

AHCA/NCAL Guidance on Staffing Consideration Post-Vaccination for COVID-19

This guidance builds upon CDC's [post-vaccine consideration for healthcare workers](#).

Background: There are two COVID-19 vaccines that will be distributed to long-term care centers in the early phases of the vaccine distribution process:

- [Pfizer-BioNTech COVID-19 Vaccine](#)
- [Moderna COVID-19 Vaccine](#)

Both vaccines are reported to cause systemic symptoms post-vaccination. The table below shows possible systemic symptoms that may occur after the vaccine, as well as a list of symptoms not consistent with the vaccine.

Possible Systemic Symptoms Post-Vaccination	Symptoms NOT consistent with Vaccine
Fever Fatigue Headache Chills Muscle aches and pain (myalgia) Joint pain (arthralgia)	Cough Shortness of breath Runny nose (rhinorrhea) Sore throat Loss of taste or smell

Frequency and Severity of Symptoms from Trial Data

Likelihood of systemic symptoms are generally similar for both vaccines and slightly more frequent after the second dose, according to the trial data. Trial participants reported the severity of their symptoms based on a standard rating scale¹:

- Grade 1 Mild (asymptomatic or mild symptoms, no intervention needed, does not interfere with activity)
- Grade 2 Moderate (minimal intervention such as acetaminophen or ibuprofen, some interference with activity)
- Grade 3 Severe (Severe or medically significant but not immediately life-threatening)
- Grade 4 Potentially Life-threatening (urgent intervention indicated)

For planning of potential staff absenteeism, facilities should focus on the probability of severe symptoms taking place post-vaccine (<5% of the time), as well as the duration of those symptoms (1-2 days), as those with severe symptoms are most likely to result in call-out. Some staff with moderate symptoms may also call out, but it is unlikely to be the majority, particularly with the use of acetaminophen or ibuprofen. The duration of symptoms was limited to 1-2 days for both vaccines.

For both vaccines, the frequency and severity of symptoms were slightly higher after Dose 2 than Dose 1. For both vaccines, fatigue, headache and new/worsened muscle pain were most

¹[FDA's Clinical Investigator Course](#)

common symptoms but most were either mild or moderate (see table below for frequency of symptoms following each dose).

Pfizer trial data is available [here](#) (pages 36-38) and summarized below for age group (15-55yrs):

% with symptoms	Dose 1			Dose 2		
	Mild	Moderate	Severe	Mild	Moderate	Severe
Fever	2.8%	0.7%	0.3%	9.2%	5.2%	1.2%
Fatigue	26.0%	19.9%	1.4%	21.1%	33.7%	4.6%
Headache	27.4%	13.4%	1.0%	25.6%	22.9%	3.2%
Chills	10.0%	3.6%	0.4%	17.1%	15.9%	2.1%
Muscle Aches	11.2%	9.5%	0.6%	15.5%	19.5%	2.2%
Joint Pain	6.4%	4.3%	0.2%	9.8%	11.2%	1.0%

Moderna trial data is available [here](#) (pages 36-38) and summarized below for the age 18 to 64:

% with symptoms	Dose 1		Dose 2	
	Mild or Moderate	Severe	Mild or Moderate	Severe
Fever	0.8%	0.1%	15.8%	1.6%
Fatigue	37.4%	1.1%	57.0%	10.6%
Headache	33.5%	1.9%	57.8%	5.0%
Chills	9.1%	0.1%	46.8%	1.5%
Muscle Aches	23.1%	0.6%	5.1%	1.0%
Joint Pain	0.0%	0.4%	0.0%	5.8%
Nausea/Vomitting	9.3%	0.1%	21.2%	0.1%

CDC Guidance for Return to Work

CDC has developed their [guidance](#) with an aim to prevent unnecessarily excluding HCW with only post-vaccination signs and symptoms from work that may mimic COVID-19, while not inadvertently allowing HCW with COVID-19 or another transmissible infection to work. The following table shows how facilities can consider whether HCW qualify to return to work under this [guidance](#) based on the symptoms they are presenting. Note that this is limited to individual who have been vaccinated within the prior three days.

Symptom(s)	Approach	Testing
Symptoms <u>not</u> typical of vaccination occurring within three days of vaccine: <ul style="list-style-type: none"> • Cough • Shortness of breath • Runny nose 	Exclude from work pending standard evaluation for COVID-19. Follow normal return to work precautions here .	Negative antigen test must be confirmed with PCR. More guidance here .

<ul style="list-style-type: none"> • Sore throat • Loss of taste or smell 		
Symptoms typical of vaccine occurring within three days of vaccine (excluding fever): <ul style="list-style-type: none"> • Fatigue • Headache • Chills • Muscle aches and pain • Joint pain 	Return to work without testing if feel well enough to work	Consider viral testing to rule out infection. A negative antigen test may not require confirmatory testing. More guidance here .
Fever (100 degrees or higher) within three days of vaccine	Ideally*, exclude from work pending evaluation, including testing If COVID-19 can be ruled out, they may return to work	Consider viral testing to rule out infection. A negative antigen test may not require confirmatory testing. More guidance here
Symptoms typical of vaccine persist for more than two days	Contact occupational health services (or another designated individual) Exclude from work pending evaluation	Consider viral testing to rule out infection. A negative antigen test may not require confirmatory testing. More guidance here

**In facilities with staffing shortages, HCW with fever may be considered to return to work if willing. These HCW should be re-evaluated, and viral testing for SARS-CoV-2 considered, if fever does not resolve within 2 days.*

Staffing Considerations

Other approaches that CDC recommends providers consider if feasible, include:

- vaccinating staff when they have the following 1-2 days off, or
- staggering staff by shift.

However, LTC facilities participating in the pharmacy partnership program may be limited to three clinic dates which makes these suggestions difficult to implement.

Considerations for staggering staff must include a risk-benefit analysis that weighs promoting vaccine uptake with reducing impact on staffing. Ease of logistics to access vaccines (e.g. being vaccinated at work) is a key factor in promoting high vaccination rates, so adding barriers or delays in vaccination may hurt uptake rates among staff. High vaccination rates among staff is vital in protecting the facility against future outbreaks.

In deciding whether to stagger, facilities should:

- Consider their current staffing levels and contingency plans for staffing (e.g. access to PRN or agency staff)

- Talk to staff about the symptoms that may occur post-vaccination, including their options to manage the symptoms (e.g., use of acetaminophen or ibuprofen) to gauge their willingness to work with mild to moderate symptoms.
 - Make sure to remind staff that these symptoms are a sign that the vaccine is working to build an immune response in their body.
- Determine how many staff intend to be vaccinated, as natural staggering may occur through individuals with vaccine hesitancy.
- Ensure access to testing with a rapid turnaround to facilitate staff returning to work as quickly as possible.
 - See guidance above for use of rapid antigen point-of-care tests (BD, Quidel, Abbott, etc.) in ruling out infection without confirmatory PCR tests

Facilities who want to stagger staff vaccinations should consider the following:

- What options are available for staff vaccinations outside of the pharmacy partnership clinics (e.g. state-sponsored vaccination programs for HCW, option to get vaccinated at a retail pharmacy store, etc.)
- Staggering half of staff at clinic one and half at clinic two will only be minimally effective since all staff would still receive a dose at clinic two

Experiences from Providers

At this early stage in the vaccination process, we are hearing of very few staff call-outs taking place after dose one. For example, West Virginia has vaccinated approximately 8,100 staff in 71 facilities as of December 22 and have experienced very few call-outs due to systemic symptoms.