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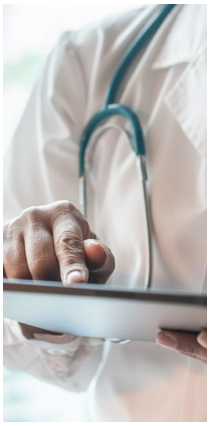

AN INDUSTRY BRIEF FROM INSTITUTE@PRECISION

Rebuilding the EHR for Primary Care

5 Opportunities to Support the Front Lines of Medicine

Laura Hahn, MD
Ross Maclean, MD

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Primary care is personal. Each patient interaction is shaped by a provider's deep knowledge of individual health needs, social context, and clinical history. Yet, the primary tool physicians rely on to deliver care, the electronic health record (EHR), often hinders more than it helps. Despite years of effort and evolution, most EHR platforms remain fundamentally misaligned with the realities of primary care. Designed for documentation-heavy hospital environments and top-down reporting, today's EHR systems often work against providers trying to deliver efficient, compassionate care in a 15-minute appointment.

Treatment in a primary care setting is individualized based on a provider's knowledge of the patient, their healthcare needs and life circumstances, and is rarely formulaic. Primary care providers (PCPs) have adapted heroically, building workarounds like dot phrases, templates, and macros. Still, many are logging hours late into the evening, struggling to complete documentation, close care gaps, and triage dozens (or hundreds) of in-basket messages. It's time for a new approach.

In this article, we outline five critical areas where EHR design can evolve to better support PCPs and their patients. Fixing the EHR won't solve every challenge in primary care, but it's a meaningful step toward reducing burnout, improving care quality, and unlocking the full potential of data at both the patient and population levels.

Figure 1. Summary of 5 themes relevant to EHR optimization

Anchor the EHR in Primary Care Workflow

Most primary care physicians (PCPs) start their morning with "pre-charting" in which they review their patient schedule for the day and make a plan for the highest priority items for each patient. When a schedule consists of twenty or more patients, one can only allocate about 3 minutes per chart before the clinic starts. Hospital follow-up appointments and new patient appointments will naturally require more chart review and planning and will consume a larger chunk of pre-charting time. PCPs would benefit from "rounding reports" to streamline the pre-charting process and ensure a more productive patient encounter, eg, assessment and plan from the last visit, recent labs and imaging, medication dispense history, overdue health maintenance items and incomplete orders or referrals.

During the actual patient encounter, PCPs are balancing pleasant small talk, taking a history, performing an exam, documenting essential findings, formulating a plan, completing order entry, writing patient instructions, and deciding on patient follow up all within 15 minutes. Weaving together all these elements during a patient visit while seamlessly interacting with the electronic health record (EHR) takes years to master yet most PCPs have found a way to do this that works for them. Pop-up reminders, ambulatory order sets and "express lane" features, which may be helpful for urgent care, emergency care or inpatient care, are not applicable to primary care because PCP visits often address multiple chronic issues and perhaps a few acute issues.

PCPs would benefit from "rounding reports" to streamline the pre-charting process

In between patient visits, PCPs are constantly battling the hundreds of items in their EHR in-basket. To support a team-based approach to patient care, the EHR should allow for redundant or clerical items to be offloaded to support staff. Similarly, support staff should have the tools to efficiently triage these items, so that PCPs can focus on direct patient care. Lastly, PCPs are inundated with requests to complete forms – digitizing and integrating them into the EHR would significantly reduce the administrative headaches PCPs experience day-to-day.

1. Declutter the EHR

Contrary to widespread belief, at no point are pop-up reminders about best practice advisories helpful to PCPs. These are disruptive to the providers' workflow, so they are dismissed without a glance and do not have any impact on closing care gaps. In addition, endless customization is not actually a desirable feature of an EHR for PCPs. The ambulatory encounter should be more "bare bones" from the outset. PCPs can add more frames, panes, or tabs as they like, but most PCPs would prefer simplicity - one page to write a SOAP note and one page to write orders. All the toolbars, side panels, flow sheets and tabs tailored to provide us with the most up-to-date information result in distraction and inefficiency. Addressing overdue health maintenance items and quality metrics typically occurs outside the actual patient encounter and is better addressed during the pre-charting process.

RECOMMENDATION:

Trust that the PCP knows their patients, why their health maintenance items are overdue or why they are not currently a priority for the patient. The default settings for the ambulatory encounter should exclude pop-ups but allow PCPs the ability to opt-in to these prompts and reminders if desired.

2. Reduce Clerical Tasks for PCPs

Balancing patient care with a deluge of clerical work is a major source of frustration and burnout for PCPs. The EHR is designed with the assumption that primary care clinics have a full-time nurse devoted to triaging these tasks appropriately; however, the assumption should be that primary care clinics are under-staffed and under-resourced. Allowing PCPs to play an active role in rebuilding the EHR in-basket within their practice or organization to reduce clerical tasks and redundant messaging is vital.

