**Department of Veterans Affairs**
**Veterans Health Administration**
**Washington, DC 20420**

**VHA DIRECTIVE 1172.03**
**Transmittal Sheet**
**August 3, 2018**

# VHA AMPUTATION SYSTEM OF CARE

**1. REASON FOR ISSUE:** This Veterans Health Administration (VHA) directive describes policies and procedures for VHA's Amputation System of Care (ASoC), which provides care and rehabilitation to Veterans with limb amputations.

**2. SUMMARY OF MAJOR CHANGES:** Major changes include:

a. Updates were made to reflect changes that have occurred since 2012 to the following sections: Background, Scope and Population Served, Organization Structure, Roles and Responsibilities.

b. The ASoC facility regional distribution and the facility levels of services have been updated to reflect changes that have occurred since 2012.

c. The Amputee Data Repository Cube was released into production in 2015 and information regarding this resource has been added to the directive.

**3. RELATED ISSUES:** VHA Directive 1410, Prevention of Amputation in Veterans Everywhere (PAVE) Program, dated March 31, 2017, and VHA Handbook 1172.01, Polytrauma System of Care, dated March 20, 2013.

**4. RESPONSIBLE OFFICE:** The Office of Patient Care Services, Deputy Chief Patient Care Services Officer for Rehabilitation and Prosthetic Services (10P4R) is responsible for the contents of this VHA Directive. Questions may be referred to 202-461-7444.

**5. RESCISSIONS:** VHA Handbook 1172.03, dated August 15, 2012, is rescinded.

**6. RECERTIFICATION:** This VHA directive is scheduled for recertification on or before the last working day of August 31, 2023. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

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Executive in Charge

**DISTRIBUTION:** Emailed to the VHA Publication Distribution List on August 9, 2018.

***NOTE:*** *All references herein to VA and VHA documents incorporate by reference subsequent VA and VHA documents on the same or similar subject matter.*

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# VHA AMPUTATION SYSTEM OF CARE

## 1. PURPOSE

This Veterans Health Administration (VHA) directive establishes policy for the implementation of the Amputation System of Care (ASoC). ASoC is an integrated care system that provides care and rehabilitation to Veterans with limb amputations. It is designed to assist VHA, Veteran Integrated Service Network (VISN), and medical facility leadership in establishing, maintaining, and improving programs and services for Veterans with limb amputations. This directive describes an integrated care system that provides specialized expertise in amputation rehabilitation incorporating the latest practices in medical management, rehabilitation therapies, prosthetic limbs, and assistive technologies. The procedures described in the appendices of this directive reflect innovations and efforts to systematize the provision of rehabilitative care for Veterans with amputations across VHA. It is anticipated that these procedures will require updates over time with advances in technology and clinical practice guidelines. **AUTHORITY:** Title 38 United States Code (U.S.C.) 1706(b); 7301(b).

## 2. BACKGROUND

a. Throughout its history, VHA has placed a high priority on care that is provided to Veterans with limb amputations. Amputations have medical, physical, social, and psychological ramifications for the Veteran and the Veteran's family. Management of Veterans and Servicemembers with amputations requires a comprehensive, coordinated, interdisciplinary program of services throughout the continuum of care. This includes offering the latest practices in medical interventions, prosthetic limbs, assistive technology, and rehabilitation strategies to restore function and thereby optimize quality of life.

b. The majority of Veterans with amputations treated within VHA have limb loss resulting from disease processes such as diabetes mellitus and peripheral vascular disease (PVD). As of August 2017, approximately 24 percent of Veterans in the Department of Veterans Affairs (VA) health care system have diabetes, making this a priority clinical issue for Veteran care. Amputations caused by diabetes and other vascular diseases generally occur in the aging Veteran population and are associated with numerous co-morbidities, such as but not limited to cardiovascular disease, hypertension, and end-stage renal disease.

c. Veterans and Servicemembers with amputations due to trauma, including combat-related injuries, are commonly younger at the time of their amputation. Although the number of combat-related amputations is small compared to the number of amputations associated with disease processes, both groups require high quality, comprehensive, life-long care. Coordination of services with the Military Health System (MHS) in the transition of combat-injured military amputees to the VHA is essential to ensure continuity of services. The Amputation System of Care (ASoC) addresses the unique needs of these patients to ensure optimal and compassionate Veteran-centric care through the VHA.

d. The Preventing Amputations in Veterans Everywhere (PAVE) program and the ASoC are closely linked and coordinate efforts in order to address the prevention of first amputation, the rehabilitation of Veterans who have had an amputation, and the prevention of a second amputation in those with an amputation.

## 3. ASOC MISSION AND VISION

a. The ASoC is an integrated, national health care delivery system that provides patient-centered, gender-sensitive, lifelong, holistic care and care coordination for the Veteran or Servicemember who has undergone amputation. Veterans with amputations may have their rehabilitation provided in a variety of environments across the continuum of care, from acute inpatient hospitalization through a spectrum of inpatient, residential, and outpatient rehabilitation care settings. Through the provision of quality rehabilitation and prosthetic care, the ASoC strives to minimize disability and to enable the highest level of social, vocational, and recreational success for Veterans with amputations.

b. ASoC Vision: Be the world leader in providing lifelong amputation care.

c. ASoC Mission:

(1) To provide state-of-the-art care to Veterans and Servicemembers with amputations across the VA system.

(2) To maximize the health and independence of Veterans and Servicemembers through a team approach and coordination of care.

(3) To be the provider of choice for Veterans with amputations.

## 4. POLICY

It is VHA policy that all VA medical facilities implement and maintain the ASoC program in order to provide the level of rehabilitative services and prosthetic limb technologies required to restore eligible Veterans with amputations to their maximum level of function and greatest quality of life.

