

Manual M-2, Clinical Programs. Part IV, Medical Service

Chapter 5, Outpatient Oxygen Therapy (Paragraphs 5.01 through 5.07)
Rescinds Chapter 5 dated October 23, 1990

This document includes:

- Title page and title page verso M-2, Part IV, dated **April 29, 1994**
- Contents page for M-2, Part IV, dated **April 29, 1994**
- Rescissions page iv for M-2, Part IV, dated **April 29, 1994**
- Rescissions page v for M-2, Part IV, dated **September 11, 1991** (Change 1)
- Contents page Chapter 5, dated **April 29, 1994**
- Rescissions page Chapter 5, dated **April 29, 1994**
- Text for Chapter 5, dated **April 29, 1994**

Transmittal sheet located at the end of the document:

Sheet dated **April 29, 1994**

Changes prior to 1994 located at the end of the document:

Sheet dated **October 23, 1990**
Change 17, dated **March 21, 1986**

Changes prior to 1986 also located at the end of the document:

Change 9, dated **April 14, 1968**
Change 8, dated **May 28, 1965**




Clinical Programs

Medical Service

April 29, 1994

Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

Department of Veterans Affairs, Veterans Health Administration manual M-2, "Clinical Programs," Part IV, "Medical Service," is published for the compliance of all concerned.



John T. Farrar, M.D.
Acting Under Secretary for Health

Distribution: RPC: 1027
FD

Printing Date: 5/94

CONTENTS

CHAPTERS

1. ADMINISTRATIVE
2. CARDIOLOGY
3. SPECIALIZED MEDICAL PROGRAMS
4. DIALYSIS PROGRAM
5. OUTPATIENT OXYGEN THERAPY
6. INFECTION CONTROL PROGRAM
7. SICKLE CELL SCREENING AND COUNSELING PROGRAM
8. ALLERGEN THERAPY
9. PREVENTIVE MEDICINE
10. HYPERTENSION

RESCISSIONS

1. COMPLETE RESCISSIONS

a. Manuals

M-2, part XV

M-2, part IV, dated April 15, 1955, and Changes 2, 3, 5, 7, 13, 15, and 17

M-2, Part IV, dated October 23, 1990, Chapters 1 through 8

b. Interim Issues

II 10-79-17

c. Regulations and Procedures

R&P 6209

d. Technical Bulletins

TB 10A-17

TB 10A-103

TB 10A-273

Paragraph 1f, 2b, 3a and b, section II, TB 10A-295

e. Circulars

10-75-45

10-79-1

10-80-18

10-83-4 and Supplement No. 1

10-85-5 and Supplement No. 1

10-85-31

10-85-67

10-85-150

f. All Station Letters and Other Communications

Letter and DateSubject

November 20, 1950

Cortisone and ACTH

December 4, 1950

Reporting of Cases of Syphilis to Health Authorities

March 15, 1951

Cortisone and ACTH

June 15, 1951

Physical Examination for Residuals of Filariasis

December 28, 1951

Letter refers to availability and use of cortisone and ACTH

August 26, 1953

Use of Antihypertensive Drugs Subsequent to Hospitalization

August 28, 1953

Purchase of Antigens for Treatment of Disease Due to Allergy

December 4, 1953

Cortisone and ACTH

February 5, 1954

Physical Examination for Residuals of Hepatitis (Viral)

August 5, 1954

Procurement of Allergenic Material From the VA Central Laboratory at Aspinwall

August 9, 1954

Special Boards for the Control of Therapeutic Management of Cases

August 9, 1954

ACTH and Cortisone Therapy

August 13, 1954

Prerequisite for Medical Therapy (Malaria)

