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Is There a Personal Doctor in the House?

Primary care medical specialty societies, including the American College of Physicians, promote the patient-centered medical home as a way to improve the U.S. health care system (1). Some of the principles of a patient-centered medical home include a personal physician, a physician-directed medical team, a whole-person orientation, care coordination, a commitment to quality and safety, and the provision of enhanced access (2). These themes are highly recognizable elements of previously published definitions of primary care (3, 4). The novelty is in the linkage of these concepts to a business proposition. Primary care advocates contend that they should be better paid to do these functions because an adequately funded, patient-centered medical home can be a cost-effective delivery model that can reduce the need for specialty and emergency department visits as well as hospitalizations (5). Payers, including Medicare, are receptive to enhanced payment for primary care as long as practices demonstrate that they adhere to the principles of a medical home and can in fact reduce overall health care costs (6). Work is under way to create measures validating a primary care practice's claim that it functions as a medical home (7) and to test whether primary care medical homes are truly cost-effective in demonstration projects (8).

In this issue, Atlas and colleagues (9) make a strong case that 1 of the basic elements of the medical home—a personal physician—increases quality. By using an innovative measure, Atlas and colleagues (9) report that patients who were more connected to a personal physician were more likely to receive recommended primary and secondary prevention services in primary care settings (9). The effect size was clinically meaningful, and patient–physician connectedness was a stronger determinant of delivered preventive services than proven predictors, such as patients' age, sex, and race or ethnicity. The findings were relatively consistent across several prevention activities and subgroups of patients defined by their disease or type of medical insurance.

The report also shows that patient–physician connectedness varies among practice organizations. The percentage of patients with a personal physician varied by more than 25% (45.6% to 71.2%) across 13 primary care practices. The rate was higher in the 9 private practices than the 4 clinics, but the statistically significant difference of 3.6% between the types of sites was relatively minor. Also, counter to conventional wisdom, graduate physicians in training enhanced rather than undermined patient–physician connectedness.

Although the findings are consistent with other studies (10, 11) and with widely held beliefs about the value of a connection to a personal primary care physician, the results of this observational study leave several questions unanswered. First, are the investigators using a valid measure of the connection between a patient and a personal physician? In a previously published article (12), the investigative team described how they identified good predictors of a strong physician–patient relationship. They started by asking 18 primary care physicians to identify patients for whom they considered themselves to be the primary physician. They then searched for administrative data that predicted a primary care relationship. The best predictors were whether a physician provides 70% or more of a patient's visits, the patient's age, the number of months since the last visit, and whether the patient resides in the same state as the practice. Patients with these predictors were highly likely to have a physician who identified him- or herself as their personal physician, more so than relying on administrative information about whether they had a primary care physician. Atlas and colleagues' current study (9) was the first attempt to see whether their measure of physician connectedness predicts anything of value—that is, whether it predicts better delivery of preventive health services. The measure of physician connectedness could prove to be useful for evaluating whether a practice is a primary care medical home if it is valid when tested in a larger and more representative pool of practices. These studies should validate patient–physician connectedness not only against physicians' self-reports that they are a patient's personal physician but also patients' reports that their designated physician really is their personal physician.

Second, what is the likelihood that the delivery of recommended preventive care would increase if steps were taken to increase patient–physician connectedness? Observational studies of prevention are often confounded by the healthy-patient bias, whereby patients who pursue preventive care differ from those who do not (13). Thus, the same characteristic that results in some patients being more likely to receive preventive care services may also make it more likely that they have a stronger connection with a personal physician. Other research tends to refute this claim. For example, requiring patients to select a primary care physician in managed care programs has been associated with an increase in the delivery of recommended preventive care, suggesting that the effect is not merely due to confounding and that the relationship between a patient and a personal physician has real value (14).

Third, will the measure of patient–physician connectedness predict receipt of other important medical care services? The authors found that patient–physician connectedness was most strongly associated with receipt of preventive services that use blood and imaging tests, which are often ordered in association with an office visit (9). The effect of patient–physician connectedness was less clear when measured by the achievement of longer-term goals, such as glucose and lipid level control, which typically require the patient to make substantial, ongoing changes in

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behavior. This observation raises questions about the importance of the authors' measure of patient–physician connectedness for predicting successful management of chronic conditions. The measure would be more valuable if greater patient–physician connectedness was associated with improved functional status and reduced costs.

Finally, assuming that physician connectedness has value, how can practices increase it? This question could have business implications if connectedness became a proxy for adherence to the patient-centered medical home model. Atlas and colleagues (9) reported higher observed rates of patient–physician connectedness among study patients in commercial managed care than commercial fee for service, suggesting that health plans may be able to play a constructive role in supporting a physician–patient relationship. However, even among the patients who used a commercial managed care plan, 28% did not have a physician connection, suggesting that either some patients resist having a personal physician or some primary care practices are not able to provide it. Clearly, we need to learn more about the role that patient preferences and provider behavior play in forming (or undermining) productive health care relationships.

The debate about and the implementation of the medical-home delivery model is progressing much faster than the accumulation of evidence about its effectiveness. The excitement is fueled in part by the widespread belief that primary care cannot continue on its current course (15). For many, the patient-centered medical home is a "make-or-break" opportunity to secure the future of primary care as a medical specialty in the United States (16). Primary care professionals are concerned that the financial rewards associated with the primary care medical home will be linked to practice redesign and the implementation of information technology rather than patient-centered aspects of primary care (17). Atlas and colleagues (9) have taken an important step by proposing a way to measure a central feature of primary care. In applying it, they show that a strong patient–physician connectedness can be a stronger predictor of patients receiving appropriate preventive care than system supports, such as nurse reminders. Their measure, which requires only administrative data, deserves wider testing.

Information technology, practice redesign, and aligned financial incentives are all likely to be important building blocks for a medical home. However, as health professionals try to respond to our nation's quest for a new and improved primary care delivery model, we would do well to remember and measure the value of a personal physician in the house.

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