Indian Health Service Best Practice for Diabetic Foot Care
A Strategy for Primary Care Clinicians

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Area Diabetes Consultant
Bemidji Area Indian Health Service
Learner Objectives

1. List risk 4 factors for diabetic foot complications
2. Be able to conduct a complete diabetic foot exam
3. List 3 interventions associated with decreased risk for foot complications
4. State 4 educational objectives for patients at high risk for foot complications
5. Describe 4 components of the chronic care model related to improving diabetic foot care
Protecting the Diabetic Foot
A Strategy for Primary Care Clinicians

• Screening for High Risk Patients
• Practical Interventions
• Implementation into Practice
Why is Foot Care Important for People with Diabetes?

- ~40% will develop peripheral neuropathy
- ~20% have an acute foot problem on foot exam
- ~15% will develop an ulceration (cost ~ $13-30K each)
- 5-10% progress to amputation (cost ~ 50K/yr each)
- 43% with ulcer and 47% with amputation die in 5 years
- Most amputations can be prevented with resources currently available in primary care
- Most patients with diabetes get their care from primary care providers

CDC, 2008; Harris, 1993; Kumar, 1994; Borrsen, 1990; Reiber, 1999; Stockl, 2004; Rith-Najarian, 2001; Moulik, 2003
## Foot Related Risk Factors for Ulceration

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Ulcer</th>
<th>LEA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neuropathy</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Deformity</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Limited Joint Mobility</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Prior Ulcer/LEA</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>PVD</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Onychomycosis</td>
<td>+</td>
<td></td>
</tr>
</tbody>
</table>

Pham, 2000; Lavery, 1998; Rosenbloom, 1996; Walters, 1992; Kumar, 1994; Fernando, 1991; Rith-Najarian, 1992; Mayfield 1996; Alder, 1999; Boyko, 2006
Non-Foot Related Risk Factors for Ulceration and Amputation

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Ulcer</th>
<th>LEA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male Sex</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>Duration DM</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>hyperglycemia</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>hypertension</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>dyslipidemia</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>smoking</td>
<td>±</td>
<td>±</td>
</tr>
<tr>
<td>Vision &lt; 20/40</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>Other complications</td>
<td>+</td>
<td>+</td>
</tr>
</tbody>
</table>

Moss, 1996; Alder, 1999; Palumbo, 1995; Moss, 1992; Moss, 1999; Litzelman, 1997; Lee, 1993; Boyko, 1999; Nelson, 1988; Selby, 1995; Lehto, 1996; Eggers, 1999; Boyko 2006.
Simple Criteria to Identify High Risk Feet in People with Diabetes

- Insensate to 10-gram monofilament
  or Insensate to 128-Hz tuning fork
- Foot deformity
- Prior ulcer or amputation
- Absent pulse or abnormal ABI pressure

Diabetes Care, 31:1679-85, 2008; Diabetes Res Clin Pract, 70:8-12, 2005
Feet Can Last a Lifetime, NIH/NIDDK, 2002
• Press perpendicular to point of bending, hold 1 second and release (Demonstrate on hand)
• Patient Closes Eyes, and acknowledges sensation of pressure with a “yes”
• Test Both Feet, 4 sites each: Great toe and 1\textsuperscript{st} 3\textsuperscript{rd} 5\textsuperscript{th} metatarsal heads (not heel or dorsum)
• Insensate in one or more area confers risk

Perkins, Diabetes Care 2001;24:250-256
Diabetes Care, 1992;15:1386-89
Vibration Sensation Testing
128 Hz Tuning Fork

• Tested over the tip of the great toe bilaterally

• An abnormal response can be defined as when the patient loses vibratory sensation and the examiner still perceives it while holding the fork on the tip of the either toe

Singh JAMA 293:217–228, 2005
Development of Foot Deformities

Bunions – hallux valgus
Foot Deformities Associated with Risk for Amputation

Bunions – hallux valgus
Foot Deformities Associated with Risk for Amputation
Foot Deformities Associated with Risk for Amputation
Charcot Foot

IHS Division of Diabetes Dec 2009
# Selected Clinical Assessment of Peripheral Arterial Vascular Status and Abnormal Thresholds

