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

Jointly developed by:

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

Updated: March 2016

Ontario

Contents

Contents 2

Preface 1

The History of Diabetes Education for Adults in Ontario 1

1.0 Introduction 2

1.1 Purpose and Use of this Manual 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 Provision of Reporting and Tracking Templates 5
1.4.2 Communication of Requirements 5
1.4.3 Provide Contact and Submission Information 6
1.4.4 Evaluate Annual Targets 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 9
2.7 Recovery and Reallocation of Funds 10
2.8 Program Audit 10
2.9 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 16
3.1.3 Part 3 – Schedule C 17
3.1.4 Part 4 – Updated Program Contact Information Form 18
3.2 Submission of the Annual Plan 18
3.3 Review and Approval of the Annual Plan 19

4.0 Procedure for Completion and Submission of Quarterly Reports 20

4.1 Completion of Quarterly Reports 20
4.1.1 Part 1 – Quarterly Work Plan Progress Report 20
4.1.2 Part 2 – Quarterly Financial Report 21
4.1.3 Part 3 – Quarterly Activity Report 21
4.2 Submission of Quarterly Reports 25
4.3 Review of Quarterly Reports 25

Glossary 26

Preface

The History of Diabetes Education for Adults in Ontario

In 1992, the Ministry of Health and Long-Term Care (MOHLTC) announced diabetes reform as a strategic priority and in consultation with health providers, diabetes educators and people affected by diabetes developed a strategic plan and vision statement in support of diabetes reform in the province. The plan's goals included:

- Providing equitable access to quality professional care with an emphasis on education and ambulatory care;
- Establishing links with research centres; and,
- Offering consistent standards of care.

The plan also outlined what Ontario needed to prevent and delay diabetes and its related complications:

- Systematic monitoring of people with diabetes to identify complications early;
- Early intervention, which is effective for managing or preventing most complications;
- Comprehensive management of diabetes through interdisciplinary teams of health professionals;
- Education for people with diabetes and health professionals to ensure adequate monitoring and management;
- Promotion of healthy lifestyles to reduce risk factors such as smoking, obesity, poor diet and lack of exercise; and,
- Continued research, especially on screening techniques, treatments and service delivery.

Announced in June 2008, the Ontario Diabetes Strategy (ODS) is a comprehensive Strategy to expand diabetes programs and improve health and health care for Ontarians impacted by diabetes. Through the ODS, the government has built on existing investments in prevention and care initiatives at each level of the health system to build capacity, improve access and improve the quality of diabetes services and care in Ontario.

The ODS initiatives continue to:

- Leverage new and existing investments in diabetes care to improve access to, and quality of, diabetes services and care; and
- Build health system capacity by enhancing prevention and improving disease management to keep people healthy and slow disease progression.

In 2013, the MOHLTC transferred responsibility for most of the Diabetes Education Program (DEP) funding agreements (i.e. those for Community Health Centres (CHCs), hospital based programs, and Community Support Service (CSS) based programs to Local Health Integration Networks (LHINs). The MOHLTC retained oversight of DEPs funded within Family Health Teams (FHTs), through the Primary Health Care Branch (PHCB). MOHLTC Implementation Branch (IB) assumed oversight primarily for DEPs in Aboriginal/ First Nations service provider organizations and other health care organizations.

The administration of LHIN-managed and MOHLTC-managed programs will continue to be aligned to ensure that DEPs are delivered in a coordinated, integrated fashion.

1.0 Introduction

1.1 Purpose and Use of this Manual

This manual is intended primarily for use by the staff and stakeholders of DEPs that are funded to provide service to adult clients by the MOHLTC or by one of Ontario's LHINs. It describes current policies and procedures which have been jointly identified and established by the LHINs and the MOHLTC. The current document replaces all previous versions. 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 DEPs 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 staff in the DEP across all organizations involved.

- **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.

Organizations that fund their own diabetes staff or programs are 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 it for their own internal tracking and reporting. Contact your local LHIN to obtain electronic copies of these tools.

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:

"Diabetes Education Program (DEP)" – The programs which 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 adult diabetes population. As mentioned in the Introduction, 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 diabetes care for adults are included in the scope of the policies and procedures defined in this manual and herein are referred to as DEPs.

"Host" – The organization (e.g. hospital, primary care organization, community agency, Aboriginal, First Nations organization etc.) that receives dedicated funding from a LHIN or the MOHLTC for the express purpose of delivering diabetes care and support for adults. 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 is herein referred to as the "host".

