Ontario

Ministry of Health

# COVID-19: Guidance for Prioritization of Phase 2 Populations for COVID-19 Vaccination

Version 1.0, March 22, 2021

### Key Messages

- An ethics and equity lens should be applied to all prioritization decision-making
- The goals of Ontario's vaccination program are to prevent death, severe illness, hospitalizations and ICU admissions and reduce transmission
- Vaccination of Phase 2 populations will be based on **age and risk factors**
- Implementation of prioritization will balance provincial consistency with public health unit decision-making based on local context

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

- 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.

# Table of Contents

# 1. Purpose

The purpose of this document is to provide guidance regarding the rollout of vaccination of Phase 2 populations identified in Ontario's COVID-19 vaccination program. As the vaccine program continues to evolve, additional guidance may be provided, including relating to the use of specific vaccines (e.g. AstraZeneca/COVISHIELD, Johnson & Johnson).

This document intends to ensure provincial consistency while maintaining regional and local flexibility to respond to local and regional contexts and data. Ontario's Phase 2 approach aligns with the recommendations issued by the National Advisory Committee on Immunization (NACI) on the prioritization of key populations for COVID-19 immunization. Information on Ontario's process for developing the Phase 2 prioritization is provided in Appendix A.

Public Health Units (PHUs) and vaccination program partners are expected to follow the guidance when planning and delivering vaccination to Phase 2 populations. All PHUs should publish their vaccination plans, in alignment with the principles of the Ethical Framework.

Individuals may fall into more than one Phase 2 group. Where overlap occurs, individuals can pursue the earliest vaccination opportunity that is presented to them.

- It is likely that vaccination of Phase 2 populations will begin before all Phase 1 populations have been offered a first dose of vaccine, and that there will be overlap of the end of Phase 1 and the beginning of Phase 2. Individuals from Phase 1 who have not yet been vaccinated, remain eligible for vaccination during Phase 2.

This guidance provides implementation considerations to support PHU and partner planning. Further implementation guidance and details may be provided beyond this document.

# 2. Background

## Vaccine Program Goals

- The following are Ontario's COVID-19 vaccine program goals (in the order identified below) guiding the prioritization of Phase 2 populations, in an equitable and fair manner, in alignment with Ontario's Ethical Framework:
    1. Prevent deaths
    2. Prevent illness, hospitalization and ICU admissions
    3. Reduce transmission
- These objectives may be updated as new evidence emerges and as the situation in Ontario evolves.

## Evidence Sources for Prioritization of Phase 2 Populations

Several sources of evidence were considered in the determination of the prioritization of Phase 2 populations, including:

- Research and analysis conducted by Ontario's COVID-19 Science Advisory Table.
- Ontario COVID-19 outbreak data obtained from the Provincial Case and Contact Management System.
- Outbreaks and case data from sector-specific Ministry databases
- Peer-reviewed publications on the impacts of age, health conditions, and comorbidities on the risk of severe outcomes from COVID-19 infection.

# 3. Roles and Responsibilities

All partners, including vaccine recipients, have important roles to play in ensuring the success of Ontario's vaccination program, and in preserving integrity and ethics in the distribution of vaccines in Ontario.

## Provincial Coordination

### Ministry of Health (MOH)

- Set priorities, sequencing and vaccination program objectives and goals. Monitor and report on provincial progress. Support healthcare system in implementation of the vaccine program.
- Provide data and advice as needed to support PHUs in developing, monitoring, and refining local vaccination programs to ensure priority population groups are reached and intended objectives are achieved.

### Other Provincial Ministries and Directorates (including SOLGEN, ARD, IAO, MMAH, OMAFRA, MCCSS, etc.)

- Provide expertise and recommendations during the prioritization process in relation to their sectors and at-risk populations.
- Engage relevant communities and organizations on vaccination priorities and appropriate models for vaccine delivery. Support policies and strategies for immunization.
- Support PHU vaccination activities as requested. For example, provide lists of congregate living facilities in each region to support PHU outreach, facilitate communications or engagement with specific sectors and communities.

## Local Coordination

### Public Health Units (PHU)

- Lead local vaccination programs working with partners from all sectors as relevant; conduct prioritization in accordance with provincial guidance and direction and in consideration of local context and the relative impact of COVID-19 on, and needs of, different populations and communities.
- Establish committees or similar groups on prioritization that include diverse views from affected parties, groups, health sector partners and community agencies and organizations to inform local decision-making.
- Communicate regional vaccination plan with all partners and the broader public.

### Ontario Health (OH)

- Support vaccination program coordination with local health system partners.

## Sector Partnerships

### Health Care Organizations

- Where relevant and appropriate, participate as partners in the planning and delivery of COVID-19 vaccines to ensure equitable access to and uptake of vaccines.
- Facilitate outreach and information sharing with vaccine-eligible patients about vaccination opportunities.

### Primary Care Professionals and Specialists

- Facilitate identification and outreach to vaccine-eligible patients with at-risk health conditions.
- Support and provide vaccination of patients with eligible at-risk health conditions.
- Support and encourage vaccination of patients through counselling, education, and answering questions.

### Pharmacies

- Support and encourage vaccination of patients through counselling, education, and answering questions.
- Provide vaccination as part of the pharmacy vaccination delivery process.
- Pharmacies participating in vaccine distribution should follow vaccine specific guidance.

### Owners and Operators of Congregate Living Facilities

- Collaboratively work with vaccinators to facilitate vaccination of congregate living populations.
- Support the informed consent process with substitute decision makers for clients who are incapable to consent for themselves
- Develop enabling policies and strategies to support vaccination.

