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

Chapter 5, Outpatient Oxygen Therapy (Paragaphs 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
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
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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The following material is rescinded: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 (Pa02) 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 Pa02 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 (pa02) 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.
   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

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   Cover page through iv
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John T. Farrar, M.D.
Acting Under Secretary for Health

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Printing Date: 5/94
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**

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Distribution: **RPC: 1027**

FD

Printing Date: 10/90
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. HOL SINGER, JR., M.D.
Chief Medical Director

Distribution: RPC: 1027
FD

Printing Date: 10/90
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
FD

Printing Date: 5/86
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.

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.)

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

H. MARTIN ENGLE, M.D.
Chief Medical Director
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".

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.

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

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

JOSEPH H. McNINCH, M.D.
Chief Medical Director
DO NOT REPRINT. Change 1, M-2, Part IV, will be revised some time in 1961. (Same for Chg. 3)

M. F. WRIGHT
POD, DMES (10E)
Jan. 3, 1961
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.
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 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 disapproved for reprint.

H. F. WRIGHT PCO, DM & S (10E)