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Training and competencies for primary care teams from the perspective of Chilean experts*

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ABSTRACT

Objective. *To describe the competencies for primary health care (PHC) teams in different topics related to direct user care and management of primary health centers, according to the perception of Chilean experts in PHC.*

Methods. *Mixed design study. An online Delphi panel survey was conducted with 29 national PHC experts.*

Results. *A matrix of specific competencies, related to direct work with families and to the management of health centers, is proposed, prioritized in three levels. Experts agreed that a critical mass of professionals with competencies in PHC is required.*

Conclusions. *The challenge of reorganizing health systems around strong, quality PHC can only be achieved with the participation of professionals who understand and practice the attributes and fundamental principles of PHC. The results of this study show a competency profile for PHC professionals aligned with international recommendations, achievable through continuing education strategies.*

Keywords Primary health care; professional competencies; health personnel; Chile.

Strengthening primary health care (PHC) has required, among other factors, a shift from an essentially curative model of care to other health models centered on prevention and promotion, and on comprehensive care (1). Since the Declaration of Alma-Ata in 1978, world health has achieved important milestones, many of them thanks to the role that PHC has played in organizing health systems and developing public health policies (2).

In Chile, health system reform was based, above all, on strengthening PHC. Under Chile's current *Modelo Integral de Salud Familiar y Comunitario* [Family and Community Comprehensive Health Model] (MAIS), the work done by health teams is guided by three core principles: people-centered, comprehensive, and continuous care (3, 4). These principles are put into action within the framework of a collaborative effort involving users, the care network, and health teams (3). MAIS promotes a relationship between health teams and the individuals, families, and communities in a catchment area that puts users at the heart of decision-making, giving them an active role in their health care. The health system is organized around user needs and seeks the highest possible level of well-being

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through comprehensive, timely, quality, and decisive health care throughout the entire provider network. This health care model is designed to be socially and culturally accepted by the population, promoting social participation in all its work and taking into account both the public's preferences and the existence of indigenous health systems (3).

According to the World Health Organization (WHO), the role of PHC is to respond to most health needs and coordinate comprehensive care and the flow of people within the health system (2, 5). It is the most efficient strategy for addressing 21st-century health issues, including the globalization of unhealthy lifestyles, acceleration of unplanned urban growth, and population aging, which are contributing to a rise in chronic diseases and generating new demands for services. Strengthening the first level of care is the strategy that has shown the best results throughout the world to date, both in developed and in developing countries. In countries where the health system is PHC-based, primary health centers can deal with up to 80% of demand at a lower cost, while delivering higher levels of population health (2, 5).

PHC is characterized by the diversity of clinical events that it addresses, and the multiple needs of its users. Research in this area suggests that PHC should be provided by health teams that have competencies specific to this level of care (6-8), i.e., with the knowledge, abilities, professional attitudes, and motivation required to successfully carry out the tasks involved in their professional role (9). In Chile, the Ministry of Health has defined the professional competencies that physicians specialized in PHC should achieve in order to resolve problems linked to the health and disease processes of the individuals, families, and communities for which they are responsible, throughout the life course. The focus should be on attaining the best possible level of health through proper management of resources in the catchment area and in the network of public and private sector providers, particularly in the area of primary care. Furthermore, health professionals should achieve attitudinal competencies and soft skills to forge empathic, respectful, and assertive professional relationships with users and with other health team members (10). However, there is no available definition of competencies that encompasses all PHC professionals, from those directly providing care to those managing PHC centers.

Therefore, this paper proposes a matrix of the competencies required by PHC teams in different areas linked to direct user care and to managing primary health centers, from the perspective of Chilean PHC experts.

MATERIALS AND METHODS

The results presented here are part of a project financed by the *Fondo Nacional de Investigación en Salud* [*National Health Research Fund*] (FONIS-SA14 ID0025).

For this mixed-design study, an online Delphi panel survey was conducted (11) to reach a consensus on an issue presented to a group of experts, using the results of previous research findings. Its predictive capacity is based on the systematic use of an intuitive opinion offered by a group of experts that was difficult to bring together, due to distance, cost, and/or time constraints. Furthermore, such an anonymous and confidential method minimized the influence of opinion leaders, enabling all participants to express themselves freely and dissent from generalized opinions and views maintained over time as uncontestable truths.