August 13, 1954

Self-Administration of Hyposensitization Therapy

RESCISSIONS

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10-75-45

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10-80-18

10-82-4 and Supplement No. 1

10-83-4 and Supplement No. 1

10-84-159

10-85-5 and Supplement No. 1

10-85-31

10-85-67

10-85-100 and Supplement No. 1

10-85-150

10-86-30 and Supplement No. 1

10-88-43

10-89-76

10-90-078

d. Regulations and Procedures

R&P 6209

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August 9, 1954	ACTH and Cortisone Therapy
August 13, 1954	Prerequisite for Medical Therapy (Malaria)
August 13, 1954	Self-Administration of Hyposensitization Therapy

g. VHA Information Letters

- IL 10-84-24
- IL 10-85-2
- IL 10-87-17
- IL 10-89-5
- IL 11-87-3
- IL 11-88-12
- IL 11-89-06

CONTENTS

CHAPTER 5. OUTPATIENT OXYGEN THERAPY

PARAGRAPH	PAGE
5.01 Policy	5-1
5.02 Scientific Background	5-1
5.03 Potential Problems in Outpatient Oxygen Therapy	5-1
5.04 Patient Selection and Clinical Indications	5-1
5.05 Mode and Duration of Therapy	5-2
5.06 Types of Oxygen Equipment and Services	5-2
5.07 Periodic Review	5-2

RESCISSIONS

The following material is rescinded:

1. Manual

M-2, Part IV, Chapter 5, dated October 23, 1990

CHAPTER 5. OUTPATIENT OXYGEN THERAPY

5.01 POLICY

It is the Department of Veterans Affairs (VA) policy to provide outpatient oxygen therapy to eligible veterans when medically indicated.

5.02 SCIENTIFIC BACKGROUND

a. The use of oxygen therapy in the home on a long-term basis is common practice and can benefit patients with chronic hypoxemia while decreasing their medical care costs.

b. Complications of hypoxemia usually occur below an arterial oxygen tension of 55 mm Hg. A number of beneficial effects of long-term oxygen therapy have been clearly documented:

- (1) Reduction in pulmonary arterial pressure and polycythemia,
- (2) Improvement in neuropsychologic performance,
- (3) Increase in exercise tolerance,
- (4) Reduction in the number of hospitalizations, and
- (5) Improvement of the quality of life.

c. In patients with hypoxemic chronic obstructive lung disease (COPD) it has been shown that mortality rate is improved by oxygen with the best prognosis in those using oxygen 24 hours a day.

NOTE: In conditions other than COPD, the same guidelines for oxygen use are generally accepted. Oxygen is usually effective when delivered at rates between 1 and 4 liters per minute.

c. Patients may develop marked hypoxemia only during exercise or sleep. Oxygen supplements during sleep and exercise may be helpful to people who have hypoxemia only during these activities.

5.03 POTENTIAL PROBLEMS IN OUTPATIENT OXYGEN THERAPY

a. Patients with hypercapnia (elevated PaCO₂) may have further elevation of PaCO₂ associated with uncontrolled oxygen use. This is usually not a problem in the chronic stable patient, but only in the setting of acute illness.

b. The effectiveness of oxygen therapy may be reduced and associated risks are increased in patients who continue to smoke. Careful evaluation of the risk and/or benefit ratio should be done before starting or renewing oxygen therapy for smokers.

5.04 PATIENT SELECTION AND CLINICAL INDICATIONS

a. The patient should be on an optimal complete medical regimen. The determination to prescribe supplemental oxygen should be made by a physician knowledgeable in the treatment of chest diseases. Smoking cessation should be strongly recommended.

b. Documentation of one or more of the following indications for chronic oxygen supplementation should exist before oxygen is prescribed:

(1) Resting arterial oxygen tension (PaO₂) below 55 mm Hg while the patient is breathing room air for 20 to 30 minutes, in a stable clinical state. Thus a patient at time of discharge from hospital with an acute respiratory illness would not be considered "stable". In such a situation it will be appropriate to repeat pO₂ or saturation measurement in 3 or 4 weeks after discharge on room air before making commitment to long term oxygen therapy. Short term oxygen therapy until stability is achieved may be appropriate in some of these patients.

