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.

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AAFP News

From the American Board of Family Medicine

Ann Fam Med 2023;21:564-566. https://doi.org/10.1370/afm.3067

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

of policy. But our research infrastructure is not yet robust enough to lead this process. As a specialty, our research punches far below the weight of our clinical role. Primary care represents by far the largest care delivery system in the United States, providing more than one-half of approximately a billion health care encounters a year, but receiving only .3% of NIH funding or $3 out of every $1,000 spent in NIH research.[5] We have family medicine departments which do substantial and excellent research, but there are many *individual* departments of internal medicine that have more research funding and more publications *than our entire specialty.* Moreover, the number of family physicians interested in getting advanced research training is now the lowest in a generation, with our most competitive residency programs unable to attract family physicians to research careers. And, as the wheel of fortune has turned again towards health care reform, too few family physicians with outstanding research track records have been available to compete for leadership roles in government and philanthropies.

This is not to say that we have been idle in developing research and training infrastructure. Confronting very challenging financing and cultural barriers, the specialty has tried to bootstrap itself on a number of occasions—the work of Carol Bland, Family Medicine for America's Health, ongoing work in research-ready large databases like PRIME,[6] reporting standards for primary care research,[7] and the ongoing work of the Building Research Capacity initiative.[8] We must build on this work, even as we expand it, broaden the focus, and rethink strategy.

The Goals of the Summit

ADFM and NAPCRG are sharing responsibility for developing the research strategy for our specialty, building on what we've done in the past and coordinating with other organizations in family medicine, with a clear understanding that this will be a long-term project. Over the last year, they have led 2 national meetings of leaders of family medicine organizations focused on strategy for research and, as summarized in Table 1, conducted scores of interviews, focus groups, and a national survey. The process identified has 3 areas of focus for building research in the specialty: building pathways and mentorship programs to develop researchers, creation of new kinds of research infrastructure, and advocacy for funding of research that matters to family medicine practice and policy. The goal of the summit was to finalize the goals for each of these areas.

Our specialty has many wise voices to learn from, but it may be helpful to suggest what might be goals for this work. A first goal is simple to say: our community should produce the evidence needed to drive practice change. This is not the case now: as an example, over the last 2 years, the ABFM National Journal Club has screened scores of journals for empirical articles that are relevant to family medicine, likely to impact practice and methodologically sound. Of the first 249 selected, only one has a first author from a department of family medicine and only 4 have any author from a family medicine department. Similarly, as we advocate for health reform and battle with payers and big tech, and as we develop interventions to improve health equity, much of the data that drives our proposals should come from our research.

To create the research we need, however, we need to build a strong cadre of young family physicians and aspiring researchers from different backgrounds who are dedicated to making meaningful impact in clinical care and policy. This starts with attracting students passionate about research into family medicine. It entails nurturing clinical curiosity early in medical school, equipping clerkship students and residents with skills in using evidence and collecting and interpretating data. In residency and beyond, we should have clear pathways and recognition for individuals who choose to dedicate their lives and lifestyles to research. Finally, we must recruit individuals from diverse backgrounds, including those with

Table 1. Participants in the Research Summit Process

Group	Interviews	Focus groups	Survey Responses	Summit participants
Practicing (academic and non-academic) family physician	9	11	135	67
Department chair	3	4	23	28
Researcher (PhD and/or master's level and/or physician)	16	11	21	62
Research director (or vice chair for research or equivalent)	7*	7	15	52
Residency director		3		
Clerkship director		3		
Resident/fellow		1	15	6
All others			47	(n/a)
Other*			26	(n/a)
Research staff			4	3
Leader of a PBRN			3	14
Patient	2		3	3
Physician or leader of another medical specialty			3	5
Health system leader			2	12
Leader of CTSA			2	5
Medical school dean			2	1
Executive administrator	3		1	3
Student		3	1	2
Total[a]	**20**	**21**	**256**	**142**

CTSA = clinical translational science awards; PBRN = practice-based research network.

[a]Totals do not add to 100% as participants could choose multiple roles.

PhDs and expertise in other clinical disciplines, who share our vision of advancing primary care and population health outcomes. The future of research is "team science" and we need teammates!

We must also evolve our research infrastructure. Traditional research training programs like the Robert Wood Johnson Clinical Scholars and HRSA-funded research training programs need modern successors; models from Canada and Europe may help guide the way.[10] Infrastructure also means developing research-ready big data sources and new methodologies while focusing on areas of potential strength in spaces such as health equity. We also need new organizational structures such as inter-institutional collaborations with large and diverse populations capable of supporting the research teams necessary for asking and answering questions that matter for primary care practice and population health.

Success will depend on effective advocacy, at both the institutional and national levels. Within academic centers, we must skillfully negotiate chair packages and uncover often hidden sources of funding. At the national level, we must advocate for the establishment of an NIH office dedicated to primary care research—this has been a successful strategy of other disciplines like emergency medicine and nursing. Let us unite in making a data-driven case for why the need for primary care research is not being met by current NIH work—and what our research priorities should be. Complementing NIH clinical research should be an expansion of AHRQ research on improving the systems of care in primary care and health care systems. Of course, effective advocacy demands good ideas, well-articulated identification of champions, both in politics and the research community, along with organization, the ability to adapt and … patience.

Next Steps

ADFM and NAPCRG are committed to communication and coordination with the specialty: they will be following up soon with the results of the summit, along with developing detailed plans, metrics for success and timelines. They are also preparing a series of papers that will lay out what we have learned and make the case for where we should go. These will be published in a special issue of *JABFM* next year.

The work ahead will be challenging, requiring new ideas, leadership, detailed planning, and coordination across the family of family medicine organizations. It will require clear thinking about practicality and the discipline to maintain. And it will require tenacity: this is at least a 5- to 10- year effort.

In conclusion, almost 20 years ago, the authors of the Future of Family Medicine report declared: "Unless there are changes in the broader health care system and within the specialty, the position of family medicine in the United States will be untenable in a 10- to 20-year time frame."[7] Since then, we have made significant progress, but there is much still left to do. An important part of our unfinished business is making research integral to our specialty and to our culture—as well as bringing about changes in broader health care and research ecosystems.

The stakes are high. Thank you to all who are bringing ideas and energy to this effort. Like residency redesign, it is one of the major tasks of our generation.

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