April 28, 2020

Ontario Health West COVID-19 Regional Allocation Committee
Terms of Reference

Background

The outbreak of novel coronavirus (COVID-19) was designated on January 30, 2020 by the World Health Organization (WHO) as a Public Health Emergency of International Concern. In March 2020, in response to the growing number of Personal Protective Equipment (PPE) and critical supplies issues and shortages emerging across the province, Ontario Health established the Regional Supply Chain Tables. The focus for this Table is to establish a transparent and ethical allocation methodology to support HMMS (as OH West Regional Lead) in the gathering, management and equitable distribution of PPE and critical supplies to in-scope sectors within the region.

Healthcare Materials Management Services (HMMS) is a joint venture between London Health Sciences Centre (LHSC) and St. Joseph's Health Care, London (St. Joseph's) to provide integrated purchasing, accounts payable and inventory management services on a regional basis, covering much of what was previously described as Local Health Integration Networks (LHIN) #1 and 2 (see here). HMMS has accepted the role of OH West Supply Chain regional lead with the responsibility for coordinating a logistics infrasture that will ensure the efficient and timely distribution of emergency PPE supplies throughout the entire continuum of care for the OH West region.

Purpose

The pandemic resulted in sudden and dramatic changes to the consumption and supply of healthcare materials; the existing strategies to deal with temporary shortages such as 'on allocation' and algebraic proportionality proved insufficient. Local strategies had been developed to address the supply chain shortages. On April 20th, 2020 the mandate expanded from Ontario Health West for an allocation committee to work on behalf of the entire region to develop conservation and allocation methodology for the Ontario West region, which resulted in the Ontario Health West COVID-19 Regional Allocation Committee (RAC).

Goal

To support social order during this state of emergency (and potentially beyond) by supporting a functioning health care system in south west Ontario by striving for fair decisions when setting priorities for scarce resources. A functioning and sustainable health care system supports optimal health and flourishing for the greatest number of people (Utilitarian principle – see Appendix 1 for more principles). This attempts to balance the health and safety of health care providers with the health and safety of patients and the public. Supply chain organizations will continue to follow their Code of Ethics in accordance to the Broader Public Sector Accountability Act (2010).

Process

Decision-making will be by consensus-building. If consensus cannot be achieved, then decisions rest with the chair. The RAC strives for fair decision-making, representing all stakeholders, and is strongly committed to this intention. The process of decision-making will reflect the conditions of fairness described by the Accountability for Reasonableness Framework (A4R - See Appendix 2). It can be anticipated that fairness may be compromised as the emergency progresses; if this occurs, optimal fairness will again be sought as the emergency starts to pass.

Appeals

In striving for fair decision-making, appeals of any decision will be allowed. (*Revision* criterion for fairness). The appeals process can only be initiated if there is new and relevant information. It can be anticipated that fairness may be compromised as the emergency tightens. Appeals may need to be refused if the pandemic reaches the worst case scenario we hear about in Italy; the resources of this RAC will also be under extreme pressure as the pandemic progresses.

Decision communication and documentation

Resource allocation decisions will be communicated promptly to all relevant stakeholders (*Publicity* criterion for fairness).

Meeting Structure and Frequency

Agendas will be prepared by the OH West Supply Chain Regional Lead and the Co-Chairs, highlighting the urgent issues for decision-making or appeals consideration.

The RAC will meet as needed; this may be daily or more frequently.

The RAC may decide to strike subcommittee(s) to handle decisions on clustered items as needed. For example, it may be warranted for a subcommittee to devote itself to decisions relating to infection prevention as opposed to patient treatment issues.

Membership

The RAC strives for diverse representation of stakeholders while also striving for an effectively functioning group since prompt decisions are required. The perspectives of customers are partly expressed through their submitted requests/orders and will be considered. The diverse list of supply chain customers is not just a business asset; these are integral partners in a well-functioning health care system. (*Empowerment* criterion for fairness). (Evidence from group-dynamics research suggests that seven is an optimal number for discussion and decision-making.)