The inclusion criteria were health professionals who had worked for at least the last five years in PHC, heads of health services, municipal health department heads, directors of PHC centers, and academics who had been working on research related to PHC. The initial sample comprised 78 Chilean professionals from all of the professions represented in PHC and from all of the country's health services, all of them with recognized experience and certified by the *Superintendencia de Salud* [Health Bureau]. Subjects were selected through convenience and snowball sampling, and invited to participate by e-mail. Once the initial group of professionals was defined, each one who agreed to participate was given an expert competency coefficient (K-comp), and the selection criterion was set as a score of ≥ 0.8; i.e. a high competency coefficient (12), which reduced the working group to 29 experts. Three rounds of semi-structured questionnaires were conducted. The design of the first questionnaire was based on the latest evidence and on the degree of agreement on the problem to be investigated. The objective of the second and third questionnaires was to consolidate, validate, and determine the degree of agreement with the results obtained in each previous questionnaire. At the end of each round, the researchers analyzed the results and shared them with the participants. The respective response rate for the three questionnaires was 72.4%, 79.3%, and 86.2%. The criteria for ending the process were: reaching a minimum consensus level of 80% for the individual estimates and achieving a stability of responses, which occurred after the third round of questionnaires. To determine response consensus level, a concordance correlation coefficient (C3) of ≥ 75% was used. The C3 varied between 83% and 100% for all of the items consulted. For the quantitative analysis, central tendency and dispersion measures of the values assigned to each response from each expert were used, reordered based on the average values obtained (11).

To avoid dropout, information was provided at the outset on the objectives, methodology, and duration of the process, as well as the potential usefulness of its results and the benefits of participating in it. Given the anonymous responses, it was not possible to know which expert answered each questionnaire; however, not participating in a round did not exclude anyone from subsequent ones. Informed consent protecting the confidentiality of the information, and the autonomy and dignity of the participants, was approved by the *Comité Ético Científico de la Facultad de Medicina de la Pontificia Universidad Católica* [Scientific Ethics Committee of the Medical School of the Pontifical Catholic University] of Chile (code 47-334), and the *Comité de Ética del Servicio Metropoliltano Sur-Oriente* [Ethics Committee of the Metropolitan South-East Service]. All participants signed the informed consent form.

RESULTS

Characteristics of the participants: In the first round of the Delphi panel, 21 experts participated, with ages ranging from 31 to 60 years old. The majority (57%) were physicians who had worked professionally in PHC for five to 30 years. In the second and third rounds, there were 23 and 25 participants, respectively, presenting characteristics similar to those of the first round. It is generally considered that the number of experts should range from seven to 30 (table 1).

The experts agreed that consolidating MAIS required a critical mass of health teams comprising health and technical professionals and administrators with PHC competencies. This would ensure that health care and the management of PHC centers were aligned with the model's guiding principles; i.e., people-centered, comprehensive, and continuous care. Therefore, the experts proposed specific areas of training (table 2) and the percentage of professionals on PHC health teams that needed to be trained in these areas in order to constitute the critical mass of specialists to ensure provide proper care at PHC centers (table 3). Finally, a training matrix was proposed in order for different professional and technical staff to work directly with patients or in the management of PHC centers to attain the competencies required to perform their work satisfactorily. This matrix considers the development of specific competencies progressively; each level is designed considering the previous one, moving up towards increasingly complex interactions (figure 1).

The proposal considers these subjects, grouped into three levels of complexity: basic, intermediate, and advanced. According to the experts consulted, the basic level comprises minimum competencies for working in PHC regardless of one's role or profession; therefore, these should be prioritized in decision-making on staff training for PHC centers. The intermediate and advanced levels are differentiated, based on the characteristics of work: either working directly with people or managing health centers.

TABLE 1. Description of the participating experts

Variables		Round 1		Round 2		Round 3	
		N	%	N	%	N	%
Gender	Female	16	76.2	19	82.6	20	80
	Male	5	23.8	4	17.4	5	20
	Total	21	100	23	100	25	100
Age (years)	31-40	7	33.33	8	36.4	11	44
	41-50	7	33.33	7	31.8	7	28
	51-60	7	33.33	7	31.8	7	28
	Total	21	100	22	100	25	100
Profession	Physician/family physician	12	57.14	13	56.52	13	52
	Nurse	5	23.81	3	13.04	5	20
	Psychologist	2	9.52	2	8.7	2	8
	Dentist	0	0.00	1	4.34	0	0
	Social worker	0	0.00	0	0.0	0	0
	Nutritionist	1	4.76	1	4.34	3	12
	Occupational therapist	0	0.00	1	4.34	0	0
	Midwife	0	0.00	1	4.34	0	0
	Other	1	4.76	1	4.34	2	8
	Total	21	100	23	100	25	100
Area of responsibility (select all applicable)	Urban	14	24.13	13	24.5	15	23.4
	Rural	4	6.9	2	3.8	3	4.7
	Adult clinic	4	6.9	4	7.5	4	6.3
	Pediatric clinic	5	8.6	3	5.7	8	12.5
	Research	2	3.5	3	5.7	3	4.7
	Management	16	27.6	15	28.3	15	23.4
	Teaching	12	20.7	12	22.6	16	25
	Other	1	1.7	1	1.9	0	0
	Total	58		53		64	
Experience in PHC (years)	5-10	5	23.81	6	27.3	8	32
	11-20	8	38.10	9	40.9	7	28
	21-30	7	33.33	5	22.7	4	16
	31-40	1	4.76	2	9.1	6	24
	Total	21	100	22	100	25	100

