Upper Hume
Primary Care Partnership

Foot Health in the Upper Hume Catchment:

A review of the system for foot care

prevention, collaboration and people

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Upper Hume
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EXECUTIVE SUMMARY:

The Upper Hume Primary Care Partnership Access and Equity Coordinator, in conjunction with the PHN and Upper Hume Chronic Care Working Group has undertaken initial mapping of primary health care service provision of foot care (including education programs, podiatry services, and scope of practice in relation to clinical risk levels) in the Upper Hume region, in response to concerns expressed at a number of forums.

The information gathered has identified some key findings:

- The referral pathway for foot health is not clear for consumers or clinicians working in the area.
- The PHN pathways program provides a great opportunity to identify and promote appropriate local pathways for foot care, and the Upper Hume Chronic Care Working Group has the capacity to inform this program about local available services.
- There is currently no outpatient High Risk Foot Clinic available; Albury Wodonga Health's current work to establish a High Risk Foot Clinic can be supported by further work across the system, to create an appropriate referral pathway into this service.
- There is no 'system' approach to the continuum of care (from prevention-Early Intervention-High Risk Foot Clinic) across the catchment.
- There is no clear foot care referral pathway across the continuum of care.
- There is little evidence of inter-disciplinary care.
- There appears to be no assigned leadership in relation to footcare for the Upper Hume catchment.
- There is no consistently understood definition of a 'High Risk Foot' by consumers or health services in the Upper Hume catchment. The National Evidence Based Guideline for the Prevention, Identification and Management of Foot Complications in Diabetes (2011) appears to be the most well accepted guideline for managing HRF complications.
- There is no consistent understanding of the criteria for a 'High Risk Foot Clinic'. There is anecdotal evidence that high numbers of avoidable amputations occur to people from the Upper Hume catchment.
- There is very limited access to early intervention podiatry care for people who fall into the 'intermediate risk' and 'high risk without complication' categories in Albury Wodonga.
- There is no Community Health funding for Podiatry in Towong Shire (RAHT service from AWH exists to service HACC eligible clients).

RECOMMENDATIONS:

As a result of the above findings, the following recommendations were identified, to the Upper Hume Chronic Care Working Group:

- Review available podiatry services across the continuum of care for foot health in the Upper Hume catchment.
- Work with PHN to ensure appropriate information is published on their 'Pathways Program', to enhance awareness of appropriate referral pathways to services based on clinical need and access principles.
- Seek and review data to determine ulceration and amputation rates in UH catchment.
- Identify evidence based models to enhance appropriate service provision and access for all people in the UH catchment requiring foot health intervention.
- Identify where gaps in service provision exist across the catchment and develop recommendations for opportunities to reduce address these gaps across the foot health continuum.
- Work with PHN and other relevant agencies (eg. NADC) to identify clinical governance structure for podiatry care across continuum of risk.
- Establish clinical support groups to enable consistent and accurate information distribution across catchment, and enable access to peer support groups, for consumers.
- AWH to utilise this report to inform application for funding options to support the development of an ongoing, sustainable High Risk Foot Clinic model at AWH.

BACKGROUND:

The Upper Hume Chronic Care Working Group is facilitated by the Upper Hume Primary Care Partnership's (UH PCP) 'Access and Equity Coordinator'. The strategic purpose of this group is 'To facilitate and support, at the local level, the development of initiatives that address actions for Chronic Care system improvements as outlined in the National Strategic Framework for Chronic Conditions (2017) and the Hume Region Chronic Care Strategy 2012-2022" (UH Integrated Chronic Care Working Group Terms of Reference, 2017).'

This group has membership which includes a Primary Health management representative from each of the following:

- Albury Wodonga Health (AWH)
- Albury Wodonga Aboriginal Health Service (AWAHS)
- Albury Wodonga Diabetes Support Group (2x consumer representatives)
- Gateway Health
- Beechworth Health
- Indigo North Health
- Tallangatta Health
- Corryong Health
- Mungabareena Aboriginal Corporation (MAC)

This group provides an opportunity to identify system challenges for chronic care, and develop and implement collaborative responses to these challenges.

The membership allows for all publically funded health services in the UH catchment to contribute to discussion, and priority setting for collaborative work.

In initial brainstorming and discussion about possible priority areas of work for the group 'Early intervention foot care education for people with Diabetes' was identified. A group discussion was able to quickly identify that no such group based educational programs are offered in an ongoing, consistent or coordinated way by any of the agencies represented, in the Upper Hume catchment. Whilst this potential priority area was one of four initially identified, it was identified from the group that it would be the main priority in respect to the fact that it was identified by a consumer on the group (Meeting Minutes, March 2017).

It was also identified that there are multiple disciplines that provide one on one foot care education within individual appointments. Disciplines identified as providing this were:

- Podiatrists
- Diabetes educators
- District nurses

The Albury Wodonga Diabetes Support Group also identified that they coordinate education sessions with specialist speakers, offered in Albury at various times throughout the year. Whilst this service has received positive reviews (as part of PCP collaboration project: Phase 1 consumer engagement component), it is identified that this group is not accessible to all areas or all people with Diabetes in the Upper Hume catchment.

