KANSAS
Palliative & Hospice Care

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COPD

PULMONOLOGY*care*

Your In-Home Care Experts

Hospice for COPD Patients

Reasons to choose Kansas Palliative & Hospice Care for COPD Patients

Our Mission is to provide the highest level of comfort and care, honoring and respecting the dignity of each individual, and enhancing the quality of living at the end of life, under the guidance of Christian

INDIVIDUALIZED CARE PLANNING

We develop individualized plans of care COPD or Chronic Obstructive Pulmonary Disease is characterized by airflow limitations. As the disease progresses we design plans that addresses pain, shortness of air, hydration, nutrition, skin care, recurrent infections and weakness - all common problems associated with COPD.

We care for patients wherever they call home –whether in their own home, a caregiver's home, a long term care facility or an assisted living community.

We will coordinate the individualized plan of care with the advice and consent of the patient's physician. The case manager will ensure that information flows between all physicians, nurses, social workers, aides, volunteers, and, if appropriate, clergy.

We will supply all medications, medical supplies and medical equipment related to the diagnosis to ensure patients have everything they need.

We will support the patient as well as the family emotionally and spiritually providing the resources to help both maintain their emotional and spiritual well-being.

We will train the caregiver on how to provide basic care to ensure the patient is comfortable and safe in the home. As the patient gets weaker, symptoms increase and communication becomes more difficult, we educate on how to best continue care.

PULMONARY HOSPICE CRITERIA

1 and 2 should be present; documentation of 3, 4, and 5 will lend supporting documentation:

1. Severe chronic lung disease as documented:
   a. Disabling dyspnea at rest, poorly responsive or unresponsive to bronchodilators, Bed-to-chair existence, fatigue, and cough. FEV1 < 30% of predicted after bronchodilator is helpful but not necessary
   b. Progression of end-stage pulmonary disease as evidenced by prior increasing ER visits or Prior hospitalizations for pulmonary infections and respiratory failure
   c. FEV1 > 40 ml/year is helpful but not necessary
2. Hypoxemia at rest on room air, as evidenced by pO2 < 55 mmHg or oxygen saturation <88%; or hypercapnia, as evidenced by pCO2 > 50 mmHg
3. Cor pulmonale and right heart failure secondary to pulmonary disease (not secondary to left heart disease or valvulopathy)
4. Unintentional progressive weight loss of greater than 10% of body weight over the preceding six months
5. Resting tachycardia > 100/min