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IN THIS ISSUE

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EDITORIAL ENQUIRIES
E siobhan.doran@podiatry.org.au
P (02) 9698 3751

ADVERTISING ENQUIRIES
Paul Andrew | **E** lorcymedia@bigpond.com
P (03) 9379 0971 **M** 0411 476 624

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The Australian Podiatry Association would like to acknowledge the traditional owners of all the many Aboriginal and Torres Strait Islander Nations that make up the great continent of Australia. We would like to pay our respects to the Aboriginal and Torres Strait Islander elders past and present, also the young community members, as the next generation of representatives.

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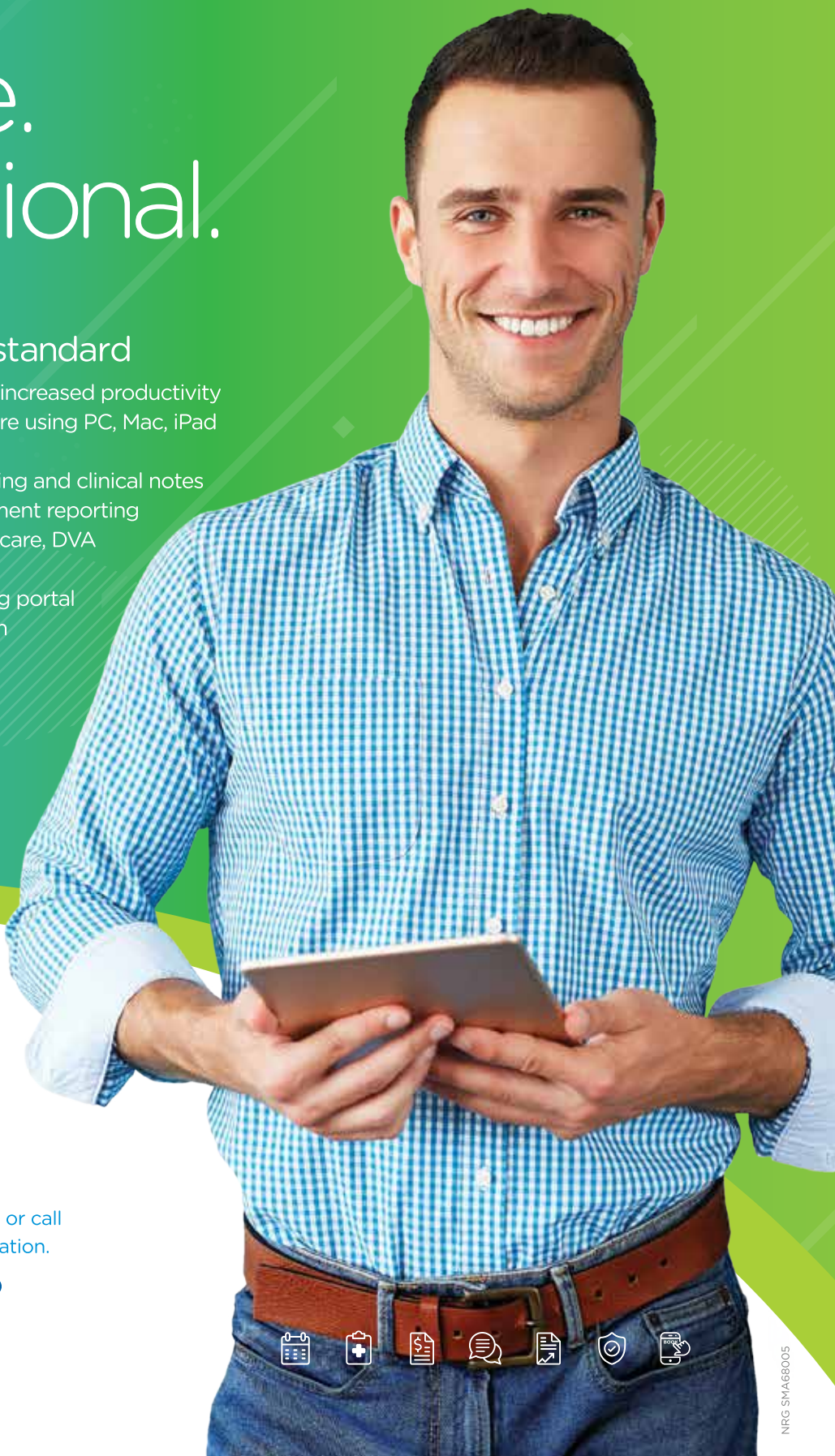

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LEADERSHIP UPDATE

From the CEO

There's no doubt that these are difficult times for many members. That is certainly true for the majority of members who have been in lockdown for a considerable period over the past 18 months (and counting).

These unsettled times only serve to add momentum to our advocacy efforts. We continue to work closely with Allied Health Professions Australia to advocate for the rights of podiatrists to continue to provide face to face consultations during lockdowns for critical clinical care. We believe that this should be the case regardless of restrictions across states or territories at any time.

And while we look to the future, don't forget that Foot Health Week is next month, between 11 to 17 October. Our teams are getting ready for a packed week of activities, all of which are digital and many are not time dependent. This way, members can take part during Foot Health Week or outside of it, when the time is right for each member. Stay up to date on these developments via **podiatry.org.au**

I want to take a moment to thank Katrina Richards for her time as President of the Association since her final term concludes this month. Katrina has driven some major change in the APodA which has enabled us to negotiate through some extremely challenging times. If I could sum up Katrina's approach, it is deeply supportive and committed to those she represents; both within the profession and whom she works alongside. Thank you Katrina for your dedication and also for your sense of fun and positivity. Your collegial outlook has been valued not only by myself but by the many peers you have impacted during your time in this role.

The new APodA President will be announced following the September Board meeting.

Above and beyond everything else, take care of yourselves and thank you for the work you seek to do in these challenging times.

Have a good September.

Nello Marino

From the President

Like Nello has said, these can be unsettling times for many of us, which conversely generates a lot of advocacy activity in response. Regardless of whether the lockdown has been lifted where you live, I want to acknowledge how well we are all dealing with the impact of COVID-19 on our daily lives.

Despite these challenges, positivity continues in other areas. As you know, the APodA is looking to the future by consulting with podiatry and industry leaders to ask what the likely challenges are for our profession in the future, and how we can mitigate these challenges.

This project, 'Stepping Up: Podiatry 2030', kicked off with a member survey which closed last month and invited a wealth of interesting responses across a range of issues such as business, patients, clinical practice and technology. Keep an eye out for ongoing updates as they emerge.

While we have been challenged in so many ways over the past 18 or more months, we are still looking to the future and keeping an all-important perspective for the sake of our profession and those we seek to help. Their needs will always be present regardless of the circumstances, and that is where our focus and passion rightly remains.

And lastly; thank you to our members, the hard-working team at the Association and my fellow board members for the vast amounts of commitment and tenacity you put into everything you do for the sake of the profession. It does not go unnoticed, and as I conclude my time in the role of President, I will take this legacy with me and reflect with immense pride on the time I have spent in the company of such fine people. Thank you.

Take care.

Katrina Richards

OUR RESPONSE:
Draft recommendations from the Primary Health Reform Steering Group

By Bronwyn Morris-Donovan, Advocacy & Government Relations

You may be aware that the Primary Health Reform Steering Group* released a series of draft recommendations to progress health system reform. There were 20 recommendations in total and the APodA has submitted our response, which you can read in full at **podiatry.org.au/documents/item/2504**

In August we responded to the final Draft Recommendations on the Government's Primary Health Care 10 Year Plan. This work has been developed by the Primary Health Reform Steering Group, convened in October 2019 to develop a Primary Health Care 10-Year Plan.

The APodA welcomed a suite of recommendations which reflect a more inclusive, contemporary approach to genuine primary health reform. We support the integration of allied health practitioners alongside their medical and nursing colleagues and see this shift as key to achieving the Quadruple Aim.

What is the Quadruple Aim?

The Quadruple Aim is a well-regarded framework for optimising health system performance. It outlines four principles that governments, health care planners and providers need to concurrently focus on when examining the design and models of primary health care delivery. Its aims are to:

1. Improve the patient experience of care (including quality of care and satisfaction);
2. Improve the health of populations;
3. Improve the cost-efficiency of the health system; and,
4. Improve the work life of health care providers.

The Steering Group have used the Quadruple Aim as a lens to test the intellectual and structural framework of their recommendations, to evaluate measures and directions captured and to prioritise actions for reform.

Our overarching frustration

Our response acknowledged primary health reform has been a focus for several Commonwealth and advisory groups over the past decade. Yet

> Despite several rounds of reform and well-intended recommendations, we have seen no valuable inputs into the allied health system. The sector remains poorly resourced by any measure.

little attention has been paid to the contribution of the allied health workforce to building a stronger, more integrated, sustainable primary health system. Despite several rounds of reform and well-intended recommendations, we have seen no valuable inputs into the allied health system. The sector remains poorly resourced by any measure.