The 'Felt Man' tool, which is an educational tool developed specifically for Aboriginal and Torres Strait Islander communities, has a training program attached, for staff wishing to utilise the tool, and some staff at AWAHS are trained in this program, however specific foot care education utilising this tool is not currently offered.

Other programs for this type of education, which are not delivered/ offered in the UH catchment include:

- The Indigenous Diabetic Foot Program (Jason Warnock)
- Meet your Feet

The OM-G Chronic Care Steering committee invited the UHPCP Executive Officer (EO) in November 2017 to attend their meetings. This group briefly considered at this meeting where and how early intervention occurs in the foot care pathway across the OM-G catchment. It was identified by members of this group that Early Intervention (EI) foot care is a clearly defined crucial area of care, but is not part of the scope of a 'High Risk Foot Clinic', which is concerned with people at high risk of loss of limb or life. Exploration of what EI services are available in the Upper Hume catchment therefore determined as important area of work by UH PCP.

Other contributing opportunities and challenges

- In 2016 AWH received an 'Advanced Practice in Allied Health' grant to establish podiatry services in the acute area of the hospital, to work with medical, nursing and surgical staff to enhance the role of podiatry in the management of people with HRF who are inpatients. The funding was for 12 months and was very successful in demonstrating positive outcomes from podiatric input. As the funding was not ongoing, AWH are now currently developing and presenting business models to consider options for developing a High Risk Foot Clinic through both continuing the current inpatient service and expanding to encompass an outpatient clinic model also.
- The Murray PHN is currently working on localizing their Pathways Program information for various areas, including Podiatry' pathways. Initial review of the Podiatry pathway showed not all services in Upper Hume were listed, and those that were had no information about scope of practice of level of care. The Murray PHN requested to work with the Upper Hume Chronic Care Working Group to gather appropriate and up to date information to ensure they articulate up to date and adequately outline appropriate referral pathways.

UHPCP Participation Guidelines

The Upper Hume Primary Care Partnership supports this work through the UH Chronic Care Working Group, consistent with the UHPCP participation guidelines in the following highlighted areas;

UHPCP will participate in an initiative WHEN:

- It requires multiple organisations to work collaboratively
- It involves collaborative work re-Social Determinants of Health
- The activity will result in system improvement
- It requires advocacy for consumers and community to enable their participation
- By invitation, or initiated by UHPCP.

WHY will UHPCP participate?

- As an impetus for action/collaboration
- If it provides an opportunity to influence an innovative approach
- To enable organisations to look beyond their own 'space' in relation to a specific issue/ challenge
- To utilise the specific skills of UHPCP staff
- To provide a strategic lens to a collaborative approach – a helicopter view
- To build capacity/to enable
- To engage necessary but reluctant organisations

What ROLE might UH PCP play?

- Lead agency
- Consortium member
- Initiator
- Funder/part funder
- Provider of framework/structure
- Backbone organization (as described in the Collective Impact Framework)
- Responsibility for specific component thus capacity building e.g. evaluation
- Capacity Building

