LOUIS STOKES CLEVELAND
VA MEDICAL CENTER
10701 East Boulevard
Cleveland, OH 44106

MEDICAL CENTER POLICY 111-007
October 1, 2015

HOME OXYGEN PROGRAM

1. **PURPOSE**. To establish policy and procedures for the Louis Stokes Cleveland VA Medical Center (LSCVAMC) Home Oxygen Program. The policy includes ordering oxygen and related oxygen accessories.

2. **POLICY**. The Home Oxygen Program will comply with Veterans Health Administration (VHA) regulations and with the Joint Commission on Accreditation Home Care standards. The criteria for home oxygen therapy will be consistent with the American Thoracic Society (ATS) standards as determined through the Nocturnal Oxygen Therapy Trials (NOTT) in the 1980's, and with the latest Medicare guidelines regarding clinical criteria for home of other medical treatments.

3. **RESPONSIBILITY**

a. Clinical Responsibility

1) The Chief, Pulmonary Section of Medical Service is responsible for the clinical oversight and organization of the Home Oxygen Program.

2) The Medical Director, Home Oxygen Program, is responsible for establishing criteria and standards for the program, and for assuring that clinical requirements and the process of ordering home oxygen follow the guidelines established by the NOTT Study, the standard for prescribing oxygen in the home. (See attachment A for criteria.)

3) The Coordinator of Pulmonary Service, along with the Home Oxygen Program Coordinator, is responsible for overseeing the day-to-day operation of the Home Oxygen Care Program, and provides back-up coverage. In addition, these individuals prepare the annual contract requirements submitted to the Contracting Officer.

4) The Home Oxygen Technician initiates the patient record in the Computerized Patient Record System (CPRS). This individual conducts diagnostic tests, when required, for new and follow-up patients and documents results in CPRS, establishes controls to assure timely follow-up and action for patient medical evaluation, and reviews all electronic consults for home oxygen for clinical completeness and accuracy, including signature of the Medical Director or designee.

5) Physicians referring patients to the Home Oxygen Program are responsible for following the process and procedures for referral. This includes the initiation of an electronic consult in CPRS.

b. Administrative Responsibility

The Chief, Prosthetic Service, is responsible for determining who is eligible for oxygen therapy at LSCVAMC expense. Details of eligibility are provided in attachment B. The Chief, Prosthetics and Sensory Aids Service, or designee will be responsible for the overall administrative control of the Home Oxygen Program and the maintenance of appropriate reports assessing workload, patient satisfaction, quality measures, and fiscal data.

4. **PROCEDURES**

a. Referral/Screening/Eligibility Process

1) All requests for home oxygen care will be sent to Pulmonary Service via electronic consultation. This consult will include information on the patient's smoking history. All changes or amendments to prescriptions will be annotated as a revision or renewal and will follow the aforementioned procedure.

2) Diagnosis and treatments for patients will be fully and appropriately documented in the medical record.

3) The Home Oxygen Technician will respond to the Home Oxygen consult. For inpatients, the Home Oxygen Technician will review the patient's oxygen needs and document them on the electronic consult. If the patient qualifies for oxygen, the consult will be completed with appropriate prescription that will be reviewed and signed by the Medical Director, Home Oxygen Program or designee. If the patient does not qualify, the results of the evaluation will be documented on the consult and closed. An alert will be generated to the requesting physician. For outpatients, the consult will be reviewed and then the patient will be scheduled to be seen in the home oxygen clinic and an evaluation will be done at that time.

b. Referral to Contractor Process

1) The Home Oxygen Technician will contact the contractor via telephone or fax, providing all the necessary information, including smoking history, to set the patient up with appropriate equipment and supplies. The local contract, together with the patient's diagnosis and liter flow-rate, will be the determining factors in accordance to the need for choosing the most cost-effective delivery (concentrator, gas, or liquid) system in each case. A copy of the completed transaction will be sent to Prosthetic Service.

