DSS inc
VistAExperts

DRM Plus

User Manual

Version 5.9 May 2012

Document Storage Systems (DSS) is a privately held corporation and has been the premier provider of health information and document imaging distribution and storage systems to Veterans Affairs facilities for over seven years. DSS is located at 12575 US Highway One, Suite 200, Juno Beach, Florida 33408.

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Introduction

Document Storage Systems, Inc.

DSS, Inc. specializes in the computerization of patient medical charts. Our core specialty within the medical market is building Windows Graphical User Interface (GUI) applications, which insert, update and retrieve patient data held in a MUMPS (M) data repository, or SQL database system. DSS offers an array of GUI products, which allow for the electronic documentation of Progress Notes and other significant parts of medical records, scanning and viewing of clinical and administrative documents and automated medical record coding through simple points and clicks.

From the Department of Veteran Affairs

Dental Record Manager Plus (DRM Plus) captures specific dentally-related information elements not readily available in CPRS. These elements include: oral cavity/tooth related diagnostic findings, dental-specific care plans and a superset of completed care information. DRM Plus aids the provider in the entry of dental diagnostic information, coding and crediting dental procedures, completing progress notes, and planning and tracking dental patient care. DRM Plus is adjunctive to CPRS and is not designed to replace CPRS for dental users. While some information from CPRS is available, and can be accessed in DRM plus, providers should use all the available tools in the VistA suite of applications, including: VistA Imaging, I-Med Consent, and any clinical system applications specific to the local sites. DRM Plus is a Dental Graphical User Interface front end for data input into the VistA Dental files, as well as the Patient Care Encounter (PCE), Text Integration Utility (TIU) and CPRS Problem List packages.

Introduction

The DRM Plus program is designed to provide dental health care facilities with an intuitive, user-friendly Windows interface for end-users to create encounter information, evaluate patient dental conditions, and develop and maintain the treatment plan. The DRM Plus program is an application that uses RPC Broker technology, which permits the facility users to store and retrieve clinical data within the VistA System.

DRM Plus supports the Veterans Health Administration, Office of Dentistry, continuous quality improvement initiatives by providing added value to the clinical and administrative management of the patient's electronic dental record. The enhanced methods of data capture included in this application continue to eliminate unnecessary paperwork and administrative functions through the automation of clinical dental data.

The use of DRM Plus results in more accurate insurance billing for dental visits, consults and procedures. This application supports the filing of Dental Encounter System (DES) within the guidelines established by the Veterans Health Administration, Office of Dentistry.

Some features of DRM Plus are summarized in the following:

- Entry of dental conditions, plans and completed procedures through the use of graphic icons with extensive use of color schemes
- Upper/Lower/Full Views with full color coded graphics
- Sequencing of Treatment Plan procedures
- Dental History with date-change capability

- Quadrant or Tooth summaries
- Head/Neck Findings availability
- Periodontal charting
- Full Mouth Plaque Index with definitions
- ADA/Local/Quick Codes
- Creation and maintenance of tooth-specific and general patient notes

Quality Improvement/Performance Measures and Benefits

DRM Plus supports the VA Administration, Office of Dentistry's continuous quality improvement initiatives by providing added value to the clinical and administrative management of the patient's electronic dental record. The efficient data capture methods included in this product eliminates unnecessary paperwork and administrative functions. Additional quality improvement benefits and sample performance measures include:

- Performances Measures
- Reductions in operating cost and improved services through better integration of VHA resources and data
- Supports high level job satisfaction by providing clinicians with feedback regarding quality of care and promotes a culture that places a high value on individual and collective accountability through reporting
- Promotes a VHA culture of ongoing quality improvement that is predicated on providing excellent health care value
- Accuracy and usefulness of data increases based on the reduction of data entry points and decreased potential for error
- Enhanced capability to measure quality of care consistent with the VA Dentistry GPRA Performance Plan

Customer Support

DRM Plus is supported in the same manner as any other nationally supported software product. Problems should be reported to the local site ADPAC and/or IRM help desk, who in turn utilize the Remedy system to log and track problems. Help desk support is provided from 8:00 AM to 7:00 PM Eastern Standard Time, Monday through Friday. Documenting problems provides a means to find and disseminate solutions to those involved in any area of DRM Plus or VistA.

DRM Plus Setup Requirements

User Setup

The following are requirements for a DRM Plus User:

1. The user must be defined in the Dental Provider file (file 220.5).
2. The user must have a Dental Person Class and Provider Type in the VistA Provider file.
3. The user must have the secondary menu option DENTV DRM DSS GUI assigned in VistA.

Note: DRM Plus providers filing data must have an eight (8) digit provider number in the Dental Provider file (see item #1).

Administrator Setup

The following are the requirements for a DRM Plus administrator:

1. All of the above setup procedures must be included.
2. Administrative users (including those with the authority to edit transactions):

   OPTION NAME: XPAR EDIT PARAMS PARAMETER DEFINITION NAME: DENTV DRM ADMINISTRATOR -- must be turned to Yes.

Note: Each site must have at least one DRM Plus administrator.

Accessing DRM Plus

Access

To access DRM Plus, first open CPRS and select the desired patient. Open the Tools menu in the CPRS tool bar, and select DRM Plus from the available options.

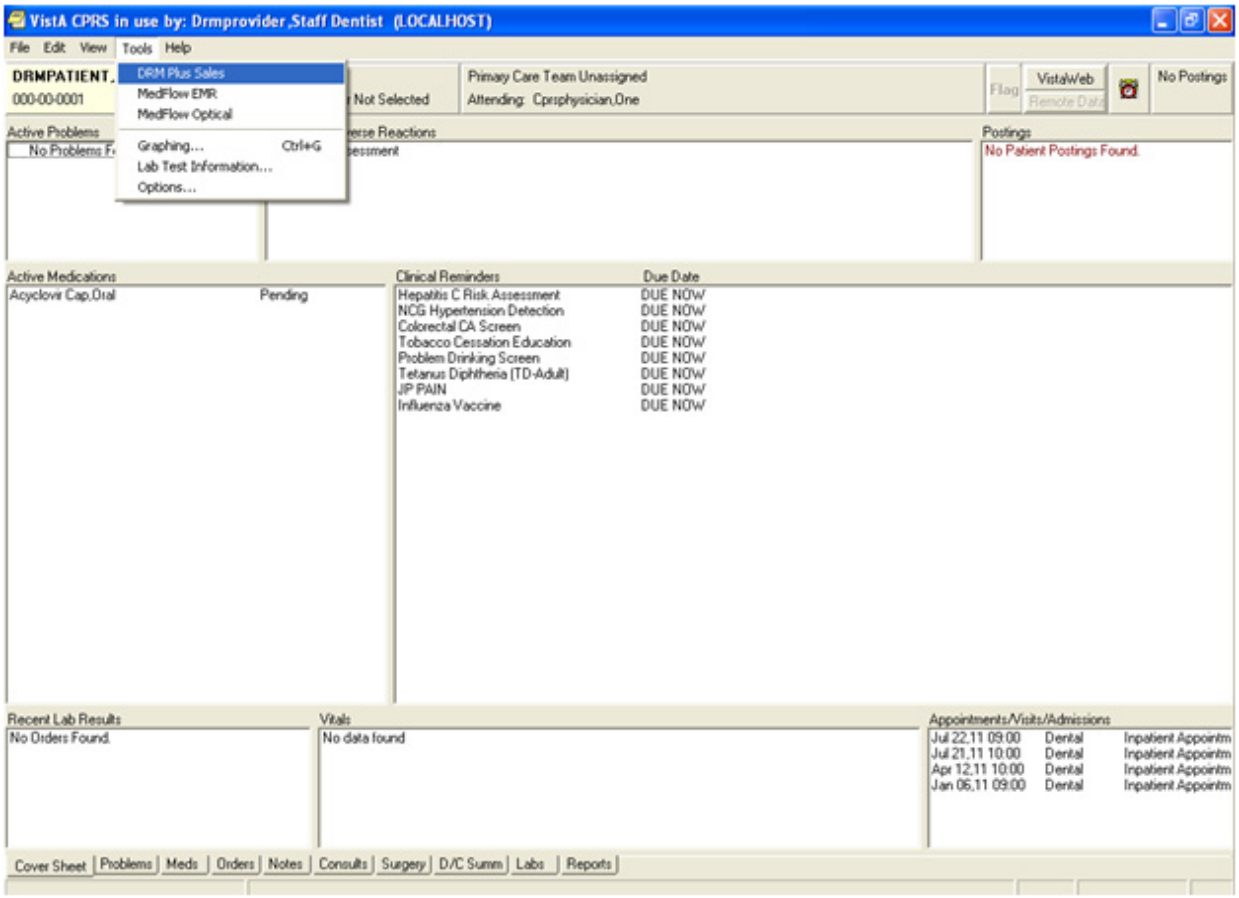


Figure 1: Access DRM Plus through CPRS

DRM Plus opens with the patient information loaded.

Note: Users may be required to re-enter Verify/Access Codes when opening DRM Plus. The default opening settings of DRM Plus are the Treatment Plan screen and the Chart/Treatment tab.

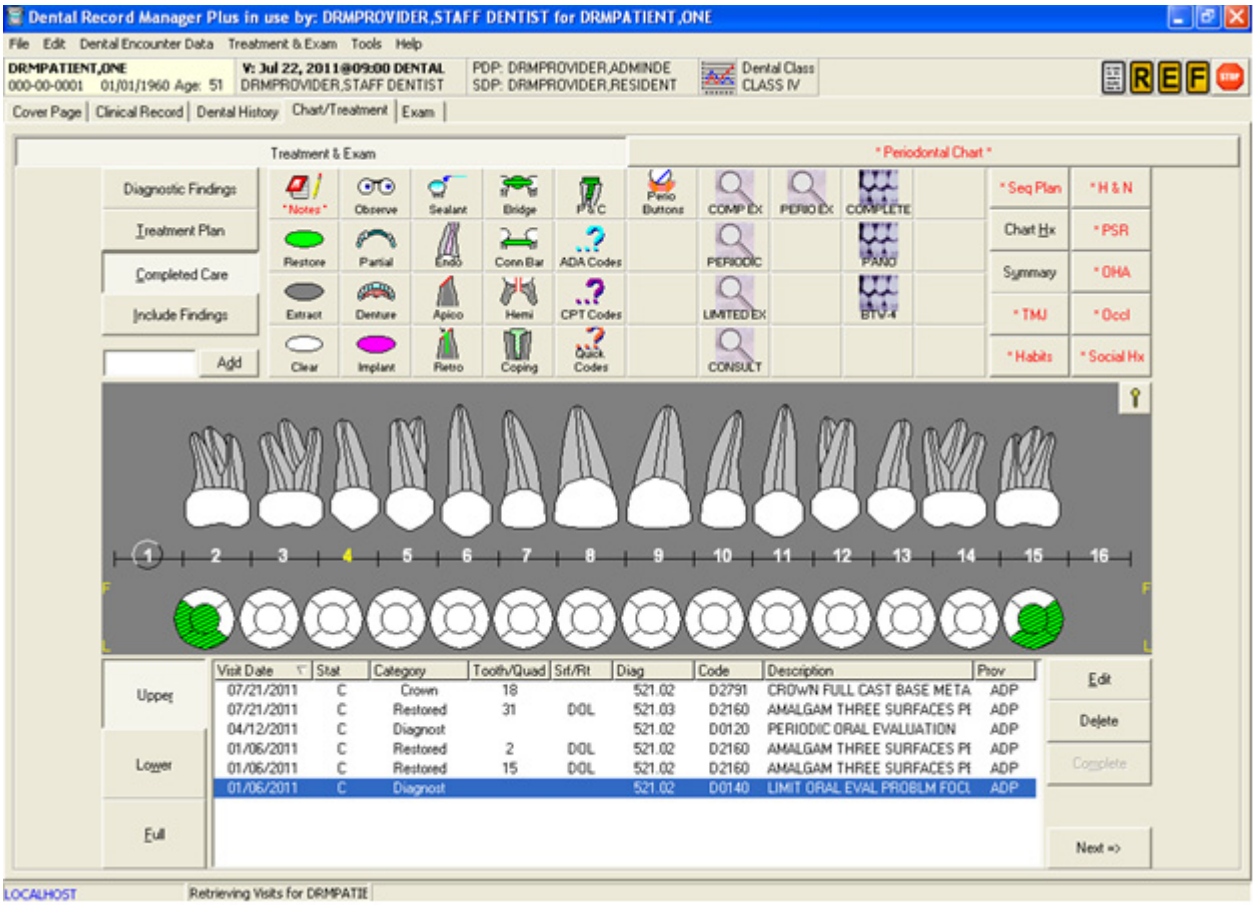


Figure 2: DRM Plus Chart/Treatment Tab

In the following pages, the various parts of DRM Plus are highlighted and the functionality of the program is explored. The main screen is broken into three distinct parts. The drop-down menus allow the user to access various menus throughout the program, regardless of which tab is in use. Some drop-down menu functions are not available with every different tab. In this case, the menu function will be grayed out when the tab is open.

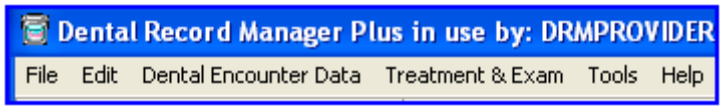


Figure 3: DRM Plus Drop-Down Menus

The banner contains patient, visit/location and provider/patient information. There are also coding standards and alerts icons on the banner.

Figure 4: DRM Plus Banner

The tabs are the heart of DRM Plus. They allow the user to create a new exam template, new treatment plan, view the dental history of a patient, view clinical records, create a text note or a text note addendum. All providers may perform a myriad of tasks by simply clicking through each of the tabs and adding the pertinent information that is allowed in the appropriate place.

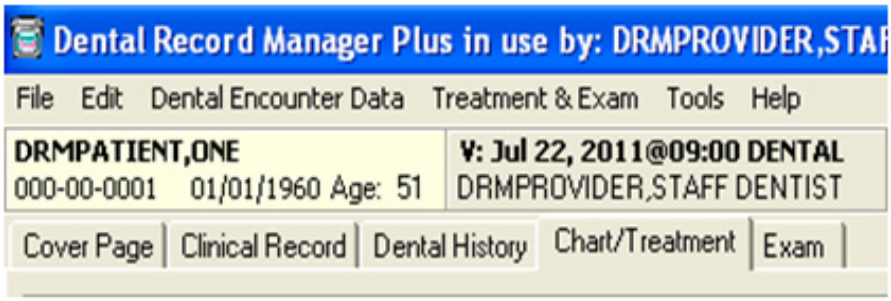


Figure 5: DRM Plus Tabs

The following chapters explore the functionality of each of the areas of the program in detail.

Using the DRM Plus Drop-Down Menus

The DRM Plus Drop-Down Menus consists of six menus: **File, Edit, Dental Encounter Data, Treatment & Exam, Tools** and **Help**.

Figure 6: DRM Plus Drop-Down Menus

File

The File menu contains seven options: **Refresh Patient Chart**, **File Administrative Time, File Fee Basis, Print, Spell Check, Save Unfilled Data** and **Exit**. The Spell Check is only active in Notes and Note Addendums.

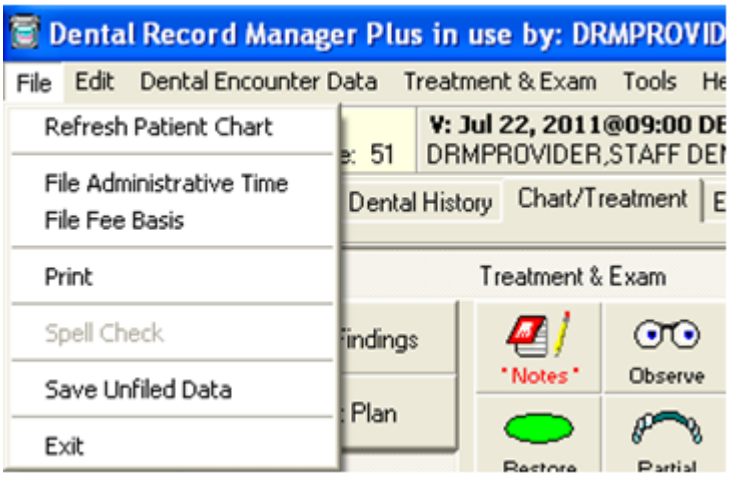


Figure 7: DRM Plus File Menu

Refresh Patient Chart

The Refresh Patient Chart option allows DRM Plus users to refresh the patient's chart while working in DRM Plus.

File Administrative Time

When the File Administrative Time option is selected from the File menu, the File Administrative Time screen appears.

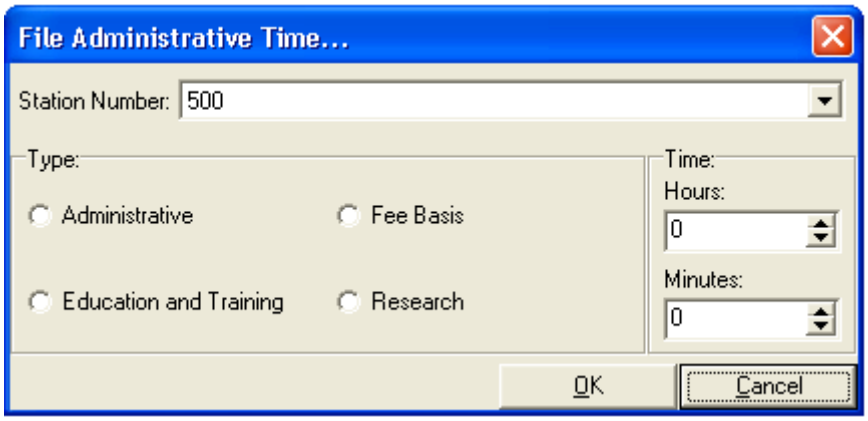


Figure 8: File Administrative Time Screen

1. Use the drop-down menu near the top of the screen to select the **desired station number**.
2. Click the appropriate **radio button** to select the type of administrative time.
3. Use the **up and down arrows** next to the hours and minutes text boxes to adjust how much time will be recorded. Note that the minutes can only be adjusted in 15 minute increments.
4. Click the **OK** button. The screen closes and files that administrative time for report usage.