## Community Partnerships

**Employers and Workplace Owner-Operators**

- Support and facilitate vaccination operations where requested.
- Promote awareness and education of vaccine for staff
- Develop enabling policies to support staff vaccination

**Professional Regulators**

- Where requested by PHUs, facilitate communications with membership about vaccination plans and opportunities, and support the provision of information to public health as relevant and appropriate for vaccination planning and implementation.

**Unions and Professional Associations**

- Facilitate communications about vaccination plans, where requested by public health.
- Encourage vaccine uptake among workers and professionals.

**Municipal Partners and Local Service Boards (e.g., Municipal Service Managers, Community Emergency Management Coordinators)**

- Support Public Health Unit vaccination programs.
- Participate on established committees, as requested, to inform local decision-making on vaccination implementation.

**Community-Based Organizations and Community Partners (e.g., faith-based organizations, community centers)**

- Partner with PHUs, vaccine clinics and other partners where requested to provide input and community perspectives on local vaccination plans and preferred vaccine delivery models, including the unique needs of different populations and communities, barriers to vaccine access and uptake, and ways to address these barriers.
- Partner with PHUs where requested to provide vaccine clinic locations.
- Collaborate with vaccine clinics, health care partners and PHUs where requested on raising awareness around eligibility for vaccine, increasing vaccine confidence, addressing concerns or misperceptions, and providing information and assistance with accessing vaccine clinics.

# 4. Phase 2 Populations for Vaccination

In Phase 2, vaccines will initially be made available to population groups based **primarily on age and risk**, including adults aged 60-79 years of age and groups recognized to have greater risk associated with hot spot communities, congregate living settings as well as highest and high risk health conditions. Additional focused strategies will support vaccination of Essential Workers Who Cannot Work from Home and At-Risk Health Conditions.

Certain vaccines, such as AstraZeneca/COVISHIELD, may be offered to individuals within Phase 2 populations through administration channels such as pharmacies and primary care, depending on supply and further Health Canada approvals (see AstraZeneca/COVISHIELD section below).

# 5. Approach to Sequencing of Phase 2 Populations

- The goal of this arm of the provincial vaccination program is to vaccinate all eligible and willing individuals as quickly as possible.
- Sequencing within the phase 2 populations should follow the priority order outlined below.
- When all reasonable efforts have been made to offer a first dose of vaccine to all those within the Primary Priority, vaccination can proceed for those in the Secondary Priority.
- PHUs should follow provincial direction on reporting on progress and status of vaccination through priority populations.
    - All efforts should be made to follow the provincial prioritization guidance while recognizing that local context may require some variation. Any major deviation from the prioritization order outlined in this guidance should be made in discussion with the Ministry of Health.
- See Appendix B for a detailed overview of the sequencing and prioritization of all Phase 2 populations

## Primary Priority

The groups identified as a Primary Priority should be offered a vaccine first in Phase 2 of Ontario's vaccination program. There is no relative prioritization within the primary priority groups (i.e., they should be offered vaccinations concurrently). PHUs should work to vaccinate these populations at an equitable pace, in consideration of the size of these populations and local context.

- Adults aged 60-79, starting with those 75-79 and decreasing in 5-year increments
- Individuals with health conditions, starting with Highest Risk and High Risk health conditions[1]
- Residents, Essential Caregivers[2] and Staff of High Risk Congregate Settings
- Adults aged 50+ in COVID-19 Hot Spot Communities, starting with older individuals and decreasing in age

## Secondary Priority

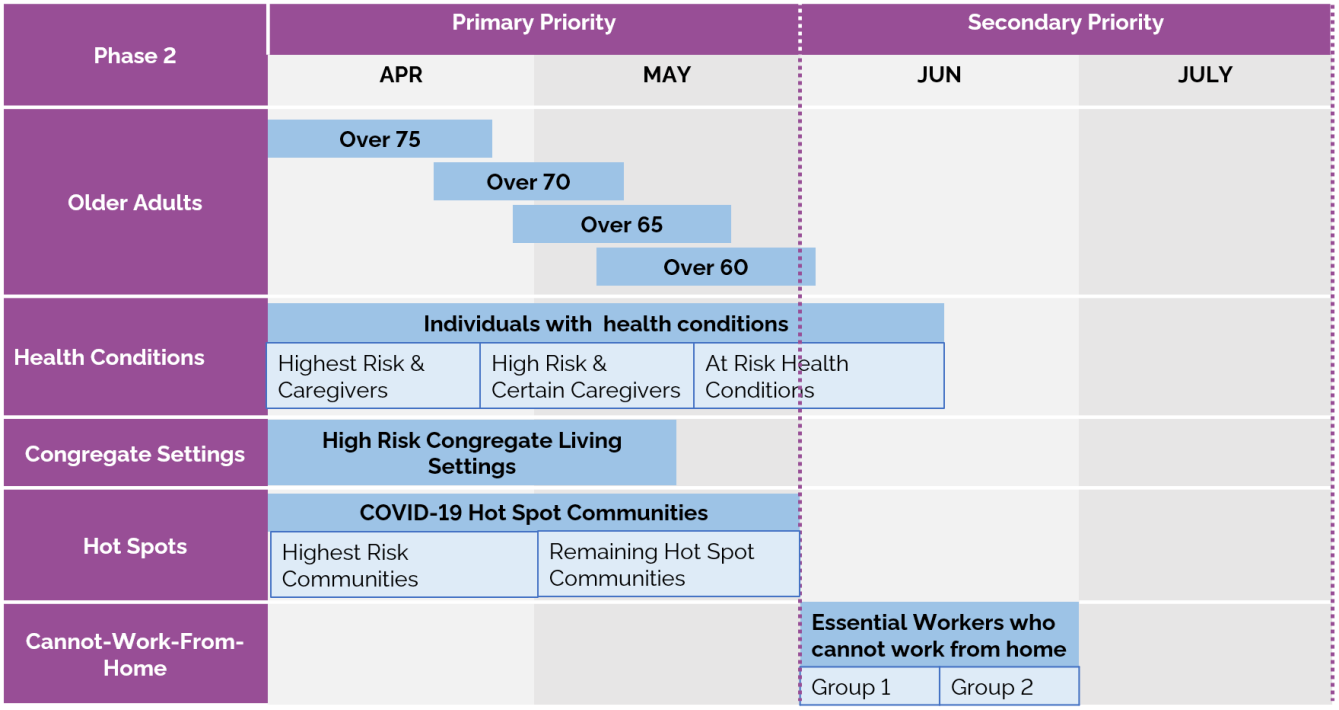
The groups identified in Secondary Priority are those that should be offered a first dose of vaccine in Phase 2 of Ontario's vaccination program when all reasonable efforts have been made to offer a first dose of vaccine to all those within the Primary Priority.