## 5. ELIGIBILITY AND ACCESS TO ASoC CARE

a. The ASoC serves Veterans with limb amputations from any etiology. The ASoC also cares for individuals with complex limb trauma and those with other injuries or disease processes resulting in a high likelihood of requiring a limb amputation.

b. The VA medical facility at which rehabilitative services and care are to be provided will be determined collaboratively by the clinical team along with the patient and the patient’s family based on individual needs, goals, and preferences.

## 6. RESPONSIBILITIES

a. **Under Secretary for Health.** The Under Secretary for Health is responsible for ensuring overall VHA compliance with this directive.

b. **Deputy Under Secretary for Health for Operations and Management (10N).** The Deputy Under Secretary for Health for Operations and Management is responsible for:

(1) Communicating the contents of this directive to each of the Veterans Integrated Services Networks (VISN).

(2) Ensuring that each VISN Director has sufficient resources to fulfill the requirements of this directive in all of the VHA medical facilities within that Director's VISN.

(3) Providing oversight of VISNs to assure compliance with this directive.

c. **Deputy Under Secretary for Health for Policy and Services.** The Deputy Under Secretary for Health for Policy and Services is responsible for:

(1) Communicating the contents of this directive throughout the office of the Deputy Under Secretary for Health for Policy and Services.

(2) Ensuring that the ASoC has sufficient resources to fulfill the requirements of this directive.

(3) Providing oversight to assure compliance with this directive.

(4) Approving ASoC program modifications submitted by the Chief Consultant, Office of Patient Care Services, VISN, and VA medical facility Directors as deemed necessary.

d. **Deputy Chief, Patient Care Services Officer for Rehabilitation and Prosthetics Services.** The Deputy Chief, Patient Care Services Officer for Rehabilitation and Prosthetics Services is responsible for:

(1) Ensuring support and resources for successful implementation of program consistent with this directive.

(2) Reviewing proposed changes to ASoC with the National Director of Physical Medicine and Rehabilitation Program and approving proposed changes to ASoC.

(3) Communicating programmatic changes to the system of care to the Deputy Under Secretary for Health for Policy and Services as well as to each of the Veterans Integrated Services Networks.

e. **National Director, Physical Medicine and Rehabilitation Program.** The National Director, Physical Medicine and Rehabilitation Program is responsible for:

(1) Providing national program leadership for the rehabilitation health care and services for Veterans with amputations.

(2) Reviewing proposed programmatic changes in the system of care with the Deputy Chief Patient Care Services Officer for Rehabilitation and Prosthetic Services, and relevant others, including the National Director and the National Program Manager for the ASoC.

f. **National Director, Amputation System of Care**. The National Director, Amputation System of Care is responsible for:

(1) Ensuring development and implementation of initiatives that enhance the ability of the ASoC to serve the needs of eligible Veterans with amputations.

(2) Ensuring development and execution of the annual ASoC strategic plan.

(3) Oversight of the ASoC annual budget.

(4) Oversight and management of ASoC national workgroups.

(5) Providing subject matter expertise to support VHA providers involved in amputation care.

(6) Evaluating potential opportunities to collaborate with external and internal stakeholders such as Veterans Service Organizations (VSO), Department of Defense, the Extremity Trauma and Amputation Center of Excellence (EACE), VHA Orthotics and Prosthetics Program, PAVE, and private organizations (e.g., Amputee Coalition).

(7) Oversight for development and implementation of education and training related to amputation rehabilitation, including clinical practice guidelines.

g. **National Program Manager, Amputation System of Care.** The National Program Manager, Amputation System of Care, is responsible for:

(1) Providing national oversight of ASoC and planning for its sustainability.

(2) Providing budget and fiscal management of the ASoC.

(3) Providing training and consultation to the Regional Amputation Centers and Polytrauma Amputation Network Sites on preparation for external review by the Commission on Accreditation of Rehabilitation Facilities (CARF).

(4) Facilitating collaboration with external and internal stakeholders such as Veteran's Service Organizations, Department of Defense, Extremity Trauma and Amputation Center of Excellence (EACE), VHA Prosthetic and Orthotic Services, and private organizations (e.g., Amputee Coalition).

(5) Ensuring a national ASoC communication plan with all components of the ASoC

including conference calls, live meetings, teleconferences and face to face meetings.

(6) Preparing ASoC annual strategic plans, reports, guidelines and directives and submitting these documents to the National Director, Physical Medicine and Rehabilitation Program.

(7) Providing leadership to clinical providers in the field to meet or exceed the health care needs of Veteran with amputations.

h. **Veterans Integrated Services Network (VISN) Director.** The VISN Director is responsible for:

(1) Implementation and support of the ASoC, balancing local conditions for access with national consistency and coordination efforts while respecting the Veteran's care location preference.

(2) Supporting all administrative components and clinical services of the ASoC and continuum of care described in this directive.

(3) Providing and facilitating necessary communication, resources, and quality improvement efforts in order to maintain expertise and quality services.

(4) Facilitating Veteran travel and access to services in accordance with VHA Directive 1094, Inter-Facility Transfer Policy, dated January 11, 2017, the established criteria for travel eligibility, and use of hardship criteria, as appropriate.

i. **VA Medical Facility Director.** The VA medical facility Director is responsible for:

(1) Designating at least one person to serve as a point of contact, who is knowledgeable about the ASoC and the available levels of services it can offer, and who can refer a Veteran to the appropriate level of care.

(2) Implementing and maintaining the appropriate staffing, clinical expertise and facility infrastructure to accomplish the mission of the ASoC programs. The FTE listed below represent the minimal requirements, additional resources should be assured based on clinical need.

(3) Having final authority over, and responsibility for, the accountability of the program within the medical facility in accordance with Appendix B.

(4) Collaborating with the operational leadership of the ASoC program including the ASoC National Director and National Program Manager.

(5) Ensuring public affairs efforts designed to inform various stakeholders regarding the services provided through the ASoC.