Note: This filing of administrative time is for local use only and does not file to the VA-DSS Labor Mapping Access Database Program.

File Fee Basis

When the **File Fee Basis option** is selected, the Dental Record Manager Fee Basis screen appears.

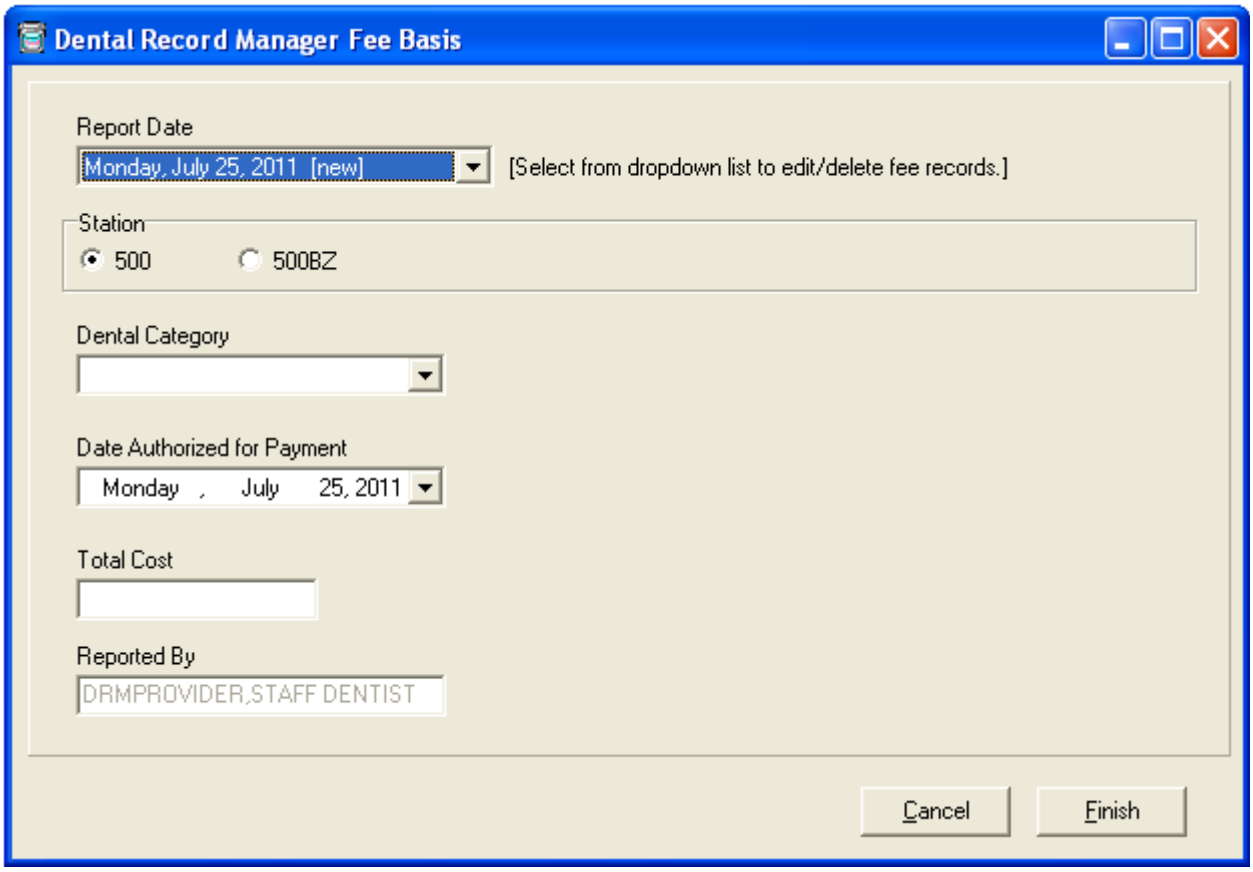


Figure 9: Dental Record Manager Fee Basis Screen

1. Use the **Report Date** drop-down menu to select a date to edit/delete a previous Fee Basis entry.
2. Choose the station by clicking the appropriate **radio button**.
3. Click the **Dental Category** drop-down menu to choose a Dental Class.
4. Click the **Date Authorized for Payment** drop-down menu to bring up a calendar. The user may toggle through this calendar to choose the authorized date for payment.
5. Enter the Total Cost in the text box.
6. Click the **Finish** button.
7. A screen appears stating that a Fee Basis record has been added. Click the **OK** button.

End-Users criteria required to allow one to enter fee basis data within DRM Plus includes:

- Does not need to be in the Dental Provider file
- Does not need a Person Class in VistA
- Does need access to CPRS
- Does need access to DRM Plus (DENTV DSS DRM GUI secondary menu options)
- Does not need DRM Plus administrative access

Note: DRM Plus administrators can run all Fee Basis reports. Patient care provided by fee should be entered in DRM Plus as Diagnostic Findings.

Note: Dental HL7 fee basis data is no longer transmitted to the CFD; however, the data is still available in DRM Plus for any site to enter the information and run a local report.

Print

Select **Print** to view the Print screen.

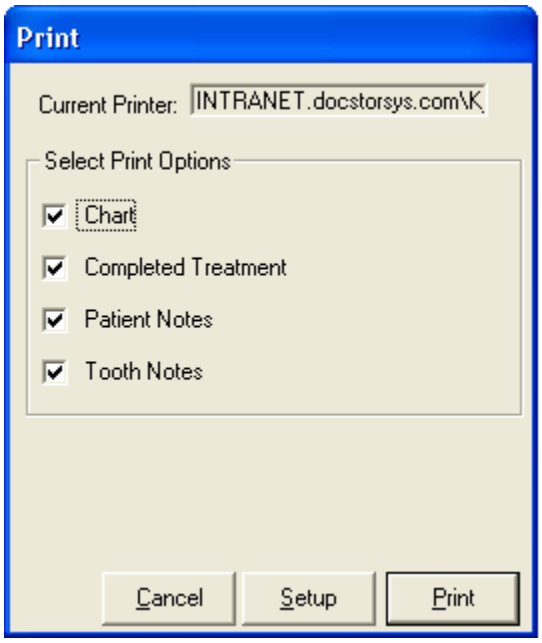


Figure 10: Print Screen

Select the **check box** that corresponds to what will be printed. The designated printer is listed at the top of the screen.

Spell Check

Select **Spell Check** to correct possible spelling errors. This feature is only active in Notes and Note Addendums.

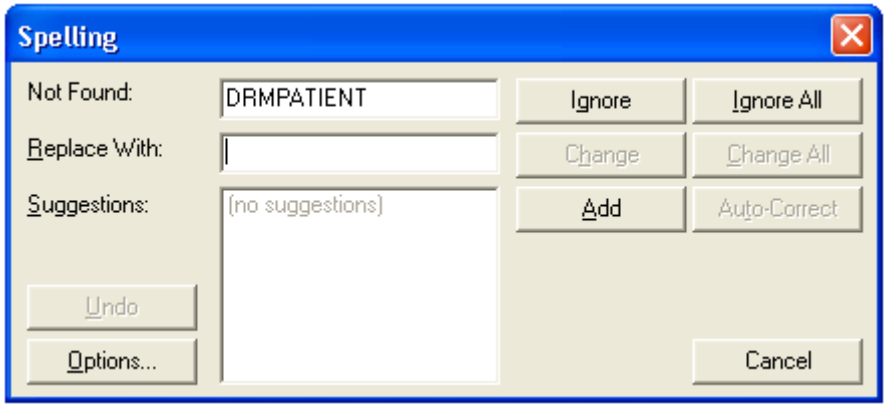


Figure 11: Spelling Screen

The program goes through the text and highlights words that may have been misspelled and suggest possible correct spellings. Use the buttons to Ignore, Change or Add words. Click the **Options** button to select various options, pick a dictionary or add a custom dictionary.

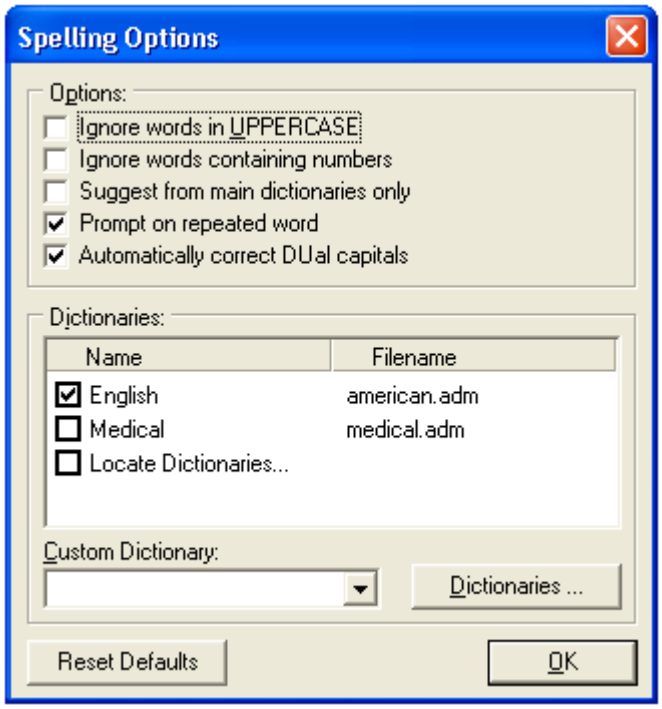


Figure 12: Spelling Options Screen

Click the checkboxes beside the desired options and dictionaries and press the **OK** button. The Spelling Screen closes.

Save Unfiled Data

Select the **Save Unfiled Data** option. The Save DRM Plus Data screen appears. Click the **Yes** button to save the unfiled data to the listed provider. A screen appears. Click the **Yes** button again to confirm.

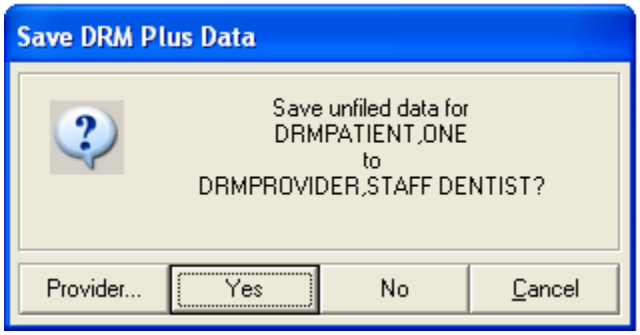


Figure 13: Save DRM Plus Data Screen

To change the save unfiled data to another provider, click the **Provider...** button.

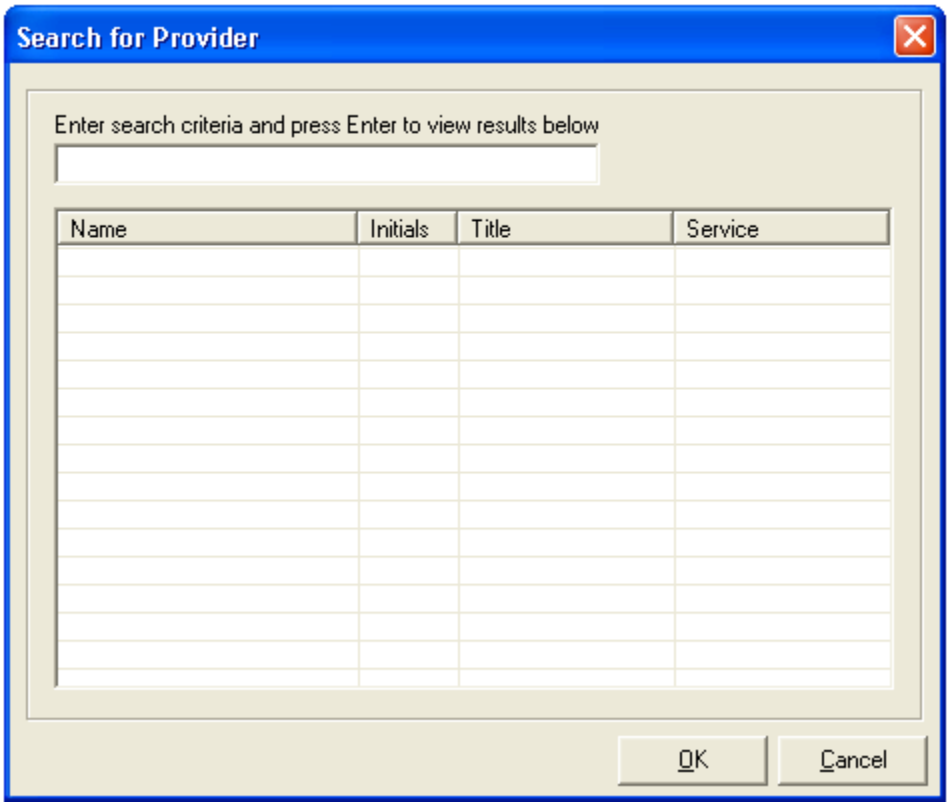


Figure 14: Search for Provider Screen

1. Enter the name or partial name of the desired provider in the search criteria text box.
2. Press the <**Enter**> key.
3. Click the needed provider from the list of results.
4. Click the **OK** button to change the provider. The Save DRM Plus Data screen appears.
5. Click the **Yes** button to save the unfiled data to the new provider.

When a DRM Plus user is saving unfiled data for another DRM Plus user or dental provider for a selected patient, who has previously saved unfiled data that has not been filed for the same selected patient, the user will receive the following screen stating "This provider already has unfiled data for this patient!"

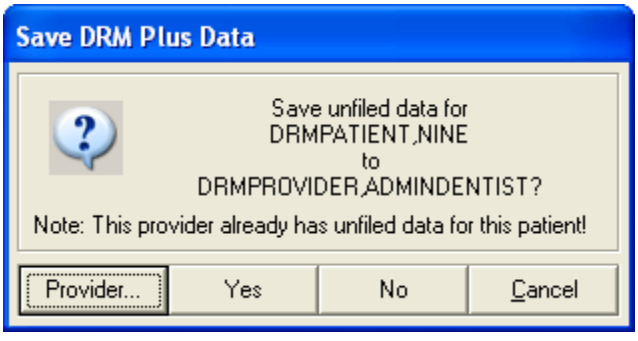


Figure 15: Provider Already Has Unfiled Data

If the user clicks the **Yes** button, previously saved unfiled data, originally saved by another dental provider, or this provider, will be overwritten. Only one unfiled data entry can be maintained by a single provider, per patient.

Exit

Exit the program by selecting the **Exit** button from the **File Menu**. The CPRS main screen appears.

Edit

The **Edit** menu consists of four options: **Copy**, **Cut**, **Paste** and **Select All**.

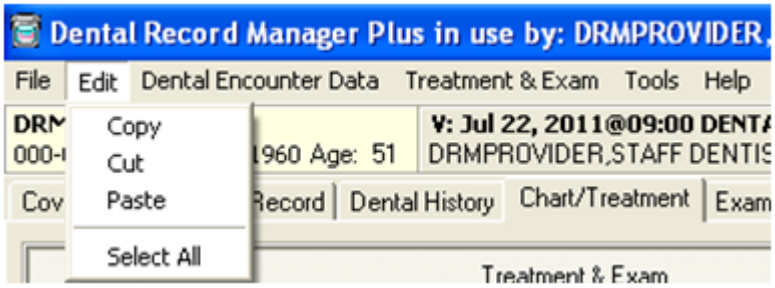


Figure 16: Edit Menu

Copy

To copy, highlight the desired text and choose **Copy**.

Cut

To cut, highlight the desired text and choose **Cut**. The selected text is removed.

Paste

To paste, move the cursor to the area where the copy or cut text will be replaced. Select the **Paste** option to add the text to the chosen area.

Select All

Select All will highlight all the text visible on the screen which can be copied and/or cut. Use the **Copy** or **Cut** function to complete the desired task.

Dental Encounter Data

The Dental Encounter Data menu has two options: **Create New PCE Visit** or **View Scheduled Appointments and Historical Visits**.

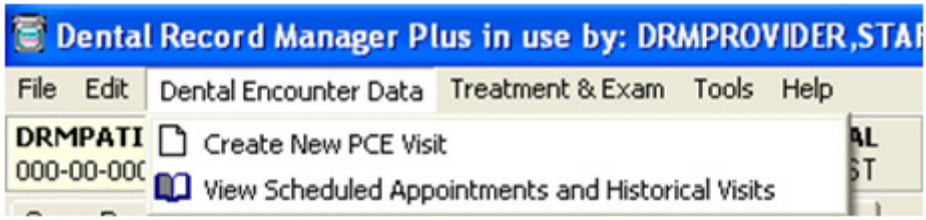


Figure 17: Dental Encounter Data Menu

Create New PCE Visit

Select the **Create New PCE Visit option** to bring up the Provider and Location/Visit screen.

Note: This option is only active or available if the DRM Plus administrator allows New PCE Visits to be created in the DRM Plus application. The opening default tab is the **New Visit** tab.