- Remaining Individuals with At-Risk Health Conditions
- Workers who cannot work from home starting with those in the First Group and then proceeding to those in the Second Group.

[1] Includes up to 1 essential caregiver for those in the Highest Risk group and certain caregivers for those in the High Risk group.

[2] Essential Caregivers are included for the following congregate settings: developmental services, mental health and addictions congregate settings, homes for special care, children's residential facilities, and Indigenous healing and wellness facilities

## Figure 1: Projected Timing of Phase 2 Sequence




All timelines subject to vaccine supply availability

# 6. Details of Phase 2 Populations for Vaccination

## Adults 60 Years of Age and Older

**Description:**

- Adults aged 60-79 years of age, beginning with adults 75-79 years of age and decreasing in 5-year increments

**Rationale:**

- In Ontario, there is an association of severe COVID-19 with increasing age and increased association of hospitalization and mortality due to COVID-19 in those over the age of 60 years.[3]

[3] Public Health Ontario. Ontario COVID-19 Data Tool.

**Implementation Considerations:**

- Mass immunization clinics will likely be the primary vaccine access point for older adults. Community clinics, primary care settings and pharmacies will be additional points of access for this population.
- Consider the accessibility and mobility needs of this population when planning implementation and communications of vaccination clinics.

# 7. Focused Strategies: Populations At Risk

Populations at risk have been identified for vaccination in Phase 2 and will be reached through focused strategies and programmatic vaccination approaches concurrently with age-based vaccination.

## Adults living in COVID-19 Hot Spot Communities

**Description:**

- Hot Spot Communities are areas within certain Public Health Units where provincial and local data demonstrate historic and ongoing high rates of COVID-19, death and severe illness (e.g., hospitalization) due to COVID-19.
- Adults 50 years of age and older residing in pre-identified "Hot Spot" communities, within specified health units.
- Vaccination should begin with the oldest individuals and decreasing in age until reaching those aged 50.
- Hot Spot areas are identified by provincial data supported by PHU local knowledge and expertise.
- As the situation in Ontario evolves, communities experiencing sustained surges in COVID-19 prevalence may be identified as COVID-19 Hot Spot communities.

**Rationale:**

- Certain communities, due to biological social, economic, and structural factors have faced an increased prevalence of COVID-19, higher risk of death and of severe outcomes at younger ages than those in other communities, as well as ongoing high transmission of COVID-19.

- Evidence demonstrates certain populations that have been disproportionately affected by COVID-19 in Ontario (e.g., Black, racialized, lower income and materially deprived) due to a number of intersecting equity factors and factors related to the determinants of health. Hot Spot Communities often have higher concentrations of these populations.

**Implementation Considerations:**

- Hot Spot areas will be identified by provincial data supported by PHU local knowledge and expertise.
- The Ministry of Health will provide the specified PHUs with supporting data and analysis to help identify Forward Sortation Areas (FSA) that have been considered as Hot Spot areas.
    - PHUs have flexibility and discretion to refine the list of communities and boundaries within FSAs, add additional communities, and determine sequencing between Hot Spot areas within their regions based on local context and implementation considerations.
        - For example, if an FSA has been identified as a potential Hot Spot, and its neighbouring FSA is determined by the PHU to be substantively similar in terms of most recent COVID-19 trends and relevant sociodemographic factors, a PHU may choose to vaccinate adults in both FSAs, subject to the PHU's vaccine supply.
    - In limited vaccine supply scenarios, PHUs may consider initially targeting a specific sub-population (e.g., specific age bands) or neighborhoods within a Hot Spot area based on risk factors, recent COVID-19 data, implementation considerations, and/or population size and density.
- Where age or address cannot be demonstrated or validated, low-barrier approaches to verification such as personal attestation are reasonable.
- PHUs should leverage the outreach and communications networks of communities and local community organizations (e.g. faith-based organizations, community centers, community leaders) to ensure that individuals within COVID-19 Hot Spot areas are reached and to help enhance vaccine confidence and address misinformation.

- To reduce barriers to accessing vaccines, PHUs should ensure that vaccination sites are accessible to the community. For example, clinics could be located within the hot spot communities, in cultural or community centers frequented by the community, or, if known, in large workplaces where community members may work.
- PHUs should engage with regional and local health care organizations and community partners (e.g. local lead agencies identified under MOH's High Priority Communities Strategy, community health centers, faith-based organizations, ethnic and linguistic community groups and associations) in order to:
    - Build vaccine confidence and reduce misinformation by developing communications and engagement materials and strategies that are tailored, inclusive and culturally appropriate, and that leverage local leaders and ambassadors, and established communications channels.
    - Identify unique needs within the community and address barriers to accessing vaccines (e.g. use of mobile clinics and partnerships to deliver vaccines within community settings such as community centers and faith/cultural institutions; pre-registration via outreach teams; extended operating hours; transportation supports; and addressing language/cultural barriers)

## High Risk Congregate Living Settings

**Description:**

- Residents and all frontline workers in high-risk congregate living settings.
- High risk congregate living settings refer to residential facilities where a high-risk client population live or stay overnight and use shared spaces (e.g., common sleeping areas, shared bathrooms, shared kitchens, communal dining spaces).[4]
- Includes homeless populations not in shelters.

