The Regional Approach to Home Care for Life-supported Persons

There exist rising concerns about the feasibility for safe and cost-effective home care programs for ventilator-dependent patients. Currently, such individuals reside for years in acute intensive care facilities at enormous costs in human and economic terms. Until recently, there were few viable institutional-based or community-oriented options. Home care demonstrations are now evolving into definite programs.

There are many pressures to develop the home care option. Home ventilator care is a proved, cost-beneficial concept which can help to counteract the rising costs of institutionalization for such persons. At the same time, home care brings enormous human benefits to the lives of patients and their families. Reimbursement agencies are now considering changes in policies, and government authorities are making changes in legislation, most significantly at the state level. An exploding home health care industry is ready and waiting to serve.

We are witnessing a transformation in health care delivery in America. Important experiences with home care and other suitable alternatives already exist which can serve as models for new evolving concepts. We can look back in history to evaluate the past experience with poliomyelitis in order to incorporate successful components of that experience that are appropriate to the current realities. In addition, we can look to Europe for existing programs that have had years of expanding experiences meeting the needs of ventilator- and oxygen-dependent persons.

Three important programs exist today that are worthy of study:

1. The Respiraunt Program is a hospital-based, operational program which provides needed services for ventilator-dependent persons in England who are either at home with family members or living in the community because of the development of other suitable alternatives. This program began in 1965 and has served 411 patients; as of 6/15/83, it benefits 223 people with a highly personal home maintenance service as well as the hospital base-unit. (Phipps Respiratory Unit—St. Thomas’ Hospital, London).

2. The ADEP Program* is a community-based, operational program which as of May 31, 1983 serves 672 ventilator- and oxygen-dependent persons in the Greater Paris Metropolitan Area. Services are provided according to a contractual arrangement with reimbursement authorities. ADEP provides equipment maintenance, quality assurance, case-monitoring, and coordination of available institutional resources. Costs vary from $3.50 to $13.35/day, depending on the clinical needs. The ADEP program includes home maintenance services, independent living centers for ventilator-dependent persons, and a documentation center providing information required by disabled people to live in the community.

3. The ALLP program† is a hospital-based (Croix-Rousse) regional program which serves 445 ventilator- and oxygen-dependent persons in the Lyon region of France. This program offers a computer-based coordination of hospital and home care services. The program also includes an independent living center and an essential transitional care concept (Bellecombe—Hauterville).

These experiences serve to illustrate the important components of success in regional programs that implement the concept of home ventilator care. It is essential to study the clinical and organization success of these approaches to learn what is applicable to our evolving home health care needs.

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* ADEP = Association d’Entraide des Polios et Handicapés (Hospi
talisés) (Association of Mutual Help for Polio and Handicapped People) (Hospitalized)
† ALLP = Association de la Région de Lyon Pour la Latte Contre la Poliomyélite (Association of the Lyon Region for the Fight Against Polio).

REFERENCES

The National High Blood Pressure Education Program Reaches Maturity

The article in this issue of *Chest* by Drs. Lenfant and Roccella (see page 459) is a significant one. The article signifies that the National High Blood Pressure Education Program (NHBPEP) has reached maturity. This public-health education program is, by all criteria, a successful one.

The article is significant for a number of other reasons. First, the results show the importance of timing in public health information programs. The NHBPEP is a perfect example of a program meshing with larger societal trends—in this case, the desire of more and more people to involve themselves in their own health care. I think it is clear that the NHBPEP was and continues to be the right program for the right time.

That leads to a second point, which is the importance of allowing sufficient time for the results of research to translate themselves into positive effects on the public health. Early on, significant results were achieved in increasing awareness of hypertension, but not as much in achieving better control of the disease. A combination of foresight and patience allowed the program to shift its educational emphasis to long-term therapy and maintenance. Consequently, we now see, 12 years later, that the number of hypertensive patients controlling their disease has more than doubled.

The NHBPEP is also a sterling example of the importance of having a sound scientific base for public health education programs. In this case, progress in science couples with progress in other fields with the result that the program's total is greater than the sum of its parts. As Drs. Lenfant and Roccella say in their article, "It is anticipated that new research findings from the biomedical community will bring better understanding of the causes of hypertension and how it can be prevented. New knowledge from the education and communication sciences will help us reach our target populations so that these encouraging trends will continue."

The prime ingredient in the success of the NHBPEP has been cooperation. In this age of conflicting jurisdictions, it is truly remarkable that a single program can comprise 15 federal agencies, 150 national organizations, nearly all the state health departments and more than 2,000 local programs. Special credit should be given to the Coordinating Committee for maintaining the consensus approach that has allowed the program to gain momentum throughout its 12-year history.

Finally, it is good to see that Drs. Lenfant and Roccella acknowledge that it may now be necessary to shift the NHBPEP's emphasis once again. For all the success achieved so far, we still have a great deal of work to do. We cannot afford to ignore sectors of the population that still show a high prevalence of hypertension. We cannot afford to take our successes for granted. We cannot afford to stop looking for better agents to control hypertension. We can be heartened, though, by what we have accomplished through the NHBPEP. It gives us a sense of direction, and as the old saying from sailing goes, "Any wind is a good wind if you don't know where you're going."

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Pulmonary Medicine and Science
Another Look at the Future by Those Who Will Direct It

We, living now, are always to ourselves, young men and women.

Gertrude Stein

The Making of Americans

Periodically, the American College of Chest Physicians sponsors a meeting of young academic-based pulmonary physicians. The first such meeting was held in 1979 at Pheasant Run outside of Chicago, and was the subject of an editorial entitled "Issues and Challenges for Pulmonary Medicine—The Next Generation's View" (*Chest* 1979;76:495-6).

Since that time, the original group of attendees has amassed a rather remarkable record of professional and academic achievement. Twenty-three of the original 27 participants remain in academic medicine today. Four have become division heads, and one is an associate dean. Since 1979, the group has produced 314 indexed scientific articles, or an average of greater than eight articles per conference attendee since 1979. They are primary authors of 124 publications in critically refereed journals and secondary authors of an additional 190 publications.