2) The contractor will contact the veteran or care provider to establish a delivery time. The set-up delivery shall take place within 24 hours.

3) All invoices from the vendor will be submitted directly to Prosthetic Service. The contractor's invoice shall identify the veteran by name and social security number and list all the services of items rendered**.** (See Attachment C) The vendor will forward

a copy of all delivery receipts signed by the patient or care giver with the monthly invoices submitted to Prosthetic Service for payment.

c. Inpatient Discharge Process

1) Patients' discharge data and the delivery of home oxygen equipment will be coordinated by the Home Oxygen Technician. For discharge planning purposes, a minimum of twenty four hours should be allowed for processing and delivery of home oxygen equipment and related supplies.

2) The Home Oxygen Technician will contact the vendor via telephone or fax, providing all the necessary information, including smoking history, to set the patient up with appropriate equipment and supplies. A copy of the completed transaction will be sent to Prosthetic Service.

3) All patients 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 patient's or caregiver's signature for consent and education.

d. Discontinuation of Oxygen

1) A patient will be discontinued from oxygen therapy if they fail to comply with the requirements listed in Attachment D “Smoking and Home Oxygen Usage”. Patients may be discontinued from the Home Oxygen Program if the patient refuses or fails to be re-evaluated or is found to be smoking in the home environment. Patients may also be discontinued if they do not comply with attending yearly renewal appointments. Patients determined no longer eligible for oxygen at LSCVAMC expense will be notified in writing thirty days prior to discontinuation that the LSCVAMC will no longer be responsible for payment. The oxygen contractor will also be notified.

2) All patients found to be non-compliant will receive a Home Oxygen Ethics Consult. After review, if the decision is made to discontinue payment for oxygen, the veteran will receive a 30 day notice prior to having the equipment picked up.

e. Reassessment Process

1) All patients in receipt of oxygen at LSCVAMC expense will be clinically re-evaluated and the need for oxygen therapy documented within three months and twelve months for the first year. Thereafter, the reassessment for continuing oxygen therapy must be completed within the next 12 months, although the patient may be required to report more frequently to the medical center for special evaluation. Established home oxygen patients can be seen in their assigned community based outpatient clinic (CBOC) for annual Home O2 prescription renewals. Wade Park VA Home O2 staff are to be notified of testing results and renewals are completed accordingly. Renewal of the physicians order for the use of home oxygen must be done yearly.

2) If upon reassessment, there is a change in the order then a "Renewal Request for Use of Supplemental Oxygen in the Home" will be initiated by the Technician, Home Oxygen Program. The processes delineated above will then be implemented.

3) If upon reassessment it is decided that the patient no longer meets eligibility criteria, then the patient will be discontinued from the Home Oxygen Program.

5. REFERENCES

a. Long –term Oxygen Treatment in Chronic Obstructive Pulmonary Disease (COPD): Recommendations for Future Research. National Heart, Lung, and Blood Institute (NHLBI) Workshop Report. American Journal of Respiratory and Critical care Medicine. Vol 174. pp. 373-378, (2006).

b. Nocturnal Oxygen Therapy Trial Group. Continuous or nocturnal oxygen therapy in hypoxemic chronic obstructive lung disease: a clinical trial. Ann Inter Med. 1980;93:391-8.

c. Veteran Health Administration (VHA) Patient Safety Alert dated January 6, 2005, Fire Response and Planning at:
http://vaww.ncps.med.va.gov/Guidelines/alerts/FireResponseAlert.pdf

d. The Joint Commission Environment of Care Standards, EC.1.30;

e. VHA National Ethics Teleconference Call, October 23, 2001, Home Oxygen for Patients Who Smoke: Prescription versus Proscription at:
http://vaww1.va.gov/vhaethics/download/Transcripts/EthicsHotlineCall10.23.01.doc;

f. VA Manuals and regulations that apply to Home Oxygen Program: M-1, Part I, Chapter 16, 16.25;M-1, Part I, Chapter 17; 1997-98; 2001-2—2, Comprehensive Accreditation Manual for Home Care, The Joint Commission.

