

## PREVENTION OF AMPUTATION IN VETERANS EVERYWHERE PROGRAM

**1. REASON FOR ISSUE:** This Veterans Health Administration (VHA) directive states policy and requirements for the Prevention of Amputation in Veterans Everywhere (PAVE) program, which outlines the scope of care and treatment provided to Veterans at risk of primary or secondary limb loss.

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

a. Updates the responsibilities for the Chair, VHA Central Office PAVE Oversight Committee to communicate the results of the PAVE Annual Report to the Assistant Under Secretary for Health for Patient Care Services, Chief Consultant for Rehabilitation and Prosthetic Services and the Chief Officer, Specialty Care Program Office.

b. Updates the roles of primary care and podiatry and the foot risk assessment in Appendix A.

**3. RELATED ISSUES:** VHA Directive 1172.03(1), VHA Amputation System of Care, dated August 3, 2018; VHA Directive 1173.3, VHA Outpatient Amputation Specialty Clinics, dated March 8, 2021; VHA Directive 1173.9, Therapeutic Footwear and In-Shoe Orthoses, dated October 22, 2021.

**4. RESPONSIBLE OFFICE:** The Office of Rehabilitation and Prosthetic Services (12RPS) and the Specialty Care Program Office (11SPEC) are responsible for the content of this directive. Questions may be addressed to the National Program Director, Podiatry Service at [VHA11SPEC21PodiatryActions@va.gov](mailto:VHA11SPEC21PodiatryActions@va.gov).

**5. RECISSIONS:** VHA Directive 1410, Prevention of Amputation in Veterans Everywhere (PAVE) Program, dated March 31, 2017, and VHA Memorandum 2022-12-14, Compliance with Annual Reporting of VHA Directive 1410, Prevention of Amputation in Veterans Everywhere (VIEWS 06295708), dated December 9, 2021, are rescinded.

**6. RECERTIFICATION:** This VHA directive is scheduled for recertification on or before the last working day of June 2027. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

June 30, 2022

VHA DIRECTIVE 1410

**BY DIRECTION OF THE OFFICE OF  
THE UNDER SECRETARY FOR HEALTH:**

/s/ Beth Taylor, DHA, RN, FAAN, NEA-BC  
Assistant Under Secretary for Health  
for Patient Care Services/CNO

***NOTE:*** All references herein to the Department of Veterans Affairs (VA) and VHA documents incorporate by reference subsequent VA and VHA documents on the same or similar subject matter.

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**CONTENTS**

**PREVENTION OF AMPUTATION IN VETERANS EVERYWHERE PROGRAM**

1. PURPOSE..... 1

2. BACKGROUND..... 1

3. DEFINITIONS ..... 2

4. POLICY ..... 2

5. RESPONSIBILITIES ..... 2

6. PREVENTION OF AMPUTATION IN VETERANS EVERYWHERE AND VHA  
AMPUTATION SYSTEM OF CARE PROGRAM ELEMENTS ..... 7

7. TRAINING ..... 8

8. RECORDS MANAGEMENT..... 8

9. REFERENCES..... 8

APPENDIX A

SUGGESTED FOOT CHECK RECOMMENDATIONS .....A-1

## PREVENTION OF AMPUTATION IN VETERANS EVERYWHERE PROGRAM

### 1. PURPOSE

This Veterans Health Administration (VHA) directive states policy and requirements for the Prevention of Amputation in Veterans Everywhere (PAVE) program, which outlines the scope of care and treatment provided to Veterans at risk of primary or secondary limb loss. **AUTHORITY:** 38 U.S.C. § 7301(b).