(6) For facilities that are designated as a Regional Amputation Center (RAC) or a Polytrauma Amputation Network Site (PANS), the Medical Facility Director is

responsible for:

(a) Designating the RAC Physician Medical Director to the ASoC as a 1.0 full-time equivalent (FTE) employee. The RAC Physician Medical Director must be trained in all aspects of amputation care including amputation specific rehabilitation, medical issues commonly encountered in Veterans with amputations, and prosthetic limb prescription.

(b) Designating the PANS Physician Medical Director to the amputation program as a 0.5 FTE. The Physician Medical Director must be well-qualified in all aspects of amputation care, including: amputation specific rehabilitation; management of common medical issues in Veterans with amputations, and prosthetic limb prescription.

(c) Designating the RAC or PANS Amputation Rehabilitation Coordinator (ARC) to the Amputation Program as a 1.0 FTE employee, with 75 percent of their time spent on ASoC duties for their facility and region of responsibility, and up to 25 percent spent on clinical duties as they relate to amputation care.

(d) Designating the RAC Prosthetist/Orthotist – (Regional Clinical Director) to the ASoC as a 1.0 FTE employee, of which, approximately 50 percent of their time will be spent on ASoC administrative duties for their facility, VISN, and region and up to 50 percent of their time spent on clinical duties as they relate to amputation care.

(7) Designating the Program Support Assistant (PSA) to the ASoC Program as a 1.0 FTE employee at both the Regional Amputation Centers and the Polytrauma Amputation Network Sites.

j. **Regional Amputation Center (RAC) Physician Medical Director.** The RAC Physical Medical Director is responsible for:

(1) The administrative leadership for the RAC. This includes: reports to local, VISN, and national leaders as requested on the state of amputation care in their region.

(2) Direct clinical oversight and administrative supervision for the Amputation Rehabilitation Coordinator, the Prosthetist/Orthotist Regional Clinical Director, and ASoC Program Support Assistant.

(3) The development and implementation of a telerehabilitation amputation program for their region.

(4) The education of both internal and external stakeholder groups on amputation care and the ASoC.

(5) New program initiatives, gap analysis determinations, and quality improvement activities as they pertain to amputation care.

(6) Supporting VA amputation-related research activities to advance the body of evidence for amputation care.

(7) Leading the ASoC in their region, coordinating effective communication between involved stakeholders, serving as chair or co-chair of calls with clinicians involved in amputation care, and making presentations to various stakeholders in their region.

(8) Participating in national and local committees as assigned by the ASoC National Director and National Program Manager.

(9) Providing leadership in the development and maintenance of CARF Specialty Certification as an Amputation Specialty Care Program.

k. **Polytrauma Amputation Network Site (PANS), Physician Medical Director.** The PANS, Physician Medical Director is responsible for:

(1) The PANS Physician Medical Director will provide leadership for the amputation care program at their medical facility as well as for their VISN. The assignment involves clinical care as well as administrative program development and leadership.

(2) In addition, the PANS Physician Medical Director is to be actively involved in:

(a) Expert level clinical care in the evaluation and treatment of all aspects of amputee rehabilitation.

(b) Leadership in the development of standardized patient evaluations and outcome assessment.

(c) Effective use of communication skills at all levels to enhance team functioning and patient care coordination.

(d) Consultation to professional staff and community providers concerning clinical assessment findings and appropriate patient treatment plans.

(e) Providing administrative leadership for the PANS amputation care program, including, but not limited to: reports to local, VISN, regional, and national leaders on the state of amputation care for their program and VISN.

(f) Participation in VISN-wide, regional and national ASoC conference calls and face-to-face meetings.

(g) Providing leadership in the development and maintenance of CARF Specialty Certification as an Amputation Specialty Care Program.

(h) Providing direct administrative supervision and clinical oversight to the PANS Amputation Rehabilitation Coordinator and PANS Program Support Assistant.

l. **Amputation Rehabilitation Coordinator (ARC) or PANS ARC.** The PANS ARC is responsible for:

(1) Being the point of contact for information about the ASoC and amputation care

for their medical facility, VISN, and region (if a RAC). They must have a visible role in their medical facility, VISN, and region as a subject matter expert within the ASoC.

(2) Participating in all required national ASoC teleconferences.

(3) Transmitting, and ensuring the transmission of, amputation-related needs and responsibilities within the ASoC.

(4) Submitting reports to the National Physical Medicine and Rehabilitation Program Office as requested.

(5) Providing education on amputation rehabilitation to providers and other stakeholders involved in amputation care.

(6) Being involved in the planning of educational conferences and programs related to ASoC.

(7) Working with local and VISN case managers to establish and maintain mechanisms that facilitate case management and care coordination.

(8) Being involved in program development and quality assurance activities for their medical facility.

(9) Developing and maintaining Telehealth Amputation Clinics (TACs) at their medical facilities, VISN or region (if a RAC) to increase Veteran access to specialty care.

(10) Supporting research efforts that will advance amputation care.

(11) Communicating with other VA medical facilities in their VISN to review amputation related practices.

(12) Providing guidance in the development and maintenance of CARF Specialty Certification as an inpatient or outpatient Amputation Specialty Care Program.

m. **Prosthetist/Orthotist – Regional Clinical Director (RAC Prosthetist).** The RAC Prosthetist is responsible for:

(1) Being well versed in orthotic and prosthetic application related to amputation care. This includes prescription, fabrication, and fitting of prosthetic limbs and orthotic technologies.

(2) Being actively involved in:

(a) The administrative aspects of the RAC and the regional amputation care program. This includes: reports to local, VISN and national leaders on the state of orthotic and prosthetic-related amputation care in their region; periodic gap analysis reports; and collaboration with the ARC and Medical Facility Director.

(b) The development and implementation of the telerehabilitation amputation program for their region. This includes identifying appropriate sites in their region, educating staff, and participating in telerehabilitation amputation clinics (TACs).

