

From Bedside to Fireside: Bridging Hospital and Home Respiratory Care



Cara Grogan, RRT

Adult Respiratory
Educator

University of Vermont Medical Center

2026

Objectives

Decrease

Decrease the knowledge gap between in-patient respiratory care and home care

Discuss

Discuss learning points using case scenarios

Understand

Understand how hospital oxygen evals translate to home care

Understand

Understand qualifications for non-invasive ventilation at home while patient is in-patient

Discuss

Discuss the importance of the SOAR Act for our patients and career

Home Oxygen Therapy



2023 review in Respiratory Care Journal 1.5 million people in US

600-800 thousand are Medicare beneficiaries



Chronic respiratory conditions

COPD, ILD, pulmonary hypertension, nocturnal related

Cardiac related



Concentrators, tanks, liquid oxygen

What delivery system is best for your patient?

Oxygen
demand

Disease
process

Lifestyle

Home
setting

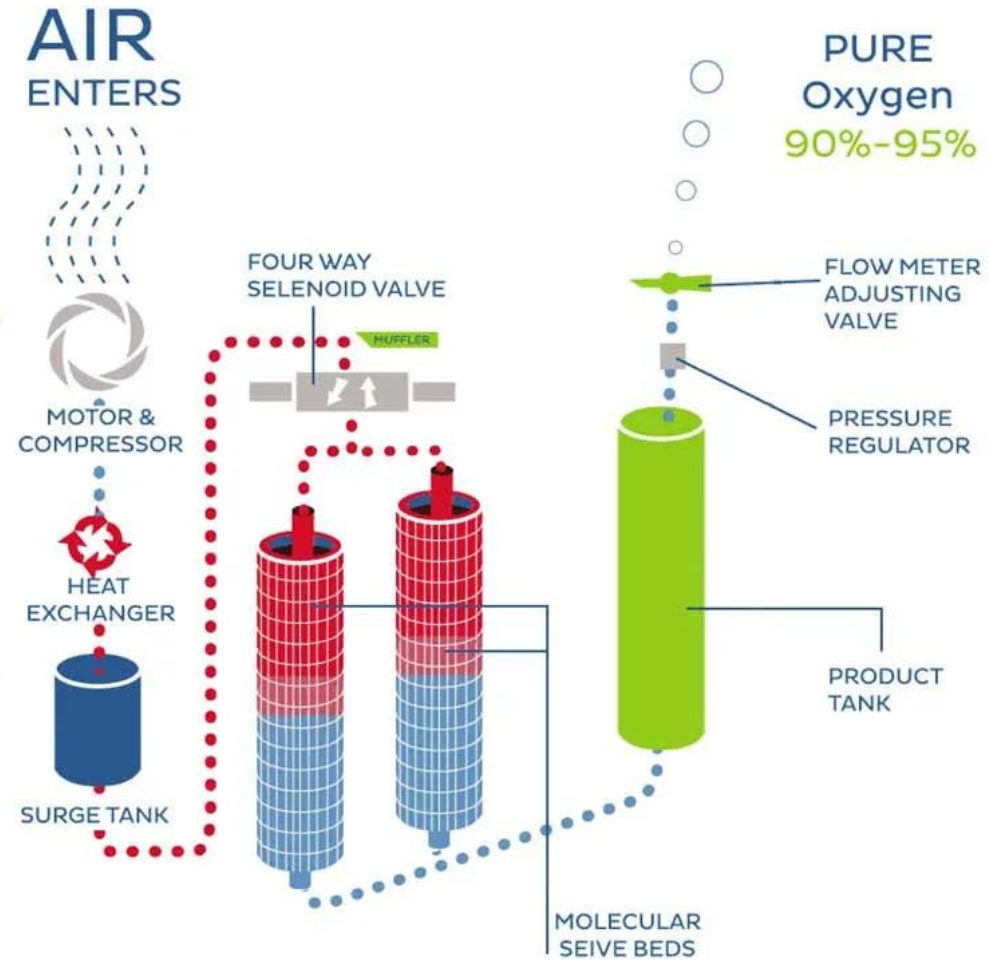
Oxygen Concentrators

- Electric or battery operated
- Long-term and cost-saving
 - No refills required
- FAA approved*
- Not combustible like a tank
- Can be offered in pulse dose or continuous flow



How an Oxygen Concentrator Works

1. Takes air from the room.
2. Compresses the oxygen.
3. Takes out nitrogen from the air.
4. Adjusts the way the air is delivered.
5. Delivers the purified air.



