Policies and Procedures Manual

Adult Diabetes Programs

Local Health Integration Networks
Effective April 1, 2013

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Note: Appendices listed below to be added to Version 2.0 of the manual. The working group will be adding the following Appendices to the manual to reflect updated forms/information.

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Introduction

1.1 Purpose and Scope

1.1.1 This manual is intended primarily for use by diabetes Health Service Provider (HSP) administrators, financial officers, other agency staff and Local Health Integration Network (LHIN) staff. The manual may also be a useful tool to supplement staff training. It describes current policies and procedures established by the Diabetes Programs as a partnership of the Ministry of Health and Long-Term Care (MOHLTC) and LHINs.

1.1.2 This manual forms part of the service accountability agreement between the LHIN and the diabetes Health Service Provider and, in combination with the Diabetes HSP/LHIN Funding Agreement comprises the minimum requirements to which an agency must adhere to receive funding. In cases of discrepancy between the *Diabetes Program Policies and Procedures Manual* and the Funding Letter, the contents of the Funding Agreement shall prevail over the manual.

1.2 Using the Manual/Amendments/Updates

This manual is structured to address the needs of a range of stakeholders with an interest in LHIN-Managed Diabetes Program Policies and Procedures. Pagination is linked to chapters, to facilitate the addition of new policy memos, which will carry a reference to the relevant chapter as well as the preceding and following policy item/page. When amendments are made, a revised table of contents reflecting the location of policy and procedure updates will be issued with the memoranda.

In addition to policies and procedures, which reflect LHIN requirements, LHINs will communicate reporting requirements and will supply templates and examples of how requirements can be met appropriately. A future committee of stakeholders representing the MOHLTC, LHINs, and providers will be established to update the manual and resources as required.

1.3 Information

Contact your Local Health Integration Network for additional copies of the *Diabetes Program Policies and Procedures Manual.* This manual is posted on each LHIN website.

The Diabetes Program

2.1 Program Background

In 1992, the 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.

ODS initiatives continue to:

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

2.2 Program Objectives

The MOHLTC- and LHIN-managed Diabetes Education Program (DEP) objectives include:

- Increasing access to quality diabetes education and management services across Ontario;
- Developing a standard approach to care and management of diabetes, including screening, based on the current Canadian Diabetes Association's Clinical Practice Guidelines and adapted for use in Aboriginal communities;
- Establishing effective community-based approaches to prevent and manage diabetes-related complications;
- Developing and promoting cost-effective ways of delivering quality diabetes care
- Developing and coordinating diabetes education and management programs across the life cycle;

- Promoting ongoing communication and collaboration among partners and organizations involved with local diabetes programming;
- Building effective partnerships and networks among community health organizations, hospitals and other providers of diabetes care; and,
- Using monitoring and evaluation, professional program development and collaboration to improve the quality of diabetes education programs in Ontario.

2.3 Principles for the Provision of Service

While the program focus may vary among diabetes HSPs, all local diabetes programs subscribe to the following principles:

- Diabetes programs provide accessible services through the optimal location and design of their facilities; through carefully planned services that are culturally and linguistically appropriate; and through services that are available at times responsive to community needs.
- Diabetes programs provide client-centred services in a family and community context.
- Diabetes programs support individuals to effectively manage their diabetes and related health conditions.

2.4 Diabetes Program Service Model

Key service components include:

- Diabetes programs provide basic to intermediate level diabetes education and management services through a model that is needs-based and community-based;
- Diabetes programs involve clients and health providers in planning and developing programs;
- Diabetes programs are staffed by a multidisciplinary team of trained health professionals that includes, as a minimum, one full-time equivalent Registered Nurse and one full-time equivalent Registered Dietitian per 1000 adults with diabetes. Benchmarks and staffing to be reviewed by a provincial MOHLTC and LHIN committee.
- The diabetes programs' education/work plans reflect an integration of current principles and practices for diabetes care as outlined in:
  - Canadian Diabetes Association Clinical Practice Guidelines Expert Committee. Canadian Diabetes Association 2013 Clinical Practice Guidelines for the Prevention and Management of Diabetes in Canada. Can J Diabetes 2013;37(suppl 1):S1-S212
  - Canadian Diabetes Association *Standards for Diabetes Education in Canada, 2009*
  - Registered Nurses Association of Ontario *Nursing Best Practice Guideline: Decreasing Foot Complications for People with Diabetes, 2004, Supplement 2007*
  - Registered Nurses Association of Ontario *Nursing Best Practice Guideline: Assessment and Management of Foot Ulcers for People with Diabetes, second edition, March, 2013*
  - Registered Nurses Association of Ontario *Nursing Best Practice Guideline: Best Practice Guideline for the Subcutaneous Administration of Insulin in Adults with Type 2 Diabetes, Revised 2006*

