Provincial Clinical Policy	

Title: Home Care - Home Oxygen Concentrator Program

Level: Provincial
Service Area: Home Care
Applicable to: All healthcare providers, organizations, and facilities across Manitoba involved in delivering health services provided or funded by the government or a health authority.

Approved by: Shared Health Executive Team

Document Number: 630.105.115
Category: 630 – Provincial Primary, Home/Community & Palliative Care Program
Subcategory: 630.105 – Home Care

Document Date: 25-Nov-2024
Last Revision Date: 7-Feb-2018

Notice: *This document has been transitioned from Manitoba Health, Seniors, and Long-Term Care to Shared Health. Shared Health is planning to complete an in-depth review of the material and post an updated version once available.*

1.0. Purpose

1.1. To outline the eligibility criteria for and parameters of the Home Oxygen Concentrator Program (HOCP).

1.2. To outline the service and equipment available under the HOCP.

1.3. To outline the provincial process to access services of the HOCP.

1.4. To outline Regional Health Authority (RHA) monitoring and audit requirements.

1.5. To outline required reporting to Manitoba Health, Seniors and Active Living (MHSAL).

1.6. Background

1.6.1 The HOCP is administered by regional health authorities (RHA) as a part of home care services. The HOCP was introduced to support individuals who require supplemental oxygen to live independently in

the community. At a later date, HOCP included individuals on regional palliative care programs.

2.0. Scope

2.1. Applies to all regional health authorities (RHA) in Manitoba, responsible for administering and coordinating Home Care and HOCP services.

2.2. Applies to all Home Care staff and regional staff and physicians within an RHA, involved in assessing and delivering Home Care and HOCP services.

3.0. Definitions

3.1. Defined Terms

3.1.1 Caregiver: A person who is providing care because of a prior relationship with a client. A caregiver may be a biological family member or “family by choice” (e.g., friends, partners, neighbors).

3.1.2 Home Care: The coordinated delivery of a broad range of health and social services to meet the needs of the persons who require assistance or support in order to remain at home or whose functioning without Home Care is likely to deteriorate making it impossible for the person to stay at home in the community.

3.1.3 Palliative Care: An approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

3.1.4 Reassessment: A specific activity, as well as an ongoing process involving the systematic re-evaluation of a patient’s or client’s needs and forms the basis for revising/refining a previously established treatment, care, and/or service plan.

3.1.5 Vendor(s): The entity/entities identified in the contract who agrees to sell the Deliverables.

3.2. Abbreviations

3.2.1 Approved Regional Respiratory Authorizer (ARRA): A designated physician, appointed by each RHA, who reviews the clinical information; consults with the Registered Respiratory Therapist (RRT),

and/or Home Care Case Coordinator (HCCC), and/or client's physician; and determines and documents the client's medical eligibility or rejection for HOCP services.

3.2.2 Designated Provincial Respiratory Consultant (DPRC): A physician contracted provincially by the RHAs purchasing division to:

3.2.2(a) Assist in the maintenance and review of the HOCP.

3.2.2(b) Organize and provide orientation training to physicians and RHA health staff as required in order to maintain the HOCP.

3.2.2(c) Provide case consultation to physicians and health care staff as required.

3.2.2(d) Determines and documents the client's medical eligibility or rejection for HOCP services.

3.2.3 Home Oxygen Concentrator Program (HOCP): A provincial program that provides eligible home care and palliative care clients in Manitoba with oxygen equipment and support to manage respiratory needs at home.

3.2.4 Manitoba Health, Seniors, and Active Living (MHSAL): A provincial government department responsible for overseeing health services, senior care, and active living initiatives across Manitoba.

3.2.5 Non-invasive Positive Pressure Ventilation (NIPPV): A way to help a person breathe by using a mask that pushes oxygen into the lungs, without the need to place a breathing tube or other artificial airway.

3.2.6 Palliative Care Program Professional (PCPP): A member of the Palliative Care team who verifies that the HOCP applicant meets the Palliative Care criteria for home oxygen.

