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## PRESERVATION-AMPUTATION CARE AND TREATMENT (PACT) PROGRAM

**1. PURPOSE:** This Veterans Health Administration (VHA) Directive expands the scope of the care and treatment provided veteran patients at risk of limb loss or with amputations.

### 2. BACKGROUND

a. Throughout the history of the Department of Veterans Affairs (VA), the care that is provided to veterans with amputation has always been under close scrutiny. To many Americans, the veteran with an amputation epitomizes the sacrifices made on our Nation's behalf. Any deficiencies, real or perceived, tend to be magnified and evoke intense feelings on the care VA provides.

b. The passage of Public Law 102-405, Veterans Medical Programs Amendments of 1992, emphasized the importance of providing the best possible amputee care. That law identified veterans with limb loss as a special disability group. It also chartered, by law, the Advisory Committee on Prosthetics and Special-Disabilities Programs. **NOTE:** *The Committee reports annually to the Secretary of Veterans Affairs on the effectiveness of such programs.*

c. VA's Preservation-Amputation Care and Treatment (PACT) program was established in 1993 to meet the changing needs of the veteran population, i.e., more neuropathic and vascular problems and fewer traumatic amputations. It represents a model of care developed to prevent or delay amputation through proactive early identification of patients who are at risk of limb loss. The problems encountered by diabetic patients best demonstrate the need for this program. The Centers for Disease Control and Prevention estimate that approximately 15 percent of individuals with diabetes will develop foot ulcers, and 15 to 20 percent of those ulcers are estimated to result in lower extremity amputations.

(1) Prior to implementation of the PACT program, approximately 9,000 amputations were performed each year at VA medical centers. Since implementation of the program, total amputations have decreased to less than 5,500 per year. More impressive is an overall decline in amputation rates to 11.6 percent since 1998 within the at-risk diabetic population, demonstrating a substantial improvement in coordinated at-risk care.

(2) With the estimated cost of care associated with amputation ranging from \$40,000 to \$75,000, effective prevention should also lead to substantial economic benefit to VHA. Although these numbers are impressive, VA's Diabetes Field Advisory Group advises that 50 percent of all amputations on diabetic patients can be prevented with proper professional and patient education, including the prescription and use of appropriate footwear to permit healing and/or prevent diabetic foot ulcers. As a result, the PACT initiative provides local, network, and VHA Headquarters leadership with an excellent opportunity for collaborative performance improvement.

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d. The PACT program will be used to provide a model of at-risk limb care. It incorporates interdisciplinary coordination of surgeon, rehabilitation physician, therapist, nurse, podiatrist, social worker and primary care, medical, diabetes team and prosthetic and/or orthotic personnel to track every patient with amputations, or those at risk of limb loss, from day of entry into the VA health care system, through all appropriate care levels, back into the community. This case management oversight will complement the activities of the medical center treatment staff and Amputee Clinic Team and is not meant to replace or be counterproductive to any phase of clinical patient care.

**3. POLICY:** It is VHA policy that the PACT program be established at all VA medical centers. This will be done in collaboration with any existing amputee clinic team or other relevant primary care clinics, and will be used to provide a model of at-risk limb care through interdisciplinary coordination in tracking patients with amputations, or those at risk of limb loss, from day of entry through all appropriate care levels, back into the community. **NOTE:** *This case management oversight will complement the activities of the medical center treatment staff and Amputee Clinic Team and is not meant to replace or be counterproductive to any phase of clinical patient care.*

### 4. ACTION

a. The Office of Chief Consultant for the Rehabilitation Strategic Health Care Group, in collaboration with the Director, VHA Headquarters, Podiatry Service, and other subsequently identified clinical leaders, is responsible for oversight of the PACT program, development of critical pathways, quality indicators of care, and performance measures.

b. The Chief Consultant of the Prosthetic and Sensory Aids Service (PSAS) Strategic Health Care Group (SHG) is responsible for the administrative management of the PACT program. This includes, but is not limited to:

- (1) Assessing the effectiveness of prosthetic delivery and patient satisfaction.
- (2) Dissemination of prosthetic information to local prosthetic services and/or amputee clinic teams.
- (3) Assessing prosthetic training needs of the PACT program.

c. The Director, Physical Medicine and Rehabilitation Service (PM&RS), is responsible for assessing the overall impact of the PACT program to include the following:

- (1) Coordination of medical and psychosocial treatment with the Directors of Surgical, Medical, Podiatry, Primary Care, Nursing and Social Work Services.
- (2) Annual reporting of External Peer Review Program (EPRP) compliance with early identification and referral of patients found to be at risk for amputation.

(3) Evaluation of Special Disability capacity maintenance and semi-annual updates to the Advisory Committee for Prosthetics and Special Disabilities regarding the overall capacity and effectiveness of the PACT program.

