



## Key elements to the Indigenous Diabetic Foot Project

Jason Warnock, Honorary Program Manager IDFP

Today, SARRAH has a business that is self-sustaining. It is required to stand on its own feet for its survival. It sells products and services to health organisations and health professionals. It gains some administrative support from the SARRAH office but not to the extent that it is a burden to the organisation.

The business is the Indigenous Diabetic Foot Program [SARRAH], IDFP for short.

This program has evolved from the Rural Health Support, Education and Training [RHSET] project, “An educational tool to assist with the identification and management of the Indigenous diabetic foot”. This project, for which I was the project manager and author, was conducted from 1st November 2003 and concluded on 30th October 2005. The IDF project produced an interactive CD ROM as the educational tool—and developed and conducted a workshop format to introduce the tool to rural podiatrists, Indigenous Health Workers and other health professionals.

SARRAH was able to provide some membership funding to have additional resources developed—this included two posters, a screening form, a video, and an educational card set in a flip chart format. This funding has been repaid to the membership fund from the sale of resources and from workshop activities.

Today, my role in the IDF Program is that of an Honorary Program Manager and I am responsible for administering, promoting, and co-ordinating the program.

I thank and acknowledge the AG Department of Health and Ageing and RHSET for providing the initial funding for the project and for their support and drive for the project to become sustainable.

The IDF program itself provides a model on which SARRAH can perhaps develop other self sustaining businesses. The IDF program could also be a model for other allied health professionals to develop their ideas into a product. This presentation today will outline how the IDF came about and what the key elements to its success as I saw it.

The Need. The IDF project was required as there was very little information available that was targeted to diabetes and feet. There was significantly less resources available for Indigenous people.

When the resources that were available were reviewed, they were found to be:

- ▷ lacking in positive messages about diabetes and feet
- ▷ lacking in the range of information from prevention to complications
- ▷ lacking in culturally sensitivity—for example the resource may have talked of foot conditions of Indigenous people and then had accompanying photos of non-indigenous feet
- ▷ lacking in culturally inclusiveness—for example the resource may have depicted the Aboriginal flag on the resource which may have excluded the Torres Strait Islander population or used a regional descriptive name like “Koori” that is not recognised nationally
- ▷ lacking in Visual or Graphical images to tell the message—and typically were too wordy in their format
- ▷ lacking in Quality of production— for example poor clarity of photography and poor quality of the paper for the resources.

Why bother at all?

Because it is serious, foot complications make an impact on people’s quality of life, they cost governments considerable health dollars, and most importantly serious foot complications can be prevented.

- ▷ FACT: The most common cause for a person with diabetes to be admitted to hospital is due to a foot complication!
- ▷ FACT: There is an estimated 1 million amputations per year, worldwide, that is one every 30 seconds





- ▷ FACT: Most diabetic foot amputations are preventable
- ▷ FACT: Foot care intervention makes an impact on the reduction of diabetic foot amputations
- ▷ FACT: Podiatrists are a scarce resource, and access to podiatry services in regional, rural and remote areas of Australia is often difficult
- ▷ FACT: There needs to more effective and appropriate use of podiatry services when they are provided

The IDFP tries to address these facts.

The abstract for this paper suggested that I would be talking about the top 20 elements that were imperative for the success of this project. You will be able to choose your top 20 as there will be plenty to choose from.

To briefly explain the 'invitation' it was as if all the planets of the universe were lining up to make the project happen.

- ▷ The Indigenous Health Worker who I worked with at Palm Island had been pestering me about the need for resources to do with diabetic feet
- ▷ I was getting calls from regional publicly based podiatrists saying "... As part of my job I'm to go to the local Aboriginal community. I am really interested in going but what am I going to do, how will I interact with the Health Worker and the community?"
- ▷ I got a call from a Western Australian podiatrist saying that she, her husband and her family were going bush for a year or so and had got jobs in a remote Aboriginal community. What was she likely to encounter and how was she going to be effective in this community?
- ▷ SARRAH had notified the membership that RHSET had advertised a funding round for project work, and that the key areas for funding seemed to fit in with my interests!
- ▷ I saw a client in my private practice who had been the Allied Health Co-ordinator for the NQ Rural Health Training Unit. Over the management of her foot condition, she was interested to learn of the new funding round for RHSET and that I was thinking of applying. Without hesitation the offer was made by the client to assist with writing the application. This was one of her roles which she enjoyed and did regularly in her Allied Health Co-ordinator role.

It was meant to be!

The experience of being born in a small rural town, of going to the local school, of living and playing with Aboriginal and Torres Strait Islander kids every day and week of the year, of coming from a family that was immersed in health issues [my Dad was a doctor, my mum a nurse] does have an impact on me and my attitudes towards providing my health services. As soon as I graduated, I left Brisbane to return to the north, and have spent all my 25 years of my professional career based in Townsville.

