HOME RESPIRATORY CARE PROGRAM (HRCP)

1. PURPOSE: To establish guidelines and procedures for the approval and continuation of Veterans for the home oxygen program.

2. POLICY: The Home Respiratory Care Team (HRCT) is responsible for

a. **Reviewing all aspects of the HRCT to include**

(1) Determination of eligibility for and entitlement to home oxygen therapy.

(2) When designated by the Contracting Officer, the Home Oxygen Coordinator (HOC) will function as the Contracting Officer's Representative (COR) for the home oxygen respiratory care by authorizing the contractor to deliver and setup the appropriately prescribed equipment. The Prosthetic Representative is the designated alternate COR and fund control point official. The COR assures all Joint Commission requirements are satisfied by the contractor in accordance with contract guidelines.

(3) Monitoring the Home Respiratory Care Program to maintain regulatory compliance including record of care documentation evaluating Veteran status while enrolled in the home oxygen program.

(4) Annually conducting a patient satisfaction survey.

(5) New Veterans will be re-evaluated in 90 days to establish stability with short-term oxygen therapy and on an annual basis for those on long-term oxygen therapy. The physician will notify Prosthetics and Sensory Aids Service (P&SAS) of this continued need or the need to terminate the oxygen therapy if indicated.

(6) Home visits will be conducted annually on 10 percent of Veterans on the Home Respiratory Care Program. Home visits will be conducted by qualified members of the HRCT. These random home visits are necessary to provide quality assurance of treatment modality.

(7) The HOC or designee will contact the contractor with the prescription and all necessary information to set the Veteran up with oxygen. The setup delivery shall take place within 24 hours of the initial contact from the HOC. If urgent or emergent care, a local vendor will be used to setup oxygen in less than 24 hours.

(8) Prosthetics and Sensory Aids Service will obligate the necessary funds on a credit card to support the Veteran for a period not to exceed one month. Chief, P&SAS or designee will sign as the authorizing official.

b. **Appropriate Controls**

(1) All Veterans in receipt of oxygen at VA expense will be clinically and physiologically re-evaluated and the need for oxygen therapy documented on initial

evaluation and then at 90 days. Thereafter, the need for continuing oxygen must be documented at least annually.

(2) A Veteran will not be discontinued from oxygen therapy unless ordered by a physician. If the Veteran refuses or fails to adhere to the safety guidelines or compliance with clinical appointments, home services will be suspended. This decision will be the responsibility of the COR / Home Oxygen Coordinator. Veterans determined to be no longer entitled to oxygen at VA expense will be notified in writing by certified letter that VA will no longer be responsible for payment thirty days prior to discontinuation. The oxygen contractor will also be notified.

(3) All changes in oxygen prescription (liter flow, equipment, frequency of use) will require assessment and qualification by the Pulmonary Department through Respiratory Therapy Clinic.

3. ACTION

a. **New/established patients**

(1) Initial oxygen request or appropriate prescription written by the Primary Care Provider (PCP) or Fee provider.

(2) Request submitted to the Chairman, Home Respiratory Care Program (HRCP) or the P&SAS for approval.

(3) Oxygen support set up within 24 hours of initial request.

(4) For Hospital discharges and/or Veterans that are referred from outside the Columbus VA Ambulatory Care Center (VA ACC) and Community Based Outpatient Clinic‘s (CBOC), the initial setup will be handled by the Columbus VA ACC. The Columbus VA ACC will schedule the initial assessment within that 30 day period to assess patient for home oxygen qualification.

(5) All Veterans being discharged on supplemental oxygen will be given a booklet and properly instructed in the use and possible complications and/or hazards involved in oxygen therapy. The Home Oxygen Coordinator or designee will provide instruction and obtain the Veterans signature for consent and education.

b. **Short Term**: Clinic Veterans: Follow-up will be completed within 90 days by the Pulmonary Department after initial issuance of home oxygen supplemental therapy. Arterial Blood Gases (ABGs) or pulse oximetry on room air will be submitted to P&SAS for entitlement.

c. **Long Term**

(1) All Veterans requiring long-term oxygen and mechanical ventilation will be re-evaluated annually. ABGs or pulse oximetry on room air will be submitted to the HOC for review.

