Policy and Procedure Manual for Diabetes Education Programs Funded to Serve Paediatric Clients

Jointly developed by:

Ministry of Health and Long-Term Care and
Ontario's Local Health Integration Networks

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Contents

Preface 1
The History of Paediatric Diabetes Education in Ontario 1

1.0 Introduction to the Manual 2
1.1 Intended Audience 2
1.2 Purpose and Use 2
1.2 Terminology Used to Describe Core Stakeholders 3
1.3 Roles of Funders 4
1.3.1 Ministry of Health and Long Term Care 4
1.3.2 Local Health Integration Networks 4
1.4 Responsibilities of Funders 5
1.4.1 Provide Reporting Tools and Tracking Templates 5
1.4.2 Communicate Reporting Dates 5
1.4.3 Provide Contact and Submission Information 6
1.4.4 Evaluate Annual Projections and Plans 6
1.4.5 Evaluate Quarterly Reports 6
1.4.6 Identify Functional Centre Code for use in MIS Reporting 6

2.0 General Policies 7
2.1 Mandate and Scope 7
2.2 Staffing 8
2.3 Quality 8
2.4 Accessibility 9
2.5 Privacy and Confidentiality 9
2.6 Management of Funding 10
2.7 Recovery and Reallocation of Funds 10
2.8 Pump Funding 11
2.9 Program Audit 11
2.10 Financial Audit 11

3.0 Procedure for Completion and Submission of the Annual Plan 12
3.1 Completion of Annual Plan 12
3.1.1 Part 1 – Schedule A 12
3.1.2 Part 2 – Schedule B 15
3.1.3 Part 3 – Schedule C 16
3.1.4 Part 4 – Updated Program Contact Information Form 17
3.2 Submission of the Annual Plan 17
3.3 Review and Approval of the Annual Plan 18

4.0 Procedure for Completion and Submission of Quarterly Reports 19
4.1 Completion of Quarterly Reports 19
4.1.1 Part 1 – Quarterly Work Plan Progress Report 19
4.1.2 Part 2 – Quarterly Financial Report 20
4.1.3 Part 3 – Quarterly Activity Report 20
4.2 Submission of Quarterly Reports 24
4.3 Review of Quarterly Reports 24

Glossary 25

Preface

The History of Paediatric Diabetes Education in Ontario

The Paediatric Diabetes Initiative was established in 2001 by the Ministry of Health and Long-Term Care (MOHLTC). The purpose of the initiative was to ensure children with diabetes had access to appropriate treatment, education, resources, and ongoing care to manage their disease with family and caregiver support. Through this initiative, funding was provided for the establishment of thirty-five Paediatric Diabetes Education Programs (PDEPs) in Ontario and the support of a paediatric insulin pump program. The are thirty-five specialized paediatric diabetes education programs (PDEPs) including thirty secondary level programs in communities across Ontario, and five tertiary level programs located in Toronto, Ottawa, London, Hamilton and Kingston. Through these PDEPs, children are matched with a team of health care professionals including registered nurses, dietitians and social workers. The majority of children with diabetes in Ontario receive services from these funded programs.[1]

In 2012, the MOHLTC transferred responsibility for most of the Paediatric Diabetes Education Programs' funding agreements from the Northern Diabetes Health Network to the Local Health Integration Networks (LHINs). A small number of PDEPs continue to be funded by and directly accountable to the MOHLTC. The administration of LHIN-managed and MOHLTC-managed programs will continue to be aligned to ensure that PDEPs services are delivered in a coordinated, integrated fashion.

The thirty-five PDEPs together form Ontario's Paediatric Diabetes Network. In May 2013, the coordination of the Network was assigned by MOHLTC to the Provincial Council for Maternal and Child Health (PCMCH). This coordination role includes supporting professional development for Network teams, promoting formal and informal linkages between programs, assisting with resource development and dissemination, promoting consistency in standards of practice, and fostering system improvement. All activities of the Network are conducted under the guidance of the provincial Paediatric Diabetes Network Advisory Committee.

[1] It was reported that in 2008, more than 90 per cent or about 6900 children with diabetes in Ontario receive services one of the 35 Paediatric Diabetes Programs funded through the Pediatric Diabetes Initiative. Ministry of Health and Long Term Care (July 22, 2008), Diabetes Programs In Ontario: Backgrounder. http://news.ontario.ca/mohltc/en/2008/07/diabetes-programs-in-ontario.html

1.0 Introduction to the Manual

1.1 Intended Audience

This manual is intended primarily for Paediatric Diabetes Education Programs (PDEPs) that receive dedicated funding from MOHLTC or from one of Ontario's LHINs for the purpose of providing diabetes education and management support for the paediatric population. This includes registered nurses, registered dietitians and social workers whose positions are supported either in whole or in part through the dedicated provisions of this funding.

It is acknowledged and required that each program have some access to the services of a specialist such as a paediatric endocrinologist, paediatrician, endocrinologist, or internist. However, as a resource funded either out of an organization's global budget or reimbursed by the Ontario Health Insurance Plan (OHIP), specialists are not governed by the policies and procedures of this manual or included in any of the reporting described herein.

Organizations that fund their own paediatric diabetes education programs are also encouraged to use this manual as it meets their needs. The templates and reporting tools can also be made available if programs wish to use them for internal tracking and reporting. Contact your local LHIN to obtain electronic copies of these tools.

1.2 Purpose and Use

This manual describes current policies and procedures which have been identified and established jointly by the LHINs and the MOHLTC. The intention of this manual is twofold:

- **To provide a clear understanding of the roles, responsibilities and expectations of funders** – The provision of historical information, and the roles and responsibilities of the funders will provide clarity and standardization to the operation and administration of MOHLTC/LHIN funded PDEPs across Ontario. It is essential that expectations be clearly documented for consistency in oversight and accountability among many stakeholders. It is anticipated that this document will be a useful tool in orienting new PDEP staff and stakeholders in the provision of paediatric diabetes services across Ontario.

- **To provide standardized interpretation of reporting requirements** – The provision of clear definitions and descriptions of variables to be collected will lead to reliable data on diabetes education across the province. Quality data can be used to inform and improve program planning at the organizational, regional and provincial levels.

The MOHLTC or any of Ontario's LHINs can be contacted for an electronic copy of this document. It will also be available electronically in both English and French.

1.2 Terminology Used to Describe Core Stakeholders

The following terms have been adopted in this document to describe key stakeholders in diabetes education:

"Paediatric Diabetes Education Program (PDEP)" – The programs that receive at least a portion of dedicated funding from a LHIN or directly from the MOHLTC for the provision of diabetes care and support for the paediatric population. As mentioned in the Introduction, paediatric diabetes education programs that are wholly funded out of the global budget of an organization are encouraged to follow these policies and procedures but are not governed by them. Programs receiving at least a portion of their funding from a LHIN or the MOHLTC for the express provision of paediatric diabetes care are included in the scope of the policies and procedures defined in this manual and herein are referred to as PDEPs.

"Host" – The organization (e.g. hospital, primary care organization, community agency, etc.) that receives dedicated funding from a LHIN or the MOHLTC for the express purpose of delivering diabetes care and support to the paediatric population. Each funding allotment designated for this purpose is flowed from a LHIN or the MOHLTC to an organization that implements, administers and is accountable for the program. This funding recipient can also be referred to as the Managing Health Service Provider or a Transfer Payment Agent/Agency. For the purposes of this document, all further reference to an organization that receives funding and is accountable to a LHIN or MOHLTC for the provision of diabetes care and support for the paediatric population is herein referred to as the "host".

"Funder" – All of the funding for programs included in the Paediatric Diabetes Initiative originates from the MOHLTC but is flowed to programs through two means. The majority of the thirty five funded PDEPs across the province receive their funding from and are accountable to the LHIN in their respective region. However, in rare instances, and for a number of reasons, the MOHLTC Implementation Branch directly funds and oversees a small number of PDEPs. For the purposes of this document all further references to the MOHLTC Implementation Branch or the specific LHIN that provides funding dedicated for paediatric diabetes care is herein referred to as the "funder."

1.3 Roles of Funders

1.3.1 Ministry of Health and Long Term Care

The principal functions of the MOHLTC are to:

- Establish overall strategic direction and provincial priorities for the health system;
- Develop legislation, regulations, standards, policies and directives to support those strategic directions;
- Monitor and report on the performance of the health system and the health of Ontarians; and
- Plan for and establish funding models and levels of funding for the health care system.

With specific respect to paediatric diabetes education in Ontario, the MOHLTC:

- Provides funding to the LHINs for the provision of paediatric diabetes education in hospitals or community organizations;
- Provides funding to the LHINs to support their role in the regional management, planning and coordination of adult and paediatric diabetes education programs;
- Provides funding for the operation of the Provincial Council of Maternal Child Health to support the oversight of the Ontario or provincial Paediatric Diabetes Network;
- Provides funding through the Toronto Central LHIN for the Paediatric Insulin Pump Education Reimbursement Program which is subsequently flowed to PDEPs through the Hospital for Sick Children.

1.3.2 Local Health Integration Networks

The principal functions of the LHINs are to:

- Establish the regional direction of the health system in alignment with local identified needs, strengths and overarching provincial priorities;
- Plan, fund, and integrate the local health system in accordance with the *Local Health System Integration Act (2006);*
- Monitor and report on the performance of the regional health system and the health of the region's residents; and
- Provide funding and oversight to hospitals, community health centres, long term care, mental health and addictions agencies, community care access centres, and community support services.

