

**VHA PROSTHETIC CLINICAL MANAGEMENT PROGRAM (PCMP)
CLINICAL PRACTICE RECOMMENDATIONS
HOME USE OF SUPPLEMENTAL OXYGEN**

I. BACKGROUND

The Under Secretary for Health directed VHA's Prosthetic and Sensory Aids Service Strategic Healthcare Group to establish a Prosthetic Clinical Management Program (PCMP). The objectives are to coordinate the development of clinical practice recommendations for prosthetic prescription practices and contracting opportunities to assure technology uniformity and ease of access to prosthetic prescriptions and patient care that will lead to valid outcome measures and analysis for research purposes.

A work group, using input from selected clinicians with expertise in home use of supplemental oxygen (home oxygen), convened to recommend clinical practice recommendations on prescribing veteran beneficiaries with home oxygen.

II. POLICY AND GOAL

The purpose of the clinical practice recommendations is to assist practitioners in clinical decision-making, to standardize and improve the quality of patient care, and to promote cost-effective prescribing of supplemental oxygen for ambulatory and home use.

The goal is to effectively treat clinically-significant hypoxemia in the ambulatory and home setting. This is usually achieved by having a patient continuously at or above a PaO₂ of 60 mmHg or an arterial oxygen saturation of 90 to 92 percent.

III. DEFINITIONS

Term	Description	Value
ABG	Arterial blood gas	
RA	Room Air - reference to breathing ambient air O ₂	21% O ₂
FiO ₂	Fraction of inspired O ₂ – level depends on level of oxygen being breathed by patient	21% - 100%
PaO ₂	Partial pressure of O ₂ measured as part of ABG	85- 95 mmHg
SaO ₂	Oxygen saturation of arterial hemoglobin measured by co-oximetry as part of ABG	95 - 97%
ScO ₂	Oxygen saturation of arterial hemoglobin calculated from ABG PaO ₂	95 - 97%

SpO ₂	Oxygen saturation of arterial hemoglobin measured by pulse oximetry	95 - 97%
Hypoxia	Insufficient delivery of oxygen to tissues that is associated with physiological effects such as anaerobic metabolism	NA
Hypoxemia	An abnormally low level of oxygen in arterial blood which in this document is defined as a level that is consistent with the need for supplemental oxygen	See Section IV

IV. CRITERIA (Any one of the following)

1) Resting PaO₂ ≤ 55 mmHg or SpO₂ ≤ 88 percent.

2) Resting PaO₂ ≥ 56 mmHg and ≤ 59 mmHg or a SpO₂ ≤ 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
- Erythrocytosis/erythrocythemia/polycythemia (e.g., a hematocrit ≥55 percent)
- Impairment of cognitive processes as determined by standard clinical evaluation (e.g., minimal status examination)

3) Exercise SpO₂ ≤ 88 percent during or following exercise.

4) Nocturnal SpO₂ ≤ 88 percent, which among other conditions, may be suggested by and should be accompanied by one or more of the following or other complication, symptom or condition considered to be the result of nocturnal hypoxemia:

- Nocturnal restlessness
- Morning headaches
- Erythrocytosis/erythrocythemia/polycythemia
- Cor pulmonale
- Pulmonary hypertension
- Unexplained daytime somnolence (1)
- Patients with obstructive sleep apnea whose nocturnal SpO₂ 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 SpO₂ <90% plus at least one measurement of SpO₂ ≤ 85% should be demonstrated during sleep. Alternatively, if the patient does not meet this criteria but spends more than 30% of sleep at a SpO₂ < 90%, this would also qualify for nocturnal oxygen (2).

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 PaO₂ is available (3).

6) Cluster headaches regardless of the arterial oxygen level with a diagnosis by an appropriate specialist such as a neurologist.

V. WHEN TO CONSIDER A HOME OXYGEN ASSESSMENT

Any patient who is discovered to be hypoxemic should be considered as a candidate for a home oxygen assessment. Typical conditions that may lead to resting, nocturnal and/or exercise hypoxemia include but are not limited to the following:

- Moderate to severe (FEV₁ < 50 percent) chronic obstructive pulmonary disease (COPD).
- Idiopathic pulmonary fibrosis, sarcoidosis, or another interstitial lung disease.
- Bronchiectasis, including cystic fibrosis.
- Terminal lung cancer.
- Kyphoscoliosis.
- Neuromuscular disease such as amyotrophic lateral sclerosis, spinal cord injury, etc. For these patients, an arterial blood gas should be performed to determine the degree of hypoventilation (i.e., hypercapnia) which may be contributing to the hypoxemia.

