# Table of Contents

**Foreword**  
Getting Started with EHR  7  
Patient Selection  8  
Selecting Patient by Medical Record Number or Name  9  
Selecting a Patient Using Scheduled Visits  10  

Visit and Provider Selection  11  
Selecting a Previous Visit under “Appointments/ Visits” Tab  11  
Creating a Visit under “New Visit” Tab  12  
Type of Visit Options  13  
Provider for the Encounter  14  
Completed Patient Selection Screen  15  

Patient Chart  16  
Vitals Entry  17  
Vitals Graphing  18  
Medications Tab  19  
LABS Review  20  
Chief Complaint  21  
Purpose of Visit  22  
Selecting POV under “Problem List” Box  22  
Selecting POV under “Visit Diagnosis” Box  23  
Selecting POV under “ICD Pick Lists” Box  24  
Health Factors  25  
Exams  26  
Education  27  
Patient Education Event  28
Super-Bills for Visit Services 29
Editing Visit Services 30

Consult 31

Creating an MNT Note 32
Selecting a Note Title 33
Selecting a Template 34
  Saving and Editing a Note Before a Signature 35
  Completing and Signing a Note 36
Making an Addendum to a Note 37

Appendix
  A. Allergies/ Adverse Reactions 39
     Complete “Create Adverse Reaction Screen” 40
  B. Creating and Updating Electronic Signature 41
  C. Entering Refusals 42
  D. Inpatient Diet Orders 43

Resources 44

Acknowledgements 45
Foreword

In 2005, the Indian Health Service (IHS), Tribal, and Urban health systems began converting all paper medical charts to an electronic health record (EHR) system. Complete conversion to EHR continues to this day in Indian health facilities.

The purpose of this guide is to provide Registered Dietitians (RD) and Nutrition Professionals (NP) an overview of the EHR and an introduction to the new Nutrition Care Process Medical Nutrition Therapy template. The guide will provide the RD/NP, step-by-step instructions on how to use EHR most efficiently for your practice. It will also provide helpful reminders for those with experience using the EHR, and provide new tips.

It is strongly recommended that you select a “Demo, Patient” when orienting to the EHR system while reviewing this guide. This will allow “real-time” training on EHR, enhancing your learning experience. This guide uses the “Demo patient” for illustrating EHR features.

Any information that you enter on the “Demo, Patient” is not stored as collective data for future reports.

It is important to note that EHR screens may look different at each facility. The screen shots shown in this guide come from several Indian health facilities. Nonetheless, the procedure of maneuvering and charting in the EHR system is the same.

We hope that you will find this guide helpful in your practice.

Sincerely,
The Medical Nutrition Therapy Action Team (MAT)
Getting Started with EHR

Logging into EHR

1. Login to EHR with your Access Code and Verify Code.

   **TIP:** Usually the EHR login is the same as the user RPMS login.
Patient Selection

NOTE: This guide uses “Demo, Patient” for illustration purposes. However, for a real patient, please find instructions on the following pages on how to select a patient.

When getting started in EHR the first step is to select a patient before reviewing or entering patient data.

Selecting a Patient

1. Click on the “Patient Not Selected” box. This first screen may vary in appearance at the various sites.
Selecting Patient by Medical Record Number or Name

1. Enter the patient’s medical record number or name in the blank field below the word “Patients”.
   A. Medical record number example: 1234
      NOTE: entering medical record numbers often require leading zeros if has too few numbers (minimum is 4 numbers possibly.) MR# 12, so example to enter in space is 0012.

   B. Name example: Smith, Joe
      NOTE: Patient name must be entered with the last name followed by a comma and then the first name. Do “NOT” put a space between the comma and the first name.
Selecting a Patient using Scheduled Visits

This step allows one to display patients who have an appointment in a specific clinic on a specific day.

1. From the “Patient Lists”, select the option (for example Default, Providers, Teams, Specialties, Clinics, etc) that will display your scheduled visits for the day. **TIP:** This is one of the advantages of using the RPMS Scheduling Package.
   A. The example shown in the center below displays the four scheduled patients listed under the “Patients (Outpatient Roz (Dietician))” box.

2. To select the patient (example: Demo, Patient Elder Mike), highlight the patient’s name and click the “OK” button.
Visit and Provider Selection

Once the patient is selected, the next step is to select the visit.
1. Click in the “Visit not selected” box.

