Interview

The hospital at home: Interest in New Brunswick's experiment is growing

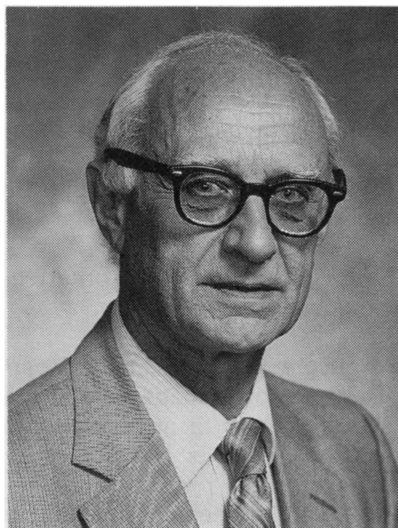
One area of growing importance in Canada is home care, a method for keeping people out of hospital or other facilities for as long as possible by bringing health care and other services to their homes. One of the major experiments in this area involves New Brunswick's Extra-Mural Hospital, a "hospital without walls" that began operating in 1981. Based on a New Zealand model, it is meant to provide services ranging from nursing and dietary care to the provision of drugs to everyone from newborns to the terminally ill. Orvill Adams, the CMA's director of medical economics, has been keeping an eye on the hospital's development for *CMAJ*. Here, he interviews its executive director, Dr. Gordon Ferguson.

Adams: It's been almost 3 years since I spoke to you about the Extra-Mural Hospital (Adams O: Hospital without walls: Is New Brunswick's Extra-Mural Hospital the way of the future? *Can Med Assoc J* 1987; 136: 861-864). How have things been going?

Ferguson: Quite satisfactorily in most respects, or at least in respect of the care we give to our patients; physical expansion, however, is going no faster.

Adams: Why? Has the change of government had anything to do with the lack of expansion?

Ferguson: I don't think so. It's not accurate to say we have had no expansion. In its first budget this government funded the Extra-Mural Hospital for three new offices, so in fact we are expanding at about the same rate as



Ferguson: medicine satisfying outside hospital, too

before. I'm dealing with my own impatience, I suppose.

Adams: Why the impatience?

Ferguson: That's easy enough. I believe we are on the right track with the hospital and I am impatient to see it developed to its full potential and have its optimal impact on health care here. As with so many things, funding is the problem. The province seems to be putting its primary emphasis on balancing the budget and few of us would quarrel with that.

Adams: Are there any other factors?

Ferguson: A Commission on Selected Health Services [conducted hearings and then reported] to the premier during the summer. It seems logical to assume that [because that report was expected] there might [have been] something of a holding period until the report [had been studied].

Adams: Will it affect you?

Ferguson: I'm in no position to say. Our board has made a submission — we hope it will be effective.

Adams: When we last spoke your services were available to about 50% of the province. What is today's figure?

Ferguson: Seventy-five percent, or even a bit above that.

Adams: That sounds pretty good. What significant developments have there been recently?

Ferguson: The most significant factor has been the appointment of a full-time medical director.

Adams: That's unusual in home health care, isn't it?

Ferguson: Yes, indeed, and this lack of a medical director and of physician input and involvement in general seems to me to account for the "poor-relation" image of home health care. I think we are all conditioned to see health care in terms of ambulatory care and institutional care — these are the areas where physicians are most heavily involved. In most home health care programs the doctor is practically invisible. I believe very firmly that the component of health care that has the most potential for significant development during the next 10 years is home care — the hospital at home — and that this will not achieve all it is capable of until there is

meaningful physician participation. That is why we place so much emphasis on getting doctors involved.

Adams: I get the impression that some other health care workers regard home care as their preserve and doctors trespass at their peril or, at best, are tolerated reluctantly.

Ferguson: To be fair, I think we must point out that the whole tenor of medical practice over the past 30 years or even longer has been towards in-hospital care. The developments in therapy and technology have practically dictated this.

Adams: Why do you think this will change?

Ferguson: Because we have reached the end of the great days of hospital construction; assessment of need for new hospitals and for additional beds will be much more stringent than before. As well, the very technology that helped to mediate the shift to institutional care may be a factor in reversing that trend. To take a very simple and unsophisticated example, intravenous therapy of all kinds required admission to hospital until relatively recently; now it is commonplace in home care and, indeed, a very obvious example of cost-effective care in the hospital at home.

Adams: Where does your medical director come into this?

Ferguson: He is our liaison with physicians. He must explain the workings of the Extra-Mural Hospital to doctors in each new location as we commence operations and demonstrate how they can best make use of our resources to benefit patients. He is also available if any problems arise in our day-to-day relations with the doctors.

Adams: Does he have other responsibilities?

Ferguson: He is an integral part of our senior management and a full participant in all operational decisions. This is the only way one can have physician-managers taking a meaningful role in senior management — as full partners. He has a more direct involvement with practising physicians through the small medical advisory committees we have set up for each of our units to advise us on the medical aspects of care. We also use these groups when we are planning to introduce new services. The medical director keeps very busy — this is no sinecure.

Adams: What else has been happening?