(2) Clinic Veterans: Follow-up will be completed within 90 days and every twelve months thereafter by the Pulmonary Department.

d. **Controls**

(1) Home respiratory services will be discontinued upon receipt of a physician's note. Veterans may be discharged from the HRCP for payment purposes if the Veteran refuses or fails to be re-evaluated.

(2) Veterans no longer eligible for the HRCP at VA expense will be notified in writing 30 days prior to termination. The oxygen contractor will also be notified.

(3) Liquid oxygen can only be prescribed for Veterans that are physically active in order to assure quality of life.

(4) Basic setup for home oxygen equipment will be as follows:

(a) One (1) concentrator,

(b) Four (4) "E" tanks,

(c) One (1) "H" tanks (back up system), and a

(d) Conservatory Device (tank type only) when recommended.

e. **Committee Membership**

Physician responsible for Respiratory Care – Chairman
(Non-Pulmonologist Physician may serve as Temporary Chairman when Pulmonologist is not available due to leave or other circumstances.)
Chief, Prosthetics – Co-Chairman
Respiratory Therapist – Contracting Officer Representative (COR)
Patient Safety Manager or designee
Quality Management designee
Ethics Management or designee
Ad Hoc: Social Work designee, Geriatrics designee
The Home Respiratory Care Program Committee reports to the Medical Executive Board (MEB). All minutes are reported to the MEB for approval.

f. **Definitions:** The term Home Oxygen Supplement refers to an array of oxygen delivering methods and various types of equipment used in the home for oxygen therapy. Three primary methods are used:

(1) Compressed Gas – Oxygen is normally provided in a large cylinder under the compressed gas system. For those Veterans who require portability, a small tank with a cart is provided. This particular system requires a regulator to adjust the flow rate, a stand to secure the large cylinder, and in some cases, a humidifier to moisten the air.

This oxygen system is normally furnished to Veterans who do not need continuous oxygen or who are prescribed a low flow-rate. Pre-set oxygen flow regulators should be provided when medically indicated or necessary.

(2) Oxygen Concentrator – The oxygen concentrator delivery system provides an economical method of therapy when a Veteran needs continuous oxygen and is relatively housebound or has minimal portability needs. The furnishing of a separate "E" cylinder of compressed gas is necessary for emergency needs or to meet temporary portability needs as such needs occur.

(3) Liquid Oxygen – The liquid oxygen system includes a reservoir/canister and a portable device which can be filled from the reservoir if the patient is ambulatory. This method has traditionally been prescribed for Veterans using extensive amounts of oxygen from portable sources.

(4) Ventilator or Bi-Pap machine is a device used for the continuous mechanical ventilation of a Veteran.

(5) Continuous Positive Air Pressure (CPAP) is a device used to provide continuous positive air pressure for breathing.

(6) Suction machines are devices used to evacuate secretions from a Veteran's lungs.

(7) Nebulizers are devices used to dispense medication with the use of an electrically operated compressor.

g. **Criteria:** Veterans eligible for oxygen supplement therapy must meet one of the following medical criteria, as established and verified by procedures outlined herein:

(1) Resting $PaO_2 \leq 55$ mmHg or $SpO_2 \leq 88$ percent.

(2) Resting $PaO_2 \geq 56$ mmHg and ≤ 59 mmHg or a $SpO_2 \leq 89$ percent as measured by oximetry with evidence of a condition that suggests tissue hypoxia as determined by clinical or laboratory findings such as: pulmonary hypertension, cor pulmonale, eyrthrocytosis/erythrocythemia/polycythemia (e.g., a hematocrit $\geq$55 percent), or impairment of cognitive processes as determined by standard clinical evaluation (e.g., minimental status examination)

(3) Exercise $SpO_2 \leq 88$ percent during or following exercise.