With specific respect to paediatric diabetes education in Ontario and diabetes care more generally, LHINs:

- Provide funding and oversight for PDEPs hosted by hospitals or other community organizations.
- Are responsible for the regional management, planning and coordination of diabetes services and programs in alignment with provincial priorities.
- Toronto Central LHIN, on behalf of all funders, flows funding from the MOHLTC for the Paediatric Insulin Pump Education Reimbursement Program through the Hospital for Sick Children to PDEPs province-wide.

1.4 Responsibilities of Funders

The policies and procedures outlined in the following sections are reflective of the requirements of the funders. To support PDEPs in their efforts to comply with these policies and procedures, the funders will provide the oversight and support described below.

1.4.1 Provide Reporting Tools and Tracking Templates

The following electronic files are available from the funders to facilitate the completion of annual and quarterly reporting requirements:

- **Schedule A Template** (Microsoft Word File) – Includes all of the components required to complete the Program Description, and Annual Work Plan (Schedule A) as well as separate allocated columns on the Annual Work Plan which are completed and submitted as the Quarterly Work Plan Progress Reports
- **Schedule B Template** (Microsoft Excel File) – Includes all of the components required to complete the Annual Budget (Schedule B) as well as separate allocated worksheets which are completed and submitted as the Quarterly Financial Reports
- **Schedule C Template** (Microsoft Excel File) – Includes all of the components required to complete the Annual Projections (Schedule C) as well as separate allocated worksheets and a summary tab for Quarterly Activity Reports
- **Updated Program Contact Information Template** (Microsoft Word File) –Inclusion of this component is at the discretion of the funder as in some cases, other mechanisms may be in place to collect this information from host organizations.

1.4.2 Communicate Reporting Dates

The funder will communicate deadlines for submissions required by PDEPs. These may be negotiated between funders and PDEPs on a case by case basis, but the funder has the ultimate responsibility to determine the due dates which also allow them to meet their own reporting requirements. Dates for the following deliverables will be communicated to PDEPs by the funder:

- Program Description and Proposed Annual Work Plan (Schedule A) – Submitted in Microsoft Word;
- Proposed Annual Budget (Schedule B) – Submitted in Microsoft Excel;
- (Signed COPY) Proposed Annual Budget (Schedule B) – Submitted in .pdf format;
- Proposed Annual Activity Projections (Schedule C) – Submitted in Microsoft Excel;
- Updated Program Contact Information Form – Submitted in Microsoft Word (if requested by the funder); and
- Quarterly Reports including:

    i) Quarterly Work Plan Progress Report – Submitted in Microsoft Word
    ii) Quarterly Financial Report – Submitted in Microsoft Excel
    iii) (Signed COPY) Quarterly Financial Report – Submitted in .pdf format
    iv) Quarterly Activity Report – Submitted in Microsoft Excel

All reports and submissions are to be submitted by the communicated dates. Requests for deadline extensions must be made and approved in writing in advance of the submission deadline.

Additional tools and tracking templates may also be available to help programs with their reporting requirements. PDEPs should contact the funder to inquire about any additional tools available.

Organizations that fund their own paediatric diabetes programs from their base or global budgets

are also encouraged to use these templates for their own internal tracking purposes. Interested Health Service Providers may contact their LHIN for electronic copies of these templates.

1.4.3 Provide Contact and Submission Information

The funder will communicate with each host organization how they can be contacted and where reports should be submitted. Generally, reports are submitted via email.

1.4.4 Evaluate Annual Projections and Plans

Each PDEP serves communities with different needs. With the increase in the incidence of Type 2 diabetes in the paediatric population the scope of work is also continually changing. In the past, ratios have existed regarding the number of funded staff resources in each team in comparison to the clients served. Current clinical practice guidelines define no clear standards regarding the frequency of appointments with the broader interdisciplinary team. Moving forward it will be the role of PDEPs to make projections for their program with the intention of providing support to all children with diabetes in the province of Ontario. All children should be referred to diabetes education for ongoing care and psychosocial support by a diabetes team with paediatric expertise in accordance with current Canadian Diabetes Association Clinical Practice Guidelines. Projections made by PDEPs in annual planning submissions will be reviewed by funders with respect to the staffing resources available and community needs. Projections or resources will be reviewed, revised or modified by the funder based on the funder's role in ensuring equitable access to quality programming across the region.

1.4.5 Evaluate Quarterly Reports

A key component of oversight and accountability is to review submissions and requests made by PDEPs. The success of the PDEPs will be evaluated according to the progress made against the approved work plan as well as the PDEP activity in comparison to client projections. Funders may have varying approaches to program evaluation. Feedback will be provided to PDEPs as needed, and any concerns or questions regarding submissions will be identified.

1.4.6 Identify Functional Centre Code for use in MIS Reporting

The Standards for Management Information Systems in Canadian Health Service Organizations (MIS Standards) is a set of national standards used across the health care system to collect and report financial and statistical data from organizations' daily operations. The funders of PDEPs in consultation with Health Data Branch of the MOHLTC will determine the appropriate code for the functional centre under which each host or host type (e.g. hospitals, community health centres) will report all of the MIS financial and statistical data. This functional centre code will be communicated to PDEPs through their respective funders or identified in Service Accountability Agreements or annual funding confirmation letters. MIS reporting is separate from the annual and quarterly PDEP reporting described in this manual. Although separate, data submitted via MIS reporting and PDEP reporting should be very strongly aligned.

2.0 General Policies

2.1 Mandate and Scope

2.1.1 PDEPs will provide diabetes education and management services for clients who are aged 18 years of age or under. Diabetes education and management may be provided for those over age 18 years of age on a case-by-case basis in the event that the following conditions have been satisfied:

- The funder and the host have mutually and jointly identified that retaining clients in the paediatric program as opposed to transitioning them to an Adult DEP is necessary due to a gap in the community for diabetes education and management. The host and funder have also agreed that this continuation of care would be the most effective strategy to meet the client's needs; and
- The PDEP has the capacity and expertise to provide safe and effective care for those over age 18.

Diabetes education and management services for an individual under age 18 may be transferred to a diabetes education and management program serving adults in the event that the following conditions have been satisfied:

- The funder and the host have mutually and jointly identified that referring clients under18 years of age to an Adult DEP is necessary due to a gap in the community for diabetes education and management. The host and funder have also agreed that this transfer of care would be the most effective strategy to meet these client's needs; and
- The Adult DEP receiving the referral has the capacity and expertise to provide safe and effective care; and
- The Adult DEP receiving the referral will accept the client without any gap in service.

2.1.2 PDEPs will focus on providing diabetes education and management services for those diagnosed with diabetes or pre-diabetes (in the case of type 2 diabetes). Screening and preventative education may be offered to those who are undiagnosed and at risk under the following conditions:

- The funder and the host have mutually and jointly identified that provision of primary prevention education is beneficial to and meets the needs of the client; and
- The existing PDEP has the capacity and expertise to provide safe and effective care without affecting access and care for those who have been diagnosed with diabetes (e.g. no increase in wait times).

2.1.3 PDEPs registered with the Assistive Devices Program (ADP) may provide paediatric insulin pump starts as part of the services provided for children with diabetes.

2.1.4 PDEPs may provide education to secondary caregivers for a child with diabetes. These secondary caregivers could include teachers, childcare providers or other community service providers. The intention of this education is to build the capacity and knowledge of others so that they may properly support the child while in their care, independent from further PDEP support.

2.2 Staffing

2.2.1 PDEPs will be staffed by a multidisciplinary team of trained health professionals that includes registered nurses (RN), registered dietitians (RD), and registered social workers (RSW). Although the RN/RD/SW triad is always present in a funded PDEP program, the full time equivalent (FTE) staff ratios numbers are not standardized across programs.

2.2.2 PDEP RN/RD/SW teams work closely with paediatricians, paediatric endocrinologists, primary care providers, and other health team members to provide comprehensive care in each paediatric diabetes centre. -These specialist physicians or primary care providers are not included as part of the funded PDEP program as their contributions are reimbursed through other means.

2.2.3 Host organizations will not decrease the permanent PDEP staff composition nor will they alter the FTE ratio of the existing RN/RD/SW complement without funder approval. Any request to alter the existing staff complement must be made to the funder in writing. The request will include rationale for the change, how the change will be managed and how high quality patient services will be maintained throughout the change. These requests will only be considered by the funder under the following conditions:

- The funder and host have mutually and jointly agreed that a gap exists that can be addressed by altering the existing staff ratios;
- The inclusion of new interdisciplinary staff or a change in the staffing ratio will add a significant benefit towards achieving optimal health outcomes for those living with or at risk for diabetes;

2.2.4 Host organizations may increase the staffing resources available to the PDEP through allocations from the host organization's global budget.

2.2.5 Host organizations will ensure that employees who provide health services will be licensed or otherwise professionally qualified to practice their profession in Ontario under prevailing legislation and regulations.

2.2.6 Host organizations will develop and implement credentialing procedures for program staff. At the time of employee hiring, upgrading or recertification, host organizations will verify credentials and maintain copies of any relevant documentation in the employee file.