"Funder" – DEPs across the province have different government bodies which provide their funding and oversight. All of the funding originates from the MOHLTC but is flowed to programs through various means. Family Health Teams (FHTs) who receive funding from the MOHLTC for the purposes of the provision of diabetes education are accountable to the MOHLTC (Primary Health Care Branch). Aboriginal/First Nations communities and other health care providers that receive funding from the MOHLTC for the purposes of the provision of diabetes education are accountable to the MOHLTC (Implementation Branch). Community health centres, hospitals, and community support services that receive dedicated funding for the purposes of the provision of diabetes education are accountable to the LHIN in their region. For the purposes of this document all further references to the MOHLTC Branch or the LHIN that provides dedicated funding to a program for the purposes of providing diabetes education and management services is herein referred to as the "funder."

Table 1: Summary of DEP Host Organizations and Respective Funders

DEP Host Organization	Funder
Community Health Centre (CHC)	LHIN
Hospital	LHIN
Community Support Services (CSS)	LHIN
Family Health Team (FHT)	MOHLTC Primary Health Care Branch
Aboriginal, First Nation or Other Health Care Organization	MOHLTC Program Implementation Branch

1.3 Roles of Funders

1.3.1 Ministry of Health and Long-Term Care

The principal functions of 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 diabetes education in Ontario and diabetes care more generally, the MOHLTC:

- Provides funding and oversight for DEPs hosted by Family Health Teams (FHTs) and Aboriginal/ First Nations organizations.
- Provides dedicated funding to the LHINs for the provision of diabetes education in hospitals, community support services, and community health centres.
- Provides dedicated funding to the LHINs to support their role in the regional management, planning and coordination of all DEPs.

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 diabetes education in Ontario and diabetes care more generally, LHINs:

- Provide funding and oversight for DEPs hosted by hospitals, community health centres and community support services.
- Are responsible for the regional management, planning and coordination of ministry funded diabetes services and programs in alignment with provincial priorities. .

1.4 Responsibilities of Funders

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

1.4.1 Provision of Reporting 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 Targets (Schedule C) as well as separate allocated worksheets and a summary tab for Quarterly Activity Reports
- **Updated Program Contact Information Template** (Microsoft Word File) – Includes all of the components required to complete the Updated Program Contact Information Form

1.4.2 Communication of Requirements

The funder will communicate deadlines for submissions required by DEPs. These may be negotiated between funders and DEPs 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 DEPs 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 Targets (Schedule C) – Submitted in Microsoft Excel;
- Updated Program Contact Information Form – Submitted in Microsoft Word; 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. DEPs should contact the funder to inquire about any additional tools available.

Organizations that fund their own 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 Targets and Plans

In order to bring a common understanding of overall success of the DEPs across a region or the province as a whole, targets must be set. It is acknowledged that each program serves a variety of populations with different needs across a range of diverse regions of the province. As diabetes prevalence in the adult population continues to rise, DEPs are required to continually reach out to new clients. Targets proposed by DEPs in annual planning submissions will be reviewed by funders with respect to the staffing resources available and community needs. Targets 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. Funders will collaborate at cross-regional and provincial levels to analyze the targets submitted. This information can then be used in future to provide a foundation of evidence to set future program targets and objectives.

1.4.5 Evaluate Quarterly Reports

A key component of oversight and accountability is to review submissions and requests made by DEPs. The success of the DEPs will be evaluated according to the progress made against the approved work plan as well as the DEP activity in comparison to client projections. Funders may have varying approaches to program evaluation. Feedback will be provided to DEPs 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 DEPs in consultation with Health Data Branch of the MOHLTC 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 DEPs through their respective funders or identified in Service Accountability Agreements or annual funding confirmation letters. MIS reporting is separate from the annual and quarterly DEP reporting described in this manual. Although separate, data submitted via MIS reporting and DEP reporting should be very strongly aligned.

2.0 General Policies

2.1 Mandate and Scope

2.1.1 DEPs help individuals to optimize their health and promote positive lifestyle behaviours. This includes their management of existing or potential diabetes as a chronic condition as well as the avoidance or minimization of the impact of secondary complications in those living with diabetes.

2.1.2 DEPs will provide diabetes education and management services for clients who are aged 18 or over. Diabetes education and management may be provided for those under age 18 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 early admission or transition to an adult program is necessary due to a gap in the community for paediatric diabetes education and management that would effectively meet the client's needs; and
- The existing DEP serving adults has the capacity and expertise to provide safe and effective care.

2.1.3 DEPs will focus on providing diabetes education and management services for those diagnosed with diabetes or pre-diabetes. Services and other activities aimed at primary prevention of diabetes may be offered to those who are undiagnosed and at risk of developing diabetes. Education on primary prevention may be offered to those 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 community; and
- The existing DEP 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).

2.1.4 DEPs will focus on providing basic to intermediate level diabetes education and management services through a model that is based on the needs of the community. More advanced level diabetes education and management services may be provided by LHIN/MOHLTC funded DEPs under the following conditions:

- The funder and the host have mutually and jointly identified a gap or need in the community for advanced level diabetes education and management; and
- The existing DEP has the capacity and expertise to provide safe and effective care.