And all within the framework of priorities and directions of the Strategic Plan

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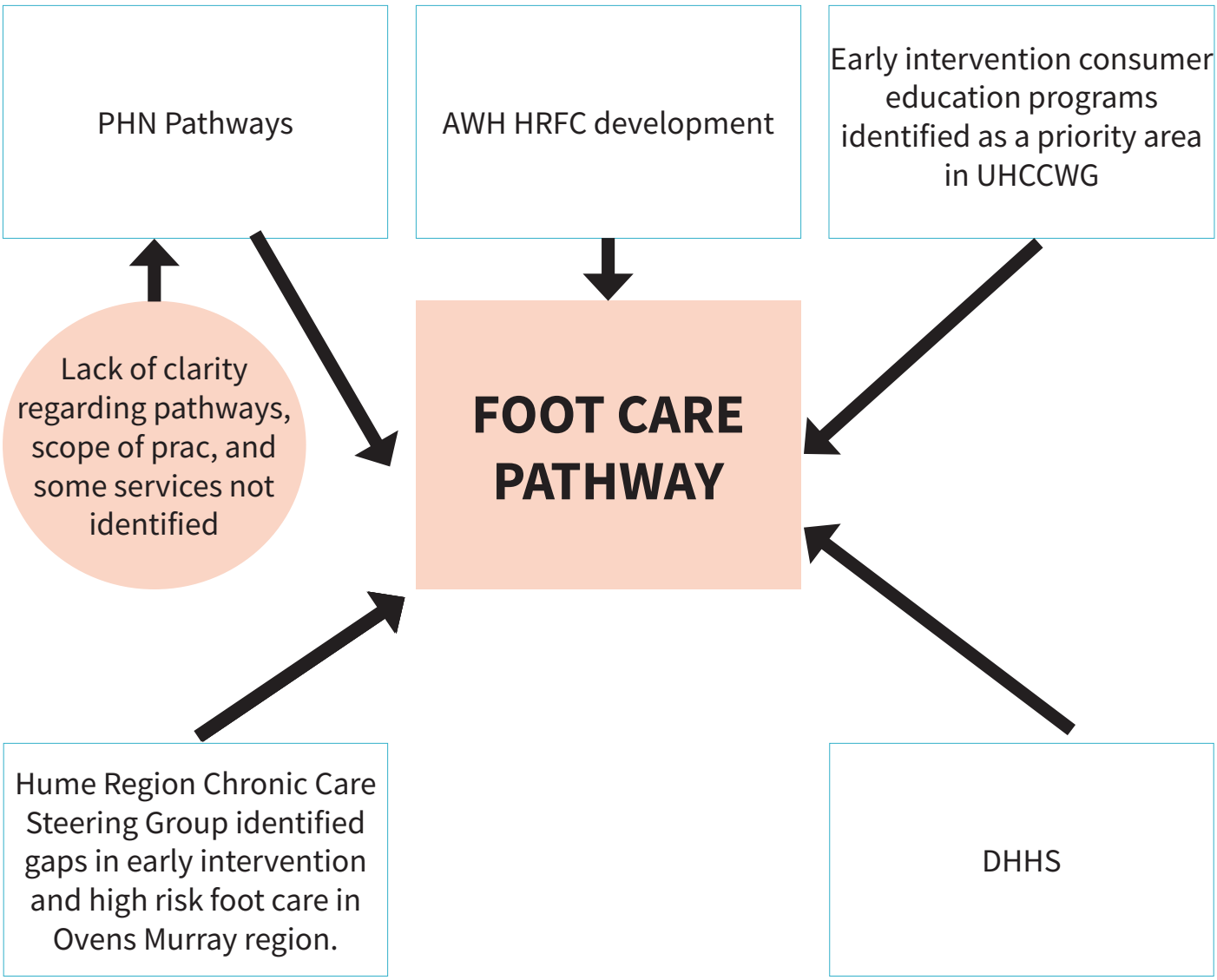

PHN Pathways
AWH HRFC development
Early intervention consumer education programs identified as a priority area in UHCCWG
Lack of clarity regarding pathways, scope of prac, and some services not identified
FOOT CARE PATHWAY
Hume Region Chronic Care Steering Group identified gaps in early intervention and high risk foot care in Ovens Murray region.
DHHS