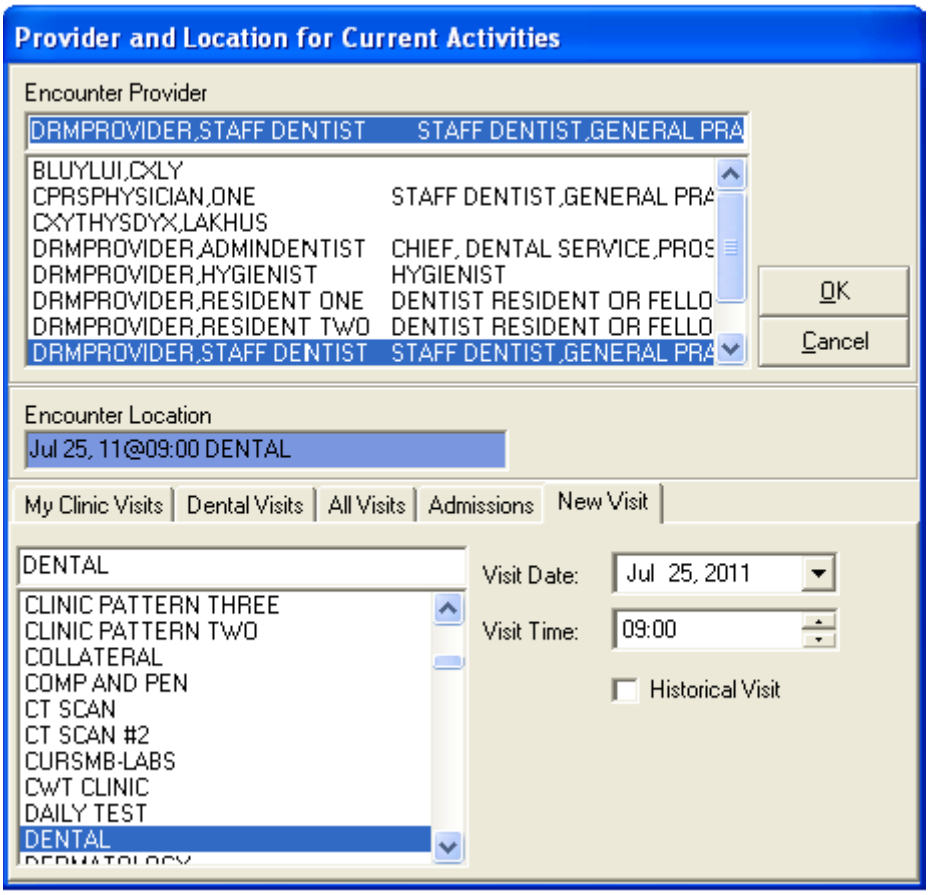


Figure 18: Provider and Location for Current Activities Screen

The Encounter Provider field should default to the correct end-user that is signed into VistA. Select the **Encounter Location** if the Default Location parameter is not set in advance. The Default Location parameter is explained in the Treatment System section under the chapter entitled Using the DRM Plus Drop-Down Menus in this manual.

Visit Date/Time defaults to the present date/time for a New Visit in the new Visit tab. The date and time may be changed if desired.

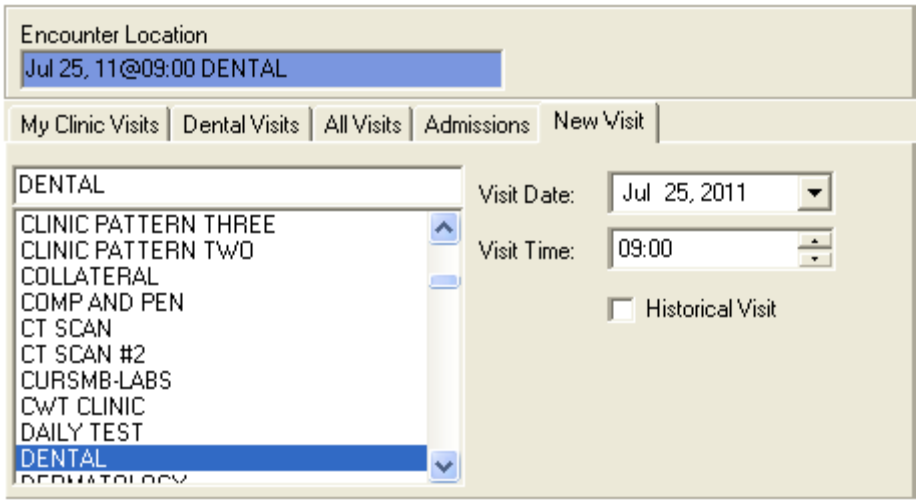


Figure 19: New Visit Tab

To record a new visit other than the present date/time:

1. DRM Plus defaults to the present provider; however, a different provider may be selected using the Encounter Provider list.
2. Select the clinic location from the scroll menu if Default Location is not set.
3. Use the drop-down arrow to toggle through the screen calendar and select a date.
4. Use the up and down arrows to adjust the Visit Time.
5. Check **Historical visit** if applicable.
6. Click the **OK** button to create the new PCE Visit.

Note: Future date appointments may not be created in DRM Plus.
Note: Creating a new PCE Visit in DRM Plus does not update Appointment Manager in VistA.

View Scheduled Appointments and Historical Visits

The My Clinic Visits tab lists the patient visits for the selected clinic. This tab only appears if a default Dental Location parameter is selected. When no default Dental Location parameter is selected, the Dental Visits tab appears.

To record the scheduled appointment for the patient:

1. DRM Plus defaults to the present provider; however, another provider may be selected from the Encounter Provider list.
2. If there is only one scheduled visit, it is automatically defaulted.
3. Select the **correct scheduled visit** in the bottom window, if it is not defaulted.
4. Click the **OK** button and the provider/location is set for the scheduled visit.

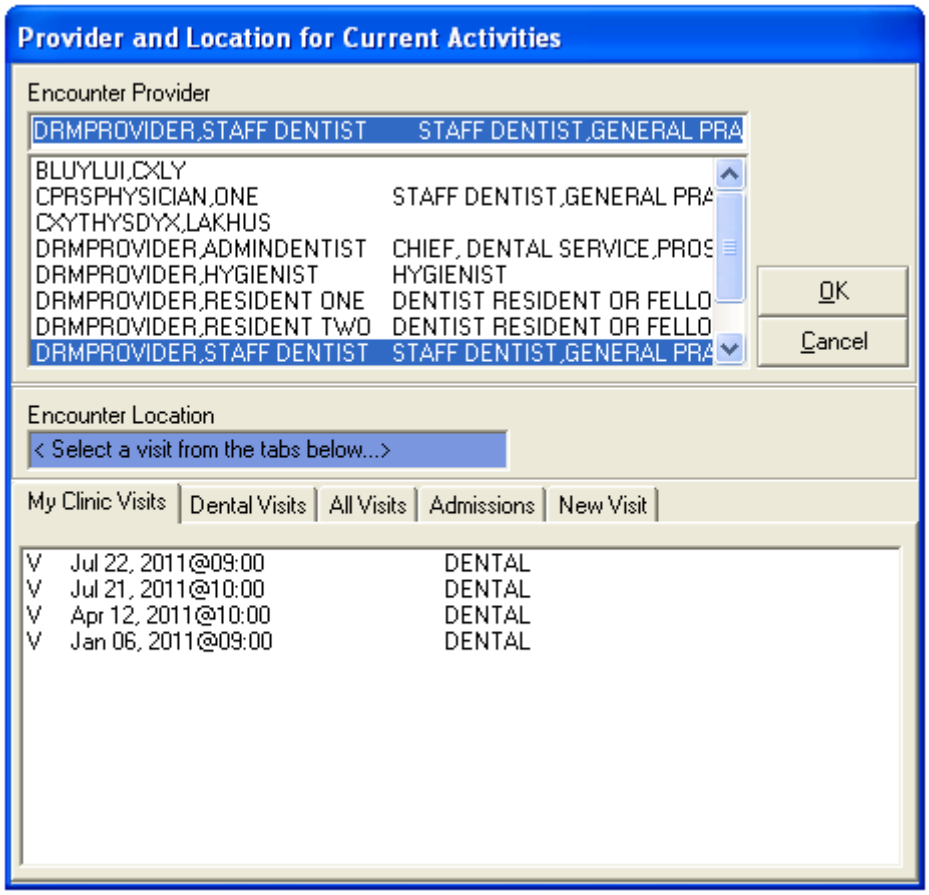


Figure 20: My Clinic Visits Tab

The Dental Visits tab lists all the dental clinic visits.

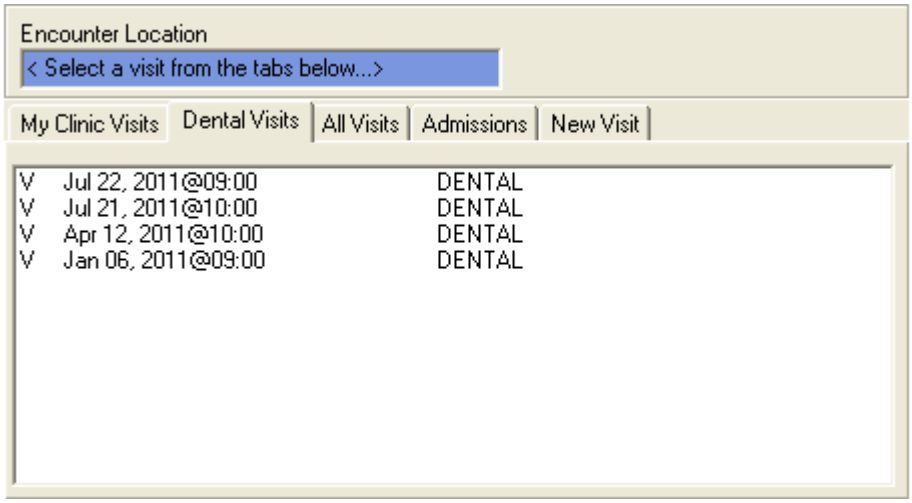


Figure 21: Dental Visits Tab

The All Visits tab lists all the clinic visits for the selected patient.

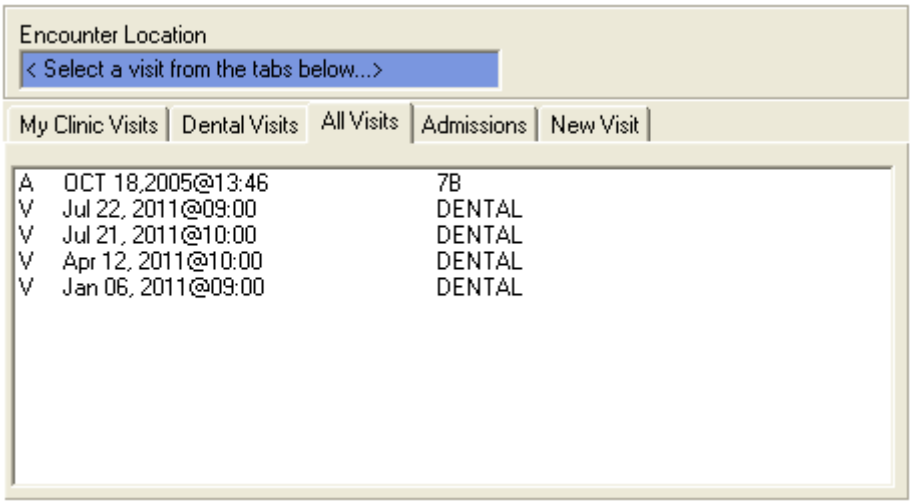


Figure 22: All Visits Tab

The Admissions tab lists the admissions for the selected patient.

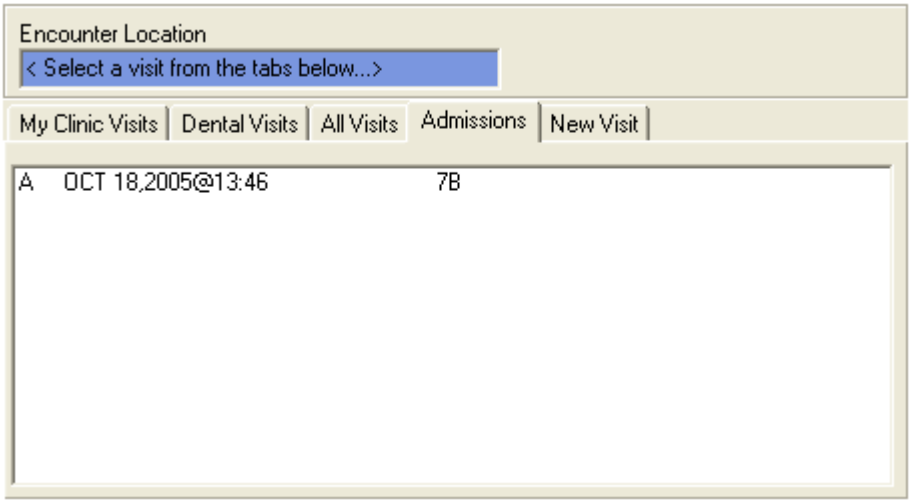


Figure 23: Admission Tab

Treatment and Exam

The Treatment & Exam menu has eight options: Show Configuration, Add/Edit personal Quicklist, Add Medical Codes to ADA table, Edit Code Information in ADA Table, Edit Procedure Costs, Filter View, Clean Sate and Undo Clean Slate.

Note: Add Medical Codes to ADA Table, Edit Code Information in ADA Table, Edit Procedure Costs, Clean Slate and Undo Clean Slate are DRM Plus Administrative Functions. Please contact a DRM Plus administrator for more information about these options.

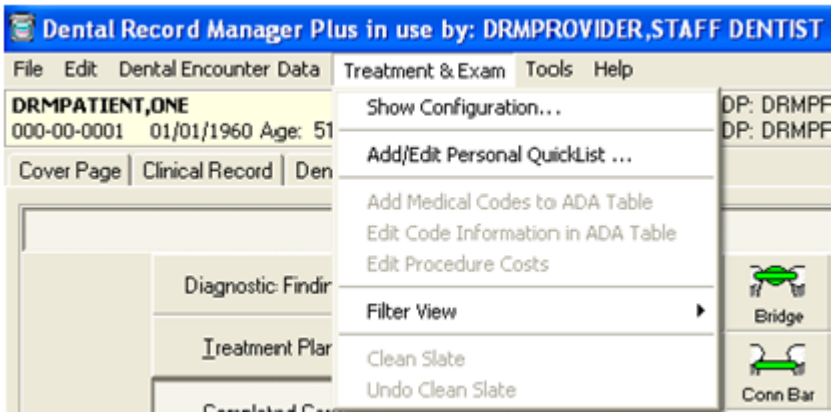


Figure 24: Treatment & Exam Menu

Show Configuration

Select Show Configuration to reach the Charting Configuration screen.

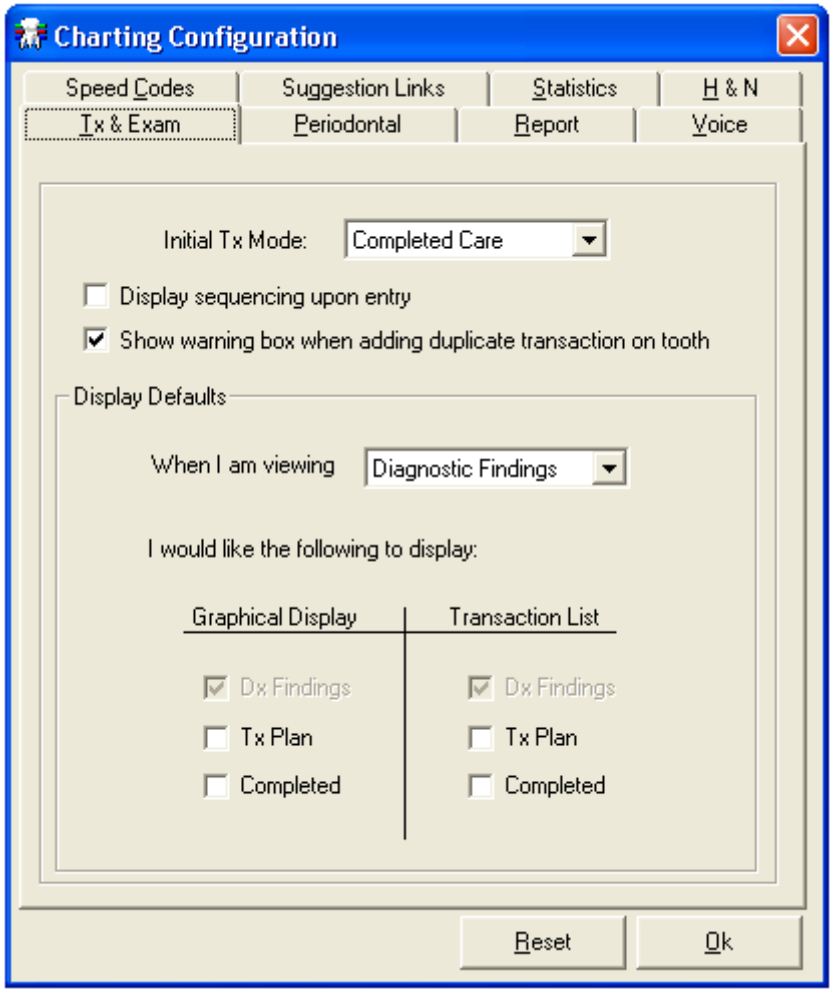


Figure 25: Charting Configuration Screen

Use the various tabs to configure the chart. The tabs are: **TX & Exam, Periodontal, Report, Voice, H&N, Statistics, Suggestion Links** and **Speed Codes**. These parameters on each tab are a user-specific function; changing it does not impact other users. When finished, click the **OK** button.

Tx & Exam

Use the **Tx & Exam** tab to change the default view screen that appears when DRM Plus is first opened. The original default view screen is the Treatment Plan view.

Sequencing screen displayed upon entry is not selected as a default parameter; however, showing a warning box when adding duplicate transaction on a tooth for each view chart is a default parameter. Use the checkboxes to change these user specific parameter functions.

Use the functions on this tab to fine tune the Display Defaults; choose Graphical Displays or Transaction Lists to display checkboxes based on the screen being viewed.

