An advocacy effort should aim to increase awareness of funders, decision makers, and partners concerned by metrics, about the time needed to develop productive partnerships, and meaningful process measures. Time well invested in this regard will definitely lead to interventions better answering the needs of patients and stakeholders.

Conclusion of the Forum

Conducting research to improve care for individuals with complex health care and social needs calls for complex interventions integrating services provided by health care and social professionals as well as community-based services. Taking time to develop and nurture partnerships and engage patients and other stakeholders in research allows a better understanding of each other's reality, increasing sustainability, and identification of more relevant research designs as well as process and outcome measures. Developing a common language and having access to combined health care and social services funds would help to promote this partnership.

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AAFP **From the American Academy of Family Physicians**

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AAFP GIVES GUIDANCE FOR HHS STRATEGIC PLAN THROUGH 2022

The US Department of Health and Human Services (HHS) has released a draft strategic plan for fiscal years 2018-2022 and invited stakeholders such as the AAFP to provide feedback. Because the Academy welcomes every opportunity to help guide HHS activities, AAFP Board Chair John Meigs, MD, of Centreville, Alabama, responded on behalf of the AAFP in an October 19, 2017 letter (http://www.aafp.org/content/dam/AAFP/documents/advocacy/legal/administrative/LT-HHS-Draft2018-2022Framework-101917.pdf) to HHS Acting Assistant Secretary John Graham.

The HHS draft plan lays out how the agency will achieve its mission over the course of the next few years through 5 strategic goals—with objectives outlined for each. Those goals, in order, are to:

- Reform, strengthen, and modernize the nation's health care system
- Protect the health of Americans where they live, learn, work, and play
- Strengthen the economic and social well-being of Americans across their lifespans
- Foster sound, sustained advances in the sciences
- Promote effective and efficient management and stewardship

The AAFP used the bulk of its 7-page letter to respond to an objective for the first goal that touches

on the need to reduce administrative regulatory and operations burdens. The AAFP argued that the final strategic plan "must specifically address" the need to reduce those burdens for practicing physicians. "Administrative simplification represents an industry-wide commitment to reducing health care costs by removing unnecessary burdens throughout the compliance, claims and billing processes," said the AAFP, and the final strategic plan should reflect HHS' commitment to such.

The AAFP produced a list of priorities and called on HHS to tackle longstanding issues that frustrate family physicians such as prior authorizations, chart documentation, Medicare certification and documentation, electronic health record (EHR) interoperability, interpretation service costs, quality measure harmonization and alignment, and inconsistent claims review.

Regarding prior authorizations, the AAFP noted that "frequent phone calls, faxes and forms (that) physicians and their staffs must manage to obtain prior authorization for an item or service" are obstacles to patient care that are "becoming increasingly common." Furthermore, prior authorizations "must be justified in terms of financial recovery, cost of administration and workflow burden," said the AAFP. Among other things, rules and criteria for prior authorization determination "must be transparent and available to the prescribing physician." In situations of denials for a service or medication, "the reviewing entity should provide the physician with the criteria for denial," and for medications, alternative choices should be provided.

On chart documentation, the AAFP noted that "documentation burdens have escalated dramatically without relief from adoption of electronic records. Indeed, current electronic record products have only added to that burden." The AAFP made it clear that "the primary purpose of medical record charting should be to document essential elements of the patient encounters and to communicate that information to other providers." Further, "the use of templated data and checking boxes should be viewed as administrative work" that does not contribute to the care and well-being of patients.

Regarding Medicare certification and documentation, the AAFP said, "Physicians want to efficiently order what their patients need to manage their disease conditions in a way that maintains their health. Unfortunately, the current procedures surrounding coverage of medical supplies and services impede this goal and add no discernible value to the care of patients." Among other points, the AAFP said:

- Physicians' orders should be sufficient
- Physicians should not have to recertify durable medical equipment supplies annually for patients with chronic conditions
- Authorizations for supplies should be generic so physician don't need to fill out a new form when patients switch brands
- Authorization forms should be universal across payers

On the topic of EHRs, the AAFP noted that surveys indicate current health IT infrastructure and products are not efficient or effective in supporting practice transformation. "Therefore, all physicians need the national health IT ecosystem to undergo more rapid transformation than has been the case to date," including systems that provide interoperability, said the AAFP. Physicians also need population management and patient engagement functionalities, and they need a user-centered design. The AAFP urged HHS to "place the burden of compliance on EHR vendors and not on physicians." Vendors "must be held accountable for the inadequate design and poor performance of their products," said the letter.

Interpretation service costs have been a burden for physicians since the implementation of new regulations in 2000, and even more so after "new and costly limited English proficiency policies went into effect" on October 17, 2016, said the AAFP. "Family physicians already operate on slim financial margins," said the letter. "We believe that HHS must fund the increased costs practices will bear to comply with these requirements," or else the requirement should be eliminated, said the AAFP.