### 2. BACKGROUND

a. The Department of Veterans Affairs (VA) Preservation-Amputation Care and Treatment Program was established in 1993 to meet the changing needs of the Veteran population (i.e., more amputations due to neuropathic and vascular conditions and fewer traumatic amputations). This program, now known as PAVE, represents a model of care developed to prevent or delay amputation through proactive early identification of Veterans who are at risk of limb loss. Currently, the prevalence of diabetes in VHA is about 24%, making this a priority clinical issue for Veteran care. To best serve Service members with traumatic amputations who are leaving the military and coming to VA for care, VHA is also addressing the unique needs of these Veterans to ensure that the Veteran receives optimal and compassionate patient-centered care through the VHA Amputation System of Care (ASoC).

b. Since its inception in 1993, the PAVE program has made significant strides in implementing evidence-based prevention practices. VA data (which does not include Medicare and private sector data) has shown a steady decrease in proximal (higher level) amputations in favor of more limb-sparing distal (lower level) amputations, which improve the Veterans' functional capacity. The PAVE program uses clinical practice guidelines to provide a model of care. The 2017 VA/Department of Defense (DoD) Clinical Practice Guideline: Management of Type 2 Diabetes Mellitus (DM) in Primary Care promotes:

(1) Performing a comprehensive foot risk assessment annually.

(2) Referring Veterans with limb-threatening conditions to the appropriate level of care for evaluation and treatment.

c. The PAVE program provides a model of care for:

(1) Those Veterans at risk for primary amputation (e.g., Veterans with diabetes, peripheral arterial disease, chronic kidney disease or any disease which causes sensory neuropathy who are considered highly susceptible to developing foot ulcers).

(2) Those Veterans who have already suffered an amputation (whether traumatic or as a complication of a disease process).

d. A VA medical facility PAVE Coordinator incorporates interdisciplinary management of care utilizing available amputation prevention and rehabilitation

resources which could include but are not limited to primary care providers, infectious disease providers, diabetes teams (e.g., diabetes educators), nurses, podiatrists, vascular surgeons, rehabilitation providers, therapists (e.g., physical, occupational, recreational), social workers, mental health care providers, and prosthetic and orthotic providers. **NOTE:** *The 2017 VA/DoD Clinical Practice Guideline: Management of Type 2 DM can be found at*

<https://www.healthquality.va.gov/guidelines/CD/diabetes/Vadoddmcpqfinal508.pdf>.

### 3. DEFINITIONS

a. **At Risk.** For the purposes of this directive, at risk is the risk assessment level of a Veteran with diabetes, peripheral arterial disease, chronic kidney disease or any disease which causes sensory neuropathy who is considered highly susceptible to develop foot ulcers.

b. **High Risk.** For the purposes of this directive, high risk is the risk assessment level of a Veteran who has had a designation of foot risk score (FRS) of 2 or 3. **NOTE:** *For more information, see Appendix A.*

### 4. POLICY

It is VHA policy that the PAVE program be established and maintained at all VA medical facilities to prevent first amputations or further amputations in Veterans who have suffered an amputation. **NOTE:** *Any newly established VA medical facility must implement the PAVE program within 6 months of opening.*

### 5. RESPONSIBILITIES

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

b. **Assistant Under Secretary for Health for Patient Care Services.** The Assistant Under Secretary for Health for Patient Care Services is responsible for:

(1) Supporting the Office of Rehabilitation and Prosthetic Services with implementation and oversight of this directive.

(2) Appointing the Chair, VHA Central Office (VHACO) PAVE Oversight Committee.

c. **Assistant Under Secretary for Health for Operations.** The Assistant Under Secretary for Health for Operations is responsible for:

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

(2) Assisting VISN Directors to resolve implementation and compliance challenges in all VA medical facilities within that VISN.

(3) Providing oversight of VISNs to ensure compliance with this directive and its effectiveness.

d. **Executive Director, Podiatry Program, VHA Central Office.** The Executive Director, Podiatry Program serves as the National PAVE Director and Chair of the VHACO PAVE Oversight Committee. The Executive Director, Podiatry Program is responsible for:

(1) Overseeing the PAVE program, including its administrative management and the development of critical pathways, clinical recommendations, quality indicators of care and performance measures.

(2) Ensuring VISN and VA medical facility compliance by distributing an annual survey to the VISN Director and VA medical facility Director and requiring corrective action when non-compliance is identified.

(3) Reviewing the PAVE Annual Report submitted by the VA medical facility Chief of Staff (CoS)/VA medical facility Associate Director of Patient Care Services (ADPCS) and subsequently submitting the report to the VHACO PAVE Oversight Committee and VISN Directors for determining compliance with this directive.