(c) The education of various stakeholder groups on amputation care and the ASoC.

(d) The education and training of other providers and disciplines related to prosthetic limb and orthotic technologies.

(e) Support of research activities, locally, regionally, or nationally to advance the knowledge base of amputation care.

(f) Serving as a subject matter expert to the field related to prosthetic limb prescription and fitting for Veterans with all levels of amputation.

(g) Assisting team members with RAC program development and quality improvement activities.

(h) Participating in national and local committees as assigned by the ASoC National Director and Program Manager.

n. **ASOC Program Support Assistant (PSA).** The ASoC PSA is responsible for:

(1) Providing direct administrative support services across various disciplines (i.e. Rehabilitation Medicine, Prosthetics, Therapy services) within each local facility and/or regional amputation program.

(2) Completing assigned program tasks to ensure the efficiency and productivity of the Amputation Program using established methods, practices, and criteria.

(3) Interpreting and applying administrative methods of best practice models with performance of assigned program tasks.

## 7. TRAINING REQUIREMENTS

There are no training requirements at this time.

## 8. RECORDS MANAGEMENT

All records regardless of format (paper, electronic, electronic systems) created by this directive shall be managed per the National Archives and Records Administration (NARA) approved records schedules found in VHA Records Control Schedule 10-1. If you have any question to the regarding any aspect of records management, you should contact your facility Records Manager or your Records Liaison.

## 9. REFERENCES

a. 38 U.S.C. 543, 1706(b), 1710, 7301(b)

b. VHA Directive 1410, Prevention of Amputation in Veterans Everywhere (PAVE) Program, dated March 31, 2017.

c. VHA Handbook 1172.01, Polytrauma System of Care, dated March 20, 2013.

d. VA/DoD Clinical Practice Guideline for Rehabilitation of Lower Limb Amputation. 2017. https://www.healthquality.va.gov/guidelines/rehab/amp/index.asp

e. VA/DoD Clinical Practice Guideline: The Management of Upper Extremity Amputation Rehabilitation. http://www.healthquality.va.gov/guidelines/rehab/uear/index.asp

f. Department of Veterans Affairs Office of Inspector General. Healthcare inspection; prosthetic limb care in VA facilities. March 8, 2012 (Report No. 11–02138–116)

g. Webster JB, Poorman CE, Cifu DX. Guest editorial: Department of Veterans Affairs Amputations System of Care: 5 Years of Accomplishments and Outcomes. Journal of Rehabilitation Research and Development. 2014;51(4):vii-xvi.

h. VHA Amputee Data Repository. VHA Support Service Center. November 2015. http://vssc.med.va.gov. ***NOTE:*** *This is an internal VA Web site that is not available to the public.*

## AMPUTATION SYSTEM OF CARE (ASoC) ORGANIZATIONAL STRUCTURE

The ASoC is organized under Patient Care Services, Office of Rehabilitation and Prosthetic Services, and the Physical Medicine and Rehabilitation (PM&R) Program Office. The ASoC is organized to provide graded levels of expertise and accessibility and is comprised of four distinct designations for VA Medical Centers: Regional Amputation Centers (RAC), one for each of seven regions; Polytrauma Amputation Network Sites (PANS), Amputation Clinic Teams (ACT), and Amputation Points of Contact (APoC).

a. **RAC.** The RAC provides the highest level of specialized expertise in clinical care and prosthetic limb technology and provides rehabilitation to the most complicated Veterans and Servicemembers with amputations. The RAC is responsible for:

(1) Hiring and maintaining four dedicated employees consisting of a Physician Medical Director, Amputation Rehabilitation Coordinator, Prosthetist-Orthotist Regional Clinical Director, and Program Support Assistant;

(2) Maintaining an Inpatient Rehabilitation Unit that is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF);

(3) Attaining and maintaining either inpatient or outpatient CARF Amputation Specialty Program accreditation;

(4) Providing regional leadership in the field of amputation rehabilitation through consultation, teaching, and publication;

(5) Maintaining the capability to fabricate prostheses on-site, and maintaining laboratory and prosthetist certification;

(6) Developing and maintaining a Peer Visitation Program; and

(7) Implementing, coordinating, and maintaining telerehabilitation amputation clinics.

b. **PANS.** PANS provide a full range of clinical and ancillary services to Veterans and Servicemembers within their catchment area. Each PANS is responsible for:

(1) Hiring and maintaining three dedicated employees: a PANS Physician Medical Director, Amputation Rehabilitation Coordinator and a Program Support Assistant;

(2) Maintaining a CARF-accredited Inpatient Rehabilitation Unit;

(3) Attaining and maintaining either inpatient or outpatient CARF Amputation Specialty Program accreditation;

(4) Developing and maintaining a Peer Visitation Program;

(5) Having an on-site orthotic and prosthetic lab and/or contract with community partner O&P services; Implementing and maintaining telerehabilitation amputation clinics (TACs).

c. **ACT.** ACTs have a core amputation specialty team to provide regular follow-up and address ongoing care needs. The ACT is responsible for:

(1) Maintaining a core interdisciplinary Amputation Care Team, including but not limited to a physician, therapist and prosthetist;

(2) Maintaining regularly scheduled Outpatient Amputation Specialty Clinics;

(3) Referral of Veterans with amputations to the most appropriate level of care;

(4) Providing access to a prosthetic and orthotic laboratory or an inpatient rehabilitation unit either by contract with private institutions or by referral to the PANS in their VISN or RAC in their region;

(5) Maintaining regular communication with the ASoC Leadership and their respective Regional Amputation Center and Polytrauma Amputation Network Site leadership.

d. **APoC.** An APoC must be identified at all other VA medical facilities within the ASoC to specifically serve as the point of contact for consultation, assessment, and referral of the Veteran to a facility capable of providing the level of services required. The APoC is responsible for educating local facility personnel and referring services on the ASoC.