(4) Nocturnal $SpO_2 \leq 88$ percent, which among other conditions, may be suggested by, and should be accompanied by, one or more of the following or other complication, symptoms or condition considered to be the result of nocturnal hypoxemia: nocturnal restlessness, morning headaches, eyrthrocytosis/erythrocythermia/ polycythemia, cor pulmonale, pulmonary hypertension, unexplained daytime somnolence, obstructive sleep apnea whose nocturnal SpO_2 is not maintained despite successful treatment of the nocturnal respiratory events.

(5) In the absence of complications or symptoms of hypoxemia at least 5 minutes of a SpO_2 <89% of total sleep time should be demonstrated during sleep. Alternatively, if the patient does not meet this criteria but spends more than 2% of total sleep at a SpO_2 < 89%, this would also qualify for nocturnal oxygen. In the absence of the criteria listed above, it may be up to the discretion of the pulmonary physician to order oxygen.

Note: *The measurement of arterial oxygen concentration for the above indications should be made or extrapolated to the altitude at which the patient typically lives. A nomogram to calculate the expected PaO_2 is available.*

(6) Room air arterial blood gas study or pulse oximetry while on room air (at least 30 minutes) must be obtained while the veteran is in stable condition. The blood sample should be obtained 24-48 hours before or after the Veterans discharge date or date of the physician's order. This precludes samples performed at admission or taken from emergency rooms where the Veteran is thought to be acutely ill and may not require long-term oxygen therapy after treatment for the acute illness has been performed.

h. **Assessment**

(1) Initial screening with oximetry may be carried out in any clinical setting by any health care provider. While a greater severity of disease may be associated with a greater likelihood of hypoxemia, all severities of disease may be associated with hypoxemia. For this reason, resting pulse oximetry screening is strongly recommended for all Veterans with a condition that may be associated with hypoxemia, regardless of severity.

(2) Any assessment beyond initial screening should be carried out in a clinical setting with appropriate resources by trained individuals experienced in home oxygen evaluation and treatment including appropriate Veteran education.

(3) Assessment Steps After Initial Screening

(a) SpO_2 will be measured via pulse oximeter at rest and exercise on RA. An ABG should be performed if qualifying SpO_2 is questionable. Situations, among others, where this may occur include poor peripheral circulation, borderline results and hyperventilating patients.

Note: *When oximetry and blood gases conflict, the arterial blood gas result should be used for determination of oxygenation status. Ensure that the oximeter being used is accurate when discrepancies occur.*

(b) Titrate oxygen liter flow (preferably using an oxygen system, such as a concentrator that the Veteran would be using at home) to a SpO_2 of 90 to 92 percent as a goal, recognizing that this may not be attainable in all patients.

(c) Exercise for the purpose of assessing a Veteran for supplemental oxygen is defined as an activity that renders the veteran dyspneic. This may occur with no or minimal exercise or with heavy exercise, depending on the Veterans sensation of dyspnea. The prescription of oxygen should be tailored to the $Sp0_2$ at rest (if necessary) and with exercise.

(d) There are many approaches to exercise from walking the Veteran at a normal pace until tired to a more formal 6 minute walk. Exercise should be performed whenever possible with the oxygen delivery device the Veteran will require for ambulation. This recommendation is based upon the findings of respiratory care practitioners that devices differ in the amount of oxygen actually delivered for the same setting; this may lead to inadequate or inappropriate oxygenation of the Veteran.

(e) Nocturnal testing, as previously indicated (Section IV) is usually based on clinical suspicion because of a sleep disturbance or unexplained Cor pulmonale. This is performed at an overnight study focused on measurement of SpO_2. Clinical assessment of Veterans receiving home oxygen for the diagnosis of sleep apnea will be evaluated on a case by case basis and will be exempt from routine annual renewal visits.

Notes:

1. Veterans who are very dyspneic at rest may not qualify for oxygen at rest or with exercise since there is a very poor correlation between dyspnea and hypoxemia. This may require a careful explanation to the Veteran as to why the Veteran does not qualify, despite dyspnea.

