Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
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PHILHEALTH CIRCULAR
No. 2017 - 0009

TO : **ALL PHILHEALTH MEMBERS, ACCREDITED AND CONTRACTED HEALTH CARE PROVIDERS, PHILHEALTH REGIONAL OFFICES AND ALL OTHERS CONCERNED**

SUBJECT : **The Z Benefits for Premature and Small Newborns**

I. BACKGROUND

The Philippines fell short of achieving the 2015 target of reducing the under-five mortality by two-thirds. Data reveals that the slow decline of under-five deaths in recent years is tied to the plateauing in reduction of newborn deaths. Further, 32 percent of newborn deaths happen as a result of factors surrounding a preterm birth. Preterm birth accounts for 14.4 percent of all under-five deaths or 65,000 newborn deaths annually. In the Philippines, 62 percent of newborn deaths are due to prematurity, translating to 20,000 deaths in a year. Physiologically, term babies with low birth weight (LBW) may experience similar risks as premature babies; both have higher risk for short- and long term morbidity as well as mortality.

The condition of prematurity and LBW can be catastrophic because of the degree of specialized care that is required. Yet, financial constraints prevent timely administration of cost-effective interventions. These include services for pregnant women at risk of preterm delivery and also those that address 75 percent of preventable deaths in premature and LBW newborns. The Philippines is committed to achieve universal health coverage, making essential health services available to the people and PhilHealth designs benefit packages to provide financial risk protection against catastrophic health spending.

II. RATIONALE

Supporting a premature or LBW delivery presents a challenging case for health care financing. The premature birth by itself is potentially catastrophic yet there is a narrow window immediately prior to delivery that could heavily influence the outcome. Survival rates can be improved with cost-effective interventions that are available locally, reducing the impact of maternal high risk conditions in a timely manner and lowering deaths due to prematurity and LBW. The catastrophic impact of a preterm birth is thus reduced.

The benefit package contents are consistent with the WHO recommendation to adopt a life stage and continuity of care approach for the care of mothers and children as reflected in the Department of Health (DOH) Administrative Order 2008-0029, "Implementing Health Reforms for Rapid Reduction of Maternal and Neonatal Mortality" and its Manual of Operations.

This benefit package is designed to provide financial risk protection in the access of preventive to catastrophic care for premature or LBW newborns. This shall complement the existing PhilHealth benefit packages for mothers and newborns, PhilHealth Circular 39 s-2009 on the expanded normal spontaneous delivery and maternity care package and PhilHealth Circular 22 s-2014 on Women About to Give Birth. Further, the current case rates for preterm labor not resulting to delivery, premature rupture of membranes, normal delivery, and those that address newborn conditions such as jaundice, congenital anemia, effect of maternal factors, and complications of prematurity and LBW are designed as per episode of care, thus, provision of services are piecemeal and fragmented.

Thus, the PhilHealth Board, per Board Resolution No. 2126 s. 2016, approved an improved, rationalized and relevant benefit package for premature and LBW newborns with the perspective of capturing the preventive to curative approach to patient care. The strategy shall drive proper and timely assessment, stabilization and referral to appropriate levels of care.

III. OBJECTIVES

This Circular aims to establish the guiding principles and define the policies and procedures in the delivery of quality of health service in all women and premature and small newborns under the Z Benefits.

IV. SCOPE

This Circular shall apply to all health care institutions (HCIs) contracted to provide the Z Benefits for premature and small newborns, and other relevant stakeholders involved in the implementation of the Z benefits.

V. DEFINITION OF TERMS

A. **Coordinated referral** - means establishing a formal and documented communication mechanism between the health providers in referring and receiving hospital / health facility that facilitates the proper and timely endorsement of the woman at risk for preterm delivery for appropriate care. The coordinated referral includes remote supervision of pre-transport stabilization procedures by the receiving hospital specialist to include but not limited to administration of the first dose of life-saving drugs, e.g. magnesium sulfate, dexamethasone, and antibiotics.

B. **Cost-effective** – referring to an intervention that is considered financially optimal if there is no other available interventions that offers a clinically appropriate benefit at a lower cost.

C. **Disability Adjusted Life Years (DALYs)** - the sum of years of potential life lost due to premature mortality and the years lost to life due to disability; summary measure to indicate overall burden of disease across a population.

D. **Eclampsia** - new onset of grand mal seizure activity and/or unexplained coma during pregnancy or postpartum in a woman with signs or symptoms of preeclampsia. It typically occurs during or after the 20th week of gestation or in the postpartum period.

E. **Evidence-based** - refers to any concept or strategy that is derived from or informed by objective evidence, most commonly, educational research or scientific investigation, that has been acquired, appraised and applied to local contexts.

F. **Financial risk protection** - is a key component of universal health coverage (UHC), which is defined as access to all needed quality health services without financial hardship.

G. **Neonatal Intensive Care** - specialized care of the sick newborn that uses a combination of advanced technology such as mechanical ventilation and skills of trained health professionals such as neonatologists and neonatal nurses.

H. **In utero transport** - transfer of the mother to a referral tertiary facility while still pregnant with her infant unborn.

I. **Kangaroo Care** - a universally available and biologically sound method of care for all newborns, but, in particular, for premature babies, with three components: a) skin-to-skin contact, b) exclusive breastfeeding and c) support to the mother-infant dyad.

J. **Low Birth Weight (LBW)** - defined as a birth weight of a live born infant of less than 2500g regardless of gestational age.

K. **Minor complications** - complications arising from prematurity or being born with LBW such as jaundice and hypothermia, not requiring intensive care.

L. **Major complications** - complications arising from prematurity or being born with LBW such as jaundice, sepsis, respiratory distress syndrome (RDS), patent ductus arteriosus (PDA), apnea, intraventricular hemorrhage (IVH), and anemia requiring intensive care.

M. **Neonatal Mortality** - is defined as a death in the first 28 days of life (0 to 27 days).

N. **Pre-eclampsia, severe** - severe preeclampsia is defined as having a systolic blood pressure (BP) of 160 mm Hg or more or a diastolic BP of more than 110 mm Hg, or both, on two (2) occasions four (4) hours apart with 3+ proteinuria in the urine in a pregnant woman after 20 weeks of age of gestation with previously normal BP with any of the following signs and/or symptoms: hyperreflexia, headache (increasing frequency unrelieved by regular analgesics), clouding or blurring of vision, oliguria (passing out less than 400 ml of urine in 24 hours), upper abdominal pain (epigastric pain or pain in right upper quadrant), pulmonary edema.

O. **Premature Newborn** - a newborn weighing from between 500g to 2,499g, or 24 to < 37 weeks fetal aging.

P. **Preterm Birth** - defined as babies born alive before the 37 weeks of pregnancy are completed. There are subcategories of preterm birth based on gestational age, these are: extremely preterm (<28 weeks), very preterm (28 to <32 weeks), moderate to late preterm (32 to <37 weeks).

Q. **Preterm Birth Rate** - is defined as the number of preterm births divided by the number of live births.

R. **Preterm pre-labor rupture of membrane (pPROM)** - rupture of membranes before onset of true uterine contractions and this before 37 weeks age of gestation.

S. **Small newborn** - a newborn weighing from between 1,500 g to 2,499 g, or 24 to < 32 weeks by Ballard exam, or early trimester ultrasound results, if available.

T. **Small for Gestational Age (SGA)** - refers to an infant born with a birth weight less than the 10th percentile for babies of the same gestational age.

U. **Very small newborn** - a newborn weighing from between 500g to 1,499g, or 32 to < 37 weeks by Ballard exam, or early trimester ultrasound results, if available.

VI. GUIDING PRINCIPLES

A. The benefit package shall be value-based that addresses the highest disability adjusted life years (DALY) averted while prioritizing and adopting cost-effective interventions. The emphasis is to ensure quality healthcare services and good health outcomes;

B. The benefit package shall contribute to the attainment of universal health coverage and financial risk protection for all members;

Eligible members and their dependents can access the health services in government hospitals with no out-of-pocket or with a known co-payment in a private accommodation;

C. The benefit package shall encourage a holistic care of the mother-baby dyad with a comprehensive primary to catastrophic approach to patient care in a multidisciplinary setting. This shall facilitate team management and strengthen referral systems within a service delivery network (SDN).

VII. CODE, DESCRIPTION AND PACKAGE RATES

A. The following benefits shall be available for pregnant women who are in their 24 to 36 and 6/7 weeks of gestation, at risk of preterm delivery. The packages for the prevention of preterm delivery are availed exclusive of each other, with or without the coordinated referral and transfer package (Z 016.4).

Table 1: Z Benefit Package codes, descriptions and rates for the prevention of preterm delivery

Z CODE	DESCRIPTION	RATE (Php)
Z 016.1	Prevention of preterm delivery, with severe pre-eclampsia / eclampsia	3,000
Z 016.2	Prevention of preterm delivery, with preterm pre-labor rupture of membrane (pPROM)	1,500
Z 016.3	Prevention of preterm delivery, without pre-eclampsia / eclampsia or rupture of membranes but with labor or vaginal bleeding or multifetal pregnancy	600
Z 016.4	With coordinated referral and transfer from a lower level facility	4,000

B. The following benefits shall be available for premature newborns who are visually small or very small, 24 weeks to < 37 weeks by fetal aging or 500 g to ≤2,499 g fetal weight

Table 2. Z Benefit package codes, descriptions and rates for preterm and small newborns (24 weeks to <32 weeks)

Z CODE	DESCRIPTION	RATE (Php)
Z 016.5	Essential interventions for 24 weeks to <32 weeks	35,000
Z 016.6	Essential interventions with minor ventilatory support and Kangaroo Care for 24 weeks to <32 weeks	85,000
Z 016.7	Essential interventions with major ventilatory support and Kangaroo care for 24 weeks to <32 weeks	135,000

Table 3. Z Benefit package codes, descriptions and rates for preterm and small newborns (32 weeks to <37 weeks)

Z CODE	DESCRIPTION	RATE (Php)
Z 016.8	Essential interventions for 32 weeks to < 37 weeks	24,000
Z 016.9	Essential interventions with mechanical ventilation and Kangaroo Care for 32 weeks to < 37 weeks	71,000

VIII. LIST OF MANDATORY AND OTHER SERVICES

Table 4. Mandatory and other services for the prevention of preterm delivery

Code	Mandatory Services	Other Services, as needed
Z 016.1	Antenatal steroid (dexamethasone IM or betamethasone IM) Anticonvulsant for severe pre-eclampsia (magnesium sulfate IM) Assessment of labor and stage using the World Health Organization (WHO) partograph	Tocolytic agent (ex. nifedipine)[1] calcium gluconate IV
Z 016.2	Antenatal steroid (dexamethasone IM or betamethasone IM) Antibiotic for pPROM (ex. erythromycin IV or ampicillin IV) Assessment of labor and stage using the WHO partograph	Tocolytic agent (ex. nifedipine)[1]
Z 016.3	Antenatal steroid (dexamethasone IM or betamethasone IM) Assessment of labor and stage using the WHO partograph	Tocolytic agent (ex. nifedipine)[1]
Z 016.4	Coordinated referral and transfer from a lower level facility	

