



Diabetes Action Canada

Preventing complications. Transforming lives.

DIABETES ACTION CANADA POLICY HANDBOOK

Updated March 17, 2023

[Abstract](#)

High-level overview of governance practices of Diabetes Action Canada

Tracy McQuire

Tracy.McQuire@uhnresearch.ca

Contents

1. TERMS OF REFERENCE	3
1.1 Steering Council Executive	3
1.2 Steering Council.....	4
1.3 Standing Committees of the Steering Council.....	6
1.3.1 Partnerships, Sustainability and Legacy Committee	6
1.3.2 Knowledge Mobilization, Implementation Science (KM-IS) and Evaluation Committee.....	7
1.3.3 Patient Engagement Committee	8
1.3.4 Equity, Diversity and Inclusion Committee	8
1.4 Patient-Oriented Research (POR) Program Committee	9
1.5 Patient Council.....	10
2. FINANCIAL COMPENSATION POLICY FOR PATIENT PARTNERS	17
3. FINANCIAL COMPENSATION POLICY FOR COMMUNITY HEALTH CARE PRACTITIONER VOLUNTEERS	24
4. MEMBERSHIP	30
4.1. Policy for SPOR Network Strategic Partner Relations	35
5. CONFIDENTIALITY POLICY & AGREEMENT	39
6. CONFLICT OF INTEREST POLICY AND AGREEMENT	40
Appendix 1: Some Categories of Conflict of Interest Situations	46
Appendix 2: Some Possible Scenarios	47

1. TERMS OF REFERENCE

1.1 Steering Council Executive

Mandate:

1. Review and approve the agendas for the Steering Council meetings;
2. Review strategic initiatives and partnership proposals brought forward by the Partnerships, Sustainability and Legacy Standing Committee;
3. Nominate new members or re-appointment of members to the Steering Council and its Standing Committees ;
4. Advise Co-Scientific Leads and Executive Director about issues arising between meetings of the Steering Council that require executive decision;
5. Work closely with the Co-Scientific Leads and Executive Director on all matters related to fulfilling the objectives of DAC2.0.

Frequency of Meetings:

Quarterly: meetings of the Executive will be scheduled before the Steering Council Meetings.

Membership:

The membership includes the following:

- Steering Council Chair (1)
- Steering Council Vice-Chair (1)
- Co-Chair from Standing Committee (1)
- Scientific Co-Leads (2)
- Executive Director & Director, Strategic Partnerships (ex officio) (2)

Membership selection will consider principles in equity, diversity and inclusion and will ensure a balance in representation of role, sex, type of diabetes, geographic location and language spoken.

Term:

Steering Council Executive Committee members will be appointed for a 2-year term with an opportunity to renew. Change in the committee will occur with clear rationale and planned transition.

Administrative Support: DAC Management will support the Steering Council Executive Committee

The terms of reference will be revisited annually and updated when appropriate.

1.2 Steering Council

Mandate

1. Ensure that the Vision and Mission of the SPOR Network are fulfilled through strategic, accountable, committed leadership and management functions;
2. Through the skill-based and partnership governance structure, create the highest quality oversight, communication, support and guidance for the conduct of the POR goals using best (corporate) governance principles;
3. Promote strategic partnership relationships with core and new members (academic, public and private) of the SPOR Network with sensitivity to balancing gender, age, language (French, English) for project development, implementation and evaluation;
4. Manage conflict of interest through appropriate processes including necessary agreements established for all aspects of governance and research partnerships; and,
5. Work closely with Standing Committees to ensure collaborative governance to fulfill the objectives of DAC2.0.

Meeting Frequency

The Steering Council will meet quarterly through video conferencing. If funding becomes available for an annual DAC meeting, an in-person meeting will be held.

Membership

The membership includes the following:

- Patient Partners (9): Representing diversity of persons living with diabetes. A minimum of 50% of the voting members including two principal knowledge users, two francophone representatives, five Co-Chairs of 4 Standing Committees as well as the Indigenous Peoples Health Council
- DAC Researchers (7): selected lead from each trans-sectoral theme and/or co-chairs of the Standing Committees and Indigenous Peoples Health Council; an early career investigator; a trainee
- Advocacy partners (2): one representative from each Diabetes Canada and JDRF
- Knowledge User (1): one policy-decision maker
- Co-Scientific Leads (2): Gary Lewis (NPA), André Carpentier
- Ex Officio (2): Tracy McQuire (Executive Director), Catharine Whiteside (Director of Strategic Partnerships).

Individuals can represent more than one category as indicated above.

Chair:

A small Nomination Committee of the Steering Council will select the volunteer Chair of the Council. The expected term will be 4 years. As the highest form of governance for the Network, the responsibilities of the Chair are as follows:

1. **LEADERSHIP:** Provide leadership and strategic advice to enable implementation of the DAC2.0 Mission to achieve the Vision:
 - o Chair meetings of the Council, including encouraging input and participation of all Steering Council members

- Provide direction in defining DAC2.0 action plans to leverage partnerships, particularly with government to enhance KM-IS
 - Ensure that the Steering Council understands and supports the frameworks, policies and activities relevant to patient-oriented research, capacity building, EDI, membership and performance management to enhance effective management and continuous improvement of outcomes and impact of DAC2.0 activities
 - Oversees the Steering Council member recruitment strategies and implementation
2. **GOVERNANCE:** In collaboration with the executive team, ensure meetings are planned effectively and conducted in a professional and efficient manner:
 - Ensures all Council members are involved in standing committees and *ad hoc* committees to support the operations, evaluation and strategic planning effort for DAC2.0
 - Ensure the governance structures and processes for DAC2.0 are reviewed, evaluated and revised as appropriate.
 3. **EVALUATION:** Ensure the Steering Council oversees evaluation of the Network to ensure its programs are fulfilling the articulated goals to achieve the Mission and Vision.

Vice Chair:

The Steering Council Executive will select a Vice-Chair from confidential nominations of Patient Partner members of the Steering Council. Nominations can either be made by members of the Steering Council or through self-nomination. Selection of the Vice-Chair will consider equity, diversity and inclusion within the Steering Council Executive and will ensure a balance in representation of role, sex, type of diabetes, geographic location, and language spoken. The responsibilities of the Vice-Chair are as follows:

1. **LEADERSHIP:** To act as the Chair, either in the absence of the Chair or as requested by the Chair, and to advise the Chair on strategic directions for DAC2.0
 - Chair meetings of the Council, in the absence of the Chair
 - Participate as a voting member on the DAC Steering Council Executive and any Standing Committees of the Steering Council, as appropriate.
 - Collaborate with the Chair on how to support the frameworks, policies and activities relevant to patient-oriented research, capacity building, EDI, membership and performance management to enhance effective management and continuous improvement of outcomes and impact of DAC2.0 activities
 - Identify emerging issues within the Network from the Patient Partner perspective and collaborate on strategies to solve problems and seize opportunities.
2. **GOVERNANCE:** In the absence of the Chair and in collaboration with the executive team, ensure meetings are planned, materials are developed and circulated and ensure meetings are conducted in a professional and efficient manner.

Term:

Steering Council members are appointed for a 2-year term with opportunity to renew. Changes in the committee will occur with clear rationale and planned transition.

Administrative Support: The Executive Director or delegate will provide support for the Steering Council

The terms of reference will be revisited annually and updated when appropriate.

1.3 Standing Committees of the Steering Council

1.3.1 Partnerships, Sustainability and Legacy Committee

Purpose

Build strategic partnerships with diabetes advocacy organizations, public and private sponsors and international collaborators to:

- Enhance and sustain Patient-Oriented Research impact on reducing the burden of diabetes and its complications by achieving equitable, effective and cost-effective health and social care services for all persons with diabetes in Canada.

Mandate

- Provide guidance, implementation tactics and performance measures to the Steering Council Chair and Vice-Chair, Co-Scientific and Research Group Leads, and Executive Director in keeping with the recommendations of DAC's Strategic Plan 2021-26 including strategic partnering and sustainability for DAC beyond 2026.
- Align strategy with the *Framework for Diabetes in Canada* Recommendations.
- Build closer working relationships with SPOR funded entities, sponsor organizations, provincial/territorial health system leaders, international partners and policy decision-makers to enable the spread and scale of the new integrated models of clinical care and prevention developed by DAC2.0 POR Programs.
- Work closely with the DAC Co-Scientific Leads and Executive Director to identify and engage in opportunities for funding from public and private sources to support and enhance DAC's infrastructure and services.

Members:

This committee will maintain a membership size of 6 to 8 members. Members will include the Chair of the Steering Council (Cindy Bell), other Steering Council members representing NGO partners (Diabetes Canada, JDRF), Co-Scientific Leads, Patient Partner(s) (Terri MacDonnell) and other stakeholders with both an interest and experience working in establishing partnerships to achieve sustainability. Additional members may include knowledge users, e.g., from other SPOR entities, patient and caregiver advocacy organizations, NGOs, and policy decision-makers. Members are expected to attend at least 50% of meeting and actively participate in planning meeting agendas and contribute to the committee's mandate.

Co- Chairs:

The Partnerships, Sustainability and Legacy Committee will be co-chaired by one Patient Partner, Tom Weisz and the DAC2.0 Director, Strategic Partnerships, Catharine Whiteside. The Patient Partner Co-Chair was selected at the time of the DAC application for continued funding through an open call among all Patient Partners and was based on individual interests and interviews with DAC leadership. Co-Chairs will ensure adherence to the committee's mandate, participate in setting meeting agendas, facilitate meetings, lead discussions and ensure that members are heard and respected. The Co-Chairs will sit on the DAC Steering Council as spokesperson for this committee

Term:

Membership term is for a 4- year term. Change in the committee will occur with clear rationale and planned transition.