(4) Updating the Advisory Committee for Prosthetics and Special Disabilities about the PAVE program when such updates are requested.

e. **Chief Consultant, Rehabilitation and Prosthetic Services.** The Chief Consultant, Rehabilitation and Prosthetic Services is responsible for assisting the Assistant Under Secretary for Health for Patient Care Services in the implementation and oversight of this directive (e.g., communicating PAVE program recommendations from the Chair, VHACO PAVE Oversight Committee).

f. **Chief Officer, Specialty Care Program Office.** The Chief Officer, Specialty Care Program Office (SCPO) is responsible for assisting the Assistant Under Secretary for Health for Patient Care Services in the implementation and oversight of this directive (e.g., communicating PAVE program recommendations from the Chair, VHACO PAVE Oversight Committee).

g. **Chair, VHA Central Office Prevention of Amputation in Veterans Everywhere Oversight Committee.** The VHACO PAVE Oversight Committee is comprised of VA medical facility and VISN clinical leaders from primary care, endocrinology or diabetes, podiatry, physical medicine and rehabilitation, prosthetics, nursing, mental health, VISN Offices of Quality and Patient Safety and other subsequently identified representatives. The Chair, VHACO PAVE Oversight Committee is responsible for:

(1) Selecting VHACO PAVE Oversight Committee members from VA medical facilities and VISNs, based on their related clinical and administrative expertise, with approval from their VA medical facility Director.

(2) Communicating to the Assistant Under Secretary for Health for Patient Care Services, Chief Consultant for Rehabilitation and Prosthetic Services and the Chief Officer, SCPO (e.g., results of the PAVE Annual Report, any request from VHACO and making recommendations for program improvements).

(3) Ensuring regularly scheduled meetings with the VHACO PAVE Oversight Committee members to finalize recommendations to the Chief Officer, SCPO and Chief Consultant, Rehabilitation and Prosthetics Services for data collection and analyses to permit evaluation of the PAVE program's foot check, surveillance, salvage and rehabilitative components, including:

(a) Identification of Veterans at risk for or who have sustained an amputation.

(b) Capturing age adjusted and stratified rates of major Above Knee Amputations (AKA), major Below Knee Amputations (BKA), minor amputations and lower extremity non-venous ulcers at the VISN and VA medical facility levels.

(c) Reports on documentation of patient knowledge and performance of recommended self-foot-care practices.

(4) Using all analyses to identify best practices from VISNs and VA medical facilities.

**NOTE:** The data captured for reporting are found in VHA Support Service Center (VSSC) Clinical Patient Care, Rehabilitation Service, Amputation Pyramid Cubes (Amputation Risk Cube, Amputee Cube, Non-healing Ulcer Cube) at <https://vssc.med.va.gov/VSSCMainApp/products.aspx?PgmArea=55>. This is an internal VA website that is not available to the public.

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

(1) Ensuring that all VA medical facilities within the VISN comply with this directive and informing leadership when barriers to compliance are identified.

(2) Reviewing the results of the annual survey, provided by the Executive Director, Podiatry Program, for each VA medical facility in the VISN annually to assess program status. **NOTE:** The data is found in the VSSC Clinical Patient Care, Rehabilitation Service, Amputation Pyramid Cubes (Amputation Risk Cube, Amputee Cube, Non-healing Ulcer Cube) at <https://vssc.med.va.gov/VSSCMainApp/products.aspx?PgmArea=55>. This is an internal VA website that is not available to the public.

(3) Identifying the need for further evaluation and restructuring of local PAVE program initiatives.

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

(1) Ensuring overall VA medical facility compliance with this directive and that appropriate corrective action is taken if non-compliance is identified.

(2) Establishing a new or maintaining an existing PAVE program by coordinating with the VA medical facility PAVE Committee Coordinator to address the primary amputation prevention needs of at-risk Veterans and the secondary amputation prevention needs for those Veterans who have already experienced an amputation. This includes Veterans who underwent their amputations outside the VA health care system (e.g., while on active duty or in a non-VA hospital).

