding recommendations are guided by the five steps of the certification framework:

RECOMMENDATION 1: ORIENT HEALTH EDUCATION AND PROFESSIONAL LICENSING TOWARDS PRIMARY CARE

The law institutionalizes the board which regulates the profession. The curriculum for each of the professions is approved and standardized by the Commission on Higher Education. Graduates of the program take a licensure examination to ensure adequacy of training and authority to practice their profession. Passers are hereby licensed as professionals recognized by the Philippine Professional Regulatory Commission (Table 2).
### Table 2. Education and Licensing of Health Professionals

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Medicine</th>
<th>Nursing</th>
<th>Midwifery</th>
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<tbody>
<tr>
<td>Curriculum Development</td>
<td>Commission on Higher Education</td>
<td>Commission on Higher Education</td>
<td>Commission on Higher Education</td>
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<tr>
<td>Requirements for Licensure</td>
<td>Graduate of Medicine</td>
<td>Graduate of BS Nursing</td>
<td>Graduate of BS Midwifery</td>
</tr>
<tr>
<td>Regulatory Body for Licensure Examinations</td>
<td>PRC Board of Medical Education</td>
<td>PRC Board of Nursing</td>
<td>PRC Board of Midwifery</td>
</tr>
<tr>
<td>Certificate of Registration/ Licensing</td>
<td>Professional Regulatory Commission</td>
<td>Professional Regulatory Commission</td>
<td>Professional Regulatory Commission</td>
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</table>

Health education in the Philippines capacitates individuals to have the necessary knowledge, skills, abilities, and traits to comply with the requirements for licensing to practice the profession. While the curriculum set by CHED and professional laws that mandate the scope of the profession certainly does have elements of the core competencies of primary care such as first-contact, coordination, comprehensive, and continuing care (especially for doctors, midwives, and nurses), most health workers are not primary-care oriented nor primary-care ready. One reason is that the contents of board examinations do not cover a substantive amount of primary care competencies. Another reason is that the mode of assessment for licensure, which is examination, can only substantially assess the knowledge aspect of a competency.

A comprehensive review and revision of health education to incorporate primary care will be necessary to address the need of a primary-care oriented curricula. Collaboration among DOH, PRC and CHED will be necessary to revise the content and examinations required for licensing. A task force led by CHED will be necessary per cadre to perform these functions of review, revisions and approvals from boards of various health professionals. Likewise, the boards of each health profession should begin their discussions on these revisions on their CHED memorandum orders or in their own professional laws. It should be noted, however, that the development of the curriculum will take around 5 years. It is envisioned that the successful implementation of a primary care curricula may cause the certification process to slow down or decrease, 10 years after UHC. By then, all graduates are expected to be able to deliver primary care services.
RECOMMENDATION 2: CONSIDER DIFFERENT POST-GRADUATE PRIMARY CARE TRAINING AND EDUCATION OPTIONS

While there are efforts to conduct postgraduate training and education for primary care competencies, these are seemingly programmatic and are clinically oriented. In addition, there is no existing integrated training system for primary care that can address the needs of all health professions.

The main training needs verbalized from FGD participants include basic clinical skills on integrated management of childhood illness (IMCI), basic life support (BLS) and basic emergency maternal, obstetric and newborn care (BEmONC), computer literacy, and health promotion. A training design, which includes these and all other identified primary care competencies, should be developed in the future. The options for the training design may either be any of the following: (1) incorporation in the health education curriculum, and/ or (2) institutionalize primary care as a specialty in the country.

Incorporation of primary care in the curricula will remove the need of additional post-graduate training. However, this will take some time and it will take at least 10 years to discern observable manifestations of its effect. In the interim, training designs which may be 2-3-day workshops or trainings may be necessary to (re)orient the existing health professionals on primary care basic core competencies. Likewise, new graduates and specialists who would like to become primary care providers should take these workshops and present a validation that majority of their activities are primary care related. Due to the urgency of implementing the UHC Law, it is best to be inclusive in the interim and consider all existing health workers – both in the public and private sector. Hence, basic knowledge and skills on these core competencies may suffice through short workshops. These workshops should be developed guided by standards mandated by the DOH, in collaboration with experts in primary care from the relevant health professions (specifically, physicians, nurses and midwives).

Another option is to institutionalize primary care as an expert field of practice. For the physicians’ sector, this is already being implemented in the country by the Philippine Academy of Family Physicians, the Philippine Society of General Internal Medicine, and the Philippine Ambulatory Pediatric Association, Inc through board certification in their respective societies. The residency training, for example, is envisioned to contribute to the creation of a cadre of primary care physicians with attributes and competencies considered to be significant as compared to a general physician thus improving the standards of quality health care (Molla, 1996). Furthermore, graduate education training provides opportunities for a robust outpatient practice and prepares them for independent work and certification. In the long run, the standards for quality of care in primary care may be set at a higher level and additional post-graduate training will be best to address this. Planning on post-graduate degree training may be initiated by the DOH-HHRDB working with appropriate Technical Working Groups whose membership should include representatives from CHED, academia and professional societies.
RECOMMENDATION 3: BUILD DOH CAPACITY TO MANAGE COMPETENCY ASSESSORS AND EVALUATE COMPETENCY ASSESSMENT METHODS

Creation of a primary care provider certification task force within the Department of Health. The certification of primary care providers is a significant new role to be taken on by DOH. Presently, no dedicated unit is responsible for the certification of primary care providers. This unit will have the following roles: setting of criteria for assessors, recruitment of potential assessors, screening of assessors, orientation of assessors, awarding of primary care provider assessors’ certificates, awarding of primary care provider certificates and review of appeals from unsuccessful primary care provider applicants. This unit is best integrated within the HRH masterplan and considered in the Health Human Resources Development Bureau restructuring. It may also be considered as a semi-independent body attached to the department.

Recruitment of assessors. Considering the DOH’s lack of structural and technical capacity to perform the assessment of all primary care providers themselves, it is recommended that individual assessors be recruited into an official pool. Instead of identifying a single professional society or institution as the sole assessor, individuals can be recruited regardless of affiliation. In this manner, the assessor pool’s capacity and diversity will not be limited.

Guidelines and criteria to be used as basis for the recruitment of assessors should be determined and must correspond to the terms of reference of an assessor. It is recommended that each professional be assessed by another professional in the same cadre, preferably an expert in the field by virtue of level of training and experience. In deciding such criteria, the following must be considered: years of experience in primary care, roles and responsibilities while working in primary care, and must himself/herself possess and demonstrate performance of the competencies indicated in the assessment tool.

Engaging different types of assessors present with advantages and disadvantages. Figure 9 below presents dimensions with regards the types of assessors. The use of multi-source performance appraisals (e.g., 360-degree feedback) suggests that evaluative information from many sources provides a more complete picture of performance than evaluations from only one perspective (Franco et al. 2000). However, multi-source appraisals reveal challenges in feasibility. Considering the limitations, an expert rater or assessor screened by the HHRDB should be sufficient.

Figure 9. Advantages and Disadvantages of Different Types of Raters (Kak et al., 2000)
Orientation of assessors. While the assessment tool is user-friendly, the pool of assessors must be oriented to its parts such as the eight core competencies, the means of verification used, and the logistical requirements of utilizing the tool. This on-boarding is necessary to ensure that assessors know what to observe and evaluate, as well as maintain the standards of competence. This orientation must be standardized to encourage fidelity to the tool and reduce impartiality and bias among assessors.

Assessment by assessors. The tool presented in Annex 2 is the recommended competency assessment tool. It uses existing modes of assessment such as observation or job sample and documents review, which includes records and performance appraisal.

Observation/Job sample

Observation allows the assessor to evaluate provider performance in an actual job setting. However, variability of competencies that can be observed are limited to what the patient’s case presents (Ready, 1994). Quality of service varies from one patient to another (Stillman et al. 1986).

Nevertheless, a single observation within 30 minutes to one hour can provide a substantial amount of data regarding a provider’s multiple competency and may provide a more holistic view on a provider’s overall assessment.

Review of medical records

Medical records provide an objective means of assessing competency. Data can be obtained retroactively and are relatively low cost compared to other methods. Data collection is less prone to observer bias or the halo effect.

However, effectiveness cannot be gauged well from records since there are currently no well-established means of rating provider performance such as client satisfaction surveys.

Performance appraisals

Periodic appraisal by supervisors or peers and self-assessment can also be used to infer competence. Self-assessment using pre-structured checklists to reduce bias when identifying areas of poor performance is suggested (Bose et al.).