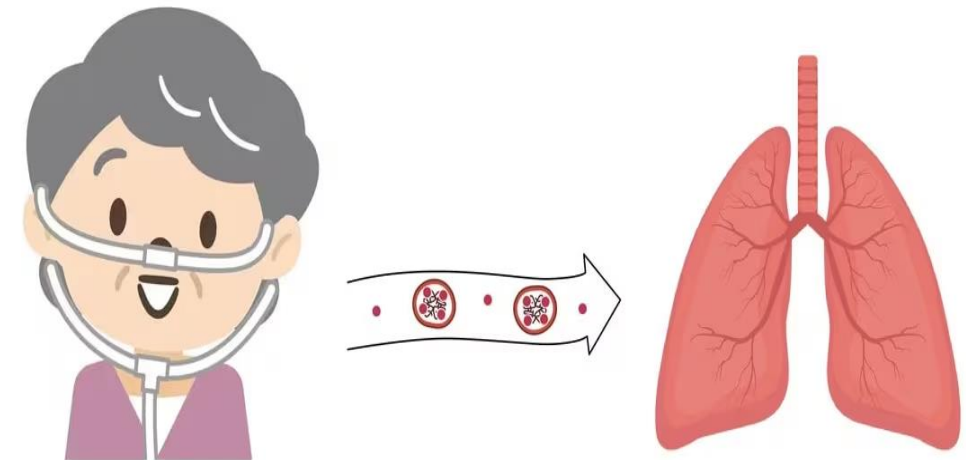
Oxygen Concentrators

Pulse Dose Concentrator



Pulse Dose Concentrator

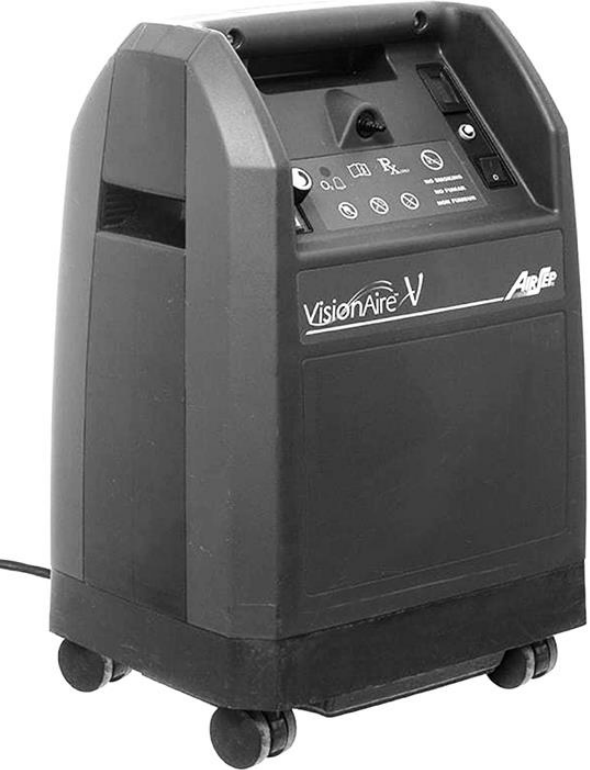
- Trigger sensor delivers breaths based on inhalation and customizes oxygen delivery to breath rate, flow, and size
- The amount delivered is measured in a bolus as milliliters per breath: settings are not based on standard L/min delivered
- Can run on battery: LOT depends on flow
- Conserves more oxygen than other delivery devices
- Portable and light weight/smaller in size
- **Typically, does not support prescribed flow of >3L**
- **Prescribed flow \neq Pulse dose setting**



Pulse Flow 

Continuous Flow 

Continuous Flow Concentrator



Continuous Flow Concentrator

- Continuous flow based directly on prescription in L/min
- Can support higher FIO₂ demand up to 10L continuous
- Can be paired with an oxymizer to reduce consumption
- To be used with CPAP machines
- Stationary (or transportable)



Model	Type	Weight	Flow (Continuous/Pulse)	Battery Life
Inogen One G5	Portable Pulse-dose	4.7 lb (single), 5.7 lb (extended)	Pulse 1–6	Single: up to 6.5 h; Double: up to 13 h
Philips SimplyGo	Portable Both	10 lb	Continuous: 0.5–2 L/min; Pulse 1–6	~3 h pulse; ~0.9 h continuous
SeQual eQuinox	Portable Both	14 lb	Continuous: 0.5–3 L/min; Pulse 1–9	12-cell: ~1.2 h cont / ~2.7 h pulse; 24-cell: ~2.75 h / ~5.9 h
CAIRE Companion 5	Stationary Continuous	36 lb	0.5–5 L/min	No battery
Invacare Platinum 10	Stationary Continuous	54 lb	2–10 L/min	No battery

Oxygen Tanks

- Continuous flow rate up to 15L/min with a regulator
- No electricity needed
- Used for mobility and will have a stationary concentrator at home
- May ask for different sized tanks
- (Offered a large tank for power outages)

- Heavy with *limited* mobility*
- Fixed amount and require refills
- Math skills required



Liquid Oxygen

- Stationary reservoirs and portable devices
- More efficient than concentrators
- Continuous flow supported up to 15L
- Lighter and more portable than tanks
- No electricity needed

- Requires refills
- Education required (-297°F)



Liquid Oxygen

- **How does it work?**

- Extremely low boiling point
- Kept in a container to insulate and prevent leakage
- Warmed back into a gaseous state and can provide continuous flow
- 1L of liquid oxygen = 860L of oxygen in gaseous form
 - 4L/min flow = 3.6 hours with portable liquid O₂
 - 4L/min flow = 2.8 hours with a full E Tank



Home Oxygen Eval: How does it work?

1. Patient with saturation $\leq 88\%$ or $\text{PaO}_2 \leq 55\text{mmHg}$ at rest on room air (or unable to wean to room air)
2. Oxygen eval order placed
3. RT (maybe) to assess patient and write results in a note
4. Case management writes the prescription order for the doctor to sign
5. Doctor signs
6. Case management sends to home care
7. Home care may or may not have an RT setting them up



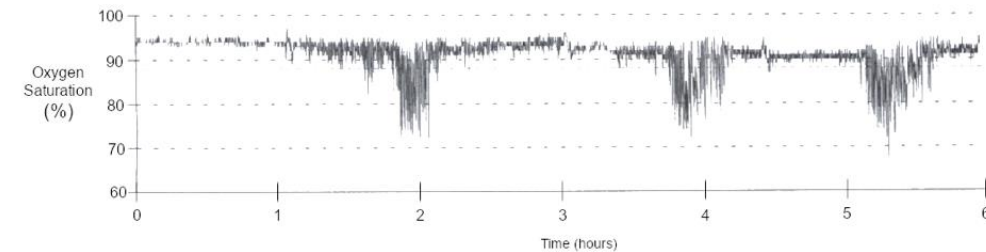
Increased Oxygen Demand

- **Patient needs new oxygen prescription**
 - Home care company needs to know the new oxygen demand.
 - Does the current delivery system support the patient getting home safely?
 - Will they require a new oxygen delivery system?
- **Patient education**
 - Discuss and educate around any changes for the patient.
 - Delivery devices, new interfaces, new flows
 - Your knowledge and educating can get the patient home safely, prevent readmissions, and delayed discharges



Overnight Oximetry



- Nocturnal oxygen test only qualifies them for nighttime oxygen
 - It does not mean they have a script for daytime
- Cannot be done on CPAP to qualify for bleed in O2, that must be done in a polysomnography
- Qualifying:
 - Patient must display oxygen saturation $\geq 89\%$ while awake
 - $\leq 88\%$ displayed while sleeping
 - Must be worn for minimally 2 hours
 - Wearing previously prescribed oxygen flow



- 75y/o Female with pmh of IPF status post VATS lung biopsy in 2020
- Esbriet therapy since 2021 and CT showing interval mild progression of diffuse pulmonary fibrosis in 2024
- followed by Dr. Kaminsky 2L of oxygen but recently increased to 3L
- direct admit for workup on worsening dyspnea on exertion
- CT scan was performed last night that shows progression of disease with more diffuse IPF
- Infectious workup so far has been negative
- 75 years old but still very active

RECOMMENDATIONS

- Continue with Morphine for air hunger and follow up palliative care
- Please place on humidified oxygen and consider Oxymizer nasal cannula
- Follow up sputum cultures
- FU with Dr. Kaminsky (Pulmonary) in 4-6 weeks

	0903
Vitals	
Heart Rate	79
Resp	18
SpO2	92
Oxygen Therapy/Pulse Ox	
O2 Flow Rate (L/min)	4
O2 Flow Rate (cc)	
Oxygen Device Setup	
 O2 Device	Oxymizer
FIO2 %	
Air Flow Rate (L/min)	
Respiratory	
Initial Consult	
 Assessment Type	Evaluation
Eval complete?	Yes
Respiratory Pattern	Regular
Chest Assessment	Chest expansion symmetrical
Breath Sounds Bilateral	Fine crackles; Diminished
Breath Sounds Right	
Breath Sounds Left	

PCP: Sarah E Vredenburg

Expiration Date: 11/15/25

Inpatient Evaluation (results were reported within the two days before discharge).