(3) Ensuring development of local processes to define the roles and responsibilities of the VA medical facility PAVE Committee and each involved service line. **NOTE:** *Examples of local processes can be found at [http://vaww.specialtycare.va.gov/podiatry/Prevention\\_of\\_Amputation\\_in\\_Veterans\\_Everywhere\\_PAVE.asp](http://vaww.specialtycare.va.gov/podiatry/Prevention_of_Amputation_in_Veterans_Everywhere_PAVE.asp). This is an internal VA website that is not available to the public.*

(4) Approving the model of care developed by the VA medical facility CoS and VA medical facility ADPCS.

(5) Completing the annual survey from the Executive Director, Podiatry Program.

(6) Approving VA medical facility staff, when requested and appropriate, for the VHACO PAVE Oversight Committee membership.

**j. VA Medical Facility Chief of Staff and VA Medical Facility Associate Director of Patient Care Services.** The VA medical facility CoS and VA medical facility ADPCS collaborate and responsible for:

(1) Designating and ensuring training of a VA medical facility PAVE Coordinator.

(2) Ensuring availability of foot specialty care and ensuring compliance with designated performance measures (e.g., External Peer Review Program).

(3) Coordinating the efforts of all medical disciplines required for treatment of Veterans at risk of limb loss or amputation.

(4) Developing local processes specifically identifying the responsibilities and actions to be taken by each of the involved services (i.e., Medical, Surgical, Physical Medicine and Rehabilitation, Podiatry, Nursing, Primary Care, Social Work, Mental Health and Prosthetic and Sensory Aids), to identify and treat Veterans at risk of limb loss or those who are amputees. **NOTE:** *For more information on local processes, see [http://vaww.specialtycare.va.gov/podiatry/Prevention\\_of\\_Amputation\\_in\\_Veterans\\_Everywhere\\_PAVE.asp](http://vaww.specialtycare.va.gov/podiatry/Prevention_of_Amputation_in_Veterans_Everywhere_PAVE.asp). This is an internal VA website that is not available to the public.*

(5) Defining local processes and care algorithms to identify and track all Veterans who are either at risk of limb loss or amputees from the day of their entry into the VA health care system through all levels of care. **NOTE:** *This includes at a minimum the numbers of Veterans in each risk score, major/minor amputation ratios, AKA and BKA amputation ratios, new ulcers per year and the percentage of those with diabetes. The data, included in VSSC PAVE Cubes, must be reported on an annual basis and reviewed by the VA medical facility COS. For more information on local processes, see*



[http://vaww.specialtycare.va.gov/podiatry/Prevention\\_of\\_Amputation\\_in\\_Veterans\\_Everywhere\\_PAVE.asp](http://vaww.specialtycare.va.gov/podiatry/Prevention_of_Amputation_in_Veterans_Everywhere_PAVE.asp). This is an internal VA website that is not available to the public.

(6) Defining the local process to provide foot checks at the entry point to the health care system, risk assessment, timely (i.e., urgent, emergent or routine) and appropriate referral and tracking from the date of entry throughout the care process. **NOTE:** This may be accomplished by the VA medical facility PAVE Coordinators incorporating their efforts with the ASoC programs or other amputation prevention committees within the VA medical facilities.

(7) Developing a formal performance plan for the VA medical facility to evaluate the PAVE program and provide evidence of the use of this data in subsequent program changes or modifications.

(8) Ensuring that VA medical facility guidelines regarding universal foot checks are updated and utilized by all VA health care providers providing care to Veterans at risk for amputation (see Appendix A).

(9) **For the VA medical facility CoS or ADPCS:** Reviewing the PAVE Annual Report submitted by the VA medical facility PAVE Coordinator, and subsequently submitting it to the Executive Director, Podiatry Program by December 30 of each year. **NOTE:** This includes a review of VA medical facility and VISN amputation ratios and new ulcers.

**k. VA Medical Facility Prevention of Amputation in Veterans Everywhere Coordinator.** The VA medical facility PAVE Coordinator is responsible for:

(1) Tracking the number of Veterans in each risk score, major and minor amputation ratios, AKA and BKA amputation ratios, new ulcers per year and the percentage of those with diabetes.