Administrative Support: DAC2.0 Management will support the Partnerships, Sustainability and Legacy Committee

Immediate Work of the Committee – Guided by the following Questions

Environmental Scan – Where are we now?

What are the unique DAC assets and the value (actual and potential) developed to date and who are the potential recipients of the SPOR Network?

Who are the current DAC partners and how are we developing mutual value?

How is DAC poised to contribute to the implementation of the Framework for Diabetes in Canada with our current partners? What new relationships are necessary to achieve impact?

Next 4 Years – How to achieve a sustainable network/enterprise?

What could DAC look like in 4 years – alternate scenarios for a valuable and valued organization? Assess examples of other similar research networks that have evolved into sustainable entities.

What are the immediate (yr1), intermediate (yr 2-3) and longer term (yr 4 and beyond) pathways to achieve the most favourable scenarios?

What partnership strategies and tactics will be necessary to engage successfully in these pathways? Who? When? How?

1.3.2 Knowledge Mobilization, Implementation Science (KM-IS) and Evaluation Committee

PROPOSED Mandate (under construction)

1. Enhance awareness of DAC2.0 activities, identify areas where POR research outcomes can impact improvements in practice and policy related to the DAC2.0 Mission, and to evaluate progress toward the achievement of the KM-IS goals.

2. Consult and oversee process and guidelines for the incorporation of KM-IS approaches and outcome measures in all the DAC2.0 projects.
3. Advise on KM strategies to communicate research outcomes to various stakeholders
4. Design and adjudicate DAC2.0 Impact Grant competitions (\$50K/year) awarded to one team per year to activate their implementation and KM-IS efforts (e.g., to assess and respond to barriers to knowledge use, implementation, sustainability, scalability via qualitative, quantitative or mixed-methods studies)
5. Consult on DAC2.0 Network Evaluation process, building on the previous two cycles of Network evaluation and providing feedback on strategies to engage with Network members.

1.3.3 Patient Engagement Committee

PROPOSED Mandate (under construction)

1. Provide guidance and direction about patient-identified priorities in the treatment, management and health care experience for those living with diabetes
2. Continue to build strong and direct involvement of a diverse range of Patient Partners from across Canada representing T1D and T2D, racialized minorities, Immigrants, older adults and persons living in marginalized environments.
3. Amplify the work for the Collective Patient Advisory Circle and Francophone and Immigrant Advisory Circle with a primary focus on developing implementation actions that align with the DAC Strategic Plan 2021-26.
4. Work with research teams to ensure patient engagement is properly embedded in research plans, Patient Partners and values and recognized for their contributions and the 'do's and don'ts for patient engagement' for DAC are adhered to appropriately

1.3.4 Equity, Diversity and Inclusion Committee

PROPOSED Mandate (under construction)

1. Ensures that EDI principles are intentionally incorporated into DAC governance, membership, research design and capacity building
2. Enhance collaborative work to create a culture that promotes inclusiveness, acceptance of the diversity of those living with diabetes in Canada, and cultural safety
3. Increases the visibility and representativeness of the underserved, under-represented, and/or marginalized populations and amplified their voice in priority-setting and research planning
4. Promote and ensure and SGBA+ lens is applied to every DAC2.0-related project
5. Operate under an ethical framework that commits to CIHR Dimensions: equity, diversity and inclusion [Charter principles](#) that recognize that an intersectional understanding of inequity, discrimination and exclusion is needed to achieve inclusive research ecosystem in Canada.

1.4 Patient-Oriented Research (POR) Program Committee

The Patient-Oriented Research (POR) Program Committee is composed of 23 Principal Applicants (PAs) including the Co-Scientific Leads and the co-Leads of each of the POR Programs and Themes. This committee meets monthly and advises the Scientific Co-Leads and the SPOR Network management on all activities of the Network. It also provides an opportunity for our Network leadership to network, report on progress, share opportunities for collaboration, and address challenges. All research and management activities are brought forward to this committee, chaired by Gary Lewis who, in turn, reports to the Steering Council.

Networking among Investigators across the POR Programs and Themes within Diabetes Action Canada is necessary to optimize collaborative integration and efficiency. The Co-Scientific Leads and Research Program and Theme Leads work together with their counterparts in the other SPOR Networks in collaboration with provincial SPOR SUPPORT Units and the CIHR SPOR Program.

Mandate

1. Coordinates and monitors all research, KM-IS and evaluation, and education translation activities within the Network with advice from the Patient Circles
2. Ensure the work plans are executed with adherence to timelines
3. Evaluative reporting on outputs and outcomes
4. Advises the Steering Council about new Network members
5. Provides guidance and feedback on strategic directions of the Network, including changes to implementation of projects or development of new opportunities
6. Advises POR Programs and Themes about new opportunities for acquiring new revenues and partners
7. Receives annual reports of all of the projects and evaluates progress toward target deliverables and milestones
8. Assists in preparation of the annual budget with the Executive Director and DAC Administrative team
9. Assists the management team in ensuring timely reporting of the revenues and expenses and assessing financial targets according to the planned budget throughout the year
10. Works closely with institutional fund-raising leads to leverage new resources to meet and exceed the target for matched funding

Meeting Frequency

The POR Committee will be meet monthly through videoconferencing.

Members

The POR Program Committee represents the core Principal Applicants, Principal Knowledge Users, and Patient Partners of DAC2.0 as well as invited subject matter experts who are

responsible for the implementation of all of the programs and projects constituting this research, knowledge mobilization and training alliance. Network leadership, including Director, Strategic Partnerships, Executive Director, Lead, Digital Health and Development Director are *ex officio* members of this committee. Members are expected to attend at least 50% of meeting and actively participate in planning meeting agendas and contribute to the committee's mandate.

Chair

The POR Program Committee is Chaired by Dr. Gary Lewis, Nominated Principal Investigator and Co-Scientific Lead for DAC. Vice-Chair for this Committee is Dr. André Carpentier, Principal Applicant and Co-Scientific Lead for DAC. The Chair and Vice-Chair report to the DAC Steering Council. DAC management team will support the co-Chairs.

Term:

Membership term is for a 4- year term. Change in the committee will occur with clear rationale and planned transition.

Administrative Support: DAC Management will support the POR Program Committee

1.5 Patient Council

UNDER REVIEW

Diabetes Action Canada Patient Circles: Overview and Terms of Reference

Goals of the Patient Circles

The goals of the Patient Circles are:

- i)** to foster patient-oriented research relevant to diabetes; and
- ii)** to contribute to better quality research on diabetes and its related complications.

To accomplish these goals, the Patient Circles aim to:

- Bring together diverse groups of people who bring a variety of backgrounds, expertise, ideas, types of diabetes, and personalities
- Foster understanding across these groups
- Create a community of people living with diabetes and their caregivers (hence referred to as Patient partners) who will be involved fully as partners of the Network
- Build capacity for patient engagement in research on diabetes and its related complications in collaboration with the Training and Mentoring Group of the Network
- Ensure that Patient partners are involved at every *level* (governance, tactical and operational) of the Network and in all *phases* of the research process (planning

of studies, conducting the studies, disseminating the studies' results, and implementing results of studies)

- Foster communication among and between researchers and those whose lives are most affected by research findings, namely, patients and their family members.

We will regularly report on our progress on these points.

Responsibilities of Members of Patient Circles

- Articulate what matters to patients, families, and communities to inform what diabetes-related research should be done and how it should be done
- Bring knowledge and ways of knowing from other communities to diabetes research
- Support a strong patient voice in working groups, committees and research teams
- Identify and establish local connections to build Diabetes Action Canada's network of Patient partners
- Share news about Diabetes Action Canada with their communities
- Help disseminate research findings within communities of people affected by diabetes (including, if desired, helping to organize meetings where researchers can bring research findings to communities or health professionals such as certified diabetes educators or dietitians can present best practices)
- Solicit feedback from members of those communities of people affected by diabetes

The Patient Circles adhere to the ***Guiding Principles*** set out by the Canadian Institutes of Health Research (CIHR) in the Patient Engagement Framework. These are:

- **Inclusiveness:** Patient engagement fully integrates a diversity of patient perspectives
- **Support:** Adequate support and flexibility are provided to patient participation to ensure that they can contribute fully to discussions and negotiations
- **Mutual Respect:** Researchers, practitioners, and patients acknowledge and value each other's expertise and experiential knowledge
- **Co-Build:** Patients, researchers, and practitioners work together from the beginning to identify problems and gaps, set priorities and work together to produce and implement solutions.

This is a living document, as the Patient Circles become more established and as Diabetes Action Canada progresses, changes may be required.

Leadership & Membership of the Patient Circles

To begin, there will be three distinct Patient Circles composed of diverse groups of people who live in Canada and who have diabetes themselves (type 1, type 2 or other types) or who are primary caregivers for persons with diabetes. Each Circle (Collective Patient Circle, Indigenous Patient Circle, Francophone Patient Circle) will include about 12-16 members. The Collective Patient Circle will include at least two liaisons from each of the other Circles. Liaisons will help facilitate smooth communication between Circles and to help ensure that the Collective Patient Circle appropriately incorporates the voices of members of specific populations. Over time, the structures of Circles may change. For example, we initially envisioned having a separate Circle of people who immigrated to Canada as adults, but members of this Circle preferred to be integrated into either the Collective or Francophone Circle, depending on preferred language. We may also add more Circles; for example, we envision possibly adding a French-speaking Indigenous Patient Circle, a Youth Circle, and perhaps others. The Circles will be structured as follows:

Collective Patient Circle

- 12-16 members, at least 4 who are also members of the other 2 Patient Circles
- Persons ensuring functioning of Circle: Holly Witteman, Olivia Drescher
- Additional support: Jon McGavock, Joyce Dogba, Marie-Claude Tremblay
- Anticipated frequency of meetings: 8 meetings per year, 90-minute teleconferences
- Language of meetings: English

Francophone Patient Circle

- 12-16 members, including at least 2 who are also members of the Collective Patient Circle
- Persons ensuring functioning of Circle: Joyce Dogba, Olivia Drescher
- Additional support: Jon McGavock, Holly Witteman, Marie-Claude Tremblay
- Anticipated frequency of meetings: 4 meetings per year
- Language of meetings: French

Indigenous Patient Circle

- 12-16 members, including at least 2 who are also members of the Collective Patient Circle
- Ideally, this Circle will include 2-3 elders
- Persons ensuring functioning of Circle: Alex McComber, Jon McGavock, Marie-Claude Tremblay, Pusha Sadi
- Additional support: Holly Witteman, Joyce Dogba, Olivia Drescher
- Anticipated frequency of meetings: 4 meetings per year

- Language of meetings: Mostly English; Indigenous languages when possible

Patient Circles' representativeness

Each Patient Circle will aim to have an approximately equal representation of men and women.