Initial mapping information for services in Upper Hume

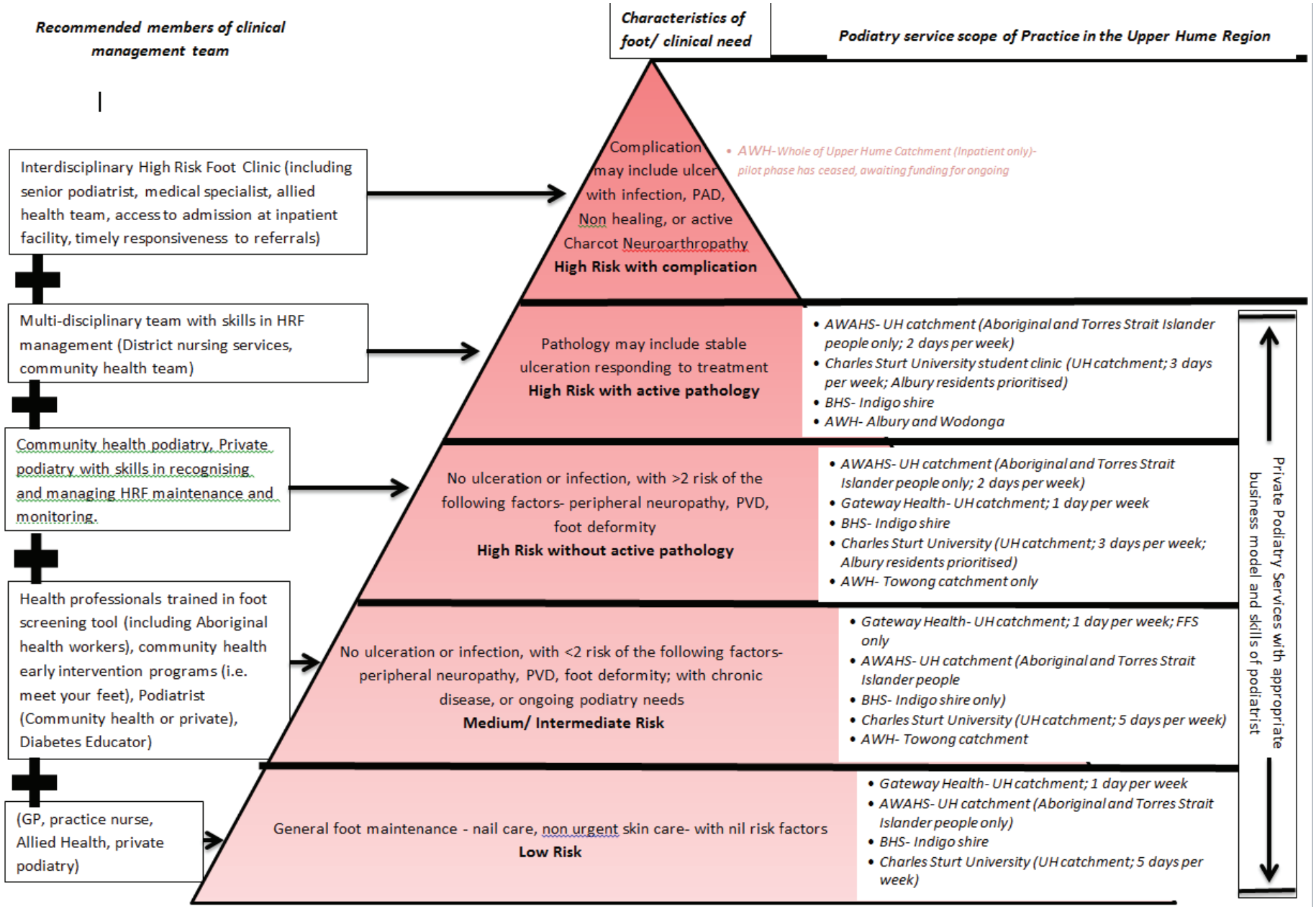
Service	**Clinic available for**	**Information for referrer**	Catchment	Referral process
Beechworth Health Service Podiatry	High risk (urgent): yes- not requiring medical intervention Medium risk (intermediate): yes Low risk (routine): yes	Beechworth - Multi disciplinary allied Health/nursing wound clinic available. $20 charge for low income, $30 for medium, $100 per hour for high. Low income fee variation/waiver available on application for financial distress; nil fee for children <18; Yackandandah - 1 day per month; $20 charge for low income, $30 for medium, $100 per hour for high. Low income fee variation/waiver available on application for financial distress; nil fee for children <18; Chiltern - $9.90 charge for low income, $15 for medium, $100 per hour for high. Low income fee variation/waiver available on application for financial distress; nil fee for children <18; Rutherglen - $9.90 charge for low income, $15 for medium, $100 per hour for high. Low income fee variation/waiver available on application for financial distress; nil fee for children <18; Tangambalanga- $20 charge for low income, $30 for medium, $100 per hour for high. Low income fee variation/waiver available on application for financial distress; nil fee for children <18;	Indigo Shire	All sites - Phone: (03) 57280200 Fax: (03) 57282288 Email: intake@bhs.hume.org.au For high risk/ urgent referrals: (03) 57280200 ask for intake officer (RN can triage urgency).

Service	Clinic available for	Information for referrer	Catchment	Referral process
Gateway Health Podiatry	High risk (urgent): no Medium risk (intermediate): yes Low risk (routine): yes	Wangaratta-low income fee variation available – MAC Referrals – CHSP, HACC & Community Health funding; TCA referrals accepted, private fee paying, DVA & service agreement Wodonga- TCA referrals accepted, private fee paying, DVA & service agreement Myrtleford- low income fee variation available – MAC Referrals – CHSP, HACC & Community Health funding; TCA referrals accepted, private fee paying, DVA & service agreement Bright- low income fee variation available – MAC Referrals – CHSP, HACC & Community Health funding Mansfield- low income fee variation available – MAC Referrals – CHSP, HACC & Community Health funding Benalla- low income fee variation available – MAC Referrals – CHSP, HACC & Community Health funding	Central and Upper Hume regions	Phone: (03) 57232097 Fax: (03) 57222313 Email: AH.Intake@gatewayhealth.org.au
Charles Sturt University Student Podiatry Clinic	High Risk (Urgent): Yes- 3 days per week Medium Risk (intermediate: Yes Low risk (routine): Yes	Supervised student clinic. No referral necessary. When booking appointment let reception know of urgency, and nature of consult. Standard $40 fee (does not include consumable or product costs which are not included but are discussed prior to implementation). Subsidised appointments available for those who meet Eligibility Criteria (Albury residents prioritised for this service)	Upper Hume region for medium and low risk Albury residents prioritised for consumers in high risk category.	Phone/ Fax: 0260519299 Email: ahcrecep@csu.edu.au

