

A Mission With A Vision: The Canadian Diabetic Foot Ulcer Policy Roundtable

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Abstract: Wounds Canada partnered with Memorial University and the Limb Preservation Alliance to host the Diabetic Foot Ulcer Policy Roundtable at the Wounds Canada National Conference on October 16, 2024, in London, Ontario. The roundtable brought key experts together to define strategies for each of the key policy areas in the prevention and management of diabetic foot ulcers towards the goal of improving quality of life for all Canadians and around the world. This article reports on some of the key discussion points and recommendations.

Key words: *diabetic foot ulcers, limb preservation, policy, Wounds Canada, Limb Preservation Alliance, revascularization, amputation prevention*

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The burden of diabetic foot complications (e.g., diabetic foot ulceration [DFU] and amputations) is alarmingly high in Canada. For individuals with diabetes, these devastating foot complications can lead to illness, lower quality of life, amputation, disability and death.

For Canadian health-care systems, the financial costs are staggering. A recent report from the Canadian Institute of Health Information (CIHI) indicated that the annual hospital costs for diabetic foot ulcers (DFU) and amputations, excluding physician fees, rehabilitation, and other related expenses, amounted to \$750 million CDN each year from 2020 to 2023 (CIHI, 2024).¹

A factor contributing to this burden is limited health-care policies that address the prevention and treatment of these complications effectively. Wounds Canada took action to address this problem, by partnering with Memorial University in Newfoundland/Labrador and the Limb Preservation Alliance to bring the *Canadian DFU Policy Roundtable: Moving Recommendations to Action* to health-care professionals and the public at the 2024 Wounds Canada National Conference held on October 16, 2024, at RBC Place in

London, Ontario Canada.

The goal of the Limb Preservation Alliance, which consists of Wounds Canada, CariWN, D-Foot International, American Limb Preservation Society and the Canadian Podiatric Medical Association, is to integrate into health policy in all jurisdictions over the next ten years the 2023 recommendations of the International Working Group on the Diabetic Foot (IWGDF).²

A study titled Systematic Priority Setting of the IWGDF Recommendations to Inform Health Policymakers: A Q-Methodological Study was conducted by researchers Dr. Kathleen Stevens and Dr. Ahtisham Younas and delivers valuable insights to inform advocacy efforts for health policies supporting the IWGDF recommendations.

Roundtable Participants

Building on this work, Wounds Canada hosted the Diabetic Foot Ulcer Policy Roundtable at their National Conference. The roundtable brought key experts together to define strategies for each of the key policy areas in the prevention and management of DFU towards the goal of improving quality of life for all Canadians.

The roundtable included a diverse group of participants from various health-care disciplines, including physicians, podiatrists, wound and ostomy care nurses, advanced foot care nurses, analysts and administrators.

These participants came from across Canada, representing Western, Central and Eastern regions. In addition, several organizations concerned with the prevention of ulceration and amputation were represented, such as Diabetes Canada, the Registered Nurses Association of Ontario, Ontario

Health and Home, the Canadian Lymphedema Framework, the Canadian Podiatric Medical Association, the Canadian Federation of Podiatric Medicine and the Zivot Limb Preservation Centre.

Dr. Zulfiqarali Abbas, Joel Alleyne, Simone McConnie, Georgia Krehbiel, Dr. Kathleen Stevens and Dr. Ahtisham Younas, as well as Memorial University and Wounds Canada staff, should be acknowledged for their expert guidance and counsel in making this workshop possible.

“I am excited about sharing our study findings and engaging in collaborative problem-solving with key stakeholders, which will lead to an action plan to address the burden of diabetic foot complications in Canada.”

Dr. Kathleen Stevens, Assistant Professor and researcher, Faculty of Nursing, Memorial University

What Is A Q-Methodological Study?

Q methodology is a mixed methods approach combining qualitative and quantitative methods to explore subjective viewpoints and elicit shared perspectives of individuals about a complex issue (Watts & Stenner, 2005).³ It is a useful when the intention is to understand differing views and examine the extent of consensus and disagreement among varied viewpoints (Younas et al., 2024;⁴ Churruca et al., 2021).⁵

Q methodology was used because prioritized IWGDF recommendations would differ across



DFU Roundtable facilitators: (left to right) Georgia Krehbiel, American Limb Preservation Society; Kathleen Stevens, Memorial University of Newfoundland; Zulfiqarali Abbas, D-Foot International; Joel Alleyne, Canadian Podiatric Medical Association and Simone McConnie, Caribbean Wounds Network

countries/regions due to contextual differences such as health-care system, patient and population needs and public health structures and specific policies.