2.2 Staffing

2.2.1 DEPs will be staffed by a multidisciplinary team of trained health professionals that includes, at a minimum, one full-time equivalent Registered Nurse (RN) and one full-time equivalent Registered Dietitian (RD).

2.2.2 Host organizations will not decrease the permanent DEP 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;

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

2.2.4 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.

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

2.3.2 DEPs 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 or College of Dietitians of Ontario); and
- Indicators of access found in quarterly activity reports. (e.g. wait times, Clients Served, outreach provided).

2.3.3 DEPs will use the results of quality audits to inform and influence planning. Any gaps or opportunities identified though 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 DEPs 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 DEPs will be accessible and responsive to client and community needs including, where possible, evening and weekend hours.

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

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

2.5 Privacy and Confidentiality

2.5.1 DEPs 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) (2004)*.

2.6 Management of Funding

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

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

2.6.3 DEPs 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 DEPs 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 DEPs 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 DEPs 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 MOHLTC/LHINs 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 DEPs 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 DEPs, 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 DEPs 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 Program Audit

2.8.1 Funders have the right of inspection including the right to perform, or have its agents perform, a full or partial audit of the DEP program and its operations. DEPs and their hosts will provide access to review the DEPs including the review of 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.

2.9 Financial Audit

2.9.1 Host organizations may include the DEPs 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 DEP 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. All DEPs will continue to receive a set portion of their allocation to cover any audit fees incurred.

2.9.2 Hospital hosts that receive funding for both an Adult DEP and a Paediatric DEP 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 Paediatric DEP 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 DEP. 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 Targets (Schedule C) – Submitted in Microsoft Excel
- Updated Program Contact Information Form – Submitted in Microsoft Word

3.1.1 Part 1 – Schedule A

3.1.1.1 DEP Annual Work Plan (Schedule A) will reflect the work of both the MOHLTC/LHIN funded staff resources allocated to the DEP 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 DEP's sites and services; and
ii) Annual Work Plan – An inventory of the planned activities, results and dates for meeting program goals and objectives.

Details on completing these sections are as follows:

i) Program Description

3.1.1.3 DEPs will provide a description of the main diabetes education site and satellite site(s). A 'DEP Main Site' and a 'DEP Satellite Site' are defined in the Glossary of this document.

ii) Annual Work Plan

3.1.1.4 DEPs 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 DEPs 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 DEPs 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 DEPs will follow the format of the examples provided in the completion of Schedule A. The examples provided are not meant to be prescriptive of the work that is expected. The examples provide a wording format which illustrates 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 DEP Services

Activities or Strategies to Achieve the Objective	Expected Results – What will be improved?	Project Start and End Dates
Example: Participate in Health Fair at XX First Nations community. Distribute prevention, screening materials and self-referral forms for those interested.	**Example:** Improved access for first nation's community for those who were unaware of DEP services. 60 attendees take materials home and 10 new self-referrals are scheduled following event.	**Example:** Health Fair Sept 2014
Example: Ensure a policy is in place for A1C screening for all patients in both local cardiac rehab programs and mental health inpatients.	**Example:** Improved access to screening for individuals who may have otherwise gone undiagnosed. 50 patients screened, 12/50	**Example:** Policy development Q1, implementation/ measurements begin Q2

	were and 7/12 accept a referral to the DEP.	
Example: Collaborate with local optometrists/ ophthalmologists to ensure patients with diabetic retinopathy are offered the services of a DEP.	**Example:** Improved access to the DEP for those who were previously not receiving service. 25 new patients are referred to the DEP from local optometrists.	**Example:** Distribute info in Q1, measure referrals beginning in Q2
Example: Implement central referral process/ form at local hospital ER for all those who seek service for hyper/ hypoglycemia, or foot ulcers.	**Example:** Improve access who may now have known about the DEP and who are not managing their DM well. 16 new DEP patients are referred from local ER during year.	**Example:** New Referral form implemented Q1, measurement begins in Q2.
Example: Provide DEP services in 3 local Long Term Care Homes. Mentor and support LTC staff in managing some of their more complex diabetes clients.	**Example:** Improved access to DEP services for seniors in LTC. 20 DEP visits provided for 12 LTC clients during the year.	**Example:** LTC Visits to begin in Q3.