[1]For women at risk of imminent preterm birth who have an otherwise uncomplicated pregnancy, the acute use of a tocolytic drug to prolong pregnancy (up to 48 hours) can be considered to provide a window for administration of antenatal steroids and/or in utero fetal transfer to an appropriate neonatal health care setting. (WHO 2015)

Table 5. Mandatory and other services for preterm and small newborns (24 weeks to <32 weeks)

Z 016.5	Mandatory Services	Other Services, as needed
Management	• Essential Intrapartum and Newborn Care (EINC) • Thermoregulation	• Newborn resuscitation • Intensive care • Surfactant therapy • Ventilatory support: mechanical ventilation/continuous positive airway pressure (CPAP) • Oxygen support • Management of infection: empirical antibiotics / antibiotics for sepsis • Management of anemia • Management of apnea • Management of IVH ; screening for IVH • Management of jaundice • Breast feeding/breast milk feeding and counseling • Kangaroo Care
Diagnostics	• Complete blood count (CBC) • Blood typing • Bedside glucose test • Blood culture	• Serum sodium, potassium, calcium • Creatinine • Chest X-ray (antero-posterior/antero-posterior & lateral) (AP/APL)/ babygram • Cranial ultrasound • Total serum bilirubin • Blood gas determination
Procedures	• Peripheral IV insertion	• Endotracheal intubation • Surfactant administration • Phototherapy • Umbilical venous cannulation • Umbilical artery cannulation
Medicines	• Erythromycin eye ointment • Vitamin K • IV fluid: D_5Water or D_{10}Water	• IV antibiotics (ampicillin, gentamicin and others as determined by the hospital antibiogram) • Inotropes (e.g. dopamine IV, dobutamine IV, epinephrine IV) • Anticoagulant (e.g. heparin) • Surfactant • 0.9 NaCl IV fluid

Table 5. (Continuation) Mandatory and other services for preterm and small newborns (24 weeks to <32 weeks)

Z 016.6	Mandatory Services	Other Services, as needed
Management	• EINC • Thermoregulation • Breast feeding / breast milk feeding and counseling • Oxygen support • Kangaroo care	• Newborn resuscitation • Intensive care • CPAP • Management of jaundice • Management of infection: empirical antibiotics/antibiotics for sepsis • Management of anemia • Management of apnea • Management of IVH; screening for IVH
Diagnostics	• CBC • Blood typing • Total serum bilirubin • Bedside glucose test • Blood culture	• Blood gas determination • Serum sodium, potassium, calcium • Creatinine • Chest x-ray (AP/AP-L)/ babygram • Cranial ultrasound
Procedures	• Peripheral IV insertion	• Umbilical venous cannulation • Phototherapy
Medicines	• Erythromycin eye ointment • Vitamin K	• IV antibiotics (ampicillin, gentamicin, and others as determined by the hospital antibiogram) • Inotropes (e.g. dopamine IV, dobutamine IV, epinephrine IV) • Anticoagulant (e.g. heparin) • Vitamins (e.g., multivitamins PO) • Anti-anemia (ferrous sulfate PO) • Dibencozide PO • Parenteral nutrition (e.g., amino acid crystalline solutions) • IV fluids such as D_5 electrolyte solution, D_{50}
Birth dose vaccines	• Bacillus Calmette-Guerin (BCG) • hepatitis B	--o--
Screening	• Newborn hearing screening (oto-acoustic emission, OAE) • Newborn metabolic screening (basic panel) • Screening for retinopathy of prematurity (ROP)	--o--
Others	• Pre-discharge counseling	--o--

Table 5. (Continuation) Mandatory and other services for preterm and small newborns (24 weeks to <32 weeks)

Z 016.7	Mandatory Services	Other Services, as needed
Management	• EINC • Thermoregulation • Breast feeding / breast milk feeding and support, • Kangaroo care • Mechanical ventilation	• Newborn resuscitation • Intensive care • Surfactant therapy • Oxygen support • Management of jaundice • Management of infection: empirical antibiotics/antibiotics for sepsis • Management of anemia • Management of apnea • Management of IVH; screening for IVH
Diagnostics	• CBC • Blood typing • Total serum bilirubin • Bedside glucose test • Blood culture • Blood gas determination • Chest x-ray (AP/AP-L)/ babygram	• Cross-matching of blood type • Prothrombin time • Cerebrospinal fluid (CSF) determination for protein, glucose, cell count • CSF culture • Serum sodium, potassium, calcium • Creatinine • 2-D echocardiography • Blood culture
Procedures	• Peripheral IV insertion • Endotracheal intubation • Umbilical venous cannulation	• Surfactant administration • Blood transfusion (pRBC) • Double volume exchange transfusion (whole blood) • Phototherapy • Thoracostomy tube insertion • Thoracentesis (chest needling) • Insertion of central line
Medicines	• Erythromycin eye ointment • Vitamin K	• IV antibiotics (ampicillin, gentamicin, amikacin and others as determined by the hospital antibiogram) • Inotropes (e.g. dopamine IV, dobutamine IV, epinephrine IV) • Calcium gluconate IV • Anticoagulant (e.g. heparin) • Surfactant • Bronchodilator (e.g., aminophylline IV) • Analgesic (e.g., paracetamol PO) • Anticonvulsant (e.g. IV or PO phenobarbital) • Vitamins (e.g., multivitamins PO)

Table 5. (Continuation) Mandatory and other services for preterm and small newborns (24 weeks to <32 weeks)

Z 016.7	Mandatory Services	Other Services, as needed
		• Anti-anemia (ferrous sulfate drops PO) • Dibencozide PO • Parenteral nutrition (e.g. amino acid crystalline solution)
Birth Dose Vaccines	• BCG • Hepatitis B	--o--
Screening	• Newborn hearing screening (OAE) • Newborn metabolic screening (basic panel), • Screening for ROP	--o--
Others	• Pre-discharge counseling	--o--

Table 6. Mandatory and other services for preterm and small newborns (32 weeks to <37 weeks)

Z 016.8	Mandatory Services	Other Services, as needed
Management	• EINC • Thermoregulation	• Newborn resuscitation • Intensive care • Surfactant therapy • Ventilatory support: mechanical ventilation/ CPAP • Oxygen support • Management of infection: empirical antibiotics/antibiotics for sepsis • Management of anemia • Management of apnea • Management of IVH; screening for IVH, • Management of jaundice • Breast feeding/breast milk feeding and support • Kangaroo Care
Diagnostics	• CBC • Blood typing • Bedside glucose test • Blood culture	• Blood gas determination • Serum sodium potassium, calcium • Creatinine • Total serum bilirubin • Chest x-ray (AP/AP-L)/ babygram

Table 6. (Continuation) Mandatory and other services for preterm and small newborns (32 weeks to <37 weeks)

Z 016.8	Mandatory Services	Other Services, as needed
Procedures	• Peripheral IV insertion	• Phototherapy • Endotracheal intubation • Surfactant administration • Umbilical venous cannulation
Medicines	• Erythromycin eye ointment • Vitamin K	• IV antibiotics (ampicillin, gentamicin, and others as determined by the hospital antibiogram) • Inotropes (e.g. dopamine IV, dobutamine IV, epinephrine IV) • Vitamins (e.g., multivitamins PO) • Anti-anemia (Ferrous sulfate drops PO) • Dibencozide PO • IV fluids D_5 electrolyte solution, D_{50}, D_5 0.9 NaCl
Birth Dose Vaccine	• BCG • Hepatitis B	--o--
Screening	• Newborn hearing screening (OAE), • Newborn metabolic screening (basic panel), • Screening for ROP	--o--
Others	Pre-discharge counseling	--o--
Z 016.9	**Mandatory Services**	**Other Services, as needed**
Management	• EINC • Thermoregulation • Mechanical ventilation • Breast feeding / breast milk feeding and support, • Kangaroo Care	• Newborn resuscitation • Intensive care • Surfactant therapy • Ventilation support: CPAP • Oxygen support • Management of jaundice • Management of infection: empirical antibiotics / antibiotics for sepsis • Management of anemia • Management of apnea • Management of IVH; screening for IVH

Table 6. (Continuation) Mandatory and other services for preterm and small newborns (32 weeks to <37 weeks)

Z 016.9	Mandatory Services	Other Services, as needed
Diagnostics	• CBC • Blood typing • Chest x-ray (AP/AP-L)/ babygram • Blood gas determination • Blood culture • Bedside glucose test • Total serum bilirubin	• Serum sodium, potassium, calcium • Creatinine • Cross-matching of blood type • Prothrombin time • CSF determination for protein, glucose, cell count • CSF culture • Cranial ultrasound
Procedures	• Peripheral IV insertion • Umbilical venous cannulation	• Endotracheal intubation • Surfactant administration • Phototherapy • Blood transfusion (pRBC)
Medicines	• Erythromycin eye ointment • Vitamin K • IV Fluids: D_5Water/D_{10}Water	• IV antibiotics (ampicillin, gentamicin, amikacin, and others as determined by the hospital antibiogram) • Vitamins (e.g., multivitamins PO), • Anti-anemia (ferrous sulfate drops PO), • Dibencozide PO • Inotropes (e.g. dopamine IV, dobutamine IV, epinephrine IV) • Calcium gluconate • Analgesic (e.g., paracetamol PO) • Anticonvulsant (e.g. phenobarbital PO) • IV Fluids: D_5LR, 0.9 NaCl, D_{50}
Birth Dose Vaccines	• BCG • Hepatitis B	--o--
Pre-discharge Screening	• Newborn hearing screening (OAE) • Newborn metabolic screening (basic panel) • Screening for ROP	--o--
Others	• Pre-discharge counseling	--o--

IX. CREATION OF A PATIENT REGISTRY

PhilHealth shall create a patient registry for the Z Benefits for premature and small newborns in collaboration with pertinent stakeholders. The policies and implementing guidelines for this shall be disseminated in a separate issuance.

In the meantime, contracted HCIs are required to submit a Checklist of Eligibility Criteria (Annex "A") to their corresponding PhilHealth Regional Office (PRO). Given that the nature of the conditions requires urgent management, the said conditions are considered emergency; thus, HCIs may submit the Checklist of Eligibility Criteria to the PRO after admission of the patient but prior to filing of claims for the availment of the Z Benefits.