(2) Providing organizational support for the PAVE program by:

(a) Ensuring the VA medical facility PAVE Committee meets at least once a year.

(b) Maintaining meeting minutes.

(c) Collecting, reviewing and analyzing program data in VSSC to drive program improvement.

(3) Communicating necessary updates about the VA medical facility's PAVE program to the VA medical facility Director, VISN Director, VA medical facility CoS, VA medical facility ADPCS and PAVE team providers.

(4) Developing, in collaboration with the PAVE Committee, VA medical facility CoS and VA medical facility ADPCS, program goals and objectives.

(5) Collaborating with amputation care providers or other related committees and

services to provide interdisciplinary management of care to Veterans. **NOTE:** Services can include but are not limited to primary care, infectious disease, endocrinology, nursing, podiatry, vascular surgery, physical medicine and rehabilitation, therapy (e.g., physical, occupational, recreational), social work, mental health, and prosthetics and orthotics.

(6) Completing the PAVE Annual Report and reviewing with the VA medical facility CoS or ADPCS. **NOTE:** Reports may be completed over time and saved each time data is entered. The draft report may be printed and must be reviewed by the VA medical facility CoS for approval but must be submitted through the PAVE website. The website for submitting the PAVE Annual Report can be found at <https://dvagov.sharepoint.com/sites/VHASCSOPS/11SPEC21>. For assistance in completing the PAVE Annual Report, data can be found on VSSC PAVE Cubes at <https://vssc.med.va.gov/VSSCMainApp/products.aspx?PgmArea=55>. These are internal VA websites that are not available to the public.

## 6. PREVENTION OF AMPUTATION IN VETERANS EVERYWHERE AND VHA AMPUTATION SYSTEM OF CARE PROGRAM ELEMENTS

The PAVE program and the ASoC program are closely linked and coordinate efforts to address the prevention of first amputation, the rehabilitation needs of Veterans who have undergone an amputation, and the prevention of a more proximal revision amputation or any additional amputations in those Veterans with an amputation. **NOTE:** For detailed information on the ASoC program, see VHA Directive 1172.03(1), VHA Amputation System of Care, dated August 3, 2018. At a minimum, the PAVE program provides for:

- a. An initial foot check for at-risk populations (e.g., Veterans with diabetes, peripheral arterial disease, chronic kidney disease or any disease which causes sensory neuropathy) that occurs in the Patient Aligned Care Team (PACT) or Primary Care or other entry point to the VA health care system (e.g., renal clinic). Findings raising suspicion of high risk for amputation (FRS 2 or 3) are referred to a podiatrist or other foot care specialist for in-depth examination and final FRS determination (see Appendix A).
- b. Timely (i.e., urgent, emergent or routine) and appropriate referral and ongoing follow-up of Veterans based on an algorithm produced by the VA medical facility PAVE Committee (see Appendix A).
- c. A referral to a mental health consultation team, as needed, to assess coping skills and to provide support in either an individual or group format.
- d. A system to identify and track Veterans with amputation or those at risk for amputation through all appropriate levels of care. **NOTE:** The VSSC Clinical Patient Care, Rehabilitation Service, Amputation Pyramid Cubes (Amputation Risk Cube, Amputee Cube, Non-healing Ulcer Cube) can be found at

<https://vssc.med.va.gov/VSSCMainApp/products.aspx?PgmArea=55>. This is an internal VA website that is not available to the public.

e. Collaboration with an Amputation Specialty Clinic team or other relevant providers to provide a model of at-risk limb care through interdisciplinary coordination in tracking Veterans with amputations, or those at risk of limb loss, from day of entry through all appropriate care levels, back into the community. This would include, at a minimum, the number of Veterans in each risk score, major and minor amputation ratios, AKA/BKA amputation ratios, new ulcers per year and the percentage of those with diabetes.

**NOTE:** This case management oversight complements the activities of the VA medical facility treatment staff and Amputation Specialty Clinic team and is not meant to replace or be counterproductive to any phase of clinical Veteran care. VA medical facilities are encouraged to establish or refer Veterans with amputations to a peer support program or Amputee Support Groups or Clinics for ongoing support.