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: Conduct 5 workshops for newly diagnosed type 2 seniors (reaching a minimum of 40 participants).	**Example:** Improved client confidence in their diabetes self-management (as reported in patient survey). 80% report feeling "more confident".	**Example:** Workshops from March –Sept 2013
Example: Audit charts of 50 newly diagnosed patients in the past year to determine if A1C was documented as "understood" by client through teach back method.	**Example:** Improvement to % of charts that included documentation of A1C understanding through-teach back method.	**Example:** Chart Audit completed during Q1, recommendations implemented in Q2
Example: Develop a procedure to ensure foot screens semi-annually for high risk clients. Create local resource listing/ handout for identified clients who require specialty foot care.	**Example:** Improved process for identifying clients at risk for foot problems. Increased patient knowledge is reported in patient feedback. 40% report they "have learned something new that will change how I care for my feet".	**Example:** Procedure developed during Q1 and Q2 and piloted/evaluated during Q3 and Q4.
Example: Conduct depression	**Example:** Improved ability	Example:

screening for every patient once every six months. Refer to appropriate services as needed.	to cope (as reported on patient survey) and improved understanding of the client's ability to set personal goals for those who receive social work support.	Screening to begin in Q1, and survey and chart audit to be completed in 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: Send 2 CDE staff members to attend the CDA conference in 2014.	**Example:** Improved staff knowledge of best practice. Staff provide 2 knowledge transfer sessions for other DEP staff following the conference.	**Example:** Presentation to staff Nov and Dec 2014
Example: The DEP will provide dietitian student placements for 2 students from X internship program for a 4 week period.	**Example:** Increased student knowledge and future capacity to support those with diabetes. 100% of both students learning objectives fulfilled.	**Example:** Student 1 – Oct 2014 Student 2 – Aug 2014
Example: Participate in quarterly meetings for all DEPs across the region	**Example:** Improved sharing of local resources and best practice among DEPs as reported in feedback from meeting evaluation.	**Example**: Meetings in April, July, Oct 2014 and Jan 2015.
Example: Provide training for each new physician to the region with overview of local diabetes services.	**Example:** Increased awareness of new physicians of local services and referral processes. 10 referrals to the DEP received from each new physician trained.	**Example:** Physician engagement occurs as new doc come to region.
Example: Participate on Health Links Community of Practice (COP) to ensure that diabetes referral and best practice is incorporated into care planning for those with chronic disease.	**Example:** Increased capacity in the community to support those with or at risk of diabetes. 5 local health links incorporate referrals to DEP or referrals to self-management training into Health Links Planning.	**Example:** COP Participation ongoing, Referral Plans completed by Q4.

3.1.1.8 DEPs 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 DEPs 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. DEPs may seek advice as needed from the funder to determine if the level of detail provided is meeting funder expectations.

3.1.1.10 DEPs will include Expected Results and Start/End Dates for each activity listed. DEPs 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

Details on completing these sections parts are as follows:

i) Budget Summary

3.1.2.2 DEPs will enter the fiscal year, DEP Host/TPA 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 MOHLTC funded DEPs will show the DEP funding from MOHLTC in the Salaries and Benefits table in "Part A – DEP specific funding (MOHLTC/LHIN)". If additional contributions are made to staffing by the host organization, these resources must be reflected in "Part B – DEP Host Organization Funding". MOHLTC funded DEPs need to report only these additional resources in terms of additional number (#) of FTEs. MOHLTC funded DEPs do not need to indicate the value of the 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.

3.1.2.4 LHIN-funded DEPs will show the DEP funding from the LHIN in the Salaries and Benefits table in "Part A – DEP specific funding (MOHLTC/LHIN)". If additional contributions are made to staffing by the host organization, these resources must be reflected in "Part B – DEP Host Organization Funding". LHIN funded DEPs 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

3.1.2.5 MOHLTC funded DEPs will show the DEP funding from MOHLTC in the Operating Expense table in "Part A – DEP specific funding (MOHLTC/LHIN)". If additional contributions are made to Operating Expenses by the host organization, this does not need to be reported by MOHLTC funded DEPs. "Part B – DEP Host Organization Funding" may be left blank.

3.1.2.6 LHIN-funded DEPs will show the DEP funding from the LHIN in the Operating Expenses table in "Part A – DEP 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 – DEP Host Organization Funding".

3.1.2.7 DEPs 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.

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

iv) Non-Recurring Expenses

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

3.1.3.2 DEPs will propose Annual Activity Targets 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)

Details on completing these sections are as follows:

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

3.1.3.4 DEPs 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.

ii) Clients Served

3.1.3.5 DEPs will include two proposed targets in Clients Served:

- A Target for the sum total of NEW clients that will be seen during the fiscal year; and,
- A Target 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 DEPs will include two proposed targets in Clinical Interactions with Clients

- A Target for the sum total of Clinical Interactions that will take place during the fiscal year with Individual Clients; and,
- A Target 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. 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 DEPs 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 DEPs 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 DEPs 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 DEPs will use the following file naming conventions (without spaces) to name the files to be submitted:

FiscalYear–ReportName-OrganizationNameDEP

- e.g. 2015–16– ScheduleA–ABCHospitalDEP
- e.g. 2015–16– ScheduleB–ABCHospitalDEP

- e.g. 2015–16– ScheduleB–Signed–ABCHospitalDEP
- e.g. 2015–16– ScheduleC–ABCHospitalDEP

3.2.2 DEPs 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 DEPs 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 Targets and request revisions or resubmissions to be made by the host or DEP as needed.

