Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY

March 31, 2022

DEPARTMENT MEMORANDUM
No. 2022 - 0141

TO: **ALL UNDERSECRETARIES AND ASSISTANT SECRETARIES; DIRECTORS OF BUREAUS/SERVICES AND CENTERS FOR HEALTH DEVELOPMENT; CHIEFS OF MEDICAL CENTERS, HOSPITALS, SANITARIA, AND TREATMENT AND REHABILITATION CENTERS; EXECUTIVE DIRECTORS OF SPECIALTY HOSPITALS AND ATTACHED AGENCIES; AND ALL OTHERS CONCERNED**

SUBJECT: **Interim Guidelines for Health Facilities in Transition to the Endemic Phase of COVID-19**

I. RATIONALE

In view of the decreasing number of COVID-19 cases and the declaration of Alert Level 1 in selected provinces and cities, the Department of Health (DOH) releases these interim guidelines to prepare health facilities for the endemic phase of COVID-19. Endemic refers to the disease frequency within an expected level of prevalence in a population within a geographic area, without posing a public health emergency. The COVID-19 Endemic Plan for health facilities considers three phases of COVID-19 namely, the pandemic phase, which is characterized by an uncontrolled community transmission of COVID-19, the transition phase, which is characterized by controlled transmission in selected areas, and the endemic phase, which is characterized by persistently low levels of community transmission with sporadic localized outbreaks. The Plan highlights the policy shifts for the operations and monitoring of hospitals, Temporary Treatment and Monitoring Facilities (TTMFs), modular facilities in hospitals, telemedicine and eHealth, and the National Patient Navigation and Referral Center - One Hospital Command Center (NPNRC-OHCC).

II. OBJECTIVE

A. General Objective

To guide health facilities across the Health Care Provider Networks (HCPNs) as they transition into the endemic phase of COVID-19.

B. Specific Objectives

1. To set policy directions for health facilities in the transition phase and endemic phase of COVID-19; and
2. To define indicators that would guide health facility monitoring in the endemic phase.

III. SCOPE OF APPLICATION

These guidelines shall apply to DOH Central Office bureaus and units, DOH Centers for Health Development (CHDs), DOH hospitals, including the Bangsamoro Autonomous Region in Muslim Mindanao subject to the applicable provisions of RA 11054 or the "Bangsamoro Organic Act" and subsequent rules and policies issued by the Bangsamoro government, Local Government Units (LGUs), all public and private health facilities, TTMFs, modular facilities, and other relevant stakeholders.

IV. GENERAL GUIDELINES

A. Upon the declaration of Alert Level 1, all health facilities and concerned offices shall follow the directions stated under the transition phase (see Annex A). The lifting of the State of Calamity or Public Health Emergency shall signal the implementation of the endemic phase of the Plan.

B. During the endemic phase, all facilities and concerned offices shall be guided by the Alert Level System. The reactivation of the surge response for health facilities specified in Administrative Order No. 2021-0042 and other relevant contingency plans during higher Alert Levels shall be done through the National, Regional, and/or Local Disaster Risk Reduction Management Council (N/R/LDRRMC).

C. All hospitals shall gradually shift from dedicating COVID-19 beds to providing infectious wards and sections that can accommodate various infectious diseases, including COVID-19.

D. All health facilities shall institutionalize appropriate infection prevention and control measures through the establishment of administrative, engineering, and environmental controls, as guided by the latest National Standards in Infection Prevention and Control for Health Facilities (bit.ly/DOHHFDBManuals).

E. All hospitals, Local Government Units, and relevant National Government Agencies (NGAs) shall assess their TTMFs and modular facilities and determine whether these facilities should be continually used as isolation facilities, converted back to their original purpose, used for non-health-related activities, or decommissioned, depending on the needs of the locality and the facilities' structural integrity.

F. The hospital indicators shall be transitioned to monitor the caseload of admitted COVID-19 cases in the endemic phase (see Annex B). The daily monitoring of TTMFs shall be implemented during surges.

G. All health facilities from primary care to hospitals shall adopt and routinely use telemedicine and other eHealth platforms for the provision of both COVID-19 and non-COVID consultations and other related services.

H. The National Patient and Navigation Center - One Hospital Command Center (NPNRC-OHCC), shall shift the focus from direct COVID-19 patient referrals to establishing and supporting the navigation system for all patients in Health Care Provider Networks in accordance with the Republic Act 11223, "Universal Health Care Act" and the AO 2020-0019, "Guidelines on the Service Delivery Design of Health Care Provider Networks".