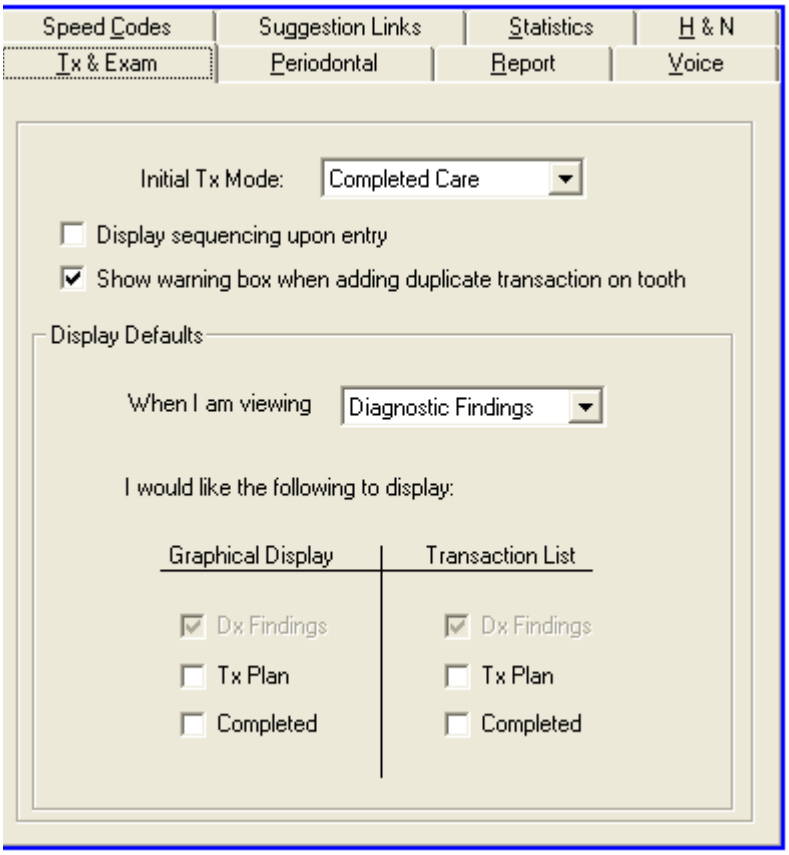


Figure 26: Tx & Exam Tab

Periodontal

Choose the Periodontal tab to set pocket depth warning and choose the colors that will appear as pocket warnings and normal pockets on the Periodontal Chart screen. Other options on this tab include MGJ Trace and Exam Sequence.

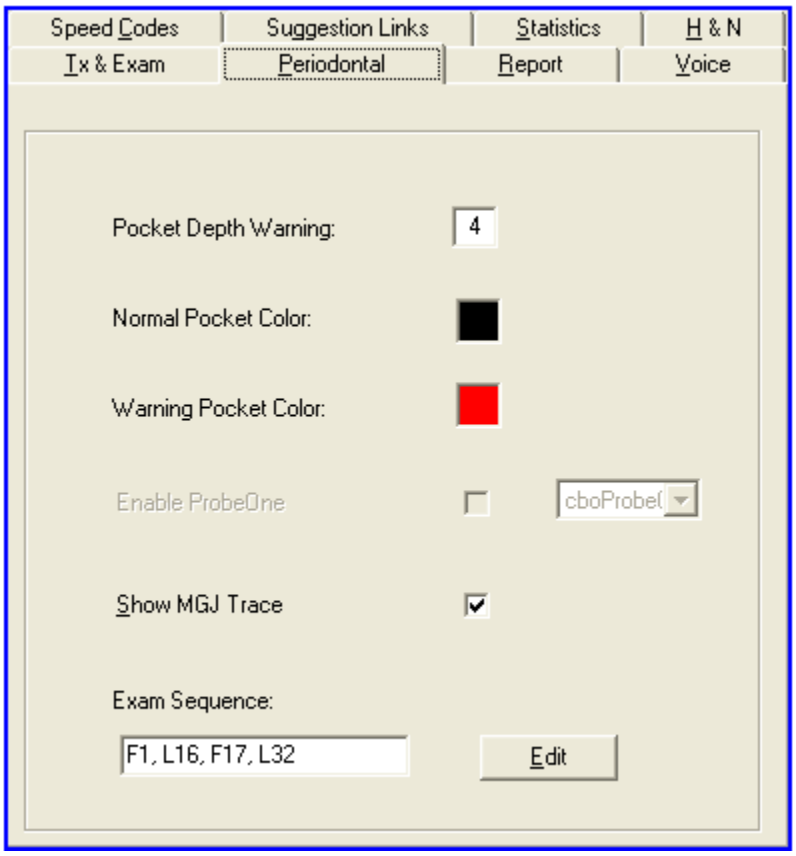


Figure 27: Periodontal Tab

To change the exam sequence:

1. Click the **Edit** button.
2. The Edit Perio Sequence screen appears.

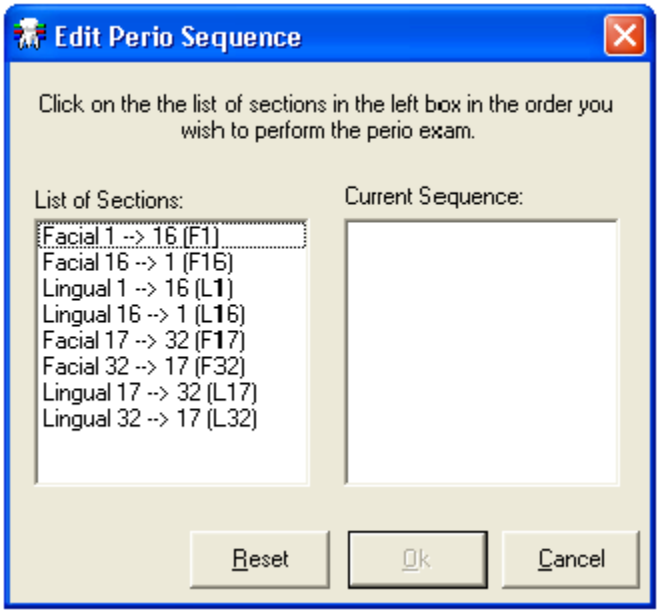


Figure 28: Edit Perio Sequence Screen

3. Click **each task** in the order in which the perio exam sequence should be performed.
4. Click the **OK** button to save the new exam sequence.

To go back to the original settings, which appeared when this screen was first displayed, click the **Reset** button. Once the exam sequence has been changed and the user has clicked the **OK** button on the Periodontal tab, this becomes the permanent default exam sequence.

Report

Use the functions on the Report tab to select certain pieces of information, which appear on individual reports when using the Print option under the Tools menu. The Chart selection prints the graphic chart, displayed on the last view screen of the Chart/Treatment tab, prior to the chosen Print option. The Transactions selection prints the transaction table, displayed on the last view screen of the Chart/Treatment tab, prior to the chosen Print option. Patient Notes and Tooth Notes selections print the entries entered using the Notes icon.

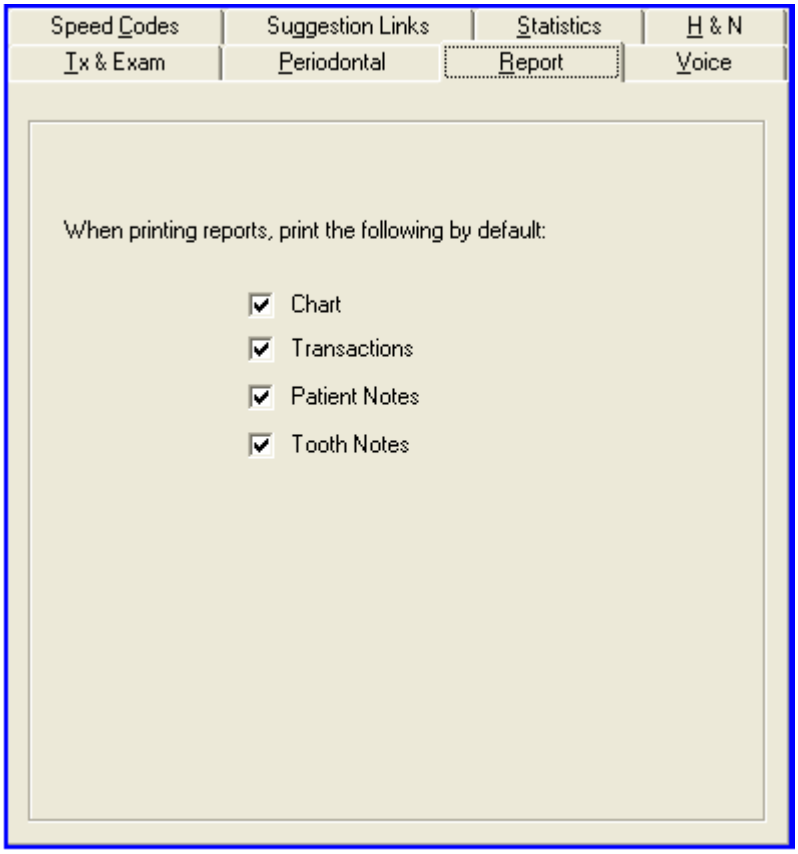


Figure 29: Report Tab

Voice

Voice is not enabled in DRM Plus.

Speed Codes

Use the Speed Codes tab to set/create individual icons in DRM Plus for frequently used procedure codes entered using the Treatment Plan or Completed Care viewing screens.

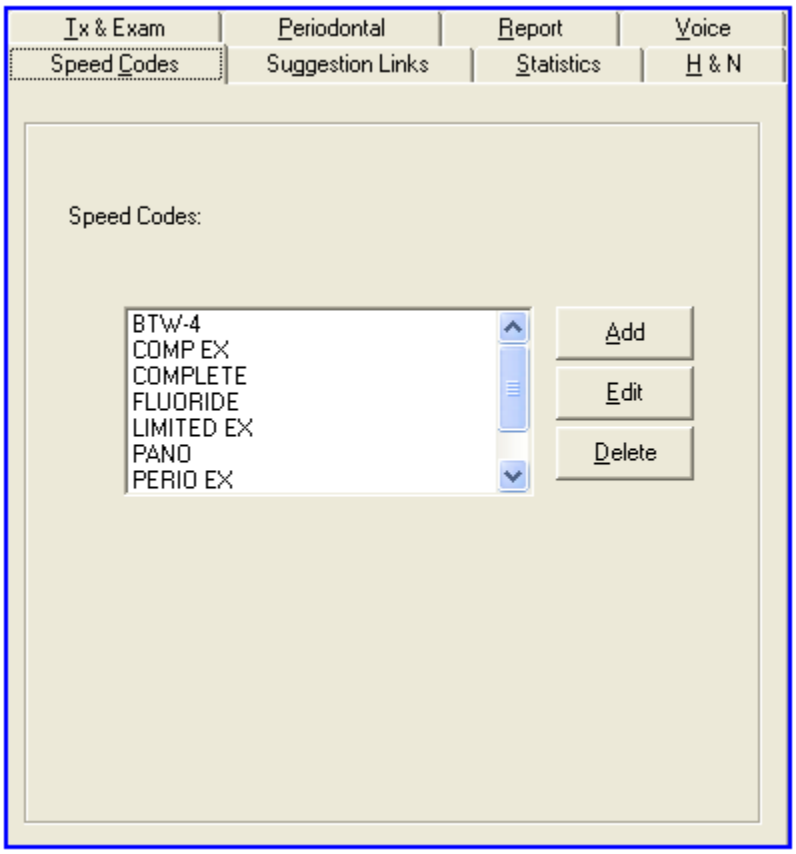


Figure 30: Speed Codes Tab

To add a Speed Code:

1. Click the **Add** button. The Edit Speed Code screen appears.
2. Add a new **Name**, which cannot exceed 10 characters. Entering a Description is optional.
3. Use the search function ADA Codes to look up a procedure code(s) and add it to the new speed code.
4. Entering an Icon is optional.
5. Click the **OK** button to begin finalization.

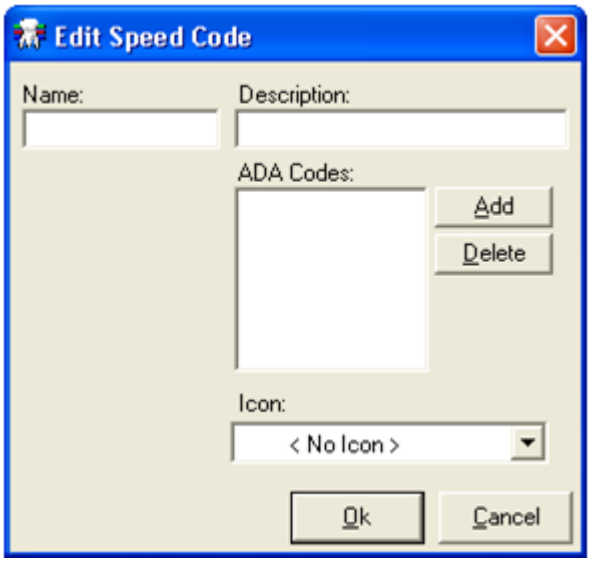


Figure 31: Edit Speed Code Screen

To edit or delete the speed code, highlight the desired name in the Speed Codes screen and click the **Edit** or **Delete** button. Provide an appropriate entry in the subsequent screens; otherwise, click the **OK** button to complete this part of the process.

To complete the Speed Code process:

1. Move to the Completed Care or Treatment Plan view of the Treatment & Exam screen.
2. Click **one of the undesignated icon squares**. The Configure Button screen appears.

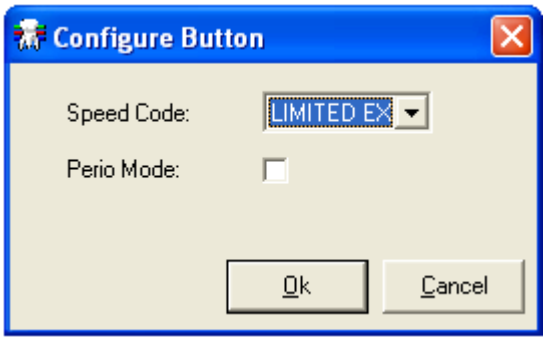


Figure 32: Configure Button Screen

3. Click the **drop-down arrow**, highlight and click the **desired Speed Code name**.
4. Click the **OK** button and the Speed Code is linked to that icon.

The Perio Mode checkbox on the Configure Button screen designates the viewing preference when the Perio Buttons icon is clicked. The Perio Buttons icon is used as a toggle for displaying another 19 available icon buttons. Clicking the Perio Buttons icon displays any 19 Speed Code icons that have been designated in the Perio Mode (checkbox clicked) while hiding any non-Perio Mode Speed Code icons from the display. Clicking the Perio Buttons icon again reverses the display. This option allows for a total of 38 Speed Code icons to be created. The 19 non-Perio Mode Speed Codes are the default Speed Code icons when DRM Plus is initially opened. Please see the section of this manual entitled Perio Buttons Icon under the chapter entitled Chart/Treatment – Treatment & Exam for more information.

Suggestion Links

Use this tab to enter code suggestions, when entering one procedure code which is linked to another procedure code(s), without having to use an icon to find the other code. A screen appears asking if other linked codes should be added providing an opportunity to decline the entry of suggested linked codes.

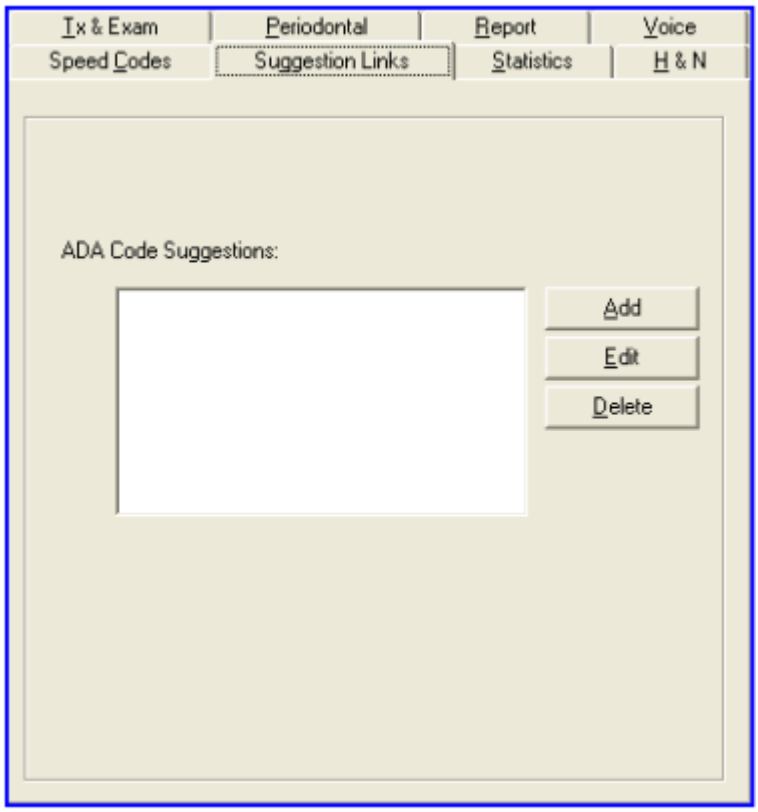


Figure 33: Suggestion Links Tab

To add a suggestion link:

1. Click the **Add** button.
2. A screen appears featuring a list of all DRM Plus procedure codes. Click the **desired primary procedure code** that other procedure codes are linked to, and then click the **OK** button.