[4] COVID-19 Resources for Congregate Living Settings | Public Health Ontario

- Includes workers who may be volunteers, learners, and third-party workers who regularly work in the setting (e.g., agency workers, other third-party workers )
- Includes 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.
- Includes essential caregivers for developmental services, mental health and addictions congregate settings, homes for special care, children's residential facilities, and Indigenous healing and wellness facilities.
- Essential caregivers are those identified through an organization's caregiver definition, or where no policy or definition is in place, assumes primary individuals providing direct, frequent and sustained in-person personal care and/or assistance with activities of daily living to a resident of a congregate living setting.
- Does not include any staff that are fully working from home or virtually.

**High Risk Congregate living settings include:**

- Supportive housing
- Developmental services / intervenor including supported independent living (SIL)
- Emergency homeless shelters
- Other homeless populations not in shelters
- Mental health and addictions congregate living (e.g., supportive housing, hospital psychiatric patients)
- Homes for special care
- Employer-provided living accommodations for temporary foreign agricultural workers
- Adult correctional facilities
- Violence Against Women (VAW) shelters
- Anti-Human Trafficking (AHT) residences
- Children's residential facilities
- Youth justice facilities
- Indigenous healing and wellness

- Bail beds & Indigenous bail beds
- Provincial and demonstration schools/ Consortium Centre Jules-Léger

Additional high-risk congregate living facilities may be identified by Public Health Units in consultation with Ministry of Health and relevant ministries based on data on COVID-19 outbreaks and related cases.

**Rationale:**

- In Ontario, a disproportionate number of COVID-19 outbreaks and associated cases have occurred in congregate living settings.[5]
- Due to the communal use of shared spaces, individuals may not always be able to exercise sufficient protective measures to adequately protect themselves or others from infection.
- The high-risk client populations served by these settings have higher morbidity and/or poorer health outcomes than the general population.
- Clients in several congregate care settings require supports for personal care and daily living activities, which necessitates the need for staff and essential caregivers to be vaccinated.

**Implementation Considerations:**

- A programmatic vaccination approach to these settings should be considered where residents, staff and essential caregivers are vaccinated at the same time.
- PHUs and vaccine clinics should work with municipal Service Managers to coordinate implementation of the vaccine program in emergency shelters and congregate supportive housing, and to develop approaches to reach people experiencing homelessness not residing in shelters, such as vaccine mobile clinics near encampments and drop-in centers.
- A majority of congregate living settings would benefit from mobile/on-site clinics to address challenges around client mobility, client security and/or public safety, and can consider partnering with a clinician that has responsibility for the home.

[5] Outbreak data in Ontario from the Provincial Case and Contact Management System.

- PHUs and vaccine clinics should work with congregate living settings to facilitate the identification of essential caregivers.
- Outreach material may need to be customized to reflect the accessibility needs of the populations in these settings (e.g., language needs, cognitive ability).
- Some settings may require suitable time to acquire consents from substitute decision makers and to arrange for essential caregivers to be on site for vaccinations.
- Owners and operators of congregate living facilities should be engaged to support acquiring appropriate consents with substitute decision makers for clients who are incapable to consent for themselves.
- Local outbreak and case outcome data should be used to inform prioritization among congregate living settings regionally.

## Individuals with Health Conditions

**Description:**

- Individuals with health conditions (as listed below), and up to one primary essential caregiver for those in the Highest-Risk Health Conditions group and for certain individuals in the High-Risk Health Conditions Group[6].
- An essential caregiver is someone providing direct, frequent and sustained in-person personal care and/or assistance with activities of daily living to the individual.
- The list of health conditions is not exhaustive. Health care practitioners will use their best medical judgement to vaccinate patients with health conditions not listed (e.g., rare diseases) that may put them at similar or greater risk to listed conditions.

**Highest-Risk Health Conditions:**

- Organ transplant recipients
- Hematopoietic stem cell transplant recipients

[6] Primary essential caregivers are included for individuals in the High-Risk Health Conditions group who require regular and sustained assistance with personal care and/or activities of daily living.

- Neurological diseases in which respiratory function may be compromised (e.g., motor neuron disease, myasthenia gravis, multiple sclerosis)
- Haematological malignancy diagnosed <1 year
- Kidney disease eGFR< 30

**High-Risk Health Conditions:**

- Obesity (BMI > 40)
- Other treatments causing immunosuppression (e.g., chemotherapy, immunity-weakening medications)
- Intellectual or developmental disabilities (e.g., Down Syndrome)

**At-Risk Health Conditions:**

- Immune deficiencies/autoimmune disorders
- Stroke/cerebrovascular disease
- Dementia
- Diabetes
- Liver disease
- All other cancers
- Respiratory diseases
- Spleen problems (e.g., asplenia)
- Heart disease
- Hypertension with end organ damage
- Diagnosis of mental disorder
- Substance use disorders
- Sickle Cell Disease
- Thalassemia
- Pregnancy
- Immunocompromising health conditions
- Other disabilities requiring direct support care in the community

**Rationale:**

- The health conditions identified are those that have been found to increase the risk of severe outcomes from COVID-19 infection, including hospitalization, admission to intensive care, intubation or mechanical ventilation, and death.