2. To select a visit, there are two options:
   A. Select visit on the “Appointments/Visits” tab
   B. Create a visit in the “New Visit” tab

A. Selecting a Previous Visit under “Appointments/Visits” Tab
   1. Select your clinic visit under the “Appointments/Visits” tab as shown below (KHC—Dietary)
B. Creating a Visit under “New Visit” Tab

1. Select the “Visit Location”, “Date of Visit”, “Time of Visit”, and “Type of Visit” as displayed below.
2. Check the “Create a Visit Now” box.
3. The system will default to your name as the “Encounter Provider”. Click “OK”

NOTE: The next two pages will further address the “Type of Visit” and the “Encounter Providers” tabs.
Type of Visit Options

1. Use the Type of Visit option box if your patient activity is different than an Ambulatory visit (ie: Chart Review, Telephonic, Historical, etc)

2. The Type of Visit options are available by clicking on the drop down arrow. Select “OK”
Provider for the Encounter

1. Highlight your name to select yourself as the Provider.

2. Click on the top teal arrow to get your name transferred to the “Providers for the Encounter” box as displayed below.

3. Click “OK”.

![Diagram of Provider Selection Process]
Completed Patient Selection Screen

This screen displays:
A. The selected patient
B. The visit type and provider

You are now ready to begin documenting the patient visit.
Patient Chart

The “COVER SHEET” of EHR is a good place to start when reviewing a patient’s information before a patient visit or chart review. Click on “COVER SHEET”. This page will provide a quick summary of the patient’s current medical status, including:

- Active Problem List
- Medication List
- Lab Orders
- Appointments/Visits
- Consult Orders
- Reminders
- Adverse Reactions
- Alerts

NOTE: This EHR screen may look different at your facility.
Vital Entry

Note: This entry option may be under the tab called “Triage” or “Vital Signs”.

This is where you can find the patient’s vitals including anthropometric data.

If you have vitals to enter:
1. Click on the empty white box next to the vital that was measured, for example: 69” for height and 150# for weight as shown below. When finished, click “Update”.

![Image of Vital Entry software interface]
Vitals Graphing

To display the graph:
1. Click on “Vital display” tab next to “Vital entry”.
2. Click on the vital that you are interested in, example: weight.
3. Now a graph will automatically display this patient’s weight changes over time.

TIP 1: The range of display may be changed by selecting a different time frame.

TIP 2: This is an outstanding tool to help patients see a particular vitals' trend.
**Medications Tab**

The “Medications” tab is where the patient’s medications can be found. Here it will show the status of the medications, when it was issued, last filled and when the prescription will expire.

**TIP:** Clicking on the “Active Only” icon will show only the active medications.

---

<table>
<thead>
<tr>
<th>Action</th>
<th>Time</th>
<th>Duration</th>
<th>Frequency</th>
<th>Status</th>
<th>Issue</th>
<th>Last Filled</th>
<th>Expire</th>
<th>Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔️</td>
<td>25-Jun-2010</td>
<td>25-Jun-2010</td>
<td>25-Jun-2010</td>
<td>Active</td>
<td>0</td>
<td>389068</td>
<td>ALTHEL+A</td>
<td></td>
</tr>
<tr>
<td>✔️</td>
<td>01-Jul-2010</td>
<td>07-Jul-2010</td>
<td>06-Jul-2010</td>
<td>Active</td>
<td>5</td>
<td>887531</td>
<td>CATARD DONALD</td>
<td></td>
</tr>
<tr>
<td>✔️</td>
<td>07-Jul-2010</td>
<td>07-Jul-2010</td>
<td>05-Oct-2010</td>
<td>Active</td>
<td>0</td>
<td>887531</td>
<td>CATARD DONALD</td>
<td></td>
</tr>
<tr>
<td>✔️</td>
<td>07-Jul-2010</td>
<td>07-Jul-2010</td>
<td>06-Aug-2010</td>
<td>Active</td>
<td>0</td>
<td>887531</td>
<td>CATARD DONALD</td>
<td></td>
</tr>
<tr>
<td>✔️</td>
<td>01-Jul-2010</td>
<td>07-Jul-2010</td>
<td>06-Jul-2011</td>
<td>Active</td>
<td>2</td>
<td>887531</td>
<td>CATARD DONALD</td>
<td></td>
</tr>
<tr>
<td>✔️</td>
<td>01-Jul-2010</td>
<td>07-Jul-2010</td>
<td>06-Jul-2011</td>
<td>Active</td>
<td>2</td>
<td>887531</td>
<td>CATARD DONALD</td>
<td></td>
</tr>
<tr>
<td>✔️</td>
<td>01-Jul-2010</td>
<td>07-Jul-2010</td>
<td>06-Aug-2010</td>
<td>Active</td>
<td>0</td>
<td>887531</td>
<td>CATARD DONALD</td>
<td></td>
</tr>
<tr>
<td>✔️</td>
<td>01-Jul-2010</td>
<td>07-Jul-2010</td>
<td>06-Aug-2010</td>
<td>Active</td>
<td>0</td>
<td>887531</td>
<td>CATARD DONALD</td>
<td></td>
</tr>
</tbody>
</table>

---

**TIP:** Clicking on the “Active Only” icon will show only the active medications.
Labs Tab

Click on the “Labs” tab to view all labs that have been performed on the patient.