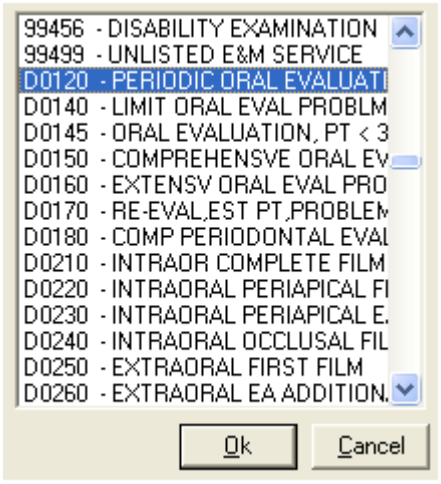


Figure 34: Suggestion Links List

3. A screen requesting the linked codes to the primary procedure code appears.

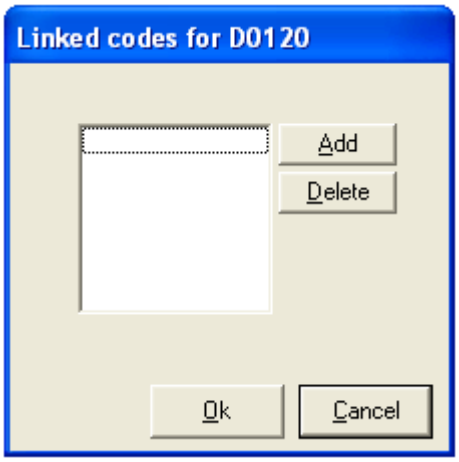


Figure 35: Linked Codes Screen

4. Click the **Add** button to add the first linked code. The list of all DRM Plus procedure codes appears again.
5. Choose the second code to be linked with the primary procedure code and click the **OK** button.
6. Add as many linked codes to the primary procedure code as desired. To finish and return to the tab, click the **OK** button.

Note: As many codes as necessary can be linked. Simply continue clicking the **Add** button on the Linked codes screen and choosing more codes from the list.

To edit the suggestion link:

1. Select a suggestion link to be edited and click the **Edit** button. The Linked Codes screen appears.
2. Click the **Add** button for another procedure code, and the list of procedure codes appear. Click the **OK** button.
3. To remove a linked code entry, click the **Delete** button and then the **OK** button.

To delete the suggestion link, select the suggestion link and click the **Delete** button.

Statistics

Choose the **Statistics** tab to set the warning level for pocket depth, free gingival margin, mucogingival junction, furcation and mobility.

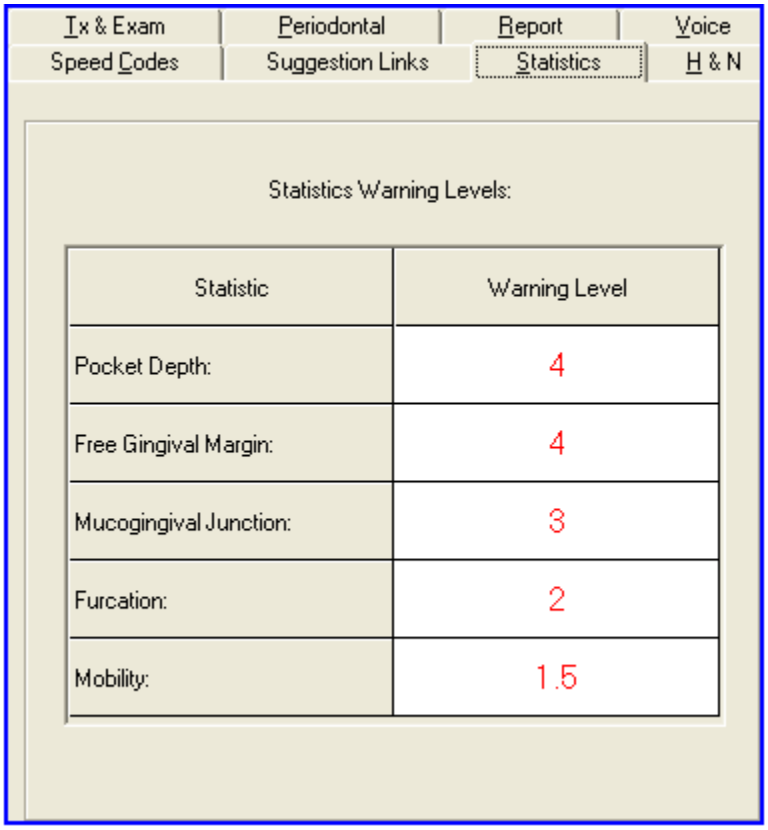


Figure 36: Statistics Tab

To change the warning level:

1. Double-click the box containing the warning level to be changed.
2. A screen appears. Enter the new warning level in the text box and click the **OK** button.

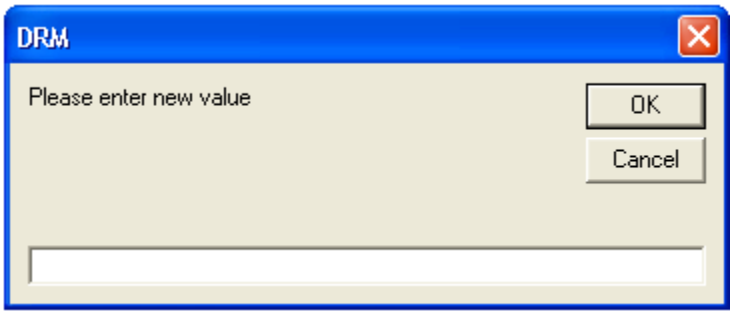


Figure 37: Adjust the Warning Level

3. The warning level is changed on the tab.

H&N

The H&N tab can be entered by any user but only saved by DRM Plus administrators. Please contact a DRM Plus administrator for more information.

Add/Edit Personal Quicklist

Select this option to manage a QuickList of codes for personal use. For additional convenience, enter frequently used procedure codes that have multi-add functionality associated with the code, into the QuickList. The Manage Personal QuickList screen appears.

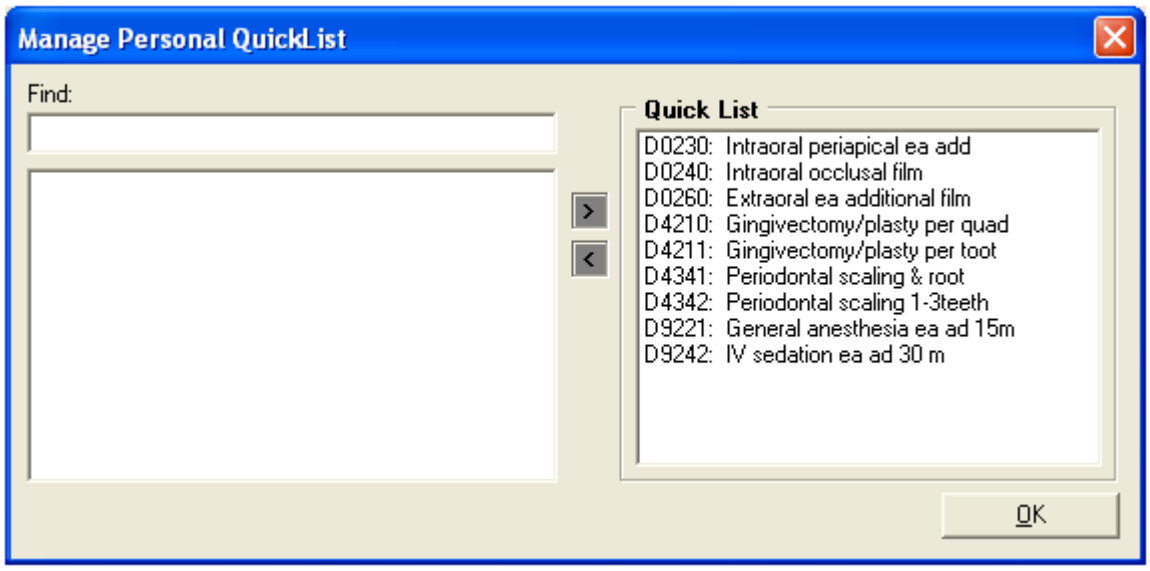


Figure 38: Manage Personal QuickList Screen

To add to the QuickList:

1. Type the search criteria into the Find text box. Search by words or numbers.
2. A matching list appears on the left side of the screen. Click **one of them** to select it.
3. Click the **right arrow** button to move the selected code to the QuickList.
4. Click the **OK** button to end and close the screen or repeat to add another code to the QuickList.

To remove from the QuickList:

1. Select an entry from the QuickList on the right side of the Manage Personal QuickList screen.
2. Click the **left arrow** to remove it form the list. A screen appears confirming that the entry is to be deleted. Click the **Yes** button to continue.

Note: Codes entered into a QuickList are accessed through the Quick Code icon.

Add Medical Codes to ADA Table

This is an administrative function. For more information, please see the DRM Plus administrative guide or speak to a local DRM Plus administrator.

Edit Code Information in the ADA Table

This is an administrative function. For more information, please see the DRM Plus administrative guide or speak to a local DRM Plus administrator.

Edit Procedure Costs

This is an administrative function. For more information, please see the DRM Plus administrative guide or speak to a local DRM Plus administrator.

Filter View

Use the Filter View function to choose which encounters appear on the Chart/Treatment tab of DRM Plus.

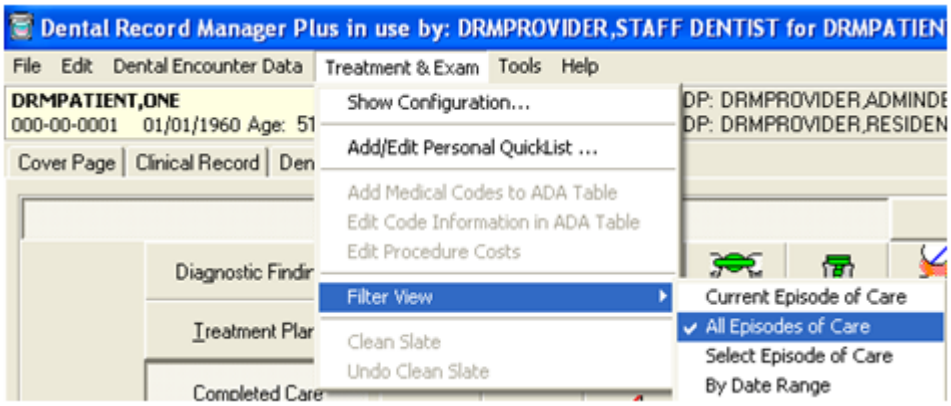


Figure 39: Filter View Options

Current Episode of Care

Choose this filter to show only those treatments that have been completed for all visits during the current disposition or patient status.

All Episodes of Care

Choose this filter to show all treatments completed for all visits. This is the default setting.

Select Episode of Care

Choose this filter to see all the treatments completed for all visits during a previous specific disposition or patient status. When this option is selected, a screen listing all previous dispositions or patient statuses associated with a given patient appears.

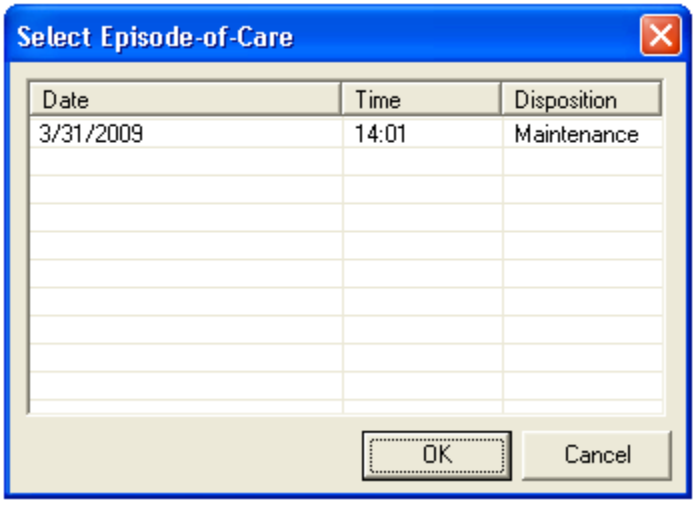


Figure 40: Select Episode of Care Screen

To select a previous disposition, click the **desired one** from the list and click the **OK** button.

Date Range

Choose this filter to show treatments that have been completed within a specified date range. When this filter is selected, a screen appears. Use this screen to select a date range.

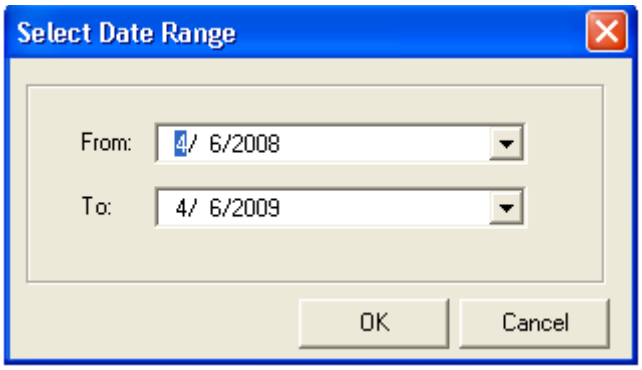


Figure 41: Select Date Range Screen

To filter by date range:

1. Use the drop-down menu to select the needed dates. Click the **OK** button.
2. The treatments completed in the entered date range appears on the screen. If no entries were made during the selected date range, DRM Plus will display as a clean slate.

Clean Slate

This is an administrative function. For more information, please see the DRM Plus administrative guide or speak to a local DRM Plus administrator.

Undo Clean Slate

This is an administrative function. For more information, please see the DRM Plus administrative guide or speak to a local DRM Plus administrator.

Tools

The Tools menu has 12 options: Windows Calculator, Windows Explorer, Windows Notepad, User Inquiry, User Options, Administrative Toolbox, provider Add/Edit, Vitals, Extract History File, new Extract History File, Reports and Service Reports.

The ADA Website option is an ancillary application that the DRM Plus administrator may customize for all users. The DRM Plus administrator may customize up to 10 ancillary applications. Please see a local DRM Plus administrator for further information.

Note: Administrative Toolbox, Provider Add/Edit, Extract History File and new Extract History File are DRM Plus Administrative Functions. Please contact a DRM Plus administrator for further information.

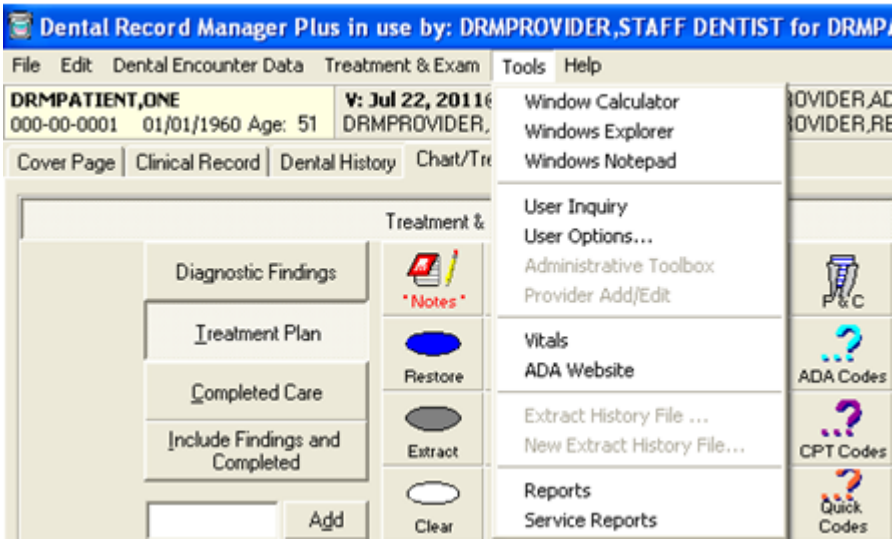


Figure 42: Tools Menu

Windows Calculator

Choosing this function opens Windows Calculator.

Windows Explorer

Choosing this function opens Windows Explorer.

Windows Notepad

Choosing this function opens Windows Notepad.

User Inquiry

Select this option to view and change the VistA fields or to view the VistA fields of other users. The VistA User Inquiry screen appears.

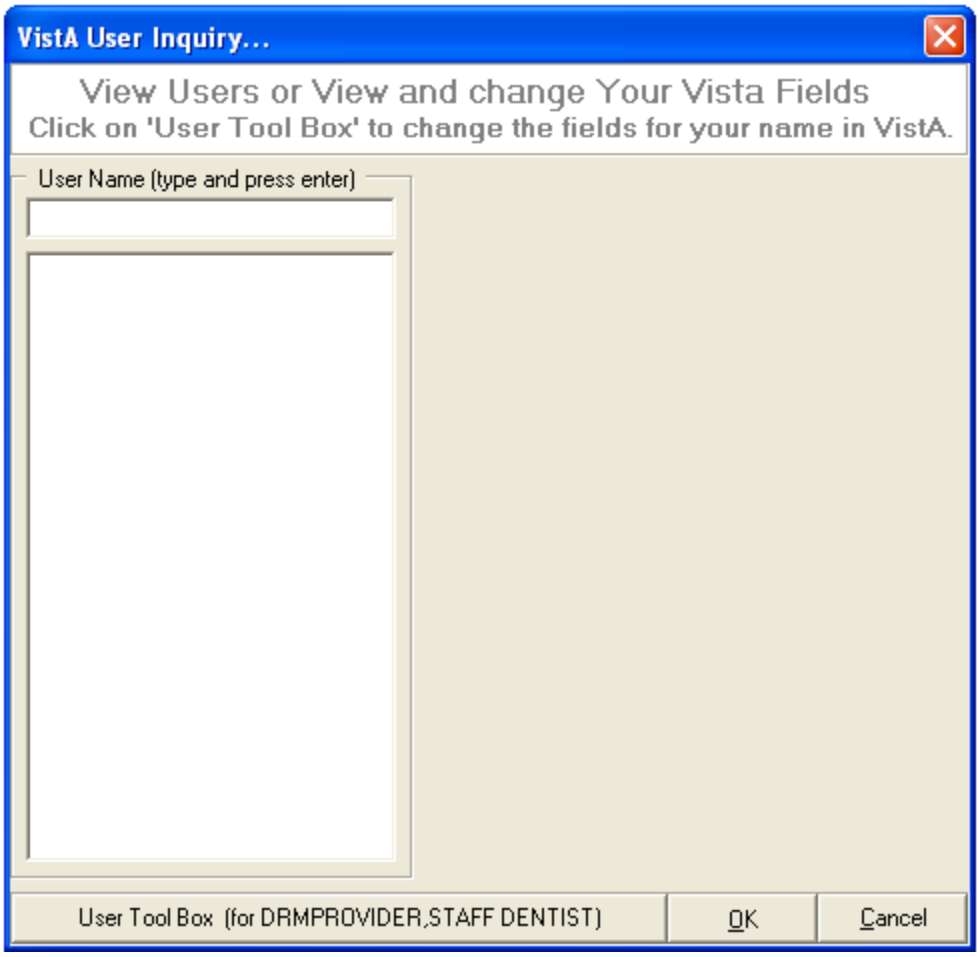


Figure 43: VistA User Inquiry Screen

1. Type the **User Name** into the input text box and press the <**Enter**> key.
2. The results appear on the left side of the screen.
3. Select a user to view. The user's information appears on the right side of the screen as shown in the next figure.