<table>
<thead>
<tr>
<th>Vascular Test</th>
<th>Abnormal Threshold</th>
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</thead>
<tbody>
<tr>
<td>Pedal Pulses:</td>
<td>Absent</td>
</tr>
<tr>
<td>Ankle Brachial Index (ABI):</td>
<td>&lt; 0.8</td>
</tr>
<tr>
<td>Toe BI:</td>
<td>&lt; 0.6</td>
</tr>
</tbody>
</table>

Pham Diabetes Care 2000;23:606-11
Wang, Circulation 2005;112:3501-3508
Arterial Anatomy of the Foot

Dorsalis Pedis artery

Posterior tibial artery
Ankle Brachial Index

1. Measure Doppler brachial pressures in each arm
2. Measure Doppler Pressure in each ankle
3. **Calculate ABI**: \( \text{ABI} = \frac{\text{Ankle BP}}{\text{Brachial BP}} \)
   
   *Divide the ankle pressure by the greater of the two brachial pressures*

From Hurley et al, *The Diabetic Foot*, 1993
# Correlation of POAD Symptoms by ABI Category

<table>
<thead>
<tr>
<th>Severity Category</th>
<th>ABI Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>1.0-1.4</td>
</tr>
<tr>
<td>Borderline</td>
<td>0.90-0.99 or &gt; 1.4</td>
</tr>
<tr>
<td>Mild</td>
<td>0.70-0.89</td>
</tr>
<tr>
<td>Moderate</td>
<td>0.40-0.69</td>
</tr>
<tr>
<td>Severe</td>
<td>&lt; 0.40</td>
</tr>
</tbody>
</table>

Wang, *Circulation* 2005; 112:3501-3508
Video of Foot Exam
Protecting the Diabetic Foot
A Strategy for Primary Care Clinicians

• Screening for High Risk Patients
• Practical Interventions
• Implementation into Practice
Pathways to Diabetic Limb Amputation: a Basis for Prevention

Nerve Damage Deformity “High Risk”

Injury

Foot ulcer

Poor circulation

Infection

Gangrene

Amputation

Pecoraro Diabetes Care 1990;13:513-21
Component Causes Present in Casual Pathways Leading to Foot Ulcers in Persons with Diabetes

Reiber, Diabetes Care, 1999;22:157-62

<table>
<thead>
<tr>
<th>Component Cause</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neuropathy</td>
<td>78</td>
</tr>
<tr>
<td>Minor Trauma</td>
<td>77</td>
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<tr>
<td>Deformity</td>
<td>63</td>
</tr>
<tr>
<td>Edema</td>
<td>37</td>
</tr>
<tr>
<td>Callus</td>
<td>30</td>
</tr>
<tr>
<td>Infection</td>
<td>1</td>
</tr>
<tr>
<td>Ischemia</td>
<td>35</td>
</tr>
</tbody>
</table>
## Strategies to Prevent or Delay Development of Common Component Causes of Foot Ulceration and Amputation

<table>
<thead>
<tr>
<th>Component Cause</th>
<th>Intervention Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neuropathy</td>
<td>Good glycemic control, Education on Risk for foot injury</td>
</tr>
<tr>
<td>Minor Trauma</td>
<td>Clear Walking Space, Nightlights, Protective footwear</td>
</tr>
<tr>
<td>Deformity</td>
<td>Accommodative footwear, Education to support footwear</td>
</tr>
</tbody>
</table>
| Edema           | Footwear accommodative to of edema  
|                 | Reduce edema: pharmacologically, compression stockings |
| Callus          | Regular removal of callus  
|                 | Footwear that minimizes callus development |
| Infection       | Education on reporting problems early |
| Ischemia        | Reduce risk for atherosclerosis (hypertension, and lipid control, smoking cessation)  
|                 | Revascularize for critical ischemia |

Reiber, Diabetes Care, 1999;22:157-62
Association of Patient Education and Amputation Prevention