The Co-Chairs are responsible for:

- chairing the RAC meetings
- determining the business to be discussed
- reviewing minutes and documents before distribution to members

Members of the RAC are responsible for:

- reviewing materials prior to meetings
- attending and actively participating in meetings
- confirming attendance for meetings

Core Members

Position	Representative	Alternate
Co-Chair	Dr. William Sischek	
Co-Chair	Melissa Farrell	
Ontario West Supply Chain Lead	Toby O'Hara	
IPAC Physician Expert – Microbiology	Dr. Michael Payne	
IPAC Physician Expert – Infectious Disease	Dr. Michael Silverman	
Regional IPAC Physician Expert	Dr. Doug MacPherson	
Occupational Health	Cathy Stark / Jeff Tucker	Greg LeBlanc / Wendy Reed
Professional Practice	Julia Marchesan / Amanda Thibeault	Alexis Smith
Risk Management	Ruth Bullas	
Ethicist	Rob Sibbald / Marleen Van Laethem	
Regional – Erie St. Clair	Karen McCullough	Erika Vitale, Monica Stanton
Regional – Waterloo Wellington	Dr. Winnie Lee	
Regional – HNHB	Bryan Herechuk	
Regional Medium Hospital	Dr. Doug MacPherson	
Regional Small Hospital	Drew Braithwaite	
Long Term Care	Dr. Andrew Whynot	
Retirement Homes	Diane Stein	
Primary Care	Dr. Briana Providence	
Indigenous Health	Lori Davis Hill	

Subject matter experts

The nuances of the decision-making may vary by type of healthcare material under deliberation and also by stage of the pandemic being experienced. Consider experts in infectious disease, microbiology, biomedical engineering, respirology, etc. Subject matter experts will be invited as relevant.

Some specific subject matter experts have been invited to participate as members of a subject matter expert gallery. Please see Appendix 4 for more information.

Potential Conflict of Interests

Members may be in a potential conflict of interest or a tension of obligations; this may relate to financial investments but also to one's personal beliefs/values, or clinical program or family members/friends who are patients in need of scarce resources. Members will necessarily have their own biases, especially subject matter experts and this is why their expertise is requested. Members are reminded to be alert to their own beliefs and values, and to any biases or obligations that may have an undue impact on the decision-making process, and to declare those to the group. Management strategies of such conflicts or tensions may need to be undertaken and may include the member recusing themselves from the discussion.

Confidentiality

Information shared for the purpose of this committee is expected to be kept confidential. Any member or invited observer who feels they might not be able to adhere to this requirement needs to discuss this with the Chair. Sharing information for the purposes of operationalization will be carried out as relevant/needed.

Rules for Discussion

It is possible, even probable, that the shortage of one or more healthcare materials and the resulting allocation decisions may result in bad outcomes such as more people becoming infected or people not receiving standard of care treatment and therefore result in increased morbidity or mortality.

The type of decisions that this group will consider will be very challenging and may be emotional. Pandemics challenge us with a significant paradigm shift from 1. supporting the care of individual patients to 2. supporting the utilitarian goals of seeking the best for the community as a whole. The RAC agrees to uphold respectful dialogue, consistent with values of teamwork and collaboration, mutual respect, continuous learning, personal and professional integrity, and total quality management.

Effective conversations, utilizing Crucial Conversation skills, will support a safe space to raise challenging issues, and maximize the number of relevant viewpoints heard so that the pool of shared meaning is as robust as possible.

Authority

The RAC has accountability to Ontario Health (West) through a broadly representative group of stakeholder participants. The RAC is sanctioned and supported by Ontario Health (West). The authority for RAC decisions falls under the authorities of the participating institutions at the table who are expected to broadly represent the interests of the region. (*Enforcement* criterion for fairness.) Members will contribute to the discussion being mindful of regional representation and in solidarity to the optimal health care functioning of the region, not any specific loyalty to their organization.

Accountability

The Ontario Health West COVID-19 Regional Allocation Committee (RAC) reports to Ontario Health West through the Health System Response Structure. The committee will communicate regular updates to Ontario Health West leadership and to all relevant stakeholders through a project communication plan. This Table will meet until the global threat of COVID-19 is reduced.