Albury Wodonga Health Podiatry	High risk (urgent): yes- 72 hour triaged response Medium risk (intermediate): yes Low risk (routine): no	Wod- Multi disciplinary allied health/ nursing available on site Community health and HACC appointments available for clients with an active wound or active Charcot Neuropathy. High risk clients who meet the Eligibility Criteria are triaged by a priority tool to be seen within 72 hours or 1 week depending on clinical need/ severity. Monday – Friday $10 HCC/pension -$15 non-HCC Alb- Community health appointments available for clients with an active wound or active Charcot Neuropathy. High risk clients who meet the Eligibility Criteria are triaged by a priority tool to be seen Every 2nd Wednesday $10 HCC/pension -$15 non-HCC Corryong- Must meet HACC eligibility criteria. Clients with high or intermediate risk levels. Every 2nd and 4th Wednesday of the month $10 Tallangatta- Must meet HACC eligibility criteria. Clients with high or intermediate risk levels. Every 1st Tuesday of the month $10 Walwa - Must meet HACC eligibility criteria. Clients with high or intermediate risk levels. 1st Wednesday of every 2nd month $10	Wod- Upper Hume Region for High Risk Clinic referrals Albury Wodonga LGAs and Towong Shire for Medium risk. Alb- Upper Hume catchment Corryong- Corryong region Tall- Tallangatta region Walwa- Walwa region	Wodonga- (02) 6051-7430 Email crcreception@awh.org.au Phone (02) 6051-7400 Albury- (02) 6058-1881 Email crcreception@awh.org.au Fax (02) 6058-1801 Corryong- (02) 6051-7400 Email crcreception@awh.org.au Tallangatta- (02) 6051-7400 Email crcreception@awh.org.au Walwa- 02 6037 1220

Service	Clinic available for	Information for referrer	Catchment	Referral process
Albury Wodonga Aboriginal Health Service Podiatry	High Risk (Urgent): Yes- 2 days per week Medium Risk (Intermediate): Yes Low Risk (routine): Yes	Aboriginal and Torres Strait Islander clients only. Nil referral required (health check and GPMP completed by GP recommended) Podiatry wound care service available.	Upper Hume Region (Aboriginal and Torres Strait Islander people only)	Phone: (02) 60 401 200 Fax (02) 60401222
Albury Wodonga Diabetes Support Group	Non Clinical Support Group Support service for people with a diagnosis of Diabetes or Pre-Diabetes, their carers & families.	Meets 2pm on a Wednesday at Albury Community Health usually in March, June & September. Meets 7pm on 3rd Wednesday at Commercial Club Albury usually in February, May & October. Annual public diabetes forum All welcome at meetings - gold coin donation. Quarterly newsletter 'Diabetes Newslink' with latest news & local diabetes events - emailed free Membership ($10/year) is not compulsory.	All of Upper Hume catchment	Phone: Jill Craig- 0400 888 446; Liz Hare- (02) 6046 0042 Email: jillcraig@iinet.net.au liz@hare.id.au Facebook: http://www.facebook.com/groups/AWDSG/ Website: coming soon

Summary of mapping information across continuum of care for Podiatry services in UH catchment:



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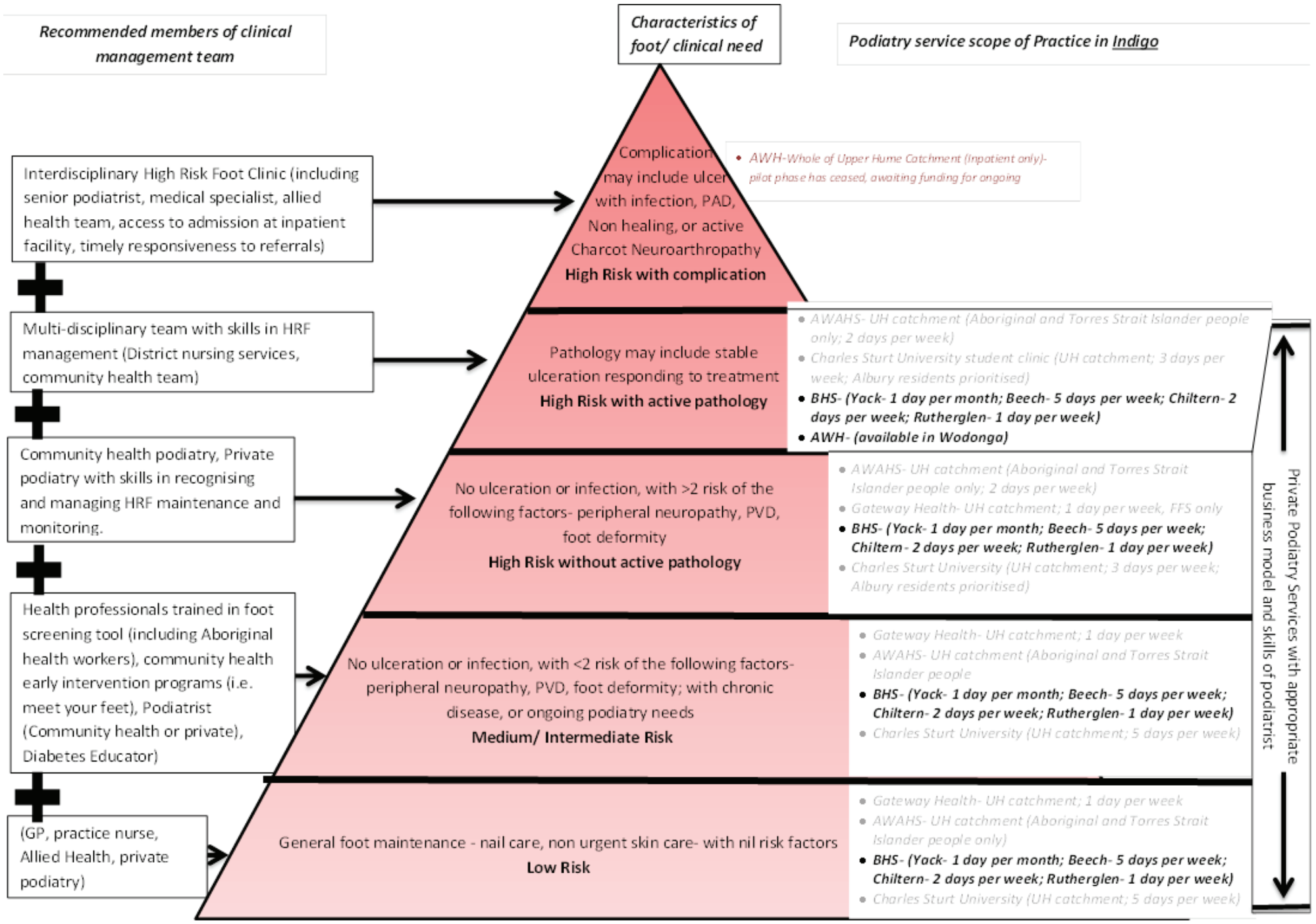
RECOMMENDATIONS:

