Illustration by Steve Derrick

Meeting patients where they are

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Home-based primary care offers a unique opportunity to improve patient outcomes, enhance patient, family, and physician satisfaction, and reduce health care costs; however, it remains underutilized.

Participation in the home-based primary care model, unlike the learning experience in traditional outpatient visits, fosters deeper patient connections, promotes contextualized learning of social determinants of health, and supports mentorship. As the aging and disabled population grows, expanding home visit programs could play a crucial role in providing access to care,[1] addressing complex medical and social needs,[2] and enriching medical education.[3] This article draws on the perspectives of a first-year medical student and a physician nearing retirement—Howard J. Eisenson, MD—to explain some of the benefits of in-home primary care. It also offers a unique model of "hybrid telehealth" whereby students leading an encounter in the home are supervised by an attending physician observing the visit via real-time video.

A meaningful way to start a career

"Hi, Mr. B, I'm the medical student here with Dr. Eisenson to see your mother for her home visit today. How is she doing this afternoon?"

"She's doing alright. We carried her downstairs yesterday for her 90th birthday party, which was great! But she's still struggling with her breathing, joint pain, and appetite. To tell you the truth, I think she's doing better than I am with how much she wakes us up at night to help her to the restroom. I'm not sure how much longer I can take it."

"I'm sorry to hear that. We'll make sure to explore solutions and resources that may help."

So began my initial patient encounter as a first-year medical student, a meaningful introduction to my medical education. I had the privilege of seeing Ms. B at home, much like the doctors who performed house calls years ago. I had volunteered with the local community health center to provide in-home primary care for low-income adults with chronic illnesses who are unable to attend outpatient appointments. A third-year medical student and I were assigned to follow two patients for several months, visiting them with our attending's supervision either in person or via video call. I made time to see these patients every other week, which aligned with my preclinical testing schedule. Serving this patient population was a compelling opportunity to gain early clinical experience with strong mentorship to provide care for those who need it most.

Even before crossing the threshold of her home, I knew a great deal about Ms. B, both from chart review and from experience with the history of our city, Durham, NC. She is an African American woman with immobility secondary to a motor-vehicle collision, colon cancer, and atrial fibrillation. She lives her son and daughter on the south side of town.

A Black community thrived in this area until the 1960s, when an Urban Renewal Project for a new highway displaced Black-owned businesses, disrupted neighborhoods, and destroyed homes. Dr. Eisenson and I entered the home and followed her son up the stairs, well aware

of the barriers that she likely faced growing up, which have impacted her health and ability to access care.

"Well, hello there, sweetheart! How are you doing today?" Dr. Eisenson announced our arrival. Ms. B smiled cheerfully as she turned down the Ella Fitzgerald playing in the background. The room smelled of bacon, eggs, and grits from her morning breakfast. The walls were covered with memories, memories clearly full of love—pictures of family and the multiple awards honoring her 30 years of service as a nurse. Dr. Eisenson, after catching up on stories, walked me through the history and physical exam. When asked about the difficulties her son brought up, she said, "Oh, I'm holding up just fine. I just get lonely up here all day by myself."

Seeing Ms. B in this setting, rather than in an office, gave us a more complete picture of her health status, including social factors such as her environment, her access to food and medications, her options and barriers for mobility aids, the financial strain on her family, caretaker fatigue, and her feelings of isolation—factors mostly out of view in clinic.[3] This understanding allowed us to more appropriately address her needs by helping her to navigate treatment strategies and community resources.

After a full evaluation, accounting for her access to the restroom and bedside commode as well as the caretaker fatigue of her family, we discussed options for behavioral modifications, medications, devices, and physical therapy. Ultimately, we were successful in the effort to avoid polypharmacy. We involved her family to limit her fluid intake in the evenings, and found an affordable external female catheter.

I saw Ms. B a total of six times with Dr. Eisenson, whether in person or via his remote supervision. His unobtrusive video presence allowed me to take ownership of my encounters. I practiced leading conversations, measuring vitals, and creating a plan. Together, we discussed a low-cost medication resource known as Senior PharmAssist and transportation options to the senior social club. The relationship we developed with Ms. B allowed us to recognize subtle changes in her health, observe what really mattered to her and her family, and tailor treatment recommendations to address those priorities.

This model also allowed for the accelerated progress of my clinical knowledge and skills. Before each visit, Dr. Eisenson and I discussed her condition, social determinants of health, and anticipated challenges. I was then able to learn through participation and leadership, all with proper supervision from Dr. Eisenson who offered real-time feedback. There was greater emphasis on provider-patient collaboration, and more opportunities for family members to share their perspectives, to feel heard, and to receive support. My post-visit debriefings allowed us to discuss key takeaways, major challenges, and areas for improvement that solidified my learning and shaped my goals for future practice. The benefits I observed in my own learning are consistent with the experiences others describe in the literature.[4–6]

After starting my clinical rotations, I cannot help but notice the contrast between home visits and outpatient visits in clinics. Instead of seeing patients in a home environment with life and character, I see patients in a small, sterile exam room. Instead of taking vitals, I watch patients' heart rates and blood pressures populate in the chart as measured by the medical assistant. Instead of conducting a detailed exam, I rely on a lower threshold of information to order lab tests and imaging. Instead of addressing multiple concerns, I must address solely the primary problem within the allotted 15 minutes or less.

I must frequently disregard and leave unaddressed social problems. Witnessing firsthand how the refrigerator is nearly empty, how the roof of the home is leaking, or how the patient has no one to help with their laundry or with their meal preparation is much more impactful than identifying social needs from a checklist.