6. RECISSION. All previous versions of Medical Center Policy 111-007 are rescinded. The next review date of this policy is October 1, 2018.

7. FOLLOW-UP RESPONSIBILITY. Chief, Pulmonary Section, Chief, Medical Service, and Chief, Prosthetics and Sensory Aids.

//s//
SUSAN M. FUEHRER
Medical Center Director

Attachments

CRITERIA FOR ORDERING HOME OXYGEN THERAPY

Indications for Home Oxygen

a. Patients eligible for oxygen therapy should be clinically stable, and on an optimal medical regimen to improve or maintain pulmonary and cardiac function. A commitment to smoking cessation is strongly encouraged, with referral to a smoking cessation program and access to nicotine replacement when medically allowed. Any patient who does not quit smoking will be discontinued from the home oxygen program until smoking cessation has been achieved. In addition, patients eligible for oxygen therapy must meet one of the following medical criteria (arterial blood gases or pulse oximetry) to qualify for oxygen therapy:

b. Resting arterial oxygen tension ($Pa0_2$) below 55mmHg (or oxygen saturation levels (SpO_2) of 88% or below). Patients meeting this criteria only during exercise will qualify for supplemental oxygen therapy with exertion.

c. Resting or exertional arterial oxygen tension ($Pa0_2$) greater than 55mmHg but less than 60 mmHg (or saturation levels of 89% or below) and with hypoxia-related dysfunction such as, but not limited to, cor pulmonale, insomnia, disturbances of mentation. Patients meeting these criteria only during exercise will qualify for supplemental oxygen therapy with exertion.

d. Documented nocturnal desaturation of 10-20% or more of sleep time will qualify for home oxygen therapy for use at night time.

e. On an exceptional basis (in patients not meeting criteria b-d above), oxygen therapy will be prescribed for sleep apnea, migraine, and other conditions where medical evidence suggests

CRITERIA FOR ESTABLISHING ELIGIBILITY FOR HOME OXYGEN THERAPY

The Veteran's Health Care Eligibility Reform Act of 1996 simplified and expanded veterans' eligibility for VA medical care. The act, signed into law on October 9, 1996, established any needed hospital and outpatient care-to the extent that Congress appropriates funds to provide this care.

a) Veterans receiving compensation for service-connected disabilities.

b) Former Prisoners of War.

c) World War I veterans.

d) Veterans exposed to Agent Orange in Vietnam, environmental hazards in the Persian Gulf, ionizing radiation, for illnesses possibly resulting from the exposure.

e) Low income veterans and veterans with a non-compensable service-connected disability who need treatment for their service-connected disability.

f) The VA may furnish any necessary hospital and outpatient care to any other veteran - but only if resources and facilities are available and only if the veteran:

1) Agrees to pay a VA co-payment, if one is required. This includes veterans with no compensable service-connected disabilities whose income and net worth are above a certain level.

2) Veterans with a VA service-connected disability rated at zero percent who are not receiving care for their service-connection or they are eligible under other criteria for cost-free care.

3) Legislation also requires the department to establish an annual patient enrollment system, based on established priorities, with the highest priority given to those veterans with service-connected conditions. Effective October 1998, many veterans must be enrolled in the plan in order to receive VA medical services. Veterans with a 50 percent or more Veterans Benefits Administration (VBA)-Horated disability seeking care for any condition may not be denied because of the enrollment requirement.

HOME OXYGEN EQUIPMENT

1. The specific oxygen dispensing equipment will be selected based on optimizing cost-effectiveness while meeting individual patient's needs. Based on current cost consideration, oxygen concentrators will be the standard primary modality for all patients, based on their individual oxygen flow needs and for patients who have limited mobility.

