Ministry of Health

COVID-19: Guidance for Prioritizing Health Care Workers for COVID-19 Vaccination

Version 1.0, January 8, 2021

Key Messages

- Demand for COVID-19 vaccine supply will initially exceed available supply; prioritization must be set among health care workers
- A stepwise approach to health care worker prioritization will be used, focusing first on sectors and settings, then on level of community risk, and lastly on individual risk
- Sectors and settings are prioritized based on risk of exposure and patient populations served
- An ethics and equity lens should be applied to all prioritization decision-making

This guidance provides basic information only. It is not intended to take the place of medical advice, diagnosis or treatment, legal advice or legal requirements.

In the event of any conflict between this guidance document and any applicable emergency orders, or directives issued by the Minister of Health, Minister of Long-Term Care, or the Chief Medical Officer of Health (CMOH), the order or directive prevails.

- Please check the Ministry of Health (MOH) COVID-19 website regularly for updates to this document, list of symptoms, other guidance documents, Directives and other information.

Purpose

The purpose of this document is to provide guidance regarding the prioritization of health care workers for vaccination in a manner that balances provincial consistency

with regional and local flexibility in recognition of the nuance of local and regional contexts and data. Verification and validation of individual prioritization will depend on the processes established by those delivering local vaccination programs.

Health care workers have been identified as a priority group for COVID-19 vaccination in Ontario and in the National Advisory Committee on Immunization (NACI) recommendations.

- This guidance complements the prioritization sequence that the Ministry of Health has developed.

Because demand for COVID-19 vaccines among Ontario's health care workers and other care staff will initially exceed available supply, priorities for voluntary vaccination must be set *among* health care workers and will be phased. COVID-19 vaccination is strongly recommended for all health care workers but remains voluntary. An employer may choose to create their own policies regarding mandatory staff immunization as a protective measure for residents and patients.

For the purposes of prioritization of vaccine doses, "health care worker" is defined as:

- Any regulated health professionals and any staff member, contract worker, student/trainee, registered volunteer, or other essential caregiver currently working in a health care organization, including workers in non-direct patient care roles such as cleaning staff, food services staff, information technology staff, security, research staff, and other administrative staff.
- Professionals providing a healthcare service or direct patient service in a congregate or community setting outside of a health care organization (e.g., nurse in a school, physiotherapist in an assisted living facility, medical first responder in the community, peer worker in a shelter).

Roles and Responsibilities

Role	Responsibilities
Ministry of Health (MOH)	Set priorities and targets, support healthcare system implementation.
Public Health Unit (PHU)	Lead local vaccination programs working with partners from health and municipal sectors; conducts prioritization based on local context. PHUs should establish committees on prioritization that include diverse views from affected parties and groups to inform local decision-making.
Ontario Health (OH)	Support vaccination program coordination with local health system partners.
Associations, Unions and Colleges	Work with MOH and PHUs to support vaccination of their members.
Health Care Organizations	Support and facilitate operations where requested and develop enabling policies and strategies to support staff to get their immunization.
Workers	Participate in immunization as vaccinators and recipients, counsel patients, address patient concerns and questions, and combat myths.

Approach to Prioritization of Health Care Workers

The goal of this arm of the provincial vaccination program is to vaccinate all eligible and willing health care workers as quickly as possible based on vaccine availability.

A stepwise approach to prioritization has been developed which considers multiple factors including the sectors and settings that people work in, local and community factors as well as individual factors. Each step should be performed in sequence to gradually refine from the broad sector/setting level down to the individual level.

Fig. 1 Approach to Prioritization

1. **Prioritize Health Care Sectors and other settings** (MOH)

- The MOH has outlined priority health sectors and settings based on the following criteria:
  - Occupational risk of exposure to COVID-19
  - Risk of severe disease and outcomes from COVID-19 among patient population served
  - Criticality of the health care sector:
    - Those who provide critical services during the pandemic by caring for patients with and without COVID-19 infection.
    - This key criterion aims to protect health care human resources by prioritizing workers who cannot work remotely or virtually

and who work in areas with limited or reduced capacity, little or no redundancy, and are essential to health system capacity.