Oxygen improves the hypoxemia that was demonstrated during exercise while on room air.

Date: 11/13/25

Time: 0930

EXERCISE EVALUATION:

O2 Sat on room air at rest: 82%

O2 Sat during exercise on room air:

O2 Sat during exercise with oxygen: Sat 90% @ 6 lpm Oximzyer

If prescribed liter flow rate will be greater than or equal to 4lpm, O2 Sat must be documented on 4lpm before proceeding to higher FIO2

@ 4lpm O2 Sat = 83%

Recommendations: 6 LPM oxymizer

AT REST EVALUATION:

O2 sat on room air taken at rest (awake).

Recommendations: 4 LPM oxymizer

Discuss...

Case 1

What delivery system is best for your patient?

Oxygen
demand

Disease
process

Lifestyle

Home
setting

RT Intervention Post Oxygen Eval

- Assess home device if they have one in the hospital
- Determine if they have a concentrator and if it's a pulse dose
- Recognize that an oxymizer requires continuous flow
- Recognize that pulse dose concentrators don't typically support >3L of flow

- State recommendations in the note
- Educate patient

Oxygen Demand:

- Patient was told she could use her pulse dose concentrator
- Patient was discharged on her concentrator on setting of 3 with oxymizer to get her home
- Patient was told she could use her new pulse concentrator that has a max setting of 6 once she got home

Disease Process:

- Patient has a progressive lung disease

Lifestyle:

- Very active

74 y.o. male with a pmhx notable for COPD, severe OSA, pulmonary HTN, severe TR, HFpEF, PAD, CAD (s/p PCI to LAD), HLD, atrial fibrillation, recent hospitalization for suspected UGIB, T2DM, CKD3, who presented to UVMHC for symptomatic hypotension s/p pressors and IVF boluses at PMC. Current presentation believed to be iso of over-diuresis resulting in AKI, with co-occurring R-sided HF.

- Has been requiring 6L/min in hospital
- Currently has 3L/min at home with a portable pulse dose concentrator
- Has his portable concentrator with him
- Home oxygen evaluation ordered prior to discharge

Discuss...

Home Oxygen Evaluation

PCP: Julie Anne Anderson

Expiration Date: 11/28/2025

Inpatient Evaluation (results were reported within the two days before discharge).

Oxygen improves the hypoxemia that was demonstrated during exercise while on room air.

Date: 11/26/2025

Time: 1015

EXERCISE EVALUATION:

O2 Sat on room air at rest: NA aest started on prescribed 3 liters

O2 Sat during exercise on room air: NA

O2 Sat during exercise with oxygen: Sat 90 @ 6 lpm Nasal Cannula

If prescribed liter flow rate will be greater than or equal to 4lpm, O2 Sat must be documented on 4lpm before proceeding to higher FIO2

@ 4lpm O2 Sat = 85

Recommendations: 6 liters

AT REST EVALUATION:

O2 sat on room air taken at rest (awake).

Recommendations: 6 liters PT will need 6 liters at all times.
PT will need tanks in the home. Does not qualify for a pulse dosing device.

How RT Smooths Transition Home

- Patient will need tanks
- Stated in recommendations on note
- Potentially could have delayed discharge
- Potentially could have sent the patient home to an unsafe situation
- Clear instructions for case management

“The very basic discussion of “pulse oxygen” vs. “continuous oxygen” never occurred and the downstream impact was life-threatening”

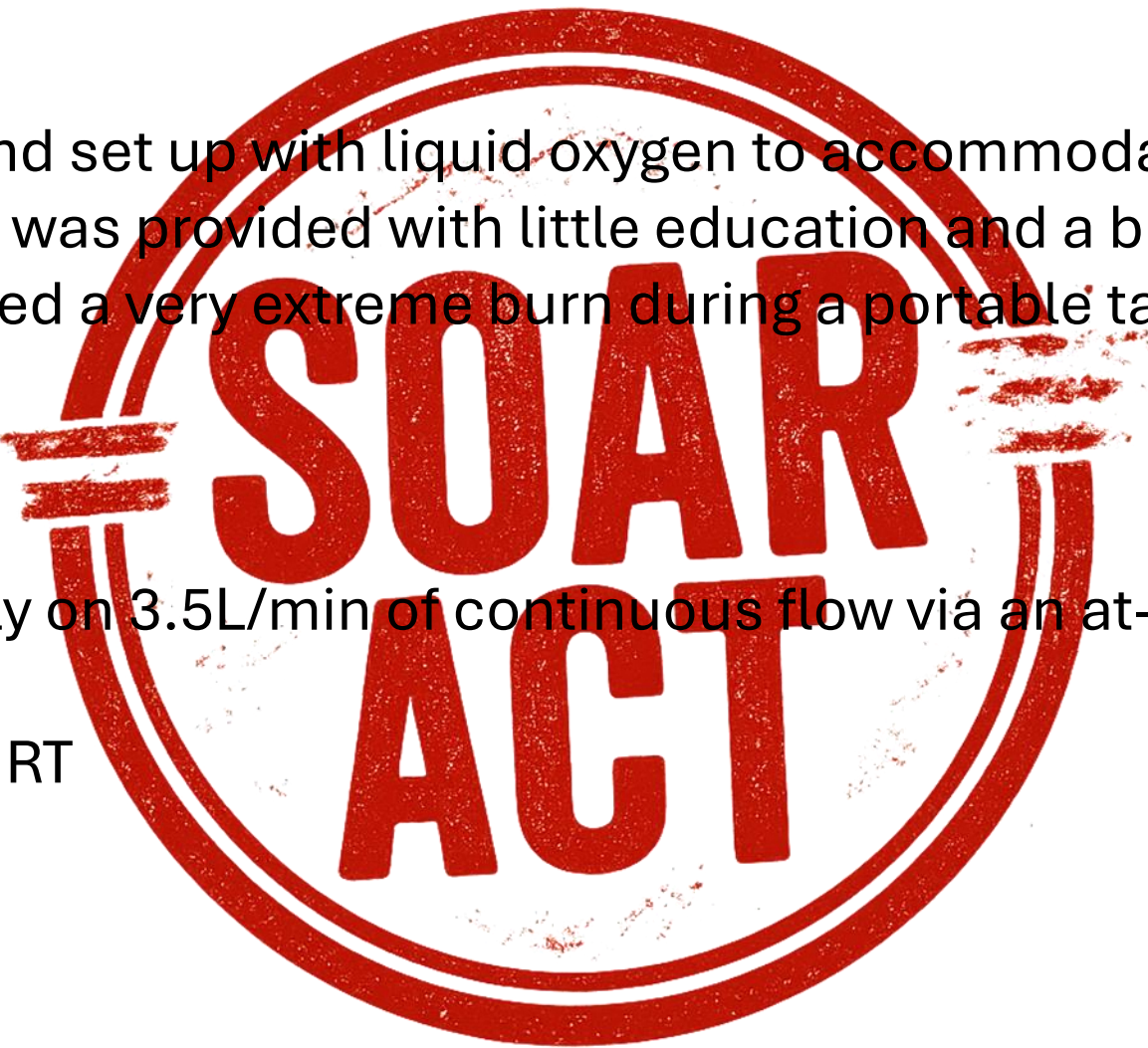


Case 3

- Patient hospitalized and discharged with new, increased oxygen demand from previous baseline.
- Sent home with her *pulse* activated concentrator, which did not meet her new demand.
- O2 sat was 70% requiring a call to EMS who was also unknowledgeable about concentrators and oxygen delivery in a home setting
- Another trip to the hospital