<table>
<thead>
<tr>
<th>Program</th>
<th>Reduction in LEA Rate</th>
<th>Author, Year</th>
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</thead>
<tbody>
<tr>
<td>Veterans, Tucson USA</td>
<td>70%</td>
<td>Malone, 1989</td>
</tr>
<tr>
<td>Kisa, Sweden</td>
<td>80%</td>
<td>Larrson, 1995</td>
</tr>
<tr>
<td>Kings College, London</td>
<td>44%</td>
<td>Edmonds, 1999</td>
</tr>
<tr>
<td>Geneva, SZ</td>
<td>85%</td>
<td>Assal, 1993</td>
</tr>
<tr>
<td>Madrid, Spain</td>
<td>50%</td>
<td>Calle-Pascual, 2001</td>
</tr>
</tbody>
</table>
Evidence-Based Education and Treatment Objectives for All Patients with Diabetes

*Low-Risk Feet*

- Control glucose
- Control Blood Pressure
- Control Lipids
- Smoking Cessation

Evidenced-Based Footcare Educational Objectives for Patients with Diabetes

High Risk Feet

• Daily washing and inspection
• Clear walking area of dangerous objects
• Appropriate footwear (selection, fitting, & use)
• Use slippers indoors – No barefoot
• Proper Nail and Callus Care (no bathroom surgery)
• Avoid extreme temperatures
• Avoid soaking
• Report problems promptly (Infections, ulcers, cuts that do not heat)

Calle-Pascual, 2001; Reiber, 1999; Ward, 1999; Barth, 1991; Malone, 1989; Edmonds, 1986
IHS Patient Education Materials on Footcare
Pre-tested for Learner Comprehension


http://www.ihs.gov/MedicalPrograms/Diabetes/RESOURCES/Catalog/rde/index.cfm?module=catalog
Footwear and Prevention of Foot Lesions

- Reduced Peak Planter Pressures > 50%
- Reduced callus formation > 30%
- Ulcer recurrence rates reduced > 50%
- LEA rate reduced > 70%

Viswanathan Diabetes Care 2004;27:474-477
Chanteleau, Diabet Med 1994;11:114-6
Ashry, J Foot Ankle Surg 1997;36:268-71
Edmonds, Q J Med 1986;60:763-71
Footwear Anatomy 101

- Collar
- Upper
- Toe Box
- Heel counter
- Insert
- Shank
- Sole
- Added depth
- Rocker sole
Footwear Selection

• Normal feet: standard shoes
• Insensate feet: quality walking shoe or added depth shoe
  • Adjustable upper
  • Firm heel counter
  • Padded insert and collar
  • Broad sole with nominal lift
• Insensate feet + Minor deformity: added depth shoe + custom insert
• Major Deformities: custom molded shoes

Tovey, Diabet Med 1984;1:69-71; Dahmen, Diabetes Care. 2001;24:705-9
Custom-Molded Inserts and Extra-Depth Shoes
Fitting Shoes

• Select shoes that match the shape of the foot
• Measure both feet while standing
• Fit while wearing standard socks
• Fit largest foot
• 1 cm length between longest toe and shoe tip

Tovey, Diabet Med 1984;1:69-71
Footwear Precautions

• Break-in:
  • Start half-hour on first day
  • Then increase by half-hour increments per day
  • Inspect for redness after wearing
• Change shoes 1 to 2 times daily
• Check for foreign bodies
• Replace when worn out
Here are Some Tips for Buying New Shoes to Help You Protect Your Feet?

- Buy shoes in the afternoon. Most people's feet will be swollen by the afternoon.
- Tell the salesperson you have diabetes.
- Have the shoe salesperson measure both feet.
- Test the shoe fit by wearing them for at least 5 minutes in the store.
- If shoes hurt when you try them on, do not buy them.
- Break in new shoes by wearing them for 1-2 hours at a time for the first few days.
- Never wear new shoes all day.
- Check your feet for redness or irritation. If the shoes are causing redness or irritation, return them as soon as possible.