2. **Sub-prioritize settings and sectors at the community level** (performed by PHU)

- Within prioritized health care sectors and settings, PHUs will prioritize those practicing in communities with a high-prevalence of COVID-19 (e.g., racialized communities), or at high risk of severe outcomes from COVID-19 infection or at increased risk due to structural and socio-economic factors as well as local staffing criticality.
- To identify priority communities for worker vaccination PHUs will consider:
    - Communities with a high-prevalence of COVID-19;
    - Communities at risk due to structural factors and considering the determinants of health and other socio-economic factors;
    - Local staffing criticality.
- Potential data sources to support PHU decision making include:
    - Ministry reports and publications on high priority communities
    - Available provincial data on exposure, risk and equity
    - Internal PHU data (e.g., case and contact management/outbreak information)
    - Institute for Clinical Evaluative Sciences (ICES) information on high-risk neighbourhoods

3. **Prioritize among workers** (performed by PHU with or by local partners[1])

- Among sectors and settings in priority communities, PHUs together with local vaccine delivery sites/ institutions/sectors/employers, identify priority workers within each sector if needed.
- The specificity of prioritization among workers should reflect what is operationally feasible and compatible with the responsibilities of the organization undertaking prioritization.

[1] The extent of involvement in this work will be informed by the vaccination model within PHUs and communities. For example, where a health care organization is delivering vaccines, they will be involved in this prioritization process.

Where feasible, prioritization among workers should use a risk matrix considering exposure risk, patient population's risk and criticality of the worker's role and responsibilities and, where demand continues to exceed available supply, individual risk for severe disease and outcomes (see Appendix).

- Where feasibility does not allow for the use of a risk matrix, prioritization at this step should consider:
    - Those who provide direct and more frequent or sustained care, or whose presence in those environments is more direct, frequent, or sustained (versus those in non-patient facing, administrative roles and health care workers who can work from home/remotely); and
    - Those who are ≥60 years old2 or who, based on voluntary self-report, consider themselves to be at higher risk due to biological, social, or geographical factors.
- Health care workers who can work from home/remotely should be deprioritized.

Priority Health Sectors and Workers

As part of the initial phase of vaccine rollout in Ontario, vaccines are available to health care workers and essential caregivers who work in hospitals, long-term care homes, retirement homes, and other congregate settings caring for seniors.

As Ontario progresses from the initial phase of vaccine rollout, the following categories have been identified by the Ministry of Health and should be used to prioritize within the category of health care workers.

This list has been developed in consideration of settings where different groups work, the risk of exposure and the patient populations served.

[2] As per PHAC recommendations that populations over 60 years of age are at risk for more severe disease or outcomes

Table 1: Health care worker primary and secondary priorities

Level of Priority	Sectors[3] [4]	Rationale
Primary Priorities	**Acute care and other hospital settings** (hospital, urgent care services) **Congregate settings** (assisted living, correctional settings, palliative care, residential facilities, shelters, supportive housing) **Community care with high risk of exposure and serving specialized patient populations** (Assessment centres, Community health centres, Home and community care, Immunization clinics, Senior day programs) **Health care services for Indigenous populations** **Community care with high risk of exposure and serving the general population** (Birth centres, Community Based Specialists, Death investigation professionals, Dentistry, Gynecology/obstetrics, Midwifery, Nurse practitioner-led clinics / contract nursing agencies, Otolaryngology (ENT), Medical First Responders (e.g., paramedics, firefighters providing	• Generally provide more direct, in person patient care • Generally, higher level of urgency and criticality, services that cannot be delayed or deferred • Generally higher likelihood of engaging in higher exposure risk procedures (e.g., Aerosol-generating medical procedures, aerosol-generating dental procedures) • Unable to work virtually or remotely

[3] In alignment with the definition of Health Care Worker that has been provided, where a health sector has been named in the priority sector, all workers in that sector (e.g., all workers in a hospital) are eligible. Where a non-health setting has been named, only professionals providing a health service or direct patient care are eligible.