## 7. TRAINING

The following training is required to be taken once by VA advanced practice providers and other clinicians (e.g., Registered Nurse, Licensed Practical Nurse) of basic foot care: Basic Foot Care Course, Talent Management System (TMS) Course ID# 28493.

## 8. RECORDS MANAGEMENT

All records regardless of format (e.g., paper, electronic, electronic systems) created by this directive must be managed as required by the National Archives and Records Administration (NARA) approved records schedules found in VHA Records Control Schedule 10-1. Questions regarding any aspect of records management should be addressed to the appropriate Records Officer.

## 9. REFERENCES

- a. 38 U.S.C. § 7301(b).
- b. VHA Directive 1172.03(1), VHA Amputation System of Care, dated August 3, 2018.
- c. VHA Directive 1173.9, Therapeutic Footwear and In-Shoe Orthoses, dated October 22, 2021.
- d. Prevention of Amputation in Veterans Everywhere PAVE.  
[http://vaww.specialtycare.va.gov/podiatry/Prevention\\_of\\_Amputation\\_in\\_Veterans\\_Everywhere\\_PAVE.asp](http://vaww.specialtycare.va.gov/podiatry/Prevention_of_Amputation_in_Veterans_Everywhere_PAVE.asp). **NOTE:** This is an internal VA website that is not available to the public.
- e. PAVE Annual Report.  
<https://dvagov.sharepoint.com/sites/VHASCSOPS/11SPEC21>. **NOTE:** This is an internal VA website that is not available to the public.

f. VA/DoD Clinical Practice Guideline: Management of Diabetes Mellitus in Primary Care.

<https://www.healthquality.va.gov/guidelines/CD/diabetes/Vadoddmcpgfinal508.pdf>.

g. VHA Prosthetic Clinical Management Program: Clinical Practice Recommendations: Diabetic Socks.

<https://dvagov.sharepoint.com/:b:/r/sites/VHARPSSTAGE/OPClinical/Main%20Document%20Library/VHA%20Prosthetic%20Clinical%20Management%20Program%20Diabetic%20Socks.pdf?csf=1&web=1&e=cc33MA>. **NOTE:** This is an internal VA website that is not available to the public.

h. VHA Support Service Center (VSSC).

<https://vssc.med.va.gov/VSSCMainApp/products.aspx?PgmArea=55>. **NOTE:** This is an internal VA website that is not available to the public.

## SUGGESTED FOOT CHECK RECOMMENDATIONS

### 1. FOOT CHECK

The Department of Veterans Affairs (VA) health care provider performs an initial foot check in the Patient Aligned Care Team (PACT), Primary Care or other entry point to the VA health care system and performs a subsequent foot check at least once a year, depending on the final foot risk score (FRS). The foot check establishes the final FRS for FRS 0 and 1. The foot check does not establish the final FRS for FRS 2 and 3 findings; it serves as a guide for appropriate and timely (i.e., urgent, emergent or routine) referral for examination and determination of FRS. This would involve:

- a. Visual inspection of the skin surface for any lesions, deformities, color or temperature changes or ulcers.
- b. Foot check for circulation (i.e., the palpation of pedal pulses in the foot).
- c. Check for loss of protective sensation using a Semmes-Weinstein 5.07 monofilament. **NOTE:** *Semmes-Weinstein 5.07 monofilament must be replaced at a level specified based on manufacturer guidelines to ensure results remain valid.*

### 2. HIGH RISK FOOT EXAMINATION

For initial FRS 2 and 3 patients, this involves in-depth evaluation of the foot's circulation and sensation as well as any deformities. During this examination, Veterans are evaluated by a foot care specialist (e.g., podiatrist, vascular surgeon, Prevention of Amputation in Veterans Everywhere (PAVE) Program member, or other health care professional demonstrating appropriate education, training, competencies and licensure necessary to provide such care). **NOTE:** *This in-depth evaluation establishes the final FRS for 2 and 3.*

### 3. RISK ASSESSMENT LEVEL AND FOOT RISK SCORE

- a. "At risk" is defined as Veterans with diabetes, peripheral arterial disease, chronic kidney disease and any disease causing sensory neuropathy who are considered highly susceptible to develop foot ulcers.
- b. "High risk" is defined as any Veteran who has had a designation of FRS of 2 or 3. **NOTE:** *Requires referral to podiatry or foot care specialist for determination of final FRS.*

(1) **Level 0, Normal Risk.** These Veterans have no evidence of sensory loss, diminished circulation, ulceration, or history of ulceration or amputation.