3.2.7 Regional Health Authorities (RHA): Refers to regional health authorities established or continued under the Government of Manitoba, Health System Governance and Accountability Act.

3.2.8 Regional Home Oxygen Administrator (RHOA): Designated RHA staff who verifies that the HOCP applicant meets Initial Medical Eligibility criteria, environmental safety and competency eligibility criteria and coordinates follow-up for reassessment for continued medical eligibility. The Regional Home Oxygen Administrator liaises with the appropriate regional programs/staff/designates (e.g. Home Care, Palliative Care, physicians) as needed to assist with determining

applicant competencies. The Regional Home Oxygen Administrator cannot approve, but may remove client from HOCP in situations detailed in 4.6 of this policy.

3.2.9 Regional Palliative Care Program (RPCP): The clinical program or team designated to provide palliative care services.

3.2.10 Request for Proposal (RFP): A form of bid solicitation used where the selection of a supplier cannot be made solely on the basis of the lowest price. An RFP is used to procure the most cost-effective solution based upon evaluation criteria identified in the RFP.

3.2.11 Service Purchase Agreement (SPA): A detailed contract that outlines the terms and conditions for the purchase of services from a service provider.

3.3. Professional Groupings

3.3.1 Home Care Case Coordinators (HCCC): A professional hired by the RHA to complete client assessments to determine eligibility, to develop the Care Plan with the client and/or family/designated other and refer exceptional case decisions to the Home Care Manager.

3.3.2 Registered Respiratory Therapist (RRT): A graduate of an accredited educational program who has successfully passed the Health Professionals Testing Canada examination in respiratory therapy.

4.0. Policy

4.1. Home Oxygen Concentrator Program (HOCP) services may be available to eligible clients of regional home care or palliative care services in Manitoba.

4.2. Eligibility Criteria

4.2.1 Client eligibility for the Home Oxygen Concentrator Program (HOCP) is established when all of the following criteria are met:

4.2.1(a) Client is eligible for regional home care or palliative care services in Manitoba;

4.2.1(b) Medical eligibility for home oxygen is confirmed by Approved Regional Respiratory Authorizer (ARRA), Designated Provincial Respiratory Consultant (DPRC) or Regional Home Oxygen Administrator (RHOA) when the defined medical criteria as outlined in Appendix 1 are met;

- The Palliative Care Program Professional (PCPP) approves clients who are eligible as meeting Criteria 9.4 in Appendix 1.
- The client is appropriate for home-based disease management/care.
- The necessary tests/reports for assessing and monitoring client's oxygen needs are completed as outlined on the Assessment/Referral form (See Appendix 2).

4.2.1(c) Environmental safety is confirmed:

- The client resides in a geographic location where it is possible to provide the equipment safely;
- The client's home ls appropriate for the safe use of the equipment; and
- The client and/or caregiver(s) is/are capable of and are in agreement to adhere to safe practices relative to the delivery of oxygen therapy, based on regional established best practice safety procedure (See Appendix 4) and vendor(s) recommendations/policy.

4.2.1(d) Competency eligibility is confirmed:

- The client and/or caregiver(s) demonstrate(s) safe use of the equipment.

4.3. Communication to client/caregiver(s), referring health professional and vendor(s) regarding eligibility, ineligibility, installation, or removal of oxygen therapy as applicable is timely and provided by RHA staff or designate as soon as possible, but no later than five (5) working days from the date complete referral form and test report documentation is received by RHA.

4.4. **Reassessment**

4.4.1 Reassessment for continued HOCP eligibility is assessed by RHOA based on eligibility criteria as defined in 4.2 of the policy:

4.4.1(a) Reassessment must be done one to three months post initial eligibility/treatment initiation and as required;

4.4.1(b) The necessary tests/reports for assessing and monitoring client's oxygen needs are completed and forwarded to the ARRA or DPRC

for approval as outlined on the Assessment/Referral form (Appendix 2).