[4] Sectors may be amended based on new evidence of exposure risk

	medical first response), Pharmacies, Primary care, Respirology (Respiratory Therapy), Walk-in clinics, Supervised Consumption Sites, Needle Exchange/Syringe Programs) **Laboratory services** **Public Health (those working on COVID-19)** **COVID-19 Vaccination Clinic Staff**	• Specialized patient populations at higher risk of negative outcomes if they contract COVID-19 • Interactions with patients/clients with less access to PPE • High criticality to health system
Secondary Priorities	**Community care with lower risk of exposure and serving special populations** (developmental services, mental health and addictions services) **Community care with lower risk of exposure and serving general population** (Campus health, Community diagnostic imaging, Daycare/school nursing, Dietary / nutrition, Independent health facilities (e.g., Opticians/Optometry, Podiatry, Audiology, medical and surgical specialties), Naturopathy / Holistic care, Social work, Sexual health clinics) **Non-acute rehabilitation and therapy** (Chiropractic, Chronic pain clinics, Kinesiology, Occupational therapy, Physiotherapy, Psychiatry, Psychology, Psychotherapy, Registered massage therapy / Acupuncture, Other therapy) **Public health** (all other public health)	• Generally lower risk of exposure relative to primary priorities • Generally less urgent care, services that can be delayed/ deferred relative to primary priorities • Services that can be provided remotely/virtually

Additional Considerations

- PHUs should work with local partners, for example through a local prioritization committee, to use the best available local, regional, and provincial data to assist in prioritization. In particular, use available data and engage with local partners regarding local populations served and settings most affected by COVID-19 to assist in prioritization.
- Use the province's Ethical Framework for COVID-19 Vaccine Distribution to guide all priority setting decisions and decision-making processes.
- Consider applying a Health Equity Impact Assessment in all decision-making processes regarding prioritization.
- **Do not prioritize based on seniority or rank**.
- Ensure that vaccine recipients will be able to return to receive their second dose within the required vaccination interval.
- Consider staggering vaccination within a unit or program's complement of staff to maintain critical functions given the possibility of reactogenicity.

Allocation among and within equally prioritized sectors and groups

- Multiple sectors, settings, communities, and workers may be equally prioritized, but demand may still exceed vaccine supply.
- If there is insufficient supply to vaccinate all workers in equally prioritized sectors or settings identified in Step 1 or equally prioritized communities identified in Step 2, vaccine doses should be allocated in proportion to the size of the health care worker population in each sector, setting, or community.
- If demand exceeds vaccine supply following Step 3 (prioritization of individual workers), random allocation (e.g., via a random number generator) should be employed to ensure fair allocation to individuals within equally prioritized groups.
- When individuals are randomized for vaccination, safeguards should be in place to ensure the integrity and fairness of the randomization process. Randomization should be done through a valid tool to ensure that the results cannot be predicted or influenced, and it should occur independently of those who are eligible to receive the vaccine in the random allocation. The process and outcomes of randomization should be clearly documented and made transparent to all those affected.