Ferguson: There have been a number of routine operational developments such as our patient classification system and the organization of a diagnostic coding system. We are just now working on what we call an appropriateness placement instrument against which we can evaluate a patient at any point in his stay with us. We anticipate that this will be of considerable value in controlling length of stay.

Adams: I gather that you consider convincing physicians that there are great practice opportunities in the realm of hospital care at home one of your tasks.

Ferguson: Yes. I think an increasing number of doctors, particularly those who are coming through the forward-looking family practice residency training programs — I'll mention Dalhousie University because it is the one I know best — are appreciating that there is a very satisfying practice of medicine outside the hospital's four walls. I also anticipate that there will be greater and greater pressure on hospital beds and that hospital management and physicians will be seeking ways to put more and more patients through an increasingly inelastic institutional system. This will not be possible unless we have a quality support system such as the Extra-Mural Hospital available. To get more and more patients into hospital, the doctor will have to get more and more of them out. That's where we come in and that is also why I anticipate a growing interest in home health care, particularly among family practitioners. I mean, where is it more logical to practise family medicine than in the home?

"A very strong vote of confidence in our visiting staff"

Adams: Are physicians responding?

Ferguson: Yes, indeed. Not a tidal wave, you understand, but a steady rising of the tide.

Adams: Has there been any basic change in the structure of your operation?

Ferguson: No. We have the Board of Trustees, the central administration and the service delivery units. It is from the units that the staff sally forth to carry the required care to patients in their homes.

Adams: Have there been any recent patient surveys?

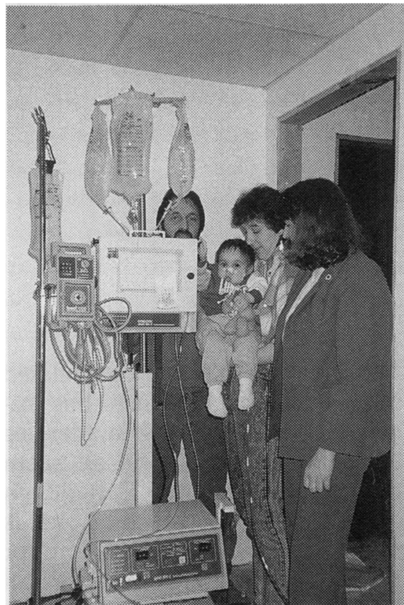
Ferguson: We conducted two somewhat selective surveys last fall. In one we got the reactions of the relatives of children 15 and younger who had been patients during fiscal year 1987–88, and in the other we surveyed the next of kin of patients who died during the same period.

Adams: And?

Ferguson: The results were identical with the survey done in 1986. Again, the return rate for questionnaires was more than 80% and again there was a 97.5% expression of satisfaction with the services we provide — another very strong vote of confidence in our visiting staff. We owe everything to their dedication, skill and human qualities.

Adams: As I recall, you were concentrating on the more acute end of the home health care spectrum, a rather unusual orientation for a home-care service.

Ferguson: Yes. Apart from some hospital-based programs that serve early-discharge patients exclusively, home health care is generally regarded as a form of long-term care. We have been very excited to have been asked to concentrate on active care with a view to facilitating early discharge from hospital and, even more interesting, keeping patients who without our care would require admission at active-treatment hospitals. These make up about 40% of our patients. This is an invisible contribution we make to hospitals and one of which they are generally unaware.



"We help facilitate early discharge from hospital"

Adams: How has this worked out?

Ferguson: Very well. A number of hospitals have told us we have made a positive difference. Of course, they don't forget to point out that as we increase their throughput of patients, we also increase their operating costs.

Adams: I guess that's because the acuity of their patients increases with shorter lengths of stay and costs go up. Do you have ambitions to expand your scope into long-term home health care?

Ferguson: Yes, indeed. It is fundamental to our philosophy that to be both cost effective and effective in the quality of care we give to patients we must be in a position to deliver a full continuum of care, adjusting that care, up or down, in accordance with the changing health status of the patient. At present we find that we are retaining patients because there is no long-term care available; that being so we might as well be organized to service such patients. Also, we find that transferring patients to other programs increases the possibility of a communication breakdown, and then the patient suffers.

Adams: Your objective is to provide a full spectrum of home health care, ranging through long-term, short-term and palliative care?

Ferguson: Yes. We see the Extra-Mural Hospital's patients falling into five categories: short-term active care, continuing active care, sustaining care, palliative care and supervisory care. The important thing is to get on with setting up a comprehensive continuum of care which will serve each category. The population is aging rapidly and the proportion of elderly may reach 15% by the turn of the century. We must be ready well in advance.

Adams: Have your views about the potential of an operation such as the Extra-Mural Hospital changed at all during your 8 years of involvement?

Ferguson: Oh, yes. I see potential now that I would not have dreamed of in 1981. I feel sure that the key is to see health care as a system and not to get blinkered and see only one's own operation in isolation. Fragmentation has been a millstone around the neck of health care but I think it is a handicap we are eliminating. Increasingly we realize that we have a duty to get the best value out of each health care dollar and that the best way to do this is through increased cooperation and collaboration. The days of splendid isolation are gone.

Adams: And in this you see opportunities for the Extra-Mural Hospital?

Ferguson: Yes, opportunities to which I was blind a few years ago, and they're there not only for us, but for the entire system.■