4.5. Inclusions

4.5.1 Client who is eligible for the HOCP receives:

4.5.1(a) Oxygen concentrator, back-up oxygen cylinder(s), collar or stand for cylinder(s), regulator for back-up cylinder(s), disposables and consumables related to the provision of oxygen therapy. Portable oxygen is the responsibility of the client. Benefits may be available through Pharmacare or private insurance;

4.5.1(b) Information and education on oxygen, treatment, and equipment as it relates to the client's disease/condition; and

4.5.1(c) Case management by qualified RHA (or designate) staff.

4.6. Discontinuation of Service

4.6.1 Client may be removed from the HOCP by RHOA for any of the following reasons below:

4.6.1(a) The client does not comply with reassessment appointment(s) required as per policy;

4.6.1(b) The client/caregiver(s) do not comply with safe use of oxygen equipment; or

4.6.1(c) Continued and persistent non-compliance with the established Oxygen Prescription/Delivery Mode after attempts to improve compliance through client education.

4.7. Responsibilities

4.7.1 RHA is responsible for the monitoring of quarterly utilization reports as provided by the vendor(s).

4.7.2 RHA provides a summary and analysis of performance measurement reports to Continuing Care Branch, Mental Health and Addictions, Primary Health Care, and Seniors (MHAPHC/S).

4.7.3 RHA compliance auditing is required to ensure that the region is in compliance with provincial policy direction. As such, all Health Authorities are required to submit evidentiary documentation

demonstrating compliance based on a schedule to be established and communicated at policy distribution.

4.7.4 RHAs through Request for Proposal (RFP)/Service Purchase Agreement (SPA) establishes comprehensive roles and responsibilities of vendor(s).

4.7.5 All RHAs are required to submit evidentiary documentation demonstrating compliance with the policy based on a schedule to be established and communicated at policy distribution. Following MHSAL's review of the documentation, RHAs will be notified in writing of compliance determinations. Should the RHA be determined to be in compliance, subsequent policy audits shall be undertaken once every two years. Should a region be determined to not be in compliance with a given policy element, a reassessment shall be undertaken 6 months from the date of the non-compliance notification.

4.8. HOCP supports may be reestablished for any client for whom services were discontinued if a current assessment confirms eligibility based on the existing program parameters.

4.9. The equipment, supplies, and supports provided through the HOCP are not extended to situations where clients travel outside of the province.

5.0. Procedure

5.1. Not Applicable

6.0. Resources

6.1. Medical Eligibility Criteria – See Appendix 1

6.2. Medical Assessment Referral/Reassessment Form – See Appendix 2

6.3. Assessment Referral/Reassessment Pathway – See Appendix 3

6.3.1 RHAs to determine specific operational procedures and may delegate tasks as deemed appropriate based on regional resources and client volumes.

6.4. Best Practice Safety Procedures – See Appendix 4

6.4.1 A sample provided by Winnipeg Regional Health Authority to guide RHAs in establishing safety assessment practice and procedures.

6.5. Blinded Six Minute Walk Test document provided to guide RHAs in ensuring accurate information for eligibility criteria are provided – See Appendix 5

7.0. References

7.1. Balfour-Lynn, I. M., Field, D. J., Gringras, P., et al. (2009). BTS guidelines for home oxygen in children. Thorax, 64 Suppl 2, ii1–ii26.

7.2. Georgopoulos, D., & Anthonisen, N. R. (1990). Continuous oxygen therapy for the chronically hypoxemic patient. *Annual Review of Medicine*, 41(1), 223–230.

7.3. Nocturnal Oxygen Therapy Trial Group. (1980). Continuous or nocturnal oxygen therapy in hypoxemic chronic obstructive lung disease: A clinical trial. *Annals of Internal Medicine*, 93(3), 391–398.

