Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8662-2588 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

PHILHEALTH CIRCULAR
No. 2024 - 0027

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

SUBJECT : **Quality Standards on the Diagnosis, Management, and Prevention of Adult Community-Acquired Pneumonia (ACAP) as Reference of the Corporation**

I. RATIONALE

The Universal Health Care Act (Republic Act No. 11223) mandates that PhilHealth supports the implementation of clinical care standards set by the Department of Health (DOH), guided by officially accepted clinical practice guidelines. Moreover, the revised Implementing Rules and Regulations of the National Health Insurance Act of 2013 (R.A. No. 10606) emphasize the significance of quality assurance standards as a benchmark to guarantee the provision of high-quality health care services.

Adult Community Acquired Pneumonia (ACAP) represents a substantial public health challenge, resulting in hospitalizations, morbidity and mortality. It stands as a prominent factor in claims reimbursement, underscoring the need for a robust policy framework to ensure adherence to evidence-based guidelines among PhilHealth-accredited healthcare providers. Such quality policy reinforces the Corporation's dedication to safeguarding public health and maintaining the highest standards of medical care.

Since the last policy update in 2016, notable advancements have been made in clinical practices, diagnostic approaches, and therapeutic strategies. To ensure optimal patient outcomes and alignment with current evidence-based guidelines, it is imperative to adopt and publish an updated quality policy. This policy builds upon previous iterations, incorporating elements and statements from earlier policies. It serves as a comprehensive reference for the Corporation in assessing the quality of care provided to members through educational resource, claims review, performance monitoring and other relevant activities.

These evidence-based policy recommendations were collaboratively developed with input from the Philippine Society for Microbiology and Infectious Diseases (PSMID), the Philippine College of Physicians (PCP), and the Philippine Academy of Family Physicians (PAFP). The policy integrates treatment guidelines derived from contemporary clinical practices and authoritative publications on adult community-acquired pneumonia.

II. OBJECTIVES

This PhilHealth Circular aims to establish the updated standards of care for the diagnosis and management of Adult Community Acquired Pneumonia, aligning with the Corporation's Quality Assurance Program.

III. SCOPE

This PhilHealth Circular covers the standards on the diagnosis, management and prevention of Adult Community-Acquired Pneumonia (ACAP).

This policy shall apply to adult patients hospitalized due to community-acquired pneumonia.

IV. DEFINITION OF TERMS

A. Adult Community-Acquired Pneumonia (ACAP) - an acute infection of the pulmonary parenchyma, characterized by acute illness and abnormal chest findings. This definition typically excludes patients who acquire the infection in hospitals or long-term care facilities.

V. POLICY STATEMENTS

A. Diagnosis

Clinical judgment is essential for diagnosing ACAP. Patients typically present with the following:

1. A history of cough within the past 24 hours or less than 2 weeks;
2. Abnormal vital signs of tachypnea (respiratory rate ≥30 breaths per minute), tachycardia (cardiac rate >125 per minute) and hypothermia or fever; and
3. At least 1 abnormal chest finding of diminished breath sounds, rhonchi, crackles, or wheezing.

B. Risk Stratification For Community Acquired Pneumonia (adapted from 2020 CPG on Adult CAP by PSMID)

	Low Risk	Moderate Risk	High Risk
Vital Signs	Stable	Unstable	Unstable
Respiratory rate	<30 cpm	≥30 cpm	≥30 cpm
Pulse rate	<125 bpm	≥125 bpm	≥125 bpm
Systolic blood pressure	≥90 mmHg	<90 mmHg	<90 mmHg
Diastolic blood pressure	>60 mmHg	≤60 mmHg	≤60 mmHg