Notes

1. Patients 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 patient as to why they do not qualify despite dyspnea.

2. Caregivers of terminally ill patients 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 gently discouraged for these patients. Other measures to relieve the anxiety that these patient 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 (4) and compressed air is as effective as oxygen (5).

VI. THE PRESCRIPTION

A. The following must be included in the medical consult when ordering home oxygen.

1. The order for oxygen and the desired flow rate.
2. The time during a 24-hour day oxygen is required:
 - a. Continuous
 - b. Intermittent (i.e., cluster headaches)

- c. During sleep only
 - d. During exertion
 - i. Number of hours of oxygen required for ambulation.
 - ii. Number of hours of oxygen required in a vehicle.
3. Type of equipment required:
- a. Concentrator
 - b. H tank or other needed for backup
 - c. Portable oxygen for outside the home*
 - d. Liquid oxygen **

B. The following must be documented in the progress notes of the medical records:

1. The patient's diagnosis that has led to the requirement for home oxygen including the appropriate ICD-9 code.
2. Arterial oxygen levels or oxygen saturation levels for supplemental oxygen at rest, during exercise and during sleep, as appropriate.
3. Reason home oxygen is being ordered (Section V).
4. Criteria that are met to justify home oxygen (Section IV).
5. When the patient should be reassessed for continuing need.

*Note

1. D tank usually with oxygen conserving device – for most ambulatory patients.
2. E cylinders for wheelchair-bound or for use in car. May be used for ambulatory patients depending on circumstances.
3. There are other portable systems including tanks smaller than D tanks such as C and M-6, M-4 and M-2 tanks and at least one portable concentrator that is currently available. These tanks and devices are almost always used with a conserver device to extend the time that a full tank can provide oxygen without being replaced or refilled. The prescription needs to also specify the number of each kind of tank (e.g., 8 E tanks; 4 D tanks) and the kind of conserver device to be used, if necessary.
4. Some patients have unique requirements. For example, a patient might need a very light portable (e.g., 240 liter cylinder) when walking but could use an E-cylinder while driving. Calculating the ambulatory and non-ambulatory hours away from home will help provide the number of each type of cylinder required by the patient.
5. Considerations should be given to patients who have handicaps. For example, a patient who has severely disabling arthritis may need a liquid system because of the inability to turn a cylinder on and off.

**Note: Liquid oxygen is appropriate for use primarily in the following circumstances for patients: a) when tanks cannot provide the necessary flow rate, b) meet the ambulatory needs, c) are not cost effective, or d) are impractical. There must be a specific reason (other than general impracticability or inconvenience for prescribing liquid oxygen) such as an inability to turn on a cylinder due to arthritis.

VII. DURATION OF HOME OXYGEN AND FOLLOW-UP

New patients should be assessed within 1 to 3 months but no longer than 6 months after institution of home oxygen therapy and yearly thereafter or when clinically indicated to determine oxygen requirements. Patients may no longer qualify at follow-up and consideration should be given to discontinuing oxygen at that time. There may be a need to repeat the evaluation if the results are borderline or viewed as atypical for a given patient. If oxygen is prescribed after an acute respiratory illness such as a COPD exacerbation, the reassessment and decision for continued long-term oxygen therapy should be done after the acute illness has fully resolved.

It is recommended that management of the home oxygen program be led by a qualified individual who is usually a licensed respiratory care practitioner.

VIII. THE ASSESSMENT

A. 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 patients with a condition, regardless of severity, that may be associated with hypoxemia.

B. 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 patient education.

C. Assessment Steps After Initial Screening

- SpO₂ via pulse oximeter at rest and exercise on RA. An ABG should be performed if qualifying SpO₂ 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.