(2) Desaturation by oximetry with a saturation below 88 percent at rest, with exercise, or during sleep, also in a stable clinical state as defined.

(3) Resting arterial oxygen tension (paO₂) of 60 mm Hs or less with hypoxic organ dysfunction such as cor pulmonale, erythrocytosis, or hypoxia associated altered mentation.

5.05 MODE AND DURATION OF THERAPY

a. Most patients show an acceptable improvement of arterial oxygen tension on oxygen at 1 to 4 liters per minute. A few patients, particularly those with restrictive lung disorders, may require higher flow rates (e.g., 5 to 8 liters per minute). In these patients, the need for higher oxygen flow rates should be documented by an arterial blood gas or saturation measurement with the patient receiving oxygen.

b. Patients with chronic lung disease and hypoxemia who have been appropriately selected for long term oxygen therapy by establishing that they are in a stable state, usually require treatment permanently.

5.06 TYPES OF OXYGEN EQUIPMENT AND SERVICES

a. The physician responsible for the Respiratory Care Program should be familiar with both the medical and economic aspects of the various methods of delivery. When low flow oxygen is prescribed, it is usually more economical to use an oxygen concentrator. The use of certain fixed flow gauges may prevent waste through unnecessarily high flow rates when tank oxygen is used.

b. Oxygen conserving cannulae, pulse dose delivery devices, and transtracheal catheters are reported to reduce the oxygen consumed by 50 to 75 percent and may be particularly useful with portable systems. It has been demonstrated in several locations that the purchase of concentrators is more economical than rental contracts. The use of liquid oxygen systems, which are substantially more costly, should be limited to those whose activity level will allow them to benefit.

5.07 PERIODIC REVIEW

These patients should be clinically and physiologically reevaluated for oxygen therapy every 6 months for the first year and at least yearly thereafter in conjunction with the patient's regular medical evaluation. Since most properly selected patients with chronic lung diseases require treatment indefinitely, these evaluations will confirm and document the need for oxygen and the appropriate continuing flow rates.

1. Transmitted is a revision to the Department of Veterans Affairs, Veterans Health Administration manual M-2, "Clinical Programs," Part IV, "Medical Service," Chapters 1 through 8.

2. Principal changes are:

a. Chapter 1: Delegates general supervision of the Medical Officer of the Day to the Chief of Staff.

b. Chapter 2: Revises and updates policies regarding cardiology.

c. Chapter 3: Defines policy for Intensive Care Units.

d. Chapter 4: Revises and updates policies on the Dialysis Program including new 38 United States Code (U.S.C.) citations.

e. Chapter 5: Establishes policy for providing outpatient oxygen therapy.

f. Chapter 6: Amended to include the Infection Control Program.

g. Chapter 7: Defines ethnic origin of applicant and includes new 38 U.S.C citations.

h. Chapter 8: Defines policy for providing Allergen Therapy.

3. Filing Instructions

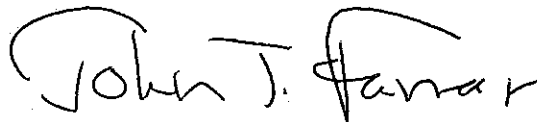
Remove pages

Cover page through iv ✓
1-i through 1-3 ✓
2-i through 2-7 ✓
3-i through 3-1 ✓
4-i through 4-7 ✓
5-i through 5-2 ✓
6-i through 6-3 ✓
7-i through 7-3 ✓
8-i through 8-1 ✓

Insert pages

Cover page through iv ✓
1-i through 1-2 ✓
2-i through 2-5 ✓
3-i through 3-1 ✓
4-i through 4-9 ✓
5-i through 5-2 ✓
6-i through 6-7 ✓
7-i through 7-4 ✓
8-i through 8-1 ✓

4. RESCISSIONS: M-2, Part IV, dated October 23, 1990, chapters 1 through 8.



John T. Farrar, M.D.
Acting Under Secretary for Health

Distribution: RPC: 1027
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Printing Date: 5/94

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1. Transmitted is a revision to Veterans Health Services and Research Administration Manual M-2, "Clinical Affairs," Part IV, "Medical Service," chapters 1 through 8. Brackets have not been used to indicate changes.