2.3 Quality

2.3.1 PDEPs will provide diabetes education and management services using their clinical expertise. Services provided by PDEPs will reflect best practices as outlined by the most current recommendations made by the Canadian Diabetes Association (CDA) both in terms of clinical practice and the provision of diabetes education. PDEPs are encouraged to leverage the current CDA Clinical Practice Guidelines, online resources, tools and publications of the Canadian Diabetes Association.

2.3.2 PDEPs should take into consideration the recommendations for best practice made by the Provincial Council for Maternal Child Health (PCMCH) through the Paediatric Diabetes Network. The Paediatric Diabetes Network and its working groups will make recommendations each year on items concerning paediatric diabetes care such as transitions in care, outreach linkages, mental health and psychosocial supports for paediatric diabetes patients, etc.

2.3.3 PDEPs will ensure that the care being provided is of high quality and clinically effective in enabling clients to achieve optimum levels of health and well-being. Indicators of quality should be measured or audited by staff annually or more frequently. Examples of potential items to be audited or evaluated include:

- Clinical outcome indicators found in client health records;
- Indicators of client satisfaction;
- Process indicators around service delivery, staffing patterns and staff satisfaction;
- Measures of practice patterns and compliance to professional standards; (e.g. standards established by the College of Nurses of Ontario, College of Dietitians of Ontario, or the Ontario College of Social Workers); and
- Indicators of access found in quarterly activity reports (e.g. new pump starts, clients served).

2.3.3 PDEPs will use the results of quality audits to inform and influence planning. Any gaps or opportunities identified through audit or evaluation will be included in the program plans for quality improvement.

2.3.4 Host organizations will make the information on the methodology and results of quality audits available for review by the funder as requested. Host organizations will perform any revised or follow-up quality audits that the funder may require.

2.4 Accessibility

2.4.1 All PDEPs will be easily accessible to those in the community. This includes outpatients, those without a primary care provider and those who are new to a community. Funded RN, RD, SW resources should be available without a formal referral. When a referral or health history is required by a specialist or the team to provide care, a patient centred process will be established to acquire this information in a timely manner without rerouting non-acute clients though emergency departments.

2.4.2 PDEPs will be accessible and responsive to client and community needs including, where possible, evening and weekend hours.

2.4.3 PDEPs will provide diabetes education and management services at no cost to clients.

2.4.4 PDEPs located in or serving one of Ontario's 25 designated regions under the *French Language Services Act (1990)* shall ensure that the services provided to the public address the needs of the Francophone community they serve.

2.4.5 PDEPs will strive to meet the cultural needs of First Nations, Métis, Inuit and clients in their community. There are a number of programs and resources that can be accessed for providers to learn more about appropriate cultural care and to access culturally appropriate resources.

2.4.6 PDEPs will identify and remove any barriers to equal and safe access to services. PDEPs will comply with requirements of the *Accessibility for Ontarians with Disabilities Act (2005).*

2.5 Privacy and Confidentiality

2.5.1 PDEPs will establish and follow policies and procedures for the protection of client privacy and right to confidentiality in compliance with all applicable federal, provincial and municipal laws, regulations, orders, rules and by-laws including *Ontario's Personal Health Information Protection Act* (PHIPA).

2.6 Management of Funding

2.6.1 MOHLTC-funded PDEPs will not transfer any amount of funds between budget lines or accounts without prior written approval by the funder, unless otherwise communicated by the funder.

2.6.2 LHIN-funded PDEPs hosted by a Community Health Centre or a Community Support Service provider will follow the Community Financial Policy. PDEPs funded through hospitals will follow similar financial management practices. Following these policies or financial management practices, LHIN-funded PDEPs may reallocate projected budget line surpluses to other existing budget lines or accounts within the PDEP's overall funding envelope without funder approval. This reallocation must enhance or support the PDEP's ability to achieve approved PDEP service targets, and surpluses cannot be applied to non-DEP expenses.

2.6.3 PDEPs may not carry funds, in any circumstances, over from one fiscal year to the next. This includes any approved reallocations which also must be spent by the last day of the fiscal year (March 31).

2.6.4 PDEPs will post expenses only for items that fall within the limitations set forth in the policies of the funder and the host organization. Examples of policies that describe these limitations include the LHIN's *Community Financial Policy*, or MOHLTC's *Travel, Meal and Hospitality Directive*. Expenses that cannot be covered by funding provided by the MOHLTC or the LHIN include, but are not limited to:

- Any expenses in excess of the approved budget;
- Professional licensing fees;
- Loans or donations;
- Fund-raising expenses;
- Expenditures for gifts, staff entertainment or parties, floral tributes, etc.;
- Fees or honoraria; and
- Parking costs at the usual place of work.

2.6.5 PDEPs projecting a surplus at the end of the fiscal year will communicate any projected year-end surplus to the funder by the end of the third quarter (December 31st) of the current fiscal year.

2.7 Recovery and Reallocation of Funds

2.7.1 PDEPs may be subject to in-year recoveries if it is determined that budget surpluses have occurred and programs will not be able to appropriately utilize their allocation.

2.7.2 Funders will conduct reconciliations for unspent funds at the end of the fiscal year following a review of the host's Annual Reconciliation Report (ARR). In addition, interest earned on current operating funds received from the funder shall be treated as recoverable income. The funder will notify the host of the amount to be recovered and the method and time of delivery. Under-spending during one fiscal year and subsequent recovery at year end may not result in a reduced budget the following year unless under-spending represents a continuing reduced need.

2.7.3 MOHLTC funded PDEPs will make a written request to the funder for any reallocations they wish to make with projected budget surpluses. Requests may include moving a surplus to another budget line for MOHLTC funded PDEPs, or allocating a surplus to another purpose or non-reoccurring expenditure. Requests to reallocate funds must be made to the funder by December 31st of the fiscal year. In most cases, requests will only be approved if they demonstrate that the proposed reallocation will contribute to achieving objectives related to diabetes education and management.

2.7.4 LHIN funded PDEPs that are projecting year end surpluses will notify their respective LHIN as early as possible in Q3. Surplus amounts may be recovered for reallocation to other diabetes programs, following the process of each LHIN.

2.8 Pump Funding

2.8.1 PDEPs registered with the Assistive Devices Program (ADP) are eligible for the Paediatric Insulin Pump Education Reimbursement Program for their provision of insulin pump training to new pump users following approval by ADP. For more information about eligibility and reimbursement, contact your funder.

The most current guidelines regarding Insulin Pump and Supplies funding can be found on the MOHLTC website. For more information contact the MOHLTC, Assistive Devices Program.
http://www.health.gov.on.ca/en/pro/programs/adp/policies_procedures_manuals/docs/insulin_pump_manual.pdf

2.9 Program Audit

2.9.1 Funders have the right of inspection including the right to perform, or have its agents perform, a full or partial audit of the PDEP program and its operations. PDEPs and their hosts will provide access to review the PDEPs including financial and administrative records. This access will be provided for funders and/or their agents at the request of the funder if the following conditions are met:

- The funder provides the host with, at minimum, 24 hours' notice prior to the audit; and
- The audit is scheduled during the normal business hours of the host.

2.10 Financial Audit

2.10.1 Host organizations may include the PDEPs within the larger financial audit of the host organizations without completing a separate audit. The host must ensure that the audited financial statements at the organizational level have sufficient detail to show revenue and expenses of the PDEP for reporting to the funder, as per the original budget allocation. In some cases auditors will not provide this level of detail without performing a separate audit.

2.10.2 Hospital host organizations that receive funding for both an Adult DEP and a PDEP may include the two programs within the larger financial audit of the host organization without completing separate audits. However, in this situation the host must ensure that the audited financial statements at the organizational level have sufficient detail to show revenue and expenses of the Adult DEP and the PDEP separately for reporting to the funder, as per the original budget allocation.

3.0 Procedure for Completion and Submission of the Annual Plan

3.1 Completion of Annual Plan

Hosts will submit an Annual Plan Submission prior to the beginning of the fiscal year on behalf of the PDEP. These will be submitted on the date determined by the funder as per the communication described in section 1.4.2 of this manual. Each of these items has a dedicated template for completion. Templates are available from the funder. The five items which form a complete Annual Plan Submission include:

- Program Description and Proposed Annual Work Plan (Schedule A) – Submitted in Microsoft Word
- Proposed Annual Budget (Schedule B) – Submitted in Microsoft Excel
- (Signed COPY) Proposed Annual Budget (Schedule B) – Submitted in .pdf format
- Proposed Annual Activity Projections (Schedule C) – Submitted in Microsoft Excel
- Updated Program Contact Information Form – Submitted in Microsoft Word (if requested by the funder)

3.1.1 Part 1 – Schedule A

3.1.1.1 PDEP Annual Work Plan (Schedule A) will reflect the work of both the MOHLTC/LHIN funded staff resources allocated to the PDEP and the work of any additional resources funded by the host organization. The work of all human resources will be captured in the completion of the Program Description, and the Annual Work Plan.

3.1.1.2 Schedule A includes two sections:

i) Program Description – A description of the PDEP's site and services; and
ii) Annual Work Plan – An inventory of the planned activities, results and dates for meeting program goals and objectives.