Appendix 1

Guiding Principles for RAC Allocation Decisions

Decision–making during a pandemic ought to be informed by ethical values. (The following are not in priority order). More than one value may be relevant in any given situation, and some values will be in tension with others. This tension is the cause of the ethical dilemmas that may emerge during a pandemic, and reinforces the importance of shared ethical language as well as decision-making processes that can assign a moral weight to each value when values are in conflict. This list may be augmented and refined as the RAC gains experience. See Appendix 3 for other principles that may be relevant during a pandemic.

Principle	Considerations / Position
Preserve critical health system functions	Where shortages of critical health care resources like PPE threaten the ability of a health system to successfully and safely function, an ethical imperative exists to ensure that those scarce resources are deployed most effectively to sustain the health system's most critical functions. Critical health system functions are those that would be expected to result in immediate and significant morbidity and mortality if they were to cease functioning safely and effectively.
Utility	Allocation will be based on best clinical evidence towards greatest clinical benefit for greatest number (of all patients in the region we serve).
Ensure health institutions are treated equitably	PPE should be allocated in a manner that best ensures similar cases are treated equally, where irrelevant characteristics such as geographic location do not serve as the basis for allocation decisions, that allocation considers the interests and needs of the most disadvantaged, and that decisions about allocation are made through fair processes.
Minimize risk of harm to health workers and patients/clients/residents	PPE is intended to protect health care workers and other health institution staff from risk of harm due to infection, and in doing so, protect others, notably patients, from subsequent transmission of infectious diseases. Given supply shortages of PPE, the allocation of PPE should strive to maximize its intended benefits, i.e., prevention of infection and the spread of disease, and therefore minimize harm, particularly among those most at risk from infection and severe illness due to infection. In particular, a reciprocal obligation exists to minimize harm among those put at risk of exposure to infection (of COVID-19 or otherwise) during their participation in critical health system functions.
Ensure a proportional response based on best available evidence	Proportionality helps to ensure the least harm to patients arising from PPE allocations and related restrictions on health services. Prioritization decisions should be proportionate to the real or anticipated limitations in PPE supply.

Principle	Considerations / Position
Solidarity	Stemming a pandemic will require solidarity among community, health care institutions, public health units, and government. Solidarity requires good, straightforward communication and open collaboration within and between these stakeholders to share information and coordinate health care delivery. By identifying the health of the general public and health care workers as resources worth protecting, these stakeholders can model values of solidarity and encourage others to broaden ethical values focused on the rights or interests of individuals to those ethical values that are more communitarian in nature, e.g. 'greatest benefit for the greatest number'.
Stewardship	Stewardship is the exercise of responsibility in relationship to the creation and the careful use of resources. This is particularly relevant in a publicly-funded health care system where the resources belong to the province. Even during the interpandemic phase, the careful stewardship of resources should be guided by the mission and values of the organization and with consideration of the common good.
Foster trust	Foster and maintain public, patient, and health care worker confidence in PPE distribution system by communicating in a clear, transparent, and timely fashion, including rationale about what criteria are informing PPE allocation decisions and staff assignment decisions expectations around accepting or refusing work assignments.

Appendix 2. Accountability for Reasonableness Framework (A4R)