The contents of the Checklist of Eligibility Criteria shall be encoded by the Z benefits coordinator designated by the contracted HCI and shall send the electronic copy to the PRO and the Benefits Development and Research Department of PhilHealth.

X. CLAIMS FILING AND REIMBURSEMENT

Table 7. Package code with corresponding amount and filing schedule of the packages for the prevention of preterm delivery

Package Code	Amount (Php)	Filing Schedule
Z 016.1	3,000	Within 30 calendar days upon discharge of the mother
Z 016.2	1,500	
Z 016.3	600	
Z 016.4	4,000	

The packages for the prevention of preterm delivery are availed exclusive of each other, with or without the coordinated referral and transfer package (Z 016.4).

Table 8. Package code and amount per tranche and filing schedule for preterm and small newborns (24 weeks to <32 weeks)

Package Code	Amount (Php)	Filing Schedule
Z 016.5	35,000	Within 30 calendar days upon discharge of the baby
Z 016.6	85,000	
Z 016.7	135,000	

Table 9. Package code and amount per tranche and filing schedule for preterm and small newborns (32 weeks to <37 weeks)

Package Code	Amount (Php)	Filing Schedule
Z 016.8	24,000	Within 30 calendar days upon discharge of the baby
Z 016.9	71,000	

The following are the rules for claims filing and reimbursement:

1. All claims shall be filed by the contracted HCI in behalf of the patients. There shall be no direct filing by PhilHealth members;

2. The package code for the Z benefits for premature and small newborns is Z016;

3. To file a claim for reimbursement, the contracted HCI shall submit the claims application and the following documents to PhilHealth:

   a. PhilHealth Benefit Eligibility Form (PBEF) printout;
   b. When the PBEF print-out indicates that the patient is not eligible to avail of PhilHealth benefits, applicable supporting documents shall be attached such as certificate of PhilHealth contributions, Claim Form 1, photocopy of official receipt of latest PhilHealth contribution, updated PhilHealth Member Registration Form or PMRF;
   c. Photocopy of the Checklist of Eligibility Criteria (Annex "A") submitted to PhilHealth prior to filing of claims
   d. Properly accomplished Claim Form 2
      i. Part I. Fill out item numbers 1, 2, 3;
      ii. Part II. Fill out item numbers 1, 2, 3, 4, 5, 6, 7, 8b, 10;
      iii. For Part II, item number 10, the attending physician must be PhilHealth accredited and must accomplish this part;
      iv. Part IIIA. If without co-pay, check the first box. If with co-pay, check the second box. Completely fill out the required information indicated in the corresponding checked item.
      v. The statement of account (SOA) shall be attached to the claim application;
      vi. Part IIIB. Accomplish this part;
      vii. Part IV. Accomplish this part.
   e. Checklist of Mandatory and Other Services (Annex "C");
   f. Photocopy of completely accomplished Z Satisfaction Questionnaire (Annex "D");
   g. Checklist of Requirements for Reimbursement (Annex "E")
   h. All other requirements as indicated in Annex "E"

4. Results of diagnostic and laboratory tests are NOT required as attachments to the claims application. However, these documents should be attached to the patient's chart and shall be checked during monitoring;

5. The Z Satisfaction Questionnaire (Annex "D") shall be administered to all patients prior to discharge from the contracted HCI. These are validated during monitoring and shall be used as basis of the Corporation for benefits enhancement, policy research and quality improvement purposes;

6. Rules on late filing of claims shall apply;

7. If the delay in filing of claims is due to natural calamities, or other fortuitous events, the contracted HCI shall be accorded an extension period of 60 calendar days as stipulated in Section 47 of the Implementing Rules and Regulation (IRR) of the National Health Insurance Act of 2013 (Republic Act 7875, as amended by RA 9241 and RA 10606.

XI. MONITORING

Field monitoring of the Z Benefits for premature and small newborns shall be conducted. The method and corresponding tools and consent forms (Annex "L") are developed for purposes of benefits monitoring, benefits enhancement, policy research and continuous quality improvement.

Moreover, the performance indicators and measures to monitor compliance to the policies of the Z benefits shall be established in collaboration with relevant stakeholders and experts. These shall be incorporated in the Health Care Provider Performance Assessment System (HCP PAS) and shall be disseminated in a separate issuance.

XII. CONTRACTING

PhilHealth shall engage with capable government and private HCIs, in the provision of services for the Z benefits for premature and small newborns. The minimum requirements for contracting capable HCIs shall be identified in collaboration with relevant stakeholders.

The service packages for mothers in preterm labor can be provided by any Maternity Care Package (MCP)-accredited facility or accredited HCI that provide services for normal vaginal delivery. Thus, no contracting arrangements are necessary for these.

XIII. POLICY REVIEW

A regular policy review of the Z Benefits for premature and small newborns shall be conducted in collaboration with all relevant stakeholders, experts and technical staff representatives from the Corporation.

XIV. REPEALING CLAUSE

All provisions of previous issuances that are inconsistent with any provision of this Circular are hereby amended, modified or repealed accordingly.

XV. EFFECTIVITY

This circular shall take effect after 15 days following the completion of its publication in the Official Gazette or in a newspaper of general circulation and shall be deposited thereafter at the Office of the National Administrative Register, University of the Philippines Law Center.

XVI. LIST OF ANNEXES

The following annexes may be downloaded from the PhilHealth website: www.philhealth.gov.ph

Annex "A" Checklist of Eligibility Criteria
Annex "C" Checklist of mandatory and other services
Annex "D" Z satisfaction questionnaire
Annex "E" Checklist of requirements for reimbursement
Annex "F" Coordinated Referral and Transfer Form
Annex "G" Essential Intrapartum Newborn Care (EINC) Protocol Checklist
Annex "H" Transmittal Form
Annex "I" Pre-discharge Counseling Services Checklist
Annex "J" Algorithm for suspected pre-term delivery
Annex "K" WHO partograph
Annex "L" Field Monitoring Tool
Annex "M" Kangaroo Care Protocol Checklist

PAULYN JEAN B. ROSELL-UBIAL, MD, MPH, CESO II
Chairperson of the Board
Date Signed: 04/26/17

MASTER DOCUMENT Date: 5/8/17

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Case No. _____

Annex "A – Checklist of Eligibility Criteria"

CHECKLIST OF ELIGIBILITY CRITERIA

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐
MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF MEMBER ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐

Tick box corresponding to the Z Benefit to be availed of and place a (✓) in the status column if YES or write NA, if not applicable.

☐ **A. For WOMAN at risk for preterm delivery (Z016.1, Z016.2, Z016.3, Z016.4*) Eligibility criteria: 1.1 or 1.2 AND 2.1 or 2.2 or 2.3 or 2.4**	**Status**
1. Estimated gestational age <37 weeks, based on:	
1.1 Fundic height < ___ cm	
1.2 ≥ 3 weeks earlier than expected date of confinement (EDC), based on:	
1.2.1 Last menstrual period (LMP); OR	
1.2.2 Early trimester ultrasound (if available)	
2. Presence of complication	
2.1 Severe pre-eclampsia	
2.1.1. Systolic BP of >/= 160 mmHg or a diastolic BP of >110 mmHg or both x 2 occasions, at 4 hours apart AND	
2.1.2 Proteinuria 3+ after 20 weeks gestational age with previously normal BP, WITH	
2.1.3 ANY of the following danger signs:	
2.1.3.1 Hyperreflexia	
2.1.3.2 Headache	
2.1.3.3 Blurring of vision	
2.1.3.4 Oliguria	
2.1.3.5 Upper abdominal pain	
2.1.3.6 Pulmonary edema	

*Eligibility for Z 016.4 shall depend on the level of the facility

Tick box corresponding to the Z Benefit to be availed of and place a (✓) in the status column if YES or write NA, if not applicable.

Cont. For WOMAN at risk for preterm delivery (Z016.1, Z016.2, Z016.3, Z016.4*)	**Status**
2.2 Preterm, pre-labor rupture of membranes (pPROM)	
2.3 Onset of labor	
2.4 Vaginal bleeding	

*Eligibility for Z 016.4 shall depend on the level of the facility

☐ **B. For NEWBORN (Z016.5, Z016.5, Z016.6, Z016.7, Z016.8, Z016.9) Eligibility criteria 1.1 or 1.2 OR 2.**	**Status**
1. Gestational Age <37 weeks, based on:	
1.1 Ballard examination	
1.2. Best obstetric estimate	
1.2.1 Early trimester ultrasound (if available) OR	
1.2.2 LMP	
2. Weight < 2.5 kg	

Certified correct by:	Conforme by:
(Printed name and signature) Attending Physician	(Printed name and signature) Parent/Guardian
PhilHealth Accreditation No.	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	

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Case No. _____

Annex "C – Preterm and Small Baby"

CHECKLIST OF MANDATORY AND OTHER SERVICES
Preterm and Small Baby

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT ☐☐ - ☐☐☐☐☐☐☐☐ - ☐
MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF MEMBER ☐☐ - ☐☐☐☐☐☐☐☐ - ☐

Place a (✓) in the status column if DONE or NA if not applicable.

MANDATORY AND OTHER SERVICES	Status
A. Management	
1. Essential intrapartum and newborn care (EINC)	
2. Thermoregulation	
3. Newborn resuscitation, as needed	
4. Intensive care, as needed	
5. Surfactant therapy, as needed	
6. Ventilatory support, as needed ☐ Mechanical ventilation ☐ Continuous positive airway pressure (CPAP)	
7. Oxygen support, as needed	
8. Management of infection: Empirical antibiotics / antibiotics for sepsis, as needed	
9. Management of anemia, as needed	
10. Management of apnea, as needed	
11. Management of intraventricular hemorrhage; screening for intraventricular hemorrhage (IVH), as needed	
12. Management of jaundice, as needed	
13. Breast feeding/breast milk feeding and counseling, as needed	
14. Kangaroo care, as needed	

Place a (✓) in the status column if DONE or NA if not applicable.