Performance appraisals usually come in the form an individual performance commitment review which is pre-filled by the provider and vetted by a superior. However, insights from stakeholder consultations show that the IPCR is prone to bias since providers are incentivized to “oversell” their qualifications in order to gain bonuses. Overselling of qualifications was admittedly done by most providers and accepted as common practice. Hence, there may be a need to triangulate/validate IPCR findings or create a separate performance appraisal form for primary care competencies.

Activity reports on accomplishments can also be a means to gauge a provider reaching his/her target in a specific program. However, if there is low demand for the intervention as affected by social, economic, and cultural factors, reaching targets may prove to be problematic and may be a poor reflection of provider performance.

Other modes of assessment are also available, and thus the means of verification used in the competency assessment tool may be expanded in the future. Each mode presents its advantages and disadvantages as shown in the table below.
While the tool currently has no means of evaluating primary care proficiency, it can, at the minimum, evaluate if the provider has the primary care competency. Hence, it is advisable that only those who meet all the competencies can be certified.

If upon assessment certain competencies are not met, a recommended window period of six to twelve months to obtain the necessary training/refreshers to meet the competency should be provided. After which, the provider can apply for re-assessment.

It is also important that the list of competencies and the means of verification is transparent to the primary care providers or health workers prior to applying for certification. Providing them these in advance allows them to self-evaluate their competencies and facilitate the necessary preparations for the records needed for review.

**Evaluation of competencies and competency assessment tool.** Feedback on the list of competencies and the competency assessment tool should be elicited regularly. It is recommended that they be reviewed every three (3) years and refined as necessary. This is especially crucial in the first few years of roll-out. The competencies can be evaluated in terms of their validity in capturing ability and proficiency for primary care provision. The competency assessment tool can be evaluated in terms of its feasibility in the field.

**Recommendation 4: Gradual Implementation and Regular Evaluation of the Certification Process**

**Roll-out of certification.** Based on the provision of RA 11223, the certification process is a responsibility to be undertaken and supervised by the DOH. Considering the limitations and breadth of responsibilities within the DOH, it is recommended that the responsible unit (HHRDB) may accredit individuals, professional societies, and organizations as assessors compliant with the accreditation requirements to be established and accepted as the standard based on the competency assessment guide.

Rolling out this provision of the law will be progressively realized because of the need to modify in a significant way the various curriculums of the various health professions. For the first five (5) years, it is recommended that at least one (1) primary care provider per
primary care facility be certified. This allows facilities to improve infrastructure and capacitate providers to achieve primary care competencies in order to be certified. This will enable facilities to adequately provide the primary care benefit package and receive payments. By the sixth (6th) year, mandatory certification for all primary care providers can be required in order to be contracted as part of a health care provider network and receive capitation payments per facility.

The validity of the certification may be aligned to the PRC license validity, hence the need to obtain CPD units and renew certification every three years.

**Evaluation of the certification process.** A routine review of the certification process is recommended to be done every three (3) years. This will enable the identification of challenges and barriers as well as the formulation of necessary incentives to improve the feasibility of certification and at the same time ensure the quality of primary care provider performance.

**RECOMMENDATION 5: LINK THE MAINTENANCE OF CERTIFICATION WITH CPD REQUIREMENTS FOR LICENSE RENEWAL**

**Arrangement with PRC regarding primary care training for CPD units.** Continuing Professional Development (CPD) ensures that professionals are up to date to continuously improve in their field. CPD courses must be able to facilitate efficient, effective, and evidence-based learning.

Harmonizing the CPD law with primary care provider certification, which requires 15 units (or credit hours) every three years, may be linked to the maintenance and renewal of certification. It is recommended that a good mix of CPD units is based on the core competencies as a primary care provider and should be required for re-certification. This means that at least 1 credit unit/ hour should be obtained for each core competency.

For monitoring to be easier, arrangement with PRC to accredit CPD units for primary care training is advised. Furthermore, a list of possible courses with corresponding CPD units per competency may be uploaded in the DOH website. These can notify providers which trainings or lectures can be used for maintenance of certification. In addition, establishing a system that helps primary care providers track their CPD units per competency will facilitate the primary care re-certification process. This can be done in the first three (3) years.

**Roll-out of maintenance of certification.** After establishing the maintenance of certification process during the first three (3) years, roll-out may be done. It is recommended that prompts for certified primary care provider whose license needs to be renewed be notified when their certification will expire to remind them to renew both their license and the primary care certification.

A competency tool with proficiency levels will help to ensure links to provider payments such that higher proficiency can be linked with provider payments. Thus maintenance of certification by acquiring advanced training can be a means to further elevate the quality of primary care and provide a clear career growth as well for providers.
VI. FINAL WORDS

This report on the technical assistance towards the development of a primary care certification framework contributes to the roll out and implementation of key provisions of R A 11223 through the following key result areas:

A. Review of the Current State of Primary Care Provision in the Philippines – reveals a chronically fragmented health care delivery system that is further aggravated because of challenges brought about by a devolved health system. This has led to irrational health seeking behavior among many Filipinos especially among the poor and marginalized sectors.

B. Elements of Primary Care Models – Literature review indicates that there is no “plug-and-play” model of primary care facilities that may be implemented. The heterogeneity in social, economic, political and cultural circumstances across the country requires that applicable models are shaped according to local settings. There are six elements of primary care models that need to be considered, to wit: population reach, scope of services, organizational type, team composition & scope of work, care pathway and governance. The appropriate mix of these elements must be aligned with the local circumstances to ensure appropriate primary care models to deliver the comprehensive primary care benefit package that is set to be rolled out under the UHC Law.

C. Primary Care Provider Competencies – Taking off from the B. Starfield et al (2005) definition of primary care, 7 foundational competencies are proposed. These core competencies represent the necessary knowledge, skills and attributes that trained and licensed health professionals should possess in order to ensure the adequate and sufficient delivery of quality primary care. Although training of health professionals, particularly physicians, nurses and midwives, indicate outcomes that are aligned with primary care, there is a recognized need for many current health professionals to undergo re-orientation and training to focus on the delivery of primary care and thus, the successful implementation of the UHC Law.

D. Primary Care Certification Framework and Tool – In light of the above, there is an urgent need to certify a sufficient number of health professionals as primary care providers that are envisioned to be part of a primary care provider facility. The providers will be part of a health care provider network that PhilHealth will contract and paid. This project is proposing a certification framework and tool that can be used in the progressive realization of the UHC Law. In order to be able to go about ensuring the success of this endeavor, aside from the certification tool, there is also a need to re-visit the curricula of the different health professions to ensure that primary care must take a central role in the training of future health professionals.

In summary, the DOH must initiate discussions towards the review of the health professions curricula to make it primary-care oriented, consider options and design for training of primary care providers in the interim and in the future; create policies and pool assessors within the DOH; monitor and evaluate the progress of certification; and ensure that certification is linked with continuing professional development. A project brief (Annex 4) is being suggested to inform stakeholders on primary care provision.

Finally, a Primary Care Provider Competency Certification Timeline is recommended to carry out this effort in a sustained manner.
Figure 11. Primary Care Provider Competency Certification Timeline

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<th>Primary Care Provider Competency Certification Timeline</th>
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<tr>
<td>Health Education</td>
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<tr>
<td>Review and alignment of Health Curricula to Primary Care</td>
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<td>Collaboration of DOH, PRC, CHED for PC CMOs and Board Examination content</td>
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<tr>
<td>Post Graduate Education and Training</td>
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<tr>
<td>Option 1: PC Certification phased out in 10 years</td>
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<tr>
<td>Create/ re-align trainings for PC</td>
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<tr>
<td>Administer PC trainings</td>
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<td>Option 2: Elevate PC as a specialty</td>
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<tr>
<td>Create post-graduate courses and residency for PC specialty</td>
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<tr>
<td>Competency Assessment</td>
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<tr>
<td>Create DOH AO on PCP Competency Certification</td>
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<tr>
<td>Identifying/ Enlisting pool of Assessors</td>
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<tr>
<td>Orientation of Assessors</td>
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<tr>
<td>Certification of Assessors</td>
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<tr>
<td>Create HHRDB unit for screening, review, and award of certificates</td>
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<tr>
<td>Review and Evaluation of Competencies and Competency Assessment Tool</td>
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<tr>
<td>Certification</td>
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<tr>
<td>Roll-out of Certification (at least one PCP certified per PCF facility)</td>
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<td>Mandatory PCP Certification</td>
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<td>Evaluation and Review of Certification Process</td>
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<td>Maintenance of Certification</td>
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<td>Arrangement with PRC regarding primary care training for CPD units</td>
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<td>Roll-out of mandatory maintenance of certification</td>
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ANNEX 1. DISCUSSIONS WITH DOH-HHRDB, KEY INFORMANT INTERVIEWS AND FOCUSED GROUP DISCUSSIONS

Consultation with DOH-HHRDB

(October 14, 2019 at DOH-HHRDB Conference Room)

Agenda: Follow-up meeting for the study on “Development of Competency Certification Framework for Primary Care Provider in the Context of UHC”

Key Members:

Dr. Pretchell Tolentino, Ebenezer Bonbon, Roberto Matala (DOH-HHRDB)
Dr. Kim Patrick Tejano (DOH-FICT), Eileen Diane Cheng -Fernandez (OCS)
Dr. Marife Yap, Dr. Louella Carpio, Viviene Apostol (Thinkwell LLC, Philippines)

There were 8 core competencies that were presented to DOH-HHRDB:

- Providing first-contact care
- Providing comprehensive care
- Providing continuing care
- Coordinating care
- Navigating for patients
- Managing patient records
- Promoting health
- Implementing public health functions

The mapped competencies were presented to DOH-HHRDB and were supported positively by the bureau. It was also agreed that a yes/no tool will be used for the interim and that these competencies should be validated by consultations.

