These levels have been developed in consideration of settings where different groups work, the risk of exposure to COVID-19, and the patient populations served.

Highest Priority

Sectors and Settings[3] [4]

Frontline health care workers in the following sectors and settings (including custodial, reception, and other staff):

- **All hospital and acute care staff in frontline roles with COVID-19 patients and/or with a high-risk of exposure to COVID-19, including those performing aerosol-generating procedures:**
  - Critical Care Units
  - Emergency Departments and Urgent Care Departments
  - COVID-19 Medical Units
  - Code Blue Teams, rapid response teams
  - General internal medicine and other specialists involved in the direct care of COVID-19 positive patients
- **All patient-facing health care workers involved in the COVID-19 response:**
  - COVID-19 Specimen Collection Centers (e.g., Assessment centers, community COVID-19 testing locations)
  - Teams supporting outbreak response (e.g., IPAC teams supporting outbreak management, inspectors in the patient environment, redeployed health care workers supporting outbreaks or staffing crisis in congregate living settings)
  - COVID-19 vaccine clinics and mobile immunization teams
  - Mobile Testing Teams

[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 are included (e.g., including custodial, security and reception staff). Where a non-health setting has been named, only workers providing a health service or direct patient care are included.

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

  - COVID-19 Isolation Centers
  - COVID-19 Laboratory Services
- **Medical First Responders** (ORNGE, paramedics, firefighters providing medical first response).
- **Community health care workers serving specialized populations including:**
  - Needle exchange/syringe programs & supervised consumption and treatment services
  - Aboriginal Health Access Centers, Indigenous Community Health Centers, Indigenous Interprofessional Primary Care Teams, and Indigenous Nurse Practitioner-Led Clinics
  - Special considerations for the following:
    - Community Health Centers serving disproportionally affected communities and/or communities experiencing highest burden of health, social and economic impacts from COVID-19
    - Highly critical health care workers in remote and hard to access communities, e.g., sole practitioner
  - Home and community care health care workers caring for recipients of chronic homecare and seniors in congregate living facilities[5] or providing hands-on care to COVID-19 patients in the community

Rationale

- Provide direct, in-person patient care to patients at highest likelihood of being COVID-19 positive or work in environments with high in-person exposure to these patients (e.g., cleaner in critical care unit).
- Hospitals are the largest source of case acquisition among health care workers and outbreak associated patient deaths outside of long-term care homes and retirement homes[6].
- Ensure vital pandemic response services are protected and maintained.

[5] Consider a programmatic vaccination approach for home care workers caring for patients who are in Phase 1 populations (see Implementation considerations, page 14)

[6] As per Provincial Case and Contact Management System

- Specialized patient populations at highest risk of negative outcomes if they contract COVID-19.
- Most critical health care workers to COVID-19 response and to highly vulnerable communities.

Very High Priority

Sectors and Settings[7] [8]

Frontline health care workers in the following sectors and settings:

- **Acute care and other hospital settings** (patient care areas not included in Highest Priority (e.g., surgical care, obstetrics, etc.)).
- **Congregate settings**[9] (assisted living, correctional settings, residential facilities, hospices and palliative care settings, shelters, supportive housing (outside of Highest Priority level)).
- **Community care with high risk of exposure and serving specialized patient populations** (Community Health Centers, Home and community care (outside of the Highest Priority level), Adult day programs for seniors).
- **Other health care services for Indigenous populations** (Community agencies with patient-facing providers delivering any type of health services to First Nations communities and Indigenous Peoples that are not captured in Highest Priority).
- **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), Pharmacies, Primary care, Respirology (Respiratory Therapy), Walk-in clinics,).
- **Laboratory services**

---

[7] 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 are included (e.g., including custodial, security and reception staff). Where a non-health setting has been named, only workers providing a health service or direct patient care are included.

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

[9] Consider a programmatic vaccination approach (see Implementation considerations, page 14)

Rationale

- 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.
- Unable to work virtually or remotely.
- Specialized patient populations at high risk of negative outcomes if they contract COVID-19.
- Interactions with patients/clients with less access to PPE.
- High criticality to health system.

High Priority

Sectors and Settings[10] [11]

Frontline health care workers in the following settings and sectors:

- **Community care with lower risk of exposure and serving special populations**[12] (developmental services, mental health and addictions services).
- **Community care with lower risk of exposure and serving general population**[13] **(**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).

---

[10] 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 are included (e.g., including custodial, security and reception staff). Where a non-health setting has been named, only workers providing a health service or direct patient care are included.

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

[12] Excludes services provided to home care clients captured under home and community care services in priority levels above.

[13] Excludes services provided to home care clients captured under home and community care services in priority levels above

- **Non-acute rehabilitation and therapy**[14] (Chiropractic, Chronic pain clinics, Kinesiology, Occupational therapy, Physiotherapy, Psychiatry, Psychology, Psychotherapy, Registered massage therapy / Acupuncture, Other therapy).
- **Public health** (all other public health).

Rationale

- Generally lower risk of exposure relative to highest and high priorities.
- Generally less urgent care, services that can be delayed/ deferred relative to highest and high priorities.
- Unable to fully work virtually or remotely.