MANDATORY AND OTHER SERVICES	Status
B. Diagnostics	
1. Complete blood count (CBC)	
2. Blood typing	
3. Bedside glucose test	
4. Blood culture	
5. Serum sodium, potassium, calcium, as needed	
6. Creatinine, as needed	
7. Chest X-ray (antero-posterior/antero-posterior & lateral) (AP/APL)/ 'babygram', as needed	
8. Cranial ultrasound, as needed	
9. Total serum bilirubin, as needed	
10. Blood gas determination, as needed	
11. Cross-matching of blood type, as needed	
12. Prothrombin time, as needed	
13. Cerebrospinal fluid (CSF) determination for protein, glucose, cell count, as needed	
14. CSF culture, as needed	
15. 2-D echocardiography, as needed	
C. Procedures	
1. Peripheral IV insertion	
2. Endotracheal intubation, as needed	
3. Surfactant administration, as needed	
4. Phototherapy, as needed	
5. Umbilical venous cannulation, as needed	
6. Umbilical artery cannulation, as needed	
7. Blood transfusion (e.g. packed RBC), as needed	
8. Double volume exchange transfusion (whole blood), as needed	
9. Thoracostomy tube insertion, as needed	
10. Thoracentesis (chest needling), as needed	
11. Insertion of central line, as needed	
D. Medicines	
1. Eye ointment (erythromycin or tetracycline)	
2. Vitamin K	
3. IV fluid: D_5Water, D_5 0.9 NaCl, D_{10}Water, D_5LR or D_{50} as needed	

Place a (✓) in the status column if DONE or NA if not applicable.

MANDATORY AND OTHER SERVICES	Status
4. IV antibiotics, as needed ☐ ampicillin ☐ gentamicin ☐ amikacin ☐ others as determined by the hospital antibiogram specify: _____	
5. Inotropes, as needed ☐ dopamine IV ☐ dobutamine IV ☐ epinephrine IV	
6. Anticoagulant (e.g. heparin), as needed	
7. Surfactant, as needed	
8. 0.9 NaCl IV fluid, as needed	
9. Vitamins (e.g. multivitamin drops PO), as needed	
10. Anti-anemia (ferrous sulfate drops PO), as needed	
11. Dibencozide PO, as needed	
12. Parenteral nutrition (e.g., amino acid crystalline solutions), as needed	
13. Calcium gluconate IV, as needed	
14. Bronchodilator (e.g. aminophylline IV), as needed	
15. Analgesic (e.g. paracetamol PO), as needed	
16. Anticonvulsant (e.g. phenobarbital IV or PO), as needed	
E. Birth dose vaccines, as needed	
1. Bacillus Calmette-Guerin (BCG)	
2. Hepatitis B	
F. Screening, as needed	
1. Newborn hearing screening (oto-acoustic emission, OAE)	
2. Newborn metabolic screening (basic panel)	
3. Screening for retinopathy of prematurity (ROP)	
G. Others, as needed	
1. Pre-discharge counseling	
2. Coordinated referral and transfer to a lower level facility	

Certified correct by:	Conforme by:
(Printed name and signature) Attending Physician	(Printed name and signature) Parent/Guardian
PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐-☐	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	

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Case No. _____

Annex "C – Prevention of Preterm Delivery"

CHECKLIST OF MANDATORY AND OTHER SERVICES
Prevention of Preterm Delivery

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐
MEMBER *(if patient is a dependent)* (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF MEMBER ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐

Place a (✓) in the status column if DONE or NA if not applicable.

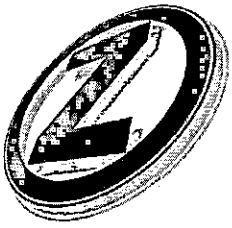
MANDATORY SERVICES	Status
A. Antenatal steroid ☐ dexamethasone IM; OR ☐ betamethasone IM	
B. Anticonvulsant for severe pre-eclampsia and/or for neuroprotection of preterm brain (magnesium sulfate IM)	
C. Antibiotic for pPROM ☐ erythromycin IV; OR ☐ ampicillin IV; OR ☐ others: (specify) _____	
D. Assessment of progression of labor and stage using the WHO simplified partograph	
E. Tocolytic agent, as needed ☐ nifedipine ☐ others: (specify) _____	
F. Calcium gluconate, as needed	
G. Coordinated referral and transfer from a lower level facility	

Certified correct by:	Conforme by:
(Printed name and signature) Attending Physician	(Printed name and signature) Patient/Parent/Guardian
PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐-☐	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	

MASTER DOCUMENT Date: 5/8/17 DC: [illegible]

PhilHealth

Annex "D"



Benefits

Share your opinion with us!

We would like to know how you feel about the services that pertain to the Z Benefit Package in order that we can improve and meet your needs. This survey will only take a few minutes. Please read the items carefully. If you need to clarify items or ask questions, you may approach your friendly health care provider or you may contact PhilHealth call center at 441-7442. Your responses will be kept confidential and anonymous.

For items 1 to 3, please tick on the appropriate box.

1. Z benefit package availed is for:
   - ☐ Acute lymphoblastic leukemia
   - ☐ Breast cancer
   - ☐ Prostate cancer
   - ☐ Kidney transplantation
   - ☐ Cervical cancer
   - ☐ Coronary artery bypass surgery
   - ☐ Surgery for Tetralogy of Fallot
   - ☐ Surgery for ventricular septal defect
   - ☐ ZMORPH/Expanded ZMORPH
   - ☐ Orthopedic implants
   - ☐ PD First Z benefits
   - ☐ Colorectal cancer
   - ☐ Prevention of preterm delivery
   - ☐ Preterm and small baby

2. Respondent's age is:
   - ☐ 19 years old & below
   - ☐ between 20 to 35
   - ☐ between 36 to 45
   - ☐ between 46 to 55
   - ☐ between 56 to 65
   - ☐ above 65 years old

3. Sex of respondent
   - ☐ male
   - ☐ female

For items 4 to 8, please select the one best response by ticking the appropriate box.

4. How would you rate the services received from the health care institution (HCI) in terms of availability of medicines or supplies needed for the treatment of your condition?
   - ☐ adequate
   - ☐ inadequate
   - ☐ don't know

5. How would you rate the patient's or family's involvement in the care in terms of patient empowerment? (You may refer to your Member Empowerment Form)
   ☐ excellent
   ☐ satisfactory
   ☐ unsatisfactory
   ☐ don't know

6. In general, how would you rate the health care professionals that provided the services for the Z benefit package in terms of doctor-patient relationship?
   ☐ excellent
   ☐ satisfactory
   ☐ unsatisfactory
   ☐ don't know

7. In your opinion, by how much has your HCI expenses been lessened by availing of the Z benefit package?
   ☐ less than half
   ☐ by half
   ☐ more than half
   ☐ don't know

8. Overall patient satisfaction (PS mark) is:
   ☐ excellent
   ☐ satisfactory
   ☐ unsatisfactory
   ☐ don't know

9. If you have other comments, please share them below:

   _____
   _____
   _____

Thank you. Your feedback is important to us!

Date accomplished: (mm/dd/yyyy)

_____

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www.philhealth.gov.ph

Case No. _____

Annex "E – Prevention of Preterm Delivery"

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT ☐☐ - ☐☐☐☐☐☐☐☐☐☐ - ☐
MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF MEMBER ☐☐ - ☐☐☐☐☐☐☐☐☐☐ - ☐

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT
Prevention of Preterm Delivery

Requirements	Please Check
1. Checklist of Eligibility Criteria (Annex A)	
2. Checklist of Requirements for Reimbursement (Annex E-Prevention of Preterm Delivery)	
3. Completed PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF) and CF 2	
4. Checklist of Mandatory and Other Services (Annex C- Prevention of Preterm Delivery)	
5. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
6. Photocopy of Coordinated Referral and Transfer Form (Annex F)	
7. Photocopy of WHO Partograph (Annex K)	
DATE COMPLETED : DATE FILED :	

Certified correct by:	Conforme by:
(Printed name and signature) Attending Physician	(Printed name and signature) Patient/Parent/Guardian
PhilHealth Accreditation No. ☐☐☐☐–☐☐☐☐☐☐–☐	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	

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Case No. _____

Annex "F –Preterm and small baby"

HEALTH CARE INSTITUTION (HCI) WHERE PATIENT IS REFERRED TO
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐
MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF MEMBER ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐

COORDINATED REFERRAL & TRANSFER FORM

☐ Antepartum ☐ Intrapartum ☐ Postpartum

Date of Transfer (mm/dd/yyyy)	Method of transport
Transfer from: (Birthing home)	Contact number of birthing home
Referred by: (Physician/Midwife)	Contact number of physician/midwife
Obstetrical Care Provider: (Physician/Midwife)	Contact number of physician/midwife
Name of Accepting Physician	Contact number of accepting physician
Date of Referral (mm/dd/yyyy)	Time: ____:____ AM/PM

Reason for Transfer ☐Retro-transfer ☐Acute transfer	☐ Maternal (describe) ☐ Fetal (describe) ☐ Small baby for continuing care
Allergies	☐ No known allergies ☐ Specify (drug, food, tape, dyes, latex, other) _____ and reactions _____
Obstetric history	☐ Copy of chart with patient and additional information, if indicated
Gravida: _____ Para: _____ LMP: _____ EDB/C: _____ Gestation (weeks + days) _____ Past C-Section or Uterine Surgery: _____ Incision Type: _____	
Labour & Birth	Onset of Labour: _____ Membranes Ruptured: ☐ Yes ☐ No Time: Colour: _____
Cervical Exam: _____ /_____ /_____ Fetal Position: A: _____ B: _____ C: _____ Placenta (multiples): ☐ DI/DI ☐MONO/DI ☐MONO/MONO ☐Other:_____ Maternal VS:BP _____ / _____ Pulse: _____ Resp: _____ Temp: _____ Partograph attached? ☐ Yes ☐ No; If Yes, correctly filled out? ☐ Yes ☐ No Comments:	

Medications	Regular medications:		
Antibiotics:	Date:	Time:	Others:
Steroids:	Date:	Time:	
$MgSO_4$ ☐Seizure prophylaxis ☐Neuroprotection	Date:	Time:	
Medical/Surgical History	☐ See chart		
Relevant medical/surgical history			
Social Issues	☐ See chart		
Intransit	☐ See transport record IV:___ TBA on arrival ___ mL Rate ___ mL/hr		

Time	FHR	Pulse	Resp	BP	Contractions			Medications	Comments
					Frequency	Duration	Intensity	Dose/Route	

Transfer Information	Departure Time: _____ Time of Arrival at Receiving HCI: _____
☐ See transport record	Accompanied by: _____ Relationship: _____ Attendant during transport _____
Signature /Status: _____	Print Name: _____

Certified correct by:	Conforme by:
(Printed name and signature) Attending Physician	(Printed name and signature) Patient/Parent/Guardian
PhilHealth Accreditation No.	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	

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Case No. _____

Annex "G – Preterm and small baby"

ESSENTIAL INTRAPARTUM NEWBORN CARE PROTOCOL CHECKLIST

(Adopted from the Harmonized Modules on Basic Emergency Obstetric and Newborn Care Training for Midwives)

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT ☐☐ - ☐☐☐☐☐☐☐☐ - ☐
MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF MEMBER ☐☐ - ☐☐☐☐☐☐☐☐ - ☐

Place a (✓) in the status column if DONE or NA if not applicable.