All sections to be completed as part of the Annual Work Plan are coloured yellow. Those coloured orange are to be left blank for quarterly reporting purposes. Details on completing these sections are as follows:

i) Program Description

3.1.1.3 PDEPs will provide a description of their program, identifying if they are a tertiary or secondary site.

ii) Annual Work Plan

3.1.1.4 PDEPs will describe the work planned for the year as it is aligned with the goals and objectives listed. The first three columns will be completed with the remaining four columns left blank for quarterly reporting. The three columns to be completed as part of the Annual Work Plan are as follows:

- Activities or Strategies – Briefly describe the activities, strategies or projects that align with one or more of the objectives. Descriptions will include clear and concrete actions: something you are going to do to improve the program. Funders are particularly interested in new innovations or changes to the program that will be pursued during the upcoming fiscal year.
- Expected Results – Describe what will be improved from the activity or strategy. Please be specific and include measurements (process or outcome measures) with quantitative values that will indicate that the expected results have been realized.
- Projected Start/End Dates or Quarter – Identify the start and end dates (or quarter) for each activity in the work plan. These dates will guide funder expectations of quarterly progress.

3.1.1.5 PDEPs will align their work with the standard goals and objectives provided in the Schedule A template. Goals and objectives will not be modified or deleted. If there are additional objectives that are being addressed by the program then they may be noted in the description in the Expected Results column.

3.1.1.6 PDEPs will describe new innovations, changes or improvements that are being added to enhance the daily provision of diabetes education and management services in the Annual Work Plan. Ongoing regular work that is well embedded as part of the program model should be included in the general description of the program in Schedule A.

3.1.1.7 PDEPs will follow the format of the examples provided in the completion of Schedule A. The examples provided are <u>not</u> meant to be prescriptive of the work that is expected. These examples provide a wording format illustrating how programs can describe their work. Examples of how Schedule A could be completed are as follows:

Examples for Goal 1 - Improving/Ensuring Access to PDEP Services

Activities or Strategies to Achieve the Objective	Expected Results – What Will be Improved?	Project Start and End Dates
EXAMPLE: *Utilize OTN to meet with children/youth living with diabetes and their families*	*Improved access to PDEP services for clients/families living in rural/remote communities.*	*Q2 and Q4*
EXAMPLE: *Develop on-call template for physicians*	*Families have access to consult physician 24/7 to reduce ED visits*	*Development Q1, Implementation Q2*
EXAMPLE: *Recruit a patient advocate to be involved with PDEP team for service feedback and planning*	*PDEP service will be more responsive to needs and able to address barriers*	*Recruitment in Q2*
EXAMPLE: *Restructure the Insulin Pump Program*	*Reduction in wait times by 50% for insulin pumps*	*Restructuring by Q2*

Examples for Goal 2 – Effectively Managing Diabetes and Preventing Secondary Complications

Activities or Strategies to Achieve the Objective	Expected Results – What Will be Improved?	Project Start and End Dates
EXAMPLE: *Set up a regular team journal club to meet twice quarterly*	*Improved awareness of best practice*	*Initiation Q1 Meetings Q2-Q4*
EXAMPLE: *Provide educational support for students living with diabetes to Public Health Nurses and school boards each school term.*	*Effective management of diabetes when children/youth living with diabetes are at school*	*September 2015 January 2016.*
EXAMPLE: *Conduct 10 goal setting meetings each quarter for clients and their families/primary caregivers*	*Improved Client /family centered care*	*Q1-Q4*
EXAMPLE: *Develop and implement a program specific patient satisfaction survey to measure effectiveness of services provided. Use results to create recommendations for quality improvement.*	*Improved program quality and client/family centredness*	*Development Q1 Implementation Q2-Q3 Analysis/Planning Q4*

Examples for Goal 3 – Supporting Best Practice and Clinical Capacity

Activities or Strategies to Achieve the Objective	Expected Results – What Will be Improved?	Project Start and End Dates
EXAMPLE: *Attend ISPAD and other relevant conferences. Staff provide 3 knowledge transfer sessions for other PDEP staff following the conference(s).*	*Improved staff knowledge of best practice.*	*Presentations to staff Q3 & Q4*
EXAMPLE: *Provide PDEP update at Endocrinology Update for Primary Care Providers*	*Increased knowledge of PDEP program and how to access service*	*Q3*
EXAMPLE: *Annual health care professional update day for outside centres*	*Increased community capacity to provide effective diabetes care in a variety of settings*	*Q1*

3.1.1.8 PDEPs will describe a given activity, strategy or project only once in the work plan, even when it aligns with more than one goal or objective (which is often the case). To avoid confusion for the reader, select one area and describe any additional goals or objectives that the activity will address in the Expected Results. For example, a resource that is being created to make services more accessible for clients could also reflect professional collaboration because of the joint effort to develop the resources.

3.1.1.9 PDEPs are not expected to have a pre-determined number of activities associated with any one goal. Rows may be added or deleted as necessary. Some programs might have a few major projects or strategies while others may be taking many small incremental steps to reaching program objectives. PDEPs may seek advice as needed from the funder to determine if the level of detail provided is meeting funder expectations.

3.1.1.10 PDEPs will include Expected Results and Start/End Dates for each activity listed. PDEPs will leave the four remaining columns (Quarterly Progress Report) blank for completion at the time of required quarterly reporting.

3.1.2 Part 2 – Schedule B

3.1.2.1 Schedule B includes four sections:

i) Budget Summary
ii) Salary & Benefits
iii) Operating Expenses
iv) Non-Recurring Expenses

There are four tabs in the Excel spreadsheet which together comprise the required components for the Schedule B portion of the Annual Planning Submission. These include tabs: "SchB-Summary", "SchB-SalaryBnft", "SchB-Operating", "SchB-Non-Recurring". Details on completing these sections are as follows:

i) Budget Summary

3.1.2.2 PDEPs will enter the fiscal year, PDEP Host/TPA (Transfer Payment Agent) Name and IFIS# into the Budget Summary so this information can be carried forward to the other worksheets. The values in the budget summary table will be pre-populated with information from the other three sections of the budget.

ii) Salaries and Benefits

3.1.2.3 PDEPs will show the PDEP funding from the LHIN/MOHLTC in the Salaries and Benefits table in "Part A – PDEP specific funding (MOHLTC/LHIN)". If additional contributions are made to staffing by the host organization, these resources must be reflected in "Part B – PDEP Host Organization Funding". LHIN funded PDEPs must report both the host allocation in terms of FTE's as well as the value of salaries and benefits contributed by the host. A notes section is provided to allow programs to explain any anomalies or additional details regarding salaries and benefits.

iii) Operating Expenses

3.1.2.4 PDEPs will show the PDEP funding from the LHIN/MOHLTC in the Operating Expenses table in "Part A – PDEP specific funding (MOHLTC/LHIN)". If additional contributions are made Operating Expenses by the host organization, these contributions and the value of those contributions must be reflected in "Part B – PDEP Host Organization Funding".

3.1.2.5 PDEPs will accurately record expenditures under the appropriate operating lines. Additional lines have been provided if needed. If an expense does not fit within the existing operating line it must be included under "Other" with a brief description. A notes section has been provided for any further details or description of items outside the preset operating lines.

3.1.2.6 PDEPs will include non-recoverable sales tax amounts with the cost of items included in the Operating Expenses.

iv) Non-Recurring Expenses

3.1.2.7 PDEPs will include the details of any one-time non-recurring requests that are believed to be critical to achieving the objectives of the program in the tab for Non-Recurring expenses. Entries in this section must be accompanied by a detailed rationale of the need. This explanation should also include why the request cannot be funded through the program's operating budget and how it aligns with the diabetes services being provided. Requests are considered by the funder according to their own requirements and within the context of the particular program. Quotes must be kept on file for requested non-recurring items over $5,000.

3.1.3 Part 3 – Schedule C

3.1.3.1 PDEP Annual Activity Projections (Schedule C) will reflect the work of both the MOHLTC/LHIN funded staff resources allocated to the PDEP, as well as the work of any additional resources funded by the host organization as noted in Schedule B.

3.1.3.2 PDEPs will put forward projections for Annual Activity that reflect community needs and realistic program development and improvement.

3.1.3.3 Schedule C includes three sections:

i) Staff Resources (# Full Time Equivalent - FTE)
ii) Clients Served
iii) Clinical Interactions with Clients (Individual Clients and Groups of Clients)

In the Excel worksheet, this required portion of the Annual planning Submission is under tab "Schedule C". Details on completing these sections are as follows:

i) Staff Resources (# Full Time Equivalent - FTE)

3.1.3.4 PDEPs will enter the Proposed Full Time Equivalent Staff Resources (both MOHLTC/LHIN and globally funded) exactly as they have proposed them in Schedule B worksheet on Salaries and Benefits. The team physician or specialist is not to be included anywhere in the staff resources section.

ii) Clients Served

3.1.3.5 PDEPs will include two proposed projections in Clients Served. These two projects will describe the anticipated number of unique clients to be seen in the upcoming fiscal year. Programs are generally expected to serve all children in their catchment area with Type 1 or Type 2 diabetes. Projections are requested to allow each quarter's progress to be measured against a baseline. This would assume that staffing and funding resources remain constant and the population served does not experience a significant increase in diabetes prevalence in the community. Past trends and client volumes can be used to determine the next year's projections. Discuss with your funder if you require assistance in establishing annual projections. Each client will only be counted once per year in one of the two following categories:

- A projection for the sum total of NEW clients that will be seen during the fiscal year; and,
- A projection for the sum total of EXISTING clients that will be seen during the fiscal year.

iii) Clinical Interactions with Clients (Individual Clients and Groups of Clients)

3.1.3.6 PDEPs will include two proposed projections in Clinical Interactions with Clients. The interactions of the team physician or specialist are not to be included anywhere in annual projections or quarterly reporting. Each of these projections is fully explained in the glossary of this manual:

- A projection for the sum total of Clinical Interactions that will take place during the fiscal year with Individual Clients ; and
- A projection for the sum total of Clinical Interactions that will take place during the fiscal year with clients in a Group Setting.