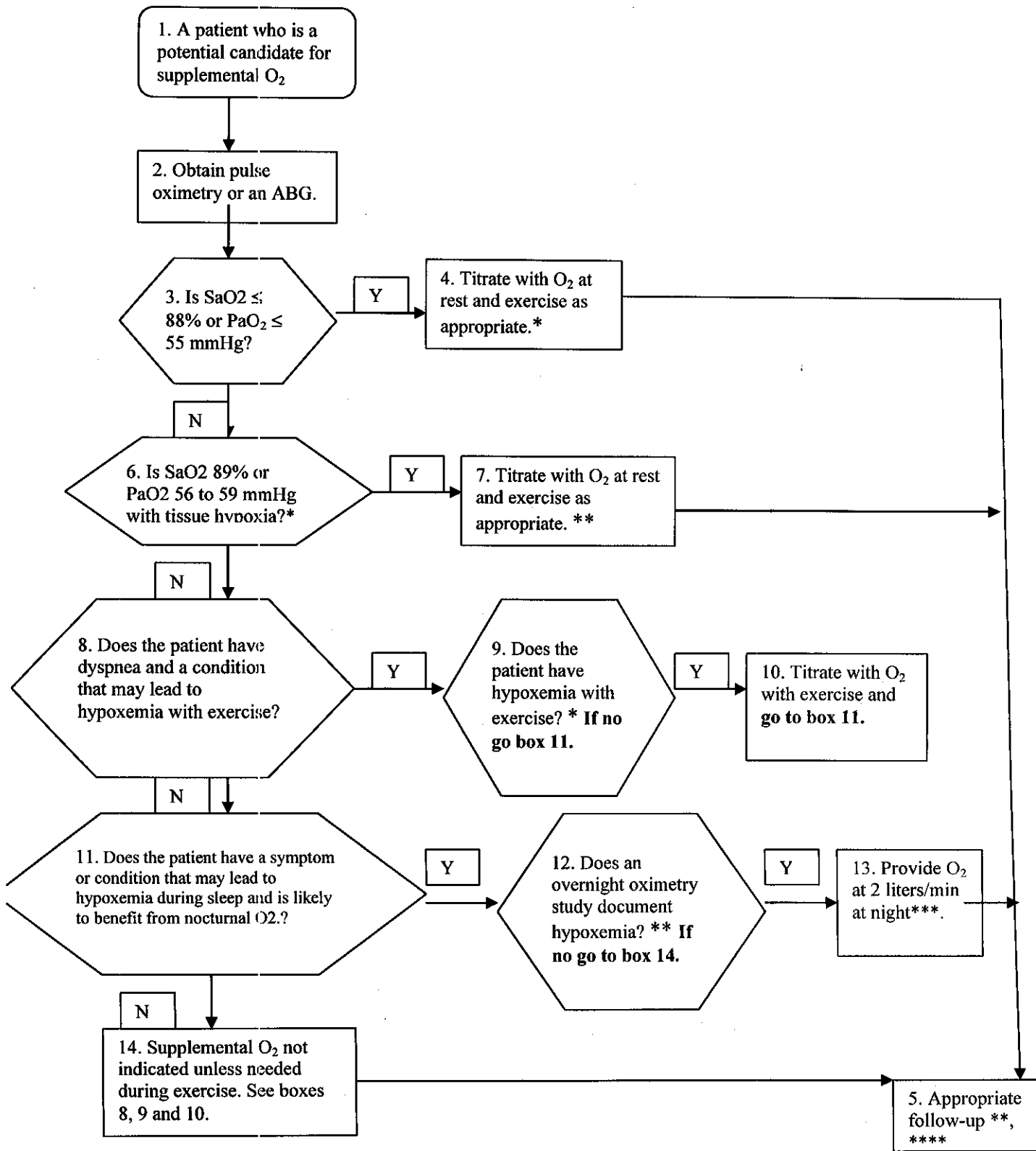
- Titrate oxygen liter flow (preferably using an oxygen system, such as a concentrator, that the patient would be using at home) to an SpO₂ of 90 to 92 percent as a goal recognizing that this may not be attainable in all patients.
- Exercise for the purpose of assessing a patient for supplemental oxygen is defined here as an activity that renders the patient dyspneic. This may occur with no or minimal exercise or with heavy exercise depending on the patient's perception of dyspnea. The prescription of oxygen should be tailored to the SpO₂ at rest (if necessary) and with exercise.