2. Caregivers of terminally ill Veterans often request oxygen without evidence of hypoxemia, as it has been widely used with the belief that it helps relieve the "breathlessness" associated with the end of life. The use of home oxygen should be discouraged for these Veterans. Other measures to relieve the anxiety that these Veterans experience may be more beneficial and less costly than the use of oxygen. For example, movement of cool air with a fan can reduce dyspnea/stimulation of the trigeminal nerve on the skin from air pressure or skin cooling may reduce the sensation of dyspnea and compressed air is as effective as oxygen.

i. **Eligibility**

(1) The HOC, or designee, shall be responsible for determining who medically qualifies for oxygen therapy at VA expense.

(2) Oxygen therapy may be provided at VA expense to:

(a) Service-connected Veterans with a service-connected pulmonary condition requiring oxygen.

(b) Veterans with compensable service-connected disabilities generally rated 10% or more.

(c) Former Prisoners of War; Veterans discharged or released from active military service for a compensable disability that was incurred or aggravated in the line of duty; and Veterans who are in receipt of section 1151 (Vocational Rehabilitation) benefits.

(d) Any non service-connected Veteran in receipt of an improved pension based on the need for aid and attendance or by reason of being permanently housebound.

(e) Any Veteran who has an annual income and net worth below the "Means Test" threshold.

(f) Compensated zero (0) percent service-connected Veterans who are receiving statutory awards, Veterans exposed to a toxic substance, radiation or environmental hazard (limited to certain disabilities).

(g) Veterans who must pay a co-payment for their care benefits.

(h) Oxygen will not be provided at VA expense to a Veteran not under continuing care of a VA facility or Fee physician.

j. **Discontinuation of Oxygen**: A Veteran will be discontinued from oxygen therapy if the Veteran fails to comply with the requirements listed in Attachment A "Smoking and Home Oxygen Usage". A Veteran may be discharged from the Home Oxygen program if the Veteran refuses or fails to be re-evaluated or is found to be smoking in the home environment. Veterans determined no longer eligible for oxygen at VA expense will be notified in writing that the VA will no longer be responsible for payment thirty (30) days prior to discontinuation. The oxygen contractor will also be notified.

k. **Traveling with Oxygen Including Relocation**

(1) The HOC, or designee, has ultimate responsibility for supplemental oxygen therapy arrangements.

(2) Veterans who travel and require extended oxygen supplies and Veterans who are planning a move, should be informed that it is their responsibility to notify the VA facility that administers their oxygen. Once notified, there are shared and separate responsibilities for the VA and the Veteran.

l. **Temporary Travel**

(1) The Veteran informs the VA of the mode of travel, the time to reach the destination and the length of time to be spent away from the VA. This must be done in a timely manner to allow for proper arrangements to be made. Generally, a minimum of two (2) weeks notice should be given in writing unless there is an emergency.

(2) If the travel is by air, the Veteran will be issued a Federal Aviation Administration (FAA) approved portable concentrator for pre, post, and in flight use.

(3) If the travel is by other public transportation, the Veteran is responsible for contacting and determining the policies of the transportation provider and conveying this information to the HOC. The supply of oxygen by the VA is dependent upon the transportation provider's policy. It is possible that some forms of public transportation may not be available for Veterans traveling with oxygen.

(4) If the travel is by personal vehicle (e.g., car, sports utility vehicle, etc.), the Veteran is responsible for working with the VA to determine the best approach to providing oxygen while traveling, taking into consideration time on the road and overnight stays. In these cases, the temporary issuance of a concentrator may be indicated. However, the Veteran is still responsible to ensure he/she adheres to hotel/motel policies pertaining to usage and/or storage of respiratory-related equipment.

(5) Once the travel arrangements are made to reach the destination, arrangements are needed to provide oxygen.

(a) This includes finding a vendor at the destination to meet the Veteran at the destination with oxygen and set up oxygen at the destination site. This may be accomplished by the current vendor on contract by the resident facility, if that vendor has a subsidiary office. If not, the VA should contact the vendor on contract with the VAMC nearest the Veteran's destination to make these arrangements. The resident facility will be responsible for any charges incurred while on temporary travel.

