PHILIPPINE HEART CENTER INCIDENT COMMAND POST	Document Type **POLICIES**	Document Code: POL-ICP-066
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	POLICY ON THE ASSESSMENT AND MANAGEMENT OF HEALTHCARE WORKERS WITH POST COVID-19 SYMPTOMS	Page: 1 of 5

REVISION HISTORY

Rev No.	Review Date	Description of Change	Date of Next Review
			October 2021

Reviewed by:	**GERARDO S MANZO MD** Incident Commander	Approved by:	**JOEL M. ABANILLA, MD** Executive Director

I. INTRODUCTION

Patients with COVID-19 pneumonia typically recover from the disease after 2-6 weeks. The World Health Organization recognizes that in some patients, respiratory symptoms such as cough and shortness of breath may recur for weeks or months following initial recovery. This phenomenon can affect even those with seemingly mild disease and those without comorbidities. The presence of lingering symptoms, do not render them infectious. However, the lingering symptoms may have multiple impacts on their personal health, quality of life and ability to perform tasks.

II. OBJECTIVE

This policy aims to provide a systematic process for the assessment and management of healthcare workers with post COVID-19 symptoms (shortness of breath and/or cough).

III. SCOPE

Healthcare workers who recovered from COVID-19, with symptoms of cough/shortness of breath 14 days after initial onset of symptoms or date of RT-PCR swab if date of symptom onset is unknown.

IV. POLICIES

- Once discharged/completed quarantine, healthcare workers must follow up at the Infirmary for return to work clearance.

- Healthcare workers who remain asymptomatic on follow up shall be cleared to return to work without restrictions.

- If healthcare worker is still symptomatic on follow up, CXray (PA-Lateral), ABG and PFT (pre and post bronchodilator) shall be done prior to referral to the Respiratory Clinic. To ensure timely follow up, healthcare workers will be given priority in the scheduling of Pulmonary Function tests.

- Latest guidelines on repeat COVID-19 RT-PCR testing shall be implemented among recovered patients who will undergo aerosol generating procedures (ie. PFT, CPET).

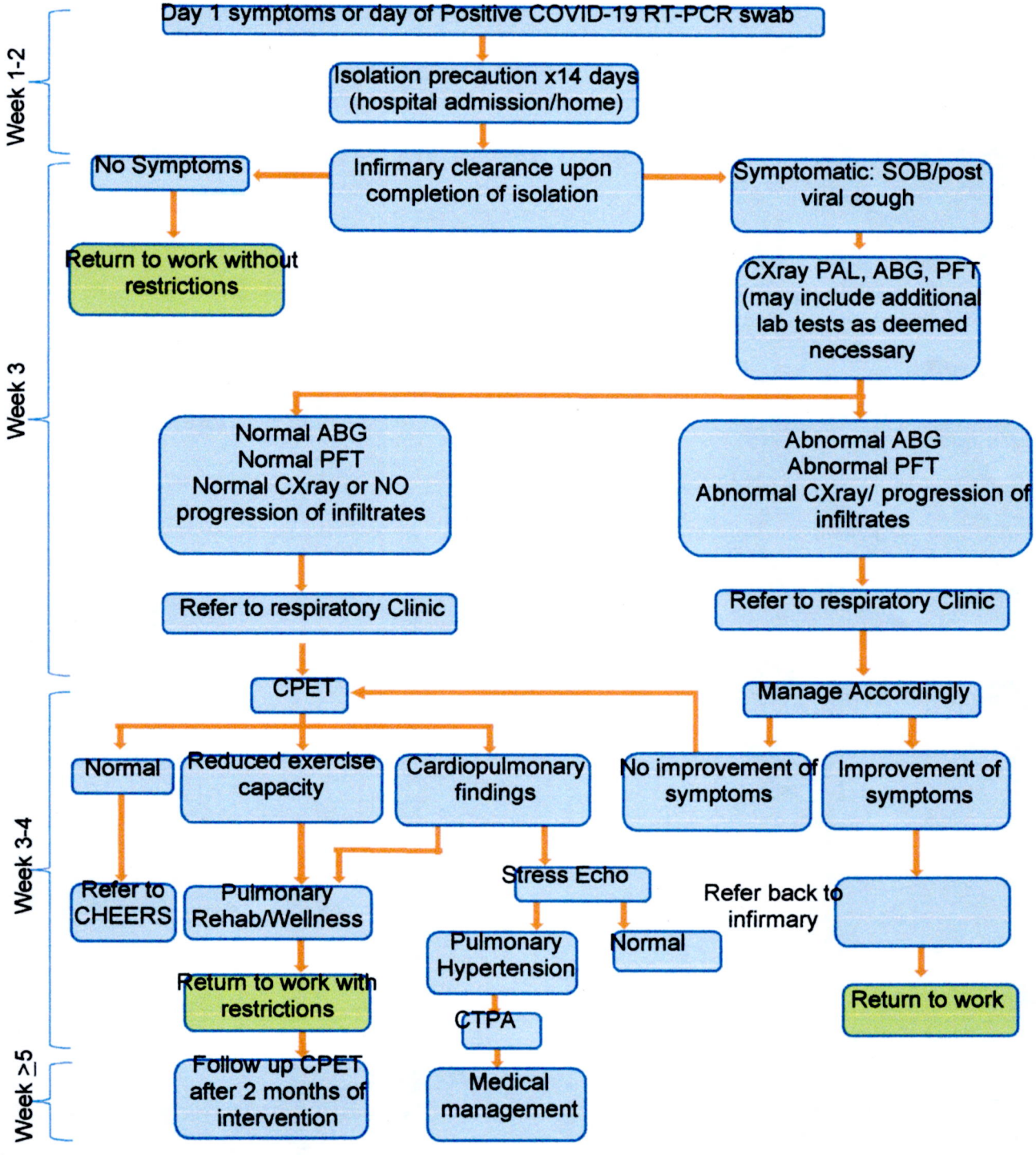
- Pulmonologists assessing healthcare workers at the Respiratory Clinic may recommend return to work or extension of leaves. However all return to work clearances/leave extensions must officially be given by the Infirmarian.