We are calling for all allied health recommendations to sit within the remit of the federal Chief Allied Health Officer. We are calling for allied health recommendations to be considered as equal to those described for other sectors including nursing and midwifery workforce and medical primary care workforce.

What we support

1. **Recognised contribution of allied health providers:** The Steering Committee has recognised the important contribution of allied health providers to primary health reform.
2. **Clear commitment to sustaining the allied health workforce:** We are pleased to see dedicated recommendations designed to strengthen and sustain the allied health workforce, including development of a minimum dataset and coordinated National Allied Health Workforce Plan.
3. **Enhanced primary health care role:** We support an enhanced primary health care role in national and local emergency preparedness. We do however note the COVID-19 pandemic has exposed the challenges associated with achieving such an aim.
4. **Leadership development as a tool for cultural change:** The APodA supports the recommendation to foster cultural change by supporting leadership development in primary care (Recommendation 9). However, despite the discussion paper describing the importance of 'strong leadership at all levels so the health system' it appears not a single allied health professional body is captured in the list of professional colleges and associations.
5. **Sub-recommendations that address long-standing issues, including:**
   a. Implementation of all recommendations in the MBS Review Taskforce report.
   b. Establishment of an allied health funding reform committee. We contend that this committee should be composed of allied health representatives from metropolitan, regional and rural practice, from a diversity of funding settings.
   c. Digital infrastructure: Provide financial subsidisation to increase digital health infrastructure for allied health practices.
   d. Improved communication: Develop secure messaging and software infrastructure to support allied health communication with general practice, My Health Record and the wider care system.
   e. The APodA is supportive of a formal allied health research agenda to consolidate and strengthen the existing research base.
   f. Strong clinical governance for allied health in primary care.

> ...despite the discussion paper describing the importance of *'strong leadership at all levels so the health system'* it appears not a single allied health professional body is captured in the list of professional colleges and associations.

Room for improvement

In light of this frustration, we believe there is more to be done. Specifically:

1. More integration of allied health practitioners: While the APodA welcomes the recommendations, which reflect a more inclusive, contemporary approach to genuine primary health reform, this report is still strongly medically focused.
2. Clearer implementation process: While we recognise the recommendations are intentionally high level, we are seeking an implementation plan, and a monitoring and evaluation framework. As with any reform agenda, we appreciate the complexity and resourcing commitment. However, the allied health sector is often the recipient of partial roll-outs, delays and commitments that remain unfulfilled. We are strongly supportive of dedicated milestones broken into short, medium and long-term. The APodA welcomes every opportunity to engage in development work to support implementation.
3. Investment in sector-wide digital infrastructure to fulfil goals: The inequity in digital health is a significant and long-standing concern held by the APodA and the whole allied health sector. Without a clear commitment to invest in sector-wide digital infrastructure, goals such as that described in 11.4 will be unachievable.

Next steps + timeframes

The APodA strongly supports development of an implementation action plan with short, medium and long-term horizons. Despite a written commitment in this discussion paper to engage with national bodies we question the genuine desire to engage with allied health leaders.

On behalf of the APodA we look forward to further engagement as an implementation and evaluation plan is developed.

MORE INFORMATION: To read our response, head to our website **podiatry.org.au** (note that the Draft Recommendations to which this paper responds to are no longer publicly accessible). ***health.gov.au/ministers/the-hon-greg-hunt-mp/media/primary-health-reform-steering-group-established**

11 – 17 OCTOBER 2021

Heads up! Foot Health Week is nearly here!

Are you getting ready for Foot Health Week? We are! Read on to see how you can get involved.

This year we're so excited about the different activities and member opportunities we have lined up...

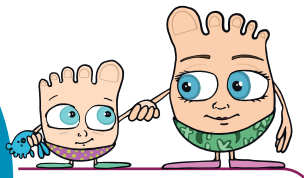
This year we are sharing the love for our feet. We know that many people think about their feet as an afterthought, yet the connection between their feet and their overall health and wellbeing is irrefutable. That's why we want people to understand that their niggling knee pain or their sore hips for example, may in fact relate to their feet. The message being: **show your feet some love, visit a podiatrist and the rest of your body will thank you for it.**

During **October 11 to 17** we'll be busy creating media opportunities, posting on social media, ensuring our members have received their Foot Health Week member pack, which includes a digital goodie bag. We'll also be carrying out a range of activities through well-known spokespeople who are as passionate about foot health as we all are.

So, please get involved. Decorate your clinic. Post on your socials. Keep tagging us*. Share the patient resources we will supply and talk to us about any local media opportunities! Let's make it happen together.

Most importantly, this year's activities are designed to be digital and not time dependent. So if you can't get involved during Foot Health Week, given all of the uncertainty around lockdowns, then don't worry as you can rally your community at any stage (and use our timeless resources to do just that!)

We can't wait to celebrate the power of our feet and share the love, given feet are often our unsung heroes.



We'll see you online (or even in person if restrictions will allow!)

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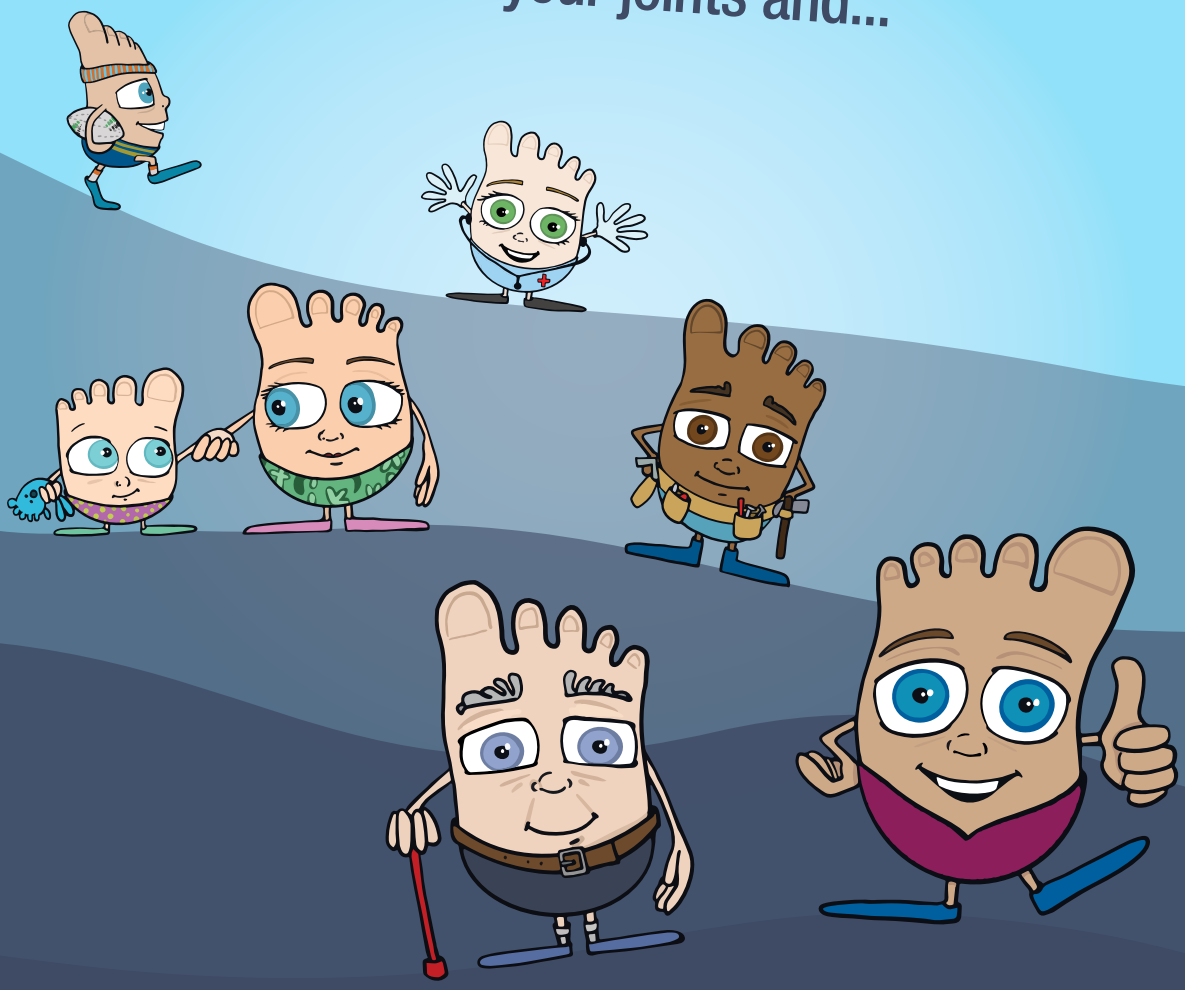
So will your hips and your knees and your neck and your glutes and your joints and...