**TIP:** The “Graph” function under “Lab Results” will show a trend for a particular lab.
Chief Complaint

The “Chief Complaint” box, located in the “Triage” tab, is where additional patient health concerns can be documented if not covered under the ‘Problem List’ section.

**NOTE:** Information entered in ‘Chief Complaint’ section will self-populate into the MNT note.

**Adding Chief Complaint**

1. Click on “Add” to enter information.
2. Type narrative in text box or select symptom in box below.
   **TIP:** This list can be defaulted to your specific needs. Consult with your local Clinical Application Coordinator (CAC).
3. Click “OK”.

---

![Chief Complaint Screen](image-url)
Purpose of Visit

The Purpose of Visit (POV) is located under the “Prob/POV” tab. The POV can be entered in several ways:

A. Problem List
B. Visit Diagnosis
C. ICD Pick Lists

A. Selecting POV under the “Problem List” box

1. Highlight the appropriate POV in “Problem List” section.

2. Select “Set as Today’s POV”. This will automatically move it over as the POV for this visit.

TIP: The first POV selected will be marked as the Primary POV.
B. Selecting POV under “Visit Diagnosis” box

1. Click on “Add” under “Visit Diagnosis” box.

2. Type the POV in the “ICD” field and select the “...” icon next to the field.

3. Verify POV, click “OK”. Exit task by clicking “Save”.

![Image of the software interface showing the process of selecting a POV under Visit Diagnosis box.]
Selecting POV under “ICD Pick Lists” box

1. Highlight the appropriate ICD Pick Lists. This will generate a box of ICD-Codes.
   **TIP:** A Pick List can be customized by a CAC or Coder.

2. Select the appropriate ICD code (diagnosis). This will automatically move it into the “Visit Diagnosis” box.
Health Factors

1. Click the “Wellness” tab that contains “Health Factors” box.
2. Click “Add” in the “Health Factors” box.
3. To expand sub category list, double click factor, or click (+) sign next to health factor.
4. Identify appropriate sub category.
5. Click “Add”.

![Image of Health Factors interface]
Exams

1. Click “Wellness” tab that contains “Exams” box.
2. Click “Add” to remark on an exam performed.
3. Double click exam performed.
4. Select exam result or insert comment.
5. Add comments as needed.
6. Click “Add”.

[Image of Exam selection and document options]
1. Click the “Wellness” tab that contains Education box.
2. Click “Add” to enter an education comment.
3. Highlight POV topic from the Education Topic Selection list.
4. Highlight subtopics of education provided, example: Carbohydrate Counting, Medical Nutrition Therapy, Exercise, etc.
5. Add “Patient Education Event” information as shown on next page.
6. Click “Add” to complete.
Patient Education Event

1. Select type of training.
2. Select appropriate comprehension level.
3. Enter time spent on education.
4. Enter comment if needed.
5. Document readiness to learn.
6. Document status or outcome of goals.
7. Select the appropriate patient learning health factors, example barriers to learning or learning preference, Click “Add”.
8. Select “Add” to complete Education Event.
Super-Bills for Visit Services

This step is important for billing the services that are provided to the ambulatory (face-to-face time) patient.

1. Click “Services/Superbill” tab.

2. Highlight the appropriate “Super-Bill” for the services provided, for example “Nutrition.” This will generate a box of MNT CPT codes for reimbursement to select from.

3. Select the appropriate CPT code. This action will generate a super-bill for visit services. The example below shows CPT code 97802-Medical Nutrition Therapy, Individual, Initial Visit.
Editing Visit Services

The MNT CPT codes default to 1 unit which is 15 minutes of time for Initial and Follow-up visits and 30 minutes for a Group visit.

1. To modify the units of time spent with the patient during the visit, highlight the CPT code under “Visit Services”, and select “Edit”. This will bring up the “Edit Procedure for Current Visit” box.

   A. Check the primary diagnosis.
   B. Change the units in the “Quantity” box to reflect the time spent with the patient. For example, 2 units represent a 30-minute visit with the individual patient.
   A. Click “Save”.