Study participants were recruited using the email distribution lists for Wounds Canada, The Canadian Podiatric Medical Association and The Canadian Association of Footcare Nurses. The research questions were:

1. What do diabetic foot experts determine are the priority IWGDF recommendations for policy implementation over the next ten years?
2. What do diabetic foot experts determine is the optimal timeline to implementation of the IWGDF recommendations?

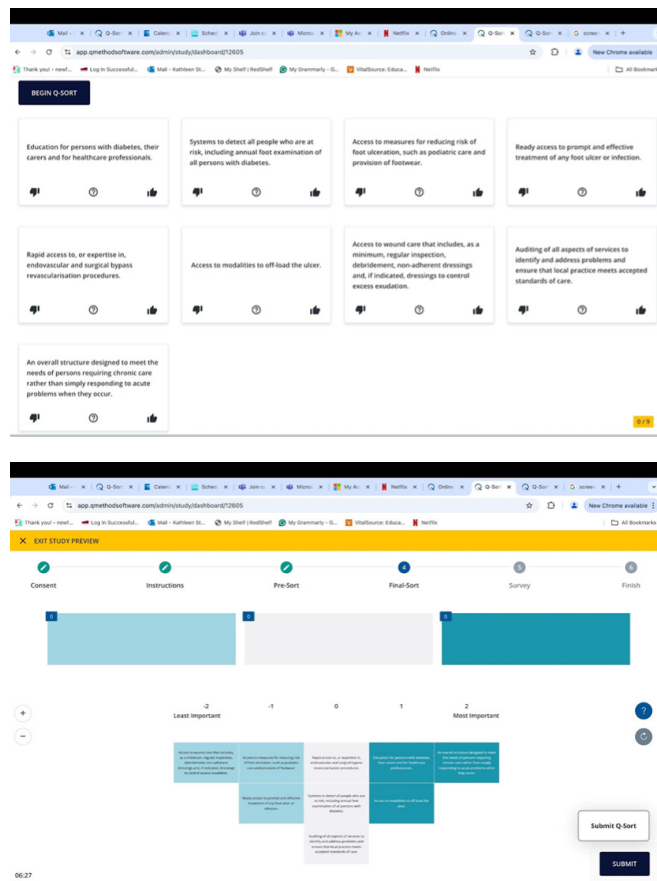


Figure 1 & 2: The Q-sort software interface captured crucial data that will be used to facilitate change Source: *Q Method Software (Lutfallah, S. & Buchanan, L. (2019). Quantifying subjective data using online Q-methodology software. The Mental Lexicon, 14(3), 415-423. doi: https://doi.org/10.1075/ml.20002.lut)*

Description Of Policy Roundtable

Attendees were seated at separate tables and received a handout (See Table 1). Each table had a facilitator and notetaker. Participants rotated through the three tables

Table 1: Attendee handout

Discussion Questions for Policy Roundtable

Each table will focus on an International Working Group on the Diabetic Foot (IWGDF) policy recommendation and address questions below as they apply. Groups will rotate from table to table.

Three Priority Recommendations for Canada for discussion:

- Access to wound care (e.g., regular inspection, debridement, non-adherent dressings and dressings to control excess exudation) (recommendation 5)
- An overall structure designed to meet the needs of persons requiring chronic care rather than simply responding to acute problems when they occur (recommendation 9)
- Rapid access to, or expertise in, endovascular and surgical bypass revascularisation procedures (recommendation 7)

Questions for each recommendation

1. Why is this a critical policy recommendation to address diabetic foot ulcers and amputation?
2. What contexts do we need to consider? (prompts: federal, provincial, rural, urban, acute care, community)
3. Who are the critical target populations? (prompts: individuals, staff, health-care providers, agencies) ***Consider the most critical target population to focus on; however, do not feel you need to restrict your discussion to this target only.
4. What are the barriers for implementing this policy recommendation? (prompts: how this recommendation might cause more burden on the system; aspects like what new infrastructure might be needed; how this will impact human resources)
5. What are the facilitators for implementing this policy recommendation? (prompts: what successes could we build on; are there policies we can piggyback on; are there any trends that we could build on)
6. What are possible strategies to implement this policy recommendation?
 - a. directed at patients and care-partners,
 - b. directed at health-care workers, and
 - c. directed at organizations (e.g., coordination of care and management of care processes, information technology)
7. What does success look like, and how could success be measured and evaluated?
8. What are the key advocacy groups? What role would they play in shaping or implementing this policy?