2. Principal change:

This is a major revision of Part IV, "Medical Service," providing updated and expanded guidance.

3. Filing Instructions

Remove pages

Cover page through vii
1 through 9
21 through 27
5-1 through 5-2

Insert pages

Cover page through iv
1-1 through 8-1

4. **RESCISSION:** M-2, part IV, dated April 15, 1955; and changes 3, 5, 7, 13, 15, and 17. Interim Issue II 10-72-13, dated May 17, 1972.


JAMES W. HOLSINGER, JR., M.D.
Chief Medical Director

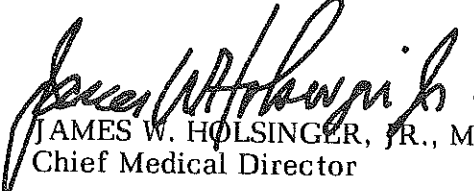
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Printing Date: 10/90

October 23, 1990

Department of Veterans Affairs
Veterans Health Services and
Research Administration
Washington, DC 20420

Veterans Health Services and Research Administration Manual M-2, "Clinical Affairs," Part IV, "Medical Service," is published for the compliance of all concerned.



JAMES W. HOLSINGER, JR., M.D.
Chief Medical Director

Distribution: RPC: 1027
FD

Printing Date: 10/90

6/17/86

Department of Medicine and Surgery
Veterans Administration
Washington, DC 20420

M-2, Part IV
Change 17

March 21, 1986

Part IV, "Medical Service," VA Department of Medicine and Surgery Manual M-2, "Clinical Affairs," is changed as indicated below:

NOTE: The purpose of this change is to add Chapter 5, "Outpatient Oxygen Therapy" to Part IV. This chapter incorporates criteria for patient selection and prescription of outpatient oxygen therapy in DM&S facilities.

Page iii, paragraph 1e: Add "Cir 10-83-4 and supp. No. 1", and "Cir. 10-85-5 and supp. No. 1".

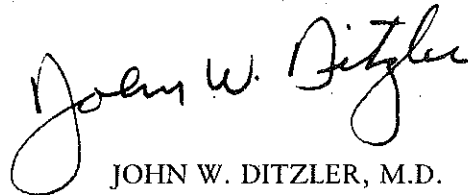
Page vii: Delete "CHAPTER 5. (Deleted by change 9.)" and insert the following:

"CHAPTER 5. OUTPATIENT OXYGEN THERAPY

5.01 General	5-1
5.02 Scientific Background	5-1
5.03 Potential Problems in Outpatient Oxygen Therapy	5-1
5.04 Patient Selection and Clinic Indications	5-1
5.05 Mode and Duration of Therapy	5-2
5.06 Types of Oxygen Equipment and Services	5-2
5.07 Periodic Review	5-2

Page 5-1 and 5-2: Insert these pages attached.

RESCISSIONS: Circulars 10-83-4 and supplement No. 1, and Circular 10-85-5 and supplement No. 1.



JOHN W. DITZLER, M.D.
Chief Medical Director

Distribution: RPC: 1027
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Printing Date: 5/86

Department of Medicine and Surgery
Veterans Administration
Washington, D.C. 20420

M-2, Part IV
Change 9.

April 14, 1966

Part IV, "Medical Service," VA Department of Medicine and Surgery Manual M-2, "Professional Services," is changed as indicated below:

NOTE: The purpose of this change is to remove from this manual part the procedures for issuance and use of emergency medical identification devices. These procedures are now being placed in chapter 17, part I, this manual, and in chapter 1, part I, M-1.

Chp 11

Page vi: After "4.07" delete the following:

"CHAPTER 5. EMERGENCY MEDICAL IDENTIFICATION

5.01 Emergency Medical Identification Card - - - - - 35

5.02 Emergency Medical Identification Symbol and Label - - - - 35"

Pages 35 and 36: Remove these pages. (Ch. 5 deleted.)