**Implementation Considerations:**

- Outreach and vaccine delivery to this patient population should principally be through specialist health service providers, primary care providers, and other key points where patients naturally intersect with the health care system.
    - For all individuals with Health Conditions, including those with At-Risk Health Conditions (i.e., the third group of health conditions), public health units should work with their health system partners to identify vaccination opportunities for these patients in the areas where they intersect with the health care system, for example through primary care providers, specialist care providers, specialist care networks, community health clinics, nurse practitioner-led clinics, family health teams, pharmacies, and others.
- Consider the physical, mobility and behavioural accessibility needs of this population group in communications and implementation planning.

## Essential Workers Who Cannot Work from Home

**Description:**

- All frontline workers who cannot work from home in sectors that are integral to the ongoing functioning of the economy, including justice and social services, critical infrastructure, agri-food and essential goods production and the supply chain.
- Frontline workers are those that hold public-facing roles or must work in-person with other workers in their workplace in order to deliver essential goods or services and where protective measures such as maintaining a physical distance of 2m from others are not always possible.
- Includes frontline workers providing response to time-critical service disruptions and preventive maintenance.

- Does not include any workers that are mostly working from home or virtually.
- Includes workers that may be working part-time or reduced hours.
- Includes workers that may be volunteers, learners, and third-party workers regularly working in the setting (e.g., agency workers, other third-party workers)
- Assume workers who are actively in their roles at the time of planned or anticipated vaccination. Workers that have been redeployed should be considered based on their place of work or role at the time of planned or anticipated vaccination.
- Note: PHUs upon consultation with the Ministry of Health and other relevant Ministries may identify additional workers who cannot work from home in essential and critical services based on local data and context.

**First Group of Essential Workers Who Cannot Work from Home**

- Elementary/ secondary school workers[7] (including educators, custodial, school bus drivers, administrative staff)
- Workers responding to critical events (including police, fire, special constables, children's aid society workers, emergency management, critical infrastructure restoration workers).
- Enforcement, inspection and compliance roles (including by-law enforcement, building inspectors, food inspectors, animal welfare inspectors, border inspection officers, labour inspectors / WSIB field workers)
- Individuals working in childcare as follows:
    - All licensees, employees and students on an educational placement who interact directly with children in licensed childcare centres and in authorized recreation and skill building programs.
    - Licensed home childcare and in-home service providers, employees of a home childcare agency and students on an educational placement
- Foster care agency workers (including customary care providers)
- Food manufacturing and distribution workers

[7] Only includes school workers who are currently working in-person and cannot perform duties remotely. PHUs may work with MOH and the Ministry of Education to address special circumstances where vaccination would allow resumption of critical in-person work.

- Agriculture and farm workers
- Funeral, crematorium and cemetery workers

**Second Group of Essential Workers Who Cannot Work from Home**

- Essential and critical retail workers (including grocery, foodbank and non-clinical pharmacy workers, ServiceOntario workers, ServiceCanada and Passport Canada workers, wholesalers and general goods, restaurant workers, LCBO)
- Manufacturing workers (including infrastructure construction, industries directly supporting the COVID-19 response and other essential businesses and services, and where facilities are at heightened risk for COVID-19 outbreaks and spread).
- Social workers and other social services staff providing **in-person client services** (including youth justice workers, OW and ODSP case workers)
- Courts and justice system workers (including probation and parole workers.)
- Transportation, warehousing and distribution workers (including public transit workers, truck drivers supporting essential services, marine and rail cargo and maintenance, highway maintenance)
- Electricity (including workers employed in system operations, generation, transmission, distribution and storage).
- Communications infrastructure workers (including cellular, satellite, landline, internet, public safety radio)
- Water and wastewater management workers
- Financial services workers (bank branch staff)
- Waste management workers
- Oil and petroleum workers (including those working in petroleum refineries; those involved in the storage, transmission and distribution of crude oil and petroleum products and those needed for the retail sale of fuel).
- Natural gas and propane gas workers (including those working in the compression, storage, transmission and distribution of natural gas and propane)
- Mine workers (including those needed to ensure the continued operation of active mines)
- Uranium processing workers (those working in the refining and conversion of uranium, and fabrication of fuel for nuclear power plants).

**Rationale:**

- A significant number of outbreaks in Ontario associated with a high number of cases have been reported within schools and childcare, agricultural production, food processing and/or packaging facilities.
- Immunizing essential workers minimizes the disproportionate burden of those taking on additional risks to maintain services essential for the functioning of society.[8]
- Absenteeism due to illness or perceived risk of illness from COVID-19 among workers most essential to the pandemic response and functioning of critical infrastructure and services may compromise the health and safety of Ontarians and negatively impact the economy.

**Implementation Considerations**

- PHUs and partners should work with employers to implement occupational or workplace-targeted vaccination clinics, as well as leverage opportunities for workplace-based vaccination of workers. Workers identified by their employer for these clinics would not need to provide personal attestation or additional validation of their status as a worker to the PHU.
- Where workers are attending clinics in the community without employer facilitation, eligible essential workers should be asked to make a personal attestation to validate their status as an essential worker who cannot work from home (See Appendix D for Sample Attestation Form). Additionally, they should be asked to provide a low-barrier method of confirmation of status as an essential workers who cannot work from home, including but not limited to one of the following:
    - Workplace ID/Badge
    - Pay stub
    - Professional identification number (for regulated professionals)
    - Statement of professional insurance
    - Letter of employment/letter from employer

[8] National Advisory Committee on Immunization (NACI). Guidance on the prioritization of key populations for COVID-19 immunization

- Employers should work with the Occupational Health and Safety departments to implement policies that facilitate and encourage worker vaccination, such as policies that enable workers to use paid time to be vaccinated.
- Consider ways to ensure that communication and delivery of vaccines among essential workers is culturally safe and appropriate and respects the rights of employees and the unique challenges and needs of those in precarious work settings.