Taken together, the Patient Circles will also aim to represent:

- People of different ages, racial, ethnic, and socioeconomic backgrounds.
- People whose lives are affected by type 1, type 2, and other types of diabetes.
- People from different regions of Canada.
- People who are Indigenous from nations located within Canada, settlers born in Canada or who immigrated as children, and people who immigrated to Canada as adults

SPOR Diabetes Network Patient Engagement and Indigenous Health Team Roles

Diabetes Action Canada's Patient Engagement and Indigenous Health teams will support and coordinate activities of the Patient Circles. They will:

- help plan the meetings;
- organize teleconferences;
- distribute materials and minutes to Patient partners, specifically:
 - send meeting documents by email as soon as they are available, in both Microsoft Word and pdf formats, and
 - aim to send a final package of meeting documents one week in advance of the meeting, noting documents that are duplicates of those previously sent; and
- Provide administrative and other aid as required by members of the Patient Circle.

Communication guidelines

Our goal in all communication is to understand and be understood. To that end, we will:

- avoid jargon and acronyms as much as possible,
- explain specialized terms whenever it is not possible to avoid using them, and
- Avoid tables and figures in documents to allow screen readers to more easily interpret the document.

Role of the Patient Circles

The Patient Circles are advisory and guidance bodies. They advise and guide Diabetes Action Canada on multiple levels to ensure that the network is responsive to what matters to patients. The Patient Circles advise the Steering Committee. The Steering Committee holds the ultimate governance responsibility for Diabetes Action Canada and has 50% patient or patient representative membership (6 members). Some of these may be members of the Patient Circles.

The Patient Circles also advise on research projects in a number of different ways. Advising on research projects includes discussing research projects at Patient Circle meetings to provide guidance to researchers to help make the research more relevant to patients. Members of Patient Circles as well as other patient members of DAC may also serve as Patient partners on research projects, bringing their expertise from their lived experience with diabetes to the research. Patients can provide expertise in many ways, including their experience of living with diabetes and, if applicable, complications; experience with the health system (care delivery), experience with specific treatments (drugs, surgeries, devices), and community needs.

Levels of Involvement & Time Commitments

All levels of participation are encouraged and welcomed in the Patient Circles. It is understood that the level of involvement and the time commitment possible will vary between members, given the diversity among the Patient Circles members' jobs, personal commitments, wellness and illness, and other supports. Depending on the level of involvement, the anticipated workload for most Patient partners will be 0.5-2 hours per week.

Members have the option to scale their commitment at any time: When a Patient partner decides to change his/ her level of commitment, he/ she may inform the lead(s) of the research team(s) or Patient Circle(s) and the Patient Engagement Coordinator. Sometimes during times of difficulty in a person's life, it may be necessary for him/her to step away from his/her role on the Circle. In such cases, the Circle may "keep the person's seat warm" so that they may return to the Circle when they are able. The Patient Circles will make sure that there is a succession plan for members for when they leave the Circle.

Learning from each other: When new Patient Circle members come on board, they will be offered a brief orientation and mentorship from another member. All Patient Circle members are strongly encouraged to participate in a free training session on Patient-Oriented Research. When a Patient Circle member leaves, the Patient Engagement team will organize a final

meeting in which that member may provide any parting thoughts and advice they have to improve our work in future.

Meeting frequency: The Collective Patient Circle will meet approximately eight (8) times per year, for 90 minutes by teleconference, online technology or other method selected by the group. Other Patient Circles will meet approximately four (4) times per year, for 60-90 minutes by teleconference, online technology, or other method selected by the group. These meetings will take place during the time of day or evening most convenient for all participants, alternating if necessary to balance needs. Full-day, in-person meetings will take place at least once per year, budget permitting, ideally in different locations. Meeting frequency and method may be adapted according to the views of Circle members. For example, a Circle may choose to have less frequent, in-person meetings.

Term length: Patient Circle members will initially be encouraged to sit for a term of 1 year, starting from the first full meeting of Diabetes Action Canada Patient Circles, May 2017. After the first year, we hope to maintain at least two thirds of Patient Circle members as active Circle members, with new members joining to help provide new perspectives and allow exiting members to pursue other activities, including possibly other roles within Diabetes Action Canada. Ultimately, we aim to have Patient Circle members take up 3-year terms, with one third of the members finishing their term each year. In this way, participation renewal will be staggered to ensure that there are experienced members, as well as new members on the Patient Circle at all times. Existing members will help informally mentor new members. As the Patient Circles take shape in the first two years, the Patient Engagement team will help to identify which members wish to continue their terms or step back, and will structure ongoing terms accordingly to balance the Circles.

Chairs: Chairship of meetings will be determined by each Circle. It is suggested that chair responsibilities be assumed by those who wish to assume them, sharing responsibilities as needed, with rotating chairs if desired. Meeting chairs will have support from the Patient Engagement team.

Decisions and Quorum: As primarily advisory bodies, Patient Circles will not need to take formal votes frequently. When decisions are required, the Circles will aim for consensus, with an ethic of collaboration, cooperation, and trust, aiming always for respectful debate in which we all seek to understand and be understood. If consensus cannot be reached, those who disagree with the group's decision may include their concerns in the final report to ensure that these are documented. Because the liaisons represent specific groups who may have particular needs, when decisions are made on the Collective Patient Circle that require a vote, liaisons will be invited to bring issues

and/or proposed decisions to their Circles for further discussion prior to the Collective Patient Circle's vote. The quorum of the Collective Patient Circle (number of members whose presence is necessary to make a binding decision) will be half of its members plus 1, with at least 1 liaison from each other Circle present.

Communication: The Patient Circles will explore options (i.e., methods and frequency) for communication between meetings of the Patient Circles. This can take the form of social media, e-mails, newsletters etc. as deemed most appropriate and effective by the members of the Patient Circles.

Working groups and committees: As the initiative evolves, a number of working groups or standing committees may be established which will provide more focused work. Members of the Patient Circles will be encouraged to join as many working groups as time and interest allows.

Compensation: In recognition for their time spent and valuable expertise, members of the Patient Circles will be offered compensation in accordance with the Diabetes Action Canada Compensation Policy. Compensation will be provided for selected activities, including both meetings and preparation time for meetings. Travel and accommodation costs will be reimbursed. Patient partners will have the option to decline to be compensated.

Opportunity for community at large to provide input to the Circles: Members of the Patient Circles will be ambassadors and champions by liaising with other community organizations and groups. They will bring back any relevant input to the Patient Circles. Members of the Patient Circles are welcome to bring in any idea and/or suggestion from the community for discussion within the Circles.

References

This document draws from a number of other documents, including the Canadian Institutes of Health Research (CIHR) [Patient Engagement Framework](#) and the Patient Council Terms of Reference developed by the Can-SOLVE CKD SPOR Network and generously shared with other SPOR Networks.

2. FINANCIAL COMPENSATION POLICY FOR PATIENT PARTNERS

Research and other research-related activities funded by Diabetes Action Canada should reflect the time and contributions of all partners. Financial compensation demonstrates recognition of the value and worth of the additional expertise brought by the perspectives of Patient Partners. Therefore, covering costs and paying for time should be seen as a tangible way to acknowledge the valued contributions of Patient Partners.

By offering compensation, we also seek to (a) reduce power hierarchies caused by the fact that others at the table receive a salary related to their role and (b) ensure that Patient Partners who cannot afford to volunteer their time are able to participate in network activities. This helps us achieve our goal that Patient Partnership in our network be inclusive.

Who can receive compensation:

All Patient Partners* can receive compensation for their contributions to the Network.

*As outlined by the Canadian Institutes of Health Research (CIHR), the term ‘patient’ under the Strategy for Patient-Oriented Research (SPOR) is understood to include individuals with personal experience of a health issue and informal caregivers, including family and friends.

Types of contributions:

The Network is committed to integrating the patient perspective into every step of the research process including identifying gaps, developing research questions, defining research objectives, recruiting participants, collecting data, evaluating results, and disseminating knowledge. Some patients have the readiness to contribute as full members of research teams, while others bring expertise in a range of other key areas such as ethics or as knowledge brokers. Overall the patients’ roles will vary according to the contributions a patient is prepared and willing to offer. Equipping Patient Partners to participate in network activities may include offering compensation for time spent in orientation (training, learning activities). The following table breaks down the different compensation rates for the various roles of Patient Partners, as well as the different eligible expenses.

All negotiations on Patient Partner compensation will occur between Diabetes Action Canada and the research teams prior to recruitment of Patient Partners. It is our goal to ensure patient engagement in research is a collaborative and equitable experience. It is the responsibility of the research team to inform Diabetes Action Canada of the time Patient Partners spent on projects and/or activities and to complete all requested forms.