Part of that included providing the first visiting podiatry service to rural towns within a two hour drive from Townsville. In 1996, I was fortunate to be contracted by Qld Health to undertake a Demonstration project to the Indigenous communities and towns in the Gulf of Carpentaria region and those surrounding Mount Isa.

For the past 12 years, I have provided a monthly visiting service to the Palm Island community.

'Being there and done that' helps the success of a project such as the IDF project. During my time, I have attempted many versions of the resources for the Indigenous diabetic foot.

The failure of these versions has been instrumental in providing the better way forward the next time. The successes of these versions have encouraged confidence and maintained the energy for further development.

The experiences of working in Indigenous communities for an extended period of time are also an element to success. The frustrations and joys, the successes and failures, the people and the places—all add to the knowledge of what makes a project such as the IDF project work!

Something has to happen to make 'the thought' to develop into 'action'.





Motivation and a desire to make the change is an essential key element. The Podiatry profession no longer saw the need to be so protective of its patch, or that's how I saw it. There was a growing acceptance that we were the most appropriate health professionals to manage foot conditions and that we were an accepted part of the multi-disciplinary health team. From this acceptance grew the confidence to be flexible with our competencies and to encourage other health professionals and health workers to assist with the management of the foot. This factor and the emergence of national clinical guidelines and pathways, with diabetes management an easy example, saw the role of allied health including podiatry as part of these management plans.

Podiatry positions seemed to be getting created in more remote areas, and getting filled. Examples being: Mount Isa via the NWQPHC Association, Thursday Island, Kalgoorlie, Broome and Katherine. Podiatry was in the grips of change and the IDF project became reality in this environment.

For me, 'the big nudge' was an article that appeared in the Australian Journal of Rural Health from the Northern Territory regarding the development of a flip chart for Indigenous diabetic feet. I was pleased to read how this all came about however disappointed that there was no podiatry input into the process. It was fine to share competencies but not to give them away? [as this was my instinctive response to this article]. Contact was made with the authors offering the podiatry network within SARRAH as a good way of providing input into future processes, and an order was placed for the flip chart. On receipt of the flip chart, I was inspired to do something ... the resource was not what I expected or desired.

SARRAH during this time was building a relationship with the AG DoHA. With the SARRAH secretariat in place and getting more credibility with the Department, SARRAH was more capable of auspicing a RHSET project. The Commonwealth was also forcing allied health changes through policy changes, with the 'More Allied Health Services' program, Regional Health Services funding, the Medicare Enhanced Primary Care program and later the Medicare Plus funding for the five allied health visits.

Meanwhile with my practice, challenges were occurring, as I was unable to recruit professional staff. I was forced to close my rural outreach services and to restructure my workload. It was during this low point that I wrote the application for RHSET.

These four major elements made it right for the IDF project to get the start it required.

These four elements would be essential to ignite other opportunities

- ▷ You have to have the proposal that others are excited about and that are being targeted at that time
- ▷ You need to be the driver of the project—you write the proposal from your experiences and knowledge—and you need to be able to carry it through to completion
- ▷ You need to have your levers pushed to make you the one to 'do' the change. You need to have the support of your peers and the host organisation needs to have effective credibility with the funder
- ▷ The project needs to occur when your request is in sequence with the funder so that you are travelling with the flow and not against the tide—the time has to be right for all the players involved.

The SARRAH Strategic Plan 2004–2009 states:

The articulation of the fundamental values that distinguishes SARRAH as an organisation ... [is the] articulation of values we call **"our" perspective**.

"our" perspective stems from values such as:

- Inclusiveness
- Fairness
- Equity
- Advocacy
- Respect





SARRAH provides individual rural and remote allied health professionals with opportunities to inform and influence by contributing “*our*” perspective to policy and planning processes that govern service delivery to rural and remote communities with the ultimate goal being enhanced community health outcomes.

“*Our*” perspective is demonstrated by qualities such as:

- Valuing the individual grass roots allied health professional
- Consultation
- Achievement orientation
- Connectedness to community
- Can-do attitude

This special SARRAH perspective underpinned and provided the values and qualities to the project. This helped to provide a clear direction and quality for the project. This is what made the IDF project clearly a SARRAH project.

Consultation with the people you are trying to assist is essential.

The IDF project was charged with the responsibility of providing an educational tool aimed at the broader workforce. The tool would provide podiatry-type information about diabetic foot care to the multi-disciplinary team—doctors, nurses, health workers, allied health professionals and other health professionals.

The conference theme of ‘Building Bridges—Crossing Borders’ is perfect for this presentation as the project goal was all about building bridges across professions to enable an impact on the incidence of foot ulceration and amputation.