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APODA Australian Podiatry Association

DR FIONA HAWKE TALKS WITH OLIVIA KING, ALLIED HEALTH RESEARCH AND TRANSLATION CO-LEAD AND ADJUNCT RESEARCH ASSOCIATE

Interviewee: Olivia King is an Allied Health Research and Translation Co-Lead (Barwon Health and South West Healthcare) and an Adjunct Research Associate with Monash Centre for Scholarship in Health Education. She is a qualified podiatrist, credentialled diabetes educator, and an early career researcher. In 2018, she completed her PhD through which she explored the role boundaries and scopes of practice in diabetes education. Her research interests include, interprofessional role boundaries, allied health workforce, sociology of the professions and health professions education.

Interviewer: Dr Fiona Hawke is a lecturer in podiatry at the University of Newcastle, with a PhD in medicine from the University of Sydney. She is currently working two days per week to raise a family. Trained as a podiatrist at the University of Western Sydney, Fiona graduated 13 years ago.

Q What are you working on at the moment?

In my current role as Allied Health Research and Translation Co-lead at Barwon Health and South West Healthcare, I support emerging allied health researchers to develop, design, and undertake research and importantly, translate research findings into practice and policy. I am involved in and lead multiple research projects, most of which have an allied health workforce, and/or allied health professions education flavour. I am also working with Western Alliance Academic Health Science Centre to develop a region-wide research capacity and capability building program for health practitioners.

Q What first got you interested in research?

I first became interested in research as an undergraduate podiatrist and went on to do the first qualitative honours project in podiatry at La Trobe University. After graduating, I predominantly worked in diabetes care teams in clinical podiatry and diabetes care coordinator roles. This led to my undertaking a Graduate Certificate in Diabetes Education, before I moved into a diabetes educator role. This move proved quite challenging as there were not many podiatrists working in these roles, even though we as podiatrists, can become a Credentialled Diabetes Educator (CDE) through the Australian Diabetes Educators

Association. I encountered some challenges from other clinicians and even managers about role boundaries. My efforts to determine what the role boundaries were between podiatrist CDEs and others, were fruitless. With a burning question on my mind, and unable to answer it using existing evidence, I started diving deeper into the literature and that is when I came across Susan Nancarrow's work. I got in touch with Susan, and she inspired me to do a PhD exploring the interprofessional role boundaries between allied health and nursing working in the field of diabetes education.

Q How have things changed since then?

Since completing my PhD, which was a sociological analysis of the role boundaries that have been constructed between diabetes educators from the different professions, I have become more interested in health workforce issues, sociology of the professions and health professions education research. I have always had a bend toward qualitative research and during my postdoctoral research fellowship with Monash Centre for Scholarship in Health Education, I learned a great deal more about interpretative/qualitative methodologies. I have a lot more to learn and I take every opportunity to find out more about contemporary qualitative methodologies at conferences and in my reading of the research literature. I also thoroughly enjoy facilitating emerging researchers' learning of and about qualitative methods.

Q Do you have a research mentor?

Yes, I most certainly have and still do. I have had several amazing mentors even prior to my research journey and cannot express just how enormous their respective influences have been on me as a researcher and person. My research career has been non-linear and quite atypical in that I moved from clinical practice while undertaking a non-clinical PhD, to academia and then back to somewhere in between that, in my current health-service embedded research role. I have had mentors along the way who have supported my self-reflection and provided guidance about career decisions – some that have been harder to make than others. I have left jobs that I have loved to pursue opportunities that fitted better with my lifestyle and family. Although I don't regret those decisions, I simply can't overstate how valuable it was to have someone to help guide that decision-making process. Then there are more pragmatic things that mentors have helped me with such as advice on grant applications, connecting me with other researchers, and identifying career-amplifying opportunities (just to name a few things).

Q What are the best parts of being a researcher?

I love learning, growing and problem-solving. To my mind, research is all about learning, solving problems, asking, and answering questions. These processes invariably lead to identifying and asking more questions. I love the variety in the type of work I do as a researcher: designing research, collecting, analysing data and my favourites, teaching and writing. I also really like that the hard things (e.g., speaking in front of large groups of people, reading and responding to critical peer review reports) are becoming less and less daunting.

Q What are the most challenging parts of being a researcher?

The competitive nature of the research when it comes to funding and grants. That said, I have always had great people around me to support my endeavours, and to console me when I have had unfavourable outcomes.

Q What advice would you give a clinical podiatrist wanting to get involved in research?

If you have a burning question, reach out to people who are working in the area/s you are interested in. You will be amazed at how receptive researchers – even high-flying academics, are. The pathway into research may not seem clear to begin with, but with the guidance of an experienced (even an early career) researcher, you will be on your way. Take that first step.

Q Where do you think your research interests will lead you next?

I mentioned earlier that my journey has been non-linear and atypical for a clinician-researcher, and so I expect that the next career turn will be as surprising and serendipitous as the last – and I am very excited to find out! ■

If you have a burning question, reach out to people who are working in the area/s you are interested in. You will be amazed at how receptive researchers – even high-flying academics, are.

JFAR UPDATE: How podiatrists can play a leading role in sustainable healthcare

> ...health care providers are a significant contributor to climate change, accounting for 4.4% of global net greenhouse gas emissions.

Climate change has been recognised as a threat to global health. Yet, ironically, health care providers are a significant contributor to climate change, accounting for 4.4% of global net greenhouse gas emissions. Some emissions stem directly from health care settings, such as heating and cooling (29% of emission). Yet most emissions come from the health care supply chain, including production, transport and use/disposal of goods and services (71%). This commentary piece by Dr Angela Evans, advocates for the adoption of 'health care without harm' approach for podiatrists.

While the relationship between climate change and health has many components, the health effects and diseases associated with climate change are many. They disproportionately affect those who are inherently more vulnerable such as children, older people, pregnant women and those with pre-existing morbidity. Not only this, but communities with geographic and income disadvantages, such as Pacific Island nations are disproportionately at risk of the negative health effects of climate change.

The causes

It has been identified that the main environmental impacts caused by the health care sector involve not only the consumption of energy, use and disposal of toxic chemicals and production and disposal of wastewater, but the 'upstream' procurement of goods and services.

Taking action

The Australian Medical Association and the Australian Podiatry Association, already have, or are in the process of, developing guidelines to educate their members about sustainable and low-emission strategies. From a practical perspective, podiatrists may consider 'upstream' factors involved in the production, packaging, transporting and disposal of clinic stock and energy supply.

Other ideas to consider are the increased use of telehealth, collaboration with sustainable footwear manufacturers and providers and increased participation in accessible and flexible physical activity.

This commentary is a vital call for podiatrists to begin acting to create a sustainable healthcare environment.

The role of the podiatry profession

Podiatrists, as allied health professionals, have wide community engagement, and hence, can model positive environmental practices, which may be effective in changing wider community behaviours, as occurred last century when doctors stopped smoking.

As foot health consumers, our patients are increasingly likely to expect more sustainable practices and products, including 'green footwear' options. Green podiatry, as a part of sustainable healthcare, directs us to be responsible energy and product consumers, and reduce our workplace emissions.

More information

Read the full study at **https://jfootankleres.biomedcentral.com/articles/10.1186/s13047-021-00483-7** ■

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WHY MORE PODIATRISTS SHOULD REGISTER AS NDIS PROVIDERS

By Nikki Marshall: Practice Excellence Coach – Podiatry

Podiatrist Nikki Marshall works for a large medical and allied health practice alongside 20 paediatricians and other in-house specialists. She is the first to admit that, given their size, she hasn't had to personally undertake the administrative load underpinning the auditing and registration process. However, she does speak about the irrefutable benefits of being an NDIS provider, if you are in a position to take the step.

> The NDIS provides... providers to be able to see complex conditions and provide satisfying, challenging good quality care to participants. On this basis alone, I would encourage other podiatrists to get involved in the NDIS.

Meet Nikki:

Nikki has been a podiatrist for the past ten years and currently works across Adelaide and Melbourne. She has spent a significant portion of her career working for Adelaide Paediatrics which was one of the first organisations across Australia to register with the National Disability Insurance Agency (NDIA). Adelaide Paediatrics is an NDIS certified organisation, which is registered to provide therapeutic supports and assistive technology to all age groups, including those under seven years of age. Nikki also works at Monash Community Health in a paediatric lower limb assessment clinic comprising physiotherapy/podiatry consultations (which also has an NDIS service attached to it). She is also the Podiatry Practice Excellence Coach for cohealth (a community non for profit organisation) which is starting to develop its NDIS capacity within the allied health space.