# 8. Vaccine Distribution

- Public Health Units will receive vaccines in proportion to their total population size, with consideration for any remaining Phase 1 groups to be immunized, and of second-dose commitments.
- PHUs should proceed equitably and in consideration of the local context through the groups in Primary Priority and then in Secondary Priority.
- In consideration of local data and context and in consultation with the Ministry of Health, PHUs may dedicate a greater proportion of vaccine to a specific group to proceed at a faster pace through the vaccination of individuals within that group if there is a public health interest to do so.

**Limited Supply Scenarios**

- In a limited supply scenario, the Ministry will provide guidance on more specific prioritization between and within Phase 2 populations.

**Remaining End-of-Day Doses**

- 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.

# 9. 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 and Anti-Racism Impact Assessment (see Appendix C) in all decision-making processes regarding prioritization.
- **When vaccinating workers, do not prioritize based on organizational seniority or rank.**
- PHUs should work with local partners through a local prioritization committee or similar group, 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.
    - Engagement with sector and community leaders can facilitate awareness of vaccine eligibility among identified groups as well as potential barriers to vaccine access and uptake to be addressed.
    - Early engagement can also leverage the assistance of community and sector leaders to help build vaccine confidence and reduce misinformation.
    - Community and sector leaders can support the development of vaccine communications and outreach strategies for different populations and communities (e.g. racialized, lower income, newcomer/immigrant, homeless/underhoused, Francophone, non-English/French-speaking, Indigenous, LGBTQ2S+ populations, and people with disabilities).

# 10. General Implementation Considerations

- Ensure that vaccine recipients will be able to return to receive their second dose (where applicable) within the required vaccination interval.
- Verification and validation of individual prioritization will depend on the processes established by those delivering local vaccination programs.

    - Verification or validation processes should not be unduly burdensome on the vaccine recipient or the vaccination program and should always ensure low-barrier access to vaccination.
    - Certain information may be reasonable to verify or validate for certain population groups, such as date of birth, postal code or address.
    - Programmatic or setting-focused vaccination strategies should be considered where validation or verification of any personal information is not reasonable, feasible nor expedient.
    - Identify any verification or validation documentation needed ahead of time so individuals, their caregivers and/or substitute decision-makers are aware of requirements and have the necessary information available and ready at time of vaccination.
- Outreach, registration and actual clinics should be accessible for clients with disabilities, those unable to access the internet, and accommodate a variety of communication modes in English and French, at minimum.
- Further implementation guidance and details may be provided beyond this document.

# 11. Prioritization of Populations for AstraZeneca/COVISHIELD Vaccine

In alignment with the recommendations from NACI, Ontario will be offering the AstraZeneca/COVISHIELD vaccine to Ontarians aged 18 years and older without contraindications if:

- The advantages of earlier vaccination outweigh the limitations of vaccinating with a less efficacious vaccine;
- The ease of transport, storage and handling of this vaccine facilitates access to vaccination which may otherwise be challenging; and
- Informed consent includes discussion about current vaccine options (e.g. efficacy) and the timing of future vaccine options.

**Implementation considerations**

- Initial rollout of the AstraZeneca/COVISHIELD vaccines will be facilitated through pharmacies and primary care settings in pre-identified communities.

# Appendix A: Approach to Developing the Phase 2 Prioritization

**Prioritization Sub-Groups**

- Prioritization sub-groups were created to provide details on the populations identified by the Government for inclusion in Phase 2
- These sub-groups developed prioritization within each group based on the best available data and evidence and engagement with key stakeholders and partners.
- The four Prioritization Sub-Groups were:
    - **Communities-At-Risk,** co-led by the Ministry of Health and the Anti-Racism Directorate with engagement with the Ontario COVID-19 Science Advisory Table
    - **Age and Health Conditions**, co-led by Dr Dirk Huyer and Dr Maxwell Smith with membership by various clinical experts and the Ministry of Health
    - **High Risk Congregate Settings,** co-led by the Ministry of Children, Community and Social Services, Ministry of Municipal Affairs and Housing, with participation by other provincial Ministries
    - **Essential Workers**, co-led by the Treasury Board Secretariat and the Ministry of the Solicitor General, with participation by other provincial Ministries

**Prioritization Leads Working Group**

- The Prioritization Leads Working Group brought together the work of the four Prioritization Sub-Groups and outlined the relative prioritization and sequencing between the Phase 2 populations.
- The Prioritization Leads Working Group was led by Dr Dirk Huyer and Dr Maxwell Smith and included two representatives from each Prioritization Sub-Group as well as representatives from Public Health Units, Public Health Ontario, and Ontario Health, and was supported by the Ministry of Health.

