Ontario

Ministry of Health

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

Version 3.0, March 17, 2021

Highlights of Changes

- Addition of certain health care workers including dental hygienists, denturists, pedorthists, chiropodists, EMAT members, police and special constables providing medical first response as part of their regular duties, a broadened range of Indigenous health care service providers (pages 9-12); as well as health students with an upcoming in-person placement (page 8)
- Considerations around relative sequencing of moderate priority health care workers within Ontario's vaccination plan (page 7)
- Considerations provided for implementation of verification or validation of HCW status (page 15)

Key Messages

- Demand for COVID-19 vaccine will initially exceed available supply; prioritization must be set among health care workers.
- Sub-prioritization of health care workers will assist with vaccine delivery to health care workers in parallel with vaccination of other Phase 1 priority populations.
- Health care workers are prioritized based on risk of exposure, patient populations served, and incidence of COVID-19 outbreaks.
- 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's (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 recognizing 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 Government of Ontario has developed.

In times of limited vaccine supply, the MOH will continue to provide detailed direction on sequencing and targets between designated priority populations. Because demand for COVID-19 vaccines among Ontario's health care workers 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 that are not providing direct patient care and are frequently in the patient environment. This includes cleaning staff, food services staff, information technology staff, security, research staff, and other administrative staff.

- Workers providing healthcare service or direct patient service in a congregate, residential or community setting outside of a health care organization (e.g., nurse providing patient care in a school, worker performing personal support services in an assisted living facility, medical first responder in the community, peer worker in a shelter).

Note that while this definition of 'health care worker' is broad and inclusive, the remainder of this document sets out the phased prioritization of those included within this definition.

Roles and Responsibilities

Role	Responsibilities
Ministry of Health (MOH)	Set priorities, sequencing and targets, support healthcare system in implementation of the vaccine program.
Public Health Unit (PHU)	Lead local vaccination programs working with partners from health and municipal sectors; conducts prioritization in accordance with provincial guidance and direction and in consideration of 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 Regulatory Colleges	Work with MOH and PHUs to support vaccination of their members. Work with membership to share information with PHUs and on behalf of PHUs to support immunization planning and rollout. Help to mobilize membership for purposes of vaccination, such as facilitating public health communications with members.

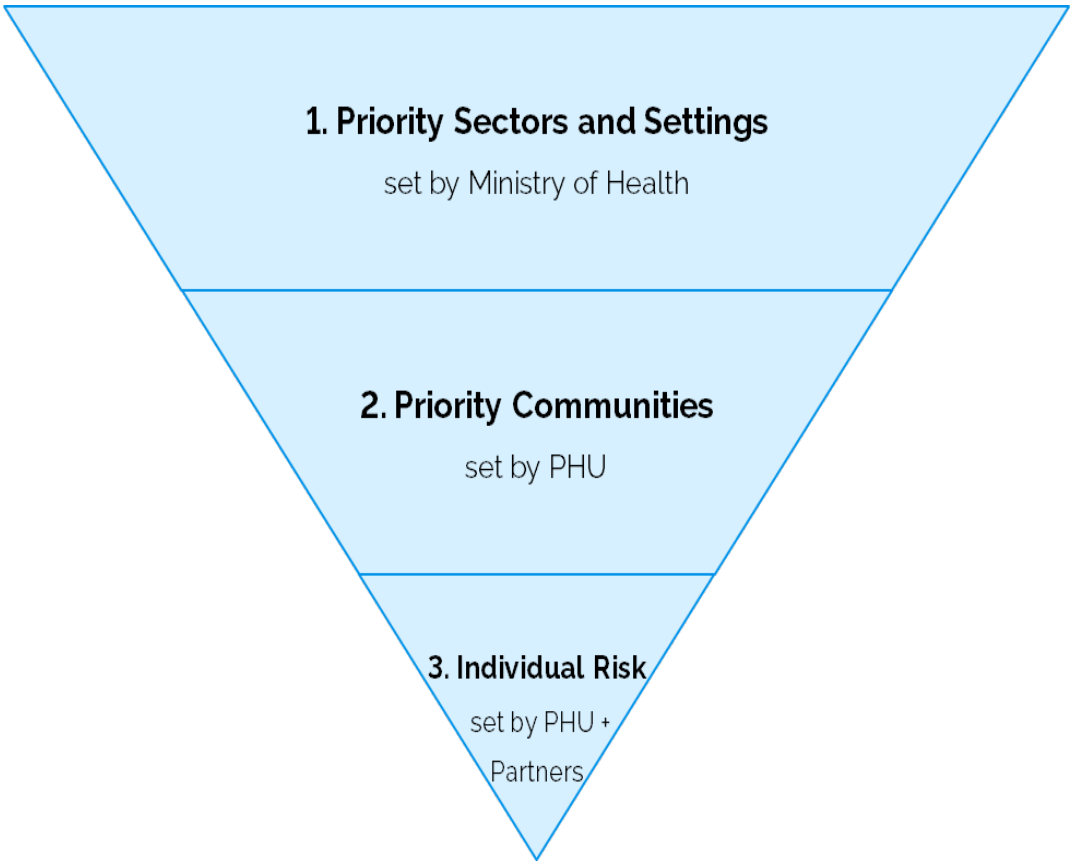
Role	Responsibilities
Health Care Organizations (HCOs) and other employers of health care workers	Support and facilitate vaccination operations where requested and develop enabling policies and strategies to support staff to get their immunization. Responsible for prioritizing health care workers and employees within the organization according to the Ministry's health care worker prioritization guidance.
Health Care 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 starting with those at highest risk of exposure to COVID-19 and who are critical to the COVID-19 pandemic response, 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.
    - Highest likelihood of COVID-19 acquisition among healthcare workers based on outbreak data.
    - 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 defined priority levels of health care sectors and settings (see page 8) PHUs will begin vaccinating first 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 .
- 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 (IC/ES) information on high-risk neighbourhoods.