Key Informant Interview 1: Primary Care Expert

(November 4, 2019)

Agenda: Consultation on the 8 identified core competencies

Key Informant Interviewee: Dr. Antonio Dans, Dr. Raffy Marfori (Philippine Primary Care Study Group)
Interviewees: Dr. Marife Yap, Dr. Louella Carpio (Thinkwell LLC, Philippines)

Recommendations:

- There is overlap of some core competencies and these can be collapsed into one:
  - Navigation and coordination can be the same thing
  - Health promotion can be under comprehensive care
  - Managing patient records can be under coordinated care
- Their group (PPCS) simplified the core functions to four (first-contact, coordinating, coordinated, continuous) to make it a common language. Expanding these 4 functions will further complicate it for the health workers. Furthermore, having 8 functions can restrict the numbers or volume of qualified primary care providers.
- It was recommended to remove the competency “implementing public health functions” as this will compete with the primary care functions. This is somewhat related to delineating primary care from primary health care.
It was recommended not to be exclusive; consider the current setup with specialists doing primary care and certify with a minimum set of competencies. In 10 years’, primary care can be a specialty with key competencies.

It was also recommended to have a 2- or 3-day workshop to re-orient on primary care.

**Key Informant Interview 2: Primary Care Expert**

(November 8, 2019)

Agenda: Consultation on the 8 identified core competencies

Key Informant Interviewee: Dr. Policarpio Joves, Dr. Zorayda Leopando (PAFP)

Interviewers: Dr. Marife Yap, Dr. Louella Carpio (Thinkwell LLC, Philippines)

**Recommendations:**

- There are overarching competencies that must be included such as ethical considerations, professionalism, lifelong-learning, quality assurance and network of management
- The spectrum of care should include those that can be delivered at home, clinic or hospital; and must include palliative and rehabilitative care
- Implementing comprehensive care should be specified for the doctor, nurse and midwife
- The primary care provider should not only be an implementer but also someone who designs and innovates public health programs

**VALIDATION FOCUSED GROUP DISCUSSIONS**

**Validation Workshop in Antique**

A validation workshop took place at Antique on November 12-13, 2019. The objective of the validation workshop and visit was to confirm and obtain an agreement with the primary care workers on the competency descriptions for the primary care providers.

The following activities were planned:

- Introduction and Rationale of Validation Workshop
- Grouping according to profession
- Groups to review and confirm the competencies for primary care providers
- Pilot test the competency assessment tool in select RHUs

Two consecutive FGDs were conducted. The first FGD was conducted in the morning with nurses and midwives while the second FGD in Antique was conducted with MHOs and a DMO from Antique. On the second day, 2 RHUs (San Jose de Buenavista and Sibalom, Antique) were visited to assess the feasibility of the competency assessment tool. Nurses and midwives were inquired on the records that may possibly verify the behavioral indicator for a primary care provider. An informed consent was solicited from each health worker who was tested with the tool.

**Program**

November 12, 2019 in San Jose de Buenavista, Antique

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<td>Time</td>
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<td>Primary Care Providers in the UHC Context</td>
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<td>Presentation/ Overview of Competencies</td>
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<td>Individual work on competencies</td>
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<td>Group work on competencies</td>
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<tr>
<td>12:00 PM</td>
<td>Group presentations</td>
</tr>
<tr>
<td>12:30 PM</td>
<td>Synthesis and Closing</td>
</tr>
<tr>
<td>12:45 PM</td>
<td>LUNCH</td>
</tr>
</tbody>
</table>

**Part 2: MHOs**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>In-Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>1:30 PM</td>
<td>Registration</td>
<td></td>
</tr>
<tr>
<td>2:00 PM</td>
<td>Prayer and National Anthem</td>
<td>Ms. Viviene Cen Apostol</td>
</tr>
<tr>
<td>2:10PM</td>
<td>Welcome Remarks</td>
<td>Dr. Maria Eufemia Yap</td>
</tr>
<tr>
<td>2:15PM</td>
<td>Introduction to ThinkWell</td>
<td>Dr. Madeline Mae Ong</td>
</tr>
<tr>
<td>2:20PM</td>
<td>Primary Care Providers in the UHC Context</td>
<td>Dr. Madeline Mae Ong</td>
</tr>
<tr>
<td>3:00PM</td>
<td>Presentation/ Overview of Competencies</td>
<td>Dr. Louella Carpio</td>
</tr>
<tr>
<td>3:15 PM</td>
<td>Individual work on competencies</td>
<td></td>
</tr>
<tr>
<td>3:45 PM</td>
<td>Plenary Discussion on competencies</td>
<td></td>
</tr>
<tr>
<td>4:20 PM</td>
<td>Synthesis and Closing</td>
<td>Dr. Maria Eufemia Yap</td>
</tr>
</tbody>
</table>

**Validation Workshop in Manila**

A validation workshop was next conducted in Manila on November 15, 2019. The objective of the validation workshop was to solicit comments on the primary care models, confirm and obtain agreement on the primary care provider competencies, and generate comments and suggestions on the competency framework.

**Program of Validation Workshop in Manila**

(November 15, 2019 at Hotel Jen, Manila)

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>In-Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:00 AM</td>
<td>Registration</td>
<td>ThinkWell Team</td>
</tr>
</tbody>
</table>
### Validation Workshop in Iloilo

A third validation workshop and competency tool testing took place in Iloilo on November 21-22, 2019. The objective of the validation workshop and visit was to confirm and obtain an agreement with the primary care workers on the competency descriptions for the primary care providers, and further assess the feasibility of the revised competency assessment tools as informed from the suggestion in Antique.

The following activities were planned:

- Introduction and Rationale of Validation Workshop
- Grouping according to profession
- Groups to review and confirm the competencies for primary care providers
- Pilot test the competency assessment tool in select RHUs
- Groups to review and comment on the competency assessment tool

### Program of Validation Workshop in Iloilo

(November 21 – 22, 2019 at Punta Villa Resort, Antique)

#### Day 1

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>In-Charge</th>
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<tbody>
<tr>
<td>9:00 AM</td>
<td>Registration</td>
<td>ThinkWell Team</td>
</tr>
<tr>
<td>9:30 AM</td>
<td>Prayer and National Anthem</td>
<td>Ms. Viviene Cen Apostol</td>
</tr>
<tr>
<td>Time</td>
<td>Activity</td>
<td>In-Charge</td>
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</tr>
<tr>
<td>9:40AM</td>
<td>Preliminaries to the Workshop</td>
<td>Dr. Gelo Apostol</td>
</tr>
<tr>
<td>9:45AM</td>
<td>Introduction to ThinkWell</td>
<td>Dr. Gelo Apostol</td>
</tr>
<tr>
<td>10:10AM</td>
<td>Primary Care Providers in the UHC Context</td>
<td>Dr. Gelo Apostol</td>
</tr>
<tr>
<td>11:00AM</td>
<td>Presentation/ Overview of Competencies</td>
<td>Dr. Madeline Mae Ong</td>
</tr>
<tr>
<td>11:15 AM</td>
<td>Individual work on competencies</td>
<td></td>
</tr>
<tr>
<td>12:00 PM</td>
<td>LUNCH</td>
<td></td>
</tr>
<tr>
<td>1:30 PM</td>
<td>Group work on competencies</td>
<td></td>
</tr>
<tr>
<td>2:30 PM</td>
<td>Group presentations and plenary</td>
<td></td>
</tr>
<tr>
<td>3:30 PM</td>
<td>Presentation of certification framework</td>
<td>Ms. Viviene Cen Apostol</td>
</tr>
<tr>
<td>4:00 PM</td>
<td>Synthesis and Closing</td>
<td>Dr. Gelo Apostol</td>
</tr>
</tbody>
</table>