The Relationship of Programs and MOHLTC, LHINs

3.1 The Ministry of Health and Long-Term Care

The MOHLTC's principal functions will be 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,
- Plan for and establish funding models and levels of funding for the health care system, and
- Provide funding and oversight to LHINs, Family Health Teams, and MOHLTC-managed Diabetes Education Programs.

In 2013, the MOHLTC transferred responsibility for most of the Diabetes Education Program funding agreements (i.e. those for Community Health Centres and hospital based programs) to LHINs.

The MOHLTC retained oversight of DEPs funded within Family Health Teams, which were transferred to the Primary Health Care Branch. Implementation Branch assumed oversight primarily for DEPs in Aboriginal / First Nations service provider organizations. The administration of LHIN-managed and MOHLTC-managed programs will continue be aligned to ensure that DEPs are delivered in a coordinated, integrated fashion.

For more information, visit your LHIN website or contact your LHIN representative.

DEPs support the first priority in Ontario's Action Plan for Health Care: Keeping Ontario Healthy, by helping people with diabetes to stay healthy and promoting healthy habits and behaviours, supporting lifestyle changes and better management of chronic conditions.

More information about the MOHLTC is available on the ministry's website at www.gov.on.ca/health

3.2 Legislative Authority,

3.2.1 LHINs are required under the Local Health Integration Act, 2006 (LHSIA) to enter into Service Accountability Agreements (SAAs) with its Health Service Providers (HSPs). Section 20 of LHSIA requires a LHIN and an HSP that receives funding under section 19 of LHSIA to enter into a service accountability agreement as set out in part III of the Commitment to the Future of Medicare Act, 2004 (CFMA). A SAA is a tool to assist LHINs with fulfilling their obligations to the MOHLTC, the Province and the taxpayers. This includes the LHINs' obligations under LHSIA to plan, fund, and integrate its local health system.

3.2.2 French Language Services

Organizations located in or serving one of Ontario's 25 designated regions under the French Language Services Act shall ensure that the services provided to the public addresses the needs of the Francophone community they serve.

3.2.3 Accessibility for Ontarians with Disabilities Act

Organizations that provide goods or services to the public or to other third parties in Ontario are legally required to comply with the requirements of the Accessibility for Ontarians with Disabilities Act to identify, remove and prevent barriers to accessibility.

3.3 The Role of the Local Health Integration Network

3.3.1 The role of the LHIN includes:

- Regional coordination and integration of diabetes programs and services
- Development of program policies and guidelines
- Determination of transfer payment funding levels
- Monitoring HSP performance
- Evaluation of services
- Ensuring accountability for the use of public funds
- Ensuring that funded services provided are having the anticipated impact on the LHINs' priorities and goals for its local system

3.3.2 LHIN staff are the primary contact between Diabetes HSPs and the LHIN. They are responsible for:

- Monitoring individual DEPs to ensure consistency with LHIN Diabetes Program objectives
- Interpreting program policies and procedures, and providing advice on the design and operation of the HSP's diabetes program in response to specific requests
- Providing advice and guidance to Health Service Providers' Senior Management, or designates, regarding annual budget submissions, as well as monitoring HSPs' expenditures and variance reports
- Establishing and maintaining effective links with MOHLTC, other LHINs, ministries, professional associations and relevant organizations. LHINs will maintain communication with DEPs funded directly through branches of the MOHLTC.