7.4. Related Policy Documents

7.4.1 Government of Manitoba (2017). *HCS 207.2 General Eligibility.* Home Care Policy Manual.

8.0. Contact(s)

8.1. Provincial Director Health Services, Primary, Home/Community and Palliative Care Program - Shared Health

For questions about the implementation and application of this controlled document, please contact your immediate manager. Management may consult with the Provincial Clinical Service Lead, Home & Community Care – Shared Health for support.

9.0. Appendix 1 – Home Oxygen Concentrator Program (HOCP) Medical Eligibility Criteria

Note: Eligibility criteria for the HOCP include a number of factors, only one of which is medical eligibility and to which Appendix 1 speaks.

While medical eligibility may be established, a client may, by virtue of other client-specific characteristics may be assessed as not eligible for the HOCP.

A client is considered medically eligible for the HOCP by the Approved Regional Respiratory Authorizer, Regional Home Oxygen Administrator or Designated Provincial Respiratory Consultant when one or more of the following medical criteria are met:

9.1. Resting Hypoxemia

An Initial Medical Assessment for Home Oxygen (O_2) Concentrator Program documents:

9.1.1 A minimum of one (1) arterial blood gas (ABG) performed on room air within four (4) days of the Assessment/Referral form being submitted to the HOCP.

9.1.1(a) Please Note: ABGs are required for the initial assessment and to determine ongoing eligibility for HOCP. However, where medical circumstances indicate adverse outcomes may occur if room air ABG is attempted, a discussion with the Designated Provincial Respiratory Consultant is required.

9.1.2 Client meets at least one (1) of the following criteria:

9.1.2(a) Adults demonstrating hypoxemia at rest: PaO_2 ≤59 mmHg on room air.

9.1.2(b) Pediatric clients (children 17 years of age or under) follow the British Thoracic Society Guidelines (Reference Document Section 7.1) and should be referred to a pediatric respirologist.

9.1.3 Oxygen is administered to achieve a PaO_2 range of ≥60 mmHg but <65 mmHg (correlating to SpO_2 of 90 - 92%).

9.1.4 Oxygen is administered at least 18 hours per day, preferably 24 hours.

9.2. Exertional Oxygen

9.2.1 Testing for exertional oxygen requirement is available only for clients who do not qualify for continuous oxygen:

9.2.1(a) One (1) room air ABG test result must be submitted to demonstrate that the client's PaO_2 Is >59 mmHg for resting hypoxemia; AND

9.2.1(b) One of:

- Evidence of desaturation on room air during exertion, to SpO_2 <89% for a minimum of one (1) minute Blinded six (6) minute walk test administered with documented improved performance on oxygen versus room air (include distance walked increases by 25% and a minimum of 30 meters).
- During the course of the Blinded six (6) minute walk test, evidence of desaturation on Room Air during exertion, to SpO_2 <80% for a minimum of one (1) minute (i.e., test may be terminated; no need to demonstrate objective measured improvement).

9.2.2 Pre-screen: To qualify for complete exertional oxygen testing, evidence of desaturation while on room air during exercise, to SpO_2 <89% for a minimum of one (1) minute.

9.2.3 A blinded six (6) minute walk test is administered with a medically stable client.

9.2.3(a) Test is administered with the client given air and oxygen in exactly the same manner and flow rate. The client is not informed whether oxygen or air is provided.

9.2.3(b) Test results to include total distance walked.

9.2.3(c) If during the course of the test, the client desaturates to SpO_2 <80% for a minimum of one (1) minute, the client is eligible for supplemental oxygen and the test is terminated. There is no need to demonstrate objective measured improvement as outlined in 9.3.4.

9.2.4 Eligibility for low flow oxygen therapy is established when a client shows objective measured improvement in his/her walking performance on oxygen compared to room air so that the distance walked increases by 25% and a minimum of 30 meters.

9.3. Nocturnal Desaturation

9.3.1 Requests for oxygen therapy are referred to the Designated Provincial Respiratory Consultant for review.

9.3.2 To determine the need for nocturnal oxygen therapy documented confirmation of nocturnal desaturation is required by either polysomnography testing completed in a sleep laboratory, by a respiratory sleep study performed in a hospital, or by an outpatient study done in the client's home.

