Upon entering medical school, it quickly became evident that the goals of practicing medicine are team-central. This philosophy is further bolstered by the writings, leadership, and vision of Dr. Holly and his work with Southeastern Texas Medical Associates. His ideas on patient collaboration and teamwork were groundbreaking to the practice of primary care, and as a student wishing to enter family practice, I am honored to be working towards expanding upon his ideals and the strong foundation he has laid for the field. As I look forward to my work as a primary care physician, I plan on building my practice around these team-based concepts and using them as the centerpiece of patient care. SETMA's success stems from their core healthcare values which provide physicians the data and analytics necessary to improve the quality of cost-effective care, reignite trust between physicians and patients, use technology to optimize care without losing the humanity of it, and invigorate the personal passion for excellence within the physician. Key features that allow SETMA to accomplish these feats are advanced analytics of quality metrics, the team approach to healthcare delivery, use of electronic medical records (EMRs), and empowering and enabling patients to embrace their plan through increased trust in their provider as described in Dr. Holly's The Future of Healthcare Innovation and Change: SETMA's Model of Care Patient-Centered Medical Home. While SETMA has clearly set the standard of excellence for primary care, I see some improvements on the horizon for the field for which I will answer the call in my own practice. These improvements include expanding and integrating the entities encompassed within the healthcare home, decreasing the administrative burden on the physician by optimizing electronic medical records, and increasing the ability for the physician to gain patient trust through meaningful conversations that effectively empower the patient to "grab the baton" of their care.

A patient centered healthcare home is an important way to understand and structure a patient's experience in the healthcare system. The SETMA model describes the entities within the healthcare home as the personal provider, nurse, clerk, management, etc. Further explanation in The Future of Healthcare Innovation and Change: SETMA's Model of Care Patient-Centered Medical Home discusses Dr. Holly's call for physicians to check a patient's mouth and teeth and encourage patients to see their dentists, illustrating the need for providers of different fields and specialties to communicate and integrate whole body health for their patients. With the rise of interprofessional experiences within healthcare graduate and doctorate programs, young medical providers are learning the key resources and tools to address this need in healthcare. Steps to integrate providers have already been taken with the incorporation and utilization of the EMR. This has enabled physicians to be more knowledgeable about the work of other providers in regards to the patient's healthcare team, specifically when looking at testing and treatments already done to improve the health and lifestyle of the patient. Thus, providers are able to walk into patient conversations with a greater understanding of the patient's whole health without a substantial increased burden of communication and time.

Though the effort to distinguish the healthcare home and integrating the care team has made monumental strides, I do believe we are missing a crucial component: insurance companies. Insurance is able to control the specific medication, imaging, and labs done for a

patient based on their set of quality standards or the cost of the intervention, limiting the quality of care a patient receives and possibly increasing the overall cost of care. As described in Your Life Your Health - Continuity, Creativity, Consistency Part IV, “the lack of a team approach at every level and in across every department of medicine creates inefficiency, increased cost, potential for errors and that it actually eviscerates the potential strength of the healthcare system”, and I feel this team approach must now include insurance companies. While it would be ideal to look at the structure of our healthcare system and adjust it to lower total cost, the idea that insurance companies will not influence the care doctors provide may never come to fruition. In turn, everyday primary care providers must adapt to work within the system of healthcare that the patient's insurance imposes. Properly administering care to patients while navigating this maze of insurance providers and plans takes many hours of research and experience, which would greatly limit the healthcare team’s time with patients. In addition, insurance companies utilize guidelines from governing medical bodies and enforce them as obligatory rules in a patient's care required for reimbursement, meaning that a patient may receive unnecessary testing in order for their visit to be covered. This creates a conundrum: we want patients to receive the full care they need in accordance with clinical evidence, but we also want physicians to have decision making power in knowing they understand their patients best and are able to make quality decisions based on the patient’s needs. When we look at the insurance stipulations and quality checks that are well known to primary care providers, we can see that some are outdated and increase both the cost of healthcare and the frustration of providers. A common example is seen in Medicare, where it is required every year as a quality metric that patients receive a urine microalbumin creatinine ratio to determine the start of diabetic nephropathy and lead physicians to start the patient on an angiotensin-converting enzyme inhibitor (ACEi). Yet in recent years, diabetic patients are started on an ACEi shortly after diagnosis because of the cardioprotective and renoprotective functions of the medication. Once patients are on an ACEi, the clinical decisions that would result from the urine microalbumin creatinine are obsolete, causing each sample subsequently collected for quality management to represent an unnecessary incurred cost to the patient. In the healthcare field, we often see issues with the coordination amongst the many moving pieces, which can lead to an increase in administrative work for the physician and a subsequent opportunity for optimization that can ultimately lead to a higher quality of care.