- There are many approaches to exercise from walking the patient at their normal pace until tired to a more formal 6 minute walk (6, 7). Exercise should be performed whenever possible with the oxygen delivery device the patient will require for ambulation. This recommendation is made since it is the experience of respiratory care practitioners that devices differ in the amount of oxygen actually delivered for the same setting and this may lead to inadequate or inappropriate oxygenation of the patient.
- 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 SpO₂.

D. Miscellaneous

1. Medical management should be optimized prior to commitment to long-term supplemental oxygen. Temporary use of oxygen may be necessary until response to treatment is maximized and the patient is no longer hypoxemic.
2. The least amount of supplemental oxygen that is necessary to prevent resting, exertional, and nocturnal hypoxemia, as appropriate, should be prescribed.
3. Patient remote and current smoking history should be assessed in detail and absolute smoking cessation should be strongly encouraged.
4. Pulmonary rehabilitation and exercise programs should be encouraged for patients since these programs improve quality of life and reduce hospitalizations (8).

IX. A TYPICAL EXAMPLE OF A FLOW CHART OF THE USUAL EVALUATION OF A PATIENT FOR SUPPLEMENTAL OXYGEN THERAPY.



* - Tissue hypoxia is insufficient delivery of oxygen to tissues that is associated with physiological effects such as anaerobic metabolism

** - Appropriate referrals (e.g., Pulmonary, Prosthetics) to conduct titration, write prescription and supply oxygen according to VA regulations and local requirements. The goal of oxygen therapy is a PaO₂ > 60 mmHg or an SaO₂ > 90% during rest, exercise and sleep.

*** - 2 liters/minute is recommended if the degree of hypoxemia is mild (e.g., ≥ 85% SaO₂) and there has not been a nocturnal oxygen titration study. If the hypoxemia is consistently more severe or if symptoms persist, consider nocturnal oxygen titration.

**** - The patient's medical care should be reviewed to ensure that the patient is on optimal medical management. If not, the patient should be reevaluated after being stable on such management and the oxygen prescription altered or discontinued, as necessary. The reevaluation should begin at a relevant point in the algorithm.

X. EVIDENCE TO SUPPORT THE RECOMMENDATIONS

- In patients with COPD and a PaO₂ ≤ 55 or a PaO₂ ≤ 60 with signs of tissue hypoxia, home use of supplemental oxygen may increase the life span by six to seven years based on a randomized controlled trial (9,10). Oximetry to measure SpO₂ is an indirect measure of PaO₂ and SpO₂ of 88 percent and 89 percent usually correspond to a PaO₂ of 55 and 60 mmHg, respectively.
- SpO₂ 90 to 92 percent or PaO₂ 60 to 65 mmHg are acceptable targets of supplemental oxygen because of the shape of the oxygen hemoglobin dissociation curve (8). In most cases, changes in flow rate are not indicated for sleep.
- In COPD patients who have PaO₂ ≥ 60 mmHg during wakefulness, signs of tissue hypoxia occur more often and survival is reduced when sleep desaturation is present (more than five minutes during the night) (2). However, studies documenting improved survival with supplemental oxygen have been inconclusive (11). One night of overnight oximetry is generally sufficient to determine the present of arterial oxygen desaturation during sleep (12).
- Studies showing the long-term benefit of oxygen solely for exercise or sleep desaturation have yet to be conducted. Short-term studies have shown more immediate benefits in reduction in dyspnea, improvement in exercise performance, and prevention of transient increases in pulmonary artery pressure and pulmonary vascular resistance (13-15). Studies suggest that COPD patients with an FEV₁ ≤ 50 percent are most likely to symptomatically benefit from supplemental oxygen during exercise. Oxygen should be administered to increase SpO₂ to 90 to 92 percent (15).
- Cluster headaches have been shown to benefit from brief periods of supplemental oxygen (16).