## LEVELS OF SERVICES FOR EACH COMPONENT OF THE AMPUTATION SYSTEM OF CARE (ASoC)

Each component of the Amputation System of Care (ASoC) is designed to provide specific services and a certain level of care. Although variations are expected in the type of services available at each facility, the following table serves as a guide for the types of services that should be available at each level of care across the ASoC.

| Facility Services | Regional Amputation Centers (RAC) | Polytrauma Amputation Network Site (PANS) | Amputation Clinic Teams (ACT) | Amputation Points of Contact (APoC) |
|---|---|---|---|---|
| Physical Medicine and Rehabilitation (PM&R) Service | x | x | x | - |
| Peri-Amputation Surgery Consultation by PM&R | x | x | x | - |
| Orthotic and Prosthetic Accredited Lab | x | x | - | - |
| Amputation Care Team | x | x | x | - |
| Commission on Accreditation of Rehabilitation Facilities (CARF) Inpatient Rehab Unit | x | x | - | - |
| CARF accredited Amputation Specialty Program | x | x | - | - |
| Outpatient Rehabilitation Services | x | x | x | - |
| Basic Prosthetic and Orthotic Prescription and Fitting | x | x | x | - |
| Advanced Prosthetic and Orthotic Prescription and Fitting | x | x | - | - |

| Facility Services | Regional Amputation Centers (RAC) | Polytrauma Amputation Network Site (PANS) | Amputation Clinic Teams (ACT) | Amputation Points of Contact (APoC) |
|---|---|---|---|---|
| Care Coordination | x | x | x | x |
| Surgical Services / Orthopedics and Podiatry | x | x | x | - |
| Mental Health Services | x | x | x | - |
| Primary Care | x | x | x | x |
| Amputee Coalition Peer Visitation Program | x | x | - | - |
| Provider Site Telehealth Amputation Clinics | x | x | - | - |
| Wound Care Complex /<br>Basic | x<br>x | x<br>x | -<br>x | -<br>- |
| Pain Management Complex /<br>Basic | x<br>x | x<br>x | -<br>x | -<br>- |
| Gait Analysis / Training<br>Complex / Basic | x<br>x | x<br>x | -<br>x | -<br>- |
| Contralateral Limb Preservation (PAVE) | x | x | x | x |
| Activities of Daily Living (ADL) and Instrumental ADL (IADL) Training | x | x | x | - |
| Driver Rehabilitation | x | x | - | - |
| Home Assessment and Equipment | x | x | x | - |

| Facility Services | Regional Amputation Centers (RAC) | Polytrauma Amputation Network Site (PANS) | Amputation Clinic Teams (ACT) | Amputation Points of Contact (APoC) |
|---|---|---|---|---|
| Assistive Technology | | | | |
| Complex | x | x | - | - |
| Basic | x | x | x | - |
| Cognitive Assessment | x | x | x | - |
| Leisure and Recreation Assessment | x | x | x | - |
| Patient Education | x | x | x | x |
| Vocational Assessment and Retraining | x | x | - | - |

## AMPUTATION SYSTEM OF CARE REGIONAL DISTRIBUTION

| ASOC Type | Facility Name | District / VISN | Facility STA_NO |
|---|---|---|---|
| RAC | James J. Peters VA Medical Center | 1V02 | 526 |
| RAC | Hunter Holmes McGuire Hospital | 1V06 | 652 |
| RAC | James A. Haley Veterans' Hospital | 2V08 | 673 |
| RAC | Minneapolis VA Medical Center | 3V23 | 618 |
| RAC | Denver VA Medical Center | 4V19 | 554 |
| RAC | Seattle VA Medical Center | 5V20 | 663 |
| RAC | Palo Alto VA Medical Center | 5V21 | 640 |
| PANS | Jamaica Plain VA Medical Center | 1V01 | 523 |
| PANS | Syracuse VA Medical Center | 1V02 | 528A7 |
| PANS | Corporal Michael J. Crescenz VA Medical Center | 1V04 | 642 |
| PANS | Washington VA Medical Center | 1V05 | 688 |
| PANS | Charlie Norwood VA Medical Center | 2V07 | 509 |
| PANS | San Juan VA Medical Center | 2V08 | 672 |
| PANS | Lexington VA Medical Center-Cooper | 2V09 | 596A4 |
| PANS | Louis Stokes Cleveland VA Medical Center | 3V10 | 541 |
| PANS | Richard L. Roudebush VA Medical Center | 3V10 | 583 |
| PANS | Edward Hines Junior Hospital | 3V12 | 578 |
| PANS | John Cochran Veterans Hospital | 3V15 | 657 |
| PANS | New Orleans VA Medical Center | 4V16 | 629 |
| PANS | Dallas VA Medical Center | 4V17 | 549 |
| PANS | Audie L. Murphy Memorial Veterans' Hospital | 4V17 | 671 |

| ASOC Type | Facility Name | District / VISN | Facility STA_NO |
|---|---|---|---|
| PANS | George E. Wahlen VA Medical Center | 4V19 | 660 |
| PANS | San Diego VA Medical Center | 5V22 | 664 |
| PANS | Tucson VA Medical Center | 5V22 | 678 |
| PANS | West Los Angeles VA Medical Center | 5V22 | 691 |
| ACT | Togus VA Medical Center | 1V01 | 402 |
| ACT | White River Junction VA Medical Center | 1V01 | 405 |
| ACT | Edith Nourse Rogers Memorial Veterans' Hospital | 1V01 | 518 |
| ACT | Manchester VA Medical Center | 1V01 | 608 |
| ACT | Edward P. Boland VA Medical Center | 1V01 | 631 |
| ACT | Providence VA Medical Center | 1V01 | 650 |
| ACT | West Haven VA Medical Center | 1V01 | 689 |
| ACT | Buffalo VA Medical Center | 1V02 | 528 |
| ACT | Canandaigua VA Medical Center | 1V02 | 528A5 |
| ACT | Samuel S. Stratton VA Medical Center | 1V02 | 528A8 |
| ACT | East Orange VA Medical Center | 1V02 | 561 |
| ACT | Lyons VA Medical Center | 1V02 | 561A4 |
| ACT | Franklin Delano Roosevelt Hospital | 1V02 | 620 |
| ACT | Castle Point VA Medical Center | 1V02 | 620A4 |
| ACT | Manhattan VA Medical Center | 1V02 | 630 |
| ACT | Brooklyn VA Medical Center | 1V02 | 630A4 |
| ACT | Northport VA Medical Center | 1V02 | 632 |
| ACT | Wilmington VA Medical Center | 1V04 | 460 |
| ACT | Coatesville VA Medical Center | 1V04 | 542 |

