social ignorance of physicians about the lived lives of our patients." We could not agree more. Part of the inspiration for our study was one of the authors (LP) taking a house call elective as a medical student with the other author (SL). During the elective we traveled to neighborhoods both poor and rich, to homes with well-manicured yards, and to those with refuse lying around. Every doorway we crossed offered new insights into the lives of our patients and, as Ian McWhinney[2] so eloquently stated, "we could see the history and dreams of our patients on the walls". We witnessed the struggles of both the patients and their family members to achieve the best care they could in their situation. In some houses the pill box was easily located, schedules of home health nursing and physical therapy appointments were available, food was in the refrigerator, the house was clean. In others, medications were disorganized, with empty bottles begging to be refilled, and urine stains were evident on the couch from when the patient did not have help to get up. The Japanese residents mentioned by Dr. Frey were correct in saying that a physician can never truly understand their patient's lives unless they make house calls. As family physicians wrestle with practice transformation and ascending the levels of the patient-centered medical home, we hope more physicians take the ultimate patient-centered step by driving to their patient's home to better understand and contextualize the lives and choices faced by our patients.

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2. McWhinney IR. Fourth annual Nicholas J. Pisacano Lecture. The doctor, the patient, and the home: returning to our roots. J Am Board Fam Pract 1997;10:430–5.

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Re: The Impact of Prior Authorization Requirements on Primary Care Physicians' Offices: Report of Two Parallel Network Studies

To the Editor: Morley et al[1] report on practice cost estimates per full-time-equivalent physician for prior authorizations in 2 Northeastern markets, noting that their results vary considerably from previous publications. Across different markets there is substantial variation in the availability and uptake of technology to facilitate this process (eg, multipayer physician/practice web-based portals providing immediate access to patient eligibility, benefits, and engines that automatically approve authorization requests). The authors collected detailed data on the workforce resources (people) expended by the practices, but did not comment on the processes used at those sites as a possible explanation for the seemingly dramatically improved efficiency compared with earlier studies.

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Reference

1. Morley CP, Badolato DJ, Hickner J, Epling JW. The impact of prior authorization requirements on primary care physicians' offices: report of two parallel network studies. J Am Board Fam Med 2013;26:93–5.

doi: 10.3122/jabfm.2013.03.130063

The above letter was referred to the author of the article in question, who offers the following reply.

Response: Re: The Impact of Prior Authorization Requirements on Primary Care Physicians' Offices: Report of Two Parallel Network Studies

To the Editor: In the letter regarding our study of prior authorization costs,[1] Schneider[2] describes a "seemingly dramatically improved efficiency compared with earlier studies." This is an incorrect reading of our results. We do not believe that our report describes an improvement in efficiency over earlier estimates. Rather, it estimates costs using an entirely different method than previous studies and comes up with different results. It is our feeling that the studies we cited—by Casalino et al,[3] Morra et al,[4] and Sakowski et al[5]—represent the high end of a range of possible estimates and that our studies represent the low end. True costs are probably somewhere in the middle and are certainly dependent on the context, as Schneider points out.

Regarding processes that may have affected cost outcomes, we currently are analyzing the existing data set using inferential statistical techniques. There are early suggestions that practice characteristics (particularly the use of electronic health records) might play a role. However, the exact mechanisms and relationships between processes and costs are by no means certain. We hope to describe results from our secondary analyses in a future report. Regardless of what we find, a much larger study than ours would be required to answer definitively questions about the effects of particular processes on prior authorization costs.

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