**Day 2**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>In-Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:30 AM</td>
<td>Prayer</td>
<td>Ms. Viviene Cen Apostol</td>
</tr>
<tr>
<td>8:35 AM</td>
<td>The Competency Assessment Tool and Pilot-Testing Instructions</td>
<td>Dr. Louella Carpio</td>
</tr>
<tr>
<td>9:00 AM</td>
<td>Deployment in 3 RHUs: Oton, Sta. Barbara, and Manduriao</td>
<td></td>
</tr>
<tr>
<td>9:30AM</td>
<td>RHU courtesies Pilot-testing of competency assessment tools</td>
<td>Participants</td>
</tr>
<tr>
<td>11:30AM</td>
<td>Return to Workshop Venue</td>
<td></td>
</tr>
<tr>
<td>12:00 PM</td>
<td>LUNCH</td>
<td></td>
</tr>
<tr>
<td>1:00 PM</td>
<td>FGD on the competency assessment tool</td>
<td></td>
</tr>
<tr>
<td>2:30 PM</td>
<td>Synthesis and Closing</td>
<td>Dr. Louella Carpio</td>
</tr>
</tbody>
</table>
ANNEX 2. PROJECT BRIEF

PROJECT BRIEF

Development of a Competency Certification Framework for Primary Care Providers in the Context of Universal Health Care in the Philippines

What is the certification for primary care providers?
Certification is a process by which the DOH awards a certificate to individuals who have demonstrated competence in a specialty area beyond the minimum requirements set for licensure, have additional education and training mechanisms to practice primary care. The certification process is DOH-supervised, with performance criteria, and assessment processes established and accepted as standard across all primary care facilities.

Competency entails having and demonstrating the “knowledge, skills, abilities, and traits” to successfully and effectively deliver high-quality services.

THE 7 CORE COMPETENCIES OF PRIMARY CARE PROVIDERS

INDIVIDUAL COMPETENCIES

PROVIDING FIRST CONTACT CARE
the ability to provide health services within a timeframe appropriate to the urgency of the health problem

PROVIDING COMPREHENSIVE CARE
the ability to provide a wide range of health services that meet the common needs across all life stages

PROVIDING CONTINUING CARE
the ability to provide a sustained partnership with the patient in the management of his/her condition

COORDINATING CARE
the ability to transfer and share responsibility across disciplines and levels of care

MANAGING PATIENT RECORDS
the ability to ensure coordination of care through accurate and timely integration of medical records in the healthcare provider network

TEAM COMPETENCIES

PROMOTING HEALTH
the ability to identify, describe, and implement programs, policies, and other health promotion interventions that are empowering, participatory, holistic, intersectoral, equitable, sustainable, and multi-strategic in nature, which aim to improve health

IMPLEMENTING PUBLIC HEALTH/POPULATION HEALTH
the ability to implement public health/population health services as mandated by the Department of Health

How can primary care models impact primary care provider competencies?
As the practice of primary care exists within a healthcare provider network, the context in which the health worker operates should be defined. The elements of a primary care model describe the context that demands these competencies to be performed.

THE 6 ELEMENTS OF A PRIMARY CARE MODEL

POPULATION REACH
Primary care services should be accessible to the whole population – small enough for personal care, large enough for impact (NHS, 2018)

SCOPE OF SERVICES
A network should be able to provide access to comprehensive primary care services (versus individual facilities)

ORGANIZATIONAL TYPE
Coordinated care and access to a wider range of care must be provided effectively and cost-efficiently

TEAM COMPOSITION AND SCOPE OF WORK
The team should provide services collectively to meet the needs of the population.

CARE PATHWAY
Quality care must be provided sustainably by the human health resources available

GOVERNANCE
The components of the network must be strategically managed to provide integrated care to the local population.
THE COMPETENCY CERTIFICATION FRAMEWORK AND RECOMMENDATIONS

- Health Education
  - Ensure orientation of health education and professional licensing towards primary care

- Post Graduate Education and Training
  - Build DOH Capacity To Manage Competency Assessors And Evaluate Competency Assessment Methods

- Competency Assessment
  - Consider Different Post-graduate Primary Care Training And Education Options

- Certification
  - Implement The Certification Gradually And Ensure Timely Evaluation

- Maintenance of Certification
  - Link The Maintenance Of Certification With CPD Requirements

What are the next steps for primary care providers and DOH-HHRDB?

For providers who want to be certified:
1. Download competency assessment tool and forms
2. Prepare documents
3. Self-assess using competency assessment tool
4. Schedule assessment based on availability of assessors
5. On-site assessment
6. Certification Results
7. Maintenance of Certification

Steps for HHRDB:
- Upload competency assessment tool to DOH websites (main and regional offices)
- Identify documents to be used
- Evaluate usability of tool
- Establish an online system/scheduling system
- Ensure pool of assessors
- Establish form for releasing results, recommendation, and appeal
- Establish form for re-certification, delivery system for results

Produced by Thinkwell LLC, Philippines
Project Team: Dr. Maria Eufemia C. Yap, Dr. Louella Patricia D. Carpio, Dr. Madeline Mae Ong, and Viviane Cen Apostol
Illustration and Design: Viviane Cen Apostol
ANNEX 3. COMPETENCY ASSESSMENT TOOL FOR THE PRIMARY CARE PROVIDER

Name: _____________________________________________  Age: _______  Sex: _______  Number of Years in Service: ________________

Designation: ____________________________________________

Municipality/ City: ________________________________  Province: ________________________________

Instructions: The first column in the table lists behavioral indicators that determine the level of performance in the workplace. In order to provide a picture of the candidate’s proficiency at demonstrating these behaviors, the tool uses a three-point rating scale that indicates standards of demonstrating a behavior in a given situation at the workplace. Place a tick mark in the corresponding standards column if the corresponding evidences to the behaviors listed in the competency criteria is fulfilled.

I. PROVIDING FIRST-CONTACT CARE

Sub-Competency: Establishes an effective partnership with patients (PCPFC01)

Task Description: evaluates the candidate’s ability to effectively communicate with patients

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Satisfactory</th>
<th>Very Satisfactory</th>
<th>Outstanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Able to effectively communicate during consultation, advise and discharge of patient</td>
<td>Able to accomplish 2 out of 5 criteria</td>
<td>Able to accomplish 3-4 out of 5 criteria</td>
<td>Able to accomplish 5 out of 5 criteria</td>
</tr>
</tbody>
</table>

As evidenced by observation of:
- Introducing self to patient or greeting or showing gestures of approachability (e.g. smiling)
- Establishing rapport with patients
- Using appropriate language for the patient’s context
- Relating to patients and colleagues with professionalism

OR as evidenced by:
- Continued follow-up of patients of families with the health worker in records
**Sub-Competency:** Assesses and manages patients clinical within the scope of profession (i.e. midwife assesses and manages maternal and child health cases) *(PCPFCO2)*

**Task Description:** evaluates the candidate’s ability to take relevant health information, perform physical examination and manage patients in accordance with the scope of their profession

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Satisfactory</th>
<th>Very Satisfactory</th>
<th>Outstanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Able to take relevant health information</td>
<td>Able to accomplish &lt; 2 out of 6 criteria</td>
<td>Able to accomplish 3-5 out of 6 criteria</td>
<td>Able to accomplish 6 out of 6 criteria</td>
</tr>
</tbody>
</table>

**As evidenced by:**

- Observation/documentation of inquiring on onset of symptoms
- Observation/documentation of inquiring on associated symptoms
- Observation/documentation of inquiring on past medical history and family history

Perform accurate physical examination

**As evidenced by:**

- Taking vital signs and interpreting appropriately
- Conduct of pertinent physical examination

Formulation of appropriate plan of management

**As evidenced by:**

- Documentation of plan of management appropriate to the diagnosis of the patient
**Sub-Competency:** Administers appropriate initial treatment within the scope of the profession (i.e. nurse manages cases of diarrhea initially with oral rehydration solution) *(PCPFC03)*

**Task Description:** evaluates the candidate’s ability to provide appropriate initial treatment within the scope of their profession