Table 1: Eligible expenses and compensation rates for Patient Partners of the Network

	ACTIVITY	DESCRIPTION	\$\$\$	half-day (\$) ²	full-day (\$) ³
ELIGIBLE EXPENSES	Travel	Travel costs for any out-of-town DAC-related meetings and/or events are covered. This includes economy class airfare, train fare, bus fare or mileage. Taxi fares are reimbursed for short distances. Car rental: Rental of a compact or mid-sized car may be reimbursed with advance approval. Original receipts must be submitted for the purpose of reimbursement.	Reimbursement or covered directly ¹	n/a	n/a
		<u>Car travel:</u> \$0.40 per kilometre	Reimbursement	n/a	n/a
		<i>** The mileage rate is currently under review.</i>			
	Overnight accommodation	The Patient Partner may need overnight accommodation (hotel, motel, bed & breakfast, lodge or other) if travelling some distance to take part in an involvement activity such as training or meetings.	Reimbursement or covered directly ¹	n/a	n/a
		Overnight accommodation -private residence-	\$25/night	n/a	n/a
	Subsistence	Subsistence costs are for time spent away from home. Meal expenses will be reimbursed for out-of-town DAC-related meetings and/or events. The maximum amount of reimbursement per day is \$50.00. Detailed, itemized receipts of the meal must be submitted for meal reimbursement. <i>** The daily cap of \$50.00 is currently under review.</i> As cash advances are not a permitted practice, Patient Partners may request a pre-paid Visa/Mastercard gift card to cover the cost of meals for out-of-town DAC-related meetings and/or events, where required.	Reimbursement or covered directly ¹	n/a	n/a
Personal assistants	Some disabled people may have a personal assistant to support them to get actively involved as Patient Partners.	Reimbursement or covered directly ¹	n/a	n/a	
Childcare	Some people may need childcare support to be fully involved as a Patient Partner.	Reimbursement or covered directly ¹	n/a	n/a	
Training and learning	The Patient Partner attends a training event (conference, online training course, etc.).	\$25/hr	75	150	

COMPE NSATIO N	Consultant role	The Patient Partner offers his/her opinion, advice or feedback (e.g. Patient Council meetings).	\$25/hr	75	150
	Collaborator role	The Patient Partner participates as a member of the research team and takes joint decisions with research projects leads.	\$25/hr	75	150
	Strategic role	The Patient Partner plays a strategic role in the Network's governance. (N.B. Compensated only at the request of Patient Partners for whom it would be difficult to enact this role without compensation.)	\$25/hr	75	150
	Patient Council members	The Patient Partner is a member of a Patient Council.	\$95/meeting (including 0.5 hrs of prep time and 2 hrs for document review) or \$50/meeting for those who cannot attend the meeting but who take time to read the documents and send comments by email		
	Patient Partnership consultant	The consultant provides specific expertise, or works to improve a particular component of the Network.	\$50/hr	150	300

¹ The travel costs will be reimbursed or covered directly, for example by booking tickets via a travel agency.

² Half-day compensation at 4 hours.

³ Full-day compensation starts at 7 hours.

Considerations for Patient Partners:

- Patient Partners should be aware of the items that are covered and the upper limits on expenditures listed in Table 1.
- All expenses are subject to institutional approval. Travel plans and appointing a personal assistant should therefore be discussed with the Patient Engagement Coordinator ahead of time to ensure that all expenses incurred are able to be reimbursed.
- When participating in a Diabetes Action Canada sponsored event, it is possible for a Patient Partner to extend his/her stay after or before the event. However, the price of the plane ticket will have to be equal or cheaper than the price of the ticket with true event dates (with reservations made at least 14 days in advance). If the price of the ticket with extended dates is more expensive, then the Patient Partner will have to buy his/her ticket and Diabetes Action Canada will reimburse the price of the ticket with true event dates. In other words, the Patient Partner will absorb the difference in price.
- When travelling by car to an event, kilometres are reimbursed according to the rate indicated in Table 1. The distance travelled is calculated using Google Maps from the address of residence to the event location.
- Reimbursement for expenses is generally not subject to tax as it is not counted as income, but if a Patient Partner is self-employed, they may need to declare expenses.
- Patient Partners receiving welfare (a.k.a. social assistance or income assistance) should be prepared to report compensation received from the Network.
- Other options for compensation can be explored.
- Patient Partners may decline compensation. If compensation is declined, the funds will be used by Diabetes Action Canada for other activities undertaken by the network, including research projects.

Procedure for recruiting Patient Partners to research activities

- 1) Research teams must always engage with Diabetes Action Canada patient engagement personnel prior to requesting Patient Partner time and expertise, even if previous relationships have been established with Patient Partners for other activities.
- 2) Diabetes Action Canada will request the following information to draft an open call to either all or a subgroup of Patient Partners depending on eligibility:
 - a. Research Team
 - b. Title
 - c. Project summary (in lay terms appropriate for non-academic audiences)
 - d. Request for participation
 - e. Time Commitment
 - f. Compensation
- 3) The paymaster for Patient Partner compensation will be decided prior to sending the open call. Diabetes Action Canada will support Patient Partner compensation for research planning and consultative purposes, but expects research teams to budget for continued Patient Partner compensation once the proposal is funded.

- 4) Diabetes Action Canada will manage recruitment for Patient Partners and provide research teams with support throughout the engagement process.
- 5) It is the responsibility of the research teams to follow the process below for Patient Partner compensation for their time and expertise.

Procedure for Patient Partners who are members of a research project

- 1) The compensation rate is defined by the [Diabetes Action Canada Patient Partner compensation policy](#). It is important that before each involvement, the number of hours of collaboration expected and the roles and responsibilities of the Patient Partners be clearly defined.

If the time needed exceeds the time estimate, Patient Partners must inform the Project team and Patient Engagement team. We depend on Patient Partners to help keep track of actual time spent in order to ensure that time estimates are reasonable. Due to budget limits, there may not always be additional funds available to compensate Patient Partners. At that point, it is up to Patient Partners to decide whether to stop or continue collaboration.

- 2) Research teams must complete the form, **DAC Patient Partner Participation Form_Other** and provide additional information as requested (i.e. call for Patient Partners, agenda, etc.) and send to Mildred Lim at Mildred.Lim@uhnresearch.ca
- 3) Payment will be processed via Direct Deposit by the University Health Network. Please note the turnaround time is 2 to 4 weeks from time of payment requisition. If cheque is the preferred method of payment, this can be accommodated, but processing time will be between 6-8 weeks. Depending on the length of the collaboration, Patient Partners may wish to receive compensation at intervals rather than at one time. Patient Partner compensation requests MUST be received within one week of collaboration.

Procedure of Patient Partners who are members of Advisory Committee

- 1) The compensation rate is defined by the [Diabetes Action Canada Patient Partner compensation policy](#). It is important that meeting frequency, prep time for meetings and meeting duration are clearly defined for Patient Partners.

If the time needed exceeds the time estimate, Patient Partners must inform the Project team and Patient Engagement team. We depend on Patient Partners to help keep track of actual time spent in order to ensure that time estimates are reasonable. Due to budget limits, there may not always be additional funds available to compensate Patient Partners. At that point, it is up to Patient Partners to decide whether to stop or continue participating on Advisory Committees.

- 2) Research teams must complete the form, **DAC Patient Partner Participation Form_Meeting** and provide additional information as requested (i.e. call for Patient Partners, agenda, etc.) and send to Mildred Lim at Mildred.Lim@uhnresearch.ca
- 3) Payment will be processed via Direct Deposit by the University Health Network. Please note the turn around time is 2 to 4 weeks from time of payment requisition. If cheque is the

preferred method of payment, this can be accommodated, but processing time will be between 6 to 8 weeks. Patient Partner compensation requests MUST be received within one week of the meeting.

Procedure of Patient Partners who are members of a Patient Council

- 1) The compensation rate is defined by the [Diabetes Action Canada Patient Partner compensation policy](#). To facilitate involvement in the Patient Councils, the number of hours required for meetings and accompanying activities of the Patient Councils has been estimated on a per meeting basis amounting to: \$95 / meeting. Members who cannot attend the scheduled Patient Council meeting for exceptional reasons but who have spent time reviewing documents and preparing for the meeting can claim a \$50 compensation.
- 2) DAC PE Personnel will complete the form, **DAC Patient Partner Participation Form_Meeting** and provide additional information as requested (i.e. call for Patient Partners, agenda, etc.) and send to Mildred Lim at Mildred.Lim@uhnresearch.ca
- 3) Payment will be processed via Direct Deposit by the University Health Network. Please note the turn around time is 2 to 4 weeks from time of payment requisition.

Please note that Patient Partner engagement at meetings and as a member of research projects is considered consulting by UHN Finance and amounts over \$500 per annum will be taxable. Patient Partners will receive a T4A from University Health Network for this remuneration.

Obtaining reimbursement for travel expenses (for all Patient Partners)

Ideally, travel expenses (e.g. plane ticket, overnight accommodation, etc.) will be paid directly by Diabetes Action Canada on behalf of the Patient Partner involved in the activity. This is to minimize the amount of out-of-pocket expenses for the person involved in the activity. Where required, Diabetes Action Canada may issue pre-paid VISA/Mastercard gift cards. However, some expenses may have to be reimbursed after the event.

Original receipts and in some cases boarding passes (please see details in statement 3 below), are required for reimbursement of expenses. Scans of original receipts cannot be accepted. Acceptable receipts show details of the items paid for and the mode of payment.

Please send all original receipts by mail to the following address:

University Health Network
c/o Mildred Lim
200 Elizabeth Street, 12EN-242
Toronto, ON
M5G 2C4

Please note:

- 1) Claims for reimbursement should be made within 30 days of return from travel or the date the expense was incurred.
- 2) Patient Partners should be aware of the four weeks' minimum delay between the date of the claim and the reimbursement. Delay may unfortunately sometimes be longer due to university schedules.
- 3) Claims for reimbursement of travel (plane, train, taxi, bus or ferry/boat) PURCHASED DIRECTLY by the Patient Partner, should include round-trip boarding passes as proof of travel. If the travel expense was paid directly by the Network, Patient Partners are asked to save their boarding passes and submit to Mildred Lim (contact below).