Firstly, I am fortunate in that I don't have to deal with the related paperwork associated with registering as a National Disability Insurance Scheme (NDIS) provider. This means I can provide care for people on the NDIS without having to get involved with what I understand can be a drawn out process.

The opportunities

As podiatrists know, the NDIS provides participants with the ability to utilise services for their disability based on their individual goals, and to build capacity around what they require and what they value in life. It also allows providers to be able to see complex conditions and provide satisfying, challenging good quality care to participants. On this basis alone, I would encourage other podiatrists to get involved in the NDIS.

The barriers

However, there's no doubt there are barriers at the moment, and this needs to improve. The main barriers for podiatrists right now appear to be:

- How much is involved in doing the actual audits
- What the associated costs are

> Have the confidence to start... I believe it will reward you and give your career the experience it deserves, so that you can help those with foot and ankle issues even more through your role.

- Repeating these steps each year and the time it takes.

The benefits

But, where possible, I would really encourage other podiatrists to register. While unregistered providers can provide NDIS services for self-managed participants and 'plan managed' participants (but the plan manager needs to be registered) – below are the benefits I have experienced as a registered NDIS provider.

1. **The NDIS website is being made simpler.** The auditing process is now different (in a positive way) for smaller podiatry clinics. The process for smaller practices requires 'verification only' and an auditor can conduct a 'desktop audit' without having to come out to the site, which is a much cheaper and easier option and would suit an everyday private practitioner. Whereas in being part of a larger certified practice, an NDIS auditor will come out to our clinics on an annual basis to conduct site audits, document reviews, and carry out interviews with NDIS workers and participants to maintain our registration.
2. **As a career move it's a really good thing.** You'll liaise with other NDIS providers and you'll network with them. If you don't enter this space you may miss out on a whole range of complex conditions, in my experience at least. While our ultimate goal is for the child to be the same as their peers by seven years of age, in reality we often undertake a long-term patient / client / provider relationship, given we treat adult cases which can start in childhood.
3. **It exposes you to interesting cases.** While it is great for podiatrists to see self managed NDIS clients, if you're not registered you'll likely only be seeing the people who are usually well placed to advocate for themselves. Whereas if you open your practice up to the other two options – either to the people who put their NDIS funds into an agency to manage it or those who do the same but through National Disability Insurance Agency (NDIA) – then these pathways are likely to expose you to interesting cases from a podiatry perspective, but also a psychosocial perspective (see examples in the breakout box over the page).
4. **It boosts the profession as a whole.** This is all about helping people who experience disability to get the best out of their lives and I feel there's not enough podiatrists out there who are providing this service as a registered NDIS offering. This means that people on the NDIS are reaching out to other health professionals for their foot and ankle care instead who don't have the same level of knowledge as podiatrists hold. In other words, this is a significant missed opportunity for the profession as a whole.
5. **Patients can otherwise miss out.** As a result of this above process, I believe these people are not getting the quality diagnosis and treatment they deserve. Podiatrists could provide this, if only they were registered. For example, most children's goals align with what they find fun, so they want to be able to keep up with their friends, play sport and do this without getting tired or having pain. Our job is to help them to do that.

Final advice

My final piece of advice is to have the confidence to start and then go through the process of registering to really enter this space. I believe it will reward you and give your career the experience it deserves, so that you can help those with foot and ankle issues even more through your role.

What typical presentations does Nikki treat?

Here are some of the most recent podiatric presentations Nikki sees in the younger age group, all through her role as a registered NDIS provider.

- **Gross motor delay:** Low tone associated with delayed walking and instability, foot or lower leg pain associated with hypotonia and hypermobility.
- **Autism Spectrum Disorder:** Toe walking, pain, sensory concerns.
- **Connective Tissue Disorders:** Such as Ehlers Danlos Syndrome, Marfan Syndrome and associated foot/joint pain (which impacts on their ability to play).
- **Cerebral Palsy:** Limiting function, range and ability to play.
- **A range of rare genetic conditions:** Cohen Syndrome, Kabuki Syndrome, Nail Patella Syndrome, Greig Syndrome are some of the most recent cases that Nikki has treated.

Get in touch

You can contact Nikki at **nicole.marshall@cohealth.org.au** or refer to the latest range of NDIS provider resources at **ndis.gov.au/providers** ■

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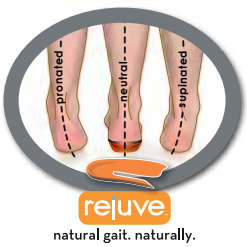

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STRENGTH TRAINING OF THE FOOT: WHERE WE CAN IMPROVE

Sports section editor John Osborne shares his opinions and insights around strength training of the foot. He reflects on where opportunities may be missed and what else can be done.

There appears to be significant uncertainty about how strength training fits in our treatment regime compared to some of our more established treatment options.

John Osborne was the first podiatrist to fulfill the criteria for title of Certified Sports Podiatrist in Australia. He currently works privately and consults with the Victorian Women's cricket team, Southside Flyers (WNBL) and Olympic and international gymnasts helping them manage lower limb pathology. John is currently completing a PhD at La Trobe University investigating the role of muscle strengthening with plantar heel pain. Prior to being a podiatrist, he was a professional dancer but now his free time is spent playing a round of golf and spending time with his family.

Foot strength is a hot topic, so I thought I would take a moment to discuss the role of foot strengthening and how to incorporate it in your management plans. However, some key points need considering first.

Foot strengthening is a relatively new area in both practice and research when compared with other foot-specific treatments such as foot orthoses and corticosteroid injections. In fact, foot strengthening for plantar heel pain has only been investigated in the last ten years. There appears to be significant uncertainty about how strength training fits in our treatment regime compared to some of our more established treatment options.

The compliance challenge

One key issue with strength and rehabilitation treatments is compliance. Increased compliance shows increases in outcomes of satisfaction and strength improvement in both ankle[1] and anterior cruciate ligament[2] rehabilitation. One criticism of foot orthoses is that it is a passive treatment, whereas exercises are an active treatment. However, I would argue that exercises which are sub-optimal (or not performed at all) is just as 'passive' as foot orthoses or similar in-shoe devices.

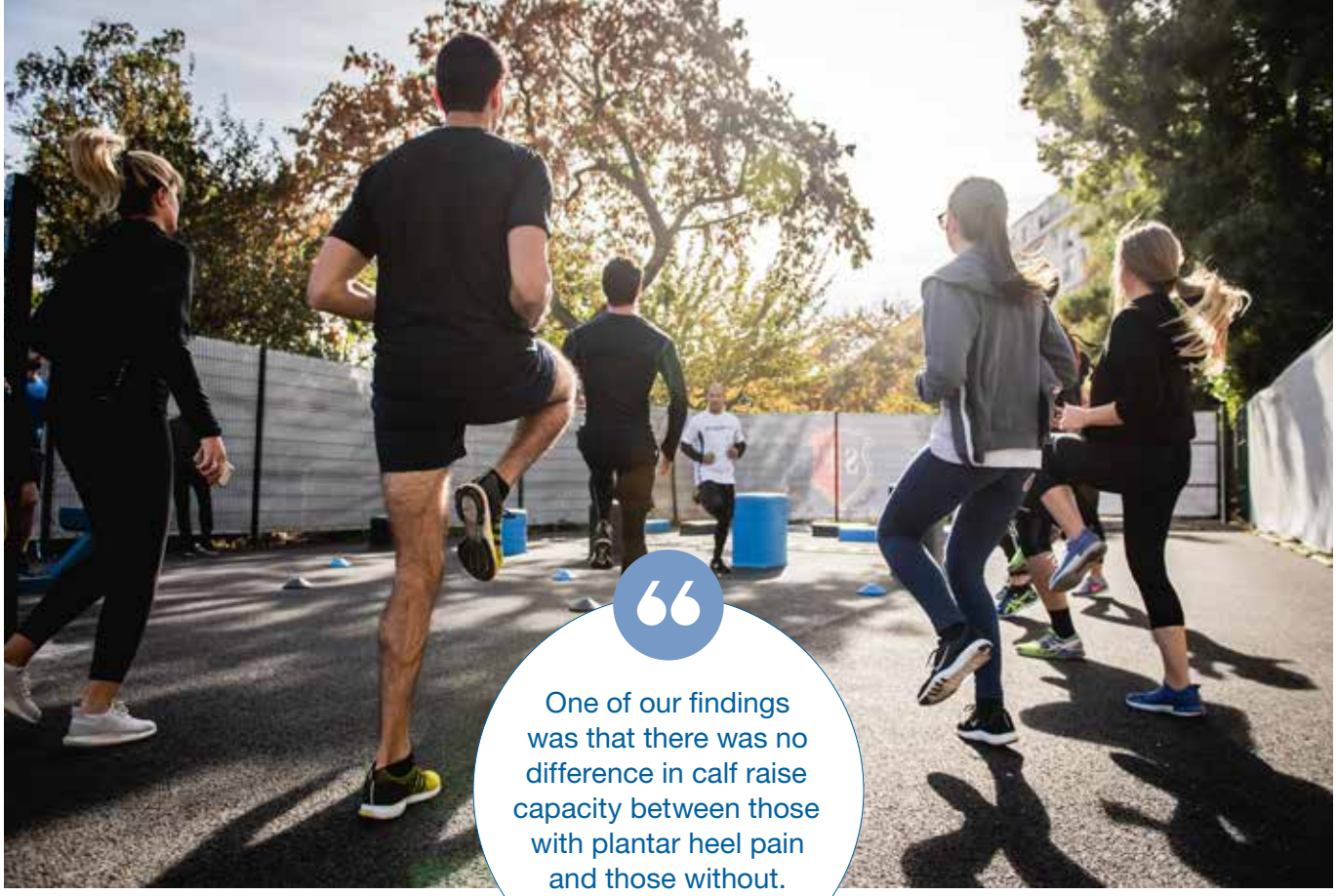
How and when do we apply foot strengthening for our patients? First, make sure the person is on board. If the patient wants to explore foot strengthening as a management option, they will be an excellent candidate and be more likely to achieve meaningful outcomes. If the patient is not on board, then modify your plan to one essential exercise and use the opportunity for education.