3.1.4 Part 4 – Updated Program Contact Information Form

3.1.4.1 In order to ensure communications are delivered appropriately and in a timely manner from the funder to programs, up-to-date contact information is required. Inclusion of this component is at the discretion of the funder as in some cases, other mechanisms may be in place to collect this information. The Updated Program Contact Information Form includes six sections:

i) General Program Information;
ii) Mailing Address;
iii) Program Contact;
iv) Finance Contact;
v) Executive Contact; and,
vi) Board Contact.

3.1.4.2 If requested by the funder, PDEPs will complete the Updated Program Contact Information Form template indicating one contact in each section as they relate to the specific program.

3.1.4.3 PDEPs will provide the legal name of the Host Organization/Managing Health Service Provider and its Integrated Financial Information System (IFIS) number on the Updated Program Contact Information Form.

3.1.4.4 PDEPs will notify and provide updated information to the funder at any point during the year if changes occur to the information listed on the Updated Program Contact Information Form.

3.2 Submission of the Annual Plan

3.2.1 PDEPs will use the following file naming conventions (without spaces) to name the files to be submitted: FiscalYear–ReportName-OrganizationNamePDEP

- e.g. 2015–16– ScheduleA–ABCHospitalPDEP
- e.g. 2015–16– ScheduleB–ABCHospitalPDEP
- e.g. 2015–16– ScheduleB–Signed–ABCHospitalPDEP
- e.g. 2015–16– ScheduleC–ABCHospitalPDEP

3.2.2 PDEPs will ensure that an authorized signing officer of the host organization approves and signs the Proposed Annual Budget. An additional copy of the budget will be submitted as a scanned or .pdf file with the signature of the proper signing authority included.

3.2.3 PDEPs will submit annual plans to the funder as per the communication described in section 1.4.2 of this manual and to the submission email address identified by the funder.

3.3 Review and Approval of the Annual Plan

3.3.1 The funder will review the Proposed Annual Work Plan, Proposed Annual Budget, and Proposed Annual Activity Projections and request revisions or resubmissions to be made by the host or PDEP as needed.

3.3.2 Hosts and PDEPs will make any requested revisions or amendments to the Proposed Annual Work Plan, Proposed Annual Budget and Proposed Projections for Annual Activity.

3.3.3 The funder will approve the Annual Work Plan (Schedule A), Annual Budget (Schedule B), and Annual Activity Projections (Schedule C) once revisions meet all funder requirements.

3.3.4 The funder will return the Schedule A, Schedule B and Schedule C with the version marked as "Approved" and dated. Approved Schedules A, B and C will form the foundation for the hosts (and thereby the PDEPs) accountability requirements for the upcoming fiscal year in relationship to the fiscal funding allocation. The three documents, summarized below become part of the accountability requirements between funder and host:

- Schedule A (Approved), which includes the Program Description and Annual Work Plan
- Schedule B (Approved), which includes Annual Budget
- Schedule C (Approved), which includes Annual Activity Projections

3.3.5 The funder will provide a funding letter or communication to the host which describes the specific deliverables and due dates for the Host/PDEP. The information that will be provided by the funder is described in section 1.4.2 of this manual.

4.0 Procedure for Completion and Submission of Quarterly Reports

4.1 Completion of Quarterly Reports

Hosts will submit four items at the end of each quarter on behalf of the PDEP. These will be submitted on the dates determined by the funder as per the communication described in section 1.4.2 of this manual. Each of these items (with the exception of the Signed Copy of Schedule B) has a template for completion within each of the electronic files for the related Schedules. Quarterly reporting templates are completed as additional components within the electronic files for Schedules A, B and C. The four items which form a complete Quarterly Submission package include:

- Quarterly Work Plan Progress Report (Quarterly Columns added to Schedule A) – Submitted in Microsoft Word
- Quarterly Financial Report (Additional Tabs in Schedule B File) – Submitted in Microsoft Excel
- (Signed COPY) Quarterly Financial Report – Submitted in .pdf format
- Quarterly Activity Report (Additional Tabs in Schedule C File) – Submitted in Microsoft Excel

4.1.1 Part 1 – Quarterly Work Plan Progress Report

4.1.1.1 PDEPs will complete and submit a Quarterly Work Plan Progress Report for the funder to track the work deliverables related to the allocation of the PDEP funding.

4.1.1.2 PDEPs will reflect the work of both the staff resources allocated to the MOHLTC/LHIN funded PDEP, and the work of any additional resources provided by the host organization in the Quarterly Work Plan Progress Report. It is acknowledged that it is very difficult to separate the work of a group that has both designated funding and globally funded resources.

4.1.1.3 PDEPs will complete the Quarterly Work Plan Progress Report by entering information into an additional blank column provided for this purpose in the Approved Schedule A's template file. At the top of the first page the quarter (coloured orange) must be indicated i.e. "Q2". Columns coloured in orange for each quarter are provided to the right of the Approved Schedule A entitled: "Quarterly Progress Report".

4.1.1.4 PDEPs will provide a brief summary comprising an update for each activity in the Approved Annual Work Plan. This update will include program achievements, milestones or projections reached, lessons learned, or unexpected issues that have arisen that affect progress on a particular activity. By year end, all four columns will be completed to show how objectives have been fulfilled through the completion of activities during the year.

4.1.1.5 PDEPs will not alter the original Program Description or the Annual Work Plan as they have been approved in Schedule A. Progress Reports completed and submitted in previous quarters will also not be modified in subsequent quarters.

4.1.2 Part 2 – Quarterly Financial Report

4.1.2.1 PDEPs will complete Quarterly Financial Reports so the funder has an accurate accounting of PDEP expenditures.

4.1.2.2 PDEPs will complete the Quarterly Financial Report by entering information into the additional worksheets provided for this purpose in the Schedule B template. The file contains several tabs, or worksheets, including instructions, glossary, the four tabs for Schedule B and four additional quarterly reporting tabs.

4.1.2.3 PDEPs will enter the current expenditures and projected expenditures for the remainder of the year. The Microsoft Excel template containing the Approved Budget should be used for completing Quarterly Financial Reports so budget information can be pre-populated and any variances can be calculated. The name of the host, fiscal year and IFIS# will populate automatically from the Budget Summary tab to all of the Quarterly Financial Reports. By year end, all four quarterly worksheets will be completed to demonstrate the allocation of budgeted funds throughout the year.

4.1.2.4 PDEPs will not alter any part of the Approved Budget in Schedule B, or any data provided in previous quarters when completing their Quarterly Financial Report.

4.1.2.5 PDEPs will complete both "Part A – MOHLTC/ LHIN Diabetes Funding" and "Part B – PDEP Host Global Diabetes Funding" in the Quarterly Financial Report to account for the funds spent on the provision of diabetes education and management by both the LHIN and the host organization.

4.1.2.6 PDEPs will provide a written explanation of all positive or negative variances greater than five per cent (±5%) from the approved year-to-date budget in any expense category. The worksheet will automatically calculate variances based on the values that are entered. An adjacent notes section is provided for explaining any variances.

4.1.2.7 PDEPs will ensure that an authorized signing officer of the host organization approves and signs each submitted Quarterly Financial Report.

4.1.3 Part 3 – Quarterly Activity Report

4.1.3.1 PDEPs will complete and submit a Quarterly Activity Report so that the funder may track the work deliverables and client activity.

4.1.3.2 PDEPs will reflect the work of both the staff resources allocated to the funded PDEP by the MOHLTC/LHIN, and the work of any additional resources provided by the host organization in the Quarterly Activity Report. It is acknowledged that it is very difficult to separate the work of a group that has both designated funding and globally funded resources. Note: **Activity reporting does not include the work of team physicians, specialist physicians or primary care providers.**

4.1.3.3 The Quarterly Activity Report includes the following sections:

i) Staff Resources
ii) Clients Served
iii) Clinical Interactions with Clients
iv) Interactions with Secondary Caregivers
v) Insulin Pump Starts and Wait Times
vi) Continuous Glucose Monitoring
vii) Other Activities and Events

Details on completing these sections are as follows:

i) Staff Resources

4.1.3.4 PDEPs will enter the percentage of budgeted FTE staff resources that have contributed to the work and activities completed during the quarter. The budgeted FTEs which have been allocated from both the MOHLTC/LHIN and the host will be prepopulated from the Schedule C worksheet. The percentage of these staff resources that were contributing to the work allows programs to demonstrate to the funder where there are prolonged absences or vacancies that may affect activity. In most cases this should be 100%. Any significant gaps in staffing indicated here will be considered by the funder when reviewing the achievements of the work plan and the activities reported in the Quarterly Activity Report. If the value of the field "Total Available Staff Resources" is less than the "Total Budgeted Staff Resources" on an ongoing basis and results in the inability of the program to meet projections, the funder may contact the host to discuss necessary changes to the PDEP or its funding. Further details and examples for calculating Total Available Staff Resources can be found in the electronic template itself or in the Glossary of this manual.

ii) Clients Served

4.1.3.5 PDEPs will enter the number of New Clients and Existing Clients Served by the program that have not been served in previous quarters of the same fiscal year. **No client (neither a New Client nor an Existing Client) will be counted more than <u>once</u> per fiscal year by any given PDEP**. Further detail for defining New Clients and Existing Clients can be found in the electronic template itself or in the Glossary of this manual.