What Were The Findings?

The results of the roundtable discussion were illuminating and will go far to help prioritize efforts to maximize implementation. Key recommendations include the following:

Policy Recommendation: An overall structure designed to meet the needs of persons requiring chronic care, rather than simply responding to acute problems when they occur.

- 1. Why is this a critical policy recommendation to address diabetic foot ulcers and amputation?*
Participants felt this was a critical policy recommendation as it is a proactive approach. Discussion ensued around how this policy aligns with the chronic care model, which aims to engage and empower patients to take an active role in their care. If the structure was designed to meet the needs of patients requiring chronic care, it would be “better equipped” to support patient behaviour change and would “force us not to ignore” chronicity.
- 2. What contexts do we need to consider?*
Several contexts were discussed considering the policy implementation: policy processes (e.g., how policies are developed and implemented), human resource availability and social factors that impact care delivery (e.g., culture, ethnicity, people with limited resources, such as lack of internet).
- 3. Who are the critical target populations?*
Participants discussed several critical target populations that should be considered when implementing structural system changes that would meet the needs of persons who require chronic care: funders, health-care providers in various settings, patients and families, and the public. Funders (e.g., politicians/policy makers) must support infrastructure and system change. Health-care providers were a

critical target population, as these providers are often caring for high-risk populations. Participants highlighted providers in primary care, all levels of elderly care (“complex continuing care”) and homecare interprofessional teams.

Patients with type 1 and type 2 diabetes and their families were critical populations considering the genetic component of these diseases. The importance of chronic disease prevention and health promotion and how this should be targeted towards younger populations was also noted. Estheticians were considered another important population to engage with because of the role that they could play in promoting foot health.

- 4. What are the barriers for implementing this policy recommendation?*
Several barriers were discussion points for participants related to changing the overall structure to focus on meeting patients’ needs with chronic disease. A clear hurdle was the political will to support this model. Participants discussed the importance of being clear about what is being asked for when advocating to politicians/policy makers for funding. For example, asking for specific services such as a professional wounds team and a yearly foot care assessment team. Another hurdle discussed was resistance to change by various “communities,” which would be “exacerbated by a lack of education.”
- 5. What are the facilitators for implementing this policy recommendation?*
Participants felt that having “buy-in” from key groups such as health-care organizations and professional associations (e.g., medical associations) would facilitate changing the structure. Demonstrating the impact on patients’ quality of life was also considered a facilitator for these system changes. Engaging champions and care providers could also be drivers for change to a focus on chronic care.

6. *What are possible strategies to implement this policy recommendation?*

- a. directed at patients and care-partners: Participants identified and discussed many strategies that could be directed at patients and care partners by health-care providers and organizations that would support the implementation of this policy recommendation. Education of families and caregivers was a primary strategy, encouraging them to advocate for a system that meets the needs of patients with diabetes. A theme in all the strategies suggested was the importance of “early screening recognition,” “catching it early” and “changing demographics” as key considerations when developing strategies directed at patients and caregivers. The education of caregivers should include recognizing early signs of complications to reduce the risk of adverse patient outcomes. The idea of an education campaign was brought forward that would “speak to people where they are” and target those “already in the field” and incorporate “hospital signage.” Participants felt technology was a way for the system to support the needs of patients with diabetes, such as an app that patients and caregivers could use.
- b. directed at health-care workers: Overall, participants thought that strategies directed at health-care workers would support a paradigm shift towards a system that focuses more on chronic care and the prevention of complications. Participants discussed the importance of a system that empowered health-care workers to provide education, early intervention and continuing care to patients with diabetes.
- c. directed at organizations: Some practical suggestions were discussed regarding strategies that could be directed at organizations to support this policy, such as consistent terminology, messaging

and hospital signage. Directing change from the “bottom-up” and employing “in-house efforts” were discussed as strategies. “In-house efforts” referred to initiatives and policies developed within an organization that are focused on meeting the needs of patients with chronic disease. Participants thought these efforts could be a powerful tool for driving change and supporting the implementation of the policy recommendation.