V. SPECIFIC GUIDELINES

A. All hospitals shall follow the directions in the transition and endemic phase (see Annex A)
   1. In the transition phase, only selected hospitals are mandated to dedicate COVID-19 beds in accordance with AO 2021-0042, "Guidelines for COVID-19 Surge Response of Health Facilities".

   2. The selected government and private hospitals for the transition phase shall follow the list of sentinel hospital sites that will be released by the Epidemiology Bureau (EB). At least one (1) hospital per province/city and one (1) hospital per component city/municipality in NCR is/are selected to ensure access to patients.

   3. The Field Implementation and Coordination Team (FICT) in coordination with the Centers for Health Development shall coordinate with the selected hospital sentinel sites regarding the implementation of the transition phase.

4. In the endemic phase, hospitals shall provide infectious rooms, wards, and sections for patients with infectious diseases.

    a. Infectious wards at the minimum shall adhere to the standards provided in AO 2021-0015, "Standards on Basic and Non-Basic Accommodation in All Hospitals".

    b. All hospitals shall endeavor to have isolation rooms with the following ratios in accordance with the latest IPC standards:
        1. For Level 1 and 2 hospitals, at least 1 isolation room per 20 Ward beds (5%); and
        2. For Level 3 hospitals, at least 1 isolation room per 10 Ward beds (10%).

    c. All emergency departments of hospitals shall have infectious and non-infectious sections.

B. All health facilities shall institutionalize IPC measures in terms of Management, Structure, Functions and Responsibilities, Standard Transmission-Based Precaution, Healthcare Waste Management, Cleaning and Disinfection of Environmental Surfaces, Testing of Healthcare Workers, HCW risk assessment and management, isolation and quarantine, and IPC Adherence Monitoring (see Annex C).

C. The directions for TTMFs in the endemic phase are as follows:
    1. Repurposed structures, such as schools and stadiums, shall be reverted back to their original purpose. The timeline for reversion may vary depending on the NGA or LGU in consultation with concerned stakeholders.

    2. For newly constructed TTMFs by LGUs, LGUs in consultation with CHDs shall assess based on their local contingency plans for future surges and determine whether the TTMF shall be:
        a. Used for health-related services such as isolation/quarantine facilities, step-down care, or transition care/halfway houses;
        b. Converted into learning centers, socialized housing, evacuation sites depending on structural integrity, if there is no identified health-related need; or
        c. Closed, transferred or stored depending on the decommissioning plans of the LGU.

    3. For newly constructed TTMF by NGAs, the concerned NGA shall do any of the following:
        a. Implement if decommissioning plans for the structure are available; and

b. Upon request of the LGU subject to the approval of NGA, endorse the TTMF to LGU for management either to provide for health services or for conversion to other facility types.

4. In the event of a surge, LGUs may request augmentation of their isolation capacity by NGAs through the NDRRMC.

D. The directions for modular facilities in hospitals are as follows:

1. For modular facilities built inside hospital compounds, the Medical Chief Center or Chief of Hospital shall assess and determine whether the modular facility shall continually be used as isolation rooms and/or ward extensions, or the facility shall be repurposed as staff quarters/dorms, etc, subject to the approval of the concerned NGA (e.g. DPWH). Further, the hospital management shall ensure compliance with existing licensing requirements should the structures be used for long-term ward extensions.

2. For modular facilities built outside hospital compounds, like Quezon Institute, the CHD, in consultation/coordination with the managing hospital shall do any of the following:
   a. Implement decommissioning plans, if available;
   b. Revert the structure back to its original purposes, if the modular facility is a repurposed structure;
   c. Continue utilization as isolation/quarantine/step-down care facilities, if these facilities are newly built; or
   d. Close the modular facility if there is no identified need with the endorsement of equipment to an identified appropriate facility.

VI. ROLES AND RESPONSIBILITIES

A. Field Implementation and Coordination Team (FICT)

1. In coordination with CHDs, coordinate with the EB-selected hospital sentinel sites that shall maintain dedicated COVID-19 beds in the transition phase;
2. Coordinate with concerned Central Office units to provide technical assistance to CHDs, Local Government Units, and health facilities regarding the policy shifts in the COVID-19 endemic phase; and
3. Oversee the monitoring of health facilities through the DOH Data Collect System.

B. Health Emergency Management Bureau (HEMB)

1. Provide technical assistance on the development of surge capacity plans in relation to other emergency and disaster plans;
2. Provide logistical and funding support to health facilities to address their surge capacity requirements; and
3. Assist in coordination and partnership with relevant stakeholders to ensure continuity of operations.