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

3.3.3 The funder will approve the Annual Work Plan (Schedule A), Annual Budget (Schedule B), and Annual Activity Targets (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 DEPs) 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 Targets

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/DEP. 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 DEP. 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 DEPs will complete and submit a Quarterly Work Plan Progress Report for the funder to track the work deliverables related to the allocation of the DEP funding.

4.1.1.2 DEPs will reflect the work of both the staff resources allocated to the MOHLTC/LHIN funded DEP, 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 DEPs 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. Columns for each quarter are provided to the right of the Approved Schedule A entitled: "Quarterly Progress Report".

4.1.1.4 DEPs 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 targets 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 DEPs 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 DEPs will complete Quarterly Financial Reports so the funder has an accurate accounting of DEP expenditures.

4.1.2.2 DEPs 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 DEPs 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 DEPs 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 LHIN funded DEPs will complete both "Part A – MOHLTC/ LHIN Diabetes Funding" and "Part B – DEP 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 MOHLTC funded DEPs will complete only "Part A – MOHLTC/ LHIN Diabetes Funding" and not "Part B – DEP Host Global Diabetes Funding" in the Quarterly Financial Report to only account for the MOHLTC funds spent on the provision of diabetes education and management.

4.1.2.7 DEPs 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.

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

4.1.3.2 DEPs will reflect the work of both the staff resources allocated to the funded DEP 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.

4.1.3.3 The Quarterly Activity Report includes the following sections:

i) Staff Resources
ii) Clients Served
iii) New Referrals to the Program by Source
iv) Clinical Interactions with Clients
v) Cancellations and No Shows
vi) Wait Times
vii) Other Activities and Events

Details on completing these sections are as follows:

i) Staff Resources

4.1.3.4 DEPs 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 targets, the funder may contact the host to discuss necessary changes to the DEP 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 DEPs 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 once per fiscal year by any given DEP**. In the rare case that an individual is registered at two separate DEPs and receives service by both in the same quarter, the client will likely be counted by both which is acceptable (and often unavoidable) for statistical reporting purposes. 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 DEPs 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 both row and column categories at which the input field intersects.

4.1.3.7 DEPs 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 DEPs 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) New Referrals to the Program by Source

4.1.3.9 DEPs will track and report on the sources of New Referrals. Every New Client will have a source from which they were referred. There may be some referrals which were received but not served, due to the client declining an appointment, a no show, or a cancellation that was not rebooked. Therefore, Total New Referrals will be at minimum equivalent to New Clients but could be somewhat greater due to the referrals in which service was never received. Total New Referrals will never be less than New Clients.

iv) Clinical Interactions with Clients

4.1.3.10 DEPs 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.

4.1.3.11 DEPs 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.

4.1.3.12 DEPs 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.

4.1.3.13 DEPs 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.

4.1.3.14 DEPs 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 <u>are not</u> 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 a group. Therefore, one staff member will need to record group participants on behalf of all staff who participated. **Each time an individual attends a single group session would be 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.

4.1.3.15 DEPs 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.

4.1.3.16 DEPs 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.

v) Cancellations and No Shows

4.1.3.17 DEPs will enter the number of cancellations and no-shows so the funder can understand staffing capacity that is left underutilized in these instances and identify any opportunities to improve efficiency. It is not intended to capture appointments that are successfully rescheduled or rebooked at the time of cancellation. Further detail for defining cancellations and no-shows can be found in the electronic template itself or in the Glossary of this manual.

4.1.3.18 Cancellations and no-shows will be tracked and reported for both Individual Client Clinical Interactions and Group Client Clinical Interactions. Further detail for defining Individual and Group Client Clinical Interactions can be found in the electronic template itself or in the Glossary of this manual.

vi) Wait Times

4.1.3.19 DEPs will track and report on: the number of days from the receipt of a paper/telephone referral to the appointment booking.

vii) Other Activities and Events

4.1.3.20 DEPs 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. Both the number of events and the total number of participants are to be included in the chart on Other Activities and Events in the Quarterly Activity Report.