2. Compressed Gas. Oxygen normally provided in a cylinder under the compressed gas system. For those who are ambulatory and in active rehabilitation and require portability, a tank with a cart may be provided. This particular system requires a regulator to adjust the flow rate and a stand or bag to secure the cylinder; as well as in some cases, a humidifier to moisten the air. This oxygen system is normally furnished to patients who meet criteria for portable oxygen in the compressed gas form. When this particular system is provided, preset oxygen flow regulators should be provided when medically indicated.

3. Oxygen Concentrator. The oxygen concentrator delivery system provides an economical method of therapy when patients need continuous oxygen, and are relatively housebound or have minimal portability needs. The furnishing of a separate M 60 cylinder of compressed gas is necessary for emergency needs or to meet temporary needs as they occur.

4. 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 mostly prescribed for patients using extensive amounts of oxygen from portable sources.

5. Travel Oxygen. The Department of Prosthetics and Sensory Aids will pay for 30 days of travel oxygen each year. Requests over 30 days are subject to the approval of the Chief of Prosthetics. Patients are strongly encouraged to contact the home oxygen clinic at least two weeks before travel date. Patients will be provided a portable concentrator as well as supplemental oxygen supplies as deemed necessary by the oxygen prescription.

6. Portable Oxygen Concentrators. Portable Oxygen Concentrators are available for travel as rentable equipment. These concentrators are not purchased routinely for patients and any requests for purchase must meet the established Veterans Integrated Service Network (VISN) criteria and approval of the Chief of Prosthetics. Portable Oxygen Concentrators may be rented on a long term basis for veterans who qualify clinically and wish to exercise this option for their portable oxygen needs.

SMOKING AND HOME OXYGEN USAGE

1. All patients being evaluated for home oxygen therapy will be assessed for tobacco use/smoking as part of their initial evaluation. This assessment will include a Carbon Monoxide (CO) breath check and possibly an Arterial Blood Gases (ABG) with Carbon Monoxide Oximetry (COX). The primary care provider or consulting physician is notified of all findings.

a. If the CO values are greater than 11-20 PPM or 20+, the patient cannot be started on home oxygen until the CO range is lowered. Patient will be educated about the policy and offered a return appointment in 30 days for another CO check. The consulting physician and/or the primary care provider will be notified.

b. If the values are in the seven-ten (7-10) Part Per Million (PPM) range, the patient may be started on home oxygen providing that the patient is committed to further cessation efforts and agrees to return for a follow up CO check in 30 days.

c. Any values in the zero-six (0-6) range are considered non-smoking.

d. Upon renewal of the home oxygen prescription– if a patient registers CO values in any smoking range, the patient must agree to smoking cessation and return in 30 days for a follow up evaluation.

2. In all home care settings where oxygen is used, the following actions are implemented:

a. A fire-risk assessment is conducted by the oxygen contractor of all new oxygen therapy home care patients, 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 patients who smoke may be ineligible for oxygen if they do not stop smoking.

b. Any patient who is known to be a current smoker when referred to the Home Oxygen Program must be offered nicotine replacement therapy or attend smoking cessation classes on admission to the program. This process is clearly delineated in the CPRS Consult for entry into the Home Oxygen Program.

c. Any contract for oxygen delivery services for home care patients must incorporate requirements that contractors provide educational and/or warning information for patients 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 patient's smoking history. Educational materials must be provided upon initial delivery and as needed.

d. The home environment of any home oxygen patient must have appropriately working smoke alarms. The presence of the smoke alarms must be verified and the patient must be instructed by the oxygen vendor to test all smoke alarms. In any home where smoke alarms are not present on each floor, the patient is educated about the need to obtain them. The vendor will check for presence of the smoke alarms at each maintenance visit, which occurs approximately every 90 days.

e. Education and orientation must be provided to each patient, and to other residents of the home who smoke in the dwelling, whenever possible, 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. This activity must be documented by the prescribing medical center and included as part of the prosthetics review prior to, or concurrent with, the onset of the home oxygen therapy**.** All patients or their caregivers will sign an agreement after the educational process agreeing to the terms set forth by the Home Oxygen Program.