| ASOC Type | Facility Name | District / VISN | Facility STA_NO |
|---|---|---|---|
| ACT | Erie VA Medical Center | 1V04 | 562 |
| ACT | Lebanon VA Medical Center | 1V04 | 595 |
| ACT | Pittsburgh VA Medical Center-University Drive | 1V04 | 646 |
| ACT | Wilkes-Barre VA Medical Center | 1V04 | 693 |
| ACT | Baltimore VA Medical Center | 1V05 | 512 |
| ACT | Beckley VA Medical Center | 1V05 | 517 |
| ACT | Louis A. Johnson VA Medical Center | 1V05 | 540 |
| ACT | Huntington VA Medical Center | 1V05 | 581 |
| ACT | Martinsburg VA Medical Center | 1V05 | 613 |
| ACT | Durham VA Medical Center | 1V06 | 558 |
| ACT | Fayetteville VA Medical Center | 1V06 | 565 |
| ACT | Hampton VA Medical Center | 1V06 | 590 |
| ACT | Charles George VA Medical Center | 1V06 | 637 |
| ACT | Salem VA Medical Center | 1V06 | 658 |
| ACT | W.G. (Bill) Hefner Salisbury VA Medical Center | 1V06 | 659 |
| ACT | Atlanta VA Medical Center | 2V07 | 508 |
| ACT | Birmingham VA Medical Center | 2V07 | 521 |
| ACT | Ralph H. Johnson VA Medical Center | 2V07 | 534 |
| ACT | Wm. Jennings Bryan Dorn VA Medical Center | 2V07 | 544 |
| ACT | Carl Vinson VA Medical Center | 2V07 | 557 |
| ACT | Central Alabama VA Medical Center-Montgomery | 2V07 | 619 |
| ACT | Central Alabama VA Medical Center-Tuskegee | 2V07 | 619A4 |
| ACT | Tuscaloosa VA Medical Center | 2V07 | 679 |

| ASOC Type | Facility Name | District / VISN | Facility STA_NO |
|---|---|---|---|
| ACT | C.W. Bill Young VA Medical Center | 2V08 | 516 |
| ACT | Bruce W. Carter VA Medical Center | 2V08 | 546 |
| ACT | Malcom Randall VA Medical Center | 2V08 | 573 |
| ACT | Orlando VA Medical Center | 2V08 | 675 |
| ACT | Robley Rex VA Medical Center | 2V09 | 603 |
| ACT | Memphis VA Medical Center | 2V09 | 614 |
| ACT | James H. Quillen VA Medical Center | 2V09 | 621 |
| ACT | Nashville VA Medical Center | 2V09 | 626 |
| ACT | Alvin C. York VA Medical Center | 2V09 | 626A4 |
| ACT | Ann Arbor VA Medical Center | 3V10 | 506 |
| ACT | Battle Creek VA Medical Center | 3V10 | 515 |
| ACT | Cincinnati VA Medical Center | 3V10 | 539 |
| ACT | Dayton VA Medical Center | 3V10 | 552 |
| ACT | John D. Dingell VA Medical Center | 3V10 | 553 |
| ACT | Marion VA Medical Center | 3V10 | 610 |
| ACT | Fort Wayne VA Medical Center | 3V10 | 610A4 |
| ACT | Chalmers P. Wylie Veterans Outpatient Clinic | 3V10 | 757 |
| ACT | Jesse Brown VA Medical Center | 3V12 | 537 |
| ACT | Danville VA Medical Center | 3V12 | 550 |
| ACT | Captain James A. Lovell Federal Health Care Center | 3V12 | 556 |
| ACT | William S. Middleton Memorial Veterans' Hospital | 3V12 | 607 |
| ACT | Tomah VA Medical Center | 3V12 | 676 |

| ASOC Type | Facility Name | District / VISN | Facility STA_NO |
|---|---|---|---|
| ACT | Clement J. Zablocki VA Medical Center | 3V12 | 695 |
| ACT | Kansas City VA Medical Center | 3V15 | 589 |
| ACT | Harry S. Truman Memorial Veterans' Hospital | 3V15 | 589A4 |
| ACT | Colmery-O'Neil VA Medical Center | 3V15 | 589A5 |
| ACT | Dwight D. Eisenhower VA Medical Center | 3V15 | 589A6 |
| ACT | Robert J. Dole VA Medical and Regional Office Center | 3V15 | 589A7 |
| ACT | Royal C. Johnson Veterans' Memorial Hospital | 3V23 | 438 |
| ACT | Omaha VA Medical Center | 3V23 | 636 |
| ACT | Lincoln VA Clinic | 3V23 | 636A5 |
| ACT | Des Moines VA Medical Center | 3V23 | 636A6 |
| ACT | Iowa City VA Medical Center | 3V23 | 636A8 |
| ACT | Alexandria VA Medical Center | 4V16 | 502 |
| ACT | Biloxi VA Medical Center | 4V16 | 520 |
| ACT | Michael E. DeBakey VA Medical Center | 4V16 | 580 |
| ACT | G.V. (Sonny) Montgomery VA Medical Center | 4V16 | 586 |
| ACT | John L. McClellan Memorial Veterans' Hospital | 4V16 | 598 |
| ACT | Eugene J. Towbin Healthcare Center | 4V16 | 598A0 |
| ACT | Overton Brooks VA Medical Center | 4V16 | 667 |
| ACT | Thomas E. Creek VA Medical Center | 4V17 | 504 |
| ACT | Olin E. Teague Veterans' Center | 4V17 | 674 |
| ACT | El Paso VA Clinic | 4V17 | 756 |
| ACT | Fort Harrison VA Medical Center | 4V19 | 436 |