4.1.3.21 DEPs 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.

4.2 Submission of Quarterly Reports

4.2.1 DEPs will use the following file naming conventions (without spaces) to name the Quarterly Reports to be submitted:

FiscalYear–Q#ReportName–OrganizationNameDEP

- e.g. 2015–16–Q1Financial–ABCHospitalDEP
- e.g. 2015–16–Q2Financial–Signed–ABCHospitalDEP
- e.g. 2015–16–Q2WorkProgress–ABCHospitalDEP
- e.g. 2015–16–Q2Activity–ABCHospitalDEP

4.2.2 DEPs 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 DEPs 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 Diabetes Education Program (DEP) 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 (DEP) and to which the program is accountable (e.g. MOHLTC or LHIN).

DEP Host – The recipient of the funding from the funder for the purposes of 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 DEP Host Organization/Managing HSP/ or TPA be identified with their Integrated Financial Information System (IFIS) number.

Diabetes Education Program (DEP) – 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 DEPs. Funded programs consist of, at minimum, one Registered Nurse (RN) and one Registered Dietitian (RD).

DEP Main Site – The primary site from which a DEP program operates. All DEPs will have one, and only one, DEP Main Site.

DEP Satellite Site – A permanent site either owned or rented by the DEP or provided in kind by another organization. This space is for the relatively exclusive use of the DEP on a regular basis. The location is listed or generally accepted by the community as a DEP office. For example, an office space (in addition to the main site) at a Family Health Team (FHT) that is rented by the non-FHT DEP for use two days per week would be a satellite site of the DEP Main Site. All other face to face client services outside of the main office (e.g. out in the community or at the offices of heath care professional) are considered "outreach" and are not to be detailed in this section.

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 DEP 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 and 1 FTE RD, if the RN is absent for 1 month (out of three in the quarter) then that position 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.

FC/Foot Care – A Chiropodist, Podiatrist, or RN dedicated within the DEP to the provision of foot care and registered with their respective professional colleges.

RK/Registered Kinesiologist – Kinesiology is the assessment of human movement and performance and its rehabilitation and management to maintain, rehabilitate or enhance movement and performance. The title kinesiologist is protected in Ontario. Only members of the College of Kinesiologists of Ontario are permitted to call themselves kinesiologists. Members must use the approved titles kinesiologist, registered kinesiologist or the designation R.Kin when providing services. The designation previously used by practitioners, "certified kinesiologist", can no longer be used in Ontario.

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 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 DEP.

Client – An individual who receives diabetes education and management services in the form of a clinical

interaction (either individual or group) from a DEP. Clients can be counted as either new clients or existing clients in the Quarterly Activity Reports. Family members or support people may attend with a client but are not counted in the Quarterly Activity Report aside from the Community Events section (in which case they could be counted as participants). A proxy who attends an appointment in place of the client would be counted as a client (e.g. spouse for client who cannot attend in person due to physical and mental disabilities). In this scenario, the data for which the individual acted as a proxy would be included in the activity statistics (e.g. type, treatment, age, gender). There are two types of clients:

New Client – A client who has not been seen by the DEP in the past two years either via an Individual or a Group Client Clinical Interaction. If they have been to another DEP in the last two years but are now coming to your DEP they are a New Client. **A client is counted <u>only once</u> as a New Client or an Existing client each fiscal year in the initial quarter that they receive service**. For example, a client who was seen five years ago and comes back to the program in Q1 is counted as a New Client in the Q1 Quarterly Activity Report. Even if this client continues to be seen every quarter for the rest of the fiscal year they will not be counted again as a client for the remainder of the fiscal year; however, their Clinical Interactions are counted in each quarter they receive service. If a client is seen at different sites of the same DEP (Main and a Satellite) they will only be counted once across all sites in a fiscal year.

Existing Client – A client served by the same DEP in the past 2 years either through an Individual or a Group Client Clinical Interaction. Clients are counted once in the fiscal year depending on the quarter in which the client has their initial client interaction. **All clients who are not counted as new clients are counted as existing clients**. For example, a client comes in Q2 of the current fiscal year who was seen one year ago is counted as an Existing Client in the Q2 Quarterly Activity Report. They will not be counted again in the fiscal year. If a client is seen at different sites of the same DEP (Main and a Satellite) they will only be counted once across all sites in a fiscal year.

"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 DEPs. These five categories for diabetes type include:

Type 1 – An individual with type 1 diabetes mellitus as diagnosed by a health care practitioner

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

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

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. - see CDA guidelines for full listing). It will also include Latent Autoimmune Diabetes in adults (LADA); the term used to describe the small number of people with apparent Type 2 diabetes who appear to have immune-mediated loss of pancreatic beta cells.

Diagnosed Pre-DM – Individual is at high risk of developing diabetes and diagnosed as having prediabetes through tests such as Impaired Fasting Glucose/Fasting Plasma Glucose (IFG/FPG), Oral Glucose Tolerance Test or HbA1c at levels defined as diagnosed pre-diabetes by the CDA.