PHC, primary health care.
Table by the authors.

TABLE 2. Areas of training for health teams at PHC centers

Subject	Percentage (%)		
	Strongly agree agreement	Agree	Total
Networked programming (HR management, organization of care, etc.)	61.9	38.1	100
Support for shared decision-making in health	76.2	14.3	90.5
Problem-solving capacity in PHC	66.7	28.6	95.3
Life course (expected and unexpected health events)	71.4	19.1	90.5
Health counseling (full and abbreviated)	90.5	9.5	100
Adult education	90.5	9.5	100
Family risk approach, risk factors, and protective factors	90.5	9.5	100
Motivational interview	85.7	9.5	95.2
Chronic care model	85.7	9.5	95.2

HR, human resources; PHC, primary health care.
Table by the authors.

DISCUSSION

This study proposes a competencies matrix for PHC workers, with three levels of increasing complexity linked to specific tasks in direct user care or health center management. In the opinion of the experts, to achieve these competencies a strategy for progressive training of PHC workers should be designed, enabling them to acquire competencies for effective, efficient, integrated, continuous care focused on the needs of the target population. These results are aligned with conclusions in the literature, which describe how PHC renewal entails growing concern for training physicians and other health professionals working at the primary care level, and capacity-building so that they can better understand and perform their role in addressing the growing needs of the population, and provide high-quality health care (13).

Among the fundamental problems holding back the success of implementing a PHC strategy, the most important are a lack of skilled human resources with comprehensive training, over-emphasis on a

TABLE 3. Percentage of health team training required to ensure people-centered, comprehensive, and continuous care

	Percentage (%)		
	≥90	65-89	<65
Networked programming (HR management, organization of care, etc.)	23.8	57.1	19.1
Support for shared decision-making in health	52.4	47.6	0
Problem-solving in PHC	42.8	52.4	4.8
Life course (expected and unexpected health events)	66.7	33.3	0
Family strategies: Health counseling (full and abbreviated), comprehensive home visits	76.2	23.8	0
Adult education	76.2	23.8	0
Family risk approach, risk factors, and protective factors	66.7	33.3	0
Motivational interview	66.7	28.6	4.8
Chronic care model	61.9	33.3	4.8

HR, human resources; PHC, primary health care.
Table by the authors.

disease-centered model, and the absence of an approach focusing on prevention and health promotion at the individual, family, and community levels, starting from the beginning of university studies (15). In South America, there is a consensus that the majority of physicians and other professionals working in PHC do not have specialized training in this area. This represents a challenge for governments, whose public policies should ensure comprehensive and quality health care for their people (14).

In this same vein, continuing training and professional development also seems crucial for PHC. Some studies propose that training should be community-oriented and include content on the PHC approach, public health, and family and community health. This would provide professionals with competencies to adapt technical and social solutions to the situation of each community (6), while acquiring competencies specifically related to health management, public health, health promotion, communication, the fostering of people's decision-making and active participation in their own care, and community empowerment. All of this is consistent with user demands and with WHO principles (16, 17), since professionals' competencies are what determine the health system's effectiveness and efficiency (18). In this regard, part of the strategy to build more effective and equitable health systems involves considering the responsibility corresponding to training institutions (15, 19), as well as the continuing education and training of PHC teams (6).

The challenge of reorganizing health systems around robust, quality PHC can only be achieved with the participation of professionals who understand the attributes and fundamental principles of PHC, and put them into practice.

Some researchers propose that achieving PHC team competencies should be addressed through continuing education strategies featuring: 1) individual and family care for the most common clinical conditions; 2) family-centered approach; 3) community-centered approach; 4) interdisciplinary teamwork; and 5) work management and planning (20). The foregoing is compatible with the subjects suggested by the Chilean experts who participated in this study.

