COVID-19 Regional Allocation Committee
Terms of Reference

Purpose

In response to the growing number of Personal Protective Equipment (PPE) and critical supplies issues and shortages emerging across the province, Ontario Health established Regional Supply Chain leads and a Regional Allocation Committee (RAC). The focus of the Regional Supply Chain Table is to gather, manage and equitably distribute PPE and critical supplies to in scope sectors within the region. The RAC will focus on the distribution of regional supplies and the dissemination of best practices/conservation strategies, but is not directly responsible for the local management of supplies for individual health service providers.

Objectives

The Regional Allocation Committee shall:

1. Implement a PPE and Critical Supplies allocation approach in alignment with the Ministry of Health's Ethical Allocation Framework for providers in Ontario Health's West Region;
2. Establish a distribution model to ensure appropriate and expeditious delivery of PPE and critical supplies to health service providers;
3. Coordinate a regional response for PPE and critical supplies issues if local providers are unable to access supplies from regular channels or implement local solutions
4. Monitor local / regional PPE and critical supply issues routinely, problem solving and collaborating to manage issues accordingly;
5. Work with local and regional partners, suppliers and local health service providers, as a first step to finding solutions to PPE and critical supply issues ;
6. Share information, best practices, guidelines and processes related to the use and conservation of PPE and critical supplies;
7. Implement and support the collection of standardized PPE and critical supply data, as requested by the Ministry of Health and Ontario Health, to support the regional and provincial process for real-time supply across Ontario; and
8. Work collaboratively with Ontario Health and the Ministry of Health to escalate urgent PPE and critical supply issues to the appropriate channel.

Goal

To support the functioning of the health care system in Western 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 with the Broader Public Sector Accountability Act (2010).

Process

Decision-making will be evidence-based, and with the goal of consensus-building. If consensus cannot be achieved, then decisions rest with the Co-Chairs, under the direction of Ontario Health – West Region. 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 subsides.

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.

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 sub-committee(s) to handle decisions on clustered items as needed. For example, it may be warranted for a subcommittee to devote itself to decisions related to infection prevention as opposed to patient treatment issues.

The RAC shall conduct all meetings as closed door with no opportunities for additional auditors or gallery members. Delegates may be supported upon approval by the Co-Chairs, as appropriate.

Membership

The RAC strives for a diverse representation of stakeholders from across the healthcare system, while also striving for an effectively functioning group since prompt decisions are required. Decisions on membership will be made by Ontario Health and the Co-Chairs. Membership will be adjusted based on the evolving needs of the COVID-19 response.

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

Members

Positions	Representative
Co-Chair (2)	Dr. Bill Sischek - London Health Sciences and St. Joseph's Health Care London Melissa Farrell - St. Joseph's Healthcare Hamilton
Committee / Project Support	Julie Sischek – Project Coordination Dan Brennan – Communications
Ontario Health (1)	Dr. Jennifer Everson – Ontario Health – West Region
Supply Chain Leads (5)	Toby O'Hara (Lead) – Healthcare Materials Management Services David Pigg – Healthcare Materials Management Services Doug Murray – Grand River Hospital Renee McIntyre – Transform Shared Services Organization Sue Nenadovic – Niagara Health
Ethicist (1)	Marleen Van Laethem - St Joseph's Health Care London
Infection Prevention and Control (3)	Dr. Michael Payne (Microbiology) - St Joseph's Health Care London Dr. Michael Silverman (Infectious Disease) – London Health Sciences Centre Dr. Doug MacPherson (Infectious Disease) - St Thomas Elgin General Hospital
Occupational Health (1)	Cathy Stark – London Health Sciences Centre
Professional Practice (1)	Amanda Thibeault - St Joseph's Health Care London
Home and Community Care (1)	TBD
Hospital (3)	Dr. Winnie Lee - Cambridge Memorial Hospital Drew Braithwaite– South Bruce Grey Health Centre Monica Stanton – Windsor Regional Hospital
Indigenous Health (1)	Lori Davis Hill – Six Nations Health Services
Long Term Care (1)	Dr. Andrew Whynot - Country Terrace
Primary Care (1)	Dr. Briana Providence - Chatham-Kent Family Health
Retirement Homes (1)	Diane Stein - Schlegel Villages

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.

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.

Authority

The RAC has accountability to Ontario Health (West Region) through a broadly representative group of stakeholder participants. The RAC is sanctioned and supported by Ontario Health (West Region). 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 the specific needs/functions of their own 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 threat of COVID-19 is reduced, or at the direction of Ontario Health leadership.

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**	▪ 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?

Conditions	Description	Testing Questions
	be learning and ongoing improvement to the process.	

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.

References

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