

HOME OXYGEN PROGRAM APPLICATION

 Inealth
 Application must be completed in full and faxed (complete with hard copy lab data) directly to an HOP Contracted Vendor

 Hospital Starts:
 MedPro Respiratory Care 1-888-310-1441
 Community Starts: Respiratory Homecare Solutions (RHS) Fax: 1-877-701-0425

1. Date of Applic	ation:		Hospital Discharge Date:					
2. Client Data								
PHN:			Referring Physici	Referring Physician or NP:				
Last Name First Middle								
				Dr.:				
DOB (dd/mm/yy):] F 🗌	Doctor No.:					
Street Address		Street Address						
City: Phone:		Postal Code: Cell:	City: Postal Code: Phone: Fax:					
Alternate Contact	:		Other Physicians involved: Respirologist Internist					
If Extended Healt	h Benefits / Third Pai	s 🗌 No	Dr.: Fax: Dr.: Fax:					
I Agency: ☐ PBC ☐ Sun Life ☐ VAC ☐ NIHB ☐ Other								
3. Clinical Information								
Primary Diagnosis:								
Precautions: (i.e. MRSA, VRE, TB, etc.): Advanced Care Plan: COPD Action Plan: Yes No								
* Co-morbidities: CHF Pulmonary Hypertension Safety: Smoker Active Drug / ETOH use								
* Evidence must be provided for co-morbid disease (i.e. Echocardiogram, Discharge summary, etc.) If this evidence is not at time of discharge, a time limited subsidy for home oxygen therapy may be provided to permit additional time for submission of evidence pertaining to the co-morbid disease.								
4. Laboratory Data: Data must be obtained <72 hours from hospital discharge and hardcopy of the study must be attached (Data on Room Air only)								
Test	Date (dd/mm/yy)	рН	PaCO ₂	PaO₂	HCO₃	BE / O₂ Sat (cal)	Oximetry SpO ₂	
OXIMETRY STUDIES: (See Reverse) Resting Room Air Study Attached Ambulatory Study Attached * Nocturnal Study Attached								
* Daytime desaturation must be present at rest or with ambulation for nocturnal oxygen therapy to be funded, subject to Medical Director review. Sleep disordered breathing only be treated with supplemental oxygen therapy if the nocturnal criteria are met despite optimal treatment (i.e. CPAP therapy).								
Additional Information:								
5. Application Source:								
□ Hospital □ Physician / NP Office □ Other: Hospital: Ward:								
					Oxygen Supplier: Application Sent / Faxed to Vendor			
6. Oxygen Prescription to maintain Oxygen Saturation ≥ 90%								
At Rest: I/min With Ambulation: I/min Nocturnal: I/min.								
Physician / NP Signature: (mandatory) Date:								
Physician/ Nurse Practitioner: By signing above you are authorizing a prescription of oxygen therapy and ongoing titration of flow rate by HOP and Oxygen Supplier Respiratory Therapist to maintain SpO ₂ ≥ at rest, on exertion and nocturnally; and are accepting the Program's Terms on the reverse on behalf of this client.								
7. HOP Subsidy Review: HOP USE ONLY								
				Approved				
	ntinuous		☐ Nocturnal					
Date of Reassess	ment:	1 month	3 months	6 month	s 🗌 1 ye	ar	Other	
Notes:		•	•	•	1			

Home Oxygen Program (HOP) Criteria and Information

1. TERMS:

- By signing this form you are (A) Completing a prescription for oxygen, (B) Ensuring all information provided is accurate, (C) Acknowledging the terms and ongoing involvement of HOP with this client.
- Completing this form does not ensure that a subsidy will be granted.
- Successful applications will be granted an oxygen system consistent with the client's clinical needs. You do not need to choose oxygen equipment; it will be determined for you.
- The HOP Respiratory Therapists will provide periodic assessments, and oxygen titration. At-home testing may include arterial blood gas, resting, ambulatory and nocturnal oximetry.
- Extended Health Benefits, Veterans Affairs Canada (VAC), NIHB, ICBC, and WCB providers are the primary sources of funding for home oxygen, not the HOP.