RECOMMENDATION:

Before implementing an EHR within a primary care practice, determine what in-basket items will be routed to staff and what will be routed to clinicians. Set ground rules for what is urgent, and what can be dealt with later. Digitize common and practice-specific referral forms for medical equipment, mobility access and medical leave and integrate them into the EHR to minimize handwritten paperwork.

3. Reduce the Administrative Burden

Clinicians are increasingly frustrated by the need to balance meaningful patient care with excessive documentation demands. In-basket messages pile up, and practices are often under-resourced to manage triage effectively. Worse, PCPs must often handle paperwork manually such as faxes, handwritten forms, and payer-specific documentation.

RECOMMENDATION:

- Digitize common forms so that they are integrated into the EHR and ready to go.
- Rebuild the in-basket workflow with PCP input: What should go to staff? What is truly urgent? What can wait?
- Assume under-resourcing, not ideal staffing and design systems that function even when teams are stretched thin.

These changes aren't just about efficiency; they're about keeping clinicians focused on patient care instead of administrative firefighting.

4. Improve Payer Integration, Especially for Prior Authorization

One of the greatest hurdles for PCPs is the inefficiency of the prior authorization (PA) process. Ideally, any medication, imaging, equipment, or referral requiring a PA would automatically initiate a PA request with the appropriate payer and send them a copy of the medical documentation from the visit detailing the need for such an order. Whether it's a medication, imaging study, or referral, the PA process is opaque, time-consuming, and disruptive and often, require follow-up calls, additional paperwork, or even faxes.

RECOMMENDATION:

Embed real-time benefit checks and automated PA initiation directly within computerized provider order entry (CPOE) workflows. When an order is placed, the EHR should:

- Identify if a PA is needed
- Pre-populate payer forms
- Attach relevant clinical notes

This not only saves time for providers, it also prevents frustrating delays for patients and avoids denials that can derail care.

Care process	**Pre-consult planning** Clinician preparation for the upcoming patient consult allowing time to identify and plan for key topics	**Consultation** Summary of past and current information relating to signs and symptoms, diagnoses, tests and procedures, and treatment	**Post-consult follow-up** Review of test results; onward referral to other health care specialists or service; or interaction with health insurers to secure required services
EHR features of value to clinical care	• 'Rounding report' function specific to primary care • Flag high risk patients • 'Lookout List' - reminders of required topics, tests, referrals, etc.	• Simplicity - space to write SOAP, space to write orders • Remove "pop-ups" and reduce information overload	• Automated link to insurer prior authorization process within CPOE • Establish framework for EHR in-basket management • Digitize forms • Practice-level population health data and predictive models
EHR features of value to research	• Ability to identify presenting complaint vs. differential diagnosis vs. discharge diagnosis • Inclusive and clear list of SDOH attributes	• Documentation of adherence to or deviation from clinical practice guidelines/ pathways and clinical rationale • Quality of care reporting	• Ability to summarize referral patterns by diagnosis, clinician, geography and referring specialty • Evaluate workflow efficiency • Identify effective interventions for high-risk patients

5. Improve Population Health Reporting

Primary care plays a vital role in managing population health, yet few EHRs provide PCPs with meaningful, actionable insights. The reporting dashboards are often too broad or too fragmented, lacking the nuance required to prioritize high-risk patients.

Primary care plays a vital role in managing population health

RECOMMENDATION:

Enhance reporting capabilities to support:

- Identification of high utilizers (eg, frequent ED visits, recent hospitalizations)
- Integration of social determinants of health to tailor outreach
- Incorporation of risk models (eg, for cancer or cardiovascular disease) to support personalized prevention
- Flexible reporting cadence, aligned with practice needs and public health priorities

The same data that powers clinical care should also support practice wide insights, research, and value-based care success. If your practice is acquiring, changing or upgrading the EHR system, be sure to consider how the EHR maps to the population-level reporting expectations that the practice is held to and the research interests and priorities of the practice, local and state public health departments.

A Better EHR Is a Better Future for Primary Care

The promise of the EHR has always been to support better care, more informed decisions, and healthier populations. But when EHRs become barriers rather than tools, everyone loses, providers, patients, and the system at large. It will take significant investment and policymaker support to save our nation's dwindling primary care workforce, but crafting a better EHR experience for PCPs is a start. Change must begin with understanding the day-to-day barriers for PCPs at the clinic level, and prioritizing EHR implementation or updates that are meaningful for them. Reforming the EHR for primary care won't happen overnight, and it won't be easy. But it's essential.

The path forward starts with:

- Centering EHR design on the unique realities of primary care
- Empowering PCPs to define what works (and what doesn't)
- Investing in systems that reduce provider workload
- Aligning data capture with clinical, operational, and population-level needs

It's time to give PCPs an EHR that works for them, not against them.

Because when we support the people on the front lines of care, everyone benefits.

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