7. *What does success look like and how could success be measured and evaluated?*

Participants discussed strategies for clearly providing evidence of success. These included decreasing amputation rates, completing screening tools and tracking screening rates.

8. *What are the key advocacy groups? What role would they play in shaping or implementing this policy?*

Participants discussed categories of advocacy groups that should advocate for an overall structure designed to meet the needs of persons requiring chronic care. These categories were: long-term and community services, patient advocacy groups, chronic-disease associations, professional associations (e.g., physicians and nurses) and industry. Some of the specific groups discussed as being key were Diabetes Canada, Accreditation Canada, Alliance for Healthier Communities and New Balance.

Policy Recommendation: Access to wound care (e.g. regular inspection, debridement, non-adherent dressings and dressings to control excess exudation).

1. *Why is this a critical policy recommendation to address diabetic foot ulcers and amputation?*

Participants agreed that access to wound care is essential because it is backed by best practice guidelines and evidence showing that proper care—like regular

inspection, debridement and appropriate dressings—prevents complications, including amputation. Without this care, diabetic foot ulcers can worsen rapidly. There was agreement that this recommendation needs to be implemented at the provincial level in primary care to improve outcomes and reduce the burden of amputations.

2. *What contexts do we need to consider?*

Participants emphasized several contexts that need to be considered. First, there are disparities between rural and urban areas, with rural regions facing challenges due to under-resourced health-care systems and a lack of private practice providers. People in these areas often must travel long distances to access care. The issue of federal vs. provincial funding was another important context, as there's often confusion over what is covered and how services are accessed.

A key concern was the need for cross-training health-care teams so that all providers can effectively manage diabetic foot ulcers. In addition, participants noted that patients often feel that amputation is inevitable, especially if other family members have had an amputation, which can affect their mindset and willingness to engage in preventative care. Finally, community care systems should be considered as they often face challenges such as high turnover rates for home support workers and difficulties keeping these workers adequately trained.

3. *Who are the critical target populations?*

The critical target populations identified by participants were the general public (to raise awareness about the importance of foot

health), migrant populations, policy makers, primary care workers and home support workers. Participants felt that these groups needed tailored messaging to effectively communicate the importance of diabetic foot health and prevention, using successful examples from other regions or countries where programs have worked.

4. *What are the barriers for implementing this policy recommendation?*

Participants identified several barriers for this policy recommendation. First is the issue of “siloes funding,” where dressings are funded in community care but not in primary care. This funding structure creates confusion and unequal access. Additionally, a lack of research in Canada on wound care, inconsistent tracking of wounds in electronic medical records (EMRs) and the reactive nature of the health-care system (focusing on treatment rather than prevention) were also seen as significant barriers. Variations in the scope of practice for podiatrists across provinces, a lack of incentives for young health professionals to work in rural areas, and the absence of clear referral systems further complicate the situation.

5. *What are the facilitators for implementing this policy recommendation?*

Facilitators identified by participants included provide data to support funding requests, track wounds across the system through EMRs, so that all parts of the system are informed and raise public awareness about the severity of diabetic foot ulcers. There was also a strong push for a national training program focusing on competency-based education rather than professional designation. Educating all health-care team members—especially in podiatry and nursing—was highlighted as essential. Additionally, securing funding for ongoing wound care maintenance (not just healing) was vital for long-term success.

“Policy makers need direction and manageable information.”

Dr. Kathleen Stevens, Assistant Professor and researcher, Faculty of Nursing, Memorial University

“Our patients with high-risk feet are walking step-by-step toward the road to amputation, and by implementing this project, we wish to take them step-by-step to the road of safety. Education is the only powerful tool we have in the world that is free for patients and effective, if properly implemented.”

Dr. Zulfiqarali Abbas, International Working Group on the Diabetic Foot (IWGDF)

6. *What are possible strategies to implement this policy recommendation?*

Participants suggested several strategies aimed at different groups. For patients and their care partners, raising awareness about the connection between diabetes and amputations is critical. For health-care workers, establishing clear care pathways and decreasing barriers for international health-care providers to practice in Canada would improve access to care. On the organizational and government level, participants recommended government-matched funding for private donations (a model that has worked in the province of Alberta), developing business plans for each province and territory that include a cost/benefit analysis, and incentivizing facilities to reduce amputation rates by tying funding to successful outcomes. Forming more multidisciplinary centres across regions and ensuring fair compensation for advanced foot care nurses and other providers were also key strategies discussed.