Primary care has often carried the burden of administrative work leading to burnout and potentially treatment inertia of the physician. This administrative work comes in various forms; whether it be government documents for disability, insurance work to confirm coverage, or endless inefficient charting from large patient loads. SETMA has worked to decrease the administrative burden by creating preformed quality metric clusters and galaxies that have improved patient outcomes. SETMA has also devised a pre-visit/preventative screening that allows physicians to easily understand what the patient needs at this visit to be up to date according to AAFP and other medical governing body guidelines as described in The Future of Healthcare Innovation and Change: SETMA’s Model of Care Patient-Centered Medical Home**.** With one of the primary goals of SETMA being to leverage technology without it defining the

clinical experience for the patient, administrative work is a major frontier that technology could make a positive difference for providers. Even for the most skilled user, working with the EMR to check and add patient information can be an inefficient process. A physician's knowledge base is greater than what an EMR is able to make readily available and an EMR does not integrate aspects of care such as regulatory requirements or personal business revenue expectations. A physician understands the patient's story, their care coordination process, and what the relevant administrative requirements are, and thus carries this portion of the workload as they use the EMR. With the advancements of artificial intelligence (AI), we can employ this technology to increase the efficiency of EMRs through examples such as updating quality metrics, selecting proper billing codes, or alerting physicians to potential care pitfalls. We discussed earlier that most insurances have an independent set of quality measures that need to be fulfilled to receive full reimbursement for the visit or procedure, while governing bodies like the AAFP also have their own set of guidelines based on clinical evidence that are updated every couple years. If we could use AI to integrate the necessary requirements for full reimbursement with the most up-to-date clinical evidence, we could improve the quality of the visit by reducing the time that the physician spends checking updated guidelines, maximizing reimbursement from insurance, and decreasing the cost of the visit for the patient. A practical way for achieving this is using AI to highlight the billing codes that a specific patient's insurance is more likely to understand and cover while also being in accordance with the current guidelines put forth by the medical governing bodies. MediCo is a company that is currently spearheading this particular field and they claim their AI is able to read the physicians note and select the most appropriate code based on the factors discussed above. Similarly, SETMA has a robust system of analytical statistics for each of their physicians that identifies potential pitfalls in the providers' care ranging from basic guidelines metrics to care equity based on ethnicity outlined by The Physician Consortium for Performance Improvement. Using an AI system that can be programmed to understand a physician's potential pitfalls will allow it to provide an alert if a misstep has been recognized or at the beginning of a visit with a patient that may fall into their specific pitfall category. As discussed on March 30, 2012, in the presentation entitled, *The Importance of Data Analytics in Physician Practice*, several complex and important tasks can be reduced to one second, or no seconds, with little energy expenditure through the use of technology. With AI, we could increase the 30 to 40 tasks a physician can do in a single patient visit, opening up opportunities for the physician to maximize time spent having meaningful conversations with the patient and provide a more effective means of passing the baton of care to the patient.

Passing of the Baton is a central idea to SETMA's home health initiative that focuses on rediscovering the trust bond between patient and provider as described in The Future of Healthcare Innovation and Change: SETMA's Model of Care Patient-Centered Medical Home. SETMA explains that the patient is responsible for the overwhelming majority of their care in areas of both time and dedication, conflicting with the current healthcare narrative that the physician should be able to fix the patient's problems within a single visit. The patient and provider team need to work together to change the narrative to the physician providing resources

and education for healthcare interventions and lifestyle changes - this is the true essence of passing the baton. When I observe clinical encounters where the physician is instituting changes, often the provider is speaking to a patient that looks overwhelmed but is trying to understand. It is apparent that the patient is falling into the “good patient” role. Subsequently, when they come back for their follow-up visit, it is likely that they have been unable to institute the changes the physician suggested. This is where the SETMA idea of the patient centered conversation comes into play. It has been addressed in Your Life Your Health - Continuity Creativity Consistency Part VII: The Patient Centered Conversation that pitfalls in instituting change and patient centered care are: “Physicians often redirect patients at the beginning of the visit, giving patients less than 30 seconds to express their concerns, later in the visit, physicians tend not to involve patients in decision making and, in general, rarely express empathy”, leading patients to “forget more than half of the physicians’…recommendations…not surprisingly, adherence to treatment is poor.” In this article, patient centered care is addressed and defined as: “patient-centered communication requires the primary care team to elicit all of a patient’s concerns, to respond with empathy and to work with the patient to prioritize the concerns”. While this rationale does cover pivotal elements to proper patient centered care, it is lacking a crucial final step. Providing the opportunity for patients to fully discuss all of their health concerns is a helpful and critical start, but for a patient to truly grab the baton they must also have a firm understanding of physician recommendations as well as the necessary motivation to carry them out. This is where my RUB-M approach can be applied. It is a form of motivational interviewing that focuses on remembering, understanding, overcoming barriers and motivating, intended to be utilized in primary health contexts for immediate prescription or lifestyle changes. The questions are: how do you remember information, how do you understand information, what barriers do you anticipate, what motivates you to change. Patient preference regarding information comprehension and retention can be assessed through an in-office paper questionnaire before the visit or the provider can simply give examples of common strategies such as teaching back, illustrations, or written information. With the knowledge of how the patient remembers and understands new information, the physician is able to present lifestyle and medication changes in a way that the patient will be able to retain following the visit. Addressing barriers to the proposed lifestyle changes will help the patient and provider solve problems before they arise while also permitting the provider to understand the larger scope of their patient's social situation. The discussion concludes with eliciting the patient’s intrinsic motivation for behavior modification, which studies of motivational interviewing have shown increases the likelihood of sustained lifestyle change. Furthermore, by thinking all the way through the change that the patient is to make enables them to come to the realization that they are a responsible and active participant in their care. SETMA speaks to a similar convergence in regards to changing healthcare from within in highlighting the difference between reformation and transformation in The Future of Healthcare Innovation and Change: SETMA’s Model of Care Patient-Centered Medical Home. When applied to direct patient care, we are looking for transformation; we must