3.4 Updating the Diabetes Program's Permanent File

3.4.1 The LHIN has a permanent file for each Diabetes HSP. The file includes documents that address the funding history and relationship, including: three years of budget proposals, work plans, financial and statistical reports, and historical documents, as provided to the LHINs via the MOHLTC's Provincial Programs Branch.

3.4.2 Diabetes Health Service Providers shall provide the LHIN with new or updated information related to the following within 30 days of the change:

- Banking information for LHIN DEP funds, including name and address of institution and bank account number
- Articles of Incorporation/Letters Patent/Supplementary Letters Patent
- Certificate of general liability insurance
- Signed lease, if applicable (prior approval from LHIN required)
- Charitable registration number, if applicable

Program Planning and Evaluation

4.1 Annual Operating Plan Submission

4.1.1 Annually, Diabetes HSPs must submit an operating plan which outlines both their past activities and describes service priorities for the coming fiscal year. A key part of this submission is the budget request.

4.1.2 The LHIN releases Guidelines and Instructions for completing the operating plan submission to Diabetes Health Service Providers each year. There is an expectation that operation plans submitted will align with LHIN needs and priorities.

4.1.3 It is anticipated that Diabetes Health Service Providers will have six weeks to complete the operating plan submission. A copy that has been signed by a signing officer is forwarded to the LHIN. Signed submissions may be submitted electronically. Beginning in 2014-15 the timing of the operating plan submission will correspond with the Community Annual Planning Submission (CAPS) for community-based programs.

4.2 Program Planning

4.2.1 Program planning and evaluation functions of the local diabetes program shall include monitoring the direction and progress of diabetes services, developing policies, and should include the following:

- Establishing a mechanism to facilitate community input in order to assess diabetes needs of the community, to establish program priorities, and to monitor the health status of the community;
- Developing long-range service directions and policies;
- Reviewing and evaluating the delivery of services regularly, including a review of service statistics, and reporting to the governing organization;
- Conducting periodic program reviews/service audits;
- Directing the local diabetes program according to the specifications of the LHIN Funding Letter and the By-Laws of the Corporation;
- Identifying the target populations of the local diabetes program and formulating goals and objectives for the provision of service by the local program, to meet the needs of eligible clients in the community;
- Regularly evaluating policy development, program effectiveness.

4.3 Program Monitoring

4.3.1 In order for the LHIN to maintain accurate program oversight, Diabetes HSPs shall complete and forward quarterly reports including statistical reports, activity reports and financial reports to the LHIN in formats provided by the LHIN. (See Appendix C.)

4.3.2 The Diabetes HSP shall provide written notification to the LHIN, in advance of the submission deadline, if the submission deadline will not be met. The schedule for LHIN receipt of quarterly program statistics is as follows: See Schedule C in the Service Accountability Agreement, where applicable.

- First quarter (April 1 to June 30) – report due by August 15, 2013
- Second quarter (July 1 to September 30) – report due by November 7, 2013
- Third quarter (October 1 to December 31) – report due by February 7, 2014
- Fourth quarter (January 1 to March 31) – report due by June 6, 2014 and be included in the ARR due June 30, 2014

Note these dates (Q2 to Q4) – correspond the reporting dates as per the MSAA.

4.3.3 The LHIN evaluates local diabetes programs based on indicators that describe how diabetes programs meet each of the following health system objectives:

- Improved access to community-based diabetes education and management services
- Increased emphasis on prevention of diabetes-related complications
- Evidence of improved service integration and coordination of care
- Client and community involvement in needs-based planning
- Appropriate and cost-effective use of the skills of a range of health professionals
- Evidence-based decision-making in preventing illness and providing diabetes education and management
- Increased ability of clients with informal supports to self-manage their diabetes
- Ability to demonstrate that the approaches offered in local diabetes programs support families and communities to take more responsibility for their own health
- Support for needs-based planning methods to ensure that program resources are directed to those in most need
- Demonstration how local diabetes programs work in partnership with local health and community service agencies to develop more effectively integrated and coordinated services

In 2013-14, a Provincial Committee will be struck to propose standardized provincial performance and accountability indicators for diabetes education and management programs.