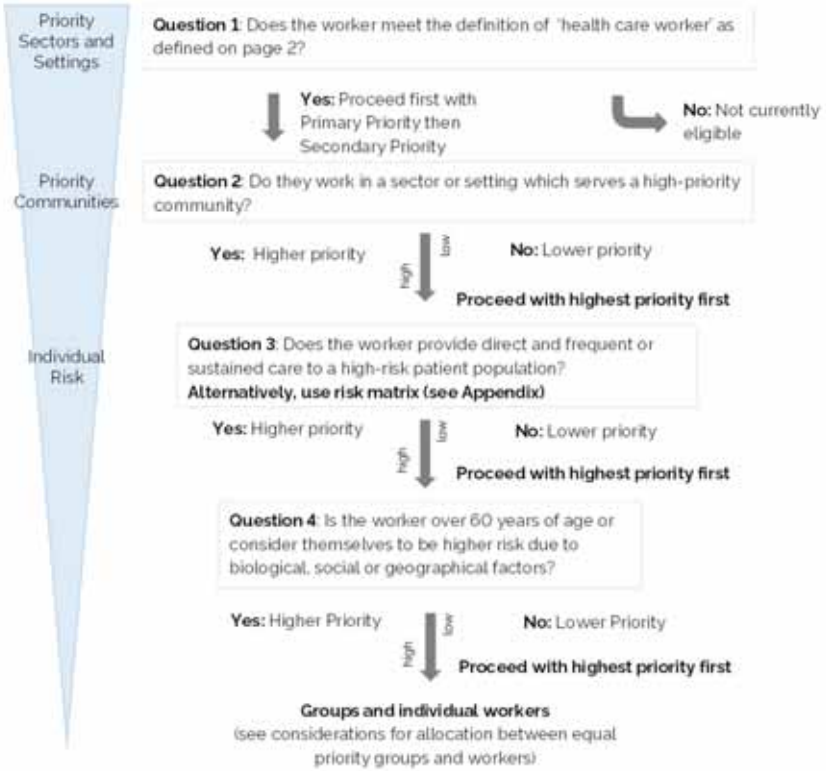
Examples

The following case examples are hypothetical situations provided to demonstrate how the prioritization guidance could be applied. They are provided for illustrative purposes only and do not necessarily reflect the assessment of all workers in the roles and settings described.

When prioritizing health care workers, consider the following questions. In alignment with the roles and responsibilities listed above, PHUs are responsible for considering questions 1 & 2. PHUs will work with healthcare organizations for questions 3 & 4 to consider group- and individual-level prioritization. Health care organizations responsible for prioritizing workers within their organization should consider these questions, too.

If an individual does not meet the definition for 'health care worker' as described on page 2, they are not currently eligible for prioritization under the health care worker category (see case example #4 below).

Fig. 2: Prioritization Decision-Making Tree



Case Example #1: A PHU is determining priority for vaccination at a vaccine clinic and considering a 61-year-old community health care provider who self-reported no individual risk factors and works in a high-prevalence neighbourhood where residents are disproportionately at risk for severe outcomes of COVID-19.

Question 1: Does the worker meet the definition of health care worker and if so, what is the relative priority of their sector or setting (as per Table 1)?

- ✓ Worker meets definition of 'health care worker' as defined on page 2
- ✓ Works in a Primary Priority sector or setting as identified by MOH (see Table 1)

Question 2: Does the worker provide care in a high-priority community?

The community has been identified as a high priority community based on local epidemiology and consideration of structural factors and determinants of health.

Question 3 (risk matrix not feasible as PHU has limited capacity to apply it to populations served by the vaccine clinic)**:** Does the worker provide direct and frequent or sustained patient care to a high risk patient population?

- ✓ Frequent interactions with vulnerable patient populations with high burden of illness
- ✓ Unable to work virtually
- ✓ Plays critical role in maintaining local health system and in pandemic response
- ✓ Moderate redundancy among community health care providers and other specialities
- ✓ Patient population is at high risk for severe outcomes of COVID-19

Question 4: Is the worker over 60 years of age or consider themselves to be at higher risk?

- ✓ Worker is aged 60 years or above
- × Worker self-reported no additional risk factors relating to biological, social or geographical risks.

Result: All staff with direct patient care/ who must work in the patient's direct environment should be considered as high priority for vaccine due to criticality of

work performed, frequent close contact with patients, burden of illness among patient group, and low position redundancy. Among these workers, those ≥60 years old or who, based on voluntary self-report, consider themselves to be at higher risk due to biological, social, or geographical factors should be considered the highest priority.

Case Example #2: A PHU is determining priority for vaccination at a vaccine clinic and considering a 42-year-old primary care provider in solo practice who provides services to a diverse patient group, moderately impacted by the social determinants of health.

Question 1: Does the worker meet the definition of health care worker and if so, what is the relative priority of their sector or setting identified in Table 1?

- ✓ Worker meets definition of 'health care worker' as defined on page 2
- ✓ Works in a Primary Priority sector or setting as identified by MOH (see Table 1)

Question 2: Does the worker provide care in a high-priority community?

- ✓ Public Health Unit has designated the community as a moderate priority based on local data, epidemiology and consideration of structural factors and determinants of health.

Question 3 (risk matrix not required/feasible as PHU has limited capacity to apply it to populations served by the vaccine clinic): Does the worker provide direct and frequent or sustained patient care to a high-risk patient population?