Undiagnosed At Risk – Individuals who have been deemed appropriate to receive diabetes education services by their Primary Care Provider or DEP staff in order to optimize their health. These individuals are not diagnosed as diabetic or pre-diabetic by a health care practitioner. 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, either or both of parents are Aboriginal, African, Asian, Hispanic, or South Asian; a woman who had gestational diabetes during pregnancy; individuals with vascular risk factors, etc.

"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.

Non-Insulin Injection and Insulin Injection – The use of a combination of insulin injection as well as non-insulin injection (see definitions below) for blood sugar control. Clients who are entered as "Non-Insulin + 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.

Non-Insulin Injection – The use of medication for blood sugar control, not including insulin that is administered by syringe or pen. Examples include GLP 1 Receptor Agonist (Exenatide (Byetta), Liraglutide (Victoza)). Clients who are entered as "Non-Insulin Injection" in quarterly activity reporting would <u>not</u> also be on insulin injection, but 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.

Referrals to the Program by Source – For the purposes of statistics collection, three different sources for new client referrals have been defined. All referrals will be counted regardless of whether they received service (e.g. declined appointment, no-show or cancellation). These defined sources of new client referrals include:

Number of Self-Referrals – The number of individuals who self-refer to the DEP. These individuals may have completed an online or paper self-referral form or may have referred themselves more informally by contacting the DEP (e.g. by phone or by dropping in) to request an appointment.

Number of Primary Care Provider Referrals – The number of individuals who are referred to the DEP by their primary care provider (PCP) such as their family doctor or nurse practitioner. Referrals from PCPs could be received in hard copy (paper) form, online, or via electronic medical record system. Referrals made by a family physician or nurse practitioner's office calling the DEP on the client's behalf are also included as a PCP referral.

Number of Other Professional Referrals – The number of individuals who are referred to the DEP by other professionals aside from a primary care provider. Other professionals could include physician specialists, personal support workers, pharmacists, therapists or mental health workers, optometrists, staff in emergency departments, or any other professional who could recognize the client's need for diabetes education and management. Referrals from other professionals could be received in hard copy (paper) form, online, or via an electronic medical record system. Referrals made by a professional calling the DEP on the client's behalf are also included as an Other Professional Referral.

Referrals to the program will also be categorized by:

- Referrals for: **Undiagnosed At Risk** – Referrals for clients who would fall under the definition above "Undiagnosed at Risk"
- Referrals for: **Diagnosed Pre-DM or DM ≤ 6 months ago** – Referrals for clients who have been recently diagnosed with diabetes or pre-diabetes in the last six months. This item is intended to capture those with a fairly new diagnosis.
- Referrals for: **Diagnosed Pre-DM or DM > 6 months ago** – Referrals for clients who have been diagnosed with diabetes or pre-diabetes for six months or more. This item is intended to capture those who are not new diagnoses.

Clinical Interaction – A discussion, consultation, appointment, visit, follow-up or meeting between a client and one or more program clinicians (RN, RD, SW, FC or other clinician) 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 depth to be included in the client's chart**. Therefore, a client that does not have a chart with the DEP cannot be counted in the statistics as having a clinical interaction. There are two defined types of Clinical Interactions:

> **Individual Client Clinical Interaction** – A clinical interaction **between an individual client and one or more providers**. "Team" interactions are no longer being counted as such. 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 <u>each</u> 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 <u>not double counted in the Clients Served section</u>**. For those that have centralized patient databases this is a reduced risk because Clinical Interactions are calculated and recorded specific to each client. For DEPs who track activity manually or through decentralized spreadsheets it needs to be agreed that one staff member <u>only</u> will enter their true date of last clinical interaction. All other staff providing an interaction either jointly or consecutively must enter the current date as both the date of the last clinical interaction and date of the interaction being recorded. This will successfully record the clinical interaction for that staff member without double counting the client in the Clients Served section. For example, if an RN and an RD meet with a client as a team on April 5th and that client's last interaction was three years ago, one provider would put the date three years ago as date of last clinical interaction and the other would record the current date as the date of last clinical interaction. Then two interactions would be noted one for the RN and one for the RD with only one of these being recorded as one New Client in the Clients Served section. This method avoids any double counting for Clients Served.
>
> **Group Client Clinical Interaction** – A clinical interaction **between a client and one or more providers that takes place <u>in a group setting with other clients</u>**. A Group Client Clinical Interaction can have one or more clinical staff members facilitating or co-facilitating the sessions. 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. If an individual client came to each of five weekly sessions in one quarter they are counted as one client served and five group Clinical Interactions. **Note about Group Client Clinical Interactions vs. Group Medical Appointments**: Group medical appointments are a relatively new way of providing service. If the whole appointment is conducted with the clients together as a group then this would be counted as a Group Client Clinical Interaction for each of the Clients Served. If during the group medical appointment some common education is presented to all as a group and then each client is taken out to have private clinical interaction then these would be counted as Individual Client Clinical Interactions as opposed to a Group Client Clinical Interactions (The event would not be counted as both). New innovations like group medical appointment should be explained in the work plan to provide further detail to the funder as appropriate.