4.4 Program Audits

4.4.1 Requirement for Routine Audit of the Quality of Care

Each local diabetes program must develop and conduct routine audits of the quality of care provided by its professional staff on a regular basis. These audits should examine adherence to professional standards as well as the overall quality of service delivery.

4.4.2 Professional Audit

Professional audits should, as a minimum, be based on medical and professional standards that comply with those established by the appropriate corresponding College or governing association (for example, College of Nurses of Ontario, College of Dietitians of Ontario).

4.4.3 Service Delivery Audits

Service delivery audits should include such quality indicators as:

- A review of the clinical performance and practice patterns of health care practitioners;
- A review of health records;
- An assessment of client satisfaction;
- An assessment of staff concerns; and,
- A review of the organization's service delivery and staffing patterns.

4.4.4 LHIN Requirements for Quality Assurance

Local diabetes programs are expected to meet routine quality assurance objectives, clinical performance and practice patterns using appropriate indicators and tools.

4.4.5 Provision of Agency Information

The local diabetes program must provide all information related to such audits if requested by the LHIN. In addition, the local diabetes program must perform such revised audits or further audits as the LHIN may require.

Service Delivery and Accessibility

5.1 Accessibility of Services

5.1.1 Local diabetes programs administered through diabetes HSPs shall establish hours of operation that are responsive to community need including, where possible, evening and weekend hours.

5.2 Fees for Service

5.2.1 Local diabetes programs administered through Diabetes HSPs may not charge individual clients for diabetes education and management activities funded by the LHIN.

5.3 Staffing and Qualifications

5.3.1 Diabetes programs are staffed by multidisciplinary teams of trained health professionals that include, at minimum, one full-time equivalent Registered Nurse and one full-time equivalent Registered Dietitian per 1000 adults with diabetes. Benchmarks and staffing requirements are to be reviewed by a provincial committee.

5.3.2 Local diabetes program staff members who provide health services shall be licensed or otherwise professionally qualified to practice their profession in Ontario under prevailing legislation and regulations. Local diabetes programs shall develop and implement credentialing procedures for program staff (i.e., ensure proper documentation of credentials, check of credentials with appropriate licensing bodies and with previous employers, etc.)

5.4 Compliance with Personal Health Information Protection Act (PHIPA)

The Ontario Personal Health Protection Act came into effect November 1, 2004 and sets out rules that health information custodians must follow when collecting, storing, using and disclosing personal health information. HSP Boards of Directors are responsible for the development of policies and procedures consistent with PHIPA regarding clinical files, organization's administration files and financial files, with a strategy for allowing appropriate sharing of information to promote integrated service delivery within the organization.

5.5 Record Keeping/Record Retention

5.5.1 Where local diabetes programs are required by law, diabetes programs shall maintain, retain and destroy files for each client receiving diabetes education and management by program staff in a confidential manner consistent with all applicable federal, provincial and municipal laws and regulations, and orders, rules and by-laws having the force of law. The file shall include records generated as a result of each encounter for the client at the diabetes program's main site of operation and all outreach locations.

5.6 Confidentiality

5.6.1 Local diabetes programs shall preserve the confidentiality of all clients' health and other personal information by:

- Establishing policies and procedures for access to client-specific information by diabetes program staff in order to ensure that only persons requiring the information related to provision of service to a client should have access to client information
- Ensuring that diabetes program staff understand and adhere to laws governing client and staff confidentiality.

5.7 Complaints

5.7.1 Local diabetes programs shall establish a policy and related procedures to handle complaints from their clients and the public.

5.7.2 The policy and related procedures will be made available to anyone wishing to lodge a complaint with the diabetes program.

Financial Requirements

6.1 Annual Operating Plan Submission

6.1.1 Each year Diabetes HSPs submit an operating plan, which includes past activities and describe service priorities for the coming fiscal year. A key part of this submission is the budget request.

6.1.2 Health Service providers submit a budget request to the LHIN each spring using a standard format developed by the LHIN.

6.1.3 Budget details will be accompanied by descriptive and statistical information as determined from time to time by the LHIN.

6.1.4 Following a review of the Diabetes HSP's budget request, the LHIN will communicate approval of the budget with its corresponding activities, activity targets and expected service volumes.

