

Two P's in a pod

A unique interprofessional practice (IPP) collaboration between a Podiatrist and Pharmacist providing multidisciplinary chronic disease care to the Aboriginal and Torres Strait Islander community in the Toowoomba region. Leveraging off each other's skills and knowledge to amplify our health messaging, treatment, and care.

The Aboriginal and Torres Strait Islander multi-disciplinary chronic disease team (pharmacist, podiatrist, dietitian, Aboriginal and Torres Strait Islander health workers) has adapted and developed since 2011, striving to meet the needs of our local Aboriginal and Torres Strait Islander community more effectively and holistically. Our team has identified three main themes of influence in our community:

- High prevalence of nicotine dependence
- High incidence of multiple co-morbidities
- Hard-to-reach clients

34% of Aboriginal and Torres Strait Islander people smoke. = >2,500 people in Toowoomba. Smoking is number 1 risk factor for disease burden.²

Leveraging off shared minimum competencies

Basic skillset of all pharmacists and podiatrists includes:

- Basic foot exam
- Basic wound care
- Basic foot diseases pathology
- Medical history taking
- Chronic disease knowledge
- Nutrition knowledge

113 basic foot exams performed by pharmacist.
23 referrals from podiatrist to pharmacist for HMR. (2023-25)⁶

Maximising messaging, treatment and care through IPP upskilling

Both professionals have developed more advanced skills in addition to the fundamental skills already attained through their profession specific training from each other.

Pharmacist

- Monofilament sensory testing
- Increased knowledge of:
 - Foot disease pathology
 - Foot risk status assessment
 - In-clinic podiatry practice

Podiatrist

- Expanded smoking cessation knowledge and assessment (both are now nicotine treatment specialists)
- Mentored by pharmacist for ongoing smoking cessation
- Increased knowledge of medications safety
- Increased knowledge of medication regarding feet:
 - Adverse drug reactions
 - Treatments

Expanded multi-disciplinary referral opportunities.



Client journey IPP triggers



Pharmacist new client

(Referred for smoking cessation/medication review or both)



Podiatrist new client

(Referred for chronic disease podiatry assessment by GP or health professional)

Chronic disease assessment

Includes medication and chronic disease management review including but not limited to; airways diseases, mental health, heart disease, diabetes, pain, chronic kidney disease, smoking and falls risks screening.

Foot disease assessment/treatment

Includes taking thorough medical history, client's chronic disease health literacy and self-management gauged, risk status for foot disease assessed.

The following may trigger referral to podiatrist:

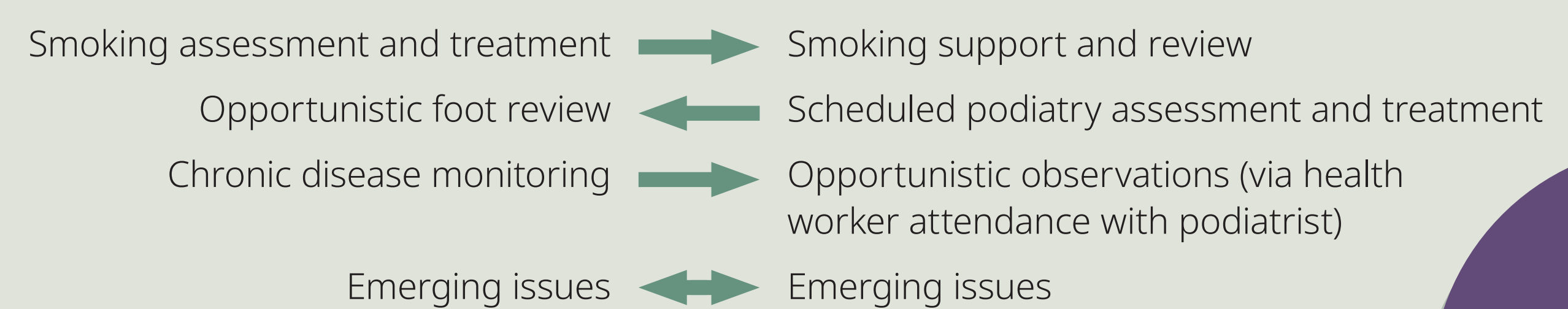
- Diabetes:
 - More than 12 months since podiatrist review
 - Routine foot screen and education resulting in detection of podiatry related issues
 - Footwear inspection and education
- Falls risks identified as being influenced by podiatry related issues
- Medication/diagnosis/symptoms relating to lower limb

The following may trigger referral to pharmacist:

- Polypharmacy or identified medication issues/client concerns
- Pain management
- Chronic disease review (e.g. diabetes, CVD, COPD, renal disease, neuropathies, restless leg syndrome)
- Specialist smoking assessment/management

18,900 (6.38%) Aboriginal and Torres Strait Islander population in Darling Downs region. 8,056 (2.72%) in Toowoomba Cluster.¹

Mutual clients



Joint client consultation | External/team case conferencing

41% of all potentially preventable hospitalizations are due to chronic disease.³



Benefits of IPP

Efficiency

- Shared competencies
- Reduced appointment numbers (joint consults where possible)
- Reduced replication of service
- Improved demand management

Access

- Earlier screening
- Engagement with hard-to-reach clients
- Referral to other Allied Health and Aboriginal and Torres Strait Islander health worker support

Consistency

- Chronic disease management and health messaging
- Case conferencing
- Wrap-around care

7.9% of Aboriginal and Torres Strait Islander adults have diabetes (T1DM and T2DM) compared to 5.1% of non-Aboriginal and Torres Strait Islander adults.⁴

5-6x Aboriginal and Torres Strait Islander people are 5-6 x more likely to develop foot complications.⁵

1 Darling Downs Health Strategic Plan
2 www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/priority-populations/aboriginal-and-torres-strait-islander-people#tobaccosmk
3 www.ncbi.nlm.nih.gov/29151893
4 www.aihw.gov.au/reports/diabetes/diabetes/contents/how-common-is-diabetes/all-diabetes
5 www.indigenoushpf.gov.au/measures/3-07-potentially-preventable-hospital-admissions
6 Darling Downs Health Activity and Costing



Acknowledgement of Country

Darling Downs Health acknowledges the Traditional Custodians of the land and pays respect to Elders past, present and future. We recognise the strength and resilience that Aboriginal and Torres Strait Islander people and their ancestors have displayed in laying a strong foundation for the generations that will follow.



Queensland Government