H. Martin Engle
H. MARTIN ENGLE, M.D.
Chief Medical Director

Distribution: DVB Publications Code 1027
FD All others: Same as M-2, part IV

Department of Medicine and Surgery
Veterans Administration
Washington, D.C. 20420

M-2, Part IV
Change 8

May 28, 1965

Part IV, "Medical Service," VA Department of Medicine and Surgery Manual M-2, "Professional Services," is changed as indicated below:

NOTE: The purpose of this change is as follows:

- a. To outline the procedures for issuance and use of emergency medical identification cards and symbols under certain conditions.
- b. To incorporate the provisions of DM&S Circular 10-64-276.
- c. To delete reference to VA Form 10-7384.

Page iii: Add:

- "e. DM&S Circulars
Cir. 10-64-276".

chg 11 Page vi

Under "CHAPTER 4. REPORTING OF PULMONARY DISEASE PROGRAMS":
Delete "Section I. Quarterly Report . . . VA Form 10-7384" and paragraphs 4.01 through 4.03.

Under paragraph 4.07: Add:

"CHAPTER 5. EMERGENCY MEDICAL IDENTIFICATION

5.01 Emergency Medical Identification Card - - - - - 35

5.02 Emergency Medical Identification Symbol and Label - - - - - 35"

Under "ILLUSTRATIONS": Delete "4.1 VA Form 10-7384, Quarterly . . . Survey - - - - - 30".

Pages 25 and 26: Delete section I. (This section to be incorporated in MP-6, pt. VI.)

Page 30: Delete figure 4.1.

chg 9 Pages 35 and 36: Insert these pages attached. (Chapter 5, "Emergency Medical Identification," added.)

Joseph H. McNinch
JOSEPH H. McNINCH, M. D.
Chief Medical Director

Distribution: DVB Publications Code 1027
FD Same as M-2, part IV

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REMARKS

DO NOT REPRINT. Change 1, M-2, Part IV, will be revised some time in 1961. *(Same for Chg. 3)*

H. F. WRIGHT
PCO, IM&S (10E)
Jan. 3, 1961

	DATE
	TEL. EXT.

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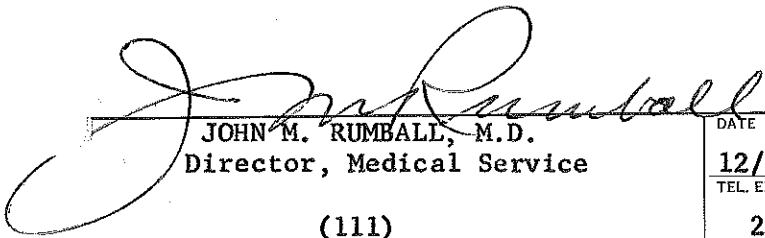
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REMARKS

The specific items requested in your note of 12/1/60 have been reviewed.

I do believe a change should be considered, however, before doing so the Area Consultants in Tropical Medicine must be consulted. This will be done in 1961.


JOHN M. RUMBALL, M.D.
 Director, Medical Service

	DATE
	12/30/60
	TEL. EXT.
(111)	2549

**VETERANS ADMINISTRATION
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REMARKS

Changes 1 and 3 of M-2, Part IV, have come up for reprinting, 100 copies each.

Would you look over these changes and let us know whether any revisions ^{are indicated} in the manual (re these pages) at your earliest convenience, since we must make reply to the Depot as soon as possible.

If you find that revisions are indicated, please return these changes, so stating, and the revisions *should* be submitted as a new change and one or both of these changes *will be* disapproved for reprint.

This should be approved by Dr. Rumball

FROM <i>R. Strachan</i> for H. F. WRIGHT PCO, DM&S (IOE)	DATE 12/1/60 TEL. EXT. 2507
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