3. For home care patients determined to be high fire-risk, the following actions are implemented:

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

b. Any patient who is identified as a smoker will be required to return to the clinic for a follow up evaluation within the first 30 days of treatment to assess compliance with smoking cessation efforts and for continued education on the hazards of smoking while on oxygen.

c. Incidents, where patients 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 patient’s provider, or appropriate designee, who must counsel the patient and/or patient’s surrogate of the potential risks associated with such activity and potential consequences of continued activity.

d. If a patient is suspected of smoking in the home they will be referred to the Home Oxygen Technician or Coordinator. She will schedule the veteran for an appointment for a CO check and a blood gas test may be obtained. If the patient’s carboxylhemoglobin level is elevated and indicates continued smoking, the patient will receive a warning about their continued smoking and be expected to return in 30 days for a follow-up appointment. If on re-assessment and a possible repeat blood gas test their CO level remains elevated their participation in the Home Oxygen Program will be terminated.

e. Prior to termination from the home oxygen program, a Home Oxygen Ethics Consult will be initiated which summarizes the non-compliance issues. The patient will be discontinued only after the Ethics review is complete.

4. **Chief of Staff (COS).** The COS, or designee, is responsible for:

a. Tracking reported incidents involving patients receiving oxygen therapy who have a close call or confirmed adverse event related to smoking. These incident reports may come from various individuals or services, including, but not limited to: the home oxygen vendor; Patient Safety Program, Quality and Performance Program, or clinical staff; family; and/or direct caregivers.

b. Each incident will be reported to the Patient Safety Office, and the Chief of Prosthetics will report to the Quality and Performance Improvement Committee, and the prescribing clinician (if not initially reported to them at the time of the incident).

5. **Prescribing Clinician for Oxygen Therapy.** The prescribing clinician for oxygen therapy or designee is responsible for discussing with the patient and/or the patient's surrogate, responsibility for complying with the terms agreed upon for safe administration of oxygen therapy when therapy is initiated. The prescribing clinician, or clinician notified of the close call or adverse event must:

a. Document, in the patient's medical record, all reported close calls and adverse events related to smoking while oxygen is in use.

b. Report all close calls and adverse events related to the patient's smoking while oxygen is in use to the facility Chief of Staff (COS), Risk Management or Patient Safety.

6. **Home Oxygen Coordinator or Designee.** The Home Oxygen Coordinator, or designee, is responsible for:

a. Documenting, in the patient's medical record, all reported close calls and adverse events related to smoking while home oxygen therapy is in use.

b. Reporting to the facility, or Home Oxygen Oversight Committee, all close calls and adverse events related to the patient's smoking while oxygen is in use.

Home Ventilator Patients

1. Patients determined to need mechanical ventilation in the home will receive a consult to Home Oxygen.

2. The Home Oxygen staff, in collaboration with the VA contracted vendor, will ascertain the following components prior to placing a ventilator in the home:

   a. The determination by the medical staff that veteran is a suitable candidate for mechanical ventilation in the home