Case 3

- 
- A large, circular red stamp with the words "SOAR" and "ACT" stacked vertically in the center. The stamp has a distressed, ink-like texture and is surrounded by horizontal brush strokes on the left and right sides.
- Discharged and set up with liquid oxygen to accommodate her demand
 - Liquid oxygen was provided with little education and a broken connector
 - Patient received a very extreme burn during a portable tank refill
 - EMS called

 - She's currently on 3.5L/min of continuous flow via an at-home high flow concentrator
 - Never saw an RT

Case 3

Non-Invasive Ventilatory Support

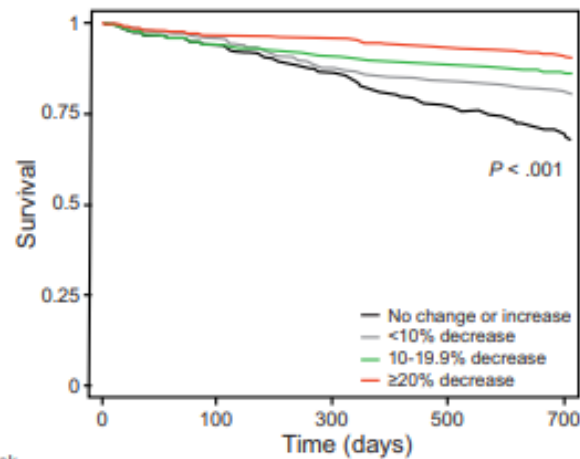
- Respiratory Assist Devices (RAD)
- **Non-obstructive processes**
- **Patient Populations**
 - COPD*
 - Restrictive Thoracic Disorder*
 - Neuromuscular weakness
 - Thoracic cage abnormality
 - Obesity Hypoventilation
 - Central or Complex Sleep Apnea

Non-Invasive Ventilatory Support

Lowering P_{CO_2} With Noninvasive Ventilation Is Associated With Improved Survival in Chronic Hypercapnic Respiratory Failure

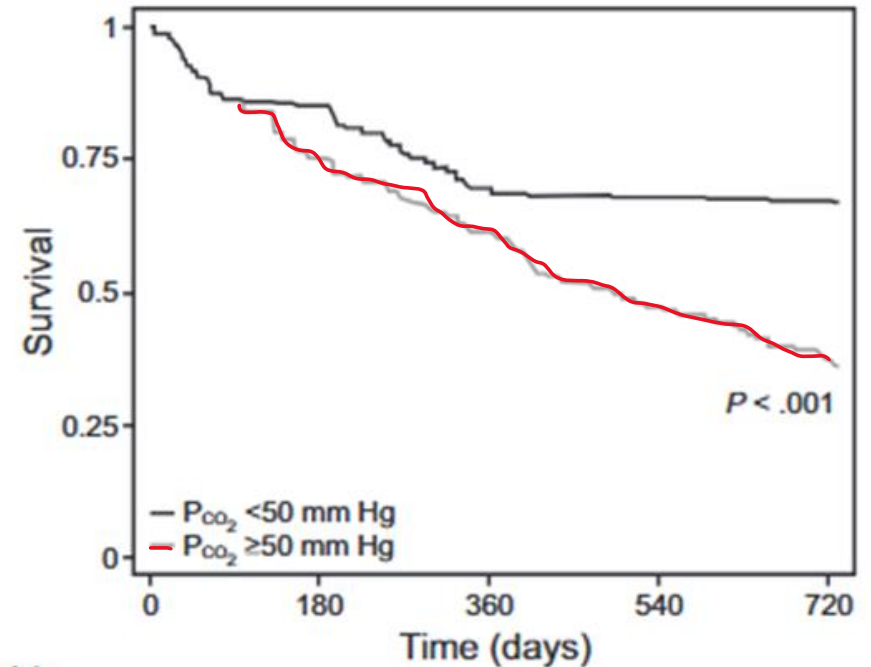
Jose Victor Jimenez, Jason Ackrivo, Jesse Y Hsu, Mathew W Wilson, Wassim W Labaki, John Hansen-Flaschen, Robert C Hyzy, and Philip J Choi

Respiratory Care Nov. 2023



Number at risk	0	100	300	500	700
No change or increase	82	65	54	41	30
<10% decrease	43	42	42	35	27
10-19.9% decrease	81	77	73	65	59
≥20% decrease	131	129	126	117	107

Fig. 2. Two-year survival by the percentage of P_{CO_2} change for the entire cohort of subjects who were hypercapnic. The model was adjusted for age, sex, body mass index, race, Charlson comorbidity index, primary diagnosis, and initial P_{CO_2} . Likelihood ratio test of equality, $P \leq .001$.



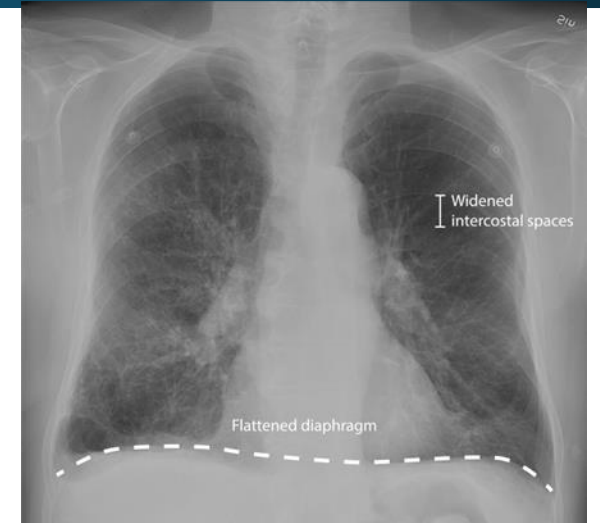
Number at risk	0	180	360	540	720
$P_{CO_2} < 50$ mm Hg	230	224	212	195	176
$P_{CO_2} \geq 50$ mm Hg	107	89	76	63	47

Fig. 3. Two-year survival by absolute P_{CO_2} higher on < 50 mm Hg for the entire cohort of subjects who were hypercapnic. The model was adjusted for age, sex, body mass index, race, Charlson comorbidity index, primary diagnosis, and initial P_{CO_2} . Likelihood ratio test of equality, $P \leq .001$.