I. STANDARD PROCEDURES	Status
A. Recommended obstetric practices	
1. Antenatal steroids for mothers in preterm labor and mothers at risk for preterm birth such as those with antenatal bleeding (placenta previa), hypertension, preterm prelabor rupture of membranes	
2. Allowing a companion of choice	
3. Mobility and position of choice during labor	
4. Use of partograph to monitor the course of labor	
5. Non-routine practice of perineal shaving, enema, NPO, IV fluid administration, episiotomy	
6. Active management of the 3rd stage of labor	
B. Recommended maternal care practices that improve neonatal outcome most especially for preterm births	
1. Antenatal steroids given to the mother at risk for preterm labor or preterm delivery	
2. Maintain thermoregulation (room temperature at 25-28°C)	
3. Performance of the four core steps of the EINC Protocol a. Immediate thorough drying at delivery b. Skin-to-skin contact of mother and baby c. Properly-timed cord clamping within 1-3 minutes of birth or when cord pulsations stop. No additional "cord care" with trimming and application of alcohol or povidone iodine d. Non-separation of mother and baby to encourage early breastfeeding initiation	

Place a (✓) in the status column if DONE or NA if not applicable.

II. PROCEDURES FROM ANTENATAL TO PERINEAL BULGING	Status
A. Antenatal	
1. At least four antenatal visits done	
2. Iron and folate supplementation given	
3. Tetanus toxoid vaccine administered	
4. Prepared a birth plan including Unang Yakap	
B. Upon arrival at facility	
1. Identifed the mother in preterm labor or the mother who might give birth to a preterm newborn at point of entry	
2. History	
3. Physical exam	
4. Vital signs	
5. Obtained birth plan	
6. Determined companion of choice	
C. During labor	
1. Allowed position of choice	
2. Used partograph to monitor labor	
3. Allowed the mother to have oral fluids and light snacks	
4. IV fluid and NPO only when indicated	
D. Prior to delivery	
1. Checked room temperature	
2. Arranged all instruments in a linear sequence	
3. Discussed care in the first hours	
4. Checked resuscitation area and equipment	
E. Perineal bulging	
1. Performed proper handwashing	
2. Put on two pairs of sterile gloves (if solitary birth attendant)	
3. No routine episiotomy or fundal pressure done	
III. PROCEDURES FROM DELIVERY TO TIME SIX HOURS POSTPARTUM	
A. Delivery	
1. Supported the perineum of the mother with controlled delivery of the head	
2. Called out time of birth and sex of the baby	
B. First 30 seconds	
1. Dried thoroughly and checked breathing of the baby	
2. Assisted in skin to skin contact	

Place a (✓) in the status column if DONE or NA if not applicable.

III. PROCEDURES FROM DELIVERY TO TIME SIX HOURS POSTPARTUM (Continuation)	**Status**
C. One minute to three minutes	
1. Gave the mother oxytocin IM after excluding a 2nd baby	
2. Did controlled traction of cord of the mother with counter-traction	
3. Massaged uterus of the mother gently	
4. Examined the birth canal for lacerations, bleeding	
5. Examined the placenta and membranes	
6. Removed soiled pair of gloves (if double gloving done)	
7. Felt for cord pulsations, clamped, cut cord	
8. Returned baby to prone position	
D. 15 to 90 minutes	
1. Supported first full breastfeed	
2. Monitored as a DYAD every 15 minutes	
3. Continued uterine massage of the mother	
4. Monitored the mother every 15 minutes	
5. Eye care done	
6. Did thorough physical exam of baby including weight, anthropometric measurements	
7. Injected vitamin K IM	
8. Injected hepatitis B vaccine IM	
9. Injected BCG vaccine ID	
10. Transported the mother and her baby to room together	
E. >Six hours	
1. Breastfeeding support on positioning and atment provided	
2. Bathing done (optional)	

Certified correct by:	Conforme by:
(Printed name and signature) Attending Physician	(Printed name and signature) Parent/Guardian
PhilHealth Accreditation No. | | | | | – | | | | | | | – | |	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	

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Annex "H"

TRANSMITTAL FORM OF CLAIMS FOR THE Z BENEFITS

NAME OF CONTRACTED HEALTH CARE INSTITUTION (HCI)	ADDRESS OF HCI

Instructions for filling out this Transmittal Form. Use additional sheets if necessary.

1. Use CAPITAL letters or UPPER CASE letters in filling out the form.
2. For the period of confinement, follow the format (mm/dd/yyyy).
3. For the Z Benefit Package Code, include the code for the order of tranche payment. Example: breast cancer, second tranche should be written as "Z0022".
4. For the Case Number, copy the case number that is provided in the approved pre-authorization checklist and request.
5. The Remarks column may include some relevant notes which pertain to the filed claim that need to be relayed to PhilHealth.

Case Number	Name of Patient (Last, First, Middle Initial, Extension)	Period of Confinement		Z Benefit Package Code	Remarks
		Date admitted	Date discharged		
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

Certified correct by authorized representative of the HCI		For PhilHealth Use Only	Initials	Date
	Designation	Received by Local Health Insurance Office (LHIO)		
Printed Name and Signature	Date signed (mm/dd/yyyy)	Received by the Benefits Administration Section (BAS)		

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Case No. _____

Annex "I – Preterm and small baby"

PRE-DISCHARGE COUNSELING CHECKLIST

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐
MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF MEMBER ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐

Place a (✓) in the status column if DONE or NA, if not applicable.

I. ACTIVITY	Status
A. Explained and discussed how and when to wash hands	
1. Proper handwashing, e.g. WHO 1-2-3-4-5 technique, using soap and clean water	
2. Before and after breastfeeding or expressing	
3. Before and after baby care e.g. bathing	
4. Before and after changing diaper	
5. After using the toilet	
6. Before and after handling food and cooking	
B. Explained and discussed how to recognize danger signs	
1. Breathing fast (> 60 breaths per minute)	
2. Irregular breathing (gasping) or noisy breathing	
3. Chest in-drawing (retractions)	
4. Stops breathing > 20 secs (apneic episode)	
5. Pale or blue color on lips and around mouth	
6. Baby feels cold	
7. Difficulty breastfeeding, recurrent vomiting, diarrhea	
8. Convulsions	
9. Yellow skin (jaundice)	
10. No spontaneous movement (moves only when stimulated)	
C. Explained and discussed actions to address problems	
1. Check temperature of the room, put in skin-to-skin contact and provide additional layers of clothing over baby's back and head if the baby is cold or has slow breathing or blue color	

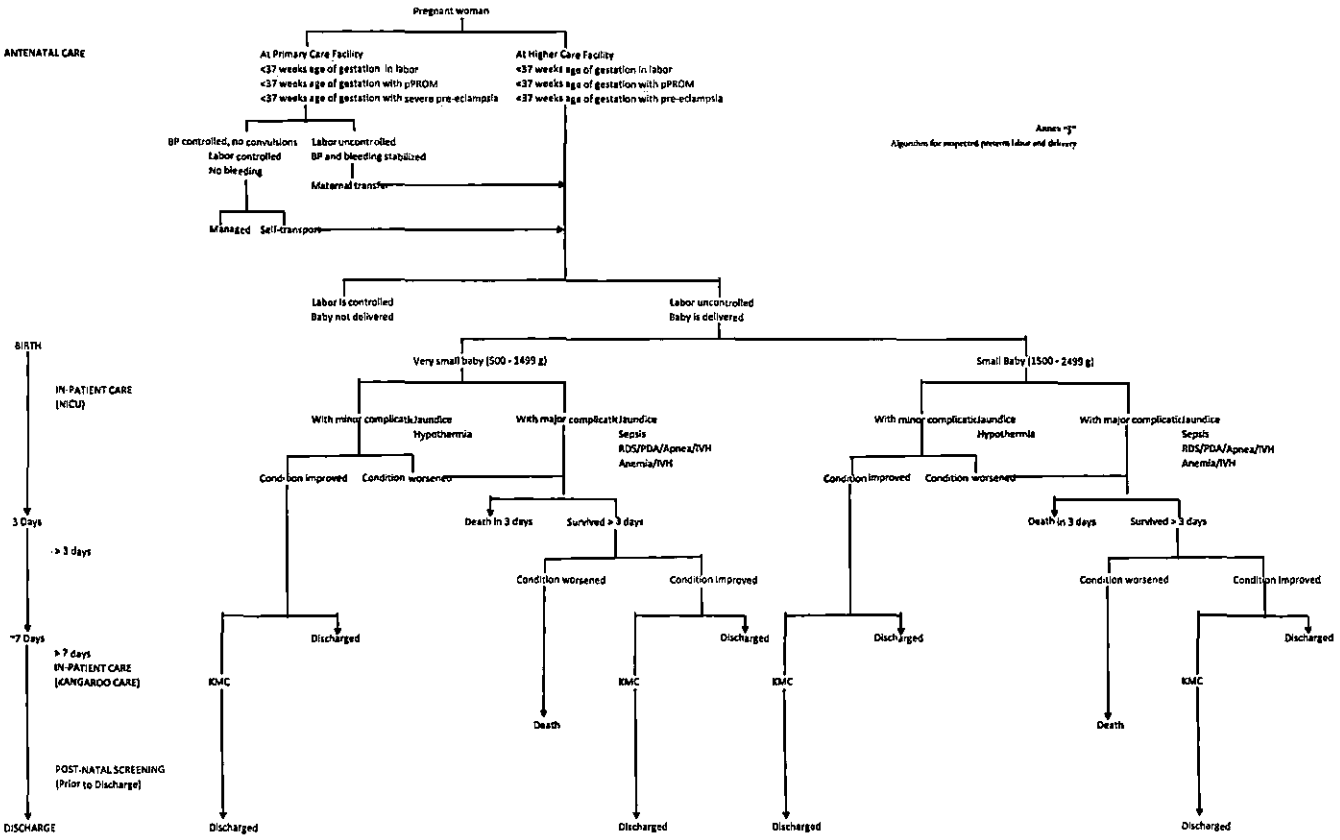
Place a (✓) in the status column if DONE or NA, if not applicable.