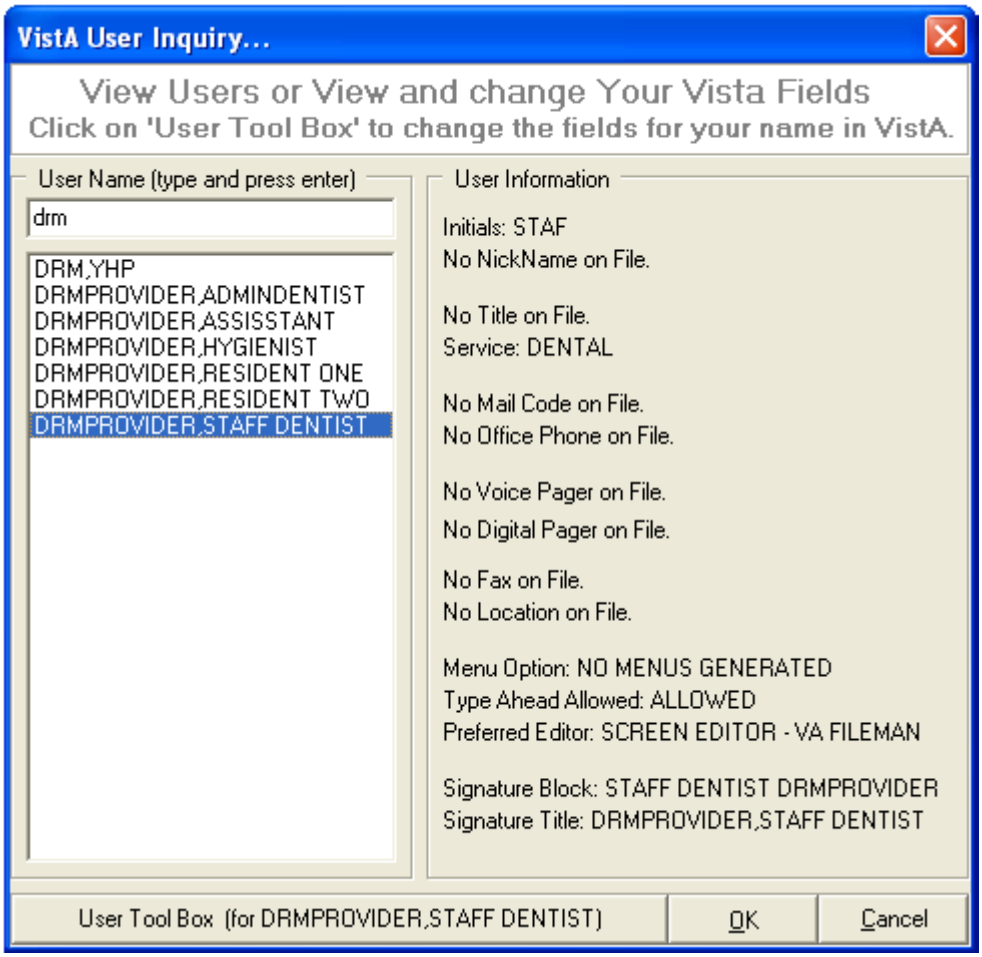


Figure 44: VistA User Entry Screen with User Information Displayed

Select the **User Tool Box** button to change personal fields in VistA. Click the **User Tool Box** button at the bottom of the screen and the User's Tbox screen appears.

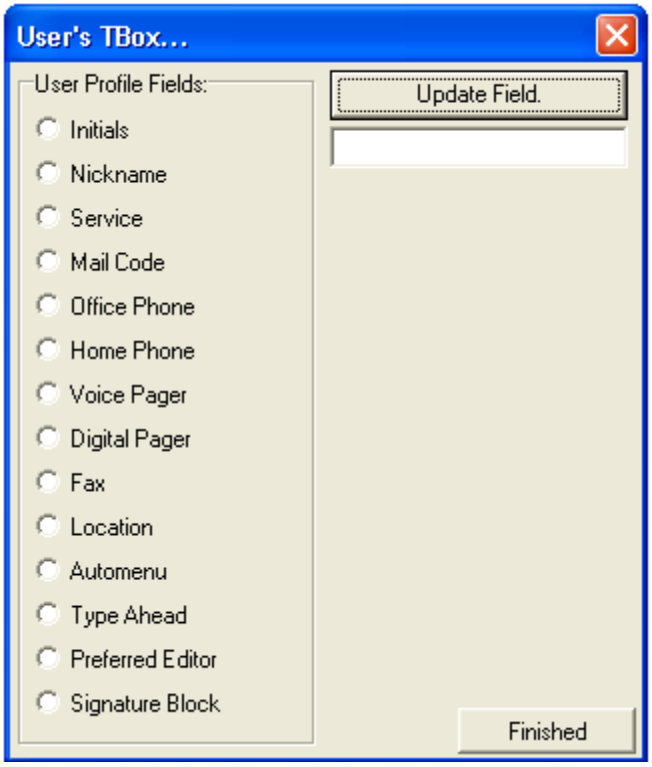


Figure 45: User's TBox Screen

4. Select the **desired User Profile Field** by clicking the corresponding radio button.
5. Edit the new text in the text box.
6. Click the **Update Field** button.
7. Click the **Finished** button. The VistA User Inquiry screen reappears.

User Options

Adjust various user settings in this option. The screen contains five tabs: General, Printing, Progress Note, Treatment System and Exam Settings.

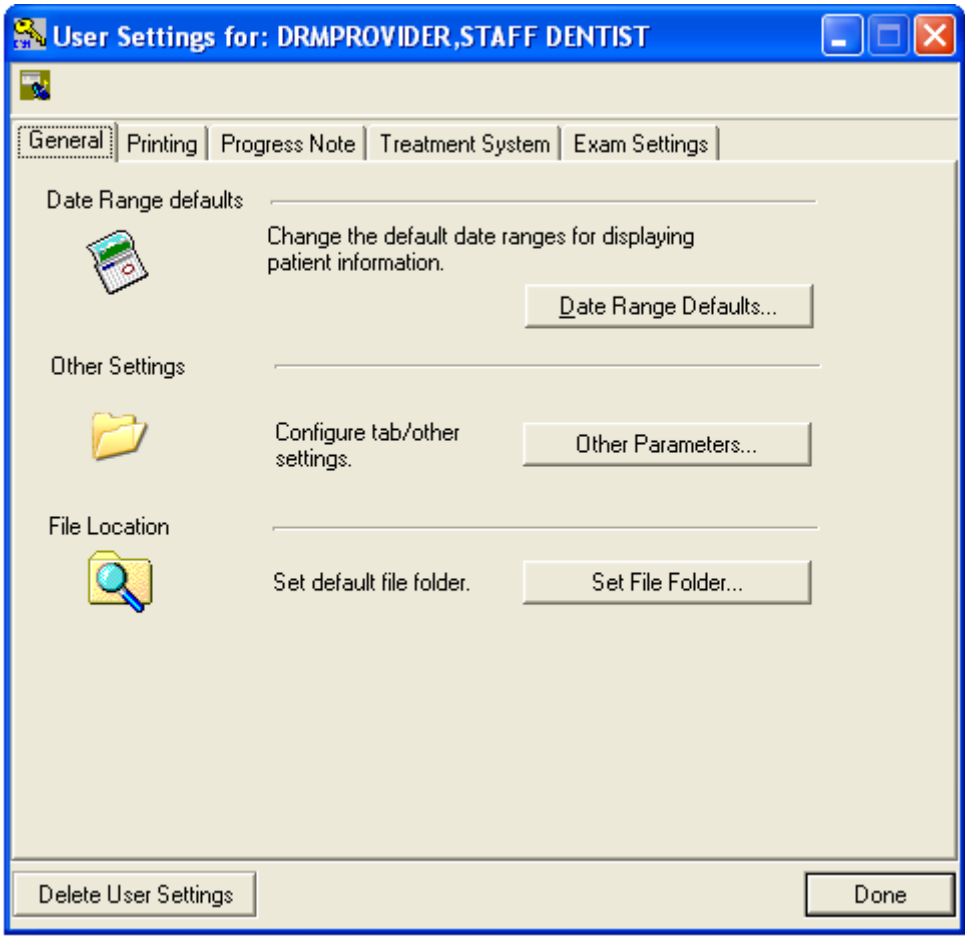


Figure 46: User Settings Screen

The Broker Call History icon  opens the Broker Calls screen. For furthur information, please see the section of this manual entitled, Last Broker Call in the chapter entitled, Using the DRM Plus Drop-Down Menus.

General

Choose this tab to change Date Range defaults, Other Settings and File Location folders.

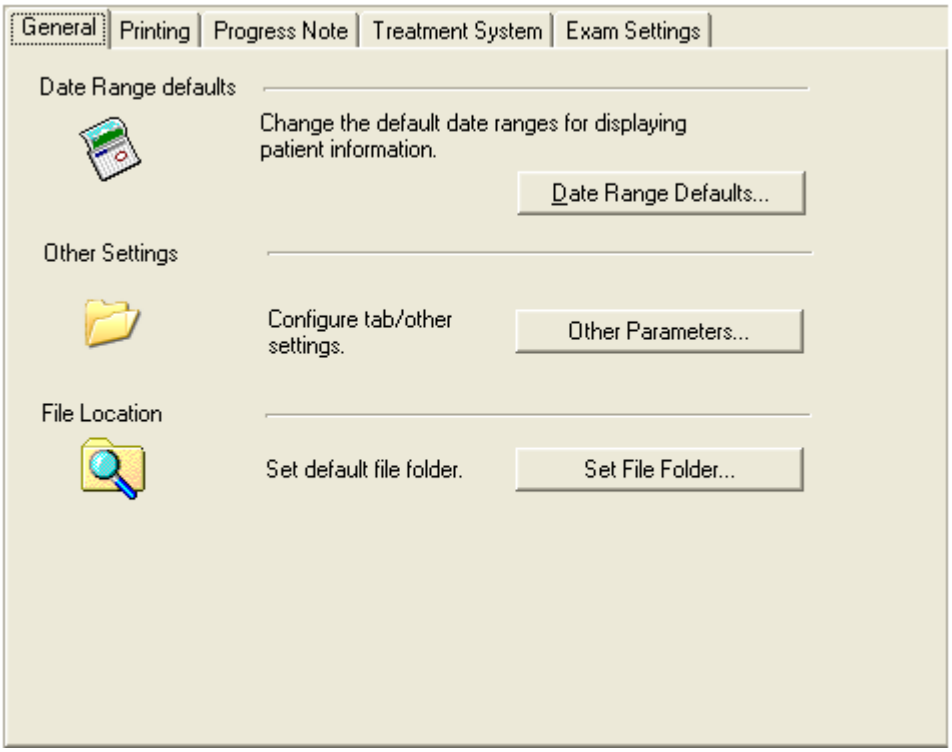


Figure 47: General Tab

To change the Date Range defaults:

1. Click the **Date Range Defaults** button.
2. The Date Range Defaults screen appears.

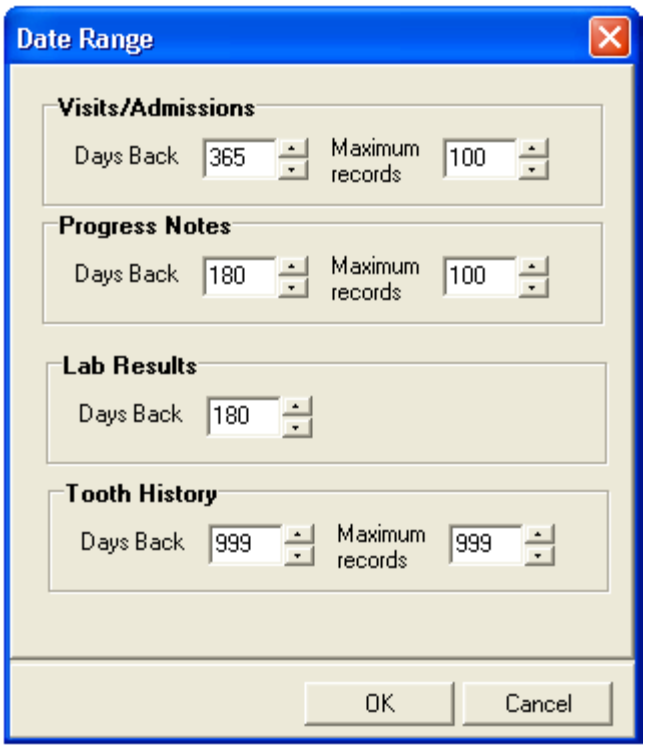


Figure 48: Date Range Defaults Screen

3. Use the **up and down arrows** to set the desired date range.
4. Click the **OK** button to return to the User Setting screen.

To change other Parameter Settings:

1. Click the **Other Parameters** button.
2. The Other Parameters screen opens.

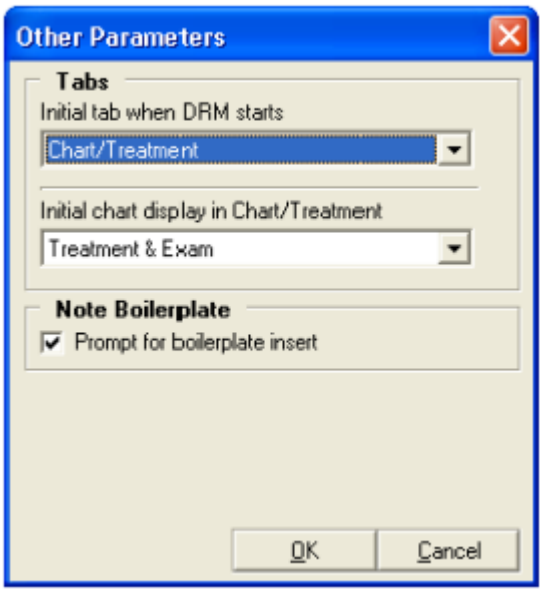


Figure 49: Other Parameters Screen

3. Use the **Tabs** drop-down menu to set the initial DRM Plus tab and chart display.
4. Use the **Note Boilerplate** checkbox to indicate whether the program should prompt for the boiler-plate insert associated with the VistA TIU note title selection.

To change the file location:

1. Click the **Set File Folder** button.
2. The DRM Plus Select Default Folder screen appears.

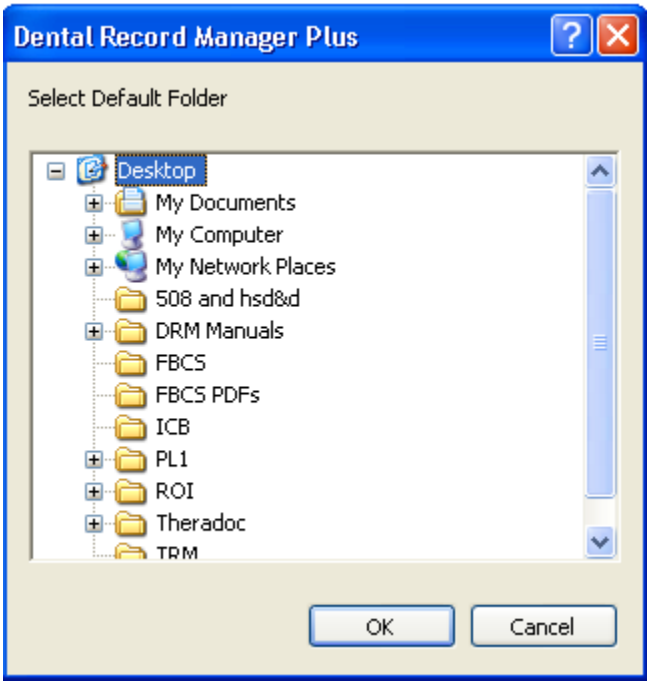


Figure 50: DRM Plus Select Default Folder Screen

3. Navigate to and click **the desired folder**.
4. Click the **OK** button to select it.

Note: This option allows the importing of information stored as a .txt file into the progress note.

Printing

Use the Printing tab to set print margins, orientations, etc.