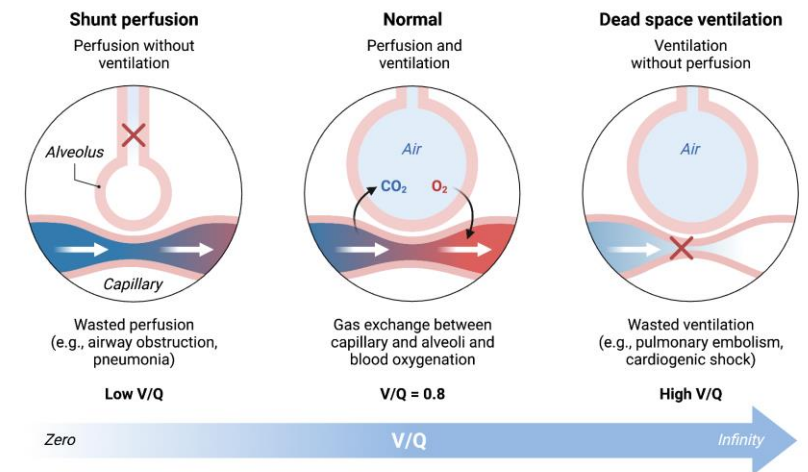
Nocturnal Vent Support: COPD

- **Respiratory Failure**

- V/Q mismatch
- Hypoventilation: Respiratory muscle weakness
 - Change in the diaphragm caused by hyperinflation
 - Compromised nutrition
 - Presumed 'exhaustion'



Ventilation-Perfusion Ratio (V/Q)



Nocturnal Vent Support: COPD

Clinical Trial > JAMA. 2017 Jun 6;317(21):2177-2186. doi: 10.1001/jama.2017.4451.

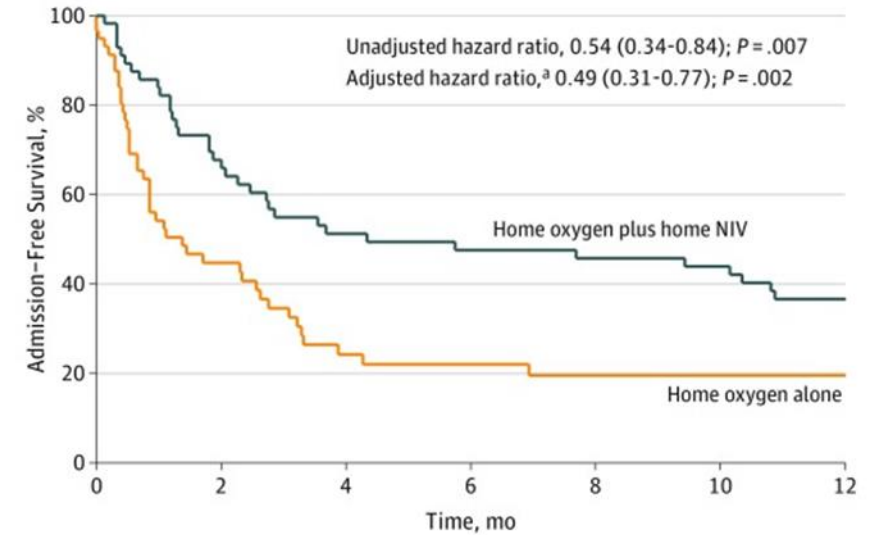
Effect of Home Noninvasive Ventilation With Oxygen Therapy vs Oxygen Therapy Alone on Hospital Readmission or Death After an Acute COPD Exacerbation: A Randomized Clinical Trial

Patrick B Murphy¹, Sunita Rehal², Gill Arbane³, Stephen Bourke⁴, Peter M A Calverley⁵, Angela M Crook², Lee Dowson⁶, Nicholas Duffy⁷, G John Gibson⁸, Philip D Hughes⁹, John R Hurst¹⁰, Keir E Lewis¹¹, Rahul Mukherjee¹², Annabel Nickol¹³, Nicholas Oscroft¹⁴, Maxime Patout³, Justin Pepperell¹⁵, Ian Smith¹⁴, John R Stradling¹³, Jadwiga A Wedzicha¹⁶, Michael I Polkey¹⁶, Mark W Elliott¹⁷, Nicholas Hart¹

Affiliations + expand

PMID: 28528348 PMCID: PMC5710342 DOI: 10.1001/jama.2017.4451

Results: A total of 116 patients (mean [SD] age of 67 [10] years, 53% female, mean BMI of 21.6 [IQR, 18.2-26.1], mean [SD] forced expiratory volume in the first second of expiration of 0.6 L [0.2 L], and mean [SD] Paco₂ while breathing room air of 59 [7] mm Hg) were randomized. Sixty-four patients (28 in home oxygen alone and 36 in home oxygen plus home NIV) completed the 12-month study period. The median time to readmission or death was 4.3 months (IQR, 1.3-13.8 months) in the home oxygen plus home NIV group vs 1.4 months (IQR, 0.5-3.9 months) in the home oxygen alone group, adjusted hazard ratio of 0.49 (95% CI, 0.31-0.77; P = .002). The 12-month risk of readmission or death was 63.4% in the home oxygen plus home NIV group vs 80.4% in the home oxygen alone group, absolute risk reduction of 17.0% (95% CI, 0.1%-34.0%). At 12 months, 16 patients had died in the home oxygen plus home NIV group vs 19 in the home oxygen alone group.



No. at risk	0	2	4	6	8	10	12
Home oxygen plus home NIV	57	37	28	26	25	24	16
Home oxygen alone	59	23	11	10	8	8	6

Nocturnal Vent Support: COPD

- **Who: Chronic stable hypercapnia**
 - PaCO₂ ≥52mmHg baseline
 - Oxygen desaturation while sleeping ≤88%
 - History of COPD hospital admission requiring NIV



Nocturnal Vent Support: COPD

- **How to qualify for hospital discharge (RAD)**
 1. ABG done while awake on prescribed oxygen
 - PaCO₂ ≥52mmHg
 2. Sleep apnea is not the predominant cause of hypercarbia
 - No sleep study needed
 3. Required BIPAP or vent usage within 24 hours pre-discharge
 4. Treating clinician determines the patient is at risk of rapid symptom exacerbation or rise in CO₂ after discharge

Nocturnal Vent Support: COPD

- **Qualifying missteps**

- VBG vs ABG
- Obtaining ABG while patient is on a CPAP/BIPAP or while sleeping
- Not identifying patients that could benefit from this

Does this patient qualify?