	Low Risk	Moderate Risk	High Risk
Temperature	>36'C or <40'C	≤36'C or ≥40'C	≤36'C or ≥40'C
Others			
Altered mental state of acute onset	Absent	Present	Present
With suspected aspiration	No	Yes	Yes
Comorbid conditions	None or stable comorbid	Unstable or decompensated ✓ Uncontrolled diabetes mellitus ✓ Active malignancies ✓ Neurologic disease in evolution ✓ Congestive heart failure Class II-IV ✓ Unstable coronary artery disease ✓ Renal failure on dialysis ✓ Uncompensated COPD ✓ Decompensated liver disease	Unstable or decompensated ✓ Uncontrolled diabetes mellitus ✓ Active malignancies ✓ Neurologic disease in evolution ✓ Congestive heart failure Class II-IV ✓ Unstable coronary artery disease ✓ Renal failure on dialysis ✓ Uncompensated COPD ✓ Decompensated liver disease
Severe Sepsis and Septic Shock	Absent	Absent	Present/Absent*
Need for mechanical ventilator	No	No	No/ Yes*
*High risk CAP: any of the clinical feature of moderate risk CAP plus any of the following: Severe sepsis and Septic shock OR need for mechanical ventilation			

C. Initial Chest Radiography

1. Chest x-ray should be done for all patients suspected of pneumonia.
2. Chest CT scan should NOT be done routinely in the evaluation of pneumonia.

D. Hospital Admission

1. All patients with CAP should be classified into three risk categories to determine the need for hospitalization. Only moderate and high-risk CAP should be admitted.

2. Chest x-ray may be repeated for hospitalized patients suspected of pneumonia that have initial "normal" chest radiographic finding.

E. Microbiologic Studies

1. For low risk CAP, gram stain and culture of respiratory secretions is not advocated.

2. It is recommended to consider gram stain and culture of respiratory secretions for patients with moderate to high-risk community-acquired pneumonia (CAP) or those at risk for multidrug-resistant organism (MDRO) infection. Samples should be collected prior to antibiotic treatment.

3. It is recommended to obtain blood cultures for patients with moderate and high-risk CAP before initiating antibiotic treatment.

4. The routine utilization of multiplex polymerase chain reaction (PCR) in community-acquired pneumonia (CAP) is not routinely recommended but optional as an added test in facilities with service capability to determine possible etiologies of CAP.

5. It is optional to do Influenza test during periods of high influenza activity (July to January) for patients with high-risk CAP preceded by influenza-like illness symptoms (sore throat, rhinorrhea, body malaise, joint pains) and any of the following risk factors: aged 60 years and above, pregnant, asthmatic, and other co-morbidities (i.e. uncontrolled diabetes mellitus, active malignancies, neurologic disease in evolution, congestive heart failure class II-IV, unstable coronary artery disease, renal failure on dialysis, uncompensated COPD, decompensated liver disease).

6. Legionella urine antigen testing may be considered for patients presenting with high risk CAP.

7. Testing should be conducted in healthcare facilities with service capabilities as per their Department of Health (DOH) license. In facilities without such capability, testing is not mandatory. However, patient health outcomes will be monitored by the Corporation through facility visits, domiciliary investigations, and chart reviews.

F. Treatment and Management

1. Treatment should be started within 4 hours as soon as diagnosis of CAP is established.

2. Empiric antimicrobial therapy, guided by initial risk stratification, is recommended for CAP patients according to the 2020 PSMID CAP CPG update (Annex A).

3. For moderate to high risk CAP patients with risk factors for MDROs, the following antibiotics are recommended (Annex B: Antimicrobial Treatment for ACAP Patients with MDROs).

4. For high-risk ACAP patients with risk factors such as age ≥60, pregnancy, asthma, uncontrolled diabetes, active malignancies, evolving neurologic disease, CHF class II-IV, unstable coronary artery disease, renal failure on dialysis, uncompensated COPD, or decompensated liver disease, antiviral therapy is recommended alongside antibacterial therapy if influenza virus is present.

5. If diagnostic tests are unavailable, empiric antiviral therapy, in addition to antibacterial therapy, is optional to give during periods of high influenza activity (July to January) for patients with high-risk Adult Community-Acquired Pneumonia (ACAP) preceded by influenza-like symptoms (sore throat, rhinorrhea, body malaise, joint pains) and any of the comorbidities mentioned in the preceding statement.

6. Routine anaerobic coverage is not recommended for suspected aspiration pneumonia unless lung abscess or empyema is suspected.