(4) Collaborating with the Director, VHA Headquarters Podiatry Service, and the appropriate VHA offices and field units to develop the appropriate data and reports of overall and network-specific information. **NOTE:** *The appropriate VHA program officials will be responsible for coordinating the actions of their field services or programs to ensure the cooperation of all elements required to treat patients at risk of limb loss or amputees.*

**NOTE:** *This information is provided to the Network Directors through the Assistant Deputy Under Secretary for Health.*

d. The Network Directors must review the performance of their networks in comparison with national rates and for objectively defining any further evaluation and restructuring of local PACT program initiatives. The network office disseminates this data to appropriate clinical and administrative personnel at the local level. In addition, the Network Director is responsible for performance improvement of EPRP measures relating to both identification of patients at risk for amputation and for referral of these patients to a formally identified foot specialist.

e. The Chief of Staff at VHA field facilities is responsible for:

(1) Coordinating the efforts of all medical disciplines required for treatment of patients at risk of limb loss or amputation. This includes the formal identification of foot specialty care, compliance with designated performance measurement (e.g., EPRP), and annual outcome evaluation of the PACT program.

(2) Developing local policy memoranda 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, and Prosthetic and Sensory Aids, to identify and treat patients at risk of limb loss or those who are amputees.

(3) Defining local policy and care algorithms to:

(a) Identify and track all patients at risk of limb loss or amputees from the day of entry into the VA health care system, through all levels of care, until discharged back into the community.

**NOTE:** *This data set should include, at a minimum, baseline tracking data as well as demographics, foot risk score, prosthetic provision and hospital utilization.*

(b) Evaluate annually the outcomes of the PACT program, including a review of local facility and network amputation rates for both diabetic and non-diabetic populations. For those facilities noted to have higher than average amputation rates, the Chief of Staff's office needs to develop a formal performance plan to evaluate the program locally and provide evidence of the use of this data in subsequent program modulation.

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(c) Ensure that facility screening guidelines regarding universal foot checks and foot screenings are developed and utilized by all clinicians providing principal care to patients at risk for amputation. (See suggested screening guidelines in Attachment A.)

**5. REFERENCES:** None.

**6. FOLLOW-UP RESPONSIBILITY:** The Chief Consultant for the Rehabilitation Strategic Health Group is responsible for the contents of this Directive.

**7. RESCISSIONS:** VHA Directive 96-007 is rescinded. This Directive expires on May 31, 2006.

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## ATTACHMENT A

### SUGGESTED SCREENING GUIDELINES

#### 1. FOOT CHECK

This would involve:

- a. Visual inspection of the skin surface for any lesions, deformities, color or temperature changes or ulcers;
- b. Screening for circulation, i.e., the palpation of pedal pulses in the foot area; and
- c. Using a monofilament to check for sensory loss.

#### 2. FOOT SCREENING

This involves a more in-depth evaluation of the foot's circulation and sensation. During this screening, patients are evaluated by a "foot care specialist," e.g., Preservation-Amputation Care and Treatment (PACT) program member, vascular surgeon, podiatrist, or other health care professional demonstrating appropriate education, training, competencies and licensure necessary to provide such care.

#### 3. RISK ASSESSMENT LEVEL

"At risk" is defined, at a minimum, as patients with diabetes, peripheral vascular disease and end stage renal disease, who are considered susceptible to ulcer development. Other at risk conditions may include chronic heart disease, liver disease, immuno-compromised conditions (i.e., Acquired Immune Deficiency Syndrome (AIDS) and/or Human Immunodeficiency Virus (HIV), chronic steroid use, immuno-suppressant medications, collagen vascular disorders, etc.).

a. **Level 0, Low Risk.** These patients have no evidence of sensory loss, diminished circulation, foot deformity, ulceration, or history of ulceration or amputation. Diabetic patients should receive foot care education and annual foot care. These patients do not need therapeutic footwear.

b. **Level 1, At Risk - Insensate.** These individuals demonstrate evidence of sensory loss (inability to perceive the Semmes-Weinstein 5.07 monofilament) and/or diminished circulation. There is no evidence of foot deformity or history of plantar ulceration. Patient education and preventative care are required. The patients in this category and the following two categories (Level 2 and Level 3) should not walk barefoot. Special attention is to be directed to shoe style and fit. These individuals do not need therapeutic footwear.

c. **Level 2, At Risk.** Insensate with foot deformity and no history of plantar ulceration. These individuals require therapeutic footwear and orthosis to accommodate foot deformities, to

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compensate for soft tissue atrophy, and to evenly distribute plantar foot pressures. Patient education, regular preventive foot care, and annual foot screening are required.

d. **Level 3, At Risk.** Insensate with history of ulceration and/or prior amputation, Charcot foot deformity, or history of rest pain. These individuals are at highest risk of lower extremity events. Individuals in this category require extra depth footwear with soft molded inserts. They may require custom molded shoes and braces (e.g., double upright brace, patella tendon bearing orthosis, etc.). More frequent clinic visits are required with careful observation, regular preventive foot care, and footwear modifications.