XI. OXYGEN CONSERVING DEVICES AND APPROACHES

- The purpose of oxygen conserving devices is to decrease the cost of oxygen. Patients should be considered for oxygen conserving devices whenever they can maintain the SpO₂ from 90 percent to 92 percent. There are three basic types of conserving systems:
 - a. Reservoir conserver (mustache or pendant) as part of the nasal cannula system, Oxygen conserving regulators, and Transtracheal oxygen
 - b. The Reservoir conserver has a small bag or pouches that are part of the nasal cannula system that allow oxygen to accumulate during exhalation and be inspired during inhalation to increase the FIO₂ at relatively low flow rates. This increases the time that a portable oxygen delivery system can be used.
 - c. Oxygen conserving regulators provide oxygen only during inspiration and may do so during less than every breath (e.g., every third breath). The type to be used in an individual patient will depend on a careful clinical evaluation.
- Transtracheal oxygen is delivered through a cannula placed surgically through a small hole in the trachea. This may increase the FIO₂ by not losing oxygen to the atmosphere when delivered through the nose or mouth.

XII. SELF-MANAGEMENT EDUCATION - PATIENT AND CAREGIVER

a. Safety of home oxygen

- Patients need to be instructed in the proper use of their oxygen devices and associated equipment in order to impress on them that oxygen supports combustion and can cause a fire under certain conditions.
- Intensify smoking cessation efforts, since smoking poses a safety hazard for patients on oxygen. The benefits of home oxygen may not be realized in patients who continue to smoke and have high levels of carboxyhemoglobin. The withdrawal of oxygen therapy in a patient who continues to smoke should only be undertaken after a careful assessment of the risks to the patient and others compared to the continued benefit of the oxygen.
- Consideration should be given to providing written instructions, perhaps in the form of a contract explaining the hazards and what all members of the family must do to make it a safe environment.

b. Length of time for portable oxygen

- Each conserving device has a table of (liter per minute) lpm times; provided and explained to the patient. There are also tables for times of E

and D cylinders needed to determine amount of time for riding or driving a car or ambulating.

- An outpatient visit at a VAMC may be lengthy. The patient's oxygen supply may not be sufficient for that full time. Prosthetics and Sensory Aids Service (P&SAS), in conjunction with the appropriate services such as Pulmonary should have in place an approach or system for the patient to have a supply of oxygen adequate to the visit.

c. Assessment	Information by provider	Expected knowledge
Do you know how oxygen works?	Supplemental O ₂ assures a near normal level of O ₂ in your blood only while in use. It keeps all organs and muscles functioning adequately.	<u>Verbalizes:</u> the goal is 90% O ₂ saturation at all times <u>Verbalizes:</u> O ₂ is vital to all body cells functioning correctly.
Do you understand this prescription?	Your prescription is determined by the blood gas or oximeter reading at rest and walking. Using more (say, when you are upset or have more difficulty breathing), may trigger your brain to not breath as much as you should. Using less may hurt vital cells in your body.	<u>Verbalizes:</u> O ₂ , in the right doses (Liter flow), keeps the body functioning correctly. <u>Verbalizes:</u> Too much or too little O ₂ can hurt the body just as too much or too little of any substance can hurt the body.
Do you know how oxygen decreases your difficulty breathing?	Muscles need oxygen to work. Muscles work better if they are conditioned (strengthened) as they hold more oxygen. When muscles hold more O ₂ the lungs do not have to work so hard and feelings of difficulty breathing are decreased.	<u>Verbalizes:</u> Need for exercise particularly strength training.
Do you always use it when active?	Your body needs more O ₂ when you are active than at rest, that is why the dose (prescription in liter flow) is less or not needed at all when at rest than when walking.	<u>Verbalizes:</u> Need to always use O ₂ as prescribed.
Do you have sore ears or a dry nose?	If your ears are sore, ear pillows, clips or a head tie may protect the ears. For dry noses, try a gel specially designed for the nose.	Verbalizes: When to ask for and where to find ear pieces and nasal gel.

XIII. TRAVELING WITH OXYGEN INCLUDING RELOCATION

- P&SAS has ultimate responsibility for supplemental oxygen therapy arrangements.
- Patients who travel and require extended oxygen supplies and patients 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 patient.

Temporary Travel

1. The patient 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 2 weeks notice, in writing, should be given unless there is an emergency.
2. If the travel is by air, the patient is responsible for contacting the airline to arrange for oxygen while on the airplane.
3. If the travel is by other public transportation, the patient is responsible for contacting and determining the policies of the transportation provider and conveying this information to P&SAS. The supplying of oxygen by the VA will be determined dependent upon the transportation provider's policy. It is possible that some forms of public transportation may not be available for patients traveling with oxygen.
4. If the travel is by personal vehicle (e.g., car, sports utility vehicle, etc.), the patient 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 patient 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 facility¹, if that vendor has a subsidiary office. If not, the resident 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

¹ Resident facility is defined as the medical center that maintains the veteran's consolidated health record/file.

the treating physician/clinic at the veteran's resident VAMC. A copy should be provided to the patient for the patient's 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 30 days of travel with a maximum of two (2) set-up charges is recommended. If more than two, the patient may be responsible for set-up cost.