(2) **Level 1, Low Risk.** These Veterans have no evidence of sensory loss, diminished circulation, ulceration, or history of ulceration or amputation. These individuals do demonstrate one or any of the following:

- (a) Foot deformity (e.g., bony foot deformity, bunion and hammertoe).
- (b) Minor foot infection (e.g., tinea pedis or paronychia and a diagnosis of diabetes).
- (c) Evidence of minor diminution of circulation (i.e., weekly palpable pedal pulses).

(3) **Level 2, Moderate Risk.** These individuals demonstrate sensory loss (inability to perceive the Semmes-Weinstein 5.07 monofilament) and may have one of the following additional findings:

(a) Diminished circulation as evidenced by absent or loss of protective sensation (this would require follow-up examination by the podiatrist to determine level of vascular disease before a final risk score can be determined).

(b) Foot deformity or minor foot infection and a diagnosis of diabetes.

(4) **Level 3, High Risk.** These individuals demonstrate peripheral neuropathy with sensory loss (i.e., inability to perceive the Semmes-Weinstein 5.07 monofilament) and may have diminished circulation and foot deformity, or minor foot infection and a diagnosis of diabetes, or any of the following by itself:

(a) Ulcer or history of prior ulcer, osteomyelitis or history of prior amputation.

(b) Severe Peripheral Arterial Disease (intermittent claudication, or critical limb ischemia manifested by rest pain, ulceration or gangrene).

(c) Charcot's joint disease with foot deformity.

(d) Chronic Kidney Disease. These individuals are at high risk of lower extremity events.

#### 4. SMOKING

A history of smoking, although not shown to be an independent risk factor for lower extremity amputation, increases the risk level for other morbid vascular complications such as peripheral arterial disease, stroke and myocardial infarction, and delayed or impaired wound healing. For Veterans with a history of smoking, cessation counseling is recommended.

#### 5. SUGGESTED REFERRAL STRATEGY

a. Level 0, Normal Risk.

(1) These Veterans should be screened annually; occurs in the PACT and Primary Care or other entry point to the VA health care system (e.g., renal clinic).

(2) Veteran education and self-care instruction which can be delivered during the encounter or can be referred to a diabetes educator. Where available Diabetes Self-Management Education Classes should be offered.

(3) Refer, if appropriate, to a primary care provider for monitoring and control of their systemic conditions.

(4) While the Veterans in this category should not walk barefoot, these individuals do not need Depth Shoes Inlay footwear for their FRS only. Special attention should be directed to proper shoe fit.

**b. Level 1, Low Risk.**

(1) These Veterans should be screened annually; screening occurs in PACT and Primary Care or other entry point to the VA health care system (e.g., renal clinic).

(2) Veteran education and self-care instruction should be delivered during the encounter or can be referred to a diabetes educator. Where available Diabetes Self-Management Education Classes should be offered.

(3) Refer, if appropriate, to primary care provider for monitoring and control of their systemic conditions.

(4) Refer to podiatry or foot care specialist for examination only if symptomatic deformity exists.

(5) While the Veterans in this category should not walk barefoot, these individuals do not need Depth Shoes Inlay footwear for their FRS only. Special attention should be directed to proper shoe fit.