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Satisfactory</th>
<th>Very Satisfactory</th>
<th>Outstanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provides the appropriate initial treatment</td>
<td>Able to accomplish 1 out of 3 criteria</td>
<td>Able to accomplish 2 out of 3 criteria</td>
<td>Able to accomplish 3 out of 3 criteria</td>
</tr>
</tbody>
</table>

As evidenced by:
- Observation of providing the appropriate pharmacologic management to a patient
- Observation of providing the appropriate non-pharmacologic management to a patient
- Documentation of compliance with local or international clinical practice guideline on the disease condition

---

**Sub-Competency:** Recognizes patients who require higher levels of care (within and outside of primary care facility) *(PCPFC04)*

**Task Description:** evaluates the candidate’s ability to recognize patients in primary care setting who may require higher levels of care

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Satisfactory</th>
<th>Very Satisfactory</th>
<th>Outstanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognizes patients who require higher levels of care</td>
<td>Able to accomplish 1 out of 3 criteria</td>
<td>Able to accomplish 2 out of 3 criteria</td>
<td>Able to accomplish 3 out of 3 criteria</td>
</tr>
</tbody>
</table>

As evidenced by:
- Observation/Documentation of eliciting red flags in signs and symptoms
- Observation/Documentation of recognizing dangers in vital signs and physical examination
II. PROVIDING COMPREHENSIVE CARE

Sub-Competency: Considers the patient’s context in planning for care management using the biopsychosocial approach (PCPCM01)

Task Description: evaluates the candidate’s ability to apply the biopsychosocial approach

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Satisfactory</th>
<th>Very Satisfactory</th>
<th>Outstanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applies the biopsychosocial approach in planning for care management</td>
<td>Able to accomplish 1 out of 3 criteria</td>
<td>Able to accomplish 2 out of 3 criteria</td>
<td>Able to accomplish 3 out of 3 criteria</td>
</tr>
</tbody>
</table>

As evidenced by:

- Observation/Documentation of inquiring on individual, family, community context of the patient
- Observation/Documentation of inquiring on socio-cultural, economic or environmental context of the patient
- Observation/Documentation of using patient context in planning and goal-setting for the patient

Sub-Competency: Implements individual and population healthcare including health screening, diagnostic, therapeutic, and preventive measures within the scope of the profession (PCPCM02)

Task Description: evaluates the candidate’s ability to provide individual and individual health care

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Satisfactory</th>
<th>Very Satisfactory</th>
<th>Outstanding</th>
</tr>
</thead>
</table>
Provides individual and population healthcare

As evidenced by:

- Conduct/documentation of vaccination
- Conduct/documentation of assessment on child’s health status
- Conduct/documentation of papsmear or VIA
- Conduct/documentation of risk assessment for NCD
- Conduct/documentation of pre-natal checkups and assessment of high-risk pregnancies
- Conduct/documentation of TB and HIV screening
- Performance/documentation of procedures on management: hydration, wound cleaning, suturing, NSD etc

Able to accomplish < 3 out of 9 criteria
Able to accomplish 4-7 out of 9 criteria
Able to accomplish > 8 out of 9 criteria

Sub-Competency: Counsels patients on general disease prevention and health promotion, including household remedies (PCPCM03)

Task Description: evaluates the candidate’s ability to provide counseling services

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Satisfactory</th>
<th>Very Satisfactory</th>
<th>Outstanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provides individual and population healthcare</td>
<td>Able to accomplish ≤ 3 out of 9 criteria</td>
<td>Able to accomplish 4-7 out of 9 criteria</td>
<td>Able to accomplish &gt; 8 out of 9 criteria</td>
</tr>
<tr>
<td>As evidenced by:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Observation/documentation of counseling on completion of vaccination</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>• Observation/documentation of counseling on breastfeeding</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>• Observation/documentation of counseling on prenatal care</td>
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</table>
• Observation/documentation of counseling on proper nutrition
• Observation/documentation of counseling on safe water and sanitation
• Observation/documentation of counseling on physical activity
• Observation/documentation of counseling on smoking cessation
• Observation/documentation of counseling on safe sex
• Observation/documentation of counseling on supplementation, if necessary

III. PROVIDING CONTINUING CARE

Sub-Competency: Sustains a harmonious and continuing relationship with patients and clients, especially those with chronic and persistent health challenges that can be managed at the primary care level (PCPCN01)

Task Description: evaluates the candidate’s ability to sustain a continuing relationship with patients and clients

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Satisfactory</th>
<th>Very Satisfactory</th>
<th>Outstanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sustains a harmonious and continuing relationship with patients and clients</td>
<td>Able to accomplish 1 out of 3 criteria</td>
<td>Able to accomplish 2 out of 3 criteria</td>
<td>Able to accomplish 3 out of 3 criteria</td>
</tr>
</tbody>
</table>

As evidenced by:

• Observation of familiarity and rapport between the patient and client
• Observation/documentation of recognizing progress or relapse of a patient’s condition
• Documentation of continuous follow-up for assessment, treatment or maintenance medications

Sub-Competency: Plans for continuing care for patients with chronic conditions, post-discharge, and those referred back to primary care (PCPCN02)

Task Description: evaluates the candidate’s ability to formulate plans for patients requiring continuing care

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Satisfactory</th>
<th>Very Satisfactory</th>
<th>Outstanding</th>
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</thead>
<tbody>
<tr>
<td>Plans for continuing care of patients</td>
<td>Able to accomplish 1 out of 3 criteria</td>
<td>Able to accomplish 2 out of 3 criteria</td>
<td>Able to accomplish 3 out of 3 criteria</td>
</tr>
</tbody>
</table>

As evidenced by:

• Observation/documentation of advice for maintenance medications or non-pharmacologic home care
• Observation/documentation of arranging for follow-up in the clinic or home visit
• Observation/documentation of arranging referral for specialist care, if necessary

IV. COORDINATING CARE

Sub-Competency: Refers to specialty care and higher levels of care as necessary (PCPCR01)

Task Description: evaluates the candidate’s ability to refer to specialty care or higher levels of care

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Satisfactory</th>
<th>Very Satisfactory</th>
<th>Outstanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refers to specialty care and higher levels of care as necessary</td>
<td>Able to accomplish 1 out of 3 criteria</td>
<td>Able to accomplish 2 out of 3 criteria</td>
<td>Able to accomplish 3 out of 3 criteria</td>
</tr>
</tbody>
</table>

As evidenced by:
• Observation/documentation of clear oral endorsement of the patient’s case to the receiving facility
• Observation/documentation of properly accomplished referral form
• Observation of adequately answering queries of the receiving facility

**Sub-Competency:** Guides patients in conduct of referrals for medications, diagnostic tests and services in the network *(PCPCR02)*

**Task Description:** evaluates the candidate’s ability to assist patients during referrals

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Satisfactory</th>
<th>Very Satisfactory</th>
<th>Outstanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guides patients in conduct of referrals</td>
<td>Able to accomplish 1 out of 3 criteria</td>
<td>Able to accomplish 2 out of 3 criteria</td>
<td>Able to accomplish 3 out of 3 criteria</td>
</tr>
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</table>

*As evidenced by:*

- Observation/documentation of providing adequate instructions to patients
- Observation/documentation of communicating well the instructions to patients
- Observation/documentation of adequately answering queries of patients

**Sub-Competency:** Participates in multi-disciplinary care and inter-professional care teams for patients when necessary *(PCPCR03)*

**Task Description:** evaluates the candidate’s ability to participate in interprofessional or multidisciplinary care teams

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Satisfactory</th>
<th>Very Satisfactory</th>
<th>Outstanding</th>
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</table>
Able to work in multi-disciplinary or interprofessional care teams

As evidenced by:

- Observation/documentation of working with other members of the care team with mutual respect and trust
- Observation/documentation of engaging other health professionals in shared patient-centered problem-solving
- Observation/documentation of reflecting on individual and team performance, as well as team improvement
- Observation/documentation of applying leadership practices that support collaborative practice and team effectiveness

Sub-Competency: Communicates effectively with the members of the team (PCPCR04)

Task Description: evaluates the candidate’s ability to communicate effectively with the members of the healthcare team

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Satisfactory</th>
<th>Very Satisfactory</th>
<th>Outstanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communicates effectively with the members of the team</td>
<td>Able to accomplish 1 out of 4 criteria</td>
<td>Able to accomplish 2-3 out of 4 criteria</td>
<td>Able to accomplish 4 out of 4 criteria</td>
</tr>
</tbody>
</table>

As evidenced by:

- Observation/documentation of expressing one’s knowledge and opinion to team members with confidence, clarity and respect
- Observation/documentation of listening actively, and encouraging ideas and opinions of other team members
• Observation/documentation of giving timely, sensitive, instructive feedback to others about the performance on the team
• Observation/documentation of choosing effective communication tools and techniques, including information systems and communication technologies to facilitate discussions

**Sub-Competency:** Assists patients in navigating through other agencies and resources in the community *(PCPCR05)*

**Task Description:** evaluates the candidate’s ability to navigate through other agencies and resources

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Satisfactory</th>
<th>Very Satisfactory</th>
<th>Outstanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Navigates through other agencies and resources</td>
<td>Able to accomplish 1 out of 3 criteria</td>
<td>Able to accomplish 2 out of 3 criteria</td>
<td>Able to accomplish 3 out of 3 criteria</td>
</tr>
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</table>

As evidenced by:

• Observation/documentation of appropriately identifying the key agencies and resources in the community
• Observation/documentation of providing adequate instructions to patients on how to access these resources
• Observation/documentation of adequately answering queries of patients

---

**V. MANAGING PATIENT RECORDS**

**Sub-Competency:** Ensures quality of patient care records in terms of accuracy, completeness, reliability and timeliness using standard protocols *(PCPMR01)*

**Task Description:** evaluates the candidate’s ability to ensure quality of patient records using standard protocols
### Sub-Competency: Maintains privacy and security of data *(PCPMR02)*

**Task Description:** evaluates the candidate’s ability to maintain data privacy and security of patient information and records

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Satisfactory</th>
<th>Very Satisfactory</th>
<th>Outstanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintains privacy and security of data</td>
<td>Able to accomplish 1 out of 3 criteria</td>
<td>Able to accomplish 2 out of 3 criteria</td>
<td>Able to accomplish 3 out of 3 criteria</td>
</tr>
</tbody>
</table>

As evidenced by:

- Observation/documentation of properly filing physical and electronic records
- Observation/documentation of patient confidentiality by not unnecessarily divulging patient data to persons beyond the care team
- Observation/documentation of recommending improvements to the maintenance of the information system

---

**Ensures quality of patient records using standard protocols**

As evidenced by:

- Observation/documentation of patient care and intervention conducted clearly
- Observation/documentation of patient care and intervention conducted concisely
- Observation/documentation of patient care and intervention conducted accurately
- Observation/documentation of patient care and intervention conducted in a timely manner

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Satisfactory</th>
<th>Very Satisfactory</th>
<th>Outstanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensures quality of patient records using standard protocols</td>
<td>Able to accomplish 1 out of 4 criteria</td>
<td>Able to accomplish 2-3 out of 4 criteria</td>
<td>Able to accomplish 4 out of 4 criteria</td>
</tr>
</tbody>
</table>
**Sub-Competency:** Demonstrates familiarity with the use of existing and mandated health information systems *(PCPMR03)*

**Task Description:** evaluates the candidate’s ability to demonstrate familiarity with the local health information system

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Satisfactory</th>
<th>Very Satisfactory</th>
<th>Outstanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demonstrates familiarity with the local health information system</td>
<td>Able to accomplish 1 out of 3 criteria</td>
<td>Able to accomplish 2 out of 3 criteria</td>
<td>Able to accomplish 3 out of 3 criteria</td>
</tr>
</tbody>
</table>

As evidenced by:

- Observation/documentation of familiarity with the different forms or EMR to be accomplished or used for reporting
- Observation/documentation of preparing reports using health information systems
- Observation/documentation of reviewing and recommending on the applicability of the health information system to the facility

---

**VI. PROMOTING HEALTH**

**Sub-Competency:** Understands fundamental concepts of health promotion and disease prevention within the scope of the profession, including national and international health goals *(PCPHP01)*

**Task Description:** evaluates the candidate’s ability to understand the fundamental concepts of health promotion

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Satisfactory</th>
<th>Very Satisfactory</th>
<th>Outstanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understands the fundamental concepts of health promotion</td>
<td>Able to accomplish ≤ 2 out of 5 criteria</td>
<td>Able to accomplish 3-4 out of 5 criteria</td>
<td>Able to accomplish 5 out of 5 criteria</td>
</tr>
</tbody>
</table>
As evidenced by:

- Observation/documentation of educating patients on disease prevention strategies
- Observation/documentation of health promotion and disease prevention concepts in team meeting on related programs/activities
- Observation/documentation of sufficiently answering queries on health promotion and disease prevention from patients, community members, or peers
- Documents showing that programs/interventions/strategies are based on concepts of disease control and prevention
- Documents revealing involvement in health promotion and prevention activities

**Sub-Competency:** Effectively communicates with families and communities on practices that promote health by contextualizing the health information to their needs (PCPHP02)

**Task Description:** evaluates the candidate’s ability to effectively communicate with families and communities on health promotion

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Satisfactory</th>
<th>Very Satisfactory</th>
<th>Outstanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effectively communicates with families and communities on health promotion</td>
<td>Able to accomplish 1 out of 3 criteria</td>
<td>Able to accomplish 2 out of 3 criteria</td>
<td>Able to accomplish 3 out of 3 criteria</td>
</tr>
</tbody>
</table>

As evidenced by:

- Documents showing that the content of patient and community education was relevant to the local and individual context
- Observation/documentation of relaying information and prescriptions on disease
promotion that are feasible for patients/community
- Observation/documentation of partnership with patients and communities such that the community showed affirmation and ownership of behavioral change

**Sub-Competency:** Implements strategies that promote inclusivity to identified vulnerable groups, and improves their access to primary care, considering their unique health needs *(PCPHP03)*

**Task Description:** evaluates the candidate’s ability to implement strategies that promote inclusivity to identified vulnerable groups

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Satisfactory</th>
<th>Very Satisfactory</th>
<th>Outstanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement strategies that promote inclusivity to identified vulnerable groups</td>
<td>Able to accomplish 1 out of 4 criteria</td>
<td>Able to accomplish 2-3 out of 4 criteria</td>
<td>Able to accomplish 4 out of 4 criteria</td>
</tr>
</tbody>
</table>

**As evidenced by:**
- Observation of ability to identify the unique health needs and context of vulnerable patients
- Observation/documentation of ability to address the unique health needs through feasible and appropriate management
- Observation/documentation of ability to respond to concerns of vulnerable patients
- Documents showing that strategies were developed to address the unique health needs of the following populations: (1) Indigenous People (RA 837, Indigenous People’s Right Act of 1997), (2) PWD (RA 7277), (3) LGBTQ (HB 4982 SOGIE Bill)
### VII. IMPLEMENTING PUBLIC HEALTH FUNCTIONS

**Sub-Competency:** Demonstrates knowledge on the basic concepts of public health surveillance and applies them appropriately on the health concerns of the community (*PCPIPH01*)

**Task Description:** evaluates the candidate’s ability to apply public health surveillance

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Satisfactory</th>
<th>Very Satisfactory</th>
<th>Outstanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applies public health surveillance</td>
<td>Able to accomplish ≤ 2 out of 6 criteria</td>
<td>Able to accomplish 3-4 out of 6 criteria</td>
<td>Able to accomplish ≥ 5 out of 6 criteria</td>
</tr>
<tr>
<td>As evidenced by:</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>• Observation/documentation of identifying relevant and appropriate sources of information</td>
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<tr>
<td>• Observation/documentation of recognizing that a health concern or issue exists</td>
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<tr>
<td>• Observation/documentation of conduct of site investigation including contact tracing and tracking of patients</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Observation/documentation of generating surveillance reports</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Observation/documentation of analyzing surveillance data</td>
<td></td>
<td></td>
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<tr>
<td>• Observation/documentation of recommending specific actions based on the analysis of the surveillance data</td>
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</tbody>
</table>
**Sub-Competency:** Implements public health programs, measures their progress and results, and effectuates a feedback mechanism (PCIPH02)

**Task Description:** evaluates the candidate’s ability to implement public health programs

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Satisfactory</th>
<th>Very Satisfactory</th>
<th>Outstanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement public health programs</td>
<td>Able to accomplish ≤ 2 out of 7 criteria</td>
<td>Able to accomplish 3-5 out of 7 criteria</td>
<td>Able to accomplish ≥ 6 out of 7 criteria</td>
</tr>
</tbody>
</table>

As evidenced by:

- Observation/Documents of participation in preparing materials and tools for program implementation
- Documents of epidemiologic reports using EMR or manually encoded data
- Documents of use of statistical and qualitative data processing tools to analyze data
- Documents of accurately collected data and/or feedback in the field
- Observation/documentation of dissemination of epidemiologic, clinical, or public health basis for interventions/ programs/activities in staff meetings
- Observation/documentation of monitoring the progress of programs
- Documentation of program adjustments done based on feedback

