Recommendations of the Fifth Oxygen Consensus Conference. 1999

Recommendation 1:
Respiratory Home Care Services are endorsed as essential in LTOT.

We recommend that LTOT should be viewed as a compendium of therapeutic services including educating patients, assessing patients, monitoring therapeutic benefits, evaluating patient compliance, communicating with primary care physicians, and providing and maintaining the necessary technology.

Establish minimum service standards with respect to supplying oxygen services for homecare providers, e.g. Respiratory Professionals, Safety, 24-hr access…

Recommendation 2:
The NIH should fund a scientific study to determine the benefits of truly portable O2 therapy in terms of survival, quality of life, healthcare utilization and physiological outcomes.

Recommendation 3:
The evolution of our healthcare system has resulted in the discharge of patients from hospital base care into the home setting at a higher acuity level and the management of more acutely ill patients in the outpatient setting.

It is recommended that patients being diagnosed with unstable respiratory disease with prescribed oxygen therapy be recertified after the initial 90 days of therapy for long-term oxygen therapy. Once the need for long-term oxygen therapy is established, repeat measurement of arterial blood gasses or saturation is not necessary or justifiable for recertification. These measurements are medically necessary and justifiable for the physician to evaluate the course of the disease and to make adjustments in oxygen flow rate.

Recommendation 4:
Standardized education of patients, caregivers and medical professionals is of prime importance, utilizing existing materials. An Education Consensus Conference is recommended for the evaluation of current literature and to define tools to be used to educate patients, caregivers and others.

Enhance education with a national oxygen awareness and lobbying effort. Employ national groups such as NHOPA, ACCP, ATS, AARC, NAMES, AACVPR, NAMDRC, PERF, VA and a manufacturer's coalition.

Recommendation 5:
Provision for ambulation oxygen portable must be defined and reimbursed accordingly.

Ambulatory- Availability for daily use, carried by the patient, weighing less than 10 pounds, minimum oxygen duration of at least 4-6 hours at 2 lpm continuous flow or equivalent.

Redefine portable O2 as equipment that can be carried by most patients on their person during ADL, weighing 10 pounds or less, 2 lpm, 4hr.

System must be selected for the needs of a specific patient.

Consider portability (weight), duration, and frequency of use.

We recommend that technology development focus on technologies that are more compatible with patients' lifestyles such as lightweight, portable oxygen systems.

Recommendation 6:
To assure patients rights and an informed choice of LTOT that meets their medical needs, an accepted definition of *access* must be developed by clinicians, which addresses issues such as access to medical care, pulmonary rehabilitation, service, equipment and supplies. Once the definition is established, it must be presented to HCFA and other third party payers.

Redefine "access to care" to facilitate provision of truly portable oxygen.

Recommendation 7:
Support O2 patients in their need for airline travel. DOT / Coast Guard criteria to be adapted by FAA/ Airlines.

Patients have a right to medically necessary oxygen therapy during all phases of air travel. Acceptable airline service must include the establishment of consistent policies and the provision of appropriate *and* sufficient oxygen, equipment and supplies (e.g. adjustable flow meters) that will meet the patient's prescribed oxygen order.

Recommendation 8:
It is recommended that upon initial setup and periodically thereafter, that all O2 therapy devices, particularly OCD, that patients be titrated to the proper flow rate at rest, exercise, and sleep, to achieve maximum benefit.

The AARC and/or AACVPR should create clinical practice guidelines for the evaluation and monitoring of LTOT. This should include both short and long term plans.

Recommendation 9:
Patient compliance is essential to the efficiency of LTOT and can be improved though initial and on-going patient education and intervention with access to appropriate services and oxygen systems. Compliance will be enhanced by optimized reimbursement and empowering the patient with choices to best meet their medical needs.

Health care professionals should continue efforts to assure compliance to MD prescription.

Recommendation 10:
An oxygen patients Bill of Rights should be developed to assure a standardized and appropriate level of patient care that will be used by all patients and health care providers. Supporting documents should include education checklists, defined patient responsibilities, and a defined role of the RCP in the care of LTOT patients.

Recommendation 11:
A system of patient advocacy should be developed to represent LTOT users and providers. The system should include a mechanism to resolve complaints and concerns, which would improve patient compliance and satisfaction. Tell HCFA about it.

Recommendation 12:
Encourage scientific investigations to explore further indications for oxygen therapy. E.g. exercise, sleep with daytime normoxia.

Recommendation 13:
Acknowledge the electrical power costs of O2 equipment device usage, as well as other hidden costs.

Recommendation 14:
Adequate reimbursement for medically necessary and technology appropriate oxygen delivery systems (e.g. ambulatory oxygen, conserving devices and transtracheal oxygen) will improve patient compliance and optimize clinical outcomes.
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