Regarding quality measure harmonization and alignment, the AAFP noted the complexity of family medicine practices and said "family physicians experience a more significant burden when multiple performance measures and quality improvement programs have no standardization or harmonization." The AAFP urged HHS to "align quality measures as part of their overall approach to reducing administrative burden" and to use the core measure sets developed by the multi-stakeholder Core Quality Measures Collaborative.

The issue of inconsistent claims review has also been a chronic source of irritation to family physicians. The AAFP pointed out that "there are a multitude of post-claims review processes under Medicare alone." "Within these audit programs, there are a multitude of requirements, appeals processes (if any), differing deadlines and governing agencies. Communications from these entities are not easily understood by busy physicians nor are their deadlines easy to meet," said the AAFP. The Academy urged HHS to streamline the programs and to "utilize one set of criteria that is universal."

The AAFP also took advantage of the opportunity in the feedback to make mention of some important work it is undertaking. In reference to HHS' stated

goal to "protect the health of Americans where they live, learn, work and play," the AAFP noted HHS' failure to acknowledge the importance of advancing health equity to improve the health of all citizens.

The AAFP then said that as an organization it has "made addressing social determinants of health—as they impact individuals, families and communities across the lifespan and striving for health equity—a strategic priority." The letter provided a link to the AAFP's Center for Diversity and Health Equity, http://www.aafp.org/patient-care/social-determinants-of-health/cdhe.html, where HHS can also get further details about a new Academy initiative to advance health equity in all communities dubbed "The Every-ONE Project."

HHS will take recommendations received from the AAFP and others to build on progress made in strategic and performance planning efforts for the future.

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AMERICAN BOARD OF FAMILY MEDICINE SELECTS NEW CHIEF EXECUTIVE OFFICER AND PRESIDENT

The American Board of Family Medicine's (ABFM) Board of Directors has selected Warren Newton, MD, MPH to become its next President and Chief Executive Officer, succeeding Dr. James C. Puffer upon his retirement. Dr. Newton will serve in the position of President and CEO Elect beginning July 1, 2018 until Dr. Puffer's retirement at the end of 2018. Upon assuming the role of President and CEO on January 1, 2019, Dr. Newton will oversee the ABFM, as well as the ABFM Foundation and Pisacano Leadership Foundation.

About Dr. Newton

Dr. Newton is currently Executive Director of the North Carolina Area Health Education Center (NC AHEC), a national leader in practice redesign, continuing professional development, health careers programming, and innovation in graduate medical education, and Vice Dean of the School of Medicine at the University of North Carolina (UNC). From 1999-2016, he served as the William B. Aycock Professor and Chair of Family Medicine at UNC.

Dr. Newton has been a personal physician for 33 years, working in a variety of settings, including the UNC Family Medicine Center, the Moncure Community Health Center, and the Randolph County Health Department. In the 1990s, he founded the first hospitalist program at UNC Hospitals and helped reorganize family medicine obstetrics into a maternal child service. Over the past 15 years, he has led practice transformation initiatives at the practice, regional, and statewide levels; North Carolina AHEC now provides support in health information technology, PCMH, and quality improvement for over 1,200 primary care practices.

As an educator, Dr. Newton served as residency director at UNC from 1992-1997; since 2004, he has co-lead the 13 collaborative of 24 primary care residencies focused on clinical transformation in the residency practices. He has also taught extensively in medical school and fellowship programs and served as Vice Dean of Medical Education at the University of North Carolina from 2008-2013, during which he led an LCME review, expanded the school, established satellite campuses, developed new curricula in professionalism and population health and expanded the enrollment of underrepresented minorities. Dr. Newton's scholarship has focused on the organization and effectiveness of health care; he has over 140 peer-reviewed publications, including over 80 published with students, and has been principal investigator on grants totaling more than $45,000,000. Finally, from 2012 to 2017, he served on the Board of Trustees of the North Carolina State Health Plan, responsible for the health and health care of approximately 700,000 state and county employees and retirees. In 2016, he served as Senior Policy Advisor to the North Carolina Secretary of Health and Human Services, helping to prepare the Medicaid 1115 innovation waiver, plan rural residency expansion, and develop quality metrics for Medicaid.

"Warren Newton's extraordinary service to the discipline of family medicine and his commitment to improving health has been a core value that has guided every aspect of his professional work over the last 3 decades," said Elizabeth G. Baxley, MD, Professor of Family Medicine at Brody School of Medicine and Chair of the ABFM Board. "I have had the privilege of working with Warren at the state and national level and can attest to his dedication to continuous improvement and innovation in clinical care and education, as well as his drive to strengthen the discipline of family