"Format" of Clinical Interaction – The format of the clinical interaction is the means or method by which the clinical interaction between the client and DEP 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 DEP Main/Satellite Site – A face to face clinical interaction between the DEP staff member and the client that is chartable and is conducted **in** the DEP Main Site or DEP Satellite Site. See the definition for "DEP Main Site" and "DEP Satellite Site" in this Glossary.

Face to Face outside DEP Main/Satellite Site – A face to face clinical interaction between the DEP staff member and the client that is chartable and is conducted **outside** of the DEP Main Site or DEP Satellite 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 DEP 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 Main/Satellite Site. This could also be considered "Outreach". DEPs that are hosted by hospitals would also count any service that they provided to patient in the emergency department or inpatient units as Face to Face **outside** of the DEP Main/Satellite. See the definition for "DEP Main Site" and "DEP Satellite Site" in this Glossary.

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. See example scenarios below for tracking interactions provided in this format:

Scenario 1 - If the DEP facilitates an OTN appointment with a specialist, then the DEP 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 the DEP was providing diabetes education between the Main DEP Site and their own DEP Satellite Site, then the interaction would only be counted by the staff providing the chartable clinical interaction. In this case it should be ensured that any one client is not counted more than once in a fiscal year at different sites in the Clients Served section.

Scenario 3 - If one DEP (DEP A) provides expertise to another separate DEP (DEP B) for specialized education such as pump management or education for those with gestational diabetes, it would be tracked as follows: DEP A would count the education provided as though those clients were their own in both the Clients Served and clinical interaction section. DEP B would not could these because they were not providing the education and management services. However, DEP B would account for this work in their work plan and explain the collaboration with DEP 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 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.

Cancellation – A scheduled appointment for either a planned Individual Client Clinical Interaction or a planned Group Client Clinical Interaction that is cancelled by the client prior to the Interaction and not re-booked at the time of the cancellation. If a client cancels leaving a message that they will reschedule at a later time it is still recorded as a cancellation.

No-Show – A scheduled appointment for either a planned Individual Client Clinical Interaction or a planned Group Client Clinical Interaction for which the client does not show up.

Wait Measure – The number of days from the receipt of a referral to the appointment booking.

Other Activities or Events –Events included will be those in which the staff of the DEP 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. The purposes of these Other Activities and Events could include:

- Marketing the DEP to either community or professionals;
- Increasing general awareness of diabetes (e.g. prevention, risks, screening methods, management, complications); or,
- Building professional capacity to prevent, screen, diagnose, and manage diabetes.

Other Activities or Events would not provide services that could also be counted as Clinical Interactions. Clients who otherwise receive services from the DEP 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.

Categories for grouping and accounting for Other Activities and Events are listed and defined as follows:

Booth, Kiosk or Table at an Event – Staff of the DEP have a booth, kiosk, or table from which they distribute resources and informally share their knowledge with those in attendance. Examples could include Canadian Diabetes Association events, a booth at a professional event such as the Ontario Pharmacy Association Conference, a table at a Health Fair, or a staffed display at local a market. Each different event is counted as **one** event (even when the event occurs over multiple days). It can be difficult to accurately track participants at these open events so it is suggested that a rough estimate is sufficient so funders have an approximate idea of the size of the audience that was reached. Estimates could be determined by keeping track of the number of people staff talk to, or the number of resources that are distributed.

Presentation, Lecture or Talk - for Public (Non-Professionals) – Staff of the DEP share their knowledge in a teaching or presentation setting to any group of non-health professionals. This could include presentations to a group of employees at a local business, school, and community centre. The number of individuals who attend the presentation are counted as participants.

Presentation, Lecture or Talk - for Health Professionals – Staff of the DEP share their knowledge in a teaching or presentation setting to any group of health professionals. This could include presentations to a group of hospital staff during rounds or a staff meeting, or a group of long-term care staff, PCPs, pharmacists, optometrists, or other allied health professionals. The numbers of individuals who attend the presentation are counted as participants.

Community Diabetes Screening Event - Staff of the DEP host or actively participate in an event to screen for diabetes risk factors. This could include assessing individual risk through tools such as CANRISK, or blood glucose screening as appropriate. The individuals screened are counted as participants.

Media Interview, Article or Advertisement – Staff of the DEP provide a media interview or write an article for either professional or public audiences. Each article, interview or advertisement in a local paper or magazine is counted as one event. Posters created, printed and posted by the DEP in the community are not included in "Advertisement". The number of participants is not applicable for this category and does not need to be reported.