# Appendix B: Phase 2 Prioritization Sequence

## 1. Primary Priority

| | |
|---|---|
| **Age** | Adults aged 60-79, starting with those 75-79 and decreasing in 5-year increments |
| **Hot Spot Communities** | Adults aged 50+, starting with oldest age groups and decreasing in age. |

| **Health Conditions** (Includes up to 1 essential caregiver for Highest risk and certain High risk individuals*) | **High-Risk Congregate Living Settings** (residents, staff and certain essential caregivers**) |
|---|---|
| **Highest risk**<br>• Organ transplant recipients; Hematopoietic stem cell transplant recipients<br>• Neurological diseases in which respiratory function may be compromised<br>• Haematological malignancy diagnosed <1 year, and<br>• Kidney disease eGFR< 30<br>**High-risk**<br>• Obesity (BMI > 40)<br>• Other treatments causing immunosuppression (e.g., chemotherapy, immunity- weakening medications), and<br>• Intellectual or developmental disabilities (e.g., Down Syndrome)<br>**At-risk**<br>• Immune deficiencies/ autoimmune disorders<br>• Stroke/cerebrovascular disease; diabetes; spleen problems<br>• Liver disease; respiratory diseases; heart disease; All cancers<br>• Pregnancy<br>• Diagnosis of mental disorder; substance use disorders; dementia<br>• Hypertension with end organ damage; Thalassemia; sickle cell disease, and<br>• Other disabilities requiring direct support care in the community | • Supportive housing<br>• Developmental services / intervenor including; supported independent living (SIL)<br>• Emergency homeless shelters<br>• Other homeless populations not in shelters<br>• Mental health and addictions congregate living (e.g., supportive housing, hospital psychiatric patients)<br>• Homes for special care<br>• Employer-provided living accommodations for temporary foreign agricultural workers<br>• Adult correctional facilities<br>• Violence Against Women (VAW) shelters<br>• Anti-Human Trafficking (AHT) residences<br>• Children's residential facilities<br>• Youth justice facilities<br>• Indigenous healing and wellness<br>• Bail beds & Indigenous bail beds<br>• Provincial and demonstration schools/ Consortium Centre Jules-Léger |

* Primary essential caregivers are included for individuals in the High Risk Health Conditions group who require regular and sustained assistance with personal care and/or activities of daily living.

**Includes essential caregivers for developmental services, mental health and addictions congregate settings, homes for special care, children's residential facilities, and Indigenous healing and wellness facilities

## 2. Secondary Priority

**Remaining Individuals with At-Risk Health Conditions**

**Essential Workers who Cannot Work from Home**

**First Group***

- Elementary/ secondary school staff (including educators, custodial, school bus drivers, administrative staff)
- Workers responding to critical events (including police, fire, special constables, children's aid society workers, emergency management, critical infrastructure restoration workers)
- Enforcement, inspection and compliance roles (including by-law enforcement, building inspectors, food inspectors, animal welfare inspectors, border inspection officers, labour inspectors/WSIB field workers)
- Individuals working in childcare as follows:
    - All licensees, employees and students on an educational placement who interact directly with children in licensed childcare centres and in authorized recreation and skill building programs.
    - Licensed home childcare and in-home service providers, employees of a home childcare agency and students on an educational placement
- Foster care agency workers (including customary care providers)
- Food manufacturing and distribution workers
- Agriculture and farm workers
- Funeral, crematorium and cemetery workers

**Second Group***

- Essential and critical retail workers (including grocery, foodbank and non-clinical pharmacy workers, ServiceOntario workers, ServiceCanada and Passport Canada workers, wholesalers and general goods, restaurant workers, LCBO)
- Manufacturing workers (including infrastructure construction, industries directly supporting the COVID-19 response and other essential businesses and services, and where facilities are at heightened risk for COVID-19 outbreaks and spread).
- Social workers and other social services staff providing **in-person client services** (including youth justice workers, OW and ODSP case workers)
- Courts and justice system workers (including probation and parole workers.)
- Transportation, warehousing and distribution workers (including public transit workers, truck drivers supporting essential services, marine and rail cargo and maintenance, highway maintenance)
- Electricity (including workers employed in system operations, generation, transmission, distribution and storage).
- Communications infrastructure workers (including cellular, satellite, landline, internet, public safety radio)
- Water and wastewater management workers
- Financial services workers (bank branch staff)
- Waste management workers
- Oil and petroleum workers (including those working in petroleum refineries; those involved in the storage, transmission and distribution of crude oil and petroleum products and those needed for the retail sale of fuel).
- Natural gas and propane gas workers (including those working in the compression, storage, transmission and distribution of natural gas and propane)
- Mine workers (including those needed to ensure the continued operation of active mines)
- Uranium processing workers (those working in the refining and conversion of uranium, and fabrication of fuel for nuclear power plants).

*Only includes frontline workers who cannot work from home meeting the description provided on page 18-19.

# Appendix C: Anti-Racism Impact Assessment

## INTRODUCTION

Systemic racism can occur as a result of unintended bias in policies, programs, decisions (e.g., procurement, funding, budgetary) or initiatives that appear neutral, but may have the effect of unduly disadvantaging Indigenous peoples and Black and racialized communities. It can take root in policies, programs, decisions (e.g., procurement, funding or budgetary) or initiatives that result in systemic barriers that impact access to opportunities and outcomes and can be perpetuated or amplified through inaction to mitigate them.

Anti-racism assessments of the impacts of policies, programs, decisions (e.g., procurement, funding or budgetary) and initiatives are integral to advancing an inclusive Ontario and in ensuring public sector programs and services are responsive to the diversity of Ontario and promote prosperity for all communities.

The Anti-Racism Directorate's (ARD) Anti-Racism Impact Assessment (ARIA) Framework establishes processes for identifying and monitoring racial equity impacts and outcomes of policies, programs, decisions and initiatives. It is a systematic, evidence-based process developed to assess a policy, program, decision or initiative's unforeseen and unintended adverse effects on racial equity and to modify it so that it does not result in negative impacts or a worsening of existing racial disparities.

Aligned with the objectives of the Anti-Racism Act, 2017, the ARIA framework is intended to enable government and broader public sector organizations to:

Apply Data-Driven decision-making: racial equity assessments support informed decision making to ensure initiatives are in the public interests

Respond to public concern:  Responsiveness is a cornerstone of citizen-centric public service and a core OPS value.  Applying a anti-racism approach helps to ensure that the experiences, needs and perspectives of all citizens are being addressed.