unveil the desire within the patient to change their health habits and establish their health goals so that healthcare interventions can be sustained by an internal drive.

One of the largest barriers to sustaining the patient drive to healthcare is disparities created by location or socioeconomic status, which has proven to be a common concern for primary care physicians. An example of these barriers is in rural West Texas and Eastern New Mexico, where there is a significant lack of access to care. Many of these patients never see a physician in their lifetime, or due to lifetime lack of proper access, do not believe in the efficacy of medical care at all. These communities are in dire need of the reach of healthcare professionals to educate them and pass them their own baton. Primary care providers may look to the way one of the largest pilot programs in the country is currently working towards health equity and leveraging technology through the use of telehealth and drones. Telehealth is nothing new and became more widespread during the COVID-19 pandemic but has the ability to drastically change the way we care for rural communities. When thinking about coordination of care within the healthcare home, Dr. Holly discusses that convenience is the new word for quality in Your Life Your Health - Continuity Creativity Consistency Part IX: Care Coordination and Convenience and nothing may be more convenient for these rural communities than leveraging technology to enhance the trust these populations have in physicians while decreasing the cost and increasing the efficiency in which they get care.

A model that is currently being tested is using healthcare to go to these communities and bring common medical equipment that will transmit data back to a physician in a larger city. This allows the physician to see these patients without actually being physically present, but still is able to listen to things such as heart and lung sounds. Additionally, most lab work done in these rural communities needs to be outsourced to larger cities, as companies like Quest or LabCorp have no equipment in these smaller towns. This requires a courier to drive from these sites to the city, which could be more than 3 hours away, to deliver blood samples. The samples will then be run and sent back, but could easily take 24 hours or more to process, meaning that any samples sent on a Thursday or Friday may not be result until the following Monday or Tuesday. When you think about this issue from a patient's perspective, you begin to see how the seeds of apathy or distrust can be sowed. A solution that is currently in the working stages is the use of drones to fly blood samples and medications from these sites to the hubs of healthcare. Since the drones can be piloted remotely and only require the loading and unloading of cargo, the time and cost of transportation decreases substantially. When this technology is leveraged with the communication and coordination of the SETMA model, this could end up revolutionizing rural healthcare by speeding up the process of moving labs, medications, or in extreme circumstances, organs for transplant while decreasing the cost of care. Now these patients can be seen remotely by a physician, have a sample result in a few hours, and receive medication if needed all in the same day. With promptness of care and the ability to have information readily available, this will increase the patient's confidence that they are at the center of care and give them more autonomy to care for themselves. These patients deserve advocates, and taking these steps can only further

pass the baton as providers try to reach more patients to take their healthcare into their own hands.

In conclusion, SETMA has provided a strong foundation for primary care through its continued pursuit of excellence in all aspects of the field. The robust system that Dr. Holly created maintains strong evidence that it continually improves patient care. In the spirit of this constant improvement, I want to enter the family medicine field and make an impact on its future, primarily through expanding the entities encompassed within the healthcare home, decreasing the administrative burden on the physician by optimizing electronic medical records, and increasing the ability for the physician to gain patient trust through meaningful conversations that effectively empower the patient to “grab the baton” of their care. While I do realize this will be a career-long pursuit, trailblazers, such as Dr. Holly, have inspired future physicians such as myself to embark upon the journey of constant improvement. At the end of the day, I want my practice to holistically care for my patients and to passionately influence the field in a direction of constant quality improvement and excellence.

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