AARC Home Oxygen Survey

The American Association for Respiratory Care (AARC), with the support of patient support groups and home medical equipment providers, is conducting a survey about oxygen services that are being provided in the home. If you use oxygen in the home, please take a few minutes to this survey. The results of the survey will be published on the AARC's web site (www.aarc.org) when it is completed.

Demographics:

1. Age ☐
2. Gender ☐ Male ☐ Female
3. Five-Digit ZIP Code ☐

1. My equipment is being provided by (select one):
    a. A national provider (Apria, Lincare, Rotech, American Home Patient or provider with locations in most states)
    b. A regional provider (Provider has locations in more than one state but not in most)
    c. A local provider (Provider has locations just in my area)
    d. I'm not sure

2. Equipment
    a. What type of respiratory equipment do you currently have in your home?
        1. Oxygen System (select all that apply):
            1. Oxygen concentrator
            2. Liquid oxygen stationary
            3. Large oxygen tanks (usually green in color)
            4. Trans-filling oxygen concentrator (a system that fills portable tanks)
            5. Portable oxygen concentrator (a system with rechargeable battery)

        2. Portable Oxygen System (select all that apply):
            1. Portable oxygen tanks (cylinders) with a "conserving" device (pulsed oxygen delivery)
            2. Portable oxygen tanks (cylinders) without a "conserving" device (pulsed oxygen delivery)
            3. Liquid oxygen portable with a "conserving" device (pulsed oxygen delivery)
            4. Liquid oxygen portable without a "conserving" device (pulsed oxygen delivery)
            5. Portable oxygen concentrator (a system with rechargeable battery)

        3. Inhaled Medication Delivery (select all that apply):

1. Inhalers (metered dose, dry powder, spin-haler, etc.)
2. Nebulizer (AC powered only)
3. Nebulizer (AC and DC powered)

4. Other Respiratory Equipment (select all that apply):
    1. Oximeter
    2. CPAP
    3. BiPAP for sleep apnea
    4. BiPAP for a condition other than sleep apnea
    5. Ventilator
    6. Mucus clearance devices – Vest, IPV, percussor

5. How many months have you been on oxygen therapy (select one)?
    1. 0-6 months
    2. 7-12 months
    3. 13-24 months
    4. 25-36 months
    5. More than 36 months

6. Have you ever purchased any respiratory equipment on your own, that is the equipment was not covered at all by your insurance and that you paid for all of it with your own money?
    1. Yes
    2. No

3. Oxygen usage
    a. When do you use your oxygen (select all that apply)?
        1. At rest during the day
        2. When active, i.e. walking, outside activities, etc.
        3. When sleeping

    b. When did your doctor tell you to use your oxygen (select all that apply)?
        1. At rest during the day
        2. When active, i.e. walking, outside activities, etc.
        3. When sleeping
        4. I'm not sure

    c. What liter flow do you use when you are:
        i. At rest during the day (select one)
            a. 1 or less
            b. 2-3
            c. More than 3
            d. I don't use it when resting

        ii. Active, i.e. walking, outside activities, etc. (select one)

a. 1 or less
b. 2-3
c. More than 3
d. I don't use it when active

iii. When sleeping (select one)
a. 1 or less
b. 2-3
c. More than 3
d. I don't use it when sleeping

a) What liter flow did your doctor tell you to use?
i. At rest during the day (select one)
a. 1 or less
b. 2-3
c. More than 3
d. My doctor did not tell me to use oxygen at rest
e. Not sure

ii. When active, i.e. walking, outside activities, etc.
a. 1 or less
b. 2-3
c. More than 3
d. My doctor did not tell me to use oxygen when active
e. Not sure

iii. When sleeping
a. 1 or less
b. 2-3
c. More than 3
d. My doctor did not tell me to use oxygen when sleeping
e. Not sure

4. Clinical Services
a. When you first started using oxygen, who <u>delivered</u> your <u>oxygen</u> equipment?
i. Delivery technician
ii. Respiratory therapist
iii. Nurse
iv. Other licensed health care provider
v. Not sure/don't remember

b. How often have you been visited by a clinician (respiratory therapist, nurse) from your equipment provider? Do not include visits from Home Health Agencies.
    I. At least once a month
    II. At least every three months
    III. At least every six months
    IV. At least once a year
    V. Never
    VI. Not sure

c. When a clinician (respiratory therapist, nurse) from your equipment provider services did they provide? Do not include visits from Home Health Agencies (select all that apply).
    I. Check equipment
    II. Asked questions about my health
    III. Performed physical assessment (listened to lungs, checked blood pressure)
    IV. Provided clinical education (e.g., how to breath, cough, eat, etc.)
    V. I have not been visited by a clinician/not sure

d. Have you been provided with any educational materials about your respiratory condition or health (not including instructions about how to use your equipment) from your home medical equipment provider?
    I. Yes
    II. No
    III. Not sure

e. The <u>first time</u> that you went home on oxygen did the hospital provide you with any educational materials about your respiratory condition or health (not including instructions about how to use your equipment from your home medical equipment provider)?
    IV. Yes
    V. No
    VI. Not sure