4.1.3.6 PDEPs will enter Clients Served data according to the rows and columns provided in the Quarterly Activity Reporting Template. The categories included in these rows and columns are defined in the Glossary of this manual. The numbers of clients that go into each field of the template are those clients who meet the criteria provided in the definitions of <u>both</u> row and column categories at which the input field intersects.

4.1.3.7 PDEPs will enter the number of New Clients and Existing Clients in each of four sections that describe the characteristics of each client. These sections include the Type, Treatment, Age and Gender of the New and Existing Clients Served. Since clients are counted in each of these four sections, the total of New Clients and Existing will be equal for Total Clients by Type, Total Clients by Treatment, Total Clients by Age, and Total Clients by Gender. Further detail for defining the items in each of the four sections (Type, Treatment, Age, and Gender) can be found in the electronic template itself or in the Glossary of this manual.

4.1.3.8 PDEPs will use their discretion and expertise to select the Type and Treatment category that most closely describes the client's diagnosis and treatment for statistical purposes. One type category, one treatment category, one age category and one gender category must be selected for every client on the Clients Served. It is acknowledged that there are many nuances to the health conditions of individual clients and that these designations are not intended for clinical purposes but for broad evaluation by the funder of activity statistics, volumes and trends.

iii) Clinical Interactions with Clients

4.1.3.9 PDEPs will enter the number of chartable Clinical Interactions conducted by clinical staff with clients. These Clinical Interactions are separated into those between an Individual Client and one or more providers, and those for Group Clients. A full explanation of what constitutes a client, a Clinical Interaction, an Individual Client Clinical Interaction and Group Client Clinical Interaction can be found in the electronic template itself or in the Glossary of this manual.

4.1.3.10 PDEPs will count only Clinical Interactions for clients conducted by clinicians who are both MOHLTC/LHIN and host funded as noted in the Total Budgeted Staff Resources in the Quarterly Activity Reports. If a temporary or contract staff joins the program to fill a gap left by leave of absence of a budgeted staff member their activity would be counted. A physician or short- term employee who represents an addition above and beyond the Total Budgeted Staff Resources would not include their contributions to the values included in the program's reporting. Interactions with the specialist, endocrinologist or physician are not counted as interactions. These statistical reports are only intended to capture the activity of the interdisciplinary (RN, RD, SW) team.

4.1.3.11 PDEPs will enter client clinical interaction data according to the rows and columns provided in the Quarterly Activity Reporting Template. The categories included in these rows and columns are defined in the Glossary of this manual. The numbers of clients that go into each field of the template are those clients who meet the criteria provided in the definitions of both row and column categories at which the input field intersects.

4.1.3.12 PDEPs will track and report Individual Client Clinical Interactions between one client and one or more clinical staff according to the type of clinical staff resource that provided the visit. **Each clinician providing service, including when they meet with the same client consecutively or concurrently, may count as one clinical interaction under their respective column for their staff type.** This allows all team members to reflect the number of clients for which they provide their expertise. **There is a risk that clinicians who track interactions manually or with decentralized spreadsheets may incorrectly double count clients in the caseload section.** Further guidance is provided in the Glossary of this manual under "Individual Client Clinical Interactions" on how to ensure double counting doesn't occur.

4.1.3.13 PDEPs will track and report Group Client Clinical Interactions for each client received in a chartable Clinical Interaction in a group setting. Group Clinical Client Interactions are not recorded according to the staff resources providing the service because it is assumed that many team members usually work together to facilitate the various sessions of group education. Therefore, one staff member will need to record group education participants on behalf of all staff who participated. **Each time an individual attends a single group education session it is counted as a separate Group Client Clinical Interaction.** Further guidance is provided in the Glossary of this manual under "Group Client Clinical Interactions" on counting clients who attend multiple sessions of a group.

4.1.3.14 PDEPs will enter Individual and Group Client Clinical Interactions in each of five sections which include Format for the Client Interaction, Type, Treatment, Age and Gender. Since clients are counted in each of these five sections, the total number of Clinical Interactions will be equal to and repeated in the totals for Format, Type, Treatment, Age and Gender. Further detail for defining the items within these five groupings can be found in the electronic template itself or in the Glossary of this manual.

4.1.3.15 PDEPs will use their discretion and expertise to select the Type and Treatment category that most closely describes the client's diagnosis and treatment for statistical purposes. It is acknowledged that there are many nuances to the health conditions of individual clients. These Type or Treatment categories are not intended for clinical purposes but for broad evaluation by the funder of activity statistics, volumes and trends. The heading for type and treatment are short forms and reference should be made to the full definitions in the Glossary of this manual or the Glossary in the electronic template itself. These more detailed definitions describe how to categorize clients who are receiving several different treatments to manage their diabetes.

iv) Interactions with Secondary Caregivers

4.1.3.16 PDEPs will track and report the number of interactions they have in providing education to secondary caregivers specific to the care of an individual child. These are not the primary caregivers who would attend an appointment with or on behalf of the client or ever make treatment decisions on the client's behalf. Each time a team clinician has training session or significant interactions with secondary caregivers for the purposes of education on the care or management of a specific client, this will be captured by the clinician type and age of the client being discussed or to whom the education is tailored.

v) Other Activities and Events

4.1.3.17 PDEPs will track and report on the Other Activities and Events that they host or take a significant role in. Other Activities and Events are those that cannot be defined as chartable Clinical Interactions with individual or groups of clients. Participants in these activities and events are not counted in either Clients Served or Clinical Interactions as a result of attending these events. Other Activities and Events are those intended to bring clients together without a chartable treatment focus or those for general education and capacity building that is not specific to one client's care. Both the number of events and the total number of participants at these events are to be included in the chart on Other Activities and Events in the Quarterly Activity Report.

4.1.3.18 PDEPs will report on the Other Activities and Events according to the categories listed in the template. The outcomes, objectives or further detail of these activities or events may be described in the Annual Work Plan and Quarterly Work Plan Progress Reports. Any additional activities and events that do not fall into the pre-defined categories can also be described in the Quarterly Work Plan Progress Report. Further definition of the categories for reporting Other Activities and Events can be found in the electronic template itself or in the Glossary of this manual.

vi) Insulin Pump Starts and Wait Times

4.1.3.19 PDEPS will track and report the following with respect to insulin pumps:

- The Total # of Clients who Started/Initiated an Insulin Pump this Quarter (A)
- The Total # of Weeks for all Clients starting pumps from their Decision/Eligibility Date to Pump Start Date (B)

Using these two values (A & B), the average number of weeks from the date of the decision to go on a pump and meeting all eligibility criteria to the actual pump start date can be calculated. (B÷A). NOTE: If aggregated reports are being created across programs or multiple quarters, be reminded that it is not correct to average multiple averages. Rather all values for (B) should be added together and divided by the sum of all clients across programs that started pumps (A) to create a new average.

vii) Continuous Glucose Monitoring (CGM)

4.1.3.20 PDEPS will track and report the number of clients who start continuous glucose monitoring during each quarter. The CGM starts that are counted in this section are those initiated by the PDEP only. CGM starts initiated through a pump company or other providers are not to be counted in this section.

4.2 Submission of Quarterly Reports

4.2.1 PDEPs will use the following file naming conventions (without spaces) to name the Quarterly Reports to be submitted: FiscalYear–Q#ReportName–OrganizationNamePDEP

- e.g. 2015–16–Q2Financial–ABCHospitalPDEP
- e.g. 2015–16–Q2Financial–Signed–ABCHospitalPDEP
- e.g. 2015–16–Q2WorkProgress–ABCHospitalPDEP
- e.g. 2015–16–Q2Activity–ABCHospitalPDEP

4.2.2 PDEPs will ensure that an authorized signing officer of the host organization approves and signs the Quarterly Financial Report. An additional copy of the Financial Report will be submitted as a scanned or .pdf file with the signature of the proper signing authority included.

4.2.3 PDEPs will submit Quarterly Reports to the funder as per the communication described in section 1.4.2 of this manual and to the submission email address identified by the funder.

4.3 Review of Quarterly Reports

4.3.1 The funder will review the Quarterly Activity Report, Quarterly Financial Report and Quarterly Work Plan Progress Report. The funder will contact the host organization if there are concerns or if follow-up information is required.

Glossary

Descriptions found below are to be used in the planning, tracking, and reporting of Paediatric Diabetes Education Program (PDEP) finances and activities in order to group service provision numbers into statistics for reporting purposes. Information which informs clinical decisions or education should always be obtained from the proper sources.

Funder – The government body that funds the Diabetes Education Program (PDEP) and to which the program is accountable (e.g. MOHLTC or LHIN).