Address the deficit

Finally, make sure you are addressing a deficit. Deficits are more than reduced strength and they may include improving range of motion or movement patterns. If there is no deficit to address, consider whether you need to use foot strengthening treatment.

As far as addressing a deficit is concerned, consider a systematic review[3] I published with colleagues from La Trobe University in 2019. One of our findings was that there was no difference in calf raise capacity between those with plantar heel pain and those without. There was a mean difference (albeit small) in digital plantarflexion in those with heel pain compared to those without. The review was of cross-sectional papers, so causality was unable to be implied.

Although these findings make me consider that addressing someone's calf



> One of our findings was that there was no difference in calf raise capacity between those with plantar heel pain and those without.

raise capacity may not be relevant if the deficit does not exist. Maybe we need to look beyond the ankle joint to find the deficit and create a more specific exercise approach for these people.

Find the deficit

How do you know if the deficit exists? There are several ways to test strength; two simple tests with minimal equipment are the paper grip test[4] and a calf raise capacity test[5]. You can consider using equipment such as the 'toe pro' or a dynamometer which will be more accurate for a range of movements, but are also more expensive. Clinically it would be useful to test at an initial appointment and then test at regular intervals to ensure objective and positive progress of the strength program provided.

Choose the strengthening

So now that you have found a deficit, addressing that deficit with specific strengthening is our next step. There are many foot exercises available, but focus on the deficit you want to address to guide your exercise choice.

For example, if you are addressing digital plantarflexion then choose an exercise to improve that. There are limited papers showing what foot-specific strength exercises do, which I believe is an area of research that still requires more understanding.

However, something to consider is how complex you make it. A great piece[6] by Michael Rathleff (a professor at the Center for General Practice in Aalborg and Department of Health Science and Technology at Aalborg University) has indicated not prescribing any more than three exercises to a patient to make it an achievable task. But choose your exercise wisely based on the patients' needs and wants. While toe yoga makes us feel good, does it make a difference for your patient? Is doing a calf raise just not stimulating enough for them? Choosing the right exercises and program is where your clinical judgement and experience will come to the fore.

It is okay to get this wrong, since you are not likely to cause damage. However, don't be lazy and perhaps do the same as you have always done. Consider how you can always make it better.

In summary

This piece is a brief introduction to foot strengthening as a management strategy you can use in clinical practice. I have tried to address some general principles and provide some initial resources. Two particular articles come to mind when considering applying foot strengthening to foot and ankle pathology: The foot core paradigm[7] by McKeon et al., and Rathleff's Protocol[6] for managing plantar heel pain. However, like all treatments, these need to be considered with our patient's needs, wants and requirements.

All in all, foot strengthening and rehabilitation are areas podiatrists can improve to develop our scope of practice and truly own the management of the foot and ankle, beyond just issuing another pair of orthoses.

Links and resources

1. pubmed.ncbi.nlm.nih.gov/17609331
2. tandfonline.com/doi/abs/10.1080/13548500410001670690
3. jospt.org/doi/abs/10.2519/jospt.2019.8588
4. pubmed.ncbi.nlm.nih.gov/32711330/
5. sciencedirect.com/science/article/abs/pii/S0031940617300226
6. pubmed.ncbi.nlm.nih.gov/25145882/
7. bjsm.bmj.com/content/49/5/290 ■

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Foot logics

IS YOUR HEALTH SERVICE AGE-FRIENDLY?

Section editor Dr Kristy Robson explains why a one size fits all approach is the last thing older people need when it comes to allied healthcare.

As an ageing population, it is now evident that most Australians are expected to live for twenty years or more past their 65th birthday. With this comes the complexity of health problems that exist with an increasing older population residing in our communities. In 2017-18 80% of Australians aged 65 and over had one or more chronic conditions. This creates a challenge for health professionals when trying to manage and support older people to live their best lives, as often the health system isn't set up to appropriately deal with this level of complexity.

Meet Kristy

Dr Kristy Robson is a senior lecturer in the School of Community Health (SCH) at Charles Sturt University. Kristy teaches across the clinical subjects and is the academic coordinator of workplace learning for podiatry at CSU. She also teaches in the areas of paediatrics, biomechanics, orthotics and healthy ageing. Kristy completed her PhD in 2016 titled, Exploration of Falls Risk in Regional Australia and she has extensive experience in healthy ageing research and enhancing mobility, particularly in older populations to maintain their quality of life. She is particularly interested in qualitative methodologies and community based participatory research approaches that value participants to have an active voice and contribute to practical solutions to problems that impact their communities within a co-creation framework.

Models of care

At the same time, the way we deliver health care is rapidly changing, and as such there are opportunities to improve our approach to support the health and wellbeing of older people. Creating age-friendly models of care are gaining momentum across the globe. These models have a focus on working with older people to understand what matters to them through implementing evidence-based care that has a coordinated approach.

As allied health professionals, we need to ensure that we are working in partnership with our clients, while understanding the diversity of needs and wishes of older people and not having a one size fits all approach to healthcare.

The fifth article in this series on the topic of aged care explores age-friendly health service models of care and how allied health professionals can contribute to facilitating age-friendly health practice.

This article's focus

In this article I will focus on:

- What is an age-friendly health service model
- Why is it important to consider this type of health care
- What can allied health professionals do to incorporate an age-friendly model into their everyday practice

Allied health services are provided across a broad range of settings within Australia, including inpatient and outpatient hospital settings, community health centres and the private sector. All these settings regularly engage with older people and as such, allied health practitioners have a role to play in ensuring that the services that they provide are age-friendly.

What is an age-friendly health se

As we slowly emerge from the current COVID pandemic, we need to consider: ***'How can we reintroduce care differently, instead of just returning to business as usual?'***

An age-friendly health system is based on the 4M's international framework that is evidence-based and is designed to prevent decline, while maintaining or improving the health and wellbeing of older people who are accessing health services.

Older people often talk about negative experiences when engaging with health professionals, such as ageism translating into sometimes insensitive or dismissive comments or management approaches.

The **4M**s as a framework

The Institute for Healthcare Improvement describes the 4Ms as a framework or model of care that is not designed to be an addition to the care that is already being provided, but rather enables health professionals to consider whether they are incorporating all the essential areas of care to improve health outcomes for older people.

The four elements of this framework include:

What Matters:

- Know what matters to the older person, what are their health outcome goals and care preferences for current and future care.

Medications:

- Consider standard process for age-friendly medication reconciliation and instigate deprescribing or adjust doses to be age-friendly.

Mobility:

- Implement an individualised mobility plan and create an environment that enables mobility.

Mentation:

- Consider whether the older person has adequate nutrition, hydration, sleep and comfort and engage with them to maximise independence and dignity.
- Identify, treat and manage dementia, delirium and depression.

Why is it important to consider this type of health care?

Health services need to be orientated towards the needs of older people rather than on the focus of health services themselves. Within the 'busyness' of the clinical day (and the competing challenges of providing quality and safe healthcare balanced by financial and time pressures) it is important to remember that active listening matters.