![Edit Procedure for Current Visit](image)
Consult

All MNT or DSMT consults will be displayed on the “NOTIFICATIONS” screen.

1. Click “NOTIFICATIONS” tab.
2. Double click on the consult. Automatically the Consults tab will open, showing the active consult.

TIP: The Notification screen is a temporary message center, so once the consult is opened, it will no longer appear in the Notifications tab. The provider’s consult order for nutrition services will still be available by clicking on the “Consult” tab.
Creating an MNT Note

Congratulations you have made it through EHR and are ready to create an MNT note. The steps that you have just completed are important for documentation and reimbursement and will also self-populate key elements in the MNT note when using the MNT Nutrition Care Process (NCP) template.

Creating a MNT Note:
1. Click “Notes” Tab.
2. Select “New Note”.
3. The “Progress Note Properties” box will open.
Selecting a Note Title

Each health service has a distinctive title name for example, “Nutrition” or “Medical Nutrition Therapy”.

1. Select the appropriate note title:
   A. Select “NUTRITION” if there is no provider consult order.
   B. Select “NUTRITION CONSULT” if a provider consult order was received.

TIP: For follow-up appointments related to this consult, continue to use “NUTRITION CONSULT” for the note title until the patient is discharged or a new consult is sent to dietitian.
Selecting a Template

1. Select the current EHR MNT Nutrition Care Process (NCP) Template.

2. Begin your MNT documentation.

**TIP:** Work with your CAC to set up your Templates folder.
Saving and Editing a Note Before a Signature

If you get interrupted while documenting, you have the options to stop and Save or Edit your note for later completion.

To **Save a note:**
1. Select “Action” from the menu bar or right click.
2. Select “Save without Signature”.

To **Edit a note:**
1. Select “Action” from the menu bar or right click.
2. Select “Edit Progress Note”.
3. Resume documentation until note is complete.
Completing and Signing a Note

1. Once the note is completed, review your note and edit as needed before signing your note. Ensure note contains all information required for MNT reimbursement.

2. There are 3 options for signing the note:
   A. Click on sign icon at the top of your screen.
   B. Right click and choose the “Sign Note Now” option.
   C. On the menu bar, select “Action” and choose “Sign Note Now”.

3. “Sign Document” box will open. Enter your e-signature.

TIP: If you do not have an e-signature, contact your CAC or Information Technology department or use “eSig” on EHR menu bar if available.
Making an Addendum to Note

1. Highlight the signed note that needs an addendum.

2. There are 2 ways to make an addendum:
   A. Right click on the note and select “Make Addendum”.
   B. On the menu bar, select “Action” and select “Make Addendum”.

3. Add the addendum and then sign the note.
APPENDIX

A. Allergies/Adverse Reactions
   Complete “Create Adverse Reaction Screen

B. Creating and Updating Electronic Signature

C. Entering Refusals

D. Inpatient Diet Orders
A. Allergies/Adverse Reactions

The Adverse Reactions box can be found on the “Cover Sheet” tab. If authorized to enter a new Food and/or Drug allergy, right click on the “Adverse Reactions” box to enter a “New Adverse Reaction”.

The following example is for entering a food allergy for soybeans

1. Enter “Soybeans” in the Causative Agent box, click Search.

2. Highlight the appropriate Causative Agent (SOYBEANS), click OK.

3. Complete the “Create Adverse Reaction” screen by entering patient’s comments as demonstrated on the next page.
Complete “Create Adverse Reactions” Screen

1. Compete the following Fields:
   A. Event Code (FOOD ALLERGY).
   B. Source of Information (PATIENT).
   C. Signs/Symptoms Available (RASH).

2. Click “OK”.

**NOTE:** You will have to perform an additional e-signature to approve adding this Adverse Reaction.

**TIP:** The final step of this process may require that the Pharmacist verify the allergy. Once the allergy is verified, the status will be changed from unverified to verified.
B. Creating and Updating Electronic Signature

Setting up new or editing e-signature for user:

1. Login to RPMS.

2. Type `tbox` at the “Select IHS Core Option”, hit “Enter/Return” on keyboard.

3. Type in: **Electronic Signature code Edit**, hit “Enter/Return”

4. Complete the following commands:
   A. **INITIAL**: DD//
   B. **SIGNATURE BLOCK PRINTED NAME**: DEBBIE DIETITIAN//
   C. **SIGNATURE BLOCK TITLE**: RD, CDE//
   D. **OFFICE PHONE**:
   E. **VOICE PAGER**:
   F. **DIGITAL PAGER**:
   G. **SIGNATURE CODE**:
      i. **Creating New Signature Code**: If the user does not have a signature code or you have cleared their e-signature in the system, create a signature code. The system will prompt you to create a signature code.
      ii. **Editing your Current Signature Code**: If the user has an existing e-signature, they will then need to enter it or if they have forgotten it, IT will need to clear it.