	Status
2. Try to breastfeed more frequently if the baby is feeding too little or tires out, weight gain is not enough or if with "physiologic" jaundice	
D. Explained and discussed discharge criteria	
1. No apnea, appears in good health	
2. Feeding well	
3. Gaining weight	
4. Temperature is stable	
5. Mother is confident of taking care of her baby using KMC (including unrestricted breastfeeding, provision of warmth, hygiene and positioning), cup feeding when separated, manual expression and storage of expressed breast milk, knows danger signs and actions	
II. DISCHARGE INSTRUCTIONS	
A. Advised the mother to return or go to the hospital immediately if:	
1. Jaundice to the soles or any of the following are present*	
2. Difficulty feeding	
3. Convulsions	
4. Movement only when stimulated	
5. Fast or slow or difficulty breathing (e.g. severe chest in-drawing)	
6. Temperature ≥ 37.5°C or < 35.5°C	

* From Lancet 2008, new IMCI algorithm for Young Infant II Study

B. Advised the mother to bring her newborn to the health facility for routine check-up at the following prescribed schedule:	
1. Postnatal visit 1: at 48-72 hours of life	
2. Postnatal visit 2: at 7 days of life	
3. Immunization visit 1: at 6 weeks of life	
C. Advised additional follow-up visits appropriate to problems in the following:	
1. Two days – if with breastfeeding difficulty, Low Birth Weight in the first week of life, red umbilicus, skin infection, eye infection, thrush or other problems.	
2. Seven days – if Low Birth Weight discharged more than a week of age and not gaining weight adequately.	
D. Advised for Newborn Screening – hearing, vision and blood screen	

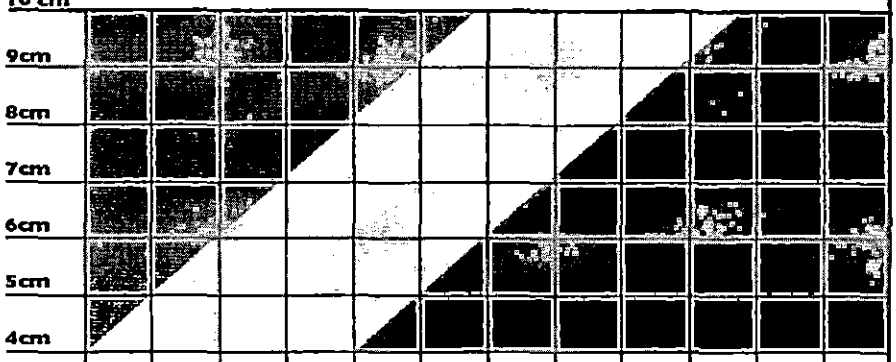
Certified correct by:	Conforme by:
(Printed name and signature) Attending Physician	(Printed name and signature) Parent/Guardian
PhilHealth Accreditation No.	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	



Annex "K"
WHO Partograph

PARTOGRAPH

Use this form for monitoring active labor



FINDINGS / Time	1	2	3	4	5	6	7	8	9	10	11	12
Hours in active labour												
Hours since ruptured membranes												
Rapid assessment												
Vaginal bleeding (0 + + +)												
Amniotic fluid (meconium stained)												
Contractions in 10 minutes												
Fetal heart rate (beats/minute)												
Urine voided												
T (axillary)												
Pulse (beats/minute)												
Blood pressure (systolic/diastolic)												
Cervical Dilation (cm)												
Delivery of Placenta (time)												
Oxytocin (time/given)												
Problem-note onset/describe below												

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Annex L - "Preterm & Small Baby"
Control Number: _____

FIELD SURVEY TOOL FOR Z BENEFIT FOR PREVENTION OF PRETERM DELIVERY AND FOR PRETERM & SMALL BABY

READ BEFORE STARTING THE INTERVIEW:

Magandang umaga/hapon. Una sa lahat, salamat sa pagpapaunlak ninyo sa interview na ito. Ako si *(sabihin ang pangalan)*, naatasang isagawa ang interview sa inyo para malaman ang estado ng serbisyong natanggap ninyo bilang isa sa mga beneficiaries ng Z benefits at malaman din kung naging sapat ba ang PhilHealth benefit na natanggap ninyo.

Na-identify kayo bilang respondent sa pamamagitan ng pagpili ng computer sa mga pasyente na naka-avail na ng Z benefit sa mga contracted hospitals. Ayon sa talaan namin, kayo ay nagclaim sa ilalim ng Z BENEFITS FOR PREMATURE and SMALL NEWBORNS noong *(state month and year)* sa *(state hospital)*.

Isasagawa natin ang interview na ito sa loob ng mahigit kumulang na 20 minutes. Hindi kami hihingi ng kahit anong personal na impormasyon sa inyo maliban lamang sa mga mahalaga para sa Z benefits monitoring. Anuman ang inyong sabihin sa interview na ito ay mananatiling confidential at hindi makakaapekto sa membership ninyo sa PhilHealth. Simulan na natin. *(If with recorder, ask permission first)*.

I. PATIENT INFORMATION

A. **Name of Patient (initials):** _____

B. **Permanent Address:** _____
_____

C. **Phone Number/s:**
1. _____
2. _____
3. _____

D. **Email address/es:**
1. _____
2. _____

E. **PhilHealth membership status:**
☐ Member ☐ Dependent

F. **Employment status:**
Currently working ☐ Yes ☐ No

If yes, nature of work:
_____
If no, who supports patient:
_____

G. **Age** (in years): _____

H. **Birthdate:** _____
(mm/dd/yyyy)

I. **Sex:** ☐ Male ☐ Female

J. **Marital status of patient:**
☐ Single
☐ Legally married
☐ Not married, with partner
☐ Widow/ widower (encircle)

K. **Educational status of patient:**
☐ Elementary
☐ High school
☐ College
☐ Vocational
☐ Post Graduate
☐ Others: specify _____

II. **RESPONDENT INFORMATION (if respondent is not the patient)**

A. **Name of Respondent:**
(Last name, first name, middle initial, extension)
_____

B. **Relationship to patient:**
- ☐ Spouse
- ☐ Parent
- ☐ Child
- ☐ Sibling
- ☐ Guardian
- ☐ Others: specify: _____

C. **Age** (in years): _____

D. **Sex:** ☐ Male ☐ Female

E. **Educational status of patient:**
- ☐ Elementary
- ☐ High school
- ☐ College
- ☐ Vocational
- ☐ Post Graduate
- ☐ Others: specify _____

III. **INFORMATION ON PATIENT'S PREGNANCY**

A. **Pangilang pagbubuntis niyo na ito?**

Number of Pregnancies:_____

B. **Sa mga nakaraang pagbubuntis po ninyo, nagkaroon din po ba kayo ng pagbubuntis na kulang sa buwan?**

☐ Oo ☐ Hindi

Kung oo, ilan po?

Number of Preterm Births: _____

C. **Kayo po ba ay nagpa-check up para sa inyong pagbubuntis na ito?**

☐ Oo ☐ Hindi

Kung oo, ilang beses at kailan?

1st (mm/yyyy) _____
2nd (mm/yyyy) _____
3rd (mm/yyyy) _____
4th (mm/yyyy) _____

D. **Alam ba ninyo kung kailan kayo dapat manganak?**

☐ Oo ☐ Hindi

Kung oo, kailan kayo dapat manganak?

(Expected Date of Delivery) (mm/yyyy):

_____

E. **Para sa pagbubuntis na ito, nagkaroon po ba kayo ng mga sumusunod na kundisyon?**

☐ Hypertension ☐ Infection (specify)

☐ Diabetes _____

☐ Pre-eclampsia ☐ Others: _____

☐ Preterm, Prelabor, Rupture of membranes

F. **Ano ang una ninyong naramdaman bago kayo napunta sa** (State hospital)?

- ☐ Pagkahilo/ pagsakit ng ulo
- ☐ Pagsusuka
- ☐ Pagsakit ng tiyan
- ☐ Pagputok ng panubigan
- ☐ Spotting
- ☐ Walang naramdaman
- ☐ Lagnat at pananakit ng katawan
- ☐ Others: _____

G. **Saan kayo unang kumunsulta pagkatapos niyo maramdaman ang sintomas na ito?**
- ☐ Lying-in\ Health Center: _____
- ☐ Hospital: _____

H. **Inirefer pa ba kayo ng health facility sa ibang lugar?**

☐ Oo ☐ Hindi

Kung oo, sa anong dahilan kaya kayo ini-refer ng health facility sa ibang lugar?

_____

IV. INFORMATION ON PRIMARY CONSULT (if answered yes in H)

A. Sa Lying-in/ health center, ano ang ibinigay sa inyong mga serbisyo? (Maaaring mas madami sa isa ang sagot.)

- ☐ Antenatal steroids (hal. dexamethasone)
- ☐ Tocolytic (hal. nifedipine)
- ☐ Partograph Monitoring
- ☐ Antibiotic
- ☐ Others: _____

B. Naipaliwanag ba sa inyo nang maayos kung ano ang inyong kundisyon?

☐ Oo ☐ Hindi

C. Ini-refer ba kayo ng maayos sa isang ospital na may kakayanan kung saan kaya alagaan ang inyong kundisyon?

☐ Oo ☐ Hindi

D. Alin sa mga sumusunod ang ginawa ng lying-in/ health center (maaaring mas madami ang sagot)

☐ Itinawag at ni-refer ako ng mga staff sa hospital na may kakayanan na alagaan ang kundisyon ko bago ako paalisin. Siniguradong tatanggapin ako ng maayos ng ospital na ito.

☐ Hinatid ako ng ambulansya na may staff na maayos na nag alaga sa akin

☐ Siniguradong maayos ang kundisyon ko sa ospital bago ako iniwan

☐ Wala sa mga ito

E. Ano ang gamit ninyong sasakyan papunta ng ospital o pasilidad?

- ☐ Public, specify _____
- ☐ Private, specify _____
- ☐ Sariling sasakayan
- ☐ Nirerentahan
- ☐ Ambulance
- ☐ Barangay/ other government vehicles
- ☐ Naglakad lang

V. BABY'S INFORMATION

A. Ano po ang pangalan ni baby?

_____

B. Ano po ang kasarian ni baby?

☐ Lalaki

☐ Babae

☐ Di-tiyak (ambiguous genitalia)

C. Kailan po ipinanganak si baby? (mm/dd/yyyy)

____/____/_____

D. Husto ba sa buwan si baby noong siya ay isinilang mo?

☐ Oo ☐ Hindi

Kung hindi, ilan linggo pa ang kulang, para ito mahusto?