Host – The recipient of the funding from the funder for the purposes of paediatric diabetes education and management services. This funding recipient can also be referred to as a Managing Health Service Provider (Managing HSP) or a Transfer Payment Agent/Agency (TPA). All annual plans, budgets, and quarterly reporting require that the PDEP Host Organization/Managing HSP/ or TPA be identified with their Integrated Financial Information System (IFIS) number.

Paediatric Diabetes Education Program (PDEP) – The complement of diabetes education and management services funded (either in whole or in part) by the MOHLTC or LHIN and delivered by the host are referred to as PDEPs. Funded programs usually consist of a combination of Registered Nurse (RN), Registered Dietitian (RD) and Registered Social Work (RSW) resources.

PDEP Site – The primary site from which a PDEP program operates. For the purposes of defining format of interactions, any interaction which takes place in a PDEP owned/rented space where the PDEP has an ongoing presence is a PDEP site. Any interaction that takes place outside of this where the staff travel to a community location, physician office or other location including the inpatient units or other departments of the hospital is considered "off site"

Tertiary Centre – The following hospitals are identified as the tertiary centres for paediatric diabetes care:

- Hospital for Sick Children, Toronto,
- Children's Hospital of Eastern Ontario, Ottawa
- London Health Sciences Centre, London,
- McMaster Children's Hospital, Hamilton
- Hotel Dieu Hospital, Kingston

Secondary Centre – All other funded paediatric diabetes education programs not identified above are categorized as secondary centres for paediatric diabetes care.

Budgeted MOHLTC/LHIN Funded Staff Resources – Approved staff resources that are funded by the MOHLTC or the LHIN for the dedicated purpose of diabetes education and management services. These are the resources that are funded and allocated to the program in the Approved Annual Contributions Summary of Schedule B.

Budgeted Host Funded Staff Resources – Approved staff resources which have been funded by the host organization from the global budget and outside of the dedicated funding provided by the MOHLTC or LHIN. These are the additional host resources that are funded by the host and are committed to the program in the Approved Annual Contributions Summary of Schedule B. These resources would work with or support the MOHLTC/LHIN Funded Staff Resources in the provision of diabetes education and management services. Host Funded Staff Resources may include either:

- Additional staff resources that work with the MOHLTC or LHIN funded staff to also provide diabetes education and management services; or
- MOHLTC/LHIN Funded Staff Resources who are funded by the host for additional hours ("topped

up") to provide additional diabetes education and management services beyond their MOHLTC/LHIN allocation. Additional hours paid for by the host that are not used to contribute to the objectives or activity of the PDEP would not be counted as a Host Funded Staff Resource.

Total Budgeted Staff Resources – The sum of Budgeted MOHLTC/LHIN Funded Staff Resources plus Budgeted Host Funded Staff Resources.

Percent (%) of Staff Resources Available – The total percentage of FTE allocated staff resources from either MOHLTC/LHIN or Host funding that are contributing to the work and activities completed during the quarter. This is where special circumstances of extended leaves, vacancies or other staffing gaps that are more than a month in duration might affect the achievement of work plan objectives or activity reported should be reflected. Calculate this value with respect to the proportion of the normal capacity. For example, in a team of 1 FTE RN, 1 FTE RD and .5 SW, if the RN is absent for 1 month (out of three in the quarter) then that position is reported as 66% while the other would be reported as 100%. In most cases all staff will be available and working and this value will be equal to the Total Budgeted Staff Resources. Total Available Staff Resources could be greater than Total Budgeted Staff Resources in the event that a short term resource that was not budgeted for is available and contributing to the activity counted in the statistics report and work plan (e.g. a student). In order to evaluate volumes equitably across programs of different sizes, funders may take the activities reported and divide by the Available Staff Resources to have a measure of activity per resource. Therefore, only resources contributing to program activity should be included in Total Available Staff Resources.

Staff Resource Type – For the purposes of budgeting and statistics collection, six categories have been defined to broadly describe the staffing resources that can be either MOHLTC/LHIN Funded Staff Resources or Host Funded Staff Resources. These staffing resource types include:

RN/Registered Nurse – A Registered Nurse or Nurse Practitioner who provides diabetes education and management services and is registered with the College of Nurses of Ontario. This category does not include nurses who are dedicated in the program solely to foot care.

RD/Registered Dietitian – A Registered Dietitian who provides diabetes education and management services and is registered with the College of Dietitians of Ontario.

SW/Social Work – A Social Worker providing support relating to diabetes education and management and is registered with the Ontario College of Social Workers.

Other Clinical – Allied healthcare professionals that provide services and support related to diabetes education and management and do not fall within the categories listed above. Examples may include Kinesiologists, Exercise Physiologists, Pharmacists, and Eye Care Professionals etc. Work of the specialist physician is <u>not</u> to be included in the reported statistics.

Clerk/Admin – Secretarial, clerk or administrative staff who support the program through work such as scheduling appointments, charting or data entry.

Mgmt/Coord – Coordinators or managers who do not provide clinical care to clients but provide leadership to the PDEP.

Client – An individual who receives diabetes education and management services in the form of a clinical interaction (either individual or group) from a PDEP. Clients can be counted as either "New" to the program or "Existing" to the program in the Quarterly Activity Reports. Primary caregivers accompanying clients to appointments are not counted as additional clients. There are two types of clients:

New Client – A client who has never before received service from the reporting PDEP. In most cases this will mean that they are a new diagnosis. In rare cases, if a previously diagnosed child moves or switches their service to a new PDEP that PDEP would count them as new.

Existing Client – A client served at any time in the past by the reporting PDEP. **All clients who receive service within the year and are not counted as new clients are counted once in the year as existing clients**.

Clients Served – The purpose of the Clients Served section is to identify in Schedule C the total number of unique individuals who are served by the PDEP annually. Each client is only counted once in a fiscal year in the "Clients Served" section. Each client is counted only in the initial quarter of the fiscal year that they receive service. If a child is diagnosed and begins in the program in May they will be entered as "New" in Q2 and then not counted again under Clients Served even if they are seen multiple times each quarter. The next year they would be counted once as "Existing". As a result, the number of "New" clients in PDEPs will always remain relatively low as compared to the number of "Existing" clients. In some cases, especially in the instance of small children, primary caregivers may attend the appointment in place of the child as a proxy. In this scenario, this would count as one client served or one client interaction, regardless of the number of primary caregivers present at the appointment. This is only applied in the situation that this primary caregiver is receiving information and discussing treatment modalities on the client behalf. **Note about analysis of Clients Served:** It is normal to have large volumes in the first and second quarters and then much smaller proportions in the third and fourth quarter. Since clients are counted only once each year and paediatric clients are served frequently throughout the year, not many clients would be uncounted in the later quarters. This trend is expected when analyzing the Clients Served statistics. Also, due to the nature of paediatric diabetes and the fact that children are rarely ever discharged from the program (unless they transition to an adult program or move) the majority of clients will be categorized as "existing".

"Type" of Diabetes – For the purposes of statistics collection, five categories have been defined to broadly describe the different types or diagnosis categories for those served by PDEPs. These five categories for diabetes type include:

Type 1 – An individual with type 1 diabetes mellitus as diagnosed by a health care practitioner. For reporting purposes this category will also include those with Maturity-Onset Diabetes of the Young (MODY). As per CDA clinical practice guidelines, most often MODY appears like a very mild version of type 1 diabetes, with some insulin production and normal insulin sensitivity. MODY is not Type 2 diabetes when in a young person.

Gestational Diabetes Mellitus (GDM) - Gestational diabetes mellitus refers to glucose intolerance with onset or first recognition during pregnancy. For quarterly activity reporting purposes GDM clients are combined with Pregnant type 1 and Pregnant type 2 in the "GDM/Pregnant type 1 or 2" category for "Type" of diabetes. For the purposes of reporting this will be combined with Pregnant Type 1/Type 2. It is acknowledged that these clients are rare in PDEPs (and are often referred to adult programs), but remain in the template for consistency.

Pregnant Type1/Type2 – An individual with pre-existing and previously diagnosed type 1 or type 2 diabetes mellitus that is also pregnant. For quarterly activity reporting purposes Pregnant type 1 and Pregnant type 2 clients are combined with GDM in the "GDM/Pregnant type 1 or 2" category for "Type" of diabetes. For the purposes of reporting this will be combined with GDM. It is acknowledged that these clients are rare in PDEPs (and are often referred to adult programs), but remain in the template for consistency.

Type 2 – Type 2 diabetes mellitus as diagnosed by a health care practitioner. For quarterly activity reporting purposes, type 2 category will also include cases for which the etiology of beta cell destruction to an autoimmune process is known (drug/chemically induced, genetic, infection etc. (e.g. steroid induced, Cystic Fibrosis – see CDA guidelines for full listing).

Diagnosed Pre-Diabetes – An individual who has a blood glucose that is above normal but not high enough to be considered diabetes. This category is specific to those who support children with Type 2 diabetes.

Undiagnosed At Risk – Those who are at high risk of developing type 2 diabetes according to identifiable risk factors. Examples of those at risk are included in current Clinical Practice Guidelines of the Canadian Diabetes Association and include but are not limited to: those who have immediate family members with diabetes, those who are Aboriginal, African, Asian, Hispanic, or South Asian; or those who are obese for example. These individuals are not diagnosed with diabetes or pre-diabetes by a health care practitioner. Most often in Paediatric programming, like the "Diagnosed Pre-Diabetes" category above, "Undiagnosed At Risk" is specific to those programs that are supporting children with or at risk for type 2 diabetes.