C. Health Facility Development Bureau (HFDB)

1. Provide technical assistance to CHDs on the monitoring of health facilities in the transition and endemic phase.

D. Knowledge Management and Information Technology Service (KMITS)

1. Develop strategies, standards, and guidelines relating to credentialing and/or accreditation of telemedicine providers, in collaboration with relevant government agencies and private institutions, and
2. Coordinate with NPNRC-OHCC in the provision of technical assistance relating to adoption and use of telemedicine and referral services to health facilities and related institutions.

E. National Patient Navigation and Referral Center - One Hospital Command Center (NPNRC-OHCC)

1. Provide technical assistance to CHDs and LGUs in the establishment of proper patient navigation in HCPNs.
2. Ensure a continuous and coordinated system of patient navigation and referral to health facilities while in transition.
3. Provide accessible and cost-effective healthcare services through telemedicine and referral to institutions that cater financial and other forms of medical assistance.
4. Support HCPN through ICT aligning moving towards the vision of "One Patient, One Data, One System", while maintaining a directory of the HCPN and component institutions by providing different pathway services for targeted navigation and referrals.

F. Centers for Health Development (CHD)

1. Monitor indicators at the province/city level for the region and ensure reporting of health facilities through the DOH Data Collect System;
2. Provide FICT with the list of hospitals that will maintain COVID-19 dedicated beds per province/city or quadrant for NCR; and
3. Provide and/or facilitate the provision of technical assistance to health facilities, TTMFs, and LGUs for the endemic phase.

VII. REPEALING CLAUSE

The Department Memorandum 2020-0268, "Interim Guidelines on Health Facilities in the New Normal" is hereby repealed.

For strict compliance and dissemination to all concerned.

By Authority of the Secretary of Health:

LEOPOLDO J. VEGA, MD, FPCS, FPATACSI, MBA-H
Undersecretary of Health
Office of the Chief of Staff
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ANNEX A. Policy Shifts for Health Facilities in the COVID-19 Endemic Phase

Table 1. Directions for Hospitals in the Transition and Endemic Phase

PARAMETER	PANDEMIC	TRANSITION	ENDEMIC
Timeline of Phases	**March 2020 to March 2022**	**April 2022 until declaration of Endemic Phase**	**Lifting of the State of Calamity or Public Health Emergency**
Hospital Beds	30%/20% COVID Dedicated Beds in Response Stage and 50%/30% in Surge Response Stage in **ALL** hospitals • Dedicated ICU, isolation, and wards	30%/20% COVID Dedicated beds in **selected** hospitals • ICU, isolation, and ward beds Beds for COVID based on demand for other hospitals	0% COVID Dedicated beds in hospitals; Allocation is **based on demand;** Admission in Regular Beds following IPC measures. • ICU, isolation, and wards for infectious patients • Level 4 PPE only in areas designated for infectious patients
Human Resources	HRH Augmentation through emergency hiring	HRH Augmentation in selected hospitals with dedicated COVID beds	• HRH assignment based on demand; or • HRH Augmentation in areas of outbreak with low HRH capacity
Emergency Department	Emergency Department with dedicated COVID beds	Emergency Department with dedicated COVID beds in selected hospitals	Emergency Department with Infectious and non-Infectious section

Table 2. Directions for the Use of Telemedicine, NPNRS-OHCC, and TTMFs in the Transition and Endemic Phase

PARAMETER	PANDEMIC	TRANSITION	ENDEMIC
Timeline of Phases	**March 2020 to March 2022**	**April 2022 until declaration of Endemic Phase**	**Lifting of the State of Calamity or Public Health Emergency**
Telemedicine	• Focused on pandemic-related consultations • Activated in affected areas with disrupted primary care and hospital services	• Includes both COVID-19 and Non-COVID consultations • Infrastructure building while complying to policies and standards	• Supplemental and complementary to existing health care service modalities • Institutionalization with certification and credentialing of telemedicine providers
NPNRS-OHCC	Coordination and referral of COVID-19 cases by the DOH Central Office	Knowledge transfer of coordination and referral of COVID-19 and non-COVID-19 cases to LGUs through CHDs	• Proper Patient Navigation by capacitated LGUs in Health Care Provider Networks (UHC Act) • Continuous technical assistance to LGU through CHDs
TTMFs	Active admission and increased beds to serve as step-down and cater asymptomatic to mild cases	• Decrease in capacity; admission only for those who cannot do home isolation • Identify facilities to be converted/ decommissioned	• Closure of TTMFs • May be activated during outbreaks

ANNEX B. Policy Shifts in Monitoring Health Facilities in the COVID-19 Endemic Phase

Table 4. New indicators for hospital beds, severe and critical admissions, and TTMFs in the Endemic Phase