Older people often talk about negative experiences when engaging with health professionals, such as ageism translating into sometimes insensitive or dismissive comments or management approaches. Hurried through appointments with distracted health professionals without having a chance to or feeling empowered to ask questions is also commonly highlighted. Some older people often feel that their health concerns are just dismissed or put down to old age without consideration of underlying pathology.

- ….he said, ***"I am the health professional here and I will tell you what is wrong with you."*** (older Australian person)
- ***"Just a look on the health professionals' face, you don't want to ask questions."*** (Cheryl, 76 year old retired teacher)

Positive encounters can be deeply gratifying for both parties by building trust and rapport.

- ***"The health professionals were sincerely concerned about my well-being… They behaved as if, at that very moment, I was their only patient."*** (Marian, 72 year old former pilot and police trainer)
- **"She listens; she treats me as an equal… we discuss things and she gives me choices."**

ervice model?

What can allied health professionals do?

Allied health professionals can incorporate an age-friendly model into their everyday practice in many ways.

While as podiatrists we aren't always able to provide all aspects of the 4M framework, we can recognise and respond to these elements by actively engaging in conversation with our older clients and facilitating appropriate referral pathways where necessary.

Here's some elements to consider in this context

What Matters: Consider how we engage with older people, including the language we use, as well as how other staff interact within our practices/organisations and embed regular health questioning on what matters to them.

Medications: Keep up to date with the medications that our older clients are taking and be proactive in referring on for medication reviews if you consider there are issues or changes that need to be made.

Mobility: For all older clients consider incorporating a mobility plan, work with them to achieve their goals and regularly review how they are going.

Mentation: You should be regularly questioning older clients on their overall health and wellbeing, and actively instigating referral pathways when you identify areas that would benefit additional support or review.

Other key things to consider

These include:

- Undertaking a comprehensive assessment to ensure you are considering the whole person
- Having shared common care and treatment goals across different health providers
- Understanding what services are available in the local area to support older people so effective referral pathways can be instigated
- Tailoring management strategies to incorporate self-management approaches
- Regularly reviewing the goals and outcomes that have been implemented
- Having ongoing conversations on what matters to the older person and what support they need using the 4M model approach.

The end goal

Working together with older people to identify and understand their needs, expectations, values and preferences is critically important given our ageing population and the complexity of health care needs older people present with. As allied health professionals, we should be responsive to the needs of our older clients and ensure that we are incorporating the spirit of an age-friendly health service model into every encounter we have.

More information

- Towards age-friendly primary health care. World Health Organisation (2004): **apps.who.int/iris/handle/10665/43030**
- Age-Friendly Health systems: Guide to using the 4Ms in the Care of Older Adults. Institute of Healthcare Improvements (2020): **ihi.org/Engage/Initiatives/Age-Friendly-Health-Systems/Documents/IHIAgeFriendlyHealthSystems_GuidetoUsing4MsCare.pdf**

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PODIATRY + RHEUMATOLOGY: THE CRITICAL CONNECTION

Dr Mike Frecklington explains why podiatrists are well placed to manage rheumatic foot conditions especially given people may not otherwise receive timely and appropriate care. And through this, podiatrists can help to grow the profession's profile.

> ...people with rheumatic conditions experience high levels of foot pain, impairment and disability... The high prevalence of foot problems in these populations positions podiatrists as a key part of this team.

Mike Frecklington is Head of Department Podiatry at AUT University (Auckland, New Zealand). He was awarded his BHSc (Hons), MPhil and PhD from AUT University. His research focuses on the impact of inflammatory arthritis on the foot.

As you would be aware, rheumatology is a rapidly changing field that covers a vast range of inflammatory, non-inflammatory and auto-immune conditions. These conditions affect multiple systems, with many having clinical manifestations at the foot and ankle, such as rheumatoid arthritis and gout.

As podiatrists we know that people with rheumatic conditions experience high levels of foot pain, impairment and disability. Due to the complex nature of these conditions, effective management often involves input from multiple health care professionals. The high prevalence of foot problems in these populations positions podiatrists as a key part of this team.

Patient pathways + barriers to care

However, for people with rheumatic conditions, the decision to engage with foot care services is complex. Many describe a unique and often prolonged journey prior to their engagement with a podiatrist. Disabling foot pain, footwear difficulties, foot ulceration are common clinical presentations. The barriers to foot care are well documented, driven by factors such as funding, access, a lack of confidence in assessing the feet from other health care professionals and awareness about the role of the podiatrist. There is an unmet need for foot care in this population, but are there other missed opportunities for podiatry?

Advocating for what we do

As the feet may be the first site of involvement, the podiatrist may be the first person to identify the presence of rheumatic disease. Expertise in debridement, wound care, footwear, foot orthoses and exercise prescription, further highlight the important role podiatrists play in the wider management of this population.

From an education perspective, podiatry programmes across Australasia embed specific content through the musculoskeletal curriculum, dedicated podiatric rheumatology papers, multidisciplinary podiatric rheumatology clinics and external placements. This provides a great opportunity for students to develop and showcase their skills surrounding gait analysis, musculoskeletal, neurological, vascular and dermatological assessment.

Whilst podiatric rheumatology is now a fundamental part of the curriculum, the pathway for career development is not as established as other areas of specialisation, such as the diabetic foot. In clinical practice, the uptake of musculoskeletal ultrasound, more advanced methods of gait analysis and other treatment modalities provide opportunities for those to apply their existing skills to a population in great need.

What is required right now

There is great potential for collaboration and integration of podiatrists into teams managing people with rheumatic conditions. The relationship between podiatry and rheumatology is clear. Are we putting our best foot forward for our patients and the profession?

In summary

The foot problems experienced by people with rheumatic conditions are complex in nature and often require input from a range of health care professionals. Podiatrists are not only well positioned to manage these foot problems, but also to advocate for better services and promote the profession by improving the lives of those with rheumatic conditions. ■

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DEEPENING THE CONVERSATION

Section editor James Gerrard sparks new conversations this month with some more conference insights, highlighting the important role of hearing First Nations' voices in developing cultural safety, and encouraging more podiatrists to review the content within the Australian Podiatry Conference's Indigenous stream.

James is a podiatry graduate who has worked in public and private settings in Victoria, New South Wales and Tasmania, and he now lectures at La Trobe University within the discipline of podiatry. James is also a current University of Newcastle PhD candidate, involved in research giving First Nations voice to foot health education, and the developing, delivering, and evaluating of cultural safety education for undergraduate podiatry students.

Over the course of the national conference, the Australian Podiatry Association broadcast 79 presentations delivered by over 60 different presenters from the UK, Canada, the USA, Singapore, New Zealand and of course, Australia. Importantly, this included Indigenous voices!

Here are some more highlights that occurred at the conference. You can access all session recordings and 'on demand' oral presentations within the conference portal under their session streams and dates, using the link you were given when you registered for the conference. All recordings in the Indigenous stream are available for review until 30 November 2021.

The concept of truth-telling

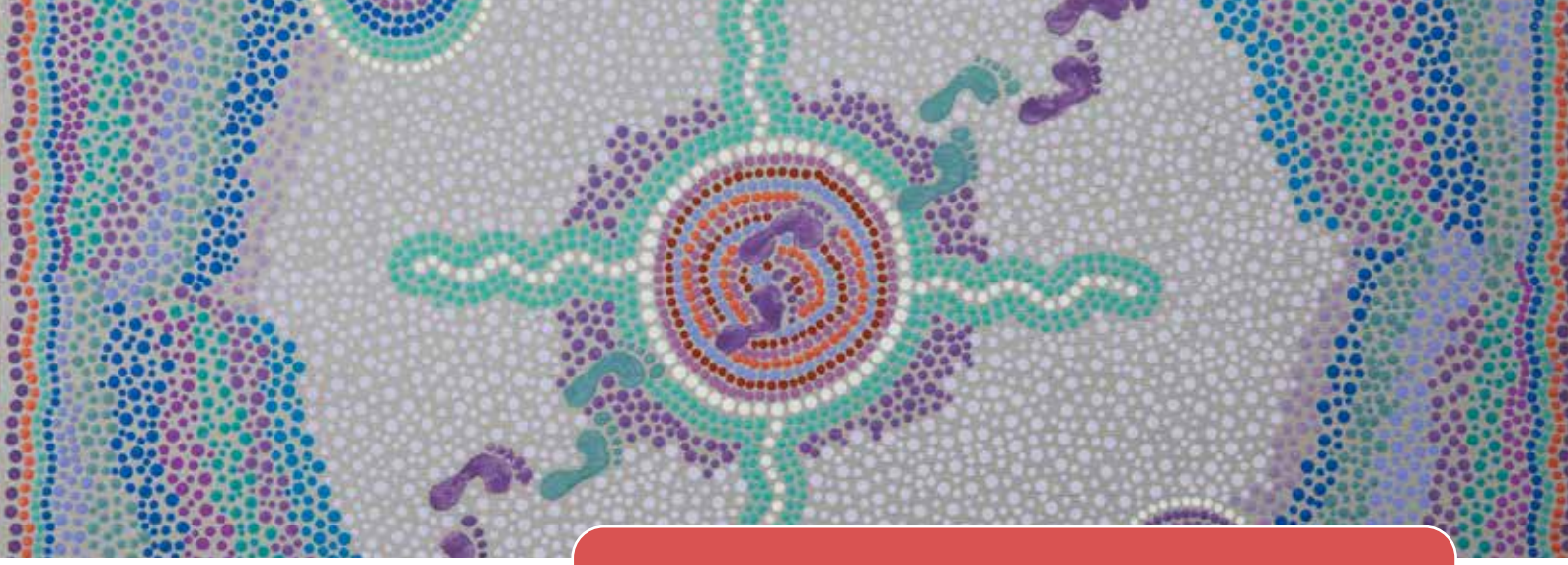
The concept of truth-telling was brought to the national conference through its Indigenous stream. Professor Megan Davis, Associate Professor Rosalind Dixon, Associate Professor Gabrielle Appleby and Noel Pearson tell us in an edited transcript of The Uluru Statement, 'truth-telling opens the way for justice, healing, the restoration of dignity and on those bases, reconciliation'.