**c. Level 2, Moderate Risk.** If found to be FRS 2, individuals in this category require:

(1) Referral to podiatry or foot care specialist for regular scheduled preventive foot care and careful observation. The addition of a foot hygienist (advanced practice providers such as Licensed Practical Nurse [LPN], Registered Nurse [RN], Nurse Practitioner [NP]) as part of the podiatric clinical team helps address the increased need for basic foot care under the direction of the Chief of Podiatry allowing the podiatric physician to treat more complex foot and ankle conditions. **NOTE:** *The required training program for advanced practice providers of basic foot care is found on Talent Management System (TMS) Course ID# 28493.*

(2) The provision of Depth Shoes Inlay footwear and orthoses to accommodate foot deformities, to compensate for soft tissue atrophy, and to evenly distribute plantar foot pressures. May also require diabetic socks based on clinical judgment.

(a) Diabetic socks are defined as hosiery specifically designed to reduce pressure or friction to the foot. **NOTE:** For more information, see VHA Prosthetic Clinical Management Program: Clinical Practice Guidelines: Diabetic Socks at <https://dvagov.sharepoint.com/:b:/r/sites/VHARPSSTAGE/OPClinical/Main%20Document%20Library/VHA%20Prosthetic%20Clinical%20Management%20Program%20Diabetic%20Socks.pdf?csf=1&web=1&e=cc33MA>. This is an internal VA website that is not available to the public.

(b) Depth Shoes Inlay footwear, which are prefabricated shoes with a higher toe box to accommodate for hammer toes and other foot deformities. This shoe may also accommodate the insertion of special inserts. **NOTE:** For more information, see VHA Directive 1173.9, Therapeutic Footwear and In-Shoe Orthoses, dated October 22, 2021.

(3) Referral for non-invasive vascular laboratory testing to determine the degree of circulatory impairment, if there is evidence of impaired circulation on the foot check.

(4) Veteran education and self-care instruction which can be delivered during the encounter or can be referred to a diabetes educator. Where available, Diabetes Self-Management Education Classes should be offered.

(5) Referral, if appropriate, to a primary care provider for monitoring and control of their systemic conditions.

d. **Level 3, High Risk.** If found to be FRS 3, individuals in this category require:

(1) Referral to podiatry or foot care specialist for regular scheduled preventive foot care and careful observation. The addition of a foot hygienist (e.g., LPN, RN, NP) as part of the podiatric clinical team helps address the increased need for basic foot care under the direction of the Chief of Podiatry allowing the podiatric physician to treat more complex foot and ankle conditions. **NOTE:** The required training program for advanced practice providers of basic foot care is found on TMS ID# 28493.

(2) Provision of Depth Shoes Inlay footwear and orthoses to accommodate foot deformities, to compensate for soft tissue atrophy, and to evenly distribute plantar foot pressures. May also require Custom- Made Therapeutic Footwear and diabetic socks based on clinical judgment.

(a) Diabetic socks are defined as hosiery specifically designed to reduce pressure or friction to the foot. **NOTE:** For more information, see VHA Prosthetic Clinical Management Program: Clinical Practice Recommendations: Diabetic Socks at <https://dvagov.sharepoint.com/:b:/r/sites/VHARPSSTAGE/OPClinical/Main%20Document%20Library/VHA%20Prosthetic%20Clinical%20Management%20Program%20Diabetic%20Socks.pdf?csf=1&web=1&e=cc33MA>. This is an internal VA website that is not available to the public.



(b) Depth Shoes Inlay footwear, which are prefabricated shoes with a higher toe box to accommodate for hammer toes and other foot deformities. This shoe may also accommodate the insertion of special inserts (refer to VHA Directive 1173.9).

(c) Custom-Made Therapeutic Footwear are shoes fabricated over special modified lasts in accordance with prescriptions and specifications to accommodate gross or greater foot deformities or shortening of a leg at least 1 and ½ inches (refer to VHA Directive 1173.9).

(3) Referral for non-invasive vascular laboratory testing to determine the degree of circulatory impairment if there is evidence of significant impaired circulation. Refer to vascular surgery if non-invasive testing finds significant impairment.

(4) Veteran education and self-care instruction, which can be delivered during the encounter or can be referred to a diabetes educator. Where available Diabetes Self-Management Education Classes should be offered.

(5) Referral if appropriate to a primary care provider for monitoring and control of their systemic condition

(6) If acute condition is present, immediate referral is indicated to the appropriate discipline.