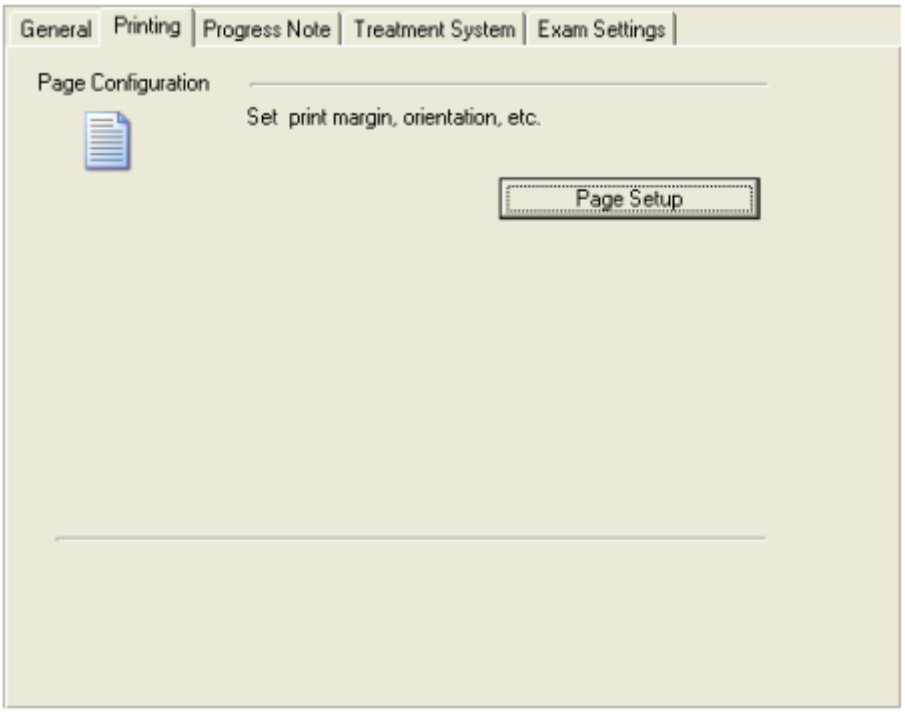


Figure 51: Printing Tab

To change the Page Configuration:

1. Click the **Page Setup** button.
2. The Page Setup screen appears.

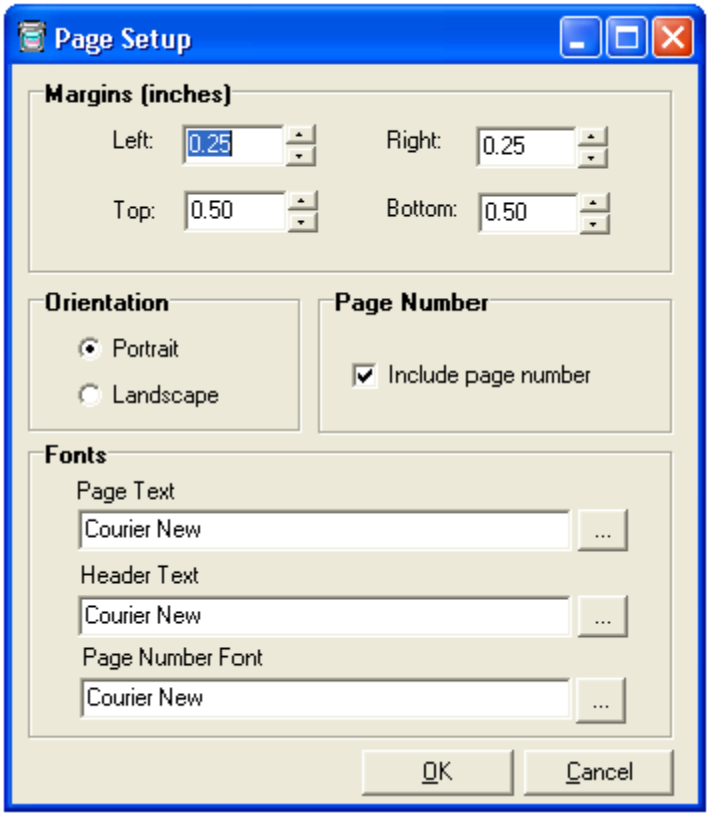


Figure 52: Page Setup Screen

3. Use the **up and down arrows** to adjust the margins.
4. Use the **Orientation** radio buttons to change the orientation of the printed document.
5. Use the **Page Number** checkbox to indicate whether page numbers will be included.
6. Use the **Ellipses** buttons to choose fonts for the Page Text, header Text and Page Number.
7. Click the **OK** button to return to the User Settings screen.

Progress Note

Use the functions in the Progress Note tab to configure Progress Note Data objects, configure Note Data Sequence and Configure Code Boilerplates.

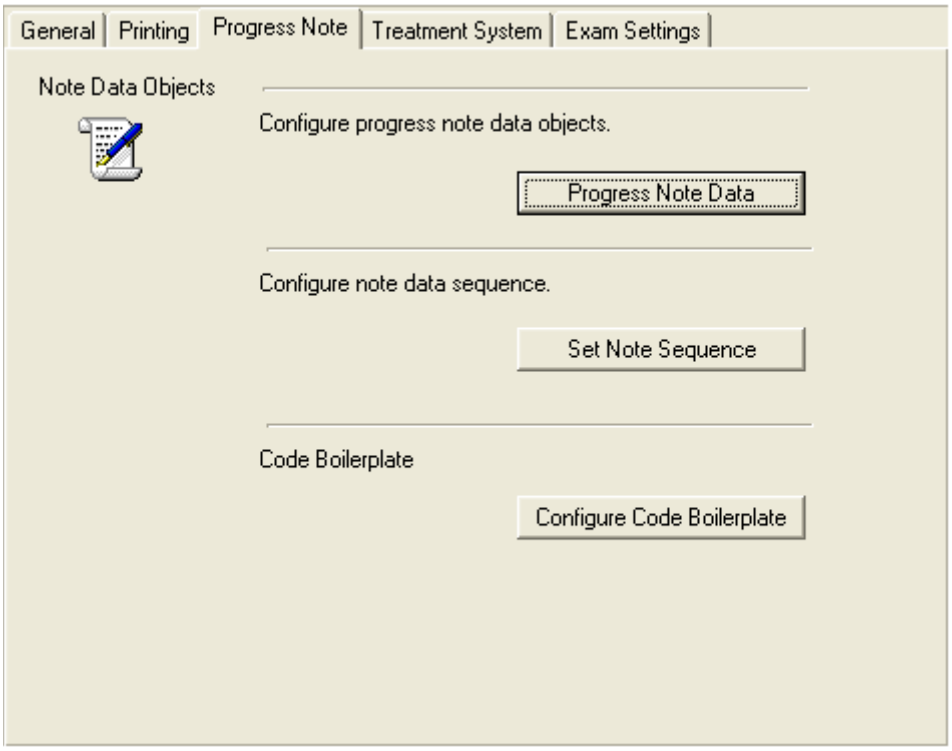


Figure 53: Progress Note Tab

To configure progress note data objects:

1. Click the **Progress Note Data** button.
2. The Progress Note Data Objects screen appears.

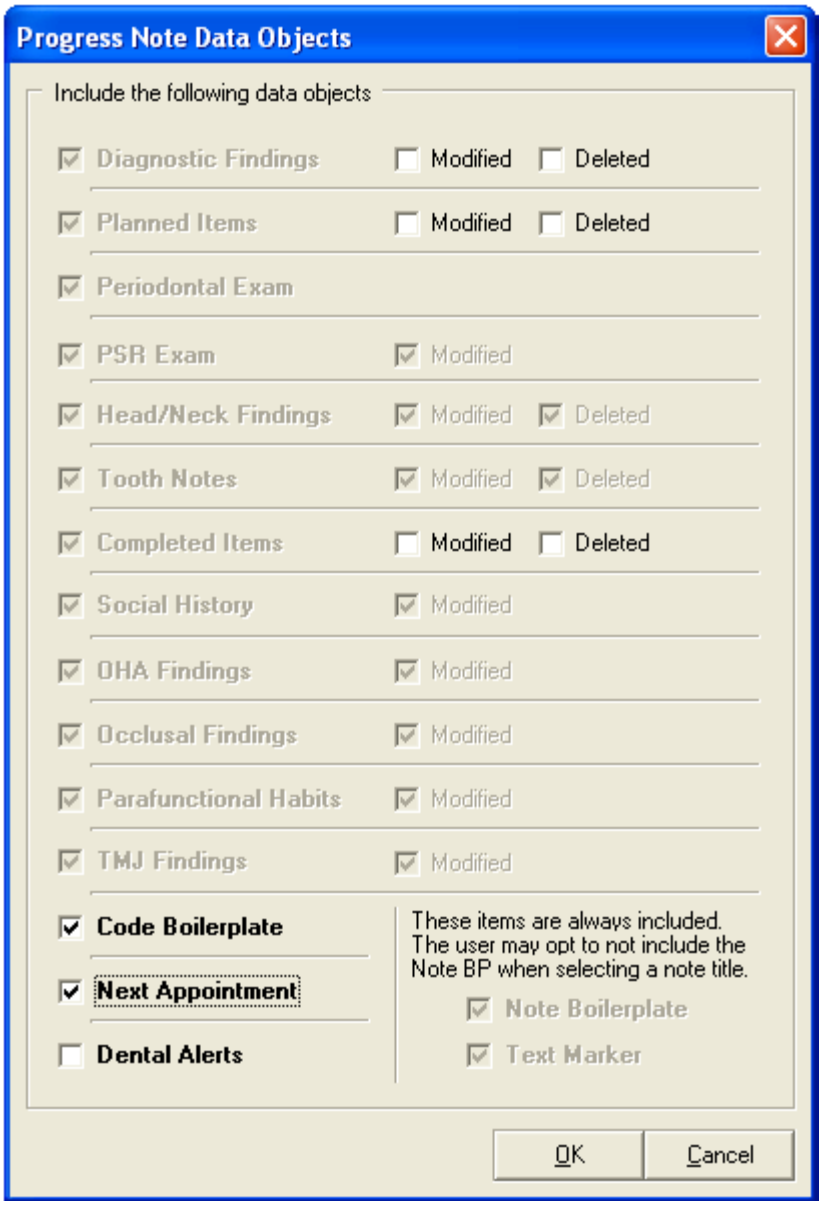


Figure 54: Progress Note Data Objects Screen

3. Use the various checkboxes to include or exclude desired progress note data objects.
4. Click the **OK** button to return to the User Settings screen.

Note: This Code Boilerplate checkbox activates the automatic importing into the Progress Note of any code boilerplate created in DRM Plus.

To configure the note data sequence:

1. Click the **Set Note Sequence** button.
2. The Note Object Sequence screen appears.

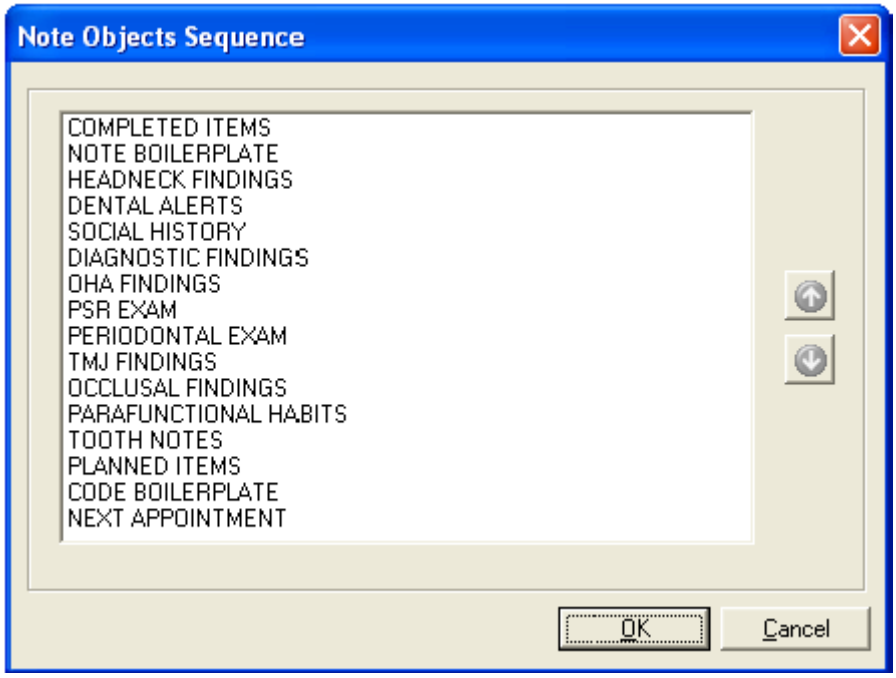


Figure 55: Note Object Sequence Screen

3. Select the Note Object to be moved in the list.
4. Use the **up and down arrows** on the right side of the screen to change the sequence of the Note Object on the list.
5. Click the **OK** button to return to the User Settings Progress Note tab screen.

To configure code boilerplate:

1. Click the **Configure Code Boilerplate** button.
2. The Code Boilerplate screen appears.

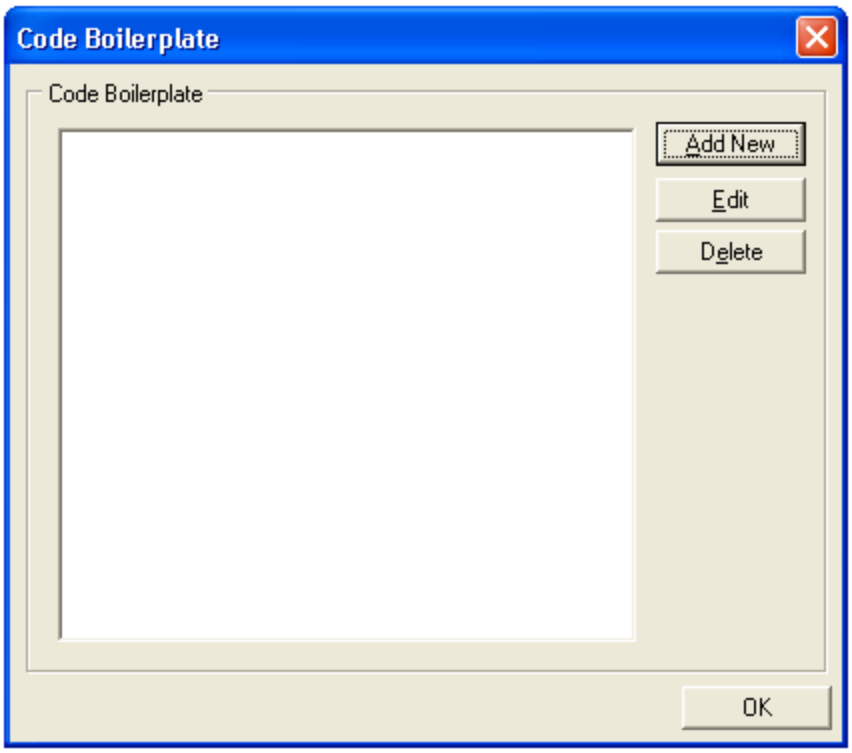


Figure 56: Code Boilerplate Screen

To add a new boilerplate:

1. Click the **Add New** button.
2. The New Boilerplate screen appears.

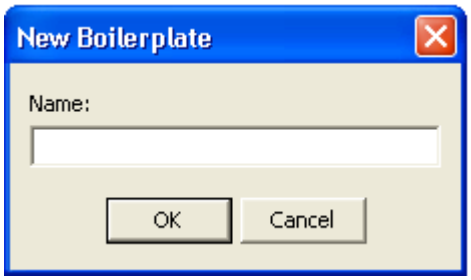


Figure 57: New Boilerplate Screen

3. Enter the name in the text box and click the **OK** button.
4. The Code Boilerplate Text screen appears.

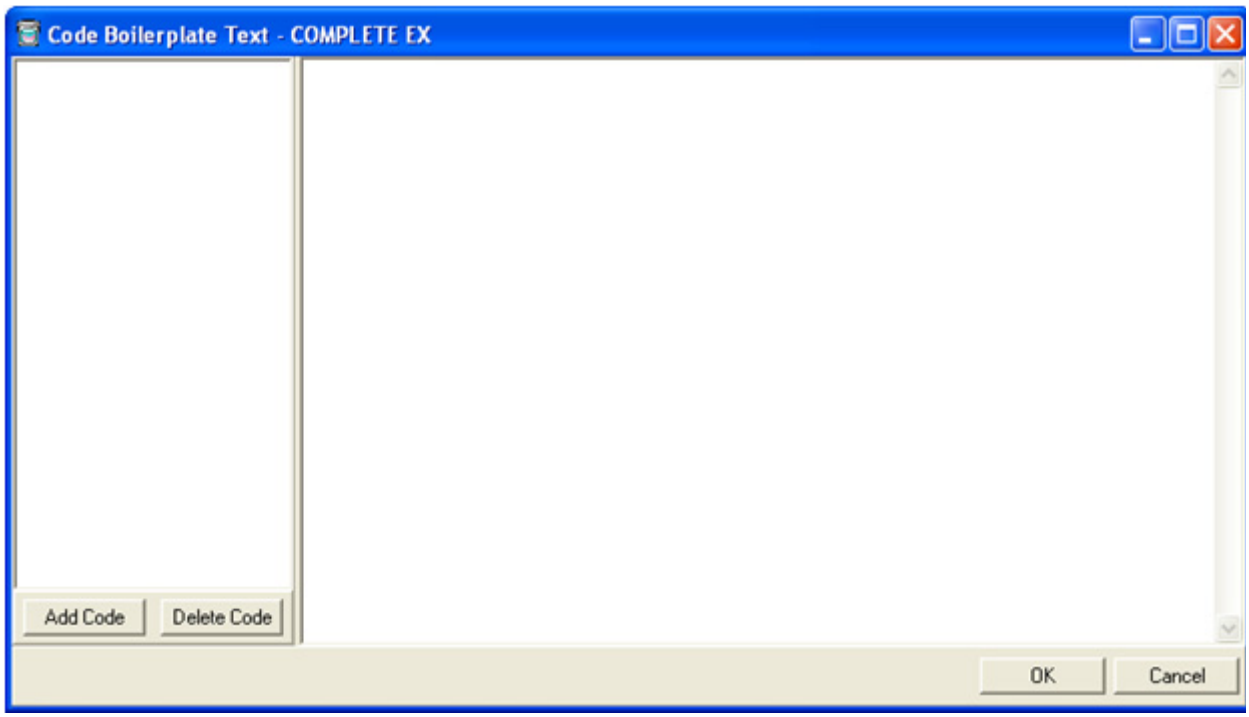


Figure 58: Code Boilerplate Text Screen

5. Click the **Add Code** button to add a code to the boilerplate.
6. The Find CPT Code or CPT Description Text screen appears.