A fulfilling end to a career

As a 68-year-old family physician, I was ready to step down from a full-time role as Chief Medical Officer at my local community health center. Hoping to enjoy a gradual transition to retirement rather than a hard stop, I was grateful for the opportunity to work part-time with the center's home-based primary care program serving homebound adults with chronic health problems, the great majority of whom are in low-income households. Many years earlier I had the opportunity to care for a few patients at home. I recalled those encounters as special, and still remember most of the patients; I was curious to reconnect with that experience.

As a family physician, I was struck by the value—and the pleasure—of getting to know my patients better in their homes than I was able to do in the clinic. This allowed me to gain a firsthand perspective of their challenges and their resources, and respond more fully to their needs. Home visits provide an opportunity to more effectively deliver the personalized, comprehensive, and

coordinated care that family physicians strive to achieve, and that patients with complex medical and social issues so greatly need.

I sought to share my enthusiasm for home care with medical students and welcomed volunteers who wished to accompany me on home visits. With nearly an hour allocated for many home care visits, these encounters are so little hurried that we can get to know the patients—learning details about their hobbies, favorite music artists, and the people and things that matter most to them in their lives. Ms. B, for example, despite her decreased fine motor skills, shared with us a piano piece that she had been practicing with the remaining function in her right hand. We were honored to be welcomed into, and share, a moment of connection with this facet of her world.

The COVID-19 pandemic had also caused me to consider caring for patients at home in a different way. Like many other physicians, I had begun using telehealth encounters during the pandemic—a valuable and well-accepted tool for patients in general, though not necessarily one accessible or useful for those patients who face multiple medical and social challenges. I envisioned the potential of an enhanced or hybrid telehealth visit, facilitated by on-site students under my remote supervision via video. Because these students were present with the patient, I could accomplish a much more complete patient assessment and form a better treatment plan than I could have done during a routine, unassisted telehealth encounter. I was also able to do this without the burden of travel to and from patient homes. An important added benefit was that my participation by video created an opportunity for the students to enjoy more autonomy—to take the lead in assessing the patient's environment, in gathering the history and performing a focused exam, and in problem-solving and providing education to patients and their caregivers, all while safely under my supervision.

Offering home visits and providing longitudinal care for patients, like Ms. B, acquaints doctors and students with more facets of a case than the standard medical history. After discovering that Ms. B's pressure sores had been cared for by family members with skills resembling those of wound-care nurses, we understood the importance of including the family in all conversations and congratulating the family on its dedication. When Ella Fitzgerald was no longer playing, however, that change alone was enough to let us know something was wrong.

As Ms. B's condition continued to worsen, and without responding to previously effective care, our longitudinal relationship helped us to decide when to begin to facilitate the family's decision to transition to hospice care.

I am convinced that working with my patients at home has enabled me to be, and become, a better doctor. At the same time, it saddens me to think of how many times over my many years in practice I may have missed the chance to form similar relationships with patients who could have benefited from home visits. I hope to provide the learners who accompany me on home visits, or engage with me in enhanced video visits, the special satisfactions that I have been fortunate to realize late in my career. I also hope that some of these learners will forge careers that include home visits when appropriate or that they will recognize how much of the patient's story they may be missing if they never see patients outside of the clinic or hospital.

Shared reflections on time, connection, and the future of care

Visiting patients in their homes, gaining insights into who they are and how they live, has been a great privilege. Truly therapeutic relationships that facilitate good care are enhanced when they involve mutual respect, trust, and positive regard. As soon as we cross the threshold of our patients' homes, we convey respect. When we get to know our patients as individuals—as people not only with vulnerabilities, but also with strengths, assets, and interesting histories, and with unique challenges in their support systems and environments—positive regard and trust naturally follow.

Data suggests that home-based primary care improves the quality of patient care and the physician experience, but also has the potential to improve public health.[7]

We are undergoing a crucial shift in American demographics. By 2050, the number of Americans over the age of 65 years will increase by nearly 50 percent, or about a quarter of the population, with the majority of those Americans having two or more chronic health conditions.[8] Appropriate use of home care could improve patient outcomes, reduce unnecessary use of emergency departments and hospitals, and decrease health care spending. Preventing a single episode of hospital-associated delirium pays for home visits many times over.[9] Unfortunately, under the currently payment paradigm, in-home primary care is too costly for wide adoption.

However, an enhanced telehealth model, if more widely adopted, would allow less time- and labor-intensive primary care, benefits that could extend to specialty care. Under a truly value-based payment model, in-home care for people who are mostly, or fully, homebound may well pay for itself.

Conducting home visits for the first time as a medical student provides an immersive, patient-centered learning experience, offering invaluable insight into patients' lives, history, and challenges, elements are often lost in the clinical setting. However, increasingly the current structure of health care limits interactions to brief, problem-focused assessments dictated by time constraints and institutional pressures. This raises concerns about the erosion of the meaningful physician-patient relationships that have traditionally formed the foundation of effective care.

From the perspective of experienced physicians, home visits can serve as a reminder of the joy in practicing medicine through unhurried, relationship-driven care, in contrast to the financial and administrative pressures that prioritize efficiency over depth of connection. The advantage of home care goes well beyond the additional time with patients. Seeing the home environment and who populates that environment often provides critical information necessary for caring for the patient. Would we really know anything about medication adherence if we did not see for ourselves the piles of unused and out-of-date medications in the bedroom?

Health care systems now stress cost-cutting and productivity metrics to such a degree as to raise questions about the future of medical education and health care delivery. How can training programs incorporate more opportunities for longitudinal, patient-centered care? What policy changes might support models that balance efficiency with humanistic, comprehensive patient interactions?

Without systemic adjustments, the medical profession risks training future doctors in an environment that diminishes the human aspects of care that home visits exemplify.

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