Whom to contact:

Please contact Mildred Lim, Business Officer.

Email: Mildred.Lim@uhnresearch.ca

Phone: 416-340-4800 x 2522

3. FINANCIAL COMPENSATION POLICY FOR COMMUNITY HEALTH CARE PRACTITIONER VOLUNTEERS

Diabetes Action Canada would like to ensure that health care practitioners, such as community physicians, dietitians, physiotherapists, nutritionist, kinesiologists, pharmacists, etc. who are volunteering to participate in activities required to implement research projects are compensated appropriately for their professional time. Since participating in Diabetes Action Canada projects, such as serving on our Diabetes Action Canada governing committees, can take health care practitioners away from their practice duties and result in lost billing hours and loss of revenue to maintain business operations, financial compensation is offered to demonstrate recognition of the value of their time and expertise. Compensation is also offered to enable participation of these individuals who would not normally be able to participate in Network activities because of obligations associated with their clinical practice. By offering compensation we seek to acknowledge the professional time lost by health care practitioner volunteers; however, Diabetes Action Canada expects that their participation in our research activities is strictly volunteer and does not result in personal gains. We expect that health care practitioner engagement in Diabetes Action Canada activities will be mutually beneficial as we endeavor define clear health care paths and remove barriers of care these individuals encounter in their treatment of people living with diabetes.

Who is eligible to receive compensation?

Diabetes Action Canada, a CIHR Strategic Patient Oriented Research Network, will follow the eligibility criteria for administering additional compensation as outlined by the Tri-Council Policy.

Health care practitioners who volunteer their expertise towards non-research activities, necessary to conduct the research projects of Diabetes Action Canada are eligible to receive compensation. Activities should enable research, such as Diabetes Action Canada Repository Research Governing Committee membership, but should not include conducting actual research. The health care practitioners are to represent the broader primary care community and provide advice and guidance on strategic research direction and feasibility of knowledge translation into clinical practice for diabetes care. These individuals can hold a university appointment, but must not receive compensation for research activities conducted at the university, from academic practice plans, or from hospital-based research institutes. Health care practitioner volunteer's compensation is to incentivize participation and can be declined.

If these health care practitioners also hold an academic appointment with a University, they must consult with their University Department to determine whether receiving CIHR funds through Diabetes Action Canada as a volunteer presents any risk related to current or future CIHR grant funding.

Types of contributions by Health Care Practitioners

Diabetes Action Canada recognizes the importance of integrating the front-line health care practitioner's perspective into research activities that affect models of health care. This perspective is very important in determining the limitations and feasibility of proposed actions in implementing applied health research (i.e., recruiting patients, collecting data, evaluating results, and disseminating knowledge). We expect that health care practitioner involvement will be primarily as consultants to the research, education and knowledge translation investigators of Diabetes Action Canada, as our Network has already engaged a wide variety of clinicians and physicians with University appointments to conduct these activities.

We also recognize that to prepare health care practitioner volunteers to participate in Diabetes Action Canada research projects that they may be offered compensation for time spent in orientation (training, learning activities). We also expect that compensation rates be determined based on loss of clinic time and the impact this will have on the operation of individuals businesses. This rate will need to be negotiated by the Goal Group Leads to understand what is feasible to engage these individuals into research activities. This could include determining different rates for different engagement levels and adjusting the rate based participation in-person versus remotely. Compensation ranges for health care practitioners can be found below in Table 1. Compensation rates should not exceed the maximums indicated in Table 1. Table 1 also outlines travel and accommodation reimbursement as well as the different eligible expenses.

Table 1: Eligible expenses and compensation rates for health care practitioner volunteers of the Network

	ACTIVITY	DESCRIPTION	\$\$\$	half-day (\$)²	full-day (\$)³
ELIGIBLE EXPENSES	Travel	Travel costs for any involvement are covered. This includes economy class airfare, train fare, bus fare or mileage. Taxi fares are reimbursed for short distances. Car rental may also be reimbursed with advance approval. <u>Car travel:</u> \$0.54 per kilometer.	Reimbursement or covered directly¹ Reimbursement	n/a n/a	n/a n/a
	Overnight accommodation	The health care practitioner volunteer may need overnight accommodation (hotel, motel, bed & breakfast, lodge or other) if travelling some distance to take part in an involvement activity such as training or meetings. Overnight accommodation -private residence-	Reimbursement or covered directly¹ \$30/night	n/a n/a	n/a n/a
	Subsistence	Subsistence costs are for time spent away from home. The maximum per diem amount that can be covered is \$55 per day (breakfast: \$11 lunch: \$17, dinner: \$27).	Reimbursement or covered directly¹	n/a	n/a
	Personal assistants	Some disabled people may have a personal assistant to support them to get actively involved as health care practitioners volunteers.	Reimbursement or covered directly¹	n/a	n/a
	Childcare	Some people may need childcare support to be fully involved as a Health care practitioners volunteer.	Reimbursement or covered directly¹	n/a	n/a
COMPENSATION	Training and leaning	The health care practitioner volunteer attends a training event (i.e. Workshop, conference, online training course, etc.).	\$25-200/hr	\$75-500	\$150-1000
	Consultant role	The health care practitioner volunteer offers his/her opinion, advice or feedback (i.e. Research Governance Committee meetings).	\$25-200hr	\$75-500	\$150-1000
	Strategic role	The health care practitioner volunteer plays a strategic role in the Network's governance. (N.B. Compensated only at the request of health care practitioners volunteers for whom it would be difficult to	\$25-200/hr	\$75-500	\$150-1000
	Health care practitioners	The consultant provides specific expertise, or works to improve a particular component of the Diabetes Action Canada projects.	\$25-200/hr	\$75-500	\$150-1000

¹ The travel costs will be reimbursed or covered directly, for example by booking tickets via a travel agency.

² Half-day compensation at 4 hours.

³ Full-day compensation starts at 7 hours.

Considerations for Health Care Practitioner volunteers

- Health care practitioner volunteers should be aware of the items that are covered and the upper limits on expenditures (e.g., per diem amounts), listed in Table 1.
- Health care practitioner volunteers should be aware of the compensation rates for their engagement and that remuneration is to recuperate costs lost by their participation and not for personal gain.
- All expenses are subject to institutional approval from the host institution that holds the research funding. Travel plans and appointing a personal assistant should therefore be discussed with the Diabetes Action Canada Administration ahead of time to ensure that all expenses incurred are able to be reimbursed.
- The per diem amounts are daily allowances to cover meals when traveling for the Network. The health care practitioner volunteers are required to show receipts for meals to receive the per diem amounts listed in Table 1. Group meals beyond this may be covered; these cases should be planned in advance and be part of the budget for the event.
- When participating in a Diabetes Action Canada sponsored event, it is possible for a health care practitioner volunteer to extend his/her stay after or before the event. However, the price of the plane ticket will have to be equal or cheaper than the price of the ticket with true event dates (with reservations made at least 14 days in advance). If the price of the ticket with extended dates is more expensive, then the health care practitioner volunteer will have to buy his/her ticket and Diabetes Action Canada will reimburse the price of the ticket with true event dates. In other words, the health care practitioner volunteer will pay the difference in price.
- When travelling by car to an event, kilometers are reimbursed according to the rate indicated in Table 1. The distance travelled is calculated using Google Maps from the address of residence to the event location.
- Reimbursement for expenses is generally not subject to tax as it is not counted as income.
- Other options for compensation can be explored.
- Health care practitioner volunteers may decline compensation. If compensation is declined, the funds will be used by Diabetes Action Canada for other activities.

Procedures for health care practitioner volunteers who are members of Diabetes Action Canada's Research Governing Committee or Data Provider Advisory Group

The compensation rate range is defined in Table 1 of this document. It is important that before each involvement, the number of hours of collaboration expected, the role and responsibilities of the health care practitioner volunteers be clearly defined.

Health care practitioner volunteers will be asked to submit their hours to the Research Project Coordinator. If time on a Research Governance Committee exceeds the time estimate, it is up to the health care practitioner volunteer to let the Project team and Diabetes Action Canada administrative team know. It is the responsibility of the health care practitioner volunteers to help keep track of actual time spent in order to ensure that time estimates are reasonable. Due to budget limits, there may not always be additional funds available to compensate health care practitioner volunteers beyond the originally planned time commitment. If time exceeds the originally budgeted commitment, it is up to health care practitioner volunteer to decide whether to stop or continue collaboration (without compensation).

Health care practitioner volunteers will be compensated via T4A income and can choose to receive compensation at the conclusion of each research activity, e.g., Diabetes Repository Research Governing Committee event or at the end of the collaboration (not exceeding one year).

Receiving Compensation

Whether attending a training event or consulting with a research team, claims for compensation should be made following the steps below (steps 1 and 2 do not need to be repeated for subsequent compensation claims):

- 1) **Email the following information to Diabetes Action Canada Administration (name, address, phone number, date of birth, social insurance number). Note this information is confidential and encrypted within the Diabetes Action Canada email system.**
- 2) **Send hours to Research Project Coordinator**
- 3) **Payment will be issued as an honorarium and will come as a check mailed directly to the Health care practitioners home address**
- 4) **Follow approval procedure (via Email).**

Obtaining reimbursement for travel expenses (for all health care practitioner volunteers)

Ideally, expenses (e.g. plane ticket, overnight accommodation, etc.) will be paid directly by the Network on behalf of the health care practitioner volunteer involved in the activity. The reason for this is to incur the least amount of out-of-pocket expenses to the person involved in the activity. In some cases, it may also be possible to issue advances; however, some expenses may have to be reimbursed after the event.