6.1.5 For submissions in 2014-15 and thereafter, there is an expectation that operation plans will align with LHIN needs and priorities.

6.2 Financial Accountability

6.2.1 The LHIN funds the Diabetes HSP to provide the services outlined in their SAA, and periodic Amending Agreements, as described in this manual.

6.2.2 Diabetes HSPs shall use designated payments received from the LHIN solely for the operation of DEP programs as specified in their Service Accountability Agreement, and in accordance with the requirements and financial guidelines outlined in this manual.

6.2.3 A HSP must provide LHIN staff and its agents, upon 24 hours' notice and during normal business hours, access to review the operation of the program and to inspect financial transactions and administrative records. The LHIN's right of inspection includes the right to perform, or have its agents perform, a full or partial audit.

6.2.4 Diabetes Health Service Providers shall receive prior written approval from the LHIN prior to transferring funds between expense categories (i.e., salaries and benefits, operating expenses, and non-recurring expenditures). The following categories are managed as an envelope and Health Service Providers can reallocate resources within these envelopes as they deem necessary as long as other LHIN requirements and expectations continue to be met:

- Salaries/Benefits
- Operating Expenditures (with the exception of the following categories: Audit Fees, Professional Development and Purchase of Service)

6.2.5 The LHIN provides funds based on maximum salary ranges approved by the LHIN. Local diabetes programs shall develop salary scales and compensate staff at a level commensurate with their skills and experience. Where local diabetes programs pay less than the maximum, unexpended funds will be recovered unless the LHIN has given the Diabetes HSP prior written approval to use the funds for other purposes. The LHIN is not liable for salary expense in excess of the amount set out in the Diabetes HSP's annual approved budget. Funds allocated for salaries shall be used only as approved for local diabetes program positions. Expenses that may not be paid out of funding received from the LHIN Diabetes Program for costs and expenses include, but are not limited to, the following:

- Any expenses in excess of the approved budget
- Professional licensing and/or professional association fees
- Loans or donations
- Fund-raising expenses
- Contingent liability such as provision for future sick leave costs, vacation pay accrual, and expected future salary awards
- Overtime (may be compensated as time-off)

- Staff bonuses
- Fees of honoraria to members of the Board of Directors
- Expenditures for gifts, staff entertainment or parties, floral tributes, etc.
- Employee transportation costs to and from place of work (mileage for local diabetes program related business is an allowable expense)

6.3 Review of Funding Agreement

6.3.1 Following the minister's original letter of funding approval, the Diabetes HSP and the LHIN sign an Agreement (the SAA) setting out contractually, the basis of service delivery. The SAA is amended each year by an Amending Agreement, which summarizes changes in the approved operating plan and related base budget.
The SAA details the obligations of the Diabetes Health Service Provider and the LHIN, including:

- Services to be provided;
- Reporting requirements;
- Confidentiality of medical records; and,
- Expenditure of funds.

In signing the SAA with the LHIN, the Diabetes HSP accepts ultimate responsibility and accountability for meeting the terms and conditions of this Agreement.

Following a review of each Diabetes HSP's annual operating plan request, the LHIN will communicate acceptance and approval and provide the relevant budget, operating and service schedules.

6.4 Financial Management and Control

6.4.1 The LHIN makes payments to Diabetes HSPs on a bi-monthly basis based on the total approved annualized budget.

6.4.2 Diabetes HSPs must place funds received in an interest bearing account and must include interest earned in each audited financial statement. All interest earned on the funding belongs to the LHIN and can be used only for purposes authorized in writing by the LHIN or must be returned to the MOHLTC upon request.

6.4.3 The Diabetes HSPs shall develop, document and adhere to a set of financial management policies and procedures with due regard for the economical and efficient use of public funds. Accountability for the development of such policies and procedures lie with the Diabetes HSP. At a minimum, these policies and procedures shall include provision for the following:

- Banking, including signing authority, new accounts, receipt of statements of account reconciliation
- Payables/receivables, including signing authority, purchase order, invoices/receipts, method of payment
- Petty cash, including signing authority, receipts, minimum/maximum amounts
- Bookkeeping, including timeliness, responsibility, recording format

6.4.4 Interest earned on current operating funds received from the LHIN shall be treated as recoverable income.

6.4.5 Diabetes HSPs may request, in writing, to the LHIN, to use in-year recoverable income for specific, one-time expenses to support DEP program delivery.