- Cardiopulmonary exercise test (CPET) shall be done on symptomatic healthcare workers with normal PFT, ABG, insignificant Chest Xray findings (normal or stable infiltrates) and those with abnormal PFT, ABG and Chest Xray who do not improve after a trial of medical management.

- Return to work recommendations may be secured following CPET results. Workload limitations shall be based on the American Heart Association & American Thoracic Society's guidelines on the evaluation of impairment secondary to respiratory disorders.

- Healthcare workers with Pulmonary/Cardiopulmonary findings on CPET shall be enrolled to the Pulmonary Rehabilitation Program and referred for Stress Echocardiography (if indicated).

Process flow for COVID-19 recovered Healthcare workers seeking return to work clearance



WORK LOADS AND THEIR APROXIMATE METABOLIC EQUIVALENTS

Work Load	VO2 mL/Kg/min	METS
Light to moderate (sitting)		
Clerical	5.6	1.6
Using repair tools	6.3	1.8
Operating Heavy Equipment	8.8	2.5
Heavy truck driving	12.6	3.0
Moderate work (standing)		
Light work, own pace	8.8	2.5
Janitorial work	10.5	3.0
Assembly line (lifts >45 lbs)	12.3	3.5
Paper hanging	14.0	4.0
Standing &/or walking (arm work)		
General heavy labor	15.8	4.5
Using heavy tools	21.0	6.0
Lifting & carrying 60-80 lbs	26.2	7.5

Adapted from the American Thoracic Society: Evaluation of impairment/disability secondary to respiratory disorders. Am Rev Respir Dis 133:1205-1209, 1986

Intensity	Heart Rate Reserve	Maximal Heart Rate %	MET equivalents
Very light (Sedentary)	<25	<30	1-1.5
Light	25-44	30-49	1.6-2.9
Moderate	45-59	50-69	3.0-5.9
Hard (Vigorous)	60-84	70-89	≥6.0
Very Hard	≥85	≥90	

Adapted from Guide to the Assessment of Physical Activity: Clinical and Research Applications Scott J. Strath, PhD, Chair, Leonard A. Kaminsky, PhD et al on behalf of the American Heart Association Physical Activity Committee of the Council on Lifestyle and Cardiometabolic Health and Cardiovascular, Exercise, Cardiac Rehabilitation and Prevention Committee of the Council on Clinical Cardiology, and Council on Cardiovascular and Stroke Nursing https://doi.org/10.1161/01.cir.0000435708.67487.daCirculation. 2013;128:2259–2279