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

Special considerations

1. The patient will need someone to accompany them to the airport, if air travel is the mode, to take back the oxygen supply (e.g., E-tank) used to reach the airport. Airlines generally do not allow passengers to bring oxygen on the airplane. However, airlines generally supply oxygen for the passenger, if prescribed. The patient should be aware that there may be areas of the airport such as the boarding area that do not allow oxygen tanks and should determine what arrangements need to be made for oxygen during those periods of time.

2. If the travel is extensive (e.g., such as a winter vacation), the travel may need to be handled as a temporary relocation. Responsibility for coordination and payment of the oxygen care falls to the resident VA for up to 3 months and to the receiving VA for a temporary relocation of more than 3 months (in which case the veteran should enroll in the receiving VA's appropriate clinic, generally the Pulmonary Clinic.) The resident VA should notify the receiving VA of such extensive or temporary relocations if the relocation is greater than 1 month.

3. Some modes of travel may not be available to the patient and trips with many destinations may be impractical.

4. Prescriptions and care plans may need to be written and faxed depending on the circumstances.

5. Some patients travel extensively by recreational vehicle (RV) with frequent stops at RV parks. This may be considered to be the patient's residence for at least that part of the year. Consideration should be given to designing a program that takes into account this type of travel. For example, the use of a transfill system incorporating a concentrator with refillable tanks and the use of a portable concentrator with DC and AC adaptors to provide power as well as batteries may be an appropriate oxygen system for such a patient. However, it may be that all contingencies cannot be addressed and that there may be limitations on what is possible.

Permanent Moves

1. The resident VA will notify the destination VA of the patient's 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 resident VA and destination VA should make all attempts possible to ensure a contracted vendor is ready to receive the patient at his/her destination.
3. A multi-month prescription and care plan should be given to the patient, from the resident VA, while the patient checks in and arranges for oxygen therapy at the destination VA.
4. The resident VA should fax or otherwise transmit all of the particulars for the patient's oxygen therapy to the destination VA.
5. The resident VA will be responsible for payment of oxygen until such time the destination VA enrolls the patient into the Pulmonary/Home Oxygen Clinic **and** the contract vendor sets the patient 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 patient.
7. Upon arrival at the destination (receiving) facility, any equipment that came with the patient 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.

Note: There should be no interruption in the patient's oxygen supplies as part of the move. The patient must be seen and set-up without delay.

XIV. QUALITY MANAGEMENT/PERFORMANCE IMPROVEMENT

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has specific requirements for home oxygen programs. These are beyond the scope of this document. In addition, they are frequently updated. It is the responsibility of the individual home oxygen program at each site to ensure that JCAHO requirements are met.

XV. P&SAS-BASED QUALITY MANAGEMENT

P&SAS are required by VA headquarters to conduct two Quality Management/Performance Indicator (QM/PI) monitors of the oxygen provider to assure the JCAHO standards are being met.

1. A P&SAS representative or the Contracting Officer Technical Representative (COTR) should conduct, at a minimum, quarterly site visits of the Home Medical Equipment (HME) provider. Sanitation procedures, equipment management, inventory control, and record keeping should be reviewed during the visit. Each visit should be documented and any violations should be corrected.