Original receipts and in some cases boarding passes (please see details in statement 3 below), are required for reimbursement of expenses. Scans of original receipts cannot be accepted. Acceptable receipts show details of the items paid for and the mode of payment.

Please send all original receipts by mail to this address:

Diabetes Action Canada
c/o Mildred Lim
Toronto General Hospital
200 Elizabeth St.
Eaton Building, Room 12EN242
Toronto ON, M5G2C4

- 1. Claims for reimbursement should be made within 30 days of return from travel or the date the expense was incurred. If an advance was issued, receipts must be submitted to the Diabetes Action Canada within 30 days.**
- 2. Health care practitioner volunteers should be aware of the three weeks' minimum delay between the moment the claim is received and the reimbursement. Delay may unfortunately sometimes be longer due to University Health Network schedules.**

Claims for reimbursement of travel (plane, train, bus or boat) PURCHASED DIRECTLY by the health care practitioner volunteer, should include printed round-trip boarding passes as proof of travel. If the travel expense was paid directly by the Network, health care practitioner volunteers do not need to save boarding passes.

Whom to contact

Please contact

Mildred Lim: Business Officer, Diabetes Action Canada

Phone: 416-340-4800 ext: 2522

Email: Mildred.Lim@uhnresearch.ca

4. MEMBERSHIP

Network Membership

Members of the Diabetes Action Canada (DAC) consist of those stakeholders who are actively contributing to the projects and activities of the Network. Network membership has four categories: Researcher (including Co-Scientific Leads) Knowledge User, Patient Partner, and Trainees.

The following policy defines the terms and conditions that constitute the requirement for commitment of expertise, resource and service with respect to governance and operational management to deliver the outcomes articulated in our DAC proposal as we evolve from a POR Network in Chronic Disease to a Network in Knowledge Mobilization and Implementations Science. Membership requires a commitment to the principles of conflict of interest and adherence to declaration of real or perceived conflict.

The Steering Council of DAC reviews and approves the Membership and Conflict of Interest Policies and relies on approval of members to the Network by the POR Program Committee. These policies will be directly communicated and made transparent to all DAC members in terms of agreement documents.

Membership Categories

Membership in DAC of Researchers, Knowledge users, Trainees and Patient Partners is essential for the fulfillment of the mission and vision of DAC. The following describes the general criteria for eligibility and the process for appointment of each member category. Below also details all the rights and privileges of membership.

Researcher

Who is eligible?

This category of membership includes the following:

- **Scientific Co-Leads:** DAC has two Scientific Co-Leads – Gary Lewis and André Carpentier. Gary Lewis is the Nominated Principal Applicant for the CIHR SPOR Network Grant. The Co-Leads report to the Steering Council and are responsible for all the activities of the SPOR Network including oversight of research, knowledge translation, training and mentoring, patient-engagement and the management of the administrative operations of the Network including support of the CIHR-approved governance function.
- **Principal Applicants:** Those researchers who signed the SPOR Network application and have committed to the mission and vision of DAC for the next 4-year term and are leading specific Programs and Themes within the Network. This investigative team is responsible for the implementation of all the programs and projects within DAC and are members of the Patient-Oriented Research (POR) Program Committee.

- **Co-investigators:** A broader team of researchers and educators engaged in the activities of DAC. These individuals may lead projects or provide significant collaboration. They become members by either signing: 1) an inter-institutional or transfer agreement as the Institutional Investigator on a SPOR Network project; or, 2) a letter of agreement with DAC.

DAC membership is only available to researchers appointed to a university, academic hospital or research institute who are engaged in diabetes-related research (basic, clinical, knowledge translation) and interested in contributing to the mission and vision of DAC. For individuals outside of Canada, academic appointment must be at an internationally recognized research-intensive university and/or academic hospital or research institute.

How is membership acquired?

Through inquiry to DAC or to one of our existing Researcher members, a researcher may be recommended for membership. A statement (maximum of 200 words), prepared by the nominating Researcher member, is required outlining the collaboration opportunity as well as the individual's potential to contribute to DAC's mission and vision. An updated summary CV that provides research interests and academic status of the individual is also required. Applications are reviewed and approved by the POR Program Committee. The final decision for membership is communicated to the Steering Council.

Duration of Membership?

Researcher members are appointed until the funding term for DAC ends on March 31st, 2026 as indicated in their signed agreement. If a Researcher member resigns from their position at the current academic institution, their membership with DAC is terminated. If a Researcher member changes academic institutions their membership at DAC remains and is updated with a new letter of agreement with DAC.

What is the value of Researcher membership?

- Networking with researchers, knowledge users, patient partners and trainees with a common interest in patient-oriented research in diabetes
- Opportunity to collaborate on DAC projects
- Review of their grant proposals and potential endorsement for research that contributes to the mission and vision of DAC
- Listing on the DAC Website
- Receives Newsletters and network communications
- Use of the title Researcher *in Diabetes Action Canada* for the term of their appointment

- Use of the DAC Logo and Word Mark on their email and other signatures.

Knowledge User

Who is eligible?

This category of membership includes the following:

- **Principal Knowledge User:** Those clinicians who signed the SPOR Network application and have committed to the mission and vision of DAC for the next 4-year term and are leading specific Programs and Themes within the Network. Principal Knowledge Users co-lead a DAC POR Program and are members of the Patient-Oriented Research (POR) Program Committee.
- **Knowledge Users:** Health care practitioners and/or leaders in health care improvement who are deeply engaged in quality improvement, governance and/or research activities within DAC, but do not run an independent research program at an academic institution.
- **Policy and decision-makers:** Municipal, provincial and federal level members of governments who are involved in DAC governance, activities and/or research planning.

How is membership acquired?

Through inquiry to DAC or to one of our Researchers or **Knowledge User** members, a Knowledge User may be recommended for membership. A statement (maximum of 200 words), prepared by the nominating Researcher or Knowledge User member, is required outlining the collaboration opportunity as well as the individual's potential to contribute to DAC's mission and vision. A summary CV that details the potential member's professional expertise is also required. Applications are reviewed and approved by the POR Program Committee. The final decision for membership is communicated to the Steering Council.

Duration of Membership?

Knowledge User members are appointed until the funding term for DAC ends March 31st, 2026 as indicated in their signed agreement. If a Knowledge User member resigns from their employment position, their membership with DAC is terminated.

What is the value of Knowledge User membership?

- Networking with researchers, knowledge users, patient partners and trainees with a common interest in patient-oriented research in diabetes
- Review of their quality improvement proposals and potential endorsement for initiatives that contributes to the mission and vision of DAC
- Opportunity to collaborate on DAC projects

- Listing on the DAC Website
- Receives Newsletters and network communications
- Use of the title *Knowledge User in Diabetes Action Canada* for the term of their appointment.
- Use the DAC Logo and Word Mark on their email and other signatures.

Patient Partners

Who is eligible?

Persons living with diabetes (either with a diagnosis of diabetes, or a family member/caregiver) who are either directly engaged as research team members in DAC POR Programs and Themes, or leaders with the Steering Council and/or Standing Committees of the Steering Council.

How is membership acquired?

The application process requires a statement of interest (maximum 200 words) from the Patient Partner with endorsement by **Researcher** or **Knowledge User** member. The statements should reflect the contributions of the Patient Partner to DAC's mission and vision and outline his/her role as a leader within the Network. Applications are reviewed and approved by the POR Program Committee and communicated to the Steering Council.

Duration of Membership?

Patient Partner members are appointed until the funding term for DAC ends March 31st, 2026 as indicated in their signed agreement. Patient Partner members can resign at any time.

What is the value of Patient Partner membership?

- Networking with researchers, knowledge users, patient partners and trainees with common interest in patient-oriented research in diabetes
- Listing on the DAC Website
- Receives Newsletters and network communications
- Use of the title *Patient Partner Leader in Diabetes Action Canada* for the term of their appointment.

Trainee

Who is eligible?

Graduate or health professional students or postdoctoral trainees engaged in research training at a Canadian, Tri-Council eligible university, academic hospital or research institute in diabetes-related

research (basic, clinical, knowledge translation) and interested in contributing to the mission and vision of DAC. For students or postdoctoral trainees outside of Canada, research must be conducted at an internationally recognized research-intensive university and/or academic hospital or research institute. DAC Research members must supervise trainee members.

How is membership acquired?

The nominating Researcher member can recommend Trainee members to DAC. A statement (maximum 150 words), prepared by the nominating Researcher member, is required outlining the capacity building opportunity and the individual's potential to contribute to DAC's mission and vision. An updated summary CV that provides research interests and academic status of the individual is also required. Applications are reviewed and approved by the POR Program Committee. The final decision for membership is communicated to the Steering Council.

Duration of Membership?

Trainee members are appointed until their research projects with DAC are completed, or the funding term for DAC ends March 31st, 2026 as indicated in their signed agreement. If a Trainee member graduates from their position at their current academic institution and does not remain in academia, their membership with DAC is terminated. If the Trainee member secures an independent research position at an academic institution, their membership can be reclassified to Researcher member, with a letter of attestation about continued interest. Reclassifications are approved by the POR Program Committee and decisions are communication to the Steering Council.

What is the value of Trainee membership?

- Networking with researchers, patient partners and trainees with common interest in patient-oriented research in diabetes
- Listing on the DAC Website
- Receives Newsletters and network communications
- Use of the title *Trainee in Diabetes Action Canada* for the term of their appointment.

Patient Partner Engagement

DAC aspires to engage Patient Partners meaningfully in all of its activities. At the outset of identifying research questions, planning projects and as ongoing projects evolve, it is expected that our research teams will include Patient Partners throughout these activities, with the assistance of our Patient Engagement Theme leaders and staff, as necessary. Since our research projects and Network activities must all address health or health-related challenges articulated by Patient Partners, the first phase of every project should begin with Patient Partner articulation of the health challenges they experience and the research questions that arise based on these needs. Patient Partners should be part of the

ongoing advisory and monitoring process as well as the reporting of outcomes. The DAC Steering Council Standing Committees on Patient Engagement and EDI will assume the role of monitoring and evaluating the success of Patient Engagement in all DAC activities and will report quarterly to the Steering Council. Guided by the Collective Patient and Indigenous Circles, the Steering Council will provide oversight and guidance about how to continually improve Patient Engagement.