Hospital Problems

[Comment](#)

Hospital Problems

Date Reviewed: 12/5/2025

	Priority	Class	Noted
Acute hypoxic respiratory failure (HCC-CMS)	Medium		11/14/2023
Advance care planning	Medium		1/14/2026
Atrial fibrillation with RVR (HCC-CMS)	Medium		1/10/2026
◆ COPD exacerbation (HCC-CMS)	Medium		1/9/2026
Palliative care by specialist	Medium		1/14/2026

Nurse To Nurse Sticky Notes

[Comment](#)

PMHx COPD (home 3.5-4L), HFpEF, Lung CA (radiation 2024), Afib (not on anticoag, or rate control meds), former ETOH disorder

1/9: Admit for COPD exacerbation. Also Afib RVR, dilt bolus in ER, then dilt PO.

1/11: tx to ICU for worsening somnolence, hypercarbia requiring BiPAP

1/12: back to floor. Eliquis started.

1/13: back to ICU for BiPAP requirement. Afib RVR, amio bolus/gtts, back to dilt PO.

1/15 (transfer to floor order)

Last edited by Sangha, Sangay, RN on 01/15/26 at 0129

Case

- 71 y.o.male with a PMHx of **severe COPD, OSA**, evidence of RV systolic dysfunction possibly 2/2 PHTN, **cirrhosis**, which are all likely contributing to acute on chronic hypercapnic and hypoxemic respiratory failure. Nocturnal and rescue **BiPAP is imperative for his safety and well being at this point**. His bicarbonate on BMP is 44, **pH is compensated on venous blood gas even with a pCO₂ ~100** which indicates that this is a chronic issue. He appears to have responded well to diuresis from a respiratory standpoint. We are providing him triple therapy via nebulizer treatments.
- Patient was placed on BPAP during this admission for persistent hypercapnia, with multiple frequent COPD exacerbations despite using with excellent compliance of his auto CPAP at home.
- Patients **OSA, hypoxemia and hypercapnia are not well controlled on his current CPAP settings**, this is evident with his blood gas analysis showing evidence of hypercapnia (PCO₂ >100 mmHg) . **He also has evidence of CPAP intolerance, and expressed better tolerance to BPAP.**
- Additionally he **has needed BPAP support during this admission continuously for 24 hours**, with intermittent breaks for feeding.
- Based on the above information he will **significantly benefit from a BPAP S**. We will initiate the qualification process while he is admitted.
- He will **benefit from the current settings:**
 - Auto BPAP :
 - IPAP max 20 cm of water
 - EPAP 8 cm of water
 - PS 10 cm of water
- Continue FFM as he does at home
- Follow up in the NIV clinic - Pulmonary .

Case

- **How to qualify for hospital discharge (RAD)**
 1. ABG done while awake on prescribed oxygen
 - PaCO₂ ≥52mmHg
 2. Sleep apnea is not the predominant cause of hypercarbia
 - No sleep study needed
 3. Required BIPAP or vent usage within 24 hours pre-discharge
 4. Treating clinician determines the patient is at risk of rapid symptom exacerbation or rise in CO₂ after discharge

01/13/2026 @ 1306

94 [▲]	O2 Saturation, Venous
7.39	pH, Venous
73 [▲]	PCO2, Venous
71 [▲]	PO2, Venous
46 [±]	tCO2, Venous
15.60 [▲]	Base Level

Case

01/16/2026 @ 1445

7.41 *	pH, Arterial, i-STAT
72 ^ *	PCO2, Arterial, i-STAT
65 v *	pO2, Arterial, i-STAT
48 ^ *	TCO2, Arterial, i-STAT
91 v *	O2 Saturation, Arterial, i-STAT
18 ^ *	Base Excess(+) / Deficit(-), Arterial...

Case

Nocturnal Vent Support: COPD

- **Goals**

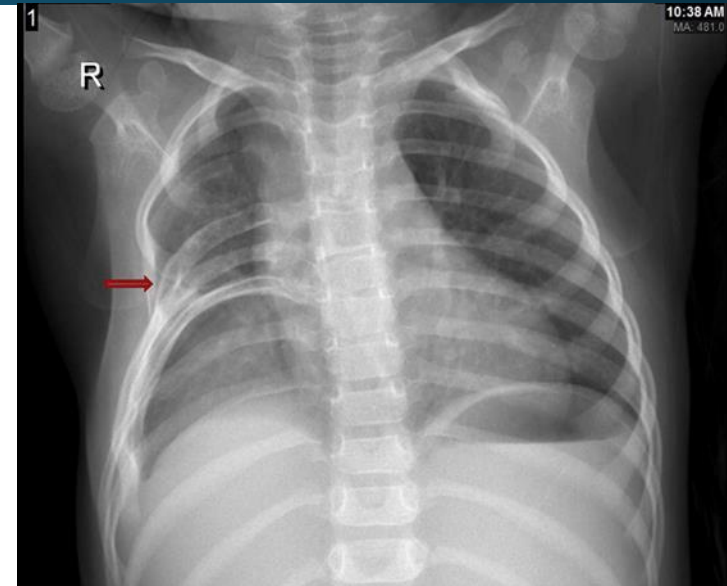
- Initiation in hospital or sleep lab so patient can be monitored
- Support ventilation without increasing air trapping
- Decreased PaCO₂ <50cmH₂O

- No specific data supporting volume target vs pressure target
- Increased volumes or delta P show reduced readmission when IPAP was “high” (25-30cmH₂O) and PEEP 5cmH₂O

Nocturnal Vent Support: Neuromuscular Disease or thoracic cage abnormality

- **Respiratory Failure: Chronic**

- V/Q mismatch
- Respiratory muscle weakness: Hypoventilation
 - Progressive neuromuscular disorder



Nocturnal Vent Support: Neuromuscular Disease or thoracic cage abnormality

- **How to qualify (RAD)**


1. Documentation of specific disease in medical record
2. Respiratory muscle weakness (neuromuscular disease only)
 - FVC <50% predicted **OR**
 - MIP <60cmH₂O
2. **OR** Chronic Hypoventilation
 - ABG while awake on prescribed oxygen PaCO₂ ≥45mmHg
2. **OR** Oxygen saturation nocturnal
 - Oxygen desat ≤88% minimal recording time 2hrs
3. COPD does not contribute to pulmonary limitations

Nocturnal Vent Support: Neuromuscular Disease or thoracic cage abnormality

- **Goals: Specific to disease**
 - Increasing FVC
 - Reduce symptomatic hypercapnia
 - Improve sleep efficiency
 - Prolonged survival

Nocturnal Vent Support: Neuromuscular Disease or thoracic cage abnormality

Impact of an early respiratory care programme with non-invasive ventilation adaptation in patients with amyotrophic lateral sclerosis

M. Vitacca^a , A. Montini^a, C. Lunetta^b, P. Banfi^c, E. Bertella^a, E. De Mattia^b, A. Lizio^b, E. Volpato^{c,d}, A. Lax^c, R. Morini^e and M. Paneroni^a on behalf of the ALS RESPILOM Study Group[†]

