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Introduction: The COVID-19 pandemic has changed the practices of occupational health in many aspects. Due to heavy caseloads, the traditional approach of contact tracing may not be implemented comprehensively, impeding the determination of causality of workplace exposure on COVID-19. The current study examines measures adopted by selected countries for recognizing work-related COVID-19.

Material and Methods: Regulation and rules of recognition of work-related COVID-19 in various countries were obtained through a systematic review of published literature and official government websites. The US, France, Germany, South Korea, Taiwan were among the fifty countries included in the comparative analysis. Data on approved and total claims cases were obtained through open data of national Workers’ Compensation systems and analyzed by types of regulation.

Results: Some countries stuck to the case-by-case investigation of causality, while others introduced unique measures, including the rebuttable presumption of compensability. In the latter cases, the work-relatedness of patients from certain high-risk occupations was automatically recognized unless the dominant evidence proved the contrary. As with traditional understandings, health care professionals and first responders were defined as high-risk in most presumption rules. However, in the context of substantial community transmission, occupations with frequent public contact, like aircrews, customs personnel, and store clerks, were also included in some countries.

Conclusions: The presumption rules had an active role in facilitating the compensation of work-related COVID-19.

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Can we monitor and contain health professionals’ work-related stress in an emergency? The experience acquired during the COVID-19 pandemic at the Local Health Unit Cuneo1 (Northern Italy)

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Introduction: COVID-19 pandemic has a big impact on health professionals’ work load, at organizational/psychological level. The Local Health Unit Cuneo1 adopted a strategy to monitor its staff on work-related stress and to return specific alerts. Material and Methods: A survey was approved by the Direction as institutional task of personnel’s risk assessment. Step1-sept2020: a validated questionnaire to detect requests/sources imbalance. Data analysis assessed distress in specific groups (at 5% significance level), by an Analysis of Variance model with distress as outcome (>value, >pressure) and sex, age, profession as predictors.

Step2-ongoing: structured interviews to managers of COVID-19 front-line structures, then descriptively analyzed.

Results: Respondents were 1/3 of Staff(1373/4155). General distress (range: -40; +92) reached a mean of 1.2, that was adverse being a positive value but slight. The model highlighted significant alerts. Women had more worries than men (mean: -3.0 vs -6.8; p=0.006). Older staff showed higher distress than 21-30yrs (-10.8): 41-50yrs (-3.1; p=0.006); 51-60yrs (-4.1; p=0.024); >60yrs (-1.5; p=0.004). Nurses had high distress (18): 7 points higher (p=0.006) than physicians’ (-5.1); administrative staff (-2.0) and technicians (-3.0) had moderate distress; psychologists had the minor one (-12.6). A total of 9 interviews were done in step2: all showed a medium pressure level.

Conclusions: These data allowed implementing focus groups and training to overcome organizational and psychological matters related to COVID-19 and to building robust readiness to face possible future health emergencies.

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One year facing Covid. Systematic evaluation of factors associated with mental distress among hospital workers in Italy

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