Foot Wear for People With Diabetes
Medicare Therapeutic Footwear Benefit

3 steps:
1. Physician Certification for Therapeutic Footwear (MD, DO)
2. Footwear Prescription (usually a Podiatrist)
3. Fitting and dispensing (usually a Pedorthist)

Routine Podiatry Care for People with Diabetes

Associated with:

Increased self-foot care knowledge and 30% reduction in callus  *Ronnemaa Diabetes Care, 1997;20:1833-1837*

54% reduction in ulceration rates in case control study of 91 diabetic patients with a history of foot ulcers  *Plank, Diabetes Care 2003;26:1691-1695*

75% reduction in LEA rates in Medicare patients with diabetes and high-risk feet who received palliate podiatry foot care services  *Sowell, J Am Podiatr Med Assoc 1999;89:312-7*
Principles of Podiatry Care for People with Diabetes

• Lubricate skin
• Trim nails
• Reduce callus

Suico, 1998; Murray, 1996
Lubricate Dry Skin

• Autonomic neuropathy contributes to dry skin
• Instructed Patients to apply a moisturizing lotion daily
• Oil or water based lotions are a matter of patient preference
• May need care giver to assist
Lubricate Dry Skin
Nail Trimming: Normal Nails

• Use nail nippers, straight or curved.
• Good lighting, comfortable position, safety glasses
• Stabilize the toe with one hand, cut with the other
• Start at one edge and follow the curve.
• File any sharp edges with emery board
Nail Trimming: Normal Nails
Nail Trimming: Curved Nails

• Use nail nippers, strait
• Good lighting, comfortable position, safety glasses
• Start at one edge and follow the curve
• Avoid cutting into corners
• File any sharp edges with emery board
Nail Trimming: Thick Mycotic

- Tend to be very brittle
- Can use nail nippers or dremmel to trim off sharp edges
- Best to refer to a podiatrist or certified foot care nurse

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Callus Debridement

- Good lighting, gloves, alcohol swab, and #15 disposable scalpel
- Wipe with alcohol swab, callus tissue will turn white
- Shave or pear down callus gradually
- Palpate intermittently to feel when you are close to pliable “normal” tissue, then stop.
Callus Debridement
Principles of Wound Care

• Assessing foot Wounds
• Classifying foot wounds
• Management of uncomplicated wounds
• Vascular Assessment
• When to refer
Assessing Foot Wounds

Begin by assessing the following criteria:

• Wound dimensions.
• Quality of the wound bed and edges.
• Surrounding erythema and cellulites.
• Penetration to deep structures (fascia, tendon, bone, FB)
• Lower extremity blood flow.
• Signs of systemic infection (Temperature, WBC)
**Standard Classification Foot Wounds**

**University of Texas Wound Classification**

<table>
<thead>
<tr>
<th>Grade</th>
<th>Grade Description</th>
<th>Stage</th>
<th>Stage Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Pre-ulcer</td>
<td>A</td>
<td>no infection or ischemia</td>
</tr>
<tr>
<td>1</td>
<td>Superficial</td>
<td>B</td>
<td>infection</td>
</tr>
<tr>
<td>2</td>
<td>Soft Tissue</td>
<td>C</td>
<td>ischemia</td>
</tr>
<tr>
<td>3</td>
<td>Bone or Joint</td>
<td>D</td>
<td>infection &amp; ischemia</td>
</tr>
</tbody>
</table>

Armstrong, Diabetes Care 1998;21:855-859
Management Principles
Uncomplicated Wounds

• Clean and moist environment
  • Wound Debridement
  • Regular Dressing Changes
• Off loading
• Oral antibiotics directed by culture
• Monitoring of size
• Outpatient management appropriate
• May need to hospitalize for off loading
• Limited use of adjective healing agents
• Control glucose
Dressing Principle

- Wet to Dry Saline gauze dressing daily is the main stay.
- Adsorbent compounds are useful for soupy wounds.
- Hydrocolloid gels and occlusive dressings have a role in dry wounds.
- Enzymatic debridement may be useful to soften eschar.
Nutrition and Wound Healing

• Positive Nitrogen Balance for Anabolic State
• Vitamin C 500mg daily
• ZnSO4 220mg Daily x 10d then MVI with trace minerals QD

Heyman, J Wound Care. 2008;17:476-8, 480
Desneves, Clinical Nutrition, 2005 Dec;24:979-87
Simple Wound: Debridement
Management Principles Complicated Wounds