3. Prioritize among workers (performed by local partners[1] including associations, unions and colleges in collaboration with the PHU)

- **Prioritizing among workers may not be required in all situations. This step should only be completed when further prioritization is required within the sectors and settings as part of steps 1 and 2 due to limited vaccine supply, and where operationally feasible.**
- Among sectors and settings in priority communities, PHUs support local vaccine delivery sites/institutions/sectors/employers, in identifying priority workers within each sector if needed.
- 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

[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.

(versus those in non-patient facing, administrative roles and health care workers who can work from home/remotely); and

- Those who are ≥60 years old[2] 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 are working entirely from home/remotely should be considered the lowest risk health care workers and are a lower priority for vaccine.
  - Note: When considering prioritization of workers who are working from home/remotely, consideration should be given to whether vaccination of that worker would lead to a resumption in providing in-person medical services, thereby increasing health service availability.
  - There may be a period of overlap between finalizing the vaccination of Phase 1 populations and starting vaccination of Phase 2 populations. Health care workers in the moderate priority group are considered lower risk workers and may be vaccinated while Phase 2 vaccinations are beginning. Public Health Units and their vaccination clinic partners may exercise discretion with this group in recognition of the local context, operational considerations, and available vaccine supply.

Priority Health Sectors and Workers

Health care workers have been identified as a priority population for Phase 1 of Ontario's vaccination program.

The following levels of priority (Highest, Very High, High, Moderate) have been identified by the MOH and should be used to sub-prioritize health care workers.

There may be overlap between the priority levels, and efforts should be made to follow the sequencing and provincial direction as closely as possible starting with individuals who fall into the Highest Priority level. In a vaccine-limited supply scenario, all efforts should be made to vaccinate all those in the Highest Priority level before moving on to the next level, and so on. With adequate vaccine supply, health units may begin a subsequent priority level concurrently to finishing a previous one to maximize efficiency.

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

The levels assume workers who are actively in their roles at the time of planned or anticipated vaccination. Workers that have been redeployed should be assessed based on their place of work or role at the time of planned or anticipated vaccination.

Health care students with confirmed upcoming in-person clinical placements may be offered vaccination prior to the start of their placement, and in accordance with the prioritization of the sector or setting where the placement takes place.

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:**

[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 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
- COVID-19 Isolation Centers
- COVID-19 Laboratory Services
- Current members of Ontario's Emergency Medical Assistance Team (EMAT) who may be deployed at any time to support an emergency response

- **Medical First Responders** (ORNGE, paramedics, firefighters providing medical first response, police and special constables providing medical first response as part of their regular duties).
- **Community health care workers serving specialized populations including:**
  - Needle exchange/syringe programs & supervised consumption and treatment services
  - Indigenous health care service providers including but not limited to: 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

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

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.
- 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).

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[6] As per Provincial Case and Contact Management System

[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)

- **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 and Dental Hygiene, Gynecology/obstetrics, Midwifery, Nurse practitioner-led clinics / contract nursing agencies, Otolaryngology (ENT), Pharmacies, Primary care, Respirology (Respiratory Therapy), Walk-in clinics, Medical transport.
- **Laboratory services**

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] (health care providers in 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/Chiropody, Audiology, medical and surgical specialties, Pedorthists, Denturists, etc.), Naturopathy, Holistic care, Social work, Sexual health clinics.
- **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.

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[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

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

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.
- Generally at lower 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.

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[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

- 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.
    - Public Health Units should work with health regulatory colleges to identify health care workers within their catchment areas that may be otherwise difficult to identify through Health Care Organizations and Service Provider Organization (e.g., independent practitioners and solo-practice providers).
    - Public Health Units, vaccination clinics, employers and health care organizations should work together to ensure workers that principally work in a setting but are not directly employed by the setting (e.g., agency workers, other third-party workers) are given an opportunity for vaccination along with other workers in the setting.
- 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.
- PHUs and partners should consider working with employers and health service providers to implement occupational or workplace-based vaccination clinics. Workers identified by their employer for these clinics would not need to provide personal attestation or additional validation of their status as a health care worker.
- Personal attestation is a generally accepted method of validating an individual's status as a health care worker.
- Public Health Units and vaccination clinic partners may choose to also consider other low-barrier methods of verification or validation of status as a health care worker, including and not limited to one of the following:
    - Letter of employment/letter from employer
    - Workplace ID/Badge
    - Pay stub
    - Professional identification number (for regulated professionals)
    - Statement of professional insurance

Relative Sequencing with Other Priority Populations

- The sequencing of health care worker vaccination relative to other priority populations should follow provincial direction. Deviation from provincial direction to respond to local context and emerging needs may be done in alignment with the Ethical Framework and in consultation with the Ministry. Supplies should be managed within the health unit's existing vaccine allocation.

- 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.

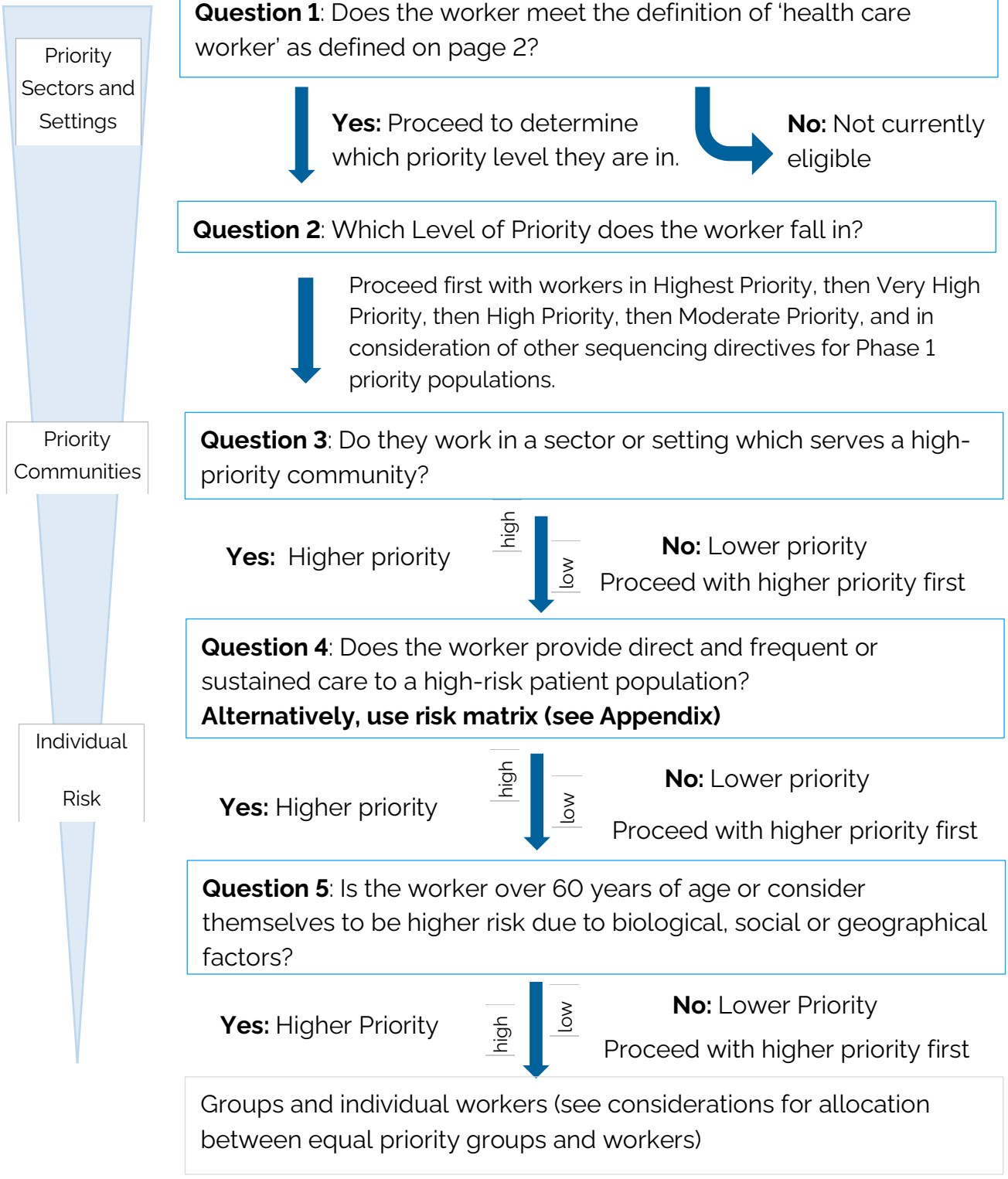
Examples

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	.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**

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