**Sub-Competency:** Engages community leaders and stakeholders in the implementation of programs (PCIPH03)

**Task Description:** evaluates the candidate’s ability to engage community leaders and stakeholders in the implementation of programs

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Satisfactory</th>
<th>Very Satisfactory</th>
<th>Outstanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engages community leaders and stakeholders in the implementation of programs</td>
<td>Able to accomplish 1 out of 3 criteria</td>
<td>Able to accomplish 2 out of 3 criteria</td>
<td>Able to accomplish 3 out of 3 criteria</td>
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</tr>
<tr>
<td>As evidenced by:</td>
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<td></td>
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<tr>
<td>• Observation/documentation of ability to identify the key stakeholders or persons of influence in the locality</td>
<td></td>
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<tr>
<td>• Observation of communicating with community leaders and stakeholders in a collaborative manner</td>
<td></td>
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<tr>
<td>• Observation/documentation of ability to maintain influential connections within and outside the organization and community</td>
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</table>
ANNEX 4. TERMINAL REPORT PRESENTATION

Development of a Competency Certification Framework for Primary Care Providers in the Context of Universal Health Care in the Philippines

TERMINAL REPORT
DECEMBER 17, 2019

OUTLINE

- The Technical Assistance
- Methods
- Results
  - Primary care provision in the Philippines
  - Primary care provider models
  - Core primary care provider competencies
- The Competency Assessment Tool
  - Certification Framework
- Recommendations
The Technical Assistance Project

CONTEXT OF THE TECHNICAL ASSISTANCE

UHC Law Section 6.

— c. The DOH and the local government units (LGUs) shall endeavor to provide a health care delivery system that will afford every Filipino a primary care provider that would act as the navigator, coordinator, and initial and continuing point of contact in the health care delivery system; Provided, that except in emergency or serious cases and when proximity is a concern, access to higher levels of care shall be coordinated by the primary care provider; and

— d. Every Filipino shall register with a public or private primary care provider of choice. The DOH shall promulgate guidelines on the licensing of primary care providers and the registration of every Filipino to a primary care provider.
Section 17.3 a: **Primary Care Provider Network (PCPN)** shall:

1. **provide primary care services**
   - serve as initial contact and navigator
   - coordinate patients to facilitate two-way referrals and remove barriers to health services
   - enable patient records to be accessible

2. **implement public health services** such as vector control and sanitation as may be determined by the DOH

Section 25.11

The DOH and the PRC shall issue guidelines for the eligibility requirements, **standard competencies**, training mechanisms, and post-graduate certification process for primary care workers

**Competency** - the **knowledge, skills, abilities, and traits** to successfully and effectively deliver high-quality services
Certification of Primary Care Providers

UHC IRR Section 41.9. Within ten (10) years from the effectivity of this Act, only those who have been certified by the DOH and PRC to be capable of providing primary care shall be eligible to be a primary care provider.

What does Certification of Primary Care Providers mean?

Certification - a process by which the DOH awards a certificate to individuals that received additional education and training, and demonstrated competence in a specialty area beyond the minimum requirements set for licensure, and training mechanisms to practice primary care.

PROJECT OBJECTIVES

1. Reality and Needs
2. Goals and Guarantees
3. Model of PC Delivery
4. PC Competency
5. PC Certification

OBJECTIVE. Develop a competency certification for primary care health workers

1. Map out the current state of primary care delivery in the Philippines
2. Develop options of primary care provider models
3. Create competency assessment tools for primary care health workers
4. Create a framework for certification of primary care providers
KEY DEFINITIONS

- **Certification** is a process by which the DOH awards a certificate to individuals who have demonstrated competence in a specialty area beyond the minimum requirements set for licensure, have additional education and training mechanisms to practice primary care (Rooney and van Ostenberg, 1999; UHC Act, 2019). The certification process is DOH-supervised, with performance criteria, and assessment processes established and accepted as standard across all DOH-hospitals.

- **Competency** entails having and demonstrating the “knowledge, skills, abilities, and traits” to successfully and effectively deliver high-quality services (Kak, 2000). It is also having “a cluster of related knowledge, skills, and attitudes (KSA) that affects a major part of one’s job (a role or a responsibility), that correlated with performance on the job, that 1) can be measured against well-accepted standards, and that 2) can be improved via training and development.” (Parry, 1996)

- **Licensing** of health professionals refers to the process of individual licensing by PRC to ensure professional competence. A certificate of registration/professional license shall be issued to an applicant who passes the examination upon payment of the prescribed fees (RA 2382, RA 9173, RA 7392)
KEY DEFINITIONS

— **Primary care** refers to initial-contact, accessible, continuous, comprehensive and coordinated care that is accessible at the time of need including a range of services for all presenting conditions, and the ability to coordinate referrals to other health care providers in the health care delivery system, when necessary (RA 11223)

— **Primary care provider** refers to a health worker, with defined competencies, who has received certification in primary care as determined by the DOH or any health institution that is licensed and certified by the DOH (RA 11223)

— **Primary care worker** refers to a health worker, who may be a health professional or community health worker/volunteer, certified by DOH to provide primary care services (IRR of RA 11223)
Phase 1: Data Synthesis and consultative meetings
- Desk review on setup of primary care provision in the Philippines; national and sectoral development agenda, local and international standards, existing policies and operational frameworks; and goals, guarantees and features of primary care provision in the Philippines
- Interviews on primary care provision in the Philippine setting

Phase 2: Development of primary care provision models
- Desk review on existing primary care models in the Philippines, and models and scenarios of primary care provision in various setups, contexts and team composition
- Stakeholder consultations on the feasibility of the developed models

Phase 3: Development of competency assessment tools
- Desk review on existing primary care competencies locally and abroad
- Consultative workshops on primary care competencies
- Key informant interviews on development of competency assessment tools and its applicability
- Focused group discussions to validate the competency assessment tool

Phase 4: Development of a PC certification framework
- Desk review on the certification frameworks for health workers locally and abroad
- Consultative workshop on the feasibility of the developed certification framework

RESULTS
Primary Care Provision in the Philippines

<table>
<thead>
<tr>
<th>Primary care governance</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Devolved to LGUs</td>
</tr>
<tr>
<td>• No gatekeeping mechanisms</td>
</tr>
<tr>
<td>• No overall governance for primary care</td>
</tr>
<tr>
<td>• Existing policies are programmatic and disease-based</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Financing primary care</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Outpatient benefits have been developed but coverage remains narrow</td>
</tr>
<tr>
<td>• Utilization of primary care benefits has lagged</td>
</tr>
<tr>
<td>• Little to no incentives on primary care</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Human Resource for Primary care</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Lacking in numbers and distribution</td>
</tr>
<tr>
<td>• Hospital-centric</td>
</tr>
<tr>
<td>• Notion of lack of competence</td>
</tr>
<tr>
<td>• No defined career path for primary care providers</td>
</tr>
</tbody>
</table>
Primary Care Models

Identified six essential elements of a primary care model:

- Population Reach
- Scope of Services
- Organizational Type
- Team Composition & Scope of Work
- Care Pathway
- Governance
PRINCIPLES

Primary care services should be accessible to the whole population – small enough for personal care, large enough for impact. (NHS, 2018)

A network should be able to provide access to comprehensive primary care services (versus individual facilities)

Coordinated care and access to a wider range of care must be provided effectively and cost-efficiently

---

PRINCIPLES

The team should provide services collectively to meet the needs of the population.