- ✓ Frequent close contact with patients
- × Some work able to be performed virtually and patients likely to have access to technology
- ✓ Supports local health system
- × Some redundancy among Primary Care Providers and other specialties

Question 4: Is the worker over 60 years of age or consider themselves to be at higher risk?

- × Worker is not in a high-risk category due to age.

Voluntary self-report of risk factors relating to biological, social or geographical risk if available could add additional considerations for individual risk.

Result: This worker should be considered for prioritization; however, they should be placed in a moderate category, recognizing the patient community are a moderate priority community and the worker's moderate level of individual risk.

Case Example #3: A PHU has designated an allocation of vaccines to a local hospital to run a vaccine clinic for its workers on-site. The hospital is determining vaccination priority among workers at the hospital and is considering the prioritization of custodial staff in the hospital.

Question 1: Does the worker meet the definition of health care worker and if so, what is the relative priority of their sector or setting (as per Table 1)?

- ✓ Worker group meets definition of 'health care worker' as defined on page 2
- ✓ Acute care sector is identified as a Primary Priority (as per Table 1)

Question 2: Does the worker provide care in a high-priority community?

- ✓ The PHU has already identified the hospital's community as a high priority.

Question 3: Hospital uses risk matrix instead of question 3 given hospital's capacity to apply it to its workforce (see below)

Patient population/exposure risk		Risk of exposure to SARS-CoV-2 within a health care setting based on worker role/responsibility		
		Low Risk	Moderate Risk	High Risk
Risk of severe disease or outcomes from COVID-19 among patient population served	Low Risk	1	2	3
	Moderate Risk	2	3	4
	High Risk	3	4	5

Rationale:

- Patient population (Moderate risk): Patient population will have varying risk of severe disease or outcomes from COVID-19
- Exposure risk (Moderate): May have interactions with potentially COVID-positive patients, while wearing appropriate PPE, unable to work virtually

Criticality		Existing health system capacity and redundancy		
		High	Moderate	Low
Essentiality to critical health system capacity	Low	0	.25	.50
	Moderate	.25	.50	1
	High	.50	1	2

Rationale:

- Essentiality (High): Plays critical role in maintaining local health system
- Redundancy (Moderate): Some redundancy in role

Key Prioritization Consideration	Score
Patient population/exposure risk	3/5
Criticality	1/2
Total	**4/7**

Question 4: Is the worker over 60 years of age or consider themselves to be at higher risk?

Consider any individual risk factors when prioritizing individual custodial staff (≥60 years old or those who, based on voluntary self-report, consider themselves to be at higher risk due to biological, social, or geographical factors).

Result: This worker group should be considered moderate priority for vaccine due to criticality of work performed, and a moderate amount of exposure to potentially COVID-19 positive patients.

Within all those in this group, consideration of age and whether there has been a voluntary self-report of high risk identifies priority individuals.

Case Example #4: A PHU is determining priority for vaccination at a vaccine clinic and considering food preparation volunteers in shelters.

Question 1: Does the worker meet the definition of health care worker and if so, what is the relative priority of their sector or setting (as per Table 1)?

× Workers do not meet the definition of 'health care worker' that would be applicable in a non-health setting, as per the definition on page 2.

Result: They are not to be considered in the health care worker prioritization.

Appendix: Risk Matrix

Exposure risk*/patient population		Risk of exposure to SARS-CoV-2 within a health care setting based on worker role/responsibility		
		Low Risk	Moderate Risk	High Risk
Risk of severe disease or outcomes from COVID-19 among patient Population served[5]	Low Risk	1	2	3
	Moderate Risk	2	3	4
	High Risk	3	4	5

*Consider those who provide direct and more frequent or sustained care, or whose presence in such environments is more direct, frequent, or sustained, in addition to those with more limited access to PPE

Criticality*		Existing health system capacity and redundancy		
		High	Moderate	Low
Essentiality to critical health system capacity	Low	0	.25	.50
	Moderate	.25	.50	1
	High	.50	1	2

*Consider those who cannot work remotely or virtually and who work in areas with limited or reduced capacity as well as little or no redundancy.

Key Prioritization Consideration	Score
Patient population exposure risk	/5
Criticality	/2
Total	**/7**

[5] See People who are at risk of more severe disease or outcomes from COVID-19