• Inpatient management appropriate initially
• Initial Surgical Wound Debridement
• Vascular Assessment and appropriate intervention
• Clean and moist environment:
  • Regular Dressing Changes
  • Consider Negative Pressure Wound Therapy
• Parental Antibiotics directed by culture
• Off loading
• Monitoring of size
• Consider use of adjunctive healing agents
Factors Associated with Diabetic Foot Wound Healing

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Adjusted Odds Ratio (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td>1.14 (1.08, 1.20)</td>
</tr>
<tr>
<td>Age</td>
<td>1.01 (1.00, 1.01)</td>
</tr>
<tr>
<td>Grade*</td>
<td>1.93 (1.82, 2.05)</td>
</tr>
<tr>
<td>Wound duration *</td>
<td>1.30 (1.27, 1.32)</td>
</tr>
<tr>
<td>Wound size*</td>
<td>1.32 (1.30, 1.34)</td>
</tr>
</tbody>
</table>

*P<0.0001

Margolis, Diabetes Care 25:1835-1839, 2002

PATIENCE!

<25% ulcers healed at 12 weeks

Margolis Diabetes Care, 1999;22:692-695
Off Loading with Commercial Healing Shoes

70% patients did not increase activity and used device only 28% of time
30% patients record more activity, but only use device 60% of time

Armstrong, Diabetes Care 26:2595-2597, 2003
Adjunctive Wound Healing Therapy

• All Associated with higher and faster healing rates
  • Growth factors (~15-25%)
  • Skin graphs (~50%)
  • Hyper baric Oxygen (~20%)
  • Electro-stimulation (?)
  • Maggot Therapy (~50%)
• Dependent on adequate vascular supply and clean wound
• High cost and not always covered by insurance

Adjunctive Wound Healing Therapy
a Rational Approach

• Ensure the basics first: clean wound, off loading, control infection, good nutrition, metabolic control, assess circulation.

• Monitor healing, if less than 50% reduction in size after 4 weeks, chances of healing < 10%. Consider adjunctive agents as resources permit. Sheehan, Diabetes Care 2003;26:1879-1882; Margolis, Diabetes Care 26:1696-1700, 2003

• Some adjunctive treatments require large capital expenditures. Resources may be better spent on a case manager which can improve all aspects of diabetic care.
Criteria for Vascular Evaluation in the Diabetic Foot

• Ulcer with clinical signs of ischemia
• Non-healing ulcer
• Rest pain
• Nocturnal pain
• Lifestyle limiting claudication
Remove Shoes Every Visit
Inspect Feet for Acute problems

No Ulcer

Annual Foot Exam
Test SWM, Inspect for Deformity, Prior Ulcer or Amputation

Low Risk
Normal Exam
- Education and Care Stressing: Control Blood Sugar and Blood Pressure
- Smoking Cessation
- Follow-up yearly

High Risk
Abnormal Exam
- Patient Education
- Protective Shoes
- Podiatry Care
- Plus measures for low-risk patients
- Follow-up every 2-3 month

Ulcer

Assess Ulcer
Debridement, Blood Count, Temperature, Wound Culture, Assess Circulation

Uncomplicated Ulcer
<2 cm, no deep tissue involved, no major infection and Adequate circulation
- Outpatient Care
  - Weekly Debridement, Daily Dressing Changes, Non-Weight bearing, oral antibiotics if limited infection
  - Weekly Visits until Healed, then treat as High-Risk. Failure to improve in 4 week, treat as Complex ulcer

Complicated Ulcer
>2 cm, deep tissue involved, major infection or inadequate circulation
- Hospital Care
  - Surgical Debridement, Dressing Changes, IV Antibiotics, Vascular Assessment and Treatment
  - Daily Visits until Infection Controlled, Circulation Restored and or ulcer size reduced, then treat as Simple Ulcer.