7. A five-day treatment duration is recommended for low to moderate risk CAP patients, provided they remain clinically stable. Stability criteria include being:

    a. Afebrile within 48 hours
    b. Ability to eat
    c. Normal blood pressure, heart rate, respiratory rate, oxygen saturation
    d. Return to baseline sensorium

8. Antibiotic therapy may be extended based on clinical considerations, including:

    a. Non-resolving pneumonia
    b. Pneumonia complicated by sepsis, meningitis, endocarditis, or other deep-seated infections
    c. Infection with less common pathogens (such as Burkholderia pseudomallei, Mycobacterium tuberculosis, endemic fungi, etc.)
    d. Infection with drug-resistant pathogens

9. De-escalation of the intravenous antibiotic regimens for *MRSA*, *Pseudomonas*, or ESBL can be transitioned to targeted or oral antibiotics with similar spectrum activity is recommended once the patient is clinically improving, hemodynamically stable, and able to tolerate oral medications.

10. Follow-up chest x-ray should NOT be routinely performed to monitor response to treatment on patients who are clinically improving.

11. Post-treatment chest x-rays are recommended after a minimum of six to eight weeks among patients with ACAP to establish baseline and exclude other conditions.

12. Following an unsatisfactory response to 72 hours of empirical antibiotic therapy, several recommendations should be considered:

a. A thorough review of the patient's clinical history, physical examination findings, and all available investigative results is paramount. Reassessment focus on potential resistance to the antibiotic administered or the presence of alternative pathogens such as Mycobacterium tuberculosis, viruses, parasites, or fungi. Treatment adjustments should be made accordingly.

b. A follow-up chest radiograph is advised to explore potential alternative diagnoses.

c. Obtaining additional specimens for microbiologic testing for comprehensive evaluation and appropriate management.

13. The use of C-reactive protein and Procalcitonin tests is not recommended to monitor treatment response among patients with ACAP.

14. Procalcitonin may be used to guide antibiotic discontinuation among patients with moderate and high risk ACAP.

G. Hospital Discharge

Patients diagnosed of CAP may be discharged based on the following criteria:

1. Absence of unstable co-existing illness or other life-threatening complication;
2. Stable vital signs; and
3. Ability to maintain oral intake

H. Prevention

The primary pillars for the prevention of adult CAP are as follows:

1. Smoking cessation
2. Influenza vaccination for all patients
3. Pneumococcal vaccination in adults 50 years old and older

I. Monitoring And Evaluation

1. 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. 2018-0019 Health Care Provider Performance Assessment System (HCP-PAS) rev.2.

2. Standards of care issued by authorized agencies/organizations shall be regularly monitored. As deemed necessary, a revision of the quality policy shall be made. Any updates, as a result of the review, shall be disseminated in another PhilHealth Circular.

VI. PENALTY CLAUSE

Any violation of this PhilHealth Circular shall be dealt with and penalized in accordance with pertinent provisions of Republic Act No. 7875, as amended by Republic Act Nos. 9241 and 10606 (National Health Insurance Act of 2013) and Republic Act No. 11223, and their respective Implementing Rules and Regulations, and other pertinent laws and rules.

VII. SEPARABILITY CLAUSE

In the event that any part or provision of this PhilHealth Circular is declared unauthorized or rendered invalid by any court of law or competent authority, those provisions not affected by such declaration shall remain valid and effective.

VIII. REPEALING CLAUSE

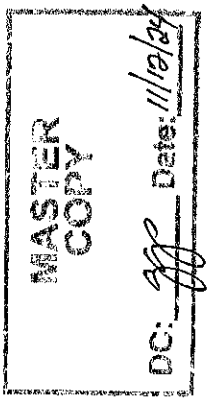
All provisions of previous issuances, PhilHealth Circulars, and directives that are inconsistent with any of the provisions of this PhilHealth Circular for this particular circumstance wherein the same is particularly applicable, are hereby amended, modified, or repealed accordingly.

IX. DATE OF EFFECTIVITY

This PhilHealth Circular shall take effect fifteen (15) days after publication in the Official Gazette or in any newspaper of general circulation. Three (3) copies shall be forwarded thereafter to the Office of the National Administrative Register (ONAR) at the University of the Philippines Law Center.