Some of the information was more directed towards the Indigenous Health Workers and close connection with this group was required to ensure uptake and appropriateness of the information. The Palm Island Health Worker team provided this connection on my monthly visits. The review of existing resources was conducted with the Palm Island Health Worker team and with the diabetic support group at TAIHS [Townsville Aboriginal and Islander Health Service]. The feedback provided me with direction for the resources, what the people with diabetes related to, the messages they identified from posters and pamphlets and the benefits from various forms of media presented.

Consideration of the how the broader health professions might accept foot health information was often contemplated. Care was taken not to be seen to burden others to take on additional workload, but to recognise that what was being asked could be opportunistically part of their assessment, part of their care for that person and to consider the overall health for that person.

The Alice Springs SARRAH conference provided the opportunity to showcase the ‘works in progress to a completely different setting. The views of the eastern Arnhem Land representatives were most appreciated. These aboriginal people were attending the conference as part of the Interpreter Service presentation and forced me to look at the way in which information is delivered to people who might not have English as a first, second or third language. The importance of telling the whole story of the effect that diabetes could have on the body and the lifestyle of the person was realised. I was able to go back home and write the complications of the diabetic foot section, and used the film previously taken on Palm Island and Charters Towers to demonstrate the impact on two people’s lives, ‘Steve’ and ‘Billy’.

Many communities have their own issues and difficulties related to delivery of health services and in particular providing foot care services. The consultations made me aware that a mail order service for the resources would not guarantee effective use of the IDF educational tool. There was a need to workshop the information to enable better use of the resources and to encourage a better understanding of what could be expected and achieved.

The IDF workshops work with each organisation or community and try to identify a way forward to find local solutions. The platform for the project is to increase the confidence of people to be able to undertake daily foot care activities. The workshops provide a mechanism for understanding the steps for self care to all health workers so that these skills can be transferred to people with diabetes. The resources themselves would not provide sufficient information or strategies.





Indigenous Health Workers are well placed to be able to provide this information to their people. There is a little equipment required:

- ▷ a container to bathe the feet in eg a bucket
- ▷ water, soap and a cloth to wash the feet
- ▷ a dry cloth to dry the feet
- ▷ a 'sanding block' to apply to thick skin
- ▷ some cream to apply to dry skin
- ▷ some form of footwear to protect the feet from injury.

However, this needs to be accompanied with some quality information to ensure the person is not setup to fail. What sort of information? How do I obtain the equipment? How hot should the water be? How long can I soak the feet for? What can I use as a sanding block? What sort of cream? Where would I get some cream? Are thongs okay?

These questions and others are considered at the IDF workshop. The facilitator's role here is to assist with the identification of the local solutions and to ensure safe practices are encouraged. The process of merging the resources and workshop delivery is essential for the greater understanding of early identification and management of the Indigenous diabetic foot.

The workshop introduces the screening of diabetic feet and to assess the risk status of diabetic foot complications. The project developed the DART chart [Diabetic foot Assessment of Risk Test]—an easy to use form to record the screening information. All members of the health team should be able to identify high risk feet. This enables a management and referral process, which may or may not involve podiatry. For communities that do not have access to podiatry it is a way of identifying the unmet need for podiatry services to the community. This would provide evidence for podiatry services and good ammunition to provide argument to the funders.

I recall the late Puggy Hunter's address to a National Rural Health Conference where he was critical of the segmentation of health into body parts rather than considering the whole of life approach to health. He identified that body parts do not get sick in isolation so why did health services get delivered in this manner. He was reflecting on such practices as "heart health, eye clinic, kidney disease, mental health etc"

With this in mind and taking it to another step I look forward to the day when we can bring the foot back into health practice. Currently, the diabetic foot check is a poorly achieved requirement of the diabetes guidelines for management of diabetes. Clinical audits have repeatedly found that annual foot checks are poorly undertaken. It seems that foot screenings are not considered like other health screenings that are undertaken by health professionals in general. Is there reluctance for health professionals to take blood pressures, body temperature, weight, and blood glucose monitoring? These health screenings are undertaken by many and varied health professionals—so why is there a reluctance to do foot checks?

The IDFP addresses this problem by providing the confidence and competence for Indigenous health workers and other health professionals in Indigenous communities to undertake this task. The screening should only take 5–10 minutes, and be recorded in the clinical notes.

Consideration of the results of the foot check then requires the selection of various pathways for management of the particular risks identified. It is important to use the local human resources available to manage the identified foot risks. This might include podiatrists, however, it will also include Indigenous health workers, nursing, medical and other allied health staff.

The foot care information needed to be delivered in a meaningful manner.