_____

E. Ano ang timbang ni baby nung siya ay pinanganak? (Birth weight)

_____

F. Alam niyo po ba ang APGAR score ni baby nang siya ay ipinanganak?

☐ Oo ☐ Hindi

Kung oo, ano? _____

G. Ano po ang pangalan ng nanay ni baby?

_____

H. Ano po ang pangalan ng tatay ni baby?

_____

I. Saan po nakatira si baby? (Address)

_____

VI. INFORMATION ON HOSPITAL STAY

A. Ano ang paraan ng inyong pangangak?

- ☐ Normal Delivery
- ☐ Cesarean Delivery

B. Ano ang serbisyo na binigay sa inyong dalawa ni baby habang nasa ospital

<Para sa Nanay>

- ☐ Antenatal steroids (hal. dexamethasone)
- ☐ Partograph Monitoring
- ☐ Tocolytic (hal. nifedipine)
- ☐ Antibiotic
- ☐ Breast feeding Support
- ☐ Counseling
- ☐ Others: _____

C. Ano ang kinahinatnan ni baby habang nasa ospital

- ☐ Nabuhay
- ☐ Namatay

<Para sa Baby>

- ☐ Laboratory: _____
- ☐ Gamot
  - ☐ Antibiotic: _____
  - ☐ Surfactant: _____
  - ☐ Others: _____
- ☐ X-ray at iba pang work-up o procedure
- ☐ Suporta sa paghinga
  - ☐ CPAP
  - ☐ Mechanical Ventilation
  - ☐ Oxygen
- ☐ Essential Intrapartum and Newborn Care (EINC) o Unang Yakap
- ☐ Kangaroo Mother Care
- ☐ Newborn screening
- ☐ Newborn hearing screening
- ☐ Newborn vision screening (ROP screen)
- ☐ Immunization
- ☐ Others: _____

D. Ilang linggo bago napauwi si baby?

_____

VII. SATISFACTION

A. Aling ospital or pasilidad ang nag enroll sa inyo sa Z BENEFITS FOR PREMATURE AND SMALL NEWBORN?

_____

B. Kayo ba ay nasiyahan sa serbisyong natanggap ninyo mula sa ospital o pasilidad na nagbigay ng Z benefits?

☐ Oo ☐ Hindi

C. Kung kayo ay nasiyahan, anu-ano ang inyong ikinasiya tungkol sa serbisyong natanggap ninyo?

_____

_____

D. Kung hindi kayo nasiyahan, anu-anong dahilan?

_____

_____

E. **Kung kayo ay nasiyahan sa serbisyong PD na inyong natanggap, paano ninyo isasalarawan ang inyong kasiyahan? (Markahan ng X)**

☐ Lubos na masaya

☐ Masaya

☐ Di masaya

VIII. PHILHEALTH BENEFIT

A. **May binayaran ba kayo mula ng kayo ay na-enroll sa Z BENEFITS FOR PREMATURE AND SMALL NEWBORN?** ☐ Meron ☐ Wala

B. **Kung "meron" anu-ano ang mga binayaran ninyo at magkano?**

Item	Amount

C. **May binayaran ba kayong professional fee ng doctor?** ☐ Meron ☐ Wala

D. **Kung "meron" magkano po ang binabayarang professional fee ng doctor kada check-up?** _____

E. **Naitago po ba ninyo ang mga resibo ng mga binayaran?** ☐ Oo ☐ Hindi

F. **Kung "oo," pwede po ba naming makita ang mga resibo at mailista o makuhanan ng picture ang mga ito?**

☐ Oo ☐ Hindi

Item	Amount indicated in receipt

IX. PATIENT COMMENTS

A. May nais ba kayong imungkahi para mapabuti pa ang benepisyo ng mga miyembro ng PhilHealth?

_____

_____

B. May nais ba kayong imungkahi para mapabuti pa ang serbisyo ng ospital o pasilidad?

_____

_____

Name of interviewer: _____ Designation: _____

Name of documenter: _____ Designation: _____

Date of interview (mm/dd/yyyy): _____ Time of interview: _____

MASTER DOCUMENT DC: 1475 Date: 5/8/17

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Citystate Centre, 709 Shaw Boulevard, Pasig City
Call Center (02) 441-7442 Trunkline (02) 441-7444
www.philhealth.gov.ph

Annex L - "Prevention of Preterm Delivery"
Control Number: _____

FIELD SURVEY TOOL FOR Z BENEFIT FOR PREVENTION OF PRETERM DELIVERY

READ BEFORE STARTING THE INTERVIEW:

Magandang umaga/hapon. Una sa lahat, salamat sa pagpapaunlak ninyo sa interview na ito. Ako si *(sabihin ang pangalan)*, naatasang isagawa ang interview sa inyo para malaman ang estado ng serbisyong natanggap ninyo bilang isa sa mga beneficiaries ng Z benefits at malaman din kung naging sapat ba ang PhilHealth benefit na natanggap ninyo.

Na-identify kayo bilang respondent sa pamamagitan ng pagpili ng computer sa mga pasyente na naka-avail na ng Z benefit sa mga contracted hospitals. Ayon sa talaan namin, kayo ay nagclaim sa ilalim ng Z BENEFITS FOR PREMATURE and SMALL NEWBORNS noong *(state month and year)* sa *(state hospital)*.

Isasagawa natin ang interview na ito sa loob ng mahigit kumulang na 20 minutes. Hindi kami hihingi ng kahit anong personal na impormasyon sa inyo maliban lamang sa mga mahalaga para sa Z benefits monitoring. Anuman ang inyong sabihin sa interview na ito ay mananatiling confidential at hindi makakaapekto sa membership ninyo sa PhilHealth. Simulan na natin. *(If with recorder, ask permission first)*.

I. PATIENT INFORMATION

A. **Name of Patient (initials):** _____

B. **Permanent Address:** _____
_____

C. **Phone Number/s:**
1. _____
2. _____
3. _____

D. **Email address/es:**
1. _____
2. _____

E. **PhilHealth membership status:**
☐ Member ☐ Dependent

F. **Employment status:**
Currently working ☐ Yes ☐ No

If yes, nature of work:
_____
If no, who supports patient:
_____

G. **Age** (in years): _____

H. **Birthdate:** _____
(mm/dd/yyyy)

I. **Sex:** ☐ Male ☐ Female

J. **Marital status of patient:**
☐ Single
☐ Legally married
☐ Not married, with partner
☐ Widow/ widower (encircle)

K. **Educational status of patient:**
☐ Elementary
☐ High school
☐ College
☐ Vocational
☐ Post Graduate
☐ Others: specify _____

II. RESPONDENT INFORMATION (if respondent is not the patient)

A. **Name of Respondent:**
(Last name, first name, middle initial, extension)
_____

B. **Relationship to patient:**
- ☐ Spouse
- ☐ Parent
- ☐ Child
- ☐ Sibling
- ☐ Guardian
- ☐ Others: specify: _____

C. **Age (in years):** _____

D. **Sex:** ☐ Male ☐ Female

E. **Educational status of patient:**
- ☐ Elementary
- ☐ High school
- ☐ College
- ☐ Vocational
- ☐ Post Graduate
- ☐ Others: specify _____

III. INFORMATION ON PATIENT'S PREGNANCY

A. **Pangilang pagbubuntis niyo na ito?**

Number of Pregnancies:_____

B. **Sa mga nakaraang pagbubuntis po ninyo, nagkaroon din po ba kayo ng pagbubuntis na kulang sa buwan?**

☐ Oo ☐ Hindi

Kung oo, ilan po?

Number of Preterm Births: _____

C. **Kayo po ba ay nagpa-check up para sa inyong pagbubuntis na ito?**

☐ Oo ☐ Hindi

Kung oo, ilang beses at kailan?

1st (mm/yyyy) _____
2nd (mm/yyyy) _____
3rd (mm/yyyy) _____
4th (mm/yyyy) _____

D. **Alam ba ninyo kung kailan kayo dapat manganak?**

☐ Oo ☐ Hindi

Kung oo, kailan kayo dapat manganak?

(Expected Date of Delivery) (mm/yyyy):

_____

E. **Para sa pagbubuntis na ito, nagkaroon po ba kayo ng mga sumusunod na kundisyon?**

☐ Hypertension ☐ Infection (specify)

☐ Diabetes _____

☐ Pre-eclampsia ☐ Others: _____

☐ Preterm, Prelabor, Rupture of membranes

F. **Ano ang una ninyong naramdaman bago kayo napunta sa (State hospital)?**

- ☐ Pagkahilo/ pagsakit ng ulo
- ☐ Pagsusuka
- ☐ Pagsakit ng tiyan
- ☐ Pagputok ng panubigan
- ☐ Spotting
- ☐ Walang naramdaman
- ☐ Lagnat at pananakit ng katawan
- ☐ Others: _____

G. **Saan kayo unang kumunsulta pagkatapos niyo maramdaman ang sintomas na ito?**
- ☐ Lying-in\ Health Center: _____
- ☐ Hospital: _____

H. **Inirefer pa ba kayo ng health facility sa ibang lugar?**

☐ Oo ☐ Hindi

Kung oo, sa anong dahilan kaya kayo ini-refer ng health facility sa ibang lugar?

_____

IV. INFORMATION ON PRIMARY CONSULT (if answered yes in H)

A. Sa Lying-in/ health center, ano ang ibinigay sa inyong mga serbisyo? (Maaring mas madami sa isa ang sagot)

- ☐ Antenatal steroids (hal. dexamethasone)
- ☐ Tocolytic (hal. nifedipine)
- ☐ Partograph Monitoring
- ☐ Antibiotic
- ☐ Others: _____

B. Napaliwanag ba ng maayos kung ano ang inyong kundisyon?

☐ Oo ☐ Hindi

C. Inerefer ba kayo ng ayos sa isang ospital na may kakayanan kung saan kaya alagaan ang inyong kundisyon?

☐ Oo ☐ Hindi

Alin sa mgasumusunod ang ginawa ng lying-in/ health center (maaring mas madami ang sagot)

☐ Itinawag at ni-refer ako ng mga staff sa hospital na may kakayanan na alagaan ang kundisyon ko bago ako paalisin. Siniguradong tatanggapin ako ng maayos ng ospital na ito

☐ Hinatid ako ng ambulansya na may staff na maayos na nag alaga sa akin

☐ Siniguradong maayos ang kundisyon ko sa ospital bago ako iniwan

☐ Wala sa mga ito

D. Ano ang gamit ninyong sasakyan papunta ng ospital o pasilidad?

- ☐ Public, specify _____
- ☐ Private, specify _____
- ☐ Sariling sasakayan
- ☐ Nirerentahan
- ☐ Ambulance
- ☐ Barangay/ other government vehicles
- ☐ Naglakad lang

V. SATISFACTION

A. Aling ospital or pasilidad ang nag enroll sa inyo sa Z BENEFITS FOR PREMATURE AND SMALL NEWBORN?

_____

B. Kayo ba ay nasiyahan sa serbisyong natanggap ninyo mula sa ospital o pasilidad na nagbigay ng Z benefits?

☐ Oo ☐ Hindi

C. Kung kayo ay nasiyahan, anu-ano ang inyong ikinasiya tungkol sa serbisyong natanggap ninyo?

_____

_____

D. Kung hindi kayo nasiyahan, anu-anong dahilan?

_____

_____

E. Kung kayo ay nasiyahan sa serbisyong PD na inyong natanggap, paano ninyo isasalarawan ang inyong kasiyahan? (Markahan ng X)

☐ Lubos na masaya

☐ Masaya

☐ Di masaya

VI. PHILHEALTH BENEFIT

A. **May binayaran ba kayo mula ng kayo ay na-enroll sa Z BENEFITS FOR PREMATURE AND SMALL NEWBORN?** ☐ Meron ☐ Wala

B. **Kung "meron" anu-ano ang mga binayaran ninyo at magkano?**

Item	Amount

C. **May binayaran ba kayong professional fee ng doctor?** ☐ Meron ☐ Wala

D. **Kung "meron" magkano po ang binabayarang professional fee ng doctor kada check-up?** _____

E. **Naitago po ba ninyo ang mga resibo ng mga binayaran?** ☐ Oo ☐ Hindi

F. **Kung "oo," pwede po ba naming makita ang mga resibo at mailista o makuhanan ng picture ang mga ito?**

☐ Oo ☐ Hindi

Item	Amount indicated in receipt

VII. PATIENT COMMENTS

A. May nais ba kayong imungkahi para mapabuti pa ang benepisyo ng mga miyembro ng PhilHealth?

_____

_____

B. May nais ba kayong imungkahi para mapabuti pa ang serbisyo ng ospital o pasilidad?

_____

_____

Name of interviewer: _____ Designation: _____

Name of documenter: _____ Designation: _____

Date of interview (mm/dd/yyyy): _____ Time of interview: _____

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
Call Center (02) 441-7442 Trunkline (02) 441-7444
www.philhealth.gov.ph

Case No. _____

Annex "M – Preterm and small baby"

KANGAROO CARE PROTOCOL CHECKLIST

(Adopted from various references in a separate list)

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT ☐☐ - ☐☐☐☐☐☐☐☐ - ☐
MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF MEMBER ☐☐ - ☐☐☐☐☐☐☐☐ - ☐

Place a (✓) in the status column if DONE or NA if not applicable.

I. PROCEDURES UPON MOTHER'S ARRIVAL AT FACILITY and PREPARATION FOR DELIVERY	**Status**
A. Upon arrival at facility	
1. Identified the mother in preterm labor or the mother who might give birth to a preterm or small newborn at point of entry	
2. History	
3. Physical exam	
4. Vital signs	
5. Determined companion of choice	
B. During labor	
1. Used partograph to monitor labor	
2. Allowed the mother to have oral fluids and light snacks, as indicated in Physician's orders	
3. Indication for IV fluid and NPO stated in patient's chart	
4. Mother in labor between 24-36 weeks, is given antenatal steroids, within one hour of arrival if not yet previously given	
5. Mother in labor ≤32 weeks, is given magnesium sulfate, within one hour of arrival	
C. Prior to delivery	
1. Prior to delivery	
2. Mother informed by professional birth attendant, on the care of her baby in the first hours of life	

Place a (✓) in the status column if DONE or NA if not applicable.

II. PROCEDURES FROM DELIVERY TO NINETY MINUTES POSTPARTUM	Status
A. Delivery and Care of the Small Baby	
1. Called out time of birth and sex of the baby	
2. Dried thoroughly and checked breathing of the baby	
3. Preterm or small baby placed skin-to-skin on the mother's chest, head covered with a cap and back covered with blanket and mother's gown	
4. Newborn attended to by another professional with special training on care of high risk neonates	
5. Vital signs taken including oxygen saturation by pulse-oximetry, every 5 minutes and recorded	
6. Oxygen 0.5-1lpm given by nasal cannula if needed, while maintaining skin-to –skin contact with mother	
7. Basic newborn resuscitation provided	
8. Advanced newborn resuscitation provided	
9. Initial dose of surfactant given	
10. Allowed to stay on mother's chest and latch on the breast if vigorous, stable and with feeding cues	
11. .After latching/first breastfeed completed, weighing and routine newborn care rendered at bedside a. Eye ointment applied b. Vitamin K given IM c. Hepatitis B given IM d. BCG given ID	
12. Roomed-in with mother in Kangaroo position	
13. Newborn ≤32 weeks, without respiratory distress, unable to latch on the breast for 60 minutes, transferred to NICU for further care	
14. Newborn ≤32 weeks, without respiratory distress, unable to latch on the breast for 60 minutes, transferred to NICU for further care	
15. Preterm or small baby on skin-to-skin contact, with pallor/cyanosis, grunting, dyspnea, tachypnea &/or desaturation <85% despite oxygen inhalation and appropriate resuscitation, transferred to NICU for further care	
B. Delivery and Care of the Mother who delivered a preterm/small baby, after another professional attends to the baby	
1. Gave the mother oxytocin IM after, excluding a 2nd baby	
2. Did controlled traction of cord with counter-traction	
3. Did controlled traction of cord with counter-traction	
4. Examined the birth canal for lacerations, bleeding	
5. Examined the placenta and membranes	
6. Removed soiled pair of gloves (if double gloving done)	
7. Felt for cord pulsations, clamped, cut cord aseptically, if not earlier done due to neonatal instability	

Place a (✓) in the status column if DONE or NA if not applicable.

II. PROCEDURES FROM DELIVERY TO NINETY MINUTES POSTPARTUM (Continuation)	Status
8. Continued uterine massage	
9. Monitored the mother every 15 minutes and recorded	
10. Transferred to room with small baby if possible (see #10-A above)	
III. KANGAROO CARE PROCEDURES FROM NINETY MINUTES UNTIL DISCHARGE OF SMALL BABY DIRECTLY ROOMED-IN WITH MOTHER	
1. Small baby enrolled to the KMC program as ordered in the chart	
2. Mother and Father/Guardian oriented and counseled on KMC policy and protocol	
3. KMC chart and other pertinent documents initiated and completed by social worker, attending Physician and Nurse on Duty	
4. Preterm or small baby stays skin-to-skin on the Mother's or Father's chest, head covered with a cap and secured in place with an expandable shirt or blouse (Kangaroo care)	
5. Diagnostic tests as indicated: a. CBC b. Blood type c. Bedside glucose test d. Blood Culture e. Total and fractionated serum bilirubin	
6. Breastfeeding and/or breastmilk feeding provided and assured	
7. Initial Newborn screening performed	
8. Adaptation to KMC evaluated and recorded in KMC adaptation score sheet every shift by NOD	
9. Small Baby examined by attending physician at least twice a day and duly noted in the chart	
10. Phototherapy provided, as indicated & ordered by attending physician	
11. Intravenous antibiotics through heparinized lock as indicated and ordered in chart	
12. Screened for ROP, if indicated	
13. Hearing Screen performed	
14. Second (expanded) Newborn screening performed	
15. Pre-discharge counselling given and countersigned by Mother	
16. Arrangement and conduction of transfer to low-level facility made, if necessary	
17. Arrangements for follow-up with other services and outpatient KMC clinic scheduled in appointment log book	
18. Discharge orders written, once eligibility criteria are met	

IV. KMC PROCEDURES ON SMALL BABY NOT DIRECTLY ROOMED-IN UNTIL TRANSFER FOR CONTINUOUS KMC IN ROOMING-IN WARD OR KMC UNIT	Status
A. Admission of small baby to NICU Level II as per policy and protocol	
1. Warming device, if unstable for KMC position (incubator or warmer)	
2. Respiratory support: a. Oxygen b. CPAP	
3. Diagnostics as indicated: a. CBC b. Blood Type c. Bedside glucose test d. Blood culture e. Blood gas analysis f. Chest radiograph g. Cranial ultrasound h. Total and fractionated serum bilirubin	
4. Peripheral intravenous fluid and parenteral nutrition	
5. Antibiotics	
6. Routine newborn care if not yet previously given a. Vitamin K b. Eye ointment c. Hepatitis B vaccine d. BCG	
7. Phototherapy as indicated	
8. Breastfeeding and/or breastmilk feeding	
9. Multivitamin and iron supplements	
10. As soon as eligibility criteria are met, the baby is enrolled to intermittent KMC as ordered by the attending physician	
11. Mother and Father/Guardian oriented and counseled on KMC protocol	
12. KMC chart and other pertinent documents initiated and completed by social worker, attending physician and nurse on duty	
13. Preterm or small baby stays skin-to-skin on the Mother's or Father's chest, head covered with a cap and secured in place with an expandable shirt or blouse, (kangaroo care) minimum of two hours per session, eight hours/day (cumulative)	
14. Adaptation to KMC evaluated and recorded in KMC adaptation score sheet every shift by NOD	
15. Newborn metabolic screen performed after feeding has been started	

IV. KMC PROCEDURES ON SMALL BABY NOT DIRECTLY ROOMED-IN UNTIL TRANSFER FOR CONTINUOUS KMC IN ROOMING-IN WARD OR KMC UNIT	Status
16. Transferred to room or KMC Unit with mother, once eligibility criteria for continuous KMC are met (Continue with procedures outlined from III-10 until discharge)	
B. Admission of preterm/small baby to NICU-III as per policy and protocol	
1. Warming device pending stabilization for kangaroo position	
2. Respiratory support: Assisted with mechanical ventilator	
3. Diagnostics: As in IV-A plus: a. Cross-matching for blood/blood product transfusion b. Prothrombin time c. CSF analysis and culture d. 2-D Echocardiogram e. Serum electrolytes f. Renal function tests (BUN, Creatinine)	
4. Procedures a. Endotracheal intubation b. Umbilical vessel/central line cannulation c. Double phototherapy d. Double volume exchange transfusion e. Packed red cell transfusion f. Surfactant administration g. Thoracentesis h. Thoracostomy	
5. Therapeutics: As in IV-A-6, plus: a. Surfactant b. Antibiotics for sepsis c. Inotropic agents (Dopamine, Dobutamine, Epinephrine) d. Anticoagulant (heparin) e. Calcium gluconate f. Bronchodilator (Aminophylline, Salbutamol nebulization) g. Analgesic (Paracetamol) h. Anticonvulsant (Phenobarbital) i. Parenteral nutrition	
6. Breastmilk feedings, progressing to direct breastfeeding	
7. As soon as eligibility criteria are met, the baby is enrolled to intermittent KMC as ordered by the attending physician	
8. Proceed with KMC protocol as outlined in IV-A #11-17, until eligible for rooming-in as outlined in section III #7-18 until discharge.	

Certified correct by:	Conforme by:
(Printed name and signature) Attending Physician	(Printed name and signature) Parent/Guardian
PhilHealth Accreditation No. ____-____-____	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	