 **TIP**: Remember that the system only will accept caps and number for this signature. But once it is set, the code is not case sensitive.

 **Note**: Once everything is completed it will return user back to the “User’s Toolbox Option” screen.
C. Entering Refusals

1. Locate “Personal Health” box under “Triage Tab”.

2. To enter a refusal, select the “Refusal” form from the drop down arrow.

3. Enter refusal information in the “Refusal” box, Click “Add”.

![Image of the software interface showing the refusal form and entry process]

Exam: NUTRITIONAL RISK SCREENING

Date Refused: 12/29/2011

Comment: Pt was too busy to be seen right now.
D. Inpatient Diet Orders

Below are screen shots of inpatient diet orders.

**TIP:** Working with the CAC and Clinical Director will ensure that diets are ordered according to facility procedures.
Resources

- Indian Health Service Division of Diabetes Treatment and Prevention website: http://www.diabetes.ihs.gov

- Indian Health Service Electronic Health Record website: http://www.ihs.gov/CIO/EHR/

- Indian Health Service Division of Diabetes Treatment and Prevention Step-by-Step Guide to Medicare Medical Nutrition Therapy (MNT) Reimbursement, 2nd Edition.

- Indian Health Service Dietitian Information Network Email: dietitian@listserv.ihs.gov

- Indian Health Service Division of Diabetes Treatment and Prevention Medical Nutrition Therapy Action Team (MAT) Email: IHSMNTActionTeam@ihs.gov
Acknowledgements

The Indian Health Service Division of Diabetes Treatment and Prevention Medical Nutrition Therapy Action Team would like give special thanks for CDR Katie Johnson & LCDR Justin Tafoya, RN of the White River Service Unit for allowing us to modify their original version of the EHR Teaching Guide.

Thank you to everyone who helped to write and review the Dietitian’s Guide to the Electronic Health Record (EHR). Your expertise and insights have been invaluable for producing this orientation guide.

Writers:

CAPT Leslye Rauth, MPH, RD, CDE, MAT Co-Chair
Clinical Applications Coordinator, IHS Office of Information Technology, IHS Headquarters, Sioux City, IA

Roslyn (Roz) Bolzer, RD, LN
Former Diabetes Coordinator/Dietitian (Retired), IHS Kyle Health Clinic, Kyle, SD

Veronica Handeland, MPH, RD, LN
Administrative Dietitian, Wagner IHS Diabetes Prevention Project, Wagner, SD

LCDR Revondolyn (Faye) Scott, RD
Coordinator, Community Nutrition Department, IHS Chinle Service Unit, Chinle, AZ

LT Shanna Moeder, RD, LD, CLC
Clinical Dietitian, Kodiak Area Native Association, Kodiak, AK

LCDR Diane Phillips, RD, LD, CDE, MAT Co-Chair
IHS Native American Cardiology Telenutrition Program, Flagstaff, AZ

LCDR Dolores Addison, RD
Area Diabetes Consultant, IHS Tucson Area, Tucson, AZ
Writers (continued):

CAPT Karen Bachman-Carter, MPH, RD
Area Diabetes Consultant, IHS Navajo Area, Shiprock, NM

CDR Susan Jones, MS, RD, LD, CNSD, CPS
Senior Clinical Dietitian, Tuba City Regional Health Care Corporation, Tuba City, AZ

Stefanie McLain, MS, RD, LD
Diabetes Program Dietitian, IHS Lawton Service Unit, Anadarko, OK

Kelli Wilson, MS, RD, LD
Training Facilitator, IHS Division of Diabetes Treatment and Prevention, Albuquerque, NM
Acknowledgements

Reviewers and Contributors:

Brenda Broussard, MPH, MBA, RD, CDE, BC-ADM
Nutrition Consultant, The Hill Group, Albuquerque, NM

LT Casey L. Cavanaugh, MS, RD, CLE
Public Health Nutritionist for Pediatrics and the Diabetes Center of Excellence, Phoenix Indian Medical Center, Phoenix, AZ

Jennifer Johns, RD
Public Health Nutritionist, IHS Chinle Service Unit, Chinle, AZ

LT Thelma Lucero, RD
Public Health/Clinical Dietitian, Phoenix Indian Medical Center, Phoenix, AZ

Carrie Thrasher, MPH, RD
Outpatient Dietitian, IHS Chinle Service Unit, Chinle, AZ