2. Another form of quality management is periodic visits to patients' homes. The P&SAS representative and/or a clinical representative may do this. The team insures the patient has been instructed properly in the use of the equipment, "No Smoking" signs have been posted, the veteran is satisfied with the HME provider, the veteran knows his/her prescription and is adhering to it, and that the equipment is working properly. Fifteen (15) home visits, at a minimum, should be conducted on a yearly basis, per program. In addition, all patients at entry into the oxygen program will be administered a dyspnea questionnaire (See *Appendix I* –for the Modified Medical Research Council questionnaire). In addition, a yearly follow-up of at least 10 percent or 15 patients (whichever is larger) must be conducted with the same survey.
3. The quality of the HME provider must be checked through patient surveys. The survey should be both relevant and brief. All patients receiving long-term oxygen therapy for the first time must fill out the survey. A yearly follow-up of at least 10 percent or 15 patients (whichever is larger) must be conducted with the same survey (See *Appendix II* – Quality Assurance Phone Survey).
4. The quality of the HME provider must be checked through surveys of the VA prosthetics and clinical staff at least quarterly. (See *Appendix III* – Questionnaire for VA to Evaluate Contractor or Equipment Service Provider(s)).
5. The VA staff must have an Oxygen Care Committee that is composed of representatives from P&SAS and staffing permitting, ideally there should be at least two representatives of P&SAS and two representatives of the clinical staff responsible for patient oxygen services (usually Pulmonary). The Committee must meet at least quarterly and keep minutes. The VA staff responsible for delivering or coordinating oxygen services must evaluate the program at least quarterly in writing. At a minimum, the members of the Oxygen Care Committee must complete the evaluation (See *Appendix IV* – Questionnaire for VA to Evaluate Itself) (e.g., Prosthetics and Pulmonary).

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Under Secretary for Health

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APPENDIX I

Modified Medical Research Council (MMRC) Dyspnea Scale

	Description
0	Not troubled with breathlessness except with strenuous exercise
1	Troubled by shortness of breath when hurrying on the level or walking up a slight hill
2	Walks slower than people of the same age on the level because of breathlessness or has to stop for breath when walking at own pace on the level
3	Stops to breathe after walking about 100 yards or after a few minutes on the level
4	Too breathless to leave the house or breathless when dressing or undressing

APPENDIX II

**PROSTHETIC & SENSORY AIDS SERVICE
QUALITY ASSURANCE PHONE SURVEY
DURABLE MEDICAL EQUIPMENT**

PATIENT NAME:

SSN:

PHONE:

DATE

1. Were you called 24 hours in advance of the delivery of your equipment? YES NO
2. Did the contractor arrive at the scheduled time? YES NO
3. Did the contractor give you your rights and responsibilities? YES NO
4. Did the contractor instruct you in the use of the equipment? YES NO
5. Was the contractor courteous and responsive to your needs? YES NO
6. Do you know who to contact at the VA if you are having a problem? YES NO
7. Were you satisfied with the services provided? YES NO

Any comments or suggestions to provide better service: _____

INTERVIEWER:

TITLE: _____

APPENDIX III

Questionnaire for VA to Evaluate Contractor or Equipment and Service Provider(s)

1. Name and Contact Number and Address of Contractor or Equivalent

2. Expectations of Contractor (e.g., supply equipment, set-up equipment, etc.) (list)

3. Have these expectations been met with respect to:

a. quality of service	YES	NO
b. response to requests	YES	NO
c. providing the services ordered	YES	NO
d. documentation	YES	NO
e. turn around time	YES	NO
f. honoring of warranties (if applicable)	YES	NO

Comments:

Person filling out questionnaire:

Title:

Date:

Note: If the VA rather than a contractor is providing some or all of the services, the relevant VA personnel should fill answer this questionnaire regarding the VA provided services. This would normally be answered by the personnel that order the services and by those personnel that depend upon some other service to deliver the services. For example, if Prosthetics is responsible for responding to orders or providing some or all of the services, then the personnel ordering the services should evaluate Prosthetics. If Pulmonary is responsible for providing some or all of the services, then Prosthetics should evaluate Pulmonary, as appropriate (e.g., documentation, expectation of delivery).

APPENDIX IV

Questionnaire for VA to Evaluate Itself (e.g., Prosthetics and Pulmonary)

1. Is there appropriate communication between your department and the other departments involved in the providing of respiratory services? YES NO
2. Do you have regular meetings of your staff with minutes? YES NO
3. Do you have regular meeting of your staff with the staff of other involved departments with minutes? YES NO
4. Do you know who to contact with a request? YES NO
5. If a patient comes to you with a question that you do not know the answer, do you know whom to contact? YES NO
6. Are all health care provider orders carried out as requested? YES NO

Comments:

Person filling out questionnaire:

Title:

Department or equivalent:

Date: