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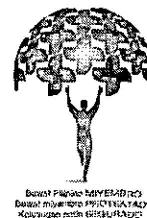

PhilHealth Circular
No. 2016 - 0004

TO : ALL ACCREDITED HEALTH CARE PROVIDERS, PHILHEALTH MEMBERS, PHILHEALTH REGIONAL OFFICES AND ALL OTHER CONCERNED

SUBJECT : Policy Statements on the Diagnosis and Management of Asthma in Adults As Reference by the Corporation in Ensuring Quality of Care

I. RATIONALE

The revised Implementing Rules and Regulations of the National Health Insurance Act of 2013 (RA 7875 as amended by RA 9241 and RA 10606) under Title V (Quality Assurance and Accreditation) Rule 1 (Quality Assurance) Section 51 provides the implementation of quality assurance standards as reference for ensuring quality of care services.

Compliance to clinical practice guidelines (CPGs) shall be one of the strategies in the implementation of quality assurance standards. The CPG recommendations based on best available evidence shall be translated into policy statements and shall be used primarily to provide guidance to doctors, hospitals and patients as to what tests, medicines, and procedures are strongly recommended if benefits clearly outweigh the harms. It shall be used by the Corporation as one of its references in assessing the quality of care rendered by PhilHealth-accredited health care providers to members through performance monitoring and other activities when necessary.

Asthma remains to be a major cause of chronic morbidity and mortality in the Philippines. There is a high prevalence of the condition in urban areas, with 27 to 33% of children and 17 to 22% of adults with definite or probable asthma (2009 Philippine Consensus Report of the PCCP). As such, the condition is considered as one of the top illnesses in claims reimbursement. The recommendations in this document incorporate updated information of the PhilHealth Policy Statements on Asthma published in the HTA Forum in 2006. The policy statements in this document are largely based on the 2009 Philippine Consensus Report on Asthma Diagnosis and Management formulated by the Philippine Council on Asthma of the Philippine College of Chest Physician (PCCP) as well as consultation with the PCCP.

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II. POLICY STATEMENTS

The Corporation shall adopt as standards the following statements in diagnosing and managing asthma which shall serve as guide to health care practitioners. However, specific provisions may be explicitly stated to affect reimbursement.

A. DEFINITION

1. Asthma is a chronic inflammation of the airways which contributes to airway hyper responsiveness that leads to recurrent episodes of wheezing, breathlessness, chest tightness, and coughing particularly at night or in the early morning. These episodes are usually with airflow obstruction within the lung that is often reversible either spontaneously or with treatment.

2. Asthma exacerbation or asthma attack – episodes of/changes in the patient's usual status such as progressive increase in asthma symptoms or a decrease in lung function.

3. Asthma control – extent of asthma manifestations (symptom control) and future risk for adverse outcomes.

4. Asthma severity – a retrospective assessment of the asthma status based on the level of treatment required to control symptoms and exacerbations.

B. CLINICAL DIAGNOSIS

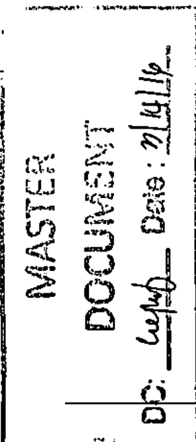
To make a diagnosis of asthma, the following should be sought in the patient's history:

1. On and off cough that gets worse at night or in the early morning
2. Wheezing
3. Episodic breathlessness
4. Chest tightness
5. Symptoms are triggered by exercise, allergen or irritant exposure, change in weather, or viral respiratory infections
6. A history of asthma and atopic disease in the family, and
7. Improvement of condition with the use of anti-asthma medications.

C. DIAGNOSTIC TESTS

The following are two acceptable methods used in the diagnosis of asthma as they provide objective measures:

- Spirometry or
- Peak Expiratory Flow (PEF)



D. HOSPITALIZATION

Patients with status asthmaticus and those who do not respond to treatment of acute asthmatic attacks in the emergency room should be admitted.

Long term treatment of asthma can be started while the patient is still admitted in the hospital.

E. TREATMENT

1. Classify all patients with asthma attacks (exacerbations) according to severity to help determine need for therapy (see Annex A)

2. The following medications may be administered to patients with asthmatic attacks:
   2.1. Inhaled corticosteroids
   2.2. Fixed dose combination of long-acting B2 agonists and inhaled corticosteroids to control symptoms and improve lung function.

3. The following medications may be administered to patients with persistent asthma:
   3.1. Inhaled B2 agonists
   3.2. Systemic or oral steroids
   3.3. Inhaled ipratropium bromide + inhaled B2-agonists

4. The recommended step-care approach in the management of asthma is as follow:

Step	Medication
1	Consider low dose inhaled corticosteroid (ICS)
2	Low dose ICS Low dose ICS or montelukast
3	Low dose ICS/LABA Low dose ICS or Moderate or high dose ICS
4	Moderate or high dose ICS/LABA or Medium dose ICS or High dose ICS + 2nd controller
5	High dose ICS/LABA + OCS or High dose ICS/LABA + other add-on agents

1.LABA (Long-acting B-agonist)
2.ICS (Inhaled corticosteroid)
3. OCS (Oral corticosteroid)

F. HOSPITAL DISCHARGE

Patients with stable vital signs for 24 hours and have the ability to maintain oral intake may be discharged.

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III. MONITORING AND EVALUATION

The health care provider shall be bound by the provisions of the Performance Commitment and subject to the rules on monitoring and evaluation of performance as provided in PhilHealth Circular No. 31 s-2014 (HCP PAS). Further, compliance to diagnostic and therapeutic interventions shall be assessed based on license service capability of the health care institution.

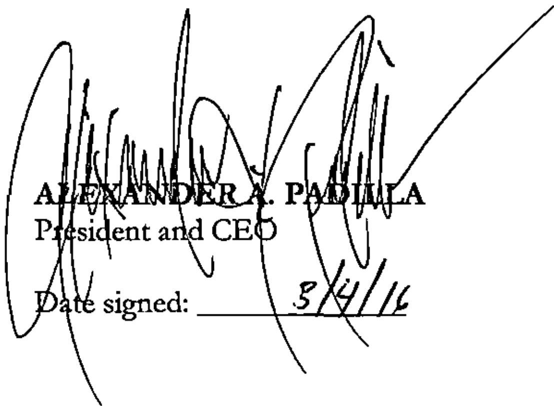
This Circular shall be reviewed periodically and as necessary.

IV. REPEALING CLAUSE

All provisions of previous issuances, circulars, and directives that are inconsistent with any of the provisions of this Circular for this particular circumstance wherein the same is particularly applicable, are hereby amended, modified or repealed accordingly.

V. EFFECTIVITY

This Circular shall take effect fifteen days after publication in any newspaper of general circulation and shall be deposited thereafter with the National Administrative Register at the University of the Philippines Law Center.



ALEXANDER A. PADILLA
President and CEO

Date signed: 3/4/16

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Annex A

Table 1. Treatment based on asthma severity

Severity	Recommended Treatment		
	Daily controller medications	**Alternative controller**	**Reliever medications**
Intermittent asthma attack (exacerbations)	None needed		SABA[1] as needed
Mild to moderate asthma attacks (exacerbations)	ICS[3] + LABA[2] combination as single inhaler	ICS[3] high dose or ICS[3] regular dose + any of the following: • SR Theophylline • Antileukotriene • Oral SR B2 agonist	SABA[1] as needed
Severe asthma attacks (exacerbations)	Oral steroids + ICS[3] + LABA[2] combination as single inhaler + any of the following: • SR Theophylline • Antileukotriene • Oral SR B2 agonist		SABA[1] as needed

1.SABA (Short-acting B-agonist)
2.LABA (Long-acting B-agonist)
3.ICS (Inhaled corticosteroid)

Table 2. Formulary Drugs for the treatment of asthma attacks (exacerbations)

Anti-inflammatory Controllers	Generic Name
Inhaled corticosteroid + LABA	Budesonide + Formoterol
	Fluticasone + Salmeterol
Inhaled corticosteroid	Beclomethasone dipropionate
	Budesonide
	Fluticasone
Oral corticosteroid	Methylprednisolone
	Prednisone
Anti-leukotrienes	Montelukast
Bronchodilator Controllers LABA	
Xanthine derivative	Theophylline
Bronchodilator Relievers SABA	
Inhaled	Salbutamol
	Terbutaline
SABA	
Oral	Salbutamol
	Terbutaline
Anti-cholinergic	Ipratropium
Anti-cholinergic + SABA	Ipratropium + Fenoterol
	Ipratroipum + Salbutamol
Xanthine derivative	Theophylline

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