Demonstrate racial equity gains as added value: Efforts to achieve racial equity help to create and inclusive and prosperous Ontario

As part of its development of the ARIA Framework, ARD has prepared the ARIA Fast Track Review Tool, which provides the Ontario Public Service (OPS) and public sector organization's (PSOs) with a set of questions to consider how policies, programs, decisions and initiatives impact equity and outcomes for Indigenous peoples and Black and racialized communities.

This Fast Track Review Tool is available for use while additional ARIA implementation tools/supports currently under development are finalized for Fall 2021.

**ARIA PROCESS: Fast Track Assessment**

The ARIA process consists of six steps: preparation, scoping, assessing impacts, assessing mitigating options, and monitoring and evaluation.

1. **PREPARATION**

A policy, program, decision (e.g., procurement, funding or budgetary) or initiative may exert differential or adverse impacts and outcomes that create and sustain racial inequities. In order to prepare for the ARIA assessment and scoping, gather relevant quantitative and qualitative data pertaining to the policy, program, decision or initiative. This may include, but is not limited to:

- relevant administrative data
- program reviews/evaluations
- performance measures (and related records of complaints from clients, stakeholders, and the public)
- consultative evidence or findings from engagement of affected communities, community stakeholders, and subject matter experts

2. **SCOPING**

To gain a preliminary understanding of the potential nature and extent of the racial disparities or lack of racial equity related to the policy, program, service or process being reviewed, the following questions should be considered:

- What problem or issue is this policy, program, decision or initiative aiming to solve/address?
- Who is the target population of the policy, program, decision or initiative and why?
- What are the expected impacts/outcomes of the policy, program, decision or initiative for the target population? What would happen in the absence of the introduction of this policy for the target population?
- What share of the target population do Indigenous, Black and racialized people comprise? Is this greater or less than the general population?

## 3. ASSESSING IMPACTS

A policy, program, decision or initiative may have adverse effects on racial equity by unduly privileging some populations and disadvantaging others.

Using the gathered quantitative and qualitative evidence, estimate how the existing or proposed policy, program, decision or initiative may differently impact Indigenous peoples, Black, and racialized communities than White populations.

Consider the following questions:

- What are the expected positive impacts/outcomes of the policy, program, decision or initiative for Indigenous peoples and Black and racialized communities, and how does that differ from White populations?
- What are the expected adverse impacts/outcomes of the policy, program, decision or initiative for Indigenous peoples, Black and racialized communities, and how does that differ from White populations?
- Is there parity in impacts and outcomes across Indigenous peoples and Black, racialized and White populations?
- What would happen in the absence of the introduction of this policy, program, decision, or initiative to Indigenous peoples and Black and racialized communities affected by this problem?
- What would happen in the absence of the introduction of this policy, program, decision, or initiative to White populations affected by this problem?

## 4. ASSESSING MITIGATION OPTIONS

To develop options to reduce, remedy, or prevent adverse impacts of initiatives on Indigenous peoples, and Black and racialized communities, consider the following questions:

- What systemic or other factors might have led to the inequities over time, i.e., its root cause/source?
- Would the problem have occurred if these causes had not been present?
- Has each identified root cause of the issue/problem/impact been evaluated to determine how best to prevent it from amplifying the harms?
- What are the options to eliminate or mitigate the adverse impacts and advance racial equity?
- Which population groups are likely to benefit from implementing the options? Who will have their benefits diminished?

## 5. IMPLEMENTATION AND REPORTING

To implement actions to mitigate, remedy, or prevent adverse impacts, ensure public transparency and accountability, and improve future actions to advance racial equity, consider the following questions:

- What option(s) are possible to implement to mitigate or eliminate adverse racial impacts/outcomes? Are there risks to implementing the option(s)? What are the risk for not implementing them? What mitigations are possible?
- What is the plan for implementing the remedial option(s)?
- How will accountability for effective implementation be ensured?
- What will be the reporting strategy, including key messages to help advance racial equity and build broad support for the option(s)?

## 6. MONITORING AND EVALUATION

To measure and understand the actual impacts on racial equity of actions taken, consider the following question:

- How will the impacts and outcomes of the remedial actions be measured, monitored and evaluated over time?

# Appendix D: Sample Attestation Form for COVID-19 Vaccination (Moderna & Pfizer-BioNTech)

*Note: This sample form can be adapted by public health units (PHU) as they see fit. It is up to the PHUs to determine how to collect, use, and disclose the attestation form and any supporting documentation, in accordance with applicable law.*

Version 1.0 March x, 2021

| |
|---|
| First and Last Name: |
| Date of Birth: |
| Cell/Phone Number: |

Ministry of Health has identified priority groups for COVID-19 vaccination in Ontario which align with the National Advisory Committee on Immunization (NACI) recommendations. Ministry of Health recently provided guidance for the Phase 2 population which complements the prioritization sequence that the Government of Ontario has developed. COVID-19 vaccination of these various groups requires a conversation to ensure that eligible individuals are being vaccinated as per the guidance provided by the Ministry.

**Please check and fill out the following:**

☐ **I am eligible to be vaccinted as per the Ministry's prioritization guidelines.**

☐ **I work at _____ as a _____.**

**By completing this form, I am confirming that I fall under the prioritization guidelines set by Ministry of Health. I further confirm that the information that I have provided within this document is accurate.**

Signature: _____ Date: _____ *(day/ month/ year)*

*Please bring proof of employment on the day of your appointment to the vaccination clinic (e.g: Work ID Card, Employment Letter, Professional Registration Card, etc.)*