PARAMETER	PANDEMIC	TRANSITION	ENDEMIC
Hospital Beds and admissions	Percent utilization of COVID-19 Dedicated Beds, ICU, mechanical ventilators	Percent utilization of COVID-19 Dedicated Beds, ICU, mechanical ventilators	• New hospital admissions per 100,000 (7-day total) • Total bed occupancy (Percent Authorized Bed Capacity (ABC) beds occupied by COVID-19 patients) • Percent Severe and Critical admissions (Total severe and critical COVID patients admitted over Total admissions)
Coverage of monitoring	All Hospitals	Selected hospitals mandated to dedicate COVID-19 Beds	Designated COVID-19 Sentinel Sites
TTMF	TTMF Utilization (daily)	TTMF Utilization (weekly)	TTMF Utilization (during local surges only)

Table 5. Hospital beds indicators in the Endemic Phase (*Adapted from Centers for Disease Control and Prevention*)

Indicators	Low	Medium	High
New COVID-19 hospital admissions per 100,000 (7-day total)	**<10**	**10-19.9**	**≥20**
Total Bed Occupancy (Percent ABC beds occupied by COVID-19 patients)	**<10%**	**10-14.9%**	**≥15%**
Percent Severe and Critical admissions (Total severe and critical COVID patients admitted over Total admissions)	**<5%**	**5-9.9%**	**≥10%**

ANNEX C. Policy Shifts in Infection Prevention and Control Standards

Table 3. Infection Prevention and Control measures to be institutionalized

	Previous Guidance	Policy Shift
Management, Structure, Functions and Responsibilities	Active **IPC Program** in ALL Levels of Health Facilities - IPC Committee - IPC Nurses and Safety Officers	Institutionalization of **IPC Unit** in All Health Facilities composed of: - Primary Care and Other Health Facilities: Designated IPC-trained healthcare officer - L1& L2: dedicated full-time IPC officer; recommended 1:100 officer to bed capacity ratio - L3 and specialty: dedicated full-time IPC unit head, IPC nurse (1:100 ratio), and IPC surveillance officer

Standard Transmission-Based Precaution	Conversion of Private Rooms and/or Wards to Temporary Isolation Rooms	Dedicated **Infectious Ward and Increase Negative Pressure (NP) Isolation Rooms**
		- Infectious Ward to follow Basic Accommodation Standards
		- Isolation Rooms
		  - L1, L2 - 1 for every 20 Ward beds (5%)
		  - L3 - 1 for every 10 Ward Beds (10%)

	No visitors allowed for COVID-19 patients	Limit visitors to patients whether infectious or non-infectious, ensuring visitor compliance to minimum public health standards
	Utilization of Acrylic barriers	**Acrylic barriers not necessary unless physical distancing cannot be maintained**
	Prescribed Zoning Areas in Health Facilities according to COVID-19 status of admitted patients	**Zoning not required; implementation of infectious and non-infectious wards and areas**
	Utilization of footbaths in entry and exit points in health facilities	**Footbath not required**
	Unidirectional foot traffic, separate entry and exit points for patients and HCW	**SAME**

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	Previous Guidance	Policy Shift
Standard Transmission Based Precaution (PPE)	Universal masking practices for all HCW in Health Facilities	Indications for PPE shall be based on setting, risk of exposure, and transmission dynamics of pathogens. PPE levels in health facilities shall follow appropriate risk assessment specific for tasks, duration of exposure, and level of body fluid exposure that may be experienced by healthcare workers Institutionalization of fit-testing program in Health Facilities
Emergency Department	Symptom and Exposure Screening at ER Triage Areas	Symptom screening at the triage area of the ED Dedicated infectious section at the ED for proper cohorting of patients, with provision of isolation rooms as applicable
Healthcare Waste Management, Cleaning and Disinfection of Environmental Surfaces	Use of the HCWM Manual 4th edition Standards for health facilities	SAME
Testing of Healthcare Workers	a. All symptomatic HCW should be isolated and tested with RT-PCR b. All asymptomatic HCW with unprotected exposure should be isolated and tested with RT-PCR. c. Test all HCW with unprotected exposure every 14 days	Follow testing protocols for healthcare workers as guided by DOH DM 2022-0013 and its updates
HCW risk assessment and management, isolation and quarantine	a. High risk for infection - quarantine for 14 days in a designating setting b. Low risk for infection - self-monitoring of symptoms for 14 days after last exposure c. Airborne precautions for aerosol-generating procedures on all suspect/confirmed COVID-19 cases	Follow isolation and quarantine protocols for healthcare workers as guided by DOH DM 2022-0013 and its updates

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	Previous Guidance	Policy Shift
IPC Adherence Monitoring	Annually As necessary during outbreaks, a. Root case analyses b. Outbreak investigations	Shift to annual assessments Use of IPC module checklist in Health Facility Profiling As needed RCA and Outbreak investigation