Given the importance of training for PHC teams, the actions linked to this point should be considered in the broadest sense. They should be framed within a national training strategy that goes beyond the exclusive scope of human resource management at a given primary health center, or in a particular catchment area. This does not preclude the responsibility of each health center to diagnose its local conditions and design a continuing improvement program for its team.

The strength of this study is that it is the first to describe, from the perspective of Chilean experts, the competencies that members of PHC teams should have, organized according to their levels of complexity.

However, the use of these results should take into account the difficulty involved in shifting from an essentially curative model of care towards a model centered on disease prevention and health promotion, and on comprehensive care in each situation. Therefore, any comparison or generalization should consider this study's particular characteristics.

CONCLUSIONS

The results of this study provide a competencies profile for PHC professionals that is aligned with those formulated elsewhere in the literature, but which includes non-professional members of the health team in specific areas. With this in mind, a matrix is proposed to design a competencies profile for PHC staff, which considers the formal training needed by each worker in different subjects. It should be kept in mind that the acquiring specific competencies is not limited to specific training activities on a given subject. Rather, such training should be continually updated—frequently enough to incorporate advances in the field and implement new methods. Finally, it should be understood that simply attending training activities does not ensure their application to direct care or to managing health centers; therefore, primary health system assessment indicators should consider measuring the relevant competencies that need to be evaluated.

Future research could focus on developing specific strategies to achieve these goals and evaluate their effectiveness.

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FIGURE 1. Matrix of competencies according to role in primary health care centers

Advanced level	Team	Networked programming	Management in health: HR, financing,and process improvement	Leadership					
	Director/manager								
	Clinical professional								
	Nursing/dental technician/aide								
	Administrator								
Intermediate level	Team	Family counseling	Abbreviated health counseling	Comprehensive home visit	Support for shared decision-making in health				
	Director/manager								
	Clinical professional								
	Nursing/dental technician/aide								
	Administrator								
Basic level	Team	Health care model	Chronic care model	Promotion of user-friendly treatment	Family approach	Motivational interview	Adult education	Problem-solving capacity in PHC	Teamwork
	Director/manager								
	Clinical professional								
	Nursing/dental technician/aide								
	Administrator								

Note: Shaded areas correspond to the competencies that different members of the health team should achieve at each level.
Figure by the authors.

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Formación y competencias para los equipos de atención primaria desde la mirada de expertos chilenos

RESUMEN

Objetivo. Describir las competencias para equipos de atención primaria en salud (APS) en distintos tópicos vinculados a la atención directa del usuario y a la gestión de los centros de salud primarios, de acuerdo a la percepción de expertos chilenos en APS.

Métodos. Estudio de diseño mixto. Se realizó un Delphi electrónico con 29 expertos nacionales en APS.

Resultados. Se propone una matriz de competencias específicas vinculada al trabajo directo con familias y a la gestión del centro de salud priorizados en tres niveles. Los expertos concuerdan que se requiere una masa crítica de profesionales que cuenten con competencias que le conciernen a la APS.

Conclusiones. El reto de reorganizar los sistemas de salud en torno a una APS fuerte y de calidad solo puede lograrse con la participación de profesionales que comprendan y practiquen los atributos y principios fundamentales de la APS. Los resultados de este estudio dan cuenta de un perfil de competencias para profesionales de APS alineado con recomendaciones internacionales alcanzable a través de estrategias de educación continua.

Palabras clave Atención primaria de salud; competencia profesional; personal de salud; Chile.

Treinamento e competências para equipes de atenção primária na perspectiva de especialistas chilenos

RESUMO

Objetivo. Descrever as habilidades para equipes de atenção primária à saúde (APS) sobre vários tópicos vinculados com a atenção direta do usuário e gestão de centros de saúde, de acordo com a percepção de especialistas chilenos na APS.

Métodos. Estudo de desenho misto. Foi realizado um Delphi eletrônico com 29 especialistas nacionais em APS.

Resultados. É proposta uma matriz de competências específicas vinculada ao trabalho direto com famílias e à gestão do centro de saúde priorizados em três níveis. Os especialistas concordam que se requer uma massa crítica de profissionais que contem com competências em APS.

Conclusões. O desafio de reorganizar os sistemas de saúde em torno de uma APS forte e de qualidade só se pode conseguir com a participação de profissionais que entendem e pratiquem os atributos e os princípios fundamentais da APS. Os resultados deste estudo mostram um perfil de competências para profissionais de APS alinhados com recomendações internacionais que podem ser alcançadas através de estratégias de educação contínua.

Palavras-chave Atenção primária à saúde; competência profissional; pessoal de saúde; Chile.