Moderate Priority

Sectors and Settings[15] [16]

Non-Frontline health care workers (e.g., those working remotely and who do not require PPE to work).

Rationale

- Services that can be provided remotely/virtually or within non patient facing areas of health care facilities.

[14] Excludes services provided to home care clients captured under home and community care services in priority levels above

[15] 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 are included (e.g., including custodial, security and reception staff). Where a non-health setting has been named, only workers providing a health service or direct patient care are included.

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

Additional Considerations

Equity and Fairness

- 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**.

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.

Implementation

- The vaccination of health care workers must follow provincial direction and progression through priority levels must be according to provincial direction.
- 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, if required. In particular, use available data and engage with local

partners regarding local populations served and settings affected by COVID-19 to assist in prioritization.

- Ensure that vaccine recipients will be able to return to receive their second dose within the required vaccination interval.
- Where possible, programmatic vaccination and strategic grouping of same-priority populations across different population groups should be pursued to maximize efficiency of vaccine delivery (e.g., programmatic vaccination of adult recipients of chronic home care and home care workers working with these patients).
- As part of a waste-minimizing strategy for last-minute cancellations, 'no-show' appointments and remaining end-of-day doses, vaccine clinics should prepare a list of stand-by alternate recipients for vaccination that may be called at short-notice.
    - Vaccine clinics should consult with the PHU on their approach in developing this list.
    - The individuals on the list should be within the same or next priority level as those currently being vaccinated, for example individuals with scheduled appointments later in the week, or who are next in line for scheduling appointments.
    - This list should be prepared in alignment with the principles of the Ethical Framework.

Relative Sequencing with Other Priority Populations

- The sequencing of health care worker vaccination relative to other priority populations must follow provincial direction.
- In a supply-limited environment, provincial direction on sequencing among priority sub-population will be more specific and may be linked to vaccination targets and directives.

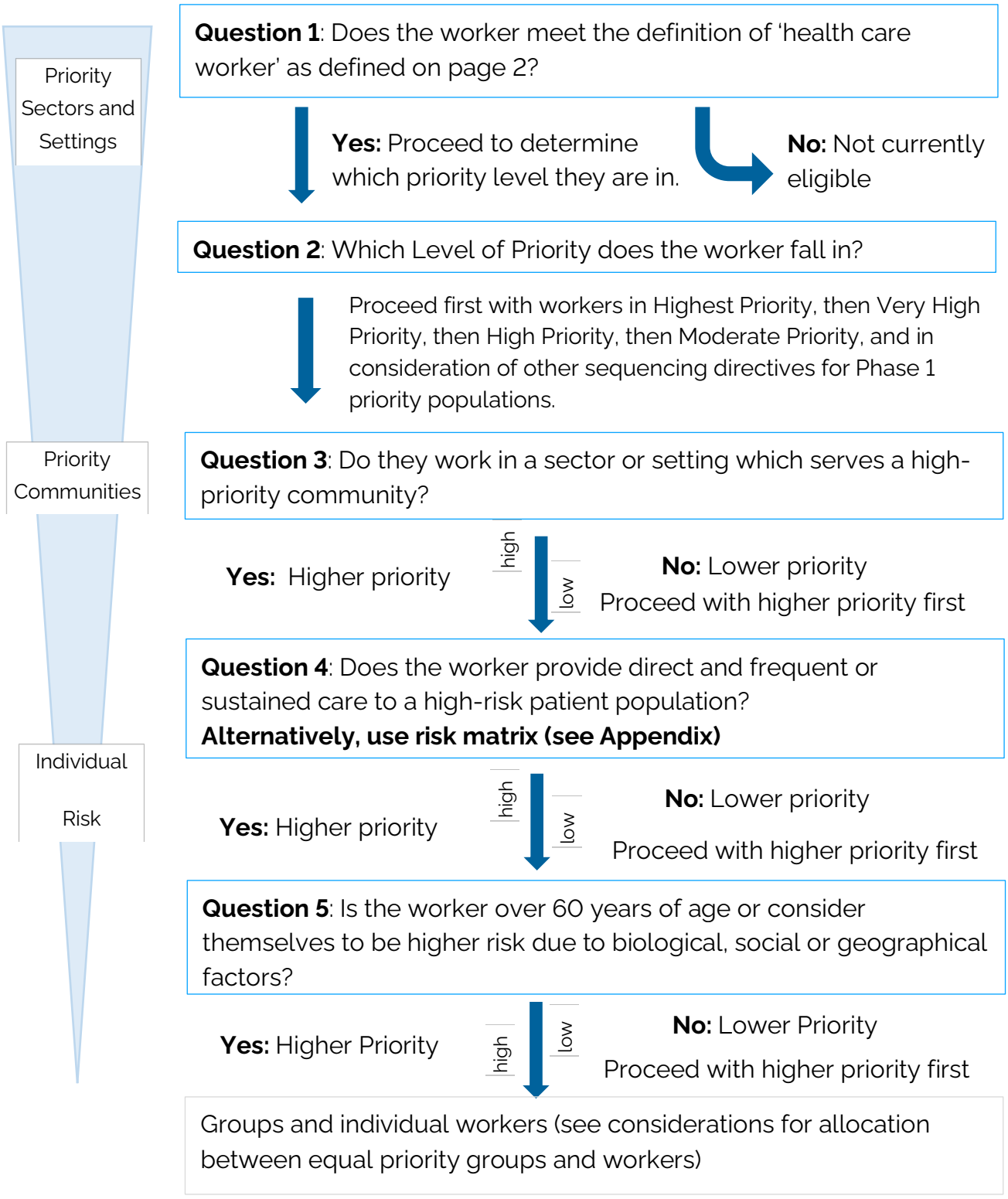
Examples

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.