European Journal of Neurology, 2017

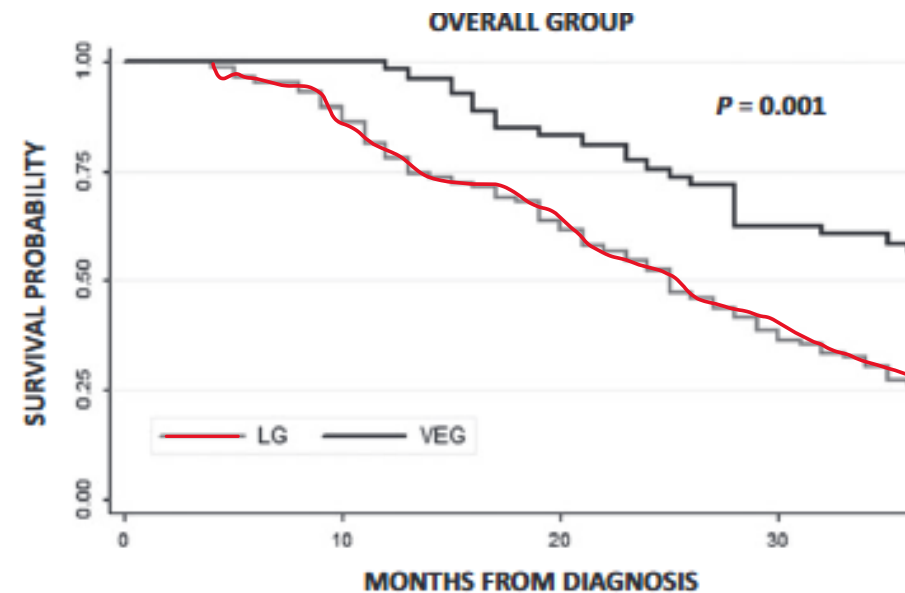


Figure 1 Time from ALS diagnosis to death (in months) for all patients. LG, late group; VEG, very early group.



Supplemental Oxygen Access Reform (SOAR) Act Overview

Improving patient access to essential oxygen
therapies

H.R. 2902

Challenges Under Current System

- **Reduced Access to Liquid Oxygen**
 - Competitive bidding caused an 80% decline in liquid oxygen use, limiting patient access to vital oxygen modalities.
- **Inefficient Oxygen Alternatives**
 - Patients rely on heavy tanks or portable concentrators that often fail higher flow oxygen demands.
 - Limiting their mobility and quality of life.
- **Education Access**
 - Many DME companies do not have a respiratory therapist on staff to help assess and educate patients.
- **Language And Terminology**
 - The term “home oxygen” indicates a patient only needs it at home.



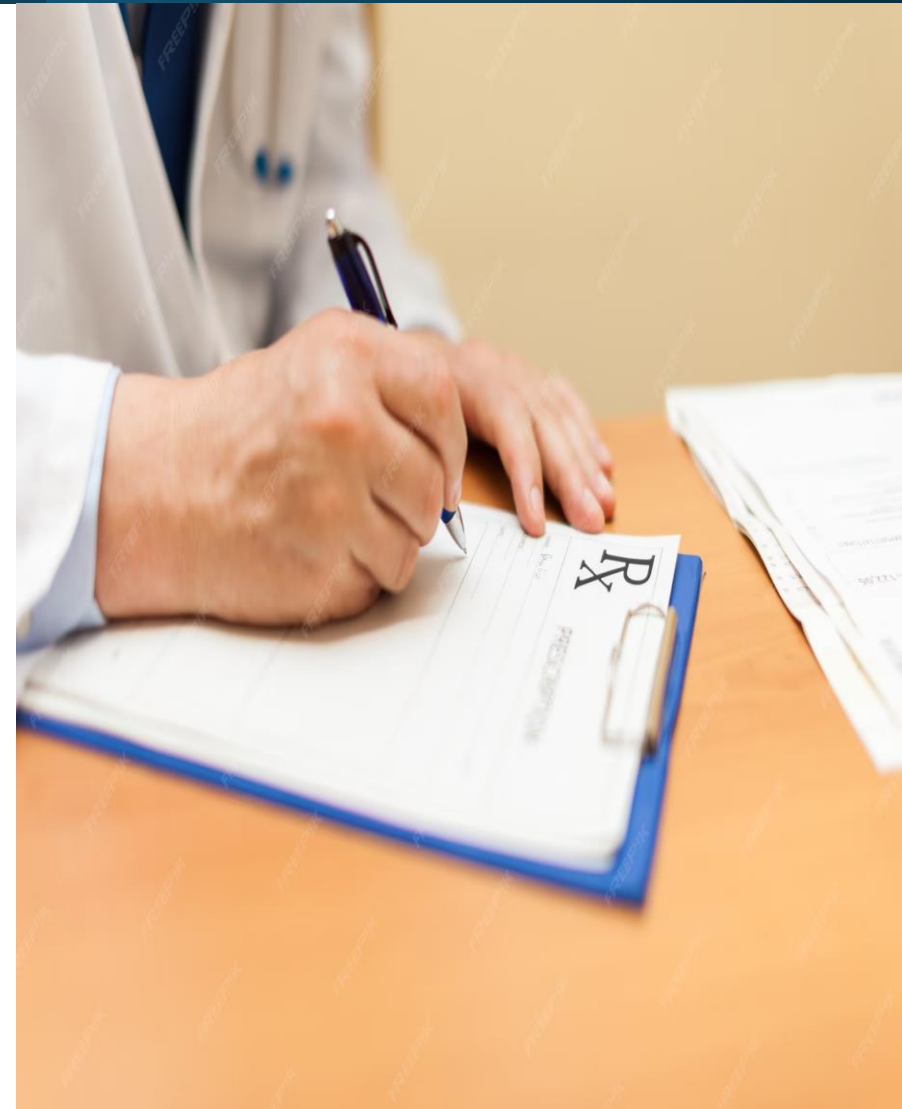
Purpose of the SOAR Act

- **Improving Oxygen Access**
 - Aims to improve access to supplemental oxygen for Medicare beneficiaries by reforming payment structures.
 - Equitable access to various oxygen modalities including liquid and portable oxygen systems.
- **Supporting Respiratory Therapists**
 - Recognizes and supports the critical role of respiratory therapists in patient care and oxygen management.
 - Reducing hospital congestion and increasing patient satisfaction.
- **Ensuring Patient-Centric Mentality**
 - Establishes patient rights to ensure choice, transparency, and timely respiratory support.
 - Change “home” to “supplemental” oxygen ensuring a life outside of home
- **Strengthen Fraud and Abuse Protections**
 - Standardized documentation requirements.