Review available podiatry services across the continuum of care for foot health in the Upper Hume catchment.	✓
Work with PHN to ensure appropriate information is published on their 'Pathways Program', to enhance awareness of appropriate referral pathways to services based on clinical need and access principles.	✓
AWH to utilise this report to inform application for funding options to support the development of an ongoing, sustainable High Risk Foot Clinic model at AWH.	
Seek and review data to determine ulceration and amputation rates in UH catchment organizational and department level data)	
Establish clinical support groups to enable consistent and accurate information distribution across catchment.	
Identify where gaps in service provision exist across the catchment and develop recommendations for opportunities to reduce address these gaps across the foot health continuum.	
Work with PHN and other relevant agencies (eg. NADC) to identify clinical governance structure for podiatry care across continuum of risk.	
Identify evidence based models to enhance appropriate service provision and access for all people in the UH catchment requiring foot health intervention.	



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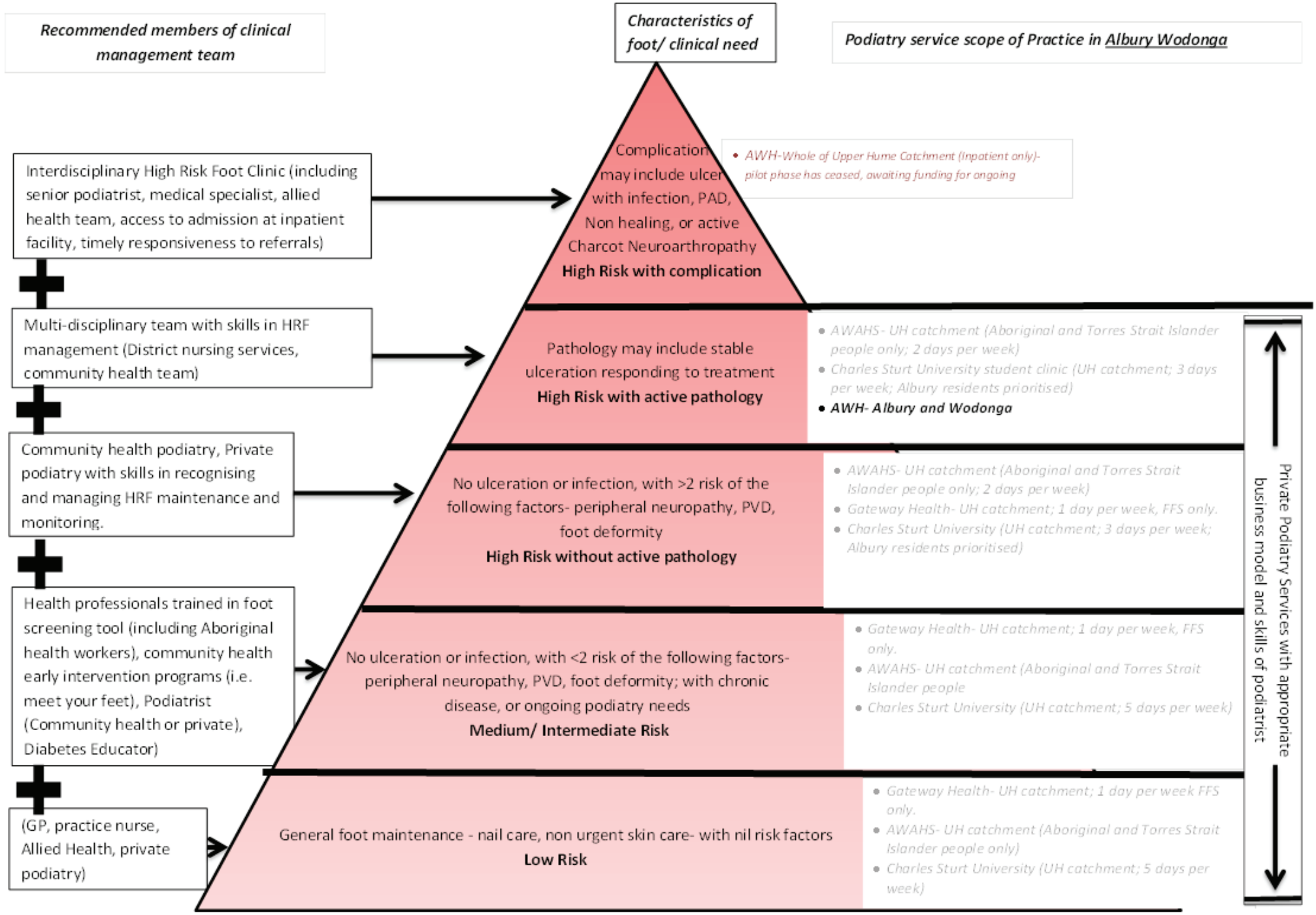
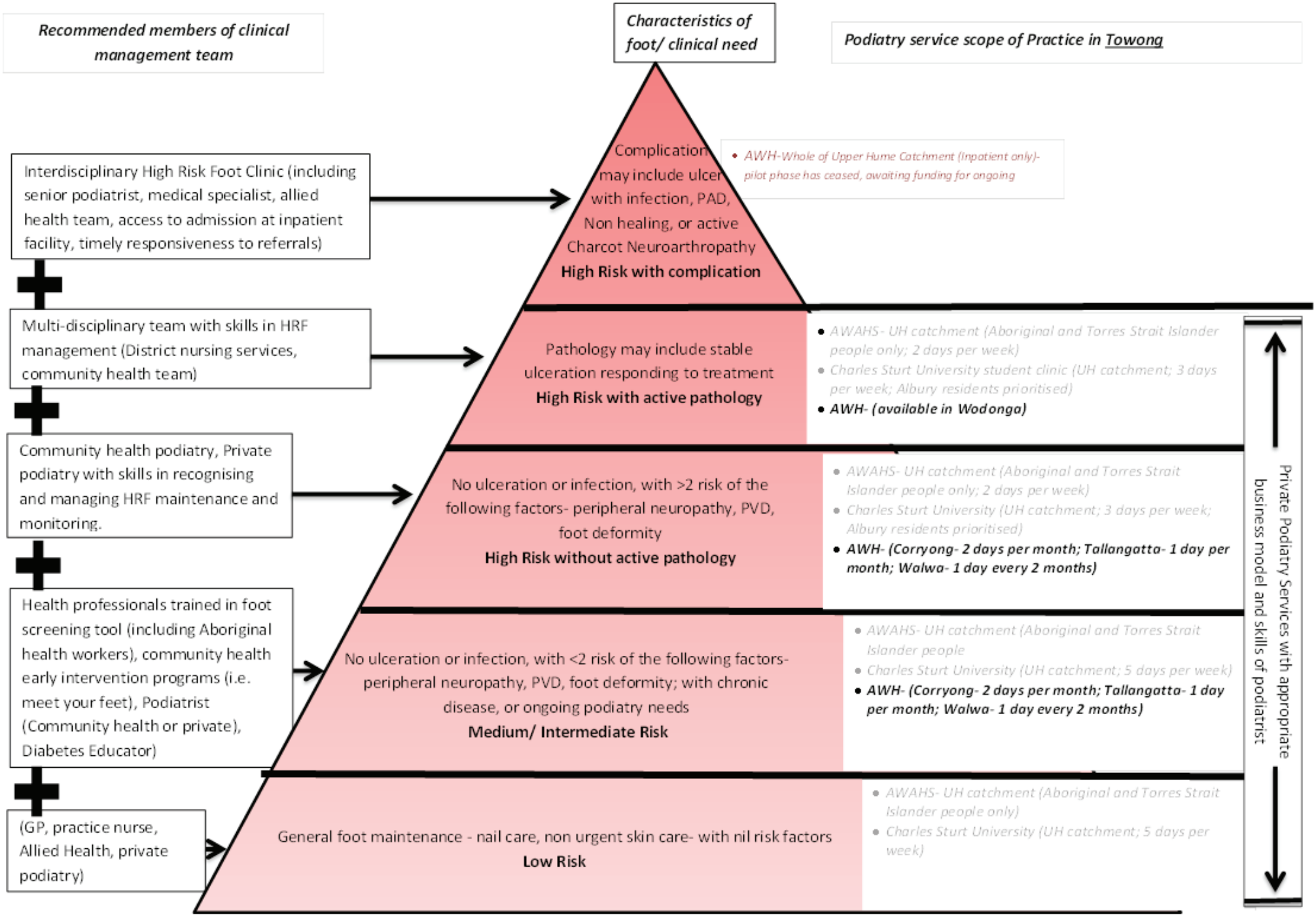