| ASOC Type | Facility Name | District / VISN | Facility STA_NO |
|---|---|---|---|
| ACT | Cheyenne VA Medical Center | 4V19 | 442 |
| ACT | Grand Junction VA Medical Center | 4V19 | 575 |
| ACT | Jack C. Montgomery VA Medical Center | 4V19 | 623 |
| ACT | Oklahoma City VA Medical Center | 4V19 | 635 |
| ACT | Boise VA Medical Center | 5V20 | 531 |
| ACT | Portland VA Medical Center | 5V20 | 648 |
| ACT | White City VA Medical Center | 5V20 | 692 |
| ACT | Spark M. Matsunaga VA Medical Center | 5V21 | 459 |
| ACT | Fresno VA Medical Center | 5V21 | 570 |
| ACT | Las Vegas VA Medical Center | 5V21 | 593 |
| ACT | Sacramento VA Medical Center | 5V21 | 612A4 |
| ACT | Ioannis A. Lougaris VA Medical Center | 5V21 | 654 |
| ACT | San Francisco VA Medical Center | 5V21 | 662 |
| ACT | Raymond G. Murphy VA Medical Center | 5V22 | 501 |
| ACT | Long Beach VA Medical Center | 5V22 | 600 |
| ACT | Jerry L. Pettis Memorial Veterans' Hospital | 5V22 | 605 |
| ACT | Carl T. Hayden VA Medical Center | 5V22 | 644 |
| ACT | Bob Stump VA Medical Center | 5V22 | 649 |
| ACT | Sepulveda VA Medical Center | 5V22 | 691A4 |
| APOC | St. Albans VA Medical Center | 1V02 | 630A5 |
| APOC | James E. Van Zandt VA Medical Center | 1V04 | 503 |
| APOC | Bath VA Medical Center | 1V02 | 528A6 |
| APOC | Butler VA Medical Center | 1V04 | 529 |

| ASOC Type | Facility Name | District / VISN | Facility STA_NO |
|---|---|---|---|
| APOC | West Palm Beach VA Medical Center | 2V08 | 548 |
| APOC | Chillicothe VA Medical Center | 3V10 | 538 |
| APOC | Aleda E. Lutz VA Medical Center | 3V10 | 655 |
| APOC | Oscar G. Johnson VA Medical Facility | 3V12 | 585 |
| APOC | John J. Pershing VA Medical Center | 3V15 | 657A4 |
| APOC | Marion VA Medical Center | 3V15 | 657A5 |
| APOC | Fargo VA Medical Center | 3V23 | 437 |
| APOC | Fort Meade VA Medical Center | 3V23 | 568 |
| APOC | Grand Island VA Medical Center | 3V23 | 636A4 |
| APOC | St. Cloud VA Medical Center | 3V23 | 656 |
| APOC | Fayetteville VA Medical Center | 4V16 | 564 |
| APOC | George H. O'Brien, Jr., VA Medical Center | 4V17 | 519 |
| APOC | Doris Miller VA Medical Center | 4V17 | 674A4 |
| APOC | Sheridan VA Medical Center | 4V19 | 666 |
| APOC | Anchorage VA Medical Center | 5V20 | 463 |
| APOC | Roseburg VA Medical Center | 5V20 | 653 |
| APOC | American Lake VA Medical Center | 5V20 | 663A4 |
| APOC | Mann-Grandstaff VA Medical Center | 5V20 | 668 |
| APOC | Jonathan M. Wainwright Memorial VA Medical Center | 5V20 | 687 |

## CLINICAL PRACTICE GUIDELINES

a. The Department of Veterans Affairs (VA) and Department of Defense (DoD) Evidence-Based Clinical Practice Work Group (EBPWG) was established with a mission to facilitate the development of clinical practice guidelines (CPGs) for the VA and DoD populations. These collaborative VA and DoD Evidence-Based Clinical Practice Guidelines are based upon the best evidence available and are designed to provide information and assist in clinical decision making. These guidelines are developed by a panel of multidisciplinary experts and provide clear explanation of the logical relationships between various care options and health outcomes while rating both the quality of the evidence and the strength of the recommendation.

b. In 2007, the VA and DoD published a Clinical Practice Guideline (CPG) for the Rehabilitation of Lower Limb Amputation (2007 LLA CPG), which was based on evidence reviewed through December 2006. This CPG was intended to provide healthcare providers with a framework from which to evaluate, treat, and manage the individual needs and preferences of patients with lower limb amputation (LLA), thereby leading to improved clinical outcomes. This CPG was adopted by the ASoC and has been extensively incorporated into clinical practice by VA providers who treat Veterans with lower limb amputations. This CPG has assisted the VA to address gaps in both the quality and consistency of amputation rehabilitation provided in the VA. This guideline and associated resources can be located at; https://www.healthquality.va.gov/guidelines/rehab/amp/index.asp

c. Since the release of the 2007 LLA CPG, a growing body of research has expanded the general knowledge and understanding of LLA. Improved recognition of the complex nature of this condition has led to the adoption of new strategies for rehabilitation. Consequently, a recommendation to update the 2007 LLA CPG was initiated in 2016 and the new LLA CPG was published in 2017. Through the inclusion of objective, evidence-based information, this CPG is intended to assist healthcare providers in all aspects of patient care, including, but not limited to, post-operative rehabilitation and long-term follow-up. The broader goal of this guideline is to improve the health and well-being of Veterans with amputations by guiding health providers who are providing rehabilitation care after LLA.

d. In order to address the rehabilitation management of Veterans with upper extremity amputations, the VA and DoD collaborated to produce the Upper Extremity Amputation Rehabilitation Clinical Practice Guideline (UEAR CPG). The guideline was published and released in September 2014. The document is the first CPG to be published in the area of upper extremity amputation and the guideline recommendations have been a valuable resource to both VA and DoD clinicians who provide care to this population. The formal CPG is accompanied by patient education materials, a clinician toolkit, and a summary document. The CPG and associated resources can be located at: http://www.healthquality.va.gov/guidelines/rehab/uear/index.asp.