5. Health Outcomes (Hospitalization/Readmissions)
    1. **<u>For your breathing problems</u>**: How many planned (i.e. check-up) doctor visits have you made in the past 12 months?
        1. None
        2. 1-2 times
        3. 3-4 times
        4. More than 4 times

    2. **<u>For your breathing problems</u>**: How many unplanned (i.e. got sick) doctor visits have you made in the past 12 months?
        1. None
        2. 1-2 times
        3. 3-4 times
        4. More than 4 times

3. **For your breathing problems**: How many times have you been to the Urgent Care or Emergency Department in the past 12 months?
    1. None
    2. 1-2 times
    3. 3-4 times
    4. More than 4 times

4. **For your breathing problems**: How many times have you stayed overnight in the hospital in the past 12 months?
    1. None
    2. 1-2 times
    3. 3-4 times
    4. More than 4 times

5. Have you participated in pulmonary rehab?
    1. Yes
    2. No
    3. Not sure

6. If you did participate in pulmonary rehab, did you participate:
    1. In the past year
    2. Longer ago than a year
    3. I have not participated in pulmonary rehab

7. Which of these are difficult for you to do by yourself (select all that apply)?
    1. Paying for medications
    2. Preparing meals
    3. Regular baths/self-cleaning
    4. Cleaning the house
    5. Quitting smoking
    6. Getting to my doctor

6.

For each question A, B, C and D below, select the statement to the right that best describes your current situation.				
A. When do you normally cough?	I cough throughout the day	I cough in the morning and occasionally during the day	I cough only in the morning	I never cough or only have an occasional morning cough
B. During which activities are you short of breath?	I am short of breath during light activity or while at rest	I am short of breath during walking, dressing, or bathing	I am short of breath during exertion, such as walking up a flight of stairs	I am not short of breath during activity.

C. How has your breathing problems reduced your activity level?	I have had to reduce normal activities due to breathing problems	Some of my normal daily activities such as walking, dressing, or bathing cause shortness of breath or fatigue	I am unable to perform strenuous activity due to shortness of breath	It has not reduced my activity at all
D. What is the highest level of treatment you treatment of your breathing problems?	I have had breathing problems that required a hospitalization using oxygen	I have had breathing problems that required an emergency room or hospital visit	I have visited a physician for breathing problems	I have not sought treatment of breathing problems

7. What type of doctor manages your <u>breathing</u> problems most of the time?
    a. Family / General Practice
    b. Internal Medicine
    c. Pulmonologist
    d. Cardiologist
    e. Other Specialist
    f. Not sure

8. Patient Satisfaction (select the number that matches your response):
    a. How would you rate the care provided by the clinician (respiratory therapist or nurse) from your equipment company?

N/A 1 2 3 4 5 6 7 8 9 10

Not Very Satisfied Very Satisfied

    b. How would you rate the education provided by your equipment company?

N/A 1 2 3 4 5 6 7 8 9 10

Not Very Satisfied Very Satisfied

    c. How would you rate the overall service provided by your equipment company?

1 2 3 4 5 6 7 8 9 10

Not Very Satisfied Very Satisfied

d. How would you rate your current quality of life?

1	2	3	4	5	6	7	8	9	10
Not Very Satisfied									Very Satisfied

9. What is your current access to the internet?
    a. I have and use internet at my home.
    b. I don't have internet access in my home but use it at some other location (e.g., public library, family member, friend).
    c. I don't use the internet.

10. What services do you use on your cell phone (select all that apply)?
    a. Phone calls
    b. Texts
    c. Email
    d. Internet
    e. I do not have a cell phone

11. If you could change one thing about how your respiratory equipment has been provided or who provided it, what would it be?

12. Note any other comments here:

Please mail your completed survey to

AARC Home Oxygen Survey

c/o Nick Macmillan

5917 Tioga Court

Bargersville, IN 46106

You may also complete your survey online using the following link:

https://www.surveymonkey.com/s/RD8KKB5