Recommended members of clinical management team
Characteristics of foot/ clinical need
Podiatry service scope of Practice in Albury Wodonga
Interdisciplinary High Risk Foot Clinic (including senior podiatrist, medical specialist, allied health team, access to admission at inpatient facility, timely responsiveness to referrals)
Multi-disciplinary team with skills in HRF management (District nursing services, community health team)
Community health podiatry, Private podiatry with skills in recognising and managing HRF maintenance and monitoring.
Health professionals trained in foot screening tool (including Aboriginal health workers), community health early intervention programs (i.e. meet your feet), Podiatrist (Community health or private), Diabetes Educator)
(GP, practice nurse, Allied Health, private podiatry)
Complication may include ulcer with infection, PAD, Non healing, or active Charcot Neuroarthropathy
High Risk with complication
AWH-Whole of Upper Hume Catchment (Inpatient only)- pilot phase has ceased, awaiting funding for ongoing
Pathology may include stable ulceration responding to treatment
High Risk with active pathology
AWAHS- UH catchment (Aboriginal and Torres Strait Islander people only; 2 days per week)
Charles Sturt University student clinic (UH catchment; 3 days per week; Albury residents prioritised)
AWH- Albury and Wodonga
No ulceration or infection, with >2 risk of the following factors- peripheral neuropathy, PVD, foot deformity
High Risk without active pathology
AWAHS- UH catchment (Aboriginal and Torres Strait Islander people only; 2 days per week)
Gateway Health- UH catchment; 1 day per week, FFS only.
Charles Sturt University (UH catchment; 3 days per week; Albury residents prioritised)
No ulceration or infection, with <2 risk of the following factors- peripheral neuropathy, PVD, foot deformity; with chronic disease, or ongoing podiatry needs
Medium/ Intermediate Risk
Gateway Health- UH catchment; 1 day per week, FFS only.
AWAHS- UH catchment (Aboriginal and Torres Strait Islander people
Charles Sturt University (UH catchment; 5 days per week)
General foot maintenance - nail care, non urgent skin care- with nil risk factors
Low Risk
Gateway Health- UH catchment; 1 day per week FFS only.
AWAHS- UH catchment (Aboriginal and Torres Strait Islander people only)
Charles Sturt University (UH catchment; 5 days per week)
Private Podiatry Services with appropriate business model and skills of podiatrist


Recommended members of clinical management team
Characteristics of foot/ clinical need
Podiatry service scope of Practice in Towong
Interdisciplinary High Risk Foot Clinic (including senior podiatrist, medical specialist, allied health team, access to admission at inpatient facility, timely responsiveness to referrals)
Multi-disciplinary team with skills in HRF management (District nursing services, community health team)
Community health podiatry, Private podiatry with skills in recognising and managing HRF maintenance and monitoring.
Health professionals trained in foot screening tool (including Aboriginal health workers), community health early intervention programs (i.e. meet your feet), Podiatrist (Community health or private), Diabetes Educator)
(GP, practice nurse, Allied Health, private podiatry)
Complication may include ulcer with infection, PAD, Non healing, or active Charcot Neuroarthropathy
High Risk with complication
AWH-Whole of Upper Hume Catchment (Inpatient only)- pilot phase has ceased, awaiting funding for ongoing
Pathology may include stable ulceration responding to treatment
High Risk with active pathology
AWAHS- UH catchment (Aboriginal and Torres Strait Islander people only; 2 days per week)
Charles Sturt University student clinic (UH catchment; 3 days per week; Albury residents prioritised)
AWH- (available in Wodonga)
No ulceration or infection, with >2 risk of the following factors- peripheral neuropathy, PVD, foot deformity
High Risk without active pathology
AWAHS- UH catchment (Aboriginal and Torres Strait Islander people only; 2 days per week)
Charles Sturt University (UH catchment; 3 days per week; Albury residents prioritised)
AWH- (Corryong- 2 days per month; Tallangatta- 1 day per month; Walwa- 1 day every 2 months)
No ulceration or infection, with <2 risk of the following factors- peripheral neuropathy, PVD, foot deformity; with chronic disease, or ongoing podiatry needs
Medium/ Intermediate Risk
AWAHS- UH catchment (Aboriginal and Torres Strait Islander people
Charles Sturt University (UH catchment; 5 days per week)
AWH- (Corryong- 2 days per month; Tallangatta- 1 day per month; Walwa- 1 day every 2 months)
General foot maintenance - nail care, non urgent skin care- with nil risk factors
Low Risk
AWAHS- UH catchment (Aboriginal and Torres Strait Islander people only)
Charles Sturt University (UH catchment; 5 days per week)
Private Podiatry Services with appropriate business model and skills of podiatrist