community member partners on a successful and meaningful research project. The Pre-Con will invite teams of participants to develop their ideas on the subject. PaCE members have already created a similar model for the "Just-Right Patient Partner" which will be presented as a Poster during the 51st Annual Meeting as well.

Raymond Haeme, Maret Felzien, Kirk Kelly, Susan Lowe, Arturo Martinez-Guijosa, Kirk Mason, David Kaplan, Joseph LeMaster, John M. Westfall, Alan Pavilanis, Anna Templeton, Leyla Haddad, Vivian R. Ramsden

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NEW RESOURCE LIBRARY OFFERS TOOLS, TECHNIQUES TO REDUCE ADMINISTRATIVE BURDEN

A new Administrative Simplification resource library from the AAFP offers solutions for eliminating or reducing administrative burdens in areas including documentation, prior authorization, and the electronic health record (EHR) inbox, as well as updates on the Academy's progress in achieving administrative simplification through its federal and state advocacy efforts.

The library is available at **https://aafp.org/simplify**

Documentation Burden

For every aspect of documentation burden, the AAFP offers innovations—techniques, technologies, and transformations—to help family physicians change their practice environment. Each provides an overview of documentation burden, describes its impact on family physicians, and discusses solutions that can provide relief.

Family physicians who want to begin tackling burden by making modest changes can adopt practical techniques that optimize current processes and workflows. The library offers tips for redesigning patient visits, for example, that can be readily implemented in virtually any family medicine practice. It also includes recommendations for optimizing EHRs to reduce the number of clicks it takes to perform simple operations, as well as guidance on using the 2021 outpatient and office visit evaluation and management coding changes to cut burden.

Those who choose to utilize an innovative technology or service that offers promise in reducing or even eliminating documentation burden will find a number of options. These include scribes and scribing services; speech recognition tools; and artificial intelligence (AI)–powered, voice-enabled digital assistants. The library outlines the pros and cons of each option and includes monthly pricing estimates for each. Resources also help family physicians review the impact that each of these technological innovations has on factors such as time saved, burden reduction, and increased efficiency and satisfaction.

Family physicians who are ready to dig in and change processes can learn about organizational changes a practice can make to modify its workflow and operations. Transformations to improve documentation burden range from expanding nonphysician clinicians' scope of work to adopting new practice models.

Prior Authorization Burden

AAFP members consistently characterize prior authorization as among the most demanding administrative burdens they and their staff deal with every day. Moreover, they say, prior authorization requirements are continually increasing, stealing time from patient care and, ultimately, hurting the bottom line.

The library offers techniques to help successfully navigate those requirements, categorized into 3 primary areas.

The first of these is to prescribe mindfully. After all, avoiding prior authorizations in the first place, such as by choosing generic medications rather than costlier brand-name drugs when possible, prevents associated downstream burdens.

Delegating prior authorization duties to designated staff and streamlining workflows also can significantly lower burden posed by prior authorizations.

EHR Inbox Burden

Some of the techniques used to address the burdens described above likewise apply to taming EHR inboxes. Delegation, for example, can play a huge role in reducing the number of EHR messages physicians need to handle themselves. For starters, information technology (IT) departments may be able to route incoming messages to a designated individual, such as a nurse or medical assistant (MA). Physicians also can collaborate with staff to identify the most

appropriate person or people to review incoming messages and route them appropriately.

The resource library helps physicians build on that process by designating staff members to perform certain tasks associated with incoming e-mail, such as filling out disability or physical exam forms. They may not be able to complete the entire document, but they can get the process rolling and save time.

Those who do plan to delegate inbox tasks to staff should create protocols for them to follow when needed. Establishing standing orders for handling urgent and emergent messages and medication refills, as well as templates for communicating test results, ensures they don't fall through the cracks. On a related note, setting aside time each day to review inbox items and forward them for staff to act on before they leave can keep physicians from being stuck with a backlog of messages that easily could have been handled.

Of course, precluding the need for messages to reach physicians' inbox in the first place is guaranteed to winnow down volume. Tactics such as ensuring the patient has enough medication to last until the next appointment and timing laboratory orders so results can be discussed at that visit can help. An AMA toolkit highlighted in the library offers more inbox management tips.

Finally, although the technological options to address EHR inbox burden are limited, 2 promising technologies stand out: unified communications platforms and AI assistants. The library offers real-world examples.

More to Come

The library is a work in progress, with more administrative simplification resources being developed, including remedies for burden posed by quality measurement requirements, chart review demands, payment, and more.

Cindy Borgmeyer
AAFP News

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A MILESTONE FOR PROMOTING RESEARCH IN FAMILY MEDICINE

On October 30, 2023, the Association of Departments of Family Medicine (ADFM) and the NAPCRG convened a national summit to advance the next generation of plans to develop research in the specialty of family medicine. The product of 3 years of planning, with extensive input from the specialty, this extraordinary gathering was not merely an event, it was a catalyst for change, a celebration of unity, and a testament to our collective dedication to the discipline of family medicine. What follows reports the context, rationale, and next steps of this milestone to the wider community.

Why and Why Now?

Our specialty does tribal gatherings. From the 1960s to the Future of Family Medicine to the Starfield Summits, when the problems are big and all hands are needed on deck, we come together for inspiration, for dialogue, and to set our path forward together. This summit was one of those events.

Fifty years ago, we came together as a specialty of counterculture. Our commitment was to create a new kind of doctor, a family physician, who could provide access to care across all communities. We grew residencies at light speed and are now the dominant primary care specialty with over 105,000 family physicians and now the most rapidly growing number of residencies of any specialty over the last 5 years.

As successful as our founding was, however, it bore the seeds of our current challenges with respect to research. Family medicine represented a rebellion against the medical establishment and against traditional academic centers and the test-tube science of the era. Family medicine faculty became largely a tribe of clinician teachers—very valuable for creating a new workforce, but not focused on the systematic development of research capacity. And that culture has continued. For example, for many years, drawing on the observation that research-intensive medical schools often produce fewer family physicians, many in our specialty concluded that research should not be an emphasis of the specialty. Yet the science of today is far removed from that of the 1960s. The intellectual disciplines that undergird family medicine, such as clinical epidemiology, management, and health behavior, have come of age: the potential for research relevant to what we do is much greater.

And now is a critical time for action. Despite pervasive rhetoric of "innovation" and "transformation," and despite continuing rapid increases in cost, US health outcomes at the population level are now getting worse. We are sicker and die early. For all ages, and for almost all diseases, Americans have worse outcomes than in all other affluent countries.[1] Our life expectancy has been dropping since 2014,[2] and COVID-19 has reminded us again that care and outcomes are unequal across race and income—and now, post COVID, our practices are fighting for survival with huge demand, staff shortages and poor reimbursement. This is a much broader issue than family medicine, of course, but we believe that family physicians, well trained and supported by the system, can help heal health and health care. That has been the focus of our major redesign of residencies[3] and substantial advocacy at the federal and state levels.[4]

But it is research that will drive what we do in practice and how far we will go in the future—the kind of research that informs improvement of practice and advancement