6.5 Financial Reporting

6.5.1 In order for the LHIN to maintain accurate control of its cash flow, Diabetes HSPs shall complete and forward a quarterly financial statement to the LHIN in a format provided by the LHIN. Diabetes HSPs shall submit a written explanation of all variances of more than five per cent from the approved year-to-date budget in any expense category (e.g., salaries and benefits, operating expenditures, non-recurring expenditures).

6.5.2 An authorized signing officer from the Diabetes HSP shall approve and sign each quarterly statement.

6.5.3 The Diabetes HSP shall provide written notification to the LHIN, in advance of the submission deadline, if the submission deadline will not be met. The schedule for LHIN receipt of quarterly financial statements is as follows:

- First quarter (April 1 to June 30) – report due by August 15, 2013
- Second quarter (July 1 to September 30) – report due by November 7, 2013
- Third quarter (October 1 to December 31) – report due by February 7, 2014
- Fourth quarter (January 1 to March 31) – June 6, 2014
- Annual Reconciliation Report – June 30, 2014

6.6 Audited Financial Statements

6.6.1. As per regular operational funding – Diabetes Education Program Funds must be included in the ARR submission due on June 30, 2014.

6.7 Recovery of Unspent Funds

6.7.1 The MOHLTC will recover unspent funds from a previous fiscal year following a review of the Diabetes HSP's ARR. The MOHLTC will notify the Diabetes HSP of the amount to be recovered and the method and time of delivery. Under-spending during one fiscal year may not result in a reduced budget the following year unless under-spending represents a continuing reduced need for the funds allocated to the Diabetes HSP.

Human Resources

7.1 Human Resources

7.1.1 The Board of Directors of the Health Service Provider organization shall be responsible for ensuring that the Diabetes Health Service Provider addresses matters pertaining to human resource planning. The primary functions should include the following:

- To determine human resource policies including the following: salary administration, recruitment and selection of staff, orientation and training, staff benefits and employee relations, termination of employment, and performance appraisals;
- To annually review and plan the Diabetes Program staffing levels with the Diabetes Program Director, in preparation for the coming year;
- To participate in the staff grievance process where established through Board policies;
- To regularly review and update the personnel policy manual; and,
- To monitor and resolve any conflicts of interest involving the board and/or Diabetes Program staff.

7.1.2 Diabetes Health Service Providers shall ensure that all human resource and personnel policies and practices are established and implemented in accordance with all applicable federal and provincial legislation and professional licensing bodies/colleges.

7.1.3 Diabetes Health Service Providers shall consult and request LHIN approval prior to implementing any organizational restructuring plan that would have the effect of reducing the FTE of any LHIN Diabetes Program funded position.

7.1.4 The LHIN's practice is to provide funding to the Diabetes Health Service Providers based on the maximum of the salary range. The difference between the maximum and the actual salary paid is recoverable by the MOHLTC.

7.1.5 Diabetes Health Service Providers shall only compensate overtime hours worked on a time-off in lieu, straight-time basis except in instances where this practice contravenes the Employment Standards Act or other provincial or federal legislation.

Appendix A

Glossary/Acronyms

Service Accountability Agreement (SAA)	Contract between a Diabetes Health Service Provider or its sponsoring agency and a Local Health Integration Network (LHIN), which sets out the terms of reference for program funding for approved Diabetes Programs; see also *Amending Agreement.*
Amending Agreement	A Contract supplementary to the SAA, between a Diabetes Health Service Provider and the LHIN , which summarizes annual funding allocations as approved on the basis if the Annual Operating Plan submission and/or periodic amendments to the SAA as approved by the parties.
CICA	Canadian Institute for Chartered Accountants
LHIN	Local Health Integration Network
Ministry	Refers to the Ontario Ministry of Health and Long-Term Care
MOHLTC	Ministry of Health and Long-Term Care
PHIPA	Personal Health Information Protection Act