Patient-Oriented Research Training Required

To assure knowledge and understanding of meaningful patient engagement, all members of DAC are required to complete a patient-oriented research workshop training program that is provided either by DAC or another element of the SPOR program. The DAC Administrative Team will assist in the arrangements for the training and track the completion.

4.1. Policy for SPOR Network Strategic Partner Relations

Framework for Private and Public Sector Partnerships

The Vision of our SPOR Network is to enable the transformation of health outcomes for all Canadians with diabetes. We will accomplish this by aligning collaborative research performed upstream with what patients and their health professional care providers perceive as most urgent to prevent and effectively treat diabetes complications. We have identified goals that will uniquely position our investigators to network their activities across disciplines and provincial boundaries. The outcomes of these strategic basic, clinical research, knowledge translation, training and patient-engagement efforts will facilitate the scale-up of new and effective interventions to prevent and treat the complications of diabetes (retinopathy, nephropathy, neuropathy and cardiac disease) using precision diagnostic and therapeutic interventions. Transformative change of clinical care will rely on novel technologies to monitor and promote patient-empowered self-care. We must translate patient-centered knowledge into customized clinical care models that will include targeted therapies for diabetes complications.

To accomplish effective and timely translation of new knowledge into clinical practice it is essential that the SPOR Network partner strategically with stakeholders in both public and private sectors. The testing and scale up of new diagnostic and therapeutic interventions will require co-investment including from for-profit corporations, that share our vision and mission over the next 5 years. Co-investment may range from direct funding of research projects, e.g., new diagnostic or drug discovery for one or more diabetes complications, to provision of infrastructure such as equipment or services, e.g., telecommunications for patient data

acquisition. In addition, the SPOR Network welcomes philanthropic support of researchers, students or specific research programs.

Depending on the negotiated arrangement, the co-investment by a private or public Strategic partner may be arranged:

- directly with the SPOR Network through a Memorandum of Understanding agreement with the Co-Leads and Steering Council (Governance body for the SPOR Network):
- through either an industry contract with a SPOR Network partner academic or health care institution (University or university –affiliated research hospital) for a SPOR Network investigator; or,
- by a standard donor agreement with a partner institution (University or Hospital Foundation).

Purpose of the Policy for SPOR Network Strategic Partner Relations

The purpose of this Policy is to reflect the framework for relationships between public and private strategic partners and Diabetes Action Canada - the SPOR Network in Diabetes and Its Related Complications. This Policy focuses on protecting the integrity of the SPOR Network’s name, brand, and reputation, while enabling productive relationships that further the mission and goals of the SPOR Network. For the purpose of this Policy, a corporation is broadly defined as:

- limited companies (those that are incorporated), including publicly traded and non-public corporations;
- sole proprietorships;
- partnerships;
- crown corporations;
- non-governmental organizations or not-for-profit organizations; or,
- foundations formed to carry out philanthropic activities on behalf of a national corporation.

Procedures for Entering into Relationships with Public and Private Strategic Partners

The SPOR Network will undertake a risk assessment of each potential relationship with a strategic partner to determine if the Network’s reputation could be adversely affected. The SPOR Network will also assess the potential impact of the relationship in achieving the overall goals of the SPOR Network. These assessments will be conducted by the SPOR Network Steering Council with advice from the Operations/Management Committee in collaboration with the host academic institution (University Health Network). Any relationship developed with a corporation may not contravene SPOR Network procedures, organizational rules or

policies. Any real or perceived conflict of interest with potential public or private strategic partners must be declared by the members of the Steering Council and Operations/Management Committee in advance of the assessment process and on an ongoing basis according to the Policy on Conflict of Interest. The terms of agreement between the SPOR Network and Strategic Partners will include, among other things, procedures about “use of name” including logos and word marks of both parties.

Endorsement

The SPOR Network will not typically endorse a commercial product or service. An “endorsement” is an explicit statement of approval that gives direct support for a product or service, its claims and its properties. If endorsement is to be considered, the Steering Council must first evaluate the product or service with advice from the Operations/Management Committee. Since the general public perceives close linkage among the terms “endorsed”, “recommended”, and “approved” the SPOR Network will consider these as synonymous.

Exclusivity

Whenever possible and feasible, the SPOR Network will seek funding for initiatives from a variety of strategic partners. It is understood that occasions may arise where a sole strategic partner is appropriate. However, the SPOR Network will not enter into relationships that involve agreements of total exclusivity that would restrict interested competing strategic partners from working with the SPOR Network on other initiatives.

Content Control

The SPOR Network will, as appropriate, maintain content control and/or approve the content of all information and health promotion resources resulting from strategic partner relationships including the use of the SPOR Network brand (logo and word mark) and trademarks. The SPOR Network will use disclaimers as necessary on all such information and health promotion resources.

Role of Strategic Partners in the SPOR Network

Those NGOs that have been recognized by the CIHR SPOR Program as relevant representatives for patients (Diabetes Canada and the Juvenile Diabetes Research Foundation) may have representation on the highest level of governance for the SPOR Network (the Steering Council)

with voting privileges. Since these NGOs have also contributed revenues (matching funds) to the SPOR Network for projects conducted by the SPOR Network, they are also Strategic Partners. Therefore, these NGOs are considered “*Patient Representative Strategic Partners*”.

Role of SPOR Network Representatives in Strategic Partner corporations

SPOR Network staff or members may at their own discretion act in an advisory capacity to strategic partners. However, in acting in that capacity, they shall not represent the SPOR Network unless pre-approved by the SPOR Network Steering Council. The individual shall provide an oral or written disclaimer (as appropriate) to the corporation stating that the views expressed are his/her own, and not those of the SPOR Network.

5. CONFIDENTIALITY POLICY & AGREEMENT

Members of the Steering Council and its Standing Committees, the Co-Scientific Leads, and ex-officio members on the Steering Council and its Standing Committees are requested to sign a Confidentiality Agreement annually.

CONFIDENTIALITY POLICY & AGREEMENT

As a member of the Steering Council or one of its Standing Committees, I recognize that I owe a duty of confidentiality to Diabetes Action Canada. All information and documentation pertaining to research activities, public and private sector relationships and emerging intellectual property of investigators or institutions that I receive from Diabetes Action Canada and others in connection with my service on the Steering Council or one of its Standing Committees will be treated with strict confidentiality. This information may include personal information related to people living with diabetes who serve on the Steering Council, its Standing Committees or the Patient Councils of Diabetes Action Canada. Neither the contents nor the existence of this information or documentation will be shared with anyone other than the Scientific Officers, Members of the Steering Council, employees and authorized agents of Diabetes Action Canada.

It is, however, understood that our corporate partners have a duty to report on the exchanges taking place at the stakeholders table. This Confidentiality Agreement therefore would not limit their ability to do so with a restricted number of people in the respective organization, so that key internal stakeholders can appreciate the efforts and progression of the Diabetes Action Canada project and justify the continued financial investments. Notwithstanding the above, there may be instances when information must remain strictly confidential and should not be disclosed to anyone outside of the Diabetes Action Canada Committee or Council. I will direct any questions regarding confidentiality obligations to the Chair of the Diabetes Action Canada Steering Council or the Executive Director.

I agree that my selection to serve on the Steering Council or one of its Standing Committees constitutes good and valuable consideration for entering into this agreement, the receipt and sufficiency of which I hereby acknowledge. I agree that this agreement continues to apply for a period of **12 months** from the effective date of cessation of my participation on the Steering Council or Standing Committee.

Signature: _____

Name: _____

Date: _____

6. CONFLICT OF INTEREST POLICY AND AGREEMENT

DIABETES ACTION CANADA - CONFLICT OF INTEREST POLICY

Objective:

Diabetes Action Canada must meet high ethical standards in order to merit the trust of partners and volunteers, as well as sponsors, donors, governments and the public. The integrity of Diabetes Action Canada depends on ethical behaviour throughout the organization, and in particular on fair, well-informed decision-making. The ability to make a decision is sometimes affected by other interests (personal or professional) of individuals in the organization. Such conflict of interest situations are a regular part of organizational and personal life and cannot simply be eliminated. The objective of this policy is to permit Diabetes Action Canada to manage real or perceived conflict of interest situations successfully and resolve them fairly.

Scope:

This policy applies to all members of the Steering Council, Investigators, Students and Trainees and all staff of Diabetes Action Canada. It also applies to volunteers and Patient Partners, but formal procedures should take into account their particular circumstances. Collectively, these groups are called “affected persons” below. Partner organizations are encouraged to establish similar policies, if not already in place, for themselves.

Definition of Conflict of Interest:

A **Conflict of interest** is a situation in which a person has a private or personal interest sufficient to appear to influence the objective exercise of his or her official duties at Diabetes Action Canada.

“**Private or Personal Interest**” refers to an individual’s self-interest (e.g., to achieve financial profit or avoid loss, or to gain another special advantage or avoid disadvantages); the interests of the individual’s immediate family or business partners or their interests of another organization in which the individual holds a position (voluntary or paid).

“**Objective exercise of duties**” refers to an individual’s ability to carry out her or his responsibilities in the best interest of Diabetes Action Canada.

Types of Conflict:

A Steering Council member, Investigator, Trainee, Staff, Patient Partner or volunteer of Diabetes Action Canada may be in a conflict of interest situation that is:

1. **Actual or real**, where official duties are or will be influenced by private interests;
2. **Perceived or apparent**, where official duties appear to be influenced by private interests; and,
3. **Foreseeable or potential**, where official duties may be influenced in the future by private interests.