9.3.2(a) A respiratory sleep study includes, at a minimum: a continuous recording of oxygen saturation, heart rate, and a direct measurement of airflow.

9.3.2(b) Diagnostic testing programs, including respiratory sleep studies, performed outside of a hospital setting require the approval of the College of Physicians & Surgeons of Manitoba.

9.3.3 A client prescribed nocturnal oxygen typically spends a significant portion of sleep time (5%) at SpO_2 ≤85%. Such a client usually exhibits severe episodes of arterial desaturation on one (1) or two (2) occasions per night, persisting for at least five (5) minutes. Documentation includes evidence that oxygen therapy improves saturation during sleep.

9.3.4 Non-invasive Positive Pressure Ventilation (NIPPV): For clients who require oxygen therapy in conjunction with NIPPV (CPAP/Bi-level therapy), the request for supplemental oxygen includes:

9.3.4(a) Documented hardcopy evidence indicating SpO_2 ≤85% on room air with NIPPV alone, during sleep.

9.3.4(b) A steep lab report showing that oxygen therapy has been titrated to approximate flows to maintain SpO_2 >85% during sleep.

9.4. Palliative Oxygen

9.4.1 Client is enrolled in a regional palliative care program.

9.4.2 An assessment for home oxygen therapy for a palliative care client is completed by a Palliative Care Program Professional. In the absence of documented need based on the established clinical parameters, oxygen may be ordered for comfort measures.

9.5. Reassessment for Continued Medical Eligibility

9.5.1 The RHA is responsible to ensure HOCP client's oxygen requirements are assessed regularly, as indicated by the individual client's status.

9.5.2 Prior to reassessment, the HOCP client is clinically stable and receiving appropriate medical treatment.

9.5.3 A client on oxygen therapy for resting hypoxemia and determined to be medically stable, requires a room air ABG at minimally one (1) month (not to exceed three [3] months) post treatment initiation. Reassessment may occur more frequently as the client's clinical profile dictates.

9.5.4 A child 17 years of age or under started on oxygen therapy for hypoxemia requires, at a minimum, yearly room air oximetry testing to confirm ongoing eligibility for the HOCP.

9.5.5 A client on oxygen therapy for exertional hypoxemia and determined to be medically stable, requires evidence of desaturation on room air during exercise to SpO_2 <89%. A six (6) minute blinded walk test administered with documented performance on oxygen versus room air minimally one (1) month (not to exceed three [3] months) post treatment initiation.

9.5.6 A client on oxygen therapy for nocturnal desaturation is eligible for continued therapy after initial medical eligibility is established.

9.5.6(a) Reauthorization is required if a significant clinical change in the client's condition occurs.

9.5.6(b) Regular reassessment by the primary care provider to determine if the client's profile has changed is recommended.

10.0. Appendix 2 – Medical Assessment/Referral Form – Home Oxygen Concentrator Program (HOCP)

10.1. The Home Oxygen Concentrator Program (HOCP) Medical Assessment/Referral Form can be accessed on the Shared Health Home Care Services page.

11.0. Appendix 3 – Home Oxygen Concentrator Program (HOCP) Assessment-Referral/Reassessment Pathway

11.1. The Home Oxygen Concentrator Program (HOCP) Assessment-Referral/Reassessment Pathway can be accessed on the Shared Health Home Care Services page.

12.0. Appendix 4 – Best Practice Safety Procedures: Sample HOCP Questionnaire

12.1. The sample Home Oxygen Safety Questionnaire and Answer Key can be accessed on the Shared Health Home Care Services page.

13.0. Appendix 5 – Sample: Blinded Six Minute Walk Test and Guidelines

13.1. The sample Home Oxygen Blinded Six Minute Walk Test and Guidelines can be accessed on the Shared Health Home Care Services page.