EMMANUEL R. LEDESMA, JR.
President and Chief Executive Officer

Date signed: 11/11/24



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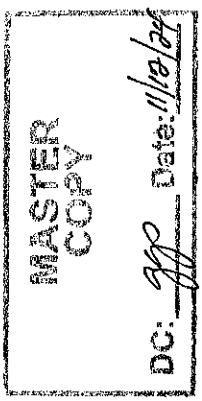
Risk Stratification	Antibiotics and Dosage
Low Risk	**Without Comorbid:** Amoxicillin 1 gram, three times daily **OR** Azithromycin 500 mg once daily **OR** Clarithromycin 500 mg, twice daily **With Stable Comorbid:** Amoxicillin + Clavulanic Acid (500 mg/ 125 mg, three times daily or 875 mg/125 mg, twice daily) **OR** Cefuroxime 500 mg, twice daily **PLUS OR MINUS (+/-)** Macrolide: Azithromycin 500 mg OD **OR** Clarithromycin 500 mg, twice daily **OR** Doxycycline 100mg, twice daily (with conditional recommendation and low quality of evidence)
Moderate Risk without MDRO	*Non-Pseudomonal Beta-lactam antibiotic* Ampicillin-Sulbactam 1.5-3 gram, every 6 hours **OR** Cefotaxime 1-2 gram, every 8 hours **OR** Ceftriaxone 1-2 gram daily **PLUS** *Macrolide* Azithromycin 500 mg daily OR Clarithromycin 500 mg, twice daily
High Risk without MDRO	**FIRST LINE THERAPY** *Non-Pseudomonal Beta-lactam antibiotic*

Risk Stratification	Antibiotics and Dosage
	Ampicillin-Sulbactam 1.5-3 gram, every 6 hours **OR** Cefotaxime 1-2 gram, every 8 hours **OR** Ceftriaxone 1-2 gram daily **PLUS** *Macrolide* Azithromycin 500 mg PO/IV daily **OR** Clarithromycin 500 mg, PO twice daily **OR** Erythromycin 500 mg, PO every 6 hours **ALTERNATIVE THERAPY** (with conditional recommendation and low quality of evidence) *Non-Pseudomonal Beta-lactam antibiotic* **PLUS** *Respiratory fluoroquinolone** Levofloxacin 750mg, PO/IV daily **OR** Moxifloxacin 400mg, PO/IV daily *given as 1 hour IV infusion



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Risk Factors and Organisms	Empiric Antibiotic Recommendations
Risk for *Methicillin-Resistant Staphylococcus aureus (MRSA)* ✓ Prior colonization or infection with MRSA within 1 year ✓ Intravenous antibiotic therapy within 90 days	*Non-Pseudomonal Beta-lactam antibiotic* **PLUS** *Macrolide* **OR** *Respiratory fluoroquinolone* **PLUS** Vancomycin 15 mg/kg, IV every 12 hours **OR** Linezolid 600mg, IV every 12 hours **OR** Clindamycin 600 mg, IV every 8 hours
Risk for Extended Spectrum Beta-Lactamase (ESBL) ✓ Prior colonization or infection with ESBL-producing organisms within 1 year	**REPLACE** *Non-Pseudomonal Beta-lactam antibiotic* with: Ertapenem 1 gram, IV every 24 hours **OR** Meropenem 1 gram, IV every 8 hours (if Ertapenem is not available) **PLUS** *Macrolide* **OR** *Respiratory fluoroquinolone*
Risk for *Pseudomonas aeruginosa* ✓ Prior colonization or infction with *P aeruginosa* within 1 year ✓ Severe bronchopulmonary disease (severe COPD, bronchiectasis, prior tracheostomy)	**REPLACE** *Non-Pseudomonal Beta-lactam antibiotic* with: Piperacillin-Tazobactam 4.5 gram, IV every 6 hours **OR** Cefepime 2 gram, IV every 8 hours **OR** Ceftazidime 2 gram, IV every 8 hours **OR** Aztreonam 2 gram, IV every 8 hours **OR** Meropenem 1 gram, IV every 8 hours (especially if with ESBL risk) **PLUS** *Macrolide* **OR** *Respiratory fluoroquinolone*