Quality care must be provided sustainably by the human health resources available

The components of the network must be strategically managed to provide integrated care to the local population
### Core Primary Care Competencies

#### WHO TO CERTIFY?

<table>
<thead>
<tr>
<th>Task</th>
<th>Doctor</th>
<th>Nurse</th>
<th>Midwife</th>
<th>Dentistry</th>
<th>Nutritionist</th>
<th>Med Tech</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient history</td>
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<td>✔</td>
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</tr>
<tr>
<td>Diagnosis</td>
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<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
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<tr>
<td>Treatment</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
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<tr>
<td>Follow-up care</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
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<td>✔️</td>
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</tr>
<tr>
<td>Coordination/Referral</td>
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<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
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<td>Health promotion</td>
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<tr>
<td>Adjust medications</td>
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<td>✔️</td>
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<td>Refill medications</td>
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<td>Primary Care Function</td>
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<tr>
<td>First contact</td>
<td>✔️</td>
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<td>Comprehensive</td>
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<td>Continuing</td>
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<td>✔️</td>
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<tr>
<td>Coordinated</td>
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**WHO TO CERTIFY?**

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<tr>
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<th>Optometry</th>
<th>Pharmacy</th>
<th>PT/OT</th>
<th>Rad Tech</th>
<th>Respiratory Tx</th>
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<td>✓</td>
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<tr>
<td>Diagnosis</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Treatment</td>
<td>✓</td>
<td></td>
<td>✓</td>
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<tr>
<td>Follow-up care</td>
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</tr>
<tr>
<td>Coordination/Referral</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Health promotion</td>
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<tr>
<td>Adjust medications</td>
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<tr>
<td>Dispense medications</td>
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<td></td>
<td>✓</td>
<td></td>
<td></td>
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<tr>
<td>Refill medications</td>
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</tbody>
</table>

**Primary care function**

- First contact
- Comprehensive
- Continuing
- Coordinated

**DOH DOCUMENTS ON COMPETENCIES**

- Updated DOH Competency Standards & Position Descriptions (2017)
- Learning and Development Framework for Rural Health Units for the Municipal Health Officers, Public Health Nurses and Rural Health Midwives (2018)

**LOCAL LITERATURE ON PC COMPETENCIES**

- Dans A et al. (2018). Proceedings from the Stakeholders’ Meeting on Training Objectives for Primary Care in the Philippines
- Dayrit M et al. (2019). Rural Health Physicians Competencies. [Unpublished]
**PROVIDING FIRST CONTACT CARE**

**Definition:** the ability to provide health services within a time frame appropriate to the urgency of the health problem

**Core description:**
— Establishes an effective and effective partnership with patients
— Assesses and manages patients clinical within the scope of profession (i.e. midwife assesses and manages maternal and child health cases)
— Administers appropriate initial treatment within the scope of the profession (i.e. nurse manages cases of diarrhea initially with oral rehydration solution)
— Recognizes patients who require higher levels of care (within and outside of primary care facility)

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**PROVIDING COMPREHENSIVE CARE**

**Definition:** the ability to provide a wide range of health services that meet the common needs across all life stages

**Core description:**
— Considers the patient’s context in planning for care management (using the biopsychosocial approach)
— Implements individual and population healthcare including health screening, diagnostic, therapeutic, and preventive measures within the scope of the profession
— Counsels patients on general disease prevention and health promotion, including household remedies
PROVIDING CONTINUING CARE

Definition: the ability to provide a sustained partnership with the patient in the management of his/her condition

Core description:
— Sustains a harmonious and continuing relationship with patients and clients, especially those with chronic and persistent health challenges that can be managed at the primary care level
— Plans for continuing care for patients with chronic conditions, post-discharge, and those referred back to primary care

Starfield B. (2003) The features of Primary Care: First Contact, Person-focused over time, Comprehensiveness and coordination

COORDINATING CARE

Definition: the ability to transfer and share responsibility across disciplines and levels of care

Core description:
— Refers to specialty care and higher levels of care as necessary
— Guides patients in conduct of referrals for medications, diagnostic tests and services in the network
— Participates in multi-disciplinary care and inter-professional care teams for patients when necessary
— Communicates effectively with care providers within the facility and the health care provider network
— Assists patients in navigating through other agencies and resources in the community

Starfield B. (2003) The features of Primary Care: First Contact, Person-focused over time, Comprehensiveness and coordination
MANAGING PATIENT RECORDS

Definition: the ability to ensure coordination of care through accurate and timely integration of medical records in the healthcare provider network

Core description:
- Ensures quality of patient care records in terms of accuracy, completeness, reliability and timeliness using standard protocols
- Maintains privacy and security of data
- Demonstrates familiarity with the use of existing and mandated health information systems

PROMOTING HEALTH

Definition: the ability to identify, describe, and implement programs, policies, and other health promotion interventions that are empowering, participatory, holistic, intersectoral, equitable, sustainable, and multi-strategic in nature, which aim to improve health

Core description:
- Understands fundamental concepts of health promotion and disease prevention within the scope of the profession, including national and international health goals
- Effectively communicates with patients, families and communities on practices that promote health by contextualizing the health information to their needs
- Implements strategies that promote inclusivity to identified vulnerable groups, and improves their access to primary care, considering their unique health needs
IMPLEMENTING PUBLIC HEALTH/POPULATION HEALTH

**Definition:** the ability to implement public health/population health services as mandated by the Department of Health

**Core description:**
— Demonstrates knowledge on the basic concepts of public health surveillance and applies them appropriately on the health concerns of the community
— Implements public health functions, measures their progress and results, and effectuates a feedback mechanism
— Engages community leaders and stakeholders in the implementation of programs
THE COMPETENCY ASSESSMENT TOOL

2 means of verification:
1. Direct Observation
2. Records Review
   a. Individual treatment record (ITR)
   b. Electronic medical record (EMR)
   c. Target Client List (TCL)
   d. Activity reports
   e. Logbook of referrals
   f. Awards
   g. List of trainings or certificate of trainings

Competency must be verified by either observation or records.

All competencies must be met.
USING THE COMPETENCY ASSESSMENT TOOL

1. Applicants must prepare all applicable records before hand, and must schedule the assessment when it is optimal to observe his/her performance.

2. How long will it take?
   1 hour for observation
   1.5 hours for review of records

1. Assessors must be knowledgeable of terminologies, best practices, and the technical knowledge and skills required for the tasks

2. Assumptions: Patients are amenable for observation and activities are well documented in available records

The Certification Framework
Recommendation 1

- Comprehensive review and revision of health education to incorporate primary care
- Collaboration among DOH, PRC and CHED
- Create task force led by CHED per cadre
**Recommendation 2**

- Harmonize workshops or trainings to orient the existing health professionals in primary care on basic core competencies in collaboration with experts.
- Consider primary care as a specialty in the future.

**Recommendation 3**

- Creation of a primary care provider certification unit within the Health Human Resources Development Bureau (HHRDB) of the Department of Health.
- Recruitment, orientation, and training of assessors.
- Evaluation of competencies and competency assessment tool.
Recommendation 4

- Roll-out of certification
- Evaluation of the certification process

Recommendation 5

- Arrangement with PRC regarding primary care training for CPD units.
- Roll-out of maintenance of certification
### Primary Care Provider Competency Certification Timeline

<table>
<thead>
<tr>
<th>Year</th>
<th>8</th>
<th>9</th>
<th>10</th>
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<tbody>
<tr>
<td>Health Education</td>
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<tr>
<td>Review and alignment of Health Curricula to Primary Care</td>
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<tr>
<td>Collaboration of DCHI, PRC, CHED for PC DOHs and Board</td>
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<td>Examination content</td>
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<tr>
<td>Post Graduate Education and Training</td>
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<tr>
<td>Options 1: PC Certification phased-out in 10 years</td>
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<td>Create/re-align training for PC</td>
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<td>Administer PC trainings</td>
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<td>Options 2: Elevate PC as a specialty</td>
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<tr>
<td>Create post-graduate courses and residency for PC specialty</td>
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<tr>
<td>Competency Assessment</td>
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<tr>
<td>Create DCHI AG on PCP Competency Certification</td>
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<tr>
<td>Identifying/Enlisting pool of Assessors</td>
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<td>Orientation of Assessors</td>
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<td>Certification of Assessors</td>
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<tr>
<td>Create HHNDB tool for screening, review, and award of certificates</td>
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<tr>
<td>Review and Evaluation of Competencies and Competency Assessment Tool</td>
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<tr>
<td>Certification</td>
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<tr>
<td>Roll-out of Certification (at least one PCP certified per PCF facility)</td>
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<tr>
<td>Mandatory PCP Certification</td>
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<tr>
<td>Evaluation and Review of Certification Process</td>
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<tr>
<td>Maintenance of Certification</td>
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<tr>
<td>Arrangement with PRC regarding primary care training for CBO units</td>
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<tr>
<td>Roll-out of mandatory maintenance of certification</td>
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### Competency Assessment and Certification Process

**For providers who want to be certified:**

1. Download competency assessment tool and forms
2. Prepare documents
3. Self-assess using competency assessment tool
4. Schedule assessment based on availability of assessors
5. On-site assessment
6. Certification Results
7. Maintenance of Certification

**Steps for HHNDB:**

- Upload competency assessment tool to DOH websites (main and regional offices)
- Identify documents to be used
- Evaluate usability of tool
- Establish an online system scheduling system
- Ensure pool of assessors
- Establish form for releasing results, recommendation, and appeal
- Establish form for re-certification, delivery system for results
Thank You