(b) Parallel to the destination arrangements being made, a prescription and a treatment plan are needed to cover the arrangements. This should be accomplished by the treating physician/clinic at the Veteran's VAMC. A copy should be provided to the Veteran for the Veterans use as needed.

(c) The number of paid travels for vacation not related to a temporary relocation (i.e., for a season) per year is not defined, but should be limited. A total of thirty (30) days of travel with a maximum of two (2) setup charges is recommended. If more than two (2), the Veteran may be responsible for setup cost.

(d) The VA will keep their contracted vendor aware of travel arrangements, as appropriate.

m. **Special considerations**

(1) Airline travel requires a portable oxygen concentrator. Education will include the Veterans responsibility for securing a portable concentrator prior to travel. The Veteran should be made aware that the portable oxygen concentrator may need to pass security inspections.

(2) Travel greater than one month is considered a temporary relocation. Oxygen coordination and payment for travel greater than one month and less than three months is the responsibility of the primary VA center. For travel greater than three months the responsibility of oxygen coordination and payment is assumed by the destination VA.

The Veteran is responsible to enroll in the destination VA's appropriate clinic. Prescriptions and care plans may need to be written and faxed.

(3) Consideration will be given for Veteran's varying modes of travel and accommodations made where possible.

n. **Permanent Moves**

(1) The VA will notify the destination VA of the Veterans plans to move. Every effort should be made in providing this notification as soon as it becomes known so the destination VA can begin to make arrival arrangements.

(2) The VA and destination VA should make all attempts possible to ensure a contracted vendor is ready to receive the Veteran at his/her destination.

(3) A multi-month prescription and care plan should be given to the Veteran, from the VA, while the Veteran checks in and arranges for oxygen therapy at the destination VA.

(4) The VA should fax or otherwise transmit all of the particulars for the Veterans oxygen therapy to the destination VA.

(5) The VA will be responsible for payment of oxygen until such time the destination VA enrolls the Veteran into the Pulmonary/Home Oxygen Clinic and the contract vendor sets the Veteran up on their equipment, unless other arrangements/agreements are made between the two VA facilities.

(6) A contact name, number and address for the destination VA should be given to the Veteran.

(7) Upon arrival at the destination (receiving) facility, any equipment that came with the Veteran and that is owned by the resident (terminating) facility or contract vendor should be shipped back to the terminating facility or contract vendor, unless the two facilities or contract vendors work out other agreements/arrangements. Any costs incurred in the shipping/handling should be the responsibility of the terminating facility.

(8) There should be no interruption in the Veterans oxygen supplies as part of the move. The Veteran must be seen and setup without delay.

o. **CPAP / BIPAP Patients**

(1) Ensure that new CPAP / BIPAP Veterans being treated for sleep apnea are scheduled for follow up at 90 days and annually thereafter. All Veterans are followed up by their primary care provider annually. The Veteran will also be required to be seen in the PAP Clinic annually. CPAP/BIPAP Veterans do not require annual prescription renewals for their equipment, but do for disposable supplies.

(2) All CPAP / BIPAP setups will be ordered and assessed through the Pulmonary Service. All CPAP and BIPAP Veterans will need to have a valid sleep study done to be issued a CPAP or BIPAP machine.

(3) BIPAP for Chronic Respiratory Failure will require an arterial blood gas PaC02, done while awake and breathing the patient's usual Fi02 in stable condition, is greater than or equal to 52 mm Hg. The contracted oxygen vendor will supply the BiPAP and supplies to ensure 24 hour clinical coverage.

p. **Nebulizer Patients**

(1) All Veterans ordered on medication nebulizers via home nebulizers will have a PFT Screen to determine qualification.

(2) An annual evaluation of machine and supplies will occur.

q. **Oxygen For Cluster Headaches**: Oxygen can be prescribed for Cluster Headaches by a physician. The order will include liter flow and duration the oxygen is to be used. An annual prescription will be required.