7. *What does success look like, and how could success be measured and evaluated?*

Participants agreed that success would be a reduction in amputation rates and an improvement in the quality of life for patients. They further discussed that success could be measured by tracking wait times from wound diagnosis to assessment (“time is tissue”), the frequency of foot inspections and

the number of education programs available to patients and health-care providers. Establishing clear funding structures at the provincial level and developing the infrastructure for comprehensive care were also discussed as important indicators of success. Evaluating these metrics would help ensure the policy is achieving its goals.

8. *What are the key advocacy groups?*

Participants identified key advocacy groups, including Diabetes Canada, the Canadian Medical Association, D-Foot International, NSWOC, Wounds Canada, the Canadian Federation of Podiatric Medicine and the Canadian Association of Footcare Nurses. Participants viewed these organizations as essential partners in advocating for policy changes and securing the resources and frameworks necessary for successful implementation.

Policy Recommendation: Rapid access to, or expertise in, endovascular and surgical bypass revascularisation procedures.

1. *Why is this a critical policy recommendation to address diabetic foot ulcers and amputation?*

Participants discussed how endovascular and surgical bypass revascularisation procedures align with best practices. These procedures are “limb and life-saving” and diabetic foot blockages are mainly below the knee and in the foot. Therefore, this is a critical policy recommendation to address DFU and amputation. Participants acknowledged that access to these procedures is vital, and more clinics are needed across Canada to support rapid access.

2. *What contexts do we need to consider?*

Participants discussed several contexts that need to be considered in relation to the implementation of this policy. Discussion

centred around the health-care system and participants felt that federal, provincial and territorial jurisdiction, private and public systems, community, long-term, acute care and the rural perspective are critical contexts to consider. How each area tracks data is an important context to consider, as data are needed to implement change. Other contexts discussed were related to infrastructure and access to primary care (e.g., number of outpatient clinics), screening (e.g., screening for persons at risk) and workforce (lack of family physicians and nurse practitioners). It was suggested that policy makers consider the role of navigators for skin, wound and foot care. Participants discussed the context of education and awareness and the importance of this context for patients, health-care providers and the public. Gaps in knowledge for patients were not knowing about foot complications. Participants shared experiences with patients who felt angry because they did not know about potential complications that could occur. For health-care providers, there are gaps in knowledge related to assessment and when to refer. Participants discussed health-care provider education as necessary to prevent over-referring and patient deterioration.

3. *Who are the critical target populations?*

Participants identified critical target populations for this policy as persons with diabetes, agencies, staff, health-care providers, health-care professional students (e.g., podiatry) and the public, with consideration for populations in rural and remote areas, unhoused clients and financially challenged clients.

4. *What are the barriers for implementing this policy recommendation?*

Participants identified numerous barriers to implementing this policy. Funding was a significant barrier. There was discussion regarding “long standing disconnections”

between community and acute care systems. The lack of clarity regarding referral systems or limited referral systems that do not consider the social determinants of health pose significant barriers. Other barriers identified were the lack of interprofessional teams screening and assessing clients; limited surgeons performing these procedures; and insufficient specialized wound centres.

Participants also highlighted a lack of understanding and knowledge by patients and policy makers. The patient perception that it is normal and accepted that “if you have diabetes, you will ultimately lose your feet” was considered a barrier to implementing this policy. Policy makers not understanding the connection between peripheral artery disease and diabetes mellitus and how the increase in diabetes will result in the need for more vascular intervention were also thought to be barriers. Where a patient lives was also considered a barrier and affected whether a patient could access these interventions, with people in rural areas having less access. The need for these interventions will increase with obesity, smoking and inactivity increasing among Canadians. Although many do not qualify for endovascular surgery because of these risk factors. Participants felt these barriers must be urgently addressed before moving forward with this policy.

5. *What are the facilitators for implementing this policy recommendation?*

Participants identified several facilitators that could support the implementation of this policy. Screening of patients where they live and using mobile vans with interprofessional teams (comprising foot care nurses, podiatrists, lab technicians, navigators and patients) was considered a facilitator. Education of family and caregivers. Communication using pathways for referral after screening and a universal record system so all providers can see what others are doing. Raising awareness of the public through the

use of data that shows there is a problem and using data to demonstrate the economic costs. Strong leaders who are and can lead change were thought to be drivers for implementing this policy. Current association-level policies could be facilitators, such as policies developed by the Canadian Podiatric Medical Association, Diabetes Canada, CLWK (BC), and Ontario Health at Home.

