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Are EHR Logouts Required Between Clinical Staff Tasks?

DEBUNKING THE MYTH

To the best of our knowledge, no state or federal law or regulation prohibits a clinically trained staff member from performing both documentation and other clinical duties during a single patient encounter.

BACKGROUND

In advanced team-based care models, clinical assistants, such as medical assistants (MA), and nurses, often perform both documentation assistance and other clinical tasks in the course of patient care. For example, a nurse may obtain and record a patient's vital signs and chief complaint, then shift to documenting clinical notes in partnership with the physician. Throughout the visit, the nurse or MA may switch frequently between these different tasks.

There is no need for a clinical support team member to log out of the EHR when they complete one portion of their work only to log back in to perform another. The Centers for Medicare & Medicaid Services (CMS) does not provide official guidance on the use of documentation assistance. Job-specific security access in electronic health records (EHRs), typically set by organizational policies, may limit what tasks can be completed when a particular type of user is logged in.[1] For example, someone designated as a documentation assistant or scribe may not have access to perform clinical tasks in the EHR. It is important for organizations to balance organizational security and access roles with policies and procedures allowing healthcare professionals to efficiently use the EHR during patient encounters while working within the scope of their training and/or certification.

ADDITIONAL INFORMATION

1. In 2012, the non-regulatory professional association American Health Informatics Management Association (AHIMA) issued guidance encouraging protocols to ensure documentation is both traceable and attributed to an authorized individual.[2] This guidance may have caused some organizations to create internal policies requiring clinical assistants to sign in and out of the EHR when task switching. In some situations, these policies may not be practical or necessary.
2. The Joint Commission does not support or prohibit the use of documentation assistants.[1]
3. In July 2018, The Joint Commission published an FAQ concerning documentation assistance after reviewing relevant literature and visiting organizations utilizing clinical support staff to help with EHR documentation. The FAQ re-defines what a documentation assistant or scribe is and what they do and provides guidance on basic competency expectations. Importantly, it encourages healthcare organizations to develop policies and procedures specific to documentation assistance, along with job descriptions defining minimum qualifications and scope of work.[1]

KEY TAKEAWAY

Health system leadership can work with EHR vendors to streamline workflows that enable authorized clinical support staff to assist physicians with documentation and other clinical tasks without unnecessarily having to log out during the same encounter. By prioritizing usability and team-based documentation practices, health systems can help free up physicians' time for direct patient care.

Resources

- 2020 AMA Steps Forward® Success Story: "Getting Rid of Unnecessary Clicks in the EHR"
- 2023 AMA Team-Based Care STEPS Forward Toolkit
- 2025 AMA Team Documentation STEPS Forward Toolkit
- 2014 FPM article: Team-Based Care: Saving Time and Improving Efficiency

References

1. The Joint Commission. What guidelines should be followed when physicians or other licensed practitioners (LP) use scribes to assist with documentation? The Joint Commission. July 26, 2018. Accessed September 22, 2025. https://www.jointcommission.org/en-us/knowledge-library/support-center/standards-interpretation/standards-faqs/000002210
2. American Health Information Management Association (AHIMA). *Information Integrity in the Electronic Health Record.* AHIMA; 2012. Accessed July 20, 2025. https://www.ahima.org/media/sxflfny0/information-integrity-in-the-electronic-health-record_axs.pdf