Truth-telling validates Aboriginal and Torres Strait Islander perspectives and acknowledges the lived realities of Aboriginal and Torres Strait Islander Peoples – elements integral to Aboriginal and Torres Strait Islander health and healing. Listening to, hearing, privileging and valuing Aboriginal and Torres Strait Islander voices supports such truth-telling.

An example

An example of truth-telling is the Yoo-rrook Justice Commission occurring in Victoria, established as the nation's first truth-telling process. You can read further about it under the 'truth and justice' section of 'Aboriginal Victoria.' (**aboriginalvictoria.vic.gov.au**).

'Yoo-rrook is the Wemba Wemba / Wamba Wamba word for truth.' The Yoo-rrook Justice Commission aims to acknowledge truths, build positive



relationships, and educate the wider community. The process will 'investigate both historical and ongoing injustices committed against Aboriginal Victorians since colonisation by the State and non-State entities, across all areas of social, political and economic life.'

The Yoo-rrook Justice Commission's historic work draws upon 'a vast range of knowledge and experience across the fields of law, sociology and systemic disadvantage, land rights, history, trauma and healing.'

Listening to Aboriginal and Torres Strait Islander voices

Listening to Aboriginal and Torres Strait Islander voices is collaborative and it is a mechanism for improving culturally safe podiatry healthcare, teaching and research. According to the study, Release of the National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025; the impacts for podiatry in Australia: a commentary – Journal of Foot and Ankle Research it challenges and changes practices and culturally co-creates a decolonised space of new knowledge, insight and understanding. A core performance indicator of culturally safe frameworks stipulated for all levels of healthcare design and delivery is the inclusion of local Aboriginal and Torres Strait Islander voices. This empowers the experts in Aboriginal and Torres Strait Islander health, Aboriginal and Torres Strait Islander Peoples themselves, to implement, direct and evaluate culturally safe initiatives. In developing our cultural safety, listening to First Nations voices is key.

Noteworthy highlights

This year conference attendees were privileged to hear keynote presentations from Kaurna man Associate Professor James Charles (above left), Murrawarri man Dr Brett Biles (above centre), and Māori woman Belinda Ihaka (above right). Particular highlights when reviewing this year's conference are:

- Associate Prof James Charles discusses data sovereignty at the beginning of his keynote address 'Aboriginal Australian Biomechanics and Foot Health'.
- Listening to Dr Brett Biles discuss Aboriginal men's health, in particular being a complex issue, 'with the continuing impacts of colonisation, marginalisation and disempowerment leading to reduced access to primary health care services and disengagement with activities that promote health and wellbeing'.
- Belinda Ihaka discussing 'Indigenous Perspectives in Podiatry: Aotearoa,' and paying particular note to the imagery and artistic model of the importance of the feet from Indigenous perspectives.

We were then lucky enough to have James, Brett and Belinda take a live Q&A, which can still be accessed via the link you were supplied when you registered for the conference.

Turn to page 10 to meet Nellie Green, the artist behind the beautiful artwork featured in this section.

Meet the artist behind this section

Nellie Green is a Badimaya woman from the Yamatji people of the Central Wheatbelt area of Western Australia. Born in Morawa, Western Australia, she lived most of her life in Perth and Fremantle, before moving to Melbourne in 2001. Nellie has three sisters and two brothers and she is an Aunty, Great-Aunty, and Great-Great Aunty.

Nellie's artwork *Gugurr yan.guwan dhadhadya ('Keep on walking strong')* shown above is dedicated to our progressively decolonised space here in STRIDE, Nellie's art educates us into First Nations perspectives of foot health. Nellie describes her work, sharing "the importance of foot health to First Nations Peoples, with footprints in the work depicting the footsteps that take us through a lifetime."

Nellie continues, "Footsteps that carry us on continuous journeys along different paths, that carry the energy, that carry the burdens, that carry the accomplishments, and that carry the stories of our own lives."

Nellie describes the colours she has used in the art. "[It is] … a means to present a serious message in good humour. While the loss of foot health is traumatic, a lot of people need to get over the stigma about feet and hiding them, and need to be proud of their feet, considering what they put up with and what we put them through."

As Nellie concludes, "We trust our feet to bring us home." ■

FOUR WAYS TO IMPROVE YOUR CYBERSECURITY

If you run a podiatry practice and want to be sure you are as protected online as possible, read on...

Cybersecurity readiness doesn't come easily. Reacting to a security breach is vastly different from being ready to act should a breach occur. If you haven't previously focused on proactively protecting your critical information assets, change is coming. The increased sophistication of today's threat heightens the chances that more businesses, such as health-based clinics, will find themselves the unlucky targets of cybercrime.

Did you know that in the past 12 months, more than 50% of Australian businesses have been hit by a cyberattack and suffered an average four days of downtime, according to an industry report? Phishing emails and malicious code can compromise computer systems, cut off access to vital data and wreak havoc to supply chains. Depending on the scope of the attack, the consequences range from minor disruption to a total breakdown of business continuity. Lost productivity, reputational damage and depressed revenue growth are among the direct costs.

What can your practice or clinic do to prepare for, respond to and recover from cyber threats?

1.

Keep up with security hygiene

"Any system is an entry point for potential threat actors."

With scale and complexity comes the notion that any business needs to only protect their business-critical assets. The challenge with this approach is that virtually any system is an entry point for potential threat actors.

So, while businesses need to classify their assets by importance and apply a set of non-negotiables to those considered business-critical, the planning shouldn't end here.

Crucial to this process is having an information security strategy in place that helps businesses make a habit of their cyber hygiene practices. Included in the design are fundamentals like access management, data management and multi-factor authentication. It's about being proactive and cultivating a threat-active mindset.

2.

Foster a culture of security

"Future-proofing your business against cyberattacks starts now with a top-down culture."

Future-proofing your business against cyberattacks starts now, with a top-down culture. When driven from above, it's possible to establish a culture that security belongs to everyone and that all employees should make intelligent decisions to defend against cyber threats.

Collaboration is required between management, teams and individual staff to ensure security protections and processes are followed through at all levels. The growing regulatory burden associated with fighting cybercrime requires a coordinated approach. The 2020 Critical Infrastructure Bill has expanded from 4 to 11 sectors, demanding a higher percentage of companies across Australia to pay closer attention to their security measures.

The Australian Prudential Regulation Authority (APRA) will also be expanding its regulatory reach and coverage, with its 2020-2024 strategy noting plans for an approximate 96% increase in coverage. This will see their range rise from 680 organisations to around 17,000 businesses. If this affects you, then it’s a good idea to start to prepare now for this increased regulatory burden.

3.

Build cyber resilience

"Computers will be at the frontline of government-backed wars between countries."

Cyber resilience is about anticipating a breach rather than reacting to it. Given the increase in nation-state cyberattacks on businesses, it's likely that computers will be at the frontline of government-backed wars between countries. So, it's essential to understand that cyberattacks aren't going away, and businesses will never protect their networks completely. But what they can do is ensure continuity of operation, so when an attack happens, the impact is minimal.

A core aspect of building cyber resilience is bolstering the whole company to be in the future state; by continually revisiting their policies, procedures and accountability framework to ensure it aligns with their overarching direction.

Teams must regularly test the capabilities of their incident response plan with real-time simulated attacks to see how a cyber incident might affect applications, systems and interfaces. Identify any weak points and process gaps before, not after, a crisis hits.

4.

Take ransomware seriously

"When you pay ransomware, you're feeding the beast."