The focus groups involving the Indigenous Health Workers and people with diabetes advised me that the information needed to have minimal text and more dependence on photography and graphics. The Alice Springs conference reminded me that many Indigenous people may not have a good grasp of English—written or spoken. My experience with Aboriginal Health Workers was they were reluctant to provide written information in clinical notes about their work.





The IDF project determined that the CD ROM was the most serviceable vehicle to deliver the information. This was decision was based on the understanding that the CD acted as a 'library' of information:

- ▷ it was possible to provide good quality photography
- ▷ it was possible to provide film and voice-over to tell the information
- ▷ it was possible to provide text information that could be printed
- ▷ it was possible to store PowerPoint presentations to assist with delivery of information to other health professionals
- ▷ it was possible to demonstrate the "how to" functions by video, like;
  - how to complete the DART chart
  - how to take the foot pulses
  - how to use a monofilament to test foot sensation
  - how to do the self care foot care practices
  - what to look for when 'looking for foot conditions'
  - how the podiatrist would use a scalpel to debride hard skin
  - how toenails can be managed
- ▷ it was possible to store the formats of the posters, screening form, card set and other resources in the CD for additional reference

The design of information delivery by a combination of workshop activities, CD ROM, VHS video tapes and print resources—posters, flip chart, stickers, magnets, and screening chart reflects the range of target groups. Which method is the most effective will be the topic of research in the future.

Indigenous health workers and health professionals have a variety of choices to encourage foot care practices in their workplaces and for their community.

I was greatly supported by my rural podiatry colleagues when constructing the detail of each of the CD segments. This started with the self care segment, where I wanted to clearly identify and explain what we were asking people to do when asking them to 'look after their feet'. Twelve different and varied steps were identified to 'looking after your feet' and when these steps were stripped down to specifics it was challenging to gain agreement on how to effectively communicate the information. It was at this early stage of the project that the complexity of the resources was realised. The video format was an effective means of telling and demonstrating the information however if all the detail was included it would be a feature film length rather than the finished product length of approximately 8 minutes. Additional information needed to be provided for those that wanted to see the 'feature film' length content. The "more information" button was added to enable the printing-off the spoken narration text plus additional information.

These colleagues might have been from rural areas with some knowledge and experience of Indigenous communities and Indigenous people, but many of them did not. What they did have was a passion for diabetic feet and the determination to provide information to prevent ulceration, infection and amputation. All this support was e-mail based. The time was right as e-mail made this process quick, efficient and effective. It would not have been possible in 1996.

The National Rural Health Alliance's e-forum similarly provided an effective method of promoting the project and developing an interest in the development of useful tools to tackle the diabetic foot problems. People from all over the country contacted me with the issues facing their organisations in trying to overcome the complexities of the Indigenous diabetic foot. This contact assisted me to keep focused to produce educational tools that would suit many of these circumstances.

The greatest strength of support and drive came from the SARRAH Executive and Management Committees, the Executive Officer, and the membership. SARRAH's geographically spread and multi-disciplinary membership reflected the scope of the impact of the project. SARRAH members repeatedly supported the nature of the project—to provide





other health professionals with the information to assist with the identification and management of the diabetic foot, to develop an understanding of how to effectively refer these people, and to gain more appropriate use of podiatrists when they were available.

To make effective resources required professional and co-operative partners. Local Townsville Company, Grail Films, provided the expertise with filming and producing the content for the resources. Grail had experience working in Communities and with Indigenous people. Grail had the dedication and attention to detail required to review and refine, to review and refine and to review and refine again. Grail Films continues to participate in the development of the Program's resources today.

Boab interaction produced the CD ROM and the first run of the posters, DART chart and Educational Card set. Boab and Grail worked closely together to ensure deadlines were met, that budgets were maintained to, and that the job was completed!

I need to acknowledge the important role of the RHSET secretariat. Ms Grace Tielu was my liaison person within the Department. Ms Tielu received my reports and provided feedback and direction for the sustainability of the project. Her friendly, constructive and timely opinions were always appreciated. I was pleased to think that the reports did not end up in a black hole, but were being read and appreciated. The funder, from my experience, should be doing more than provide the funding. This should not be taken to indicate that I think they should be involved in directing the project however they could compliment and support the project to achieve its goals.

The unsung supporters come from family. Recall that I was short staffed when writing the proposal and this continued through the first 12 months when writing and producing the project. Many late hours and weekends were spent in my study and my wife and children endured my absence and lack of participation in 'their time'. The IDF project belongs to them too.

The IDFP has provided workshops for:

- ▷ 66 podiatrists
- ▷ 90 other health professionals [nurses, allied health professionals, and doctors]
- ▷ 81 Indigenous health workers

The momentum is growing and hopefully the identification and management of the Indigenous diabetic foot is improving as a result.