6. *What are possible strategies to implement this policy recommendation?*

Advocating and obtaining funding to support this intervention was considered a key strategy. Participants felt that having data regarding the effectiveness and cost-benefit of these interventions could influence change and policy. Providing the federal government with a clear business reason would support implementation. Participants felt that we can learn lessons from the establishment of breast and colonoscopy screening.

7. *What does success look like, and how could success be measured and evaluated?*

Participants thought success with this policy would be when there is an investment of government funds into interprofessional teams (integrated teams with foot care nurses, podiatry, lab, navigators and patients), clearer clinical care pathways, access to basic foot care, foot health teams that are involved when an issue is identified and funding of screening and prevention. Measuring success would include considering the impact of prevention activities, interprofessional teams, behavioural changes, amputation rates, hospitalizations (e.g., costs) and collaboration between provinces and territories for podiatry services.

8. *What are the key advocacy groups? What role would they play in shaping or implementing this policy?*

There were many key advocacy groups that participants thought would be involved in shaping and implementing this policy:

primary care groups (family physicians), professional associations (nurse practitioners and physician associations), chronic care groups, community service groups, Nurse Home Associations, Wounds Canada and Accreditation Canada. Wounds Canada could promote their *Diabetes, Healthy Feet, and You* program, which is ready to roll out across Canada if funding is obtained. Expanding *Diabetic Foot Day* in November to *Diabetic Foot Month* would support the shaping and implementation of this policy.

Reflections And Takeaways

At the end of the roundtable, the participants came together as a larger group to share reflections and takeaways on the roundtable discussions and to identify action steps. The reflections were positive, and participants felt it was a valuable experience to be involved in the exercise.

A review of the evaluations completed by participants showed that participants appreciated the collaborative discussion and interactions with other providers from different parts of Canada and gained an understanding of their perspectives and the barriers they face. One participant stated on the evaluation that they found the most valuable part of the day was the “diversity of responses and moments of consensus,” and another noted the “open discussion regarding how specific recommendations may be implemented.” Key takeaways captured the urgency and complexity of DFU prevention and management regarding policy and system changes. One participant stated, “diabetic foot needs a revamp in its care, specifically for screening.” Another participant stated, “Implementation and policy change need to be done strategically and with careful planning and support.”

Many participants planned to apply what they learned by continuing to advocate for change or increasing their advocacy efforts. One person stated, “I plan to educate each diabetic patient” and another stated, “I will apply in my everyday practice but also have to be part of the bigger aim/strategy”

Action Steps

Action steps were discussed next, and participants were asked to suggest the specific tasks, initiatives and activities needed to move forward with combatting DFU amputation. Some general comments were that we should start with recommendations with fewer regional differences and start building a strategy to combat DFU and amputation, focusing on education, systemic changes and collaboration at the national level. There was consensus that a unified approach is critical.

It was also suggested that it was important to consider how we can use implementation science/

research to support change and bring together different groups. Many action steps were identified that could be divided into three categories: collection of data to support change, working together and engaging with others, interventions and strategies that should be developed and implemented and strategies and tools that are available now (See Table 2).

The conclusion drawn following the action step discussion was that a national program needs to be implemented to increase knowledge of diabetic foot and its complications, targeting each stakeholder. However, we all must do what we can now and use the tools we have.

Table 2: Action Steps Identified by Policy Roundtable Participants

Collect Data to Support the Need for Policy	Working Together to Advocate for Policy Change	Development and Implementation (present and future)
<ul style="list-style-type: none"> Establish a health equity committee to collect health economic data to provide a better case to government and insurers Collect national data related to wounds (e.g., track the wound care diagnosis and what happens to patients as they move through the system to calculate costs/cost savings) 	<ul style="list-style-type: none"> Identify the key advocates involved in diabetes and wound care Form a coalition of advocacy groups across Canada Establish a task force focused on creating a vision and a strategy for what the future of diabetic foot looks like and, from this form a clear ask/vision for resources at the government level Assemble a communications team to collate education/messaging so that it is targeted to each stakeholder (e.g., patients, caregivers, HCPs, the public and policy makers) Establish regional multidisciplinary diabetic foot wound/care teams across Canada Become part of the <i>Wounds Canada Diabetes, Healthy Feet and You</i> team 	<ul style="list-style-type: none"> Spend five minutes educating patients, caregivers, and health-care professionals Implement mandatory standard foot screening across the health-care system Utilize digital educational materials to educate patients Explore AI-based solutions for home and health-care settings Develop a clinical pathway for point-click care for diabetic feet Review the current <i>Inlow's 60-second Diabetic Foot Screen</i>; update it to its most user-friendly version, and develop an e-version suitable for a database. Conduct research related to diabetes and foot complications Develop a competency framework for diabetic foot care for all health-care providers Develop and implement a relay called "Defeat D-Foot" that would incorporate diabetic foot screening with the event Implement mobile assessment units for isolated areas