Ransomware attacks are escalating, affecting businesses of all sizes across multiple industries. In 2020, 61% of companies reported they had been impacted by ransomware, up by 20% from the previous year. When a business is faced with the crippling realisation that their files are now inaccessible and can only be decrypted by paying the attacker, many choose to pay the ransom to make the problem go away.

Palo Alto's 2021 Ransomware Threat Report shows the average ransom paid for organisations increased from US$115,123 in 2019 to $312,493 in 2020, a 171% increase. In 2020, the highest ransom demand hit $30 million.

It's a difficult decision, but the bottom line is that when you pay ransomware, you're feeding the beast. And it's not even a get-out-of-jail-free card because once you've paid, your business is more likely to be impacted a second time. According to a recent global survey of security professionals, some 80% of businesses that chose to pay a ransom demand suffered a second ransomware attack, often at the hands of the same group.

Notably, it shouldn't be up to the cyber incident response team to wear this decision. A playbook should already be in place outlining the precise plan for what happens when there has been a breach. Playbook content might include projected productivity loss thresholds and reputational impacts to help navigate the way forward. ■

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How to sell your podiatry product

By Ben Lindsay: biomedical engineer, technologist and futurist

Ben Lindsay takes podiatrists turned inventors (or innovators) through the steps involved in selling your podiatry product to the customer. These steps can be applied to a range of other circumstances too!

Ben Lindsay is the inventor of the Solushin medical device and Program Manager of INCUBATE. You can contact him via **ben@solushin.com** or on LinkedIn.

Last month we touched base on how to determine what people really want in a product, the problems they face and how you can quantify their pain points. Now we are onto the next, big and often scary step, selling your product.

You may have heard of the expression, "Every conversation is a sales conversation. You're either selling or being sold to." I like to think of sales a little bit differently: Rather than trying to convince someone that you are right or they should purchase your podiatry product, you are a problem solver.

This month, I will provide you with a framework around how to structure your sales conversations which is easy to follow, and it makes the conversation about your customer. It also shows why long-time value in podiatry trumps any short-term wins.

'SPIN selling' is a framework of questions established by author Neil Rackman: situation, problem, implication and need payoff.

In a nutshell, if we start with cognitively easier questions and set the tone of the conversation, we can truly understand the individual we are talking to. If we ask a confusing or confronting question too soon, we not only miss out on truly understanding them, but they might get defensive. A note here, you need to learn to adapt these questions depending on their responses to previous questions. Use this as a framework, not a script.

#1 Situation

Situational questions set the tone. Questions like, “Can you please tell me about your experiences treating plantar fasciitis?” let the individual know you are there to talk about plantar fasciitis. It also puts the ball in their court and informs you of their experiences.

#2 Problem

Problem questions take the next step, and they begin to dive into the issues within that situation. You might ask, “What have you found most difficult in treating plantar fasciitis?”.

Again, the ball is in the customer's court. You’re letting them explain their pains and frustrations. You aren’t leading them with your own bias. For the sake of the next question, let’s assume exercise compliance is what they’re struggling with.

#3 Implication

Implication questions are the most forgotten step. What does that problem actually mean for the person in front of you? Does it mean they aren’t happy with the patients’ outcomes? Do they find it difficult and upsetting that the patients are not respecting their instructions? Do they feel they’re wasting their time with these patients? Let’s find out. Perhaps in this example you ask something like, “When patients are compliant with the exercises, does that impact you or your clinic?”

#4 Need payoff

Need payoff questions are the best questions. Here we establish what it would mean to solve the implication of the problem. “What would it mean to improve your patient outcomes? Improve compliance? Get that time back you wasted on non-compliant patients?”

From SPIN, we get a clear framework of what your customers' problems are. However, you need to be respectful now and answer honestly, “Does your product or solution solve the problem and satisfy the ‘need payoff’ question?” This is where sales can get manipulative.

If you show a deep understanding of your customer and knowingly push a product onto them that doesn’t actually hit all of those things – sure you might get a short-term win, but in the long-term, the truth will become evident. You won’t have a happy customer yourself.

What matters

My recommendation? Focus on the lifetime value of your customers. You might have a new product for them in the future that is better suited, or they might not be in need of your product just yet. There is nothing more trustworthy than a salesperson who tells the customer they don’t think the current product is right for them.

Disclaimer: My SPIN examples were incredibly simple. I recommend you do your own research on this framework to get a variety of examples to better understand the concept. ■

More information

Buy Neil Rackman’s book on any major website such as Amazon: **amazon.com.au/Spin-Selling-Neil-Rackham/dp/0070511136**


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REFRESHER: COVID-19 workplace relations

By Jack Byrnes, APodA HR Advisory Service

As the COVID-19 pandemic continues to drag on, it is important to remain informed about your workplace rights, entitlements and obligations during this time. This article answers some of the key COVID-19 workplace relations questions that may arise in your practice.

Q: I am an employee and I have been ordered by government/ health authorities to isolate after returning from interstate. What am I entitled to be paid?

The Health Professionals and Support Services Award 2020 currently contains a specific entitlement of up to 2 weeks unpaid pandemic leave which can be used in circumstances where an employee is unable to work as a result of the pandemic. If you prefer to be paid, you can request to take annual leave (or long service leave if applicable/allowed in your state/territory). Personal/carer's leave (sick leave) should only be used if you are genuinely unfit for work due to an illness or injury or if caring for someone.

Q: My state/territory government has just announced a snap lockdown. What does this mean for my staff?

This will depend on the precise terms of the lockdown and in particular, whether the lockdown requires the practice to close/substantially restrict operations (such as telehealth only). In the event where your practice is ordered to close, or restrict operations to the point where it would not be viable to remain open (such as if telehealth was not an option at your practice etc.), then a Stand Down under Section 524 of the Fair Work Act 2009 may be permissible.

These Stand Down provisions state that staff can be stood down without pay if they cannot be usefully employed due to a stoppage of work for which the employer cannot reasonably be held responsible. Before standing staff down however, other paid options should be explored – such as agreeing to take annual leave or long service leave if applicable. Please contact the APodA HR Advisory Service for more information on this.

In a lockdown which does not place any specific restrictions/limitations on your practice, you cannot use the stand down provisions. If you still wish to make changes to staffing arrangements due to a potential loss of revenue etc., you will need to seek agreement from employees to either temporarily reduce their hours or take a period of paid leave. For further advice on managing staff during lockdowns, please contact the APodA HR Advisory Service.

Q: Can an employer force staff to receive the vaccine?

With the Delta variant spreading across much of the country, employers need to consider whether mandating the COVID-19 vaccine for their staff is a necessary step to ensure they are fulfilling their legal obligations with regard to work (occupational) health and safety. For a mandate to be enforceable however, there either needs to be a specific law in place (such as a public health order) that requires a worker to receive the COVID-19 vaccine, OR, in the absence of such a law, the direction for a worker to be vaccinated needs to be considered lawful and reasonable. There are a number of different factors that should be considered when determining whether a direction for a particular staff

member to be vaccinated is lawful and reasonable and each individual direction is assessed on a case by case basis. Members are strongly encouraged to contact the APodA HR Advisory Service or seek independent legal advice if they are looking to mandate the vaccine in their workplace.

Q: I provide care to a school aged child and their school has been closed suddenly due to a confirmed positive case of COVID-19. What am I entitled to be paid for the period of the closure?

Given the school closure was unexpected, you are entitled to personal/carer's leave if you are a permanent employee. This is because personal/carer's leave can be used in the event of an "unexpected emergency".

Q: I have cold/flu-like symptoms, should I go to work?

No, stay home and get tested. Contact your employer and request to use your personal/carer's leave entitlement and only return to work when you feel better and have received a negative test result.

Q: Can I force my employee to get a COVID-19 test if I suspect they may have been exposed to the virus?

Under Work, Health and Safety laws, an employer has an obligation to do everything reasonable to ensure the health and safety of those in their workplace. Therefore, if you have genuine reason to suspect that your employee may have been exposed to the virus, then a direction for them not to attend work until they receive a negative COVID-19 test result will likely be considered reasonable. If the direction is strictly coming from the employer – i.e., the employee has not been required to get tested by a health authority – they will need to be paid normal wages for any ordinary hours that would have otherwise been worked during the time taken to receive the negative test result.

**Please note, the information in this article applies to the National System employers and their employees throughout Australia. If your practice is in the Western Australian State System, please contact the APodA HR Advisory Service for information on staff rights and entitlements during the COVID-19 pandemic.* ■

Need more information?

For further advice, please contact the APodA HR Advisory Service on 1300 620 641 or **hrhotline@podiatry.org.au**. As always, our online resources are available 24/7 at **podiatry.org.au/member-resources/human-resources-portal**

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