Department: Health Information Management (HIM)

Policy Number: HHS-4120-HIM **Attachments:**

Policy Title: Students Accessing and Using the RPMS Electronic Health Record

Date: 12/12 **Revised:**

Approved by: Date: 3/13/13

Policy Statement:
The Mille Lacs Band Health Services recognizes the importance of establishing policy and procedures addressing how students may access and use the RPMS EHR.

POLICY:
Students (medical, interns, residents, technicians, allied health, ancillary, etc.) who have access to the RPMS EHR should document information they have collected from the patient, on behalf of the provider, or document the care they provided to the patient.

PROCEDURE:
Requesting Access and Setup:

1. The student will complete necessary forms requesting access to the network, RPMS, and EHR during the student orientation process.
2. The facility will provide appropriate orientation and training to all students on EHR, RPMS, Computer Security, Privacy Act, and Health Insurance Portability and Accountability Act (HIPAA).
3. The student will route the form to Information Management or appropriate person who shall enter the student into the RPMS database; assign access and verify codes, and network access.
4. The student will be assigned a provider code.
5. Students shall be assigned to the EHR User Class of "Student". This User Class restricts functionality as follows:
    a. Allows students to view all components of EHR
    b. Allows students to write notes and require co-signature
6. Students will be instructed to enter an "electronic signature" that includes the appropriate credentials at the end of the signature.
7. Additional functionality requests will be reviewed by the student's immediate supervisor (preceptor) and the Privacy/Security Officer.

Writing Notes:

1. Students may write a note in EHR using an appropriate template identified by the preceptor.
2. The student shall identify a co-signer (the preceptor for that encounter) for all notes.
3. The preceptor shall review and co-sign the note at the time of the encounter.
4. Student documentation is not intended to be a "stand alone" documentation of a patient encounter and is not acceptable for billing purposes; it is only considered complete with the preceptor's attached note.

a. The preceptor shall edit the note initiated by the student.
b. Only the review of systems and past, family and social history may be documented by the student. It shall be noted when appropriate "History taken in presence of attending provider."
c. All other components to a complete note must be completed by the preceptor, such as the history of present illness, physical exam and any medical decision making activities of the visit.
d. Providers are ultimately responsible for the completeness and accuracy of the entries in the health record. The process of writing notes is an irreplaceable learning tool in the education of a future healthcare professional, but the record must clearly indicate if the preceptor agrees or disagrees with what the student has written.
    i. In the paper record, the preceptor is able to correct the student note by lining through inaccuracies and making corrections/additions and initialing changes. In the EHR the preceptor can edit student's note and then write his or her observations or assessment as appropriate

Monitoring:

1. Health Information professionals shall monitor un-cosigned student notes on a daily basis through the TIU Reports function.
2. The co-signer will be notified via EHR notification that they have a pending note to be signed.
3. It is the co-signer's responsibility to ensure all student notes are signed within 24 hours.
4. The facility is responsible for monitoring of student encounters.

ATTACHMENTS:

REFERENCES:

RECISSION:

DISTRIBUTION: All Staff