Conditions	Description	Testing Questions
1. Relevance	**Decisions are based on relevant reasons under the circumstances (i.e. goals, principles, evidence, values). See Appendix 2 for a list of principles and values.**	▪ Are we clear on the criteria we will use in making this decision? Do we anticipate any emerging decision factors that will inform our decision (e.g., MOH directions)? ▪ Have we got the data/information we will need to apply the criteria? ▪ Which stakeholders will be most affected by this decision and what are their specific interests?
2. Publicity	**Reasons for the decision are transparent. This transparency includes goals, criteria, processes, decisions and rationale. There should be an effective communication plan.**	▪ Have we clearly articulated the context, goal(s), criteria, processes, and possible outcomes of our decision-making process? What mechanism will we use to communicate our decisions and rationales to affected stakeholders? ▪ How will we communicate with stakeholders about the implications of these decisions?
3. Revision	**There are opportunities to revisit/revise decisions and a meaningful mechanism to resolve disputes.**	▪ If stakeholders have concerns about the decision process or the outcomes, what mechanism should they use to address these concerns to us? ▪ If new information emerges or errors are identified, what mechanism will be used to revise our decisions?
4. Empowerment	**Relevant stakeholders should be identified; their participation should be effective and inclusive.**	▪ Given our stakeholders' competing interests, how will we ensure that less powerful groups or vulnerable populations have a fair chance of voicing these interests to inform our decision-making? ▪ If we are asking physicians, staff, and other stakeholders to contribute to the decision-making process, what needs do they have and what can be done to support these within our timeframe to ensure their effective and constructive participation? ▪ Given the differential impact of our decisions on stakeholders, what supports do we have in place to facilitate the implementation process?
5. Enforcement	**Mechanisms are in place to ensure/enforce all 5 conditions are met and ethical decision-making is sustained throughout the response. There should also be learning and ongoing improvement to the process.**	▪ What am I going to do to make sure we stay true to these Terms of Reference? What are we going to do as a team to ensure we stay true to these Terms of Reference? ▪ What mechanism do we have in place to learn from this experience to improve future iterations?

Appendix 3

Other Ethical Principles

These other principles and values also arise during pandemics and are used in other types of decision-making. They are included here as they may provide support during the RAC deliberations.

Principle	Considerations / Position
Protection of the Public from Harm	Public health authorities have an obligation to protect the public from serious harm. For public health to fulfill this obligation and minimize serious illness, death, and social disruption, public health may isolate people or use other containment strategies, and/or require health care facilities to restrict public access to some areas or limit some services. For these protective measures to be effective, citizens must comply with them. The ethical value of individual liberty is often in tension with the obligation to protect the public from harm; however, it is also in individuals' interests to serve the public good and minimize harm to others.
Beneficence	Maintain highest quality of safe and effective care within resource constraints by: - Ensuring standard of care and leading practices whenever possible - Minimizing pain and suffering of individuals - Using alternative drugs or treatments where evidence suggests similar clinical efficacy - Informing and educating health providers about benefits, risks and appropriate use of alternative treatments, including risk mitigation strategies - Enabling individuals to receive care in the most appropriate setting. (Beneficence is considered the opposite to non-maleficence – do no harm or seek to minimize harm.)
Duty to Provide Care	Health care workers have an ethical duty to provide care and respond to suffering of others, who depend on their special skills and training. During a pandemic, demands for care may overwhelm health care workers and their institutions, and create challenges related to resources, scope of practice, professional liability, and workplace conditions including safety. Health care workers may have to weigh their duty to provide care to others against competing obligations (i.e., to their own health, family, and friends). When health care workers cannot provide appropriate care because of constraints caused by the pandemic, they may be faced with moral dilemmas or a crisis of conscience.

Appendix 4: Gallery Membership

In addition to the Core membership, the daily meetings include a Gallery Membership of subject matter experts that are regularly requested to provide ad hoc expert input to help facilitate decision making for the RAC. These members are not decision-making members.

Position	Representative	Alternate
Ontario Health West Clinical	Dr. Jennifer Everson	
Ontario Health West Quality	Steven Carswell	
Supply Chain Regional Sublead SW	David Pigg	
Supply Chain Regional Sublead HNHB	Sue Nenadovic	
Supply Chain Regional Sublead ESC	Katelyn Dryden	
Supply Chain Regional Sublead WW	Doug Murray	
Finance	Lori Higgs	
ONA Representation	Carlie Dinn, Ricki Leigh Dolsen	
Communications	Dan Brennan	
Communications	Dave Richie	