Examples of Conflict of Interest:

[See Appendix 1 for some categories of conflict situations, as well as Appendix 2 for some longer scenarios.]

Responsibilities:

Overall Responsibility

Members of the Steering Council, Investigators, Trainees Staff, Patient Partners and volunteers are responsible for managing conflict of interest situations in order to ensure that workplace behaviour and decision-making throughout are not influenced by conflicting interests.

Responsibility for Prevention

Diabetes Action Canada supports an organizational culture in which people freely take responsibility for both “self-declaring” possible conflicts of interest, and respectfully raising possible conflicts faced by others in the organization. This culture makes it possible to avoid many such situations from arising in the first place. Staff, volunteers and Steering Council members have the responsibility to implement practical preventive measures, such as:

- Providing education about what to do when gifts and hospitality are offered;
- Providing meeting agendas in advance to enable participants to foresee possible conflicts;

- Ensuring that people are clearly told when information must be protected from improper use;
- Declining involvement in action (such as supporting a questionable outside activity)

Responsibility for Managing

Where prevention is not the solution, conflict of interest situations must be managed. Here are the steps to be taken by those involved in such situations, working together and supporting one another's ethical responsibilities.

1. **Declare it.** Ensure transparency by self-declaration, and by making sure that a record of the declaration is made.
2. **Discuss it.** In a doubtful situation, take a moment for a quick word with the chair of your meeting, or undertake a full dialogue with the group, if the situation warrants it.
3. **Deal with it.** Measures to mitigate or eliminate a conflict of interest will depend on what is appropriate to the severity of the situation. Options include:
 - a. **Restrict the involvement of the individuals.** For example, withdraw from decision-making. This would not be appropriate if the conflict of interest arises frequently, or if the individual cannot be separated from parts of the activity.
 - b. **Recruit a third part to assist.** For example, ask a disinterested party to sit on a hiring board. There will be situations where no appropriate third party is available.
 - c. **Remove the individual from affected duties.** When restrict and recruit are not suitable options, the individual with the conflict may be removed from duties related to the conflict. The individual could transfer to other duties.
 - d. **Relinquish the private interest.** In cases of serious conflict, the individual may choose to drop the private interest, such as membership on the Board of another organization, which is causing the conflict.
 - e. **Resign from the official duties.** In serious cases where other solutions are not possible, the individual may have to resign from the position creating the conflict.
4. **Document what has been done.** Steering Council minutes, correspondence to interested parties, or other documentation will provide a record of steps taken.

Policy Application:

1. This policy must be explained to all new Steering Council members, Investigators, Students, Trainees, Patient Partners and volunteers. All such affected persons must agree in writing, at the outset of taking a position or volunteering with Diabetes Action Canada, that they will abide by this policy.
2. Investigators, Students and Trainees are expected to adhere to the Codes of Conduct and Conflict of Interest Policies of their institutions.
3. At that time, Steering Council members and staff must disclose possible conflict situations to the Executive Director (or Steering Council Chair if appropriate) in confidence. Subsequent material changes must be disclosed when they first emerge. Volunteers and Patient Partners must inform their coordinator and Patient Engagement Project Coordinator respectively of possible conflict situations.
4. The Executive Director (or Steering Council Chair if appropriate) will indicate to each individual whether any further action is necessary to manage the possible conflicts of interest disclosed. Actions might include the following, depending on the severity of the conflict:
 - a. Declaring the conflict to all concerned before discussion or decision-making;
 - b. Withdrawing from final decision-making only;
 - c. Withdrawing from all aspects of discussion and decision-making.
5. The Executive Director (or Steering Council Chair if appropriate) is also the final authority on resolving disputes for example when an individual does not agree with the perception that he or she is facing a conflict of interest.
6. The Executive Director (or Steering Council Chair if appropriate) is the authority on dealing with real conflicts of interest which are discovered “after the fact”. A variety of serious measures, such as cancelling a contract or hiring decision, may have to be considered, case by case, in such situations.

For the purposes of this policy, the Steering Council Chair is the appropriate authority in all matters related to the affairs of the Steering Council, and to any issues involving the Executive Director’s own affairs. Any issues involving the Steering Council Chair’s own affairs will be dealt with by the Steering Council Vice-Chair and the Steering Council. The Executive Director is the authority in all other matters.

Transparency:

The application of this policy involves two types of transparency:

1. **Confidential Disclosure:** Affected persons must provide information on possible conflicts of interest and related matters to the Executive Director (or Steering Council Chair if appropriate). This information will be kept strictly confidential.
2. **Declaration to Concerned Parties:** If the Executive Director (or Steering Council Chair if appropriate) deems that a particular element of information on a possible conflict of interest must be provided to a wider audience of concerned parties (such as the members of a committee or the Steering Council, or the public at large), then a declaration of the conflict of interest situation will be made and recorded. The person involved should be consulted prior to the wider declaration.
3. Staff may not use their Diabetes Action Canada title when providing public statements that are unrelated to official Diabetes Action Canada business and they should clearly state that the opinion they are expressing reflects their own private opinion and does not reflect the policy of their employer organization.
4. Investigators and patient partners should clearly state that the opinion they are expressing reflects their own private opinion and does not reflect the policy of Diabetes Action Canada.

Good Judgement

The application of this policy relies heavily on the good judgment and common sense of those affected, following the ethical principles outline in the CIHR Code of Conduct

www.cihr-irsc.gc.ca/e/41722.html, and the University of Toronto Policy on Conflict of Interest Academic Staff

www.governingcouncil.utoronto/Assets/Governing+Council+Digital+Assets/Policies/ppjun221994.pdf

Accountability

Every member of staff is responsible for his or her own conflict of interest situation:

1. Awareness of the policy;
2. Self-declaring potential problems to superior;
3. Respectfully identifying potential problems of other staff members;
4. Undertaking follow-up action determined by the Executive Director; and,
5. Making disclosures when circumstances change significantly.

Volunteers and Patient Partners are responsible for respecting this policy. They should take any questions in this regard to their coordinator and the Patient Engagement Project Coordinator. **Coordinators of volunteers and Patient Partners** will apply the policy to them under the general direction of the Executive Director.

The **Executive Director** is responsible for the ongoing application of the policy and procedures to staff. The Executive Director will:

1. Provide a point of contact for advice about conflict of interest matters;
2. Determine the actions required as a result of confidential disclosures by staff;
3. Receive complaints about possible breaches of the policy;
4. Determine the actions required by breaches of the policy; and,
5. Make annual reports on the overall situation of conflict of interest of Investigators, Students and Trainees, staff, Patient Partners and volunteers to the Steering Council.

The Executive Director's own conflict of interest situation is the responsibility of the Steering Council Chair.

The **Steering Council Chair** is the key person to establish the ethical climate for Diabetes Action Canada and its Steering Council, and for ongoing attention to conflict of interest issues on the Steering Council. The Chair is also responsible for resolution of conflict of interest situation, and related disputes, among members of the Steering Council.

The **Steering Council Vice-Chair** will, together with the Steering Council, deal with the Steering Council Chair's own conflict of interest situation.

The **Steering Council** bears great responsibility for the good name of the organization and as such has a special responsibility for ethical matters. The Steering Council is also ultimately responsible for policy and should review of the conflict of interest policy every 5 years, or when the nature of the organization changes significantly.

Appendix 1: Some Categories of Conflict of Interest Situations

- **Self-interested funding, contracting or hiring:** when an affected person uses a position in Diabetes Action Canada to influence a decision to provide function or contracts to another organization in which he or she has an interest, or to go outside normal hiring processes to give a job to a friend or family member
- **Improper influence:** when an affected person solicits or accepts some form of benefit in return for influencing Diabetes Action Canada activities or promoting someone else's interests in Diabetes Action Canada
- **Misuse of information or property:** when an affected person uses information or property to which the person has access at work, and to which others would not have access, for some personal benefit
- **Inappropriate outside activity:** when an affected person's activities outside Diabetes Action Canada are in conflict with the interests of Diabetes Action Canada
- **Accepting undue benefits:** such as significant gifts which place an affected person under obligation to the donor

Appendix 2: Some Possible Scenarios

The scenarios below illustrate the application of the policy, showing the kinds of judgments, values and measure involved.

- **Gifts** – People in partner organizations and communities frequently offer gifts that it would be impolite to refuse. It is important to distinguish gifts and favours that represent goodwill and friendship from those that are designed to create an indebtedness on the part of the recipient. A conflict of interest may also arise when gifts are larger than a normal token in a given situation. Key ethical principles in resolving the situation are **integrity** (i.e. action in line with our policy and values), **transparency** (including honesty in discussing the issue), and **respect** (for the gift giver). A possible action would be to explain that policy will only allow the gift to be accepted on behalf of the organization. If there is an appearance of indebtedness, it may be necessary to respectfully decline the gift.
- **Network members involved in funding and decisions** – The terms of reference for a coalition should state clearly that the first duty of the coalition’s Steering Council members is to the coalition. When the coalition members provide funding and are active in decisions about programs, there is a possibility of conflicts arising between the interests of the coalition and the members’ own organizations. Such conflict situations must be **declared** and discussed by the Steering Council. Then, depending on the extent of the possible conflict, the Steering Council will decide to what sort of **restrictions** should be placed on the concerned individual in discussions and decisions. The resolution of the issue should be **documented** in the minutes.
- **Awards committees** – Members of awards committees are in a similar situation to the coalition members described above, but the situation is even more serious because they are making decisions about the disbursement of funds. In addition to **declaring** conflicts, and **removing** themselves from the awards process as it relates to their home organization, members of such committees must remove themselves from the application process in their **home organization**. They may also have to **recruit** someone else to undertake some of the duties they cannot fulfill as a result.