4. REFERENCES: VHA Directive 2001-057, Home Respiratory Care Program, dated September 19, 2001; VHA Handbook 1173.13, Home Respiratory Care Program, and the Joint Commission Home Care Manual.

5. RESPONSIBILITY: The Respiratory Therapy Supervisor is responsible for the contents of this Policy Memorandum.

6. RESCISSION: Policy Memorandum 121-07, Home Respiratory Care Program, dated May 21, 2011.

7. RECERTIFICATION: This Policy Memorandum will be recertified on or before October 1, 2018.

KEITH SULLIVAN, FACHE
Director

Attachments: Attachment A, Smoking and Home Oxygen Usage

SMOKING AND HOME OXYGEN USAGE

1. In all home care settings where oxygen is used, the following actions should be implemented:

a. A fire-risk assessment is conducted by the oxygen contractor of all new oxygen therapy home care Veterans, and a reassessment is conducted when renewing an oxygen prescription, or at any time there is a change in the patient's oxygen therapy (e.g., equipment). Those Veterans who smoke may be ineligible for oxygen if they are deemed a fire-risk.

b. Any contract for oxygen delivery services for home care Veterans must incorporate requirements that contractors provide educational and/or warning information for Veterans and their families and/or caregivers on the hazards of smoking while oxygen is in use. The vendor will be notified in the referral form of the Veterans smoking history. Educational materials must be provided upon initial delivery and every 6 months thereafter.

c. The home environment of any home health care Veteran must have appropriately working smoke alarms. The presence of the smoke alarms must be verified and the Veteran must be instructed by the oxygen vendor to test all smoke alarms monthly. In any home where smoke alarms are not present, the contractor must notify the appropriate clinical staff (e.g., home oxygen technician) for further review and potential action.

d. Each Veteran placed on home oxygen will have an initial evaluation done by a respiratory therapist and will be identified as a smoker or non-smoker, or a Veteran that lives in an environment where others smoke. The therapist will explain the smoking safety agreement to the Veteran and offer smoking cessation information. The Veteran will be identified as a smoker on the Home Oxygen Consult that is sent to the home oxygen vendor. The respiratory therapist will re-evaluate the Veteran within 90 days and then at least annually to evaluate and educate.

e. Education and orientation must be provided to each Veteran, and to other residents of the home who smoke in the dwelling regarding the hazards of smoking while oxygen is being administered. This includes the placement and provision of proper "NO SMOKING" signs. In addition to the educational material, each facility must provide a checklist or other cognitive aid to promote safe home oxygen use by the Veteran. A Veteran will be identified as high risk if the Veteran is observed smoking while oxygen is in use, or starts a fire while smoking with oxygen in use.

2. For home care Veterans determined to be high fire risk, the following actions should be implemented:

a. The Home Oxygen Technician must alert the home oxygen vendor that the Veteran is at high-risk for smoking while oxygen is in use.

b. At the discretion of the Home Oxygen Technician, Respiratory Practitioner, or equivalent, the Veteran may be called or visited within the first 30 days of treatment and every six (6) months thereafter to assess compliance with education on the hazards of smoking while on oxygen.

c. Incidents where Veterans are reported as non-compliant with the guidelines set forth in the education and orientation material and/or whose behavior poses a risk of self harm or harm to others, are documented and reported to the Home Oxygen Technician, Respiratory Practitioner, or equivalent. The Home Oxygen Technician, Respiratory Practitioner, or equivalent must report non-compliant behavior to the Veterans provider, safety officer, and pulmonary physician, who must counsel the Veteran and/or s surrogate of the potential risks associated with such activity and potential consequences of continued activity.

d. If the Veteran is found to be in non-compliance with this policy after the first incident, an appointment will be made with the home oxygen coordinator for follow up and re-education. If there is a second incident involving the Veteran, an appointment will be made with the Pulmonary Physician for the evaluation of home oxygen appropriateness and the determination to continue Home Oxygen Order or to discontinue use.