Appendix 5: Organizations Represented on Committee

Committee Position	Name	Title	Organization
Co-Chair	Dr. William Sischek	IVP, Medical and Academic	London Health Sciences Centre & St. Joseph's Health Care London
Co-Chair	Melissa Farrell	Presidents & CEO	St. Joseph's Healthcare Hamilton
Ontario West Supply Chain Lead	Toby O'Hara	General Manager	HMMS
IPAC Physician Expert – Microbiology	Dr. Michael Payne	IPAC Lead, Molecular Microbiology,	London Health Sciences Centre
IPAC Physician Expert – Infectious Disease	Dr. Michael Silverman	IPAC Lead, Infectious Disease	St. Joseph's Health Care London
Regional IPAC Physician Expert	Dr. Doug MacPherson	IPAC Lead, Medical Microbiology,	St. Thomas Elgin General Hospital
Occupational Health	Cathy Stark	Director, Wellness, Safety, Risk & Privacy	London Health Sciences Centre
Occupational Health	Jeff Tucker	Safety Consultant	St. Joseph's Health Care London
Professional Practice	Julia Marchesan	Director, Professional Practice	London Health Sciences Centre
Professional Practice	Amanda Thibeault	Director, Professional Practice	St. Joseph's Health Care London
Risk Management	Ruth Bullas	Chief Privacy & Risk Officer	St. Joseph's Health Care London
Ethicist	Rob Sibbald	Director, Ethics, Patient Experience & Relations, and Office of the Indigenous Liaison	London Health Sciences Centre
Ethicist	Marleen Van Laethem	Clinical Ethicist	St. Joseph's Health Care London
Regional – Erie St. Clair	Karen McCullough	Chief Operating Officer and Chief Nursing Executive	Windsor Regional Hospital
Regional – Waterloo Wellington	Dr. Winnie Lee	Interim Chief of Staff	Cambridge Memorial Hospital
Regional – HNHB	Bryan Herechuk	Manager, Quality & Value Improvement	Hamilton Health Sciences
Regional Medium Hospital	Dr. Doug MacPherson	IPAC Lead, Medical Microbiology,	St. Thomas Elgin General Hospital
Regional Small Hospital	Drew Braithwaite	Vice President, Corporate Services, Chief Financial Officer	South Bruce Grey Health Centre
Long Term Care	Dr. Andrew Whynot	Medical Director	Country Terrace LTC
Retirement Homes	Diane Stein	Director of Purchasing	Schlegel Villages
Primary Care	Dr. Briana Providence	Family Medicine Physician, Vice Lead Chatham Kent Family Health Team, Ontario Health CK Primary Care Lead	Chatham Kent Family Health Team Ontario Health
Indigenous Health	Lori Davis Hill	Director	Six Nations Health Services

Committee Position	Name	Title	Organization
(Gallery) Ontario Health West Clinical	Dr. Jennifer Everson	VP, Clinical	Ontario Health West
(Gallery) Ontario Health West Quality	Steven Carswell	Director, Quality	Ontario Health West
(Gallery) Supply Chain Regional Sublead SW	David Pigg	Director, Inventory & Logistics	HMMS
(Gallery) Supply Chain Regional Sublead HNHB	Sue Nenadovic	Regional Director, Materials Management	Niagara Health System
(Gallery) Supply Chain Regional Sublead ESC	Katelyn Dryden	Manager, Supply Chain Operations	TransForm Shared Service Organziaton
(Gallery)Supply Chain Regional Sublead WW	Doug Murray	VP Corporate Services & Chief Financial Offier	Grand River Hospital
(Gallery) Regional ESC	Monica Stanton	Director, Guest Services	Windsor Regional Hospital
(Gallery) Finance	Lori Higgs	Vice President Clinical Support and Chief Financial Offier	St. Joseph's Health Care London
(Gallery) ONA Representation	Carlie Dinn	Registered Nurse, Forensics ONA Representative	St. Joseph's Health Care London ONA
(Gallery) ONA Representation	Ricki Leigh Dolsen	Registered Nurse, Renal ONA Representative	London Health Sciences Centre ONA
(Gallery) Communications	Dan Brennan	Director of Communications	Ontario Health West
(Gallery) Communications	Dave Richie	Manager, Communications, Public Affairs	Ontario Health West

References

Ontario Health, *Personal Protective Equipment (PPE) use during the COVID-19 Pandemic*
Recommendations on the use and conservation of PPE from Ontario Health
Release date: March 25, 2020

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http://jcb.utoronto.ca/news/documents/Ethical-Framework-for-the-Allocation-of-Personal-Protective-Equipment-2020.pdf