2. BC HOME OXYGEN MEDICAL CRITERIA REQUIRED FOR FUNDING:

Provide as much recent and appropriate information as possible. Data submitted must be taken within 72 hours of application with acute discharges. Oximetry data shown as a single digit will not be accepted. All HOP subsidy applicants are expected to seek and be compliant with optimal medical treatment. The safe use of oxygen therapy is vital. Information to support the co-morbid disease is required (e.g. consultation note, discharge summary, spirometry, echocardiogram, etc.).

Resting Oxygen: Patients must be rested on room air for a minimum of 10 minutes prior to obtaining an arterial blood gas (ABG) sample.

- A. An ABG with a partial pressure of arterial oxygen (PaO₂) ≤ 55 mmHg on room air. <u>Note</u>: in exceptional circumstances an arterial oxygen saturation measured by pulse oximetry (SpO₂) < 88% sustained continuously for 6 minutes may be accepted. OR
- B. An ABG with a PaO₂ of ≤ 60 mmHg on room air, with evidence of one of the following conditions: Clinically significant CHF and/or Pulmonary hypertension

Nocturnal Oxygen: Obstructive sleep apnea (OSA) must be ruled out or maximally treated. A nocturnal overnight study on room air is required for approval of nocturnal oxygen therapy. SpO₂ < 88% for > then 30% of a minimum 4-hour nocturnal oximetry study.

<u>Ambulation-Only Oxygen</u>: As per the HOP Medical Director, Hospital discharge is appropriate and safe (on room air) if the patient has a resting, room air SpO₂ greater than 88% (despite desaturation with activity).

There will need to be documented evidence of co-morbidities such as restrictive lung disease, heart failure, PHTN, pre-transplant program, cystic fibrosis, and/or enrollment in an exercise rehab program in order to qualify for ambulation only O_2 or at the discretion of the HOP Medical Director **Dr. Brett Baumann** or Respirologist.

To determine O_2 ambulation requirements for clients that have already qualified for resting O2 please follow ambulation testing procedure. Ambulation testing procedure: Perform on a flat surface only. If the client is unable to walk for at least **one minute** or a **minimum of 33 meters**, ambulation oxygen therapy will not be useful and will not be funded. Clients should be tested with their usual mobility device such as canes, walkers, etc., and walk as far as possible within the **6 minute** test. <u>Note</u>: Any post ambulation saturation values submitted will not be accepted.

Infants: Separate qualifying criteria may exist for subsidies involving infants and children. In general, Neonatologists or Pediatricians determine the chronic needs for oxygen for infants or children.

Palliative: Palliative diagnosis does not ensure a home oxygen subsidy. Palliative clients must qualify with the above criteria.

3. NON-MEDICAL CRITERIA:

- Must be a BC citizen for more than 3 months.
- Must be eligible for and have valid BC Medical Services Plan coverage.
- Must spend ≥ 6 months of a calendar year and continue to maintain their home in BC to maintain BC MSP coverage.
- Must be a permanent resident of Island Health, and not reside in a facility governed by the Hospital Act.
- Must be capable of handling oxygen safely in the home.
- The referring physician must sign the application.
- Applications involving Veterans Affairs Canada (VAC) may be reviewed by HOP then submitted to VAC for further processing.

HOP will not provide client funding:

- If above eligibility criteria are not met
- For placebo effects.
- After the second reported safety offense.
- For misuse of oxygen or equipment.
- To operate nebulizers.

- For outpatient use from a hospital
- For travel outside of Canada
- For noncompliance with the prescription or terms of the HOP
- Workers Compensation and ICBC claimants

4. PROCESS:

Fax the completed form directly to the vendor. To establish a setup timeframe, contact the vendor by phone. <u>Hospital starts</u>: MedPro Respiratory Care Fax 1-888-310-1441 / PH: 1-888-310-1444

Community starts: Respiratory Homecare Solutions (RHS) Fax 1-877-701-0425 / PH: 1-877-701-0424