

Amended on October 19, 2018

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

**VHA DIRECTIVE 1172.03(1)
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:

a. Amendment dated October 19, 2018 corrects the ASoC Types in Appendix C to read:

- (1) ACT Marion VA Medical Center, District/VISN 3V15, Station Number 657A5; and
- (2) APOC Marion VA Medical Center, District/VISN 3V10, Station Number 610.

b. Major changes include:

(1) 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.

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

(3) 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 RESCISSIONS: VHA Handbook 1172.03, dated August 15, 2012, is rescinded.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 This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

Richard A. Stone, M.D.
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 Website 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 / Basic	X X	X X	- X	- -
Pain Management Complex / Basic	X X	X X	- X	- -
Gait Analysis / Training Complex / Basic	X X	X X	- X	- -
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	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
ACT	Clement J. Zablocki VA Medical Center	3V12	695

ASOC Type	Facility Name	District / VISN	Facility STA_NO
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	Marion VA Medical Center	3V15	657A5
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	Marion VA Medical Center	3V10	610
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	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 web site and is not available to the public.*

e. In addition, an addendum to the CBT Manual specifically for telerehabilitation and specialty clinics such as amputation has been developed and can be found at: <http://vaww.infoshare.va.gov/sites/telehealth/docs/trehab-scs.docx>. **NOTE:** *This is an internal 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 Website 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.