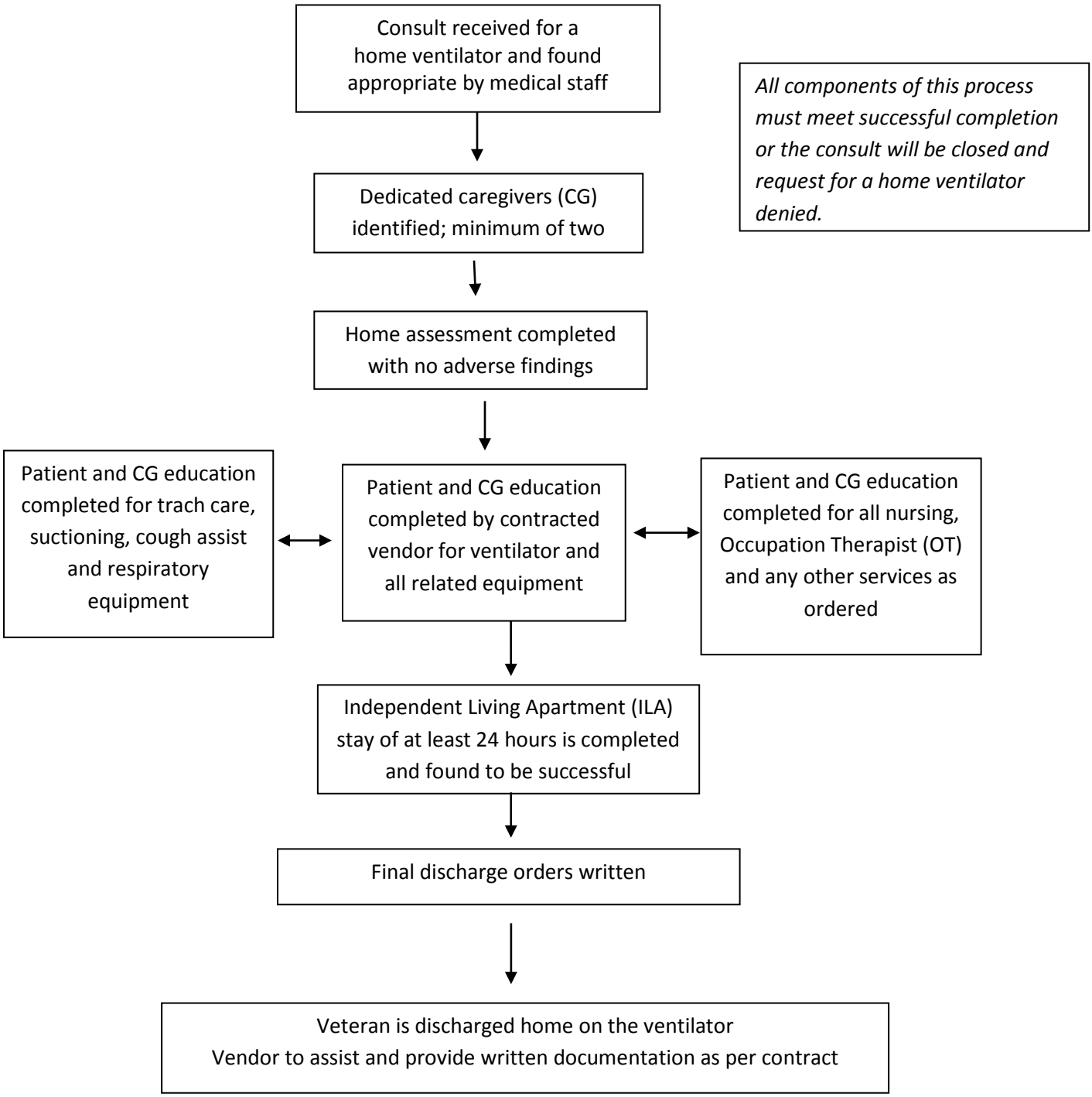
   b. The determination that there are - at minimum –two dedicated caregivers for the veteran at all times

   c. The understanding and assurance that the caregivers must learn to competently care for the veteran; this education and care is to include: tracheostomy care, trach tube changes, suctioning, cough assist (if ordered), ventilator usage and emergency procedures

   d. A home assessment that determines the safety of the veteran and all required equipment in the home

   e. The veteran and caregivers must complete - at minimum - a 24 hour independent stay if veteran is a new ventilator patient

3. The Home Oxygen Program staff will oversee the completion of all necessary educational components of both VA and vendor staff.

4. The Home Oxygen Program staff will coordinate care with the vendor; to include regular written reports on a monthly basis.

Louis Stokes Cleveland VA Home Oxygen Program
Home Ventilator Process