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Protecting the Diabetic Foot
A Strategy for Primary Care Clinicians

• Screening for High Risk Patients
• Practical Interventions
• Implementation into Practice
Improving Chronic Disease Care: The Chronic Care Model

Chronic Care Model – Diabetic Foot Care
Best Practice

Reiber, Lancet, 2005;366:1676-7
http://www.ihs.gov/MedicalPrograms/diabetes/resources/bestpractices.asp
System Redesign: Foot Care Team

Physician/PCP

Nurse Educator

Registrar and Patient Scheduling

PHN

Podiatrist

CHR

Surgeon

Clinic Administration and leadership
Decision Support
Foot Care Guidelines

Rith-Najarian, J Fam Pract 1998;47:128-132
1994-1996 System Redesign
Foot Care Team

Moving the Guideline to Practice

Team Coordination

• Input from the team to customize Guidelines
• Delineation of roles
• Documentation
• Training needs
• Measures for monitoring and evaluation
Example of Customization Questions

Remove Shoes Every Visit
Inspect Feet for Acute Problems

No Ulcer

Ulcer

Annual Foot Exam

Low Risk
Routine Education and Yearly Screen

High Risk
Intensive Foot care education
Podiatry referral
Follow up 3 mo

Annual Foot Exams are performed by:

_____________________________  
_____________________________

Documented on Form_____
Form is located ____________
Information from exam goes to 
_____________________________
_____________________________

Staff trained to perform exam and refer high risk and acute problems 
_____________________________
1994-1996 System Redesign
Reminders and Documentation Forms

• Exam & Risk Factors
• Assessment
• Treatment plan
• Referrals
System Redesign: Foot Care Case
Manager
Foot and Nail Care Certification
Wound, Ostomy and Continence Nurses Certification Board

Exam Eligibility Requirements
• Current RN license, and either #2 or #3:
• Completion of formal foot and nail program including five hours didactic; three hours of clinical practice with direct foot and nail care, or
• Completion of experiential pathway including five hours CE; plus eight hours of clinical practice (under supervision of expert).

Information Technology
Electronic Diabetes Registry
<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Age/YRS</th>
<th>Foot Exa.</th>
<th>Next Appt Clinic</th>
<th>Next Appt Prov/Id</th>
<th>Diabetes</th>
<th>Poor Gluc</th>
<th>Controlled</th>
<th>LDL A1c</th>
</tr>
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<tbody>
<tr>
<td>45 YRS</td>
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<td>NO</td>
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<td>75 YRS</td>
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<td>63 YRS</td>
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<td>NO</td>
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<td></td>
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National Performance Measures data from CRN 2007
Current as of: Apr 03, 2008 07:41 PM
Community Linkages
Referrals for Therapeutic Footwear
Community Linkage
Wound Care Outreach Clinic
Average Annual Incidence Lower Extremity Amputations (LEA) among Diabetic Patients according to Chronic Care Model Intervention Period in an Indian Health Service Primary Care Setting


IHS Division of Diabetes Dec 2009
Stepped Approach for IHS “Best Practice” for Diabetic Foot Care

**Comprehensive Program**
Includes all of the previous elements plus …
☑ footcare team ☑ Wound healing ☑ Outreach services
☑ track outcomes

**Intermediate Program**
Includes all of the previous elements plus…
☑ Footcare CPGs ☑ Podiatry and Footwear available ☑ Field Health trained ☑ Track care process

**Basic Program**
☑ DM Team adopts standards of care ☑ DM Registry
☑ Annual Foot screening ☑ Risk Appropriate Foot Education
☑ Podiatry, footwear & field health referrals
☑ Annual Diabetes Audit

**Is Your Program Ready?**
Do we have the following items in place?
☑ Perceived need by providers & community ☑ Administrative Support for CQI ☑ Functional IT support ☑ Access to Footcare services ☑ Functional Diabetes team

http://www.ihs.gov/MedicalPrograms/diabetes/resources/bestpractices.asp
Selected Internet Resources for Diabetic Foot Care

- IHS Best Practices – Foot Care

- Feet Can Last a Lifetime - NIH
  http://www.ndep.nih.gov/resources/feet/index.htm

- Lower Extremity Amputation Prevention Program (LEAP) - HRSA
  http://bphc.hrsa.gov/leap/default.html