PHUs, Health care organizations, associations, unions, and regulatory colleges who are undertaking prioritization of workers should consider the following questions.

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), but may eligible under other priority populations and as such could be considered for a programmatic vaccination approach.

Fig. 2: Prioritization Decision-Making Tree



Case Example #1: A 61-year-old community health care worker at a community health center 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.

The PHU has identified all sectors and settings within its catchment area that fall within the Highest Priority level and has approached the organizations and employers in these sectors and settings to identify eligible workers who meet the definition of health care worker and are frontline workers so that they may be booked at a local vaccine clinic.

Question 1: Does the worker meet the definition of health care worker?

- ✓ Worker meets definition of 'health care worker' as defined on page 2.

Question 2: What Level of Priority does the sector or setting fall under?

- ✓ Community health center in a high-prevalence neighbourhood where residents are disproportionately at risk for severe outcomes of COVID-19 is a setting identified in the Highest Priority Level.

Question 3: 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 4 (or use Risk Matrix): Does the worker provide direct and frequent or sustained patient care to a high risk patient population?

The Health Care Organization has assessed:

- ✓ 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 5: 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: This worker would be considered in the Highest Priority for vaccine due to being a frontline worker in a Highest Priority setting. In a period of limited vaccine supply, the health unit could further prioritize this worker according to the fact of serving a high risk community. If further prioritization is needed, the health unit would consider the HCO's assessment that the worker provides direct and frequent or sustained patient care to a high risk patient population and is ≥60 years old.

Case Example #2: A 42-year-old optometrist in independent practice who provides services to a diverse patient group in a community moderately impacted by the determinants of health is considered for vaccination.

The PHU has worked with the regulatory college (College of Optometrists of Ontario) and the professional association (Ontario Association of Optometrists) to inform the prioritization of optometrists in independent practice, to obtain information about the location of their businesses and facilitate communication with these workers.

Question 1: Does the worker meet the definition of health care worker?

- ✓ Worker meets definition of 'health care worker' as defined on page 2.

Question 2: What Level of Priority does the sector or setting fall under?

- ✓ Independent optometry practice would fall under the High Priority level.

Question 3: Does the worker provide care in a high-priority community?

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

Question 4: Does the worker provide direct and frequent or sustained patient care to a high-risk patient population?

(Risk matrix not required/feasible as PHU has limited capacity to apply it to populations served by the vaccine clinic. Alternately the regulatory college and professional association may provide a general assessment of the risk of this profession based on the characteristics of professional practice).

- ✓ Frequent close contact with patients.
- ✓ Able to perform some work virtually and patients likely to have access to technology, but all urgent care provided in person.
- ✓ Supports local health system.
- × Redundancy among optometrists.

Question 5: 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 in the High Priority level for prioritization and would be contacted for an appointment at a vaccine clinic when it is the turn for High Priority health care workers to be vaccinated. If further prioritization is needed within this level, the worker would be placed in a moderate category, recognizing the patient community are a moderate priority community If further prioritization is needed due to limited vaccine supply, the worker's moderate level of individual risk would be considered.

Case Example #3: A PHU has designated an allocation of vaccines to a local hospital to run a vaccine clinic on-site for its workers in frontline roles with COVID-19 patients and/or with a high-risk of exposure to COVID-19, including those performing aerosol-generating procedures. The hospital is determining vaccination priority among workers at the hospital and is considering the prioritization of custodial staff in the hospital's COVID-19 Assessment Center.

Question 1: Does the worker meet the definition of health care worker?

- ✓ Worker group meets definition of 'health care worker' as defined on page 2.

Question 2: What Level of Priority does the sector or setting fall under?

- ✓ All frontline staff in a COVID-19 Specimen Collection Center such as COVID-19 Assessment Centers, are in the Highest Priority**.**

Question 3: Does the worker provide care in a high-priority community?

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

Question 4: 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 (High): highly likely to have interactions with potentially COVID-19positive 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	4/5
Criticality	1/2
Total	***5/7***

Question 5: 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 group of custodial staff should be considered Highest Priority for vaccine due to criticality of work performed, and a High amount of exposure to potentially COVID-19 positive patients.

Within all those in this level, where further prioritization is needed due to limited supply of vaccine, consideration of age and whether there has been a voluntary self-report of high risk due to biological, social or geographic factors 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?

× 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, however may be considered as part of other priority populations.

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 [17]	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	.5 0
	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**

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