"Treatment" of Diabetes – For the purposes of statistics collection, categories have been defined to broadly describe the different methods of managing or controlling diabetes. Each client is only entered in one treatment category. Categories have been somewhat ordered in terms of complexity with each treatment potentially being inclusive of other treatments below it. In the definitions these inclusions are defined. **Clients should be included in the highest category that describes the method by which they manage or control their diabetes.** "Treatment" categories are as follows:

Insulin Pump – The use of an Insulin Pump or Continuous Subcutaneous Insulin Injection (CSII) for the purposes of blood sugar control. Clients who are entered as "Insulin Pump" in quarterly activity reporting could also be on an Oral Hypoglycemic Agent (see below) and/or controlling their diabetes through lifestyle (diet and exercise) management.

Insulin Injection – The use of insulin for blood sugar control that is administered by syringe *or* insulin pen. Examples include Bolus / Rapid Acting, Basal/Intermediate Acting, Premixed. Clients who are entered as "Insulin Injection" in quarterly activity reporting could also be on an Oral Hypoglycemic Agent (see below) and/or controlling their diabetes through lifestyle (diet and exercise) management.

Oral Hypoglycemic Agent – An **oral medication** (e.g. a pill or liquid taken by mouth) for the purposes of blood sugar control. Oral Hypoglycemic Agents (OHA) are in the broader category of Antihyperglycemic Agents (AHA). OHA's are sometimes also referred to as Antidiabetes Agent (ADA). Examples of Oral Hypoglycemic Agents can include: Biguinide, Alpha glucosidase Inhibitor, Insulin Secretagogue, Sulfonylurea, DPP4 Inhibitor. Oral medications for purposes beyond blood sugar control (e.g. cholesterol or blood pressure) would not be included in this category. Clients entered as "Oral Hypoglycemic Agent" could also be controlling their diabetes through lifestyle (diet and exercise) management.

Lifestyle Management Only – The use of diet and physical activity/exercise to manage and control blood sugar. Clients who are entered as "Lifestyle Management Only" would not be attempting to manage or control their diabetes, pre-diabetes or high risk status through any other means described in the categories above. This treatment category would predominantly include any pre-diabetes or undiagnosed at risk for type 2 diabetes.

Clinical Interaction – A discussion, consultation, appointment, visit, follow-up or meeting between a client and one or more PDEP clinicians (RN, RD, SW or other allied health) for the purposes of provision of diabetes education and management for that client. This discussion, consultation, appointment, visit, follow-up or meeting could be among one client and one or more clinicians or a group of clients and one or more clinicians. It could be conducted face to face, over video, telephone or electronically, **but must be of sufficient significance and be included in the client's chart**. Therefore, a client that does not have a chart with the PDEP cannot be counted in the statistics as having a clinical interaction. There are two defined types of Clinical Interactions:

Individual Client Clinical Interaction – A chartable clinical interaction **between an individual client and one or more providers**. Each clinical provider within the MOHLTC/LHIN or globally funded resources that provides the client with a clinical interaction can count one clinical interaction under their respective staff resource type. When interactions are on the same day or multiple team members serve the client in a joint or "team" setting it can be counted by each of the staff resources who have made a "chartable" contribution to the clinical interaction. **Note about tracking Individual Client Clinical Interactions:** When multiple team members are working with the same client at the same time or on the same day each staff resource can count the Individual Client Interaction. **However, it is important to ensure that these clients are not double counted in the Clients Served**. For those that have centralized patient databases this is a reduced risk because Clinical Interactions are calculated and recorded specific to each client.

Group Client Clinical Interaction – A chartable clinical interaction for the purposes of education (as opposed to social) **between a client and one or more providers that takes place in a group setting with other clients**. A Group Client Clinical Interaction can have one or more clinical staff members facilitating or co-facilitating the sessions. The number of clinicians working with a group is not factored into the tracking of group client interactions, only the number of clients. Each member of a group that is considered to have a chartable interaction as defined in "Clinical Interaction" is recorded as having an interaction for each session they attended, even when these sessions make up one series. Group medical appointments would also be included in this section. If two individual clients came to each of five weekly sessions in one quarter they are counted as two client served (either new or existing for the first session if this was the first time you saw them in the year) and ten group Clinical Interactions (2 clients x both attending 5 group sessions in a quarter = 10 group clinical interactions) . See the definition of "Other Activities and Events" (below) also for non-clinical events with multiple participants. A group event cannot be entered as both a Group Client Clinical Interaction and under Other Activities or Events.

"Format" of Clinical Interaction – The format of the clinical interaction is the means or method by which the clinical interaction between the client and PDEP staff resource is conducted. The "format" section is one component of the clinical interaction reporting of the quarterly report. Every interaction with a client would be counted once in the format area. There are five defined formats in which a Clinical Interaction can occur. The final two "Phone Conversation" and "Email Thread" are grouped as one category on the tracking template:

Face to Face in the PDEP Site – A face to face clinical interaction between the PDEP staff member and the client that is chartable and is conducted **at** the PDEP Site. See the definition of the "PDEP Site" in this glossary.

Face to Face outside the PDEP Site – A face to face clinical interaction between the PDEP staff member and the client that is chartable and is conducted **outside** of the PDEP Site. Examples of where these face to face Clinical Interactions could take place include the client's home, a long term care home, a physician's office, a patient's hospital room or a group held offsite or out in the community. If a PDEP staff member provides face to face interactions at a location where they must pack up their files and materials at the end of the day (as opposed to leaving them in a permanent space) this is a Face to Face **outside** of the PDEP Site. PDEPs that are hosted by hospitals would also count any service that they provided to patients in the emergency department or inpatient units as Face to Face **outside** of the PDEP.

OTN, Video, or Telemedicine - A chartable clinical interaction for the purposes of providing diabetes education and management services that is conducted over Ontario Telemedicine Network (OTN), videoconference, or telemedicine by a member of the PDEP RN/RD/SW interdisciplinary team (as in all statistics this does not include interactions by physicians/specialists). See example scenarios below for tracking interactions provided in this format:

Scenario 1 - If the PDEP facilitates an OTN appointment with a specialist, then the PDEP would not include this client in their caseload or Clinical Interactions for this particular event. This is because the appointment was not specifically a diabetes education session and the clinician was not a LHIN/MOHLTC or host funded diabetes staff resource.

Scenario 2 - If one PDEP (PDEP A) provides expertise to another separate PDEP (PDEP B) for specialized education such as pump management or education for those with gestational diabetes, it would be tracked as follows: PDEP A would count the education provided as though those clients were their own in both the Clients Served and clinical interaction section. PDEP B would not count these because they were not providing the education and management services. However, PDEP B would account for this work in their work plan and explain the collaboration with PDEP A as an innovative strategy to improve equitable access for "X" number of clients in their geographic area.

Phone Conversation – A Clinical Interaction which takes place with the client and the provider. The interaction would need to be of sufficient clinical significance to be included in the client chart. Administrative calls, reminder calls, or a brief check in with a client would not be included as a clinical interaction by phone. Clinical Interactions via a phone conversation would be included with email threads (see below) in the "Phone/Email Thread" category for "Format" of clinical interaction.

Email Thread – A Clinical Interaction which takes place as a detailed telephone conversation with the client or as a detailed thread/conversation of emails back and forth between client and provider. Clinical Interactions via an email thread would be included with phone conversation (see above) in the "Phone/Email Thread" category for "Format" of clinical interaction.

Primary Caregiver – Those who would attend an appointment with or on behalf of the client and make treatment decisions on the client's behalf. Examples of primary caregivers could include parents with or without primary custody, as well as parenting grandparents, foster parents or guardian with custody and the primary role to make treatment decisions. When a primary caregiver attends an appointment on behalf of the child (but does not bring the child with them) this is still counted as an interaction for the clients as though they were present. When multiple parents or primary caregivers attend an appointment on a child's behalf this does not count as additional interactions or clients served. Data would be entered for the format of the interaction and the type, treatment, age, and gender of the child being represented.

Secondary Caregiver – Those who are not the key decision makers for the child's treatment and as such would not attend an appointment to discuss the child's treatment in place of the primary caregiver(s). More often these are the individuals who care for the child on a part time basis and as such may need specific training to be educated or supported to learn how to manage the child diabetes while in their care. Examples of secondary caregivers could include grandparents or relatives who care for the child on a part time basis, relief foster parents, social service workers, day or home care providers, teachers, coaches etc.

Other Activities or Events –Events included will be those in which the staff of the PDEP hosts, presents, teaches or otherwise actively participates (as opposed to attending). Other Activities and Events could be targeted to professionals, the general public, or the community with the intention to support positive health outcomes. Other Activities and Events are those intended to bring clients together without a chartable treatment focus or those for general education and capacity building that is not specific to one client's care. The categories for reporting "Other Activities and Events" are as follows:

- Special Activity or Event for Clients/Families
- General Awareness/Education (e.g. School Assembly, Community Event)
- Community Diabetes Screening Event
- Other Activities and Events (Non-Clinical Interactions)

Clients who otherwise receive services from the PDEP could be counted as participants in an activity or event, but this participation would not also be counted as a Clinical Interaction. Any Other Events or Activities that do not fit in the categories provided can be included in the Work Plan and Quarterly Work Plan Progress Report.