Title I – Beneficiary Access

- **Ensuring Beneficiary Access**
 - Protects patient access by removing oxygen equipment from Medicare's Competitive Acquisition Program.
- **Adequate Reimbursement**
 - Sets proper reimbursement, including special provisions for liquid oxygen to support patient needs.
- **Comprehensive Patient Evaluations**
 - Mandates thorough patient evaluations by RTs to determine the most suitable oxygen therapy modality.
- **Supplier Responsibilities**
 - Suppliers must provide equipment education, safety checks, and 24-hour on-call support for patient safety.



Title II – Respiratory Therapist Services

- **Role of Respiratory Therapists**

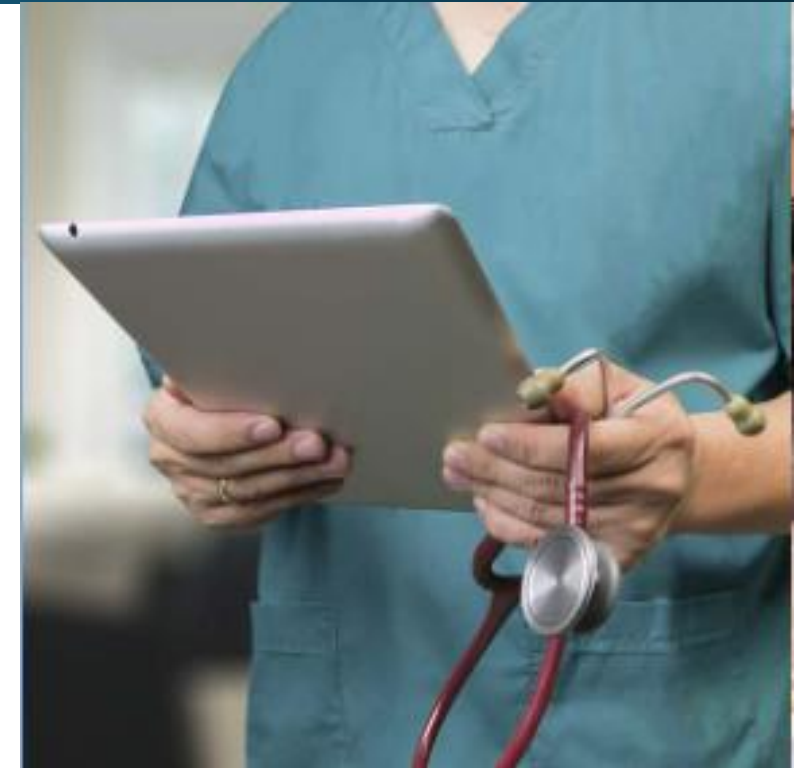
- Play a critical role in managing oxygen-dependent patients and ensuring proper care.

- **Medicare Reimbursement**

- The SOAR Act introduces Medicare reimbursement for respiratory therapist services, acknowledging their vital contributions.

- **Patient Education and Safety**

- Respiratory therapists provide essential patient education and safety oversight to optimize therapy outcomes and reduce complications.



Support and Progress

- **Bipartisan Legislation Support**

- The SOAR Act received strong bipartisan backing from both chambers of Congress in 2021 and 2022 sessions.

- **Advocacy By Medical Organizations**

- Leading groups like American Lung Association, AARC, and the COPD foundation advocated strongly for the SOAR Act to improve oxygen therapy access.
- *And your own VT/NH Society for Respiratory Care*

- **Advocacy By You**

- Be an AARC member



**SOAR
ACT**



Respiratory Care Fly-In 2025



In Summary

- Oxygen delivery devices
 - Different devices support oxygen demands, diseases, and lifestyles
 - Get your patient home safely
- Overnight oximetry tests
 - Used to assess for nocturnal oxygen demand
 - Does not qualify for NIV bleed-in, may be done in conjunction with NIV qualifications
- Non-obstructive NIV
 - Prolongs life and reduces re-admission time
 - Qualifications are specific to disease, documentation must be clear
- SOAR Act
 - Patient access and quality of life
 - Your career recognized

Citations

- *Home-Based Noninvasive Positive Pressure Ventilation to Treat Chronic Respiratory Failure due to Chronic Obstructive Pulmonary Disease Related Change Request (CR) Information Title: Noninvasive Positive Pressure Ventilation (NIPPV) in the Home for the Treatment of Chronic Respiratory Failure (CRF) Consequent to Chronic Obstructive Pulmonary Disease (COPD)*. Accessed March 31, 2026. <https://www.cms.gov/files/document/mm14177-home-based-noninvasive-positive-pressure-ventilation-treat-chronic-respiratory-failure-due.pdf>
- Jimenez, J. V., Ackrivo, J., Hsu, J. Y., Wilson, M. W., Labaki, W. W., Hansen-Flaschen, J., Hyzy, R. C., & Choi, P. J. (2023). Lowering PCO₂ With Noninvasive Ventilation Is Associated With Improved Survival in Chronic Hypercapnic Respiratory Failure. *Respiratory Care*, 68(12), 1613–1622. <https://doi.org/10.4187/respcare.10813>
- *Medicare National Coverage Determinations Manual Chapter 1, Part 4 (Sections 200 -310.1) Coverage Determinations*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf
- Murphy, P. B., Rehal, S., Arbane, G., Bourke, S., Calverley, P. M. A., Crook, A. M., Dowson, L., Duffy, N., Gibson, G. J., Hughes, P. D., Hurst, J. R., Lewis, K. E., Mukherjee, R., Nickol, A., Oscroft, N., Patout, M., Pepperell, J., Smith, I., Stradling, J. R., ... Hart, N. (2017). Effect of Home Noninvasive Ventilation With Oxygen Therapy vs Oxygen Therapy Alone on Hospital Readmission or Death After an Acute COPD Exacerbation: A Randomized Clinical Trial. *JAMA : The Journal of the American Medical Association*, 317(21), 2177–2186. <https://doi.org/10.1001/jama.2017.4451>
- Nocturnal ventilatory support in COPD: UpToDate, [Peter C Gay, MD](#)
- Noninvasive ventilation in adults with chronic respiratory failure from neuromuscular and chest wall diseases: Patient selection and alternative methods of ventilatory support UpToDate AUTHORS: [Nicholas S Hill, MD](#) [Naomi R Kramer, MD](#)
- Oxygen & Oxygen Equipment | CMS. Cms.gov. Published 2024. <https://www.cms.gov/training-education/medicare-learning-network-mln/compliance/medicare-provider-compliance-tips/oxygen>
- Respiratory muscle weakness due to neuromuscular disorder: Management: [Scott K Epstein, MD](#), [Jason Ackrivo, MD, MSCE](#)
- Vitacca, M., Montini, A., Lunetta, C., Banfi, P., Bertella, E., De Mattia, E., Lizio, A., Volpato, E., Lax, A., Morini, R., & Paneroni, M. (2018). Impact of an early respiratory care programme with non-invasive ventilation adaptation in patients with amyotrophic lateral sclerosis. *European Journal of Neurology*, 25(3), 556-e33. <https://doi.org/10.1111/ene.13547>