## TELEREHABILITATION AMPUTATION SERVICES

a. Telerehabilitation Amputation Services, are recommended but not required to, provide clinical access between Veterans with amputations and the amputation care team providers through VA's secure video conferencing network. The utilization of Telerehabilitation Amputation Services is encouraged to improve access to specialty amputation care for Veterans in rural and highly rural areas. Telerehabilitation Amputation Services are key factors in making VA's comprehensive system of amputation care possible. Telerehabilitation Amputation Services can be used to provide consultative services to smaller facilities without specialized amputation care services, and preclude Veterans from having to travel long-distances for such care.

b. Many Veterans with amputations have mobility issues and avoiding the cost and inconvenience of travel is important. For Veterans who have realized the active lifestyle that prosthetics and rehabilitation services have made possible, frequent travel can affect their employment. They want to minimize the time they need to be away from their jobs for clinic appointments. Telehealth programs make it possible for patients to receive specialty care more rapidly. The benefits that can be expected from telehealth as a result of improved access to specialty care include:

(1) Improved continuity of care for Veterans in rural and highly rural areas, and

(2) Improved access to specialty services.

c. Telerehabilitation Amputation Services provide clinical expertise to Veterans without having them travel. Telerehabilitation Amputation Services provide a significant training benefit to clinicians at the site where the patient is seen, enabling a specialist to instruct the practitioner at the patient site on how to assess and manage patients with an amputation.

d. Telerehabilitation Amputation Services are conducted using real-time videoconferencing, which is termed Clinical Video Telehealth (CVT). CVT is a part of Clinic-based Telehealth (CBT) along with Store and Forward (SF) Telehealth. An Operations Manual has been developed for CBT and can be found at: http://vaww.infoshare.va.gov/sites/telehealth/docs/cbt-ops-manual.docx. ***NOTE:*** *This is an internal VA Web site and is not available to the public.*

e. In addition, an addendum to the Telehealth Manual specifically for telerehabilitation and specialty clinics such as amputation can be found at: https://vaww.infoshare.va.gov/sites/telehealth/docs/tampc-spp.pdf. ***NOTE:*** *This is an internal VA Web site and is not available to the public.*

## AMPUTEE DATA REPOSITORY

a. The Amputee Data Repository was developed with the support of the VHA Support Service Center (VSSC) and serves as a valuable tool for clinicians as well as for research scientists. The development and implementation of the Amputee Data Repository took place over several years and the product was officially released into publication in November 2015.

b. The variables described in this resource include general demographics of Veterans with amputations, amputation characteristics, co-morbid medical conditions, clinical encounter and prosthetic utilization data. The overall goals of this resource are to provide a data system for the ASoC to identify clinical care volumes and patterns of treatment; better understand the demographics of the Veteran amputee population; assess the effectiveness of new treatment strategies; and utilize data analysis outcomes to influence clinical practice. This resource can also be used to help identify variations in rehabilitation care, utilization of healthcare and prosthetic services, incidence of complications, and outcomes. Ultimately, the acquisition and analysis of this information will provide justification for the modification of clinical practice and enhanced quality of care for all Veterans with amputations who receive their care in the VA.

c. Major Domains of Amputee Repository Data

1) Demographics: (Age, Gender, Location)

2) Service Era: (OEF/OIF/OND or non-OEF/OIF/OND)

3) Co-morbidities: (Medical Conditions and Complications)

4) Amputation Characteristics: (Amputation level, Major/Minor)

5) Clinical Encounters: (Inpatient/Outpatient, Amputee Clinic/Other)

6) Prosthetics Data: (Artificial Limbs, Mobility Devices, Other)

7) Mortality / Amputation Progression

d. Access to the Amputee Data Repository can be obtained through the VSSC Homepage http://vssc.med.va.gov under the Clinical Care Section. ***NOTE:*** *This is an internal VA Web site that is not available to the public.*

e. Access to the Amputee Data Registry for research purposes follows the standard process for all VSSC products. Access must be requested through VINCI. (http://vaww.vinci.med.va.gov/vincicentral/default.aspx) Once a project is approved for research, VINCI will assist the researchers with their data extraction.

# ACCREDITATION

## 1. Commission on Accreditation for Rehabilitation Facilities (CARF).

a. CARF provides an international, independent, peer review system of accreditation that is widely-recognized by Federal agencies, state governments, major insurers, and professional organizations, as well as by consumer and advocacy organizations throughout the United States. Established in 1966, CARF serves as the pre-eminent standards setting and accreditation body promoting the delivery of quality rehabilitation services for people with disabilities. The standards developed by CARF are consumer-focused, field-driven, state-of-the-art national and international standards for rehabilitation. CARF standards are applicable to both inpatient and outpatient settings and a variety of specialized programs.

b. CARF offers specialty accreditation in amputation care for both inpatient and outpatient programs. This accreditation status signifies the attainment of a distinguished level of expertise and the provision of a comprehensive spectrum of services related to amputation care and rehabilitation. The Amputation System of Care has established the expectation that each of the RAC and PANS locations will obtain and maintain CARF Amputation Specialty accreditation.