Discussion And Conclusion

The policy roundtable approach offered several advantages, similar to those reported by Romich and Fentress (2019). This policy roundtable provided an opportunity for key stakeholders across Canada to discuss current research findings from the Q-Method study related to the priority recommendations for the organization of diabetic foot care in Canada, as well as provided the researchers an opportunity to share their research findings.

All participants indicated that they gained a further understanding of the incidence, prevalence and impact of DFUs and amputation. Another advantage was that the discussion, knowledge and perspectives shared by participants allowed for further refinement of the application of the research findings. The model also allowed for the establishment of connections between groups and individuals that hold promise in addressing the complexity of DFU and amputation and organizational and public policy development.

Finally, engaging with key groups and individuals with diverse expertise allowed for a fulsome discussion of a complex issue that would not readily happen in a “siloe” space (Romich & Fentress, 2019)⁶ which resulted in action steps that we can now build on individually and together to combat DFU and amputations in Canada. As commented by two participants on their evaluations, “With collaboration, much can be achieved” and “Let’s reconvene next year – I would like to continue these discussions.”

Wounds Canada will provide an update on policy efforts at the next 2025 Wounds Canada National Conference to be held in Toronto, Ontario from October 2-4, where important efforts such as these will continue in order to better the quality of life for all Canadians. The latest updates can be found at <https://www.woundscanada.ca/>

About Wounds Canada: Established in 1995, Wounds Canada is a charitable organization dedicated to the advancement of wound prevention and management. We accomplish this by advocating for a population health approach that promotes

best practices to support persons at risk of or living with wounds, health decision makers and frontline clinicians. We develop and provide educational programs and resources as well as support research to further advance this holistic, risk-based approach. We foster relationships with interested individuals and organizations to expand and sustain a robust wound community in Canada that also has mutually beneficial global connections. Our goal is to reduce the prevalence and incidence of wounds of all types and the negative consequences they bring—including patient suffering and wasted health-care dollars.

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Larry A Sawyer* BA is with Wounds Canada.

**Editor’s note: It is with great sadness that we note the sudden passing of co-author Larry A Sawyer shortly before publication of this article.*

References

1. Schaper NC, van Netten JJ, Apelqvist J, Bus SA, FitrIDGE R, et al; IWGDF Editorial Board. Practical guidelines on the prevention and management of diabetes-related foot disease (IWGDF 2023 update). *Diabetes Metab Res Rev*. 2024 Mar;40(3):e3657. doi: 10.1002/dmrr.3657.
2. Romich J, Fentress T. The policy roundtable model: encouraging scholar-practitioner collaborations to address poverty-related social problems. *Journal of Social Service Research*. 2019 Jan 1;45(1):76-86
3. Watts S, Stenner P. (2005). Doing Q methodology: theory, method and interpretation. *Qualitative Research in Psychology*. 2005; 2(1), 67–91.
4. Younas A, Maddigan J, Moore JE, Whitehead D. Designing and conducting Q methodology in implementation research: a methodological discussion. *Global Implementation Research and Applications*. 2024 Jun;4(2):125-38.
5. Canadian Institute of Health Information. Advancing equity in diabetes prevention and care. 2024. Available from: <https://www.cihi.ca/en/equity-in-diabetes-care-a-focus-on-lower-limb-amputation/advancing-equity-in-diabetes-prevention-and-care>
6. Churruca K, Ludlow K, Wu W, Gibbons K, Nguyen HM, Ellis LA, Braithwaite J. A scoping review of Q-methodology in healthcare research. *BMC Med Res Methodol*. 2021 Jun 21;21(1):125.