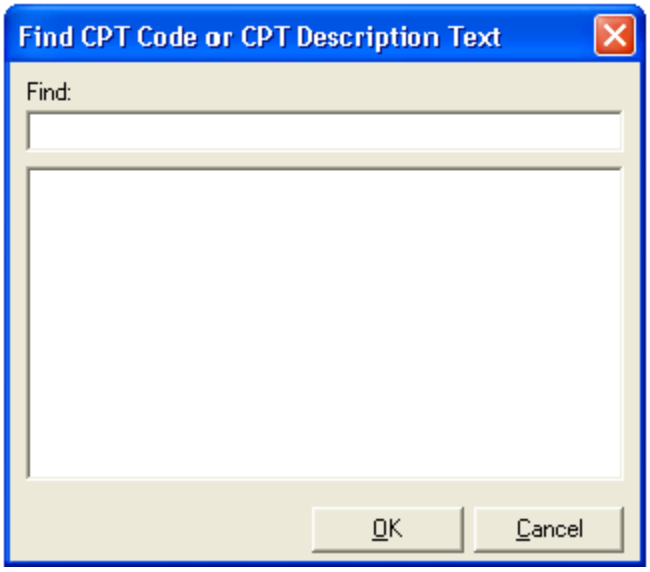


Figure 59: Find CPT Code or CPT Description Text Screen

7. Type in the CPT code. A partial number is acceptable. Press the <**Enter**> key.
8. The search results appear in the screen. Select one and click the **OK** button.
9. The selected code appears on the Code Boilerplate Text screen. The provider may add more than one CPT code to this code boilerplate.

10. To delete that code, click the **Delete Code** button in the Code Boilerplate Text screen.
11. Type the desired associated text into the right side of the Code Boilerplate Text screen.
12. Click the **OK** button. A confirmation screen appears. Click the **OK** button to return to the Code Boilerplate screen.

To edit a Code Boilerplate:

1. Select the code boilerplate to be edited from the Code Boilerplate screen.
2. Click the **Edit** button.
3. The Code Boilerplate Text screen appears.

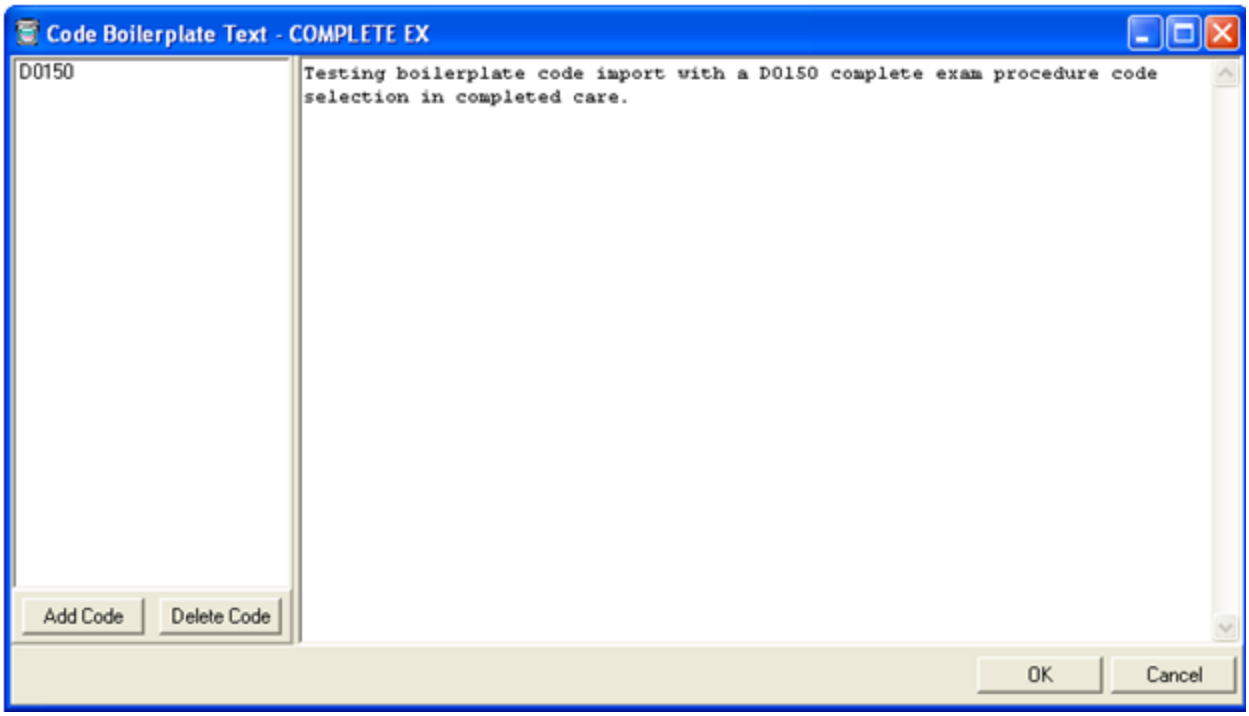


Figure 60: Code Boilerplate Text Screen

4. From here, type in the right side of the screen to add or delete text from the boilerplate. Use the **Add Code** and **Delete Code** buttons to add or delete codes form the boilerplate.
5. Click the **OK** button. An information screen appears. Click the **OK** button to return to the Code Boilerplate Screen.

To Delete a Code Boilerplate:

1. Select a code boilerplate from the list on the Code Boilerplate screen.
2. Click the **Delete** button.
3. A confirmation screen appears. Click the **Yes** button to delete the boilerplate.
4. An information screen appears. Click the **OK** button to return to the Code boilerplate screen.

Treatment System

The Treatment System tab allows access to additional options.

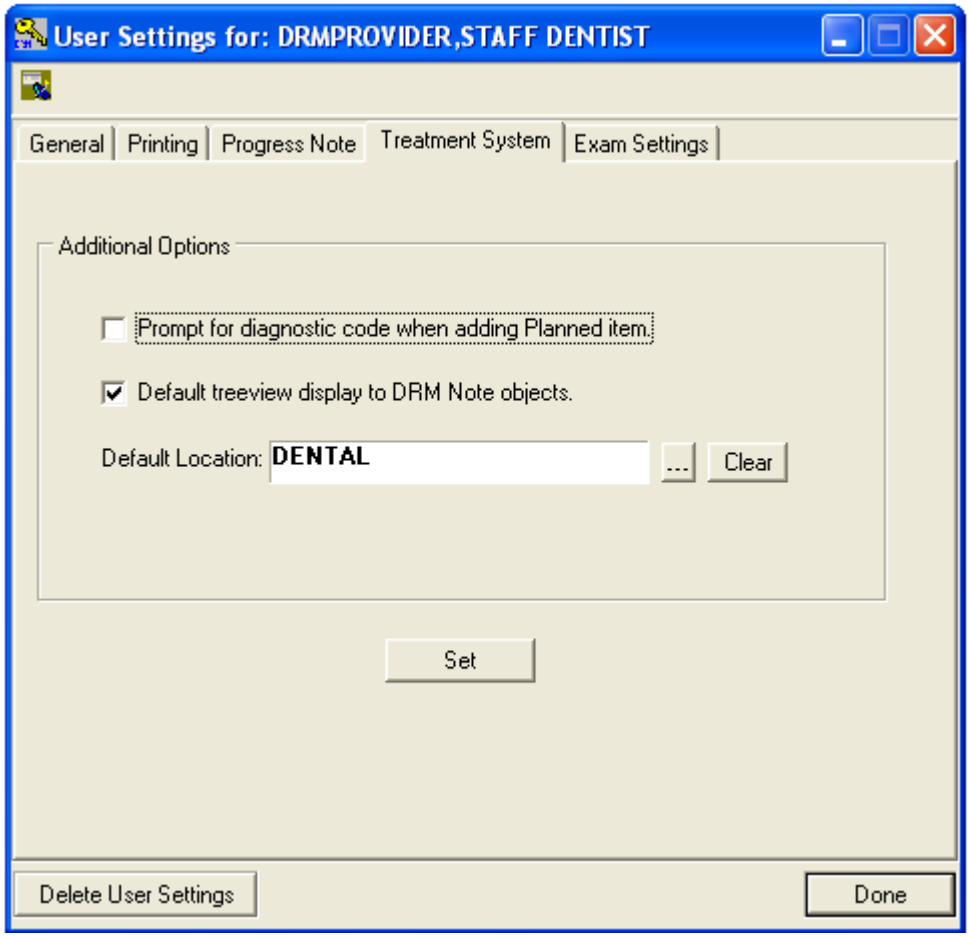


Figure 61: Treatment System Tab

Use the **checkboxes** to choose whether to prompt for diagnostic code when adding a planned item, or select the default tree view display to DRM Note objects.

To choose a default location:

1. Click the **ellipses (**...**)** button next to the Default Location text box.
2. The Select Location screen appears.

Figure 62: Select Location Screen

3. Type the location into the text box and press the <**Enter**> key.
4. Search results will appear on the Select Location screen.
5. Choose the desired location and click the **OK** button.
6. Click the **Set** button to save any changes to this screen.
7. Use the **Clear** button if no location is desired, then click the **Set** button.

The **Delete User Settings** button located on the lower left hand corner of the screen appears in all the tabs. Use this button to delete all user settings.

Note: The Delete User Settings function only applies to the user that is currently logged in. Other users will not be affected if one chooses to delete all user settings.

Exam Settings

The Exam Settings tab provides the user with several options. These include: Canned Statements, Next/ Back Button and Requirements.

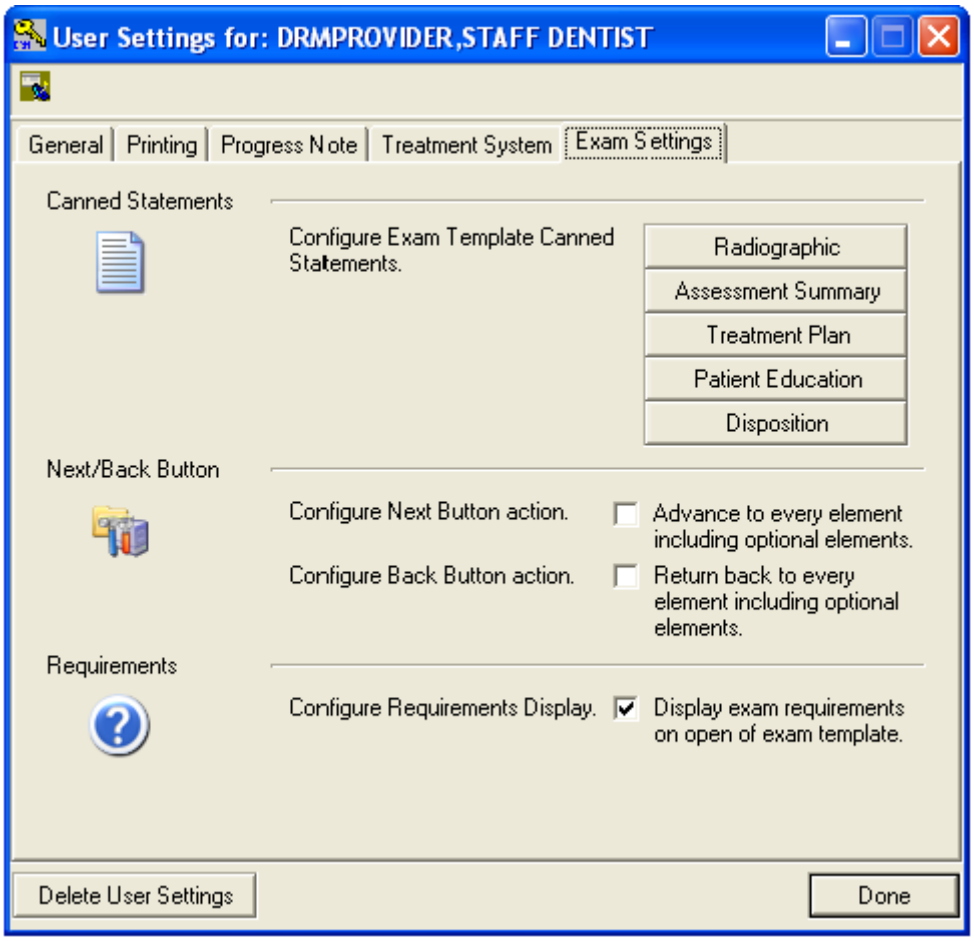


Figure 63: Exam Settings

The Canned Statements parameter allows the addition of additional pre-defined statements by the end-user to four elements. All local providers are end-users when utilizing this function from the User Options, whether or not they are administrators. Any changes made from the User Settings screen will effect only the individual end user.

Pre-defined statements are broken into five categories: Radiographic, Assessment Summary and Treatment Plan (located in the same element), Patient Education and Disposition.

The local DRM Plus administrator has priority when entering these statements system-wide, utilizing the administrator settings parameter (not displayed here).

When any of these element categories are maxed out with pre-defined statements, if the DRM Plus administrator wishes to add another, they can do so by utilizing the administrator settings parameter. This will hide the last pre-defined statement entered by any end-user, and only effect those end-users with twelve entered and displayed in the given category.

To add a pre-defined statement (admin or non-admin) from the User Options screen:

1. Select one of the **five pre-defined statement** buttons, such as Assessment Summary.
2. Type or copy/paste a pre-defined statement in the lower text box.
3. Click the green **Add (+)** button.
4. Click the **OK** button to confirm the new pre-defined statement addition.

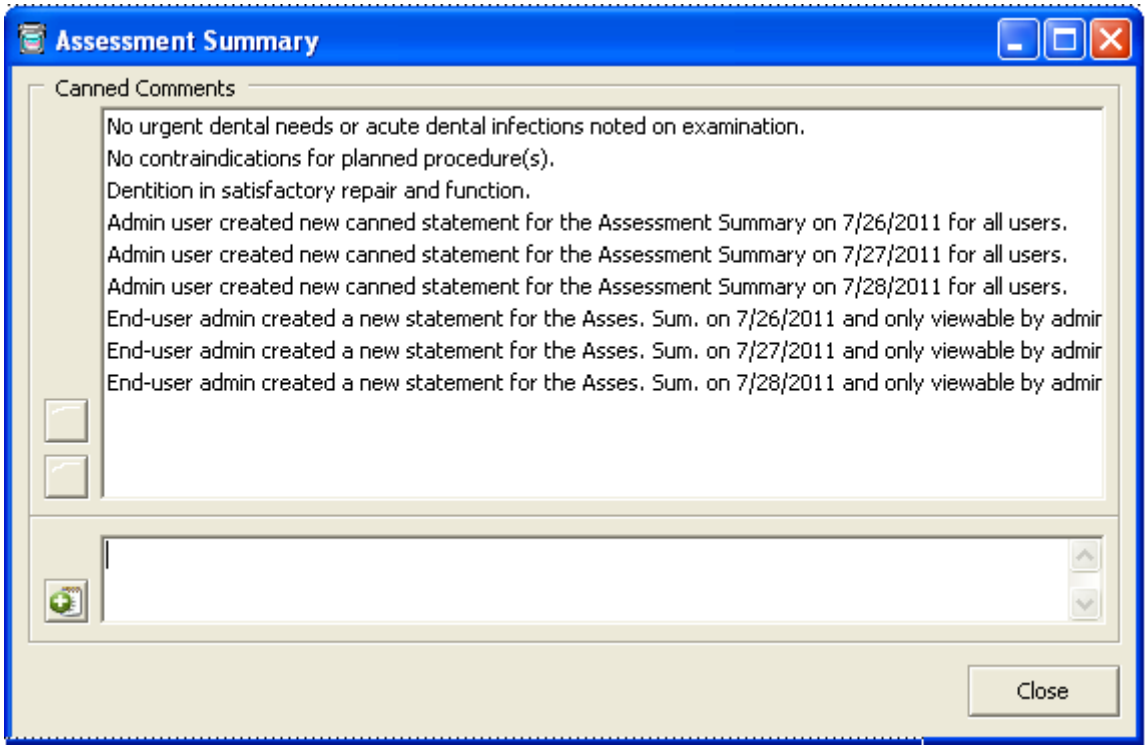


Figure 64: Add Pre-Defined Statement Screen

The end-user may highlight any of the pre-defined statements that were entered from their User Settings and either delete that statement or move the statement's position in the list. This deletion or rearranging the order will only affect the end-user's list of pre-defined statements and not any entered by the DRM Plus administrator or any national pre-defined comments that were kept by the DRM Plus administrator; these are listed at the top.

The Next/Back Button parameter setting allows the end-user when selecting the **Next** or **Back** buttons, located on any Exam tab element screen, to go directly to the next proceeding or previous required element screen for that exam code and skip all optional element screens.

Note: There is no **Back** button on the first Presentation/Chief Complaint element screen and there is no **Next** button on the last Disposition element screen.

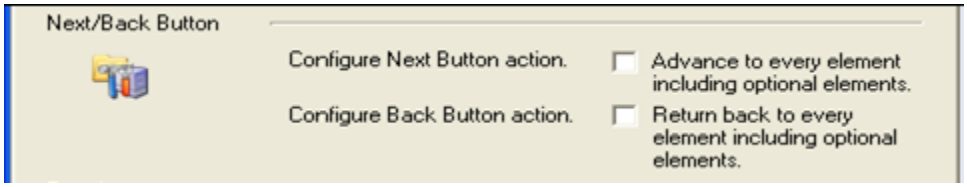


Figure 65: Next/Back Button Parameters

Both options are unchecked by default. When unchecked, the **Next** button skips any element that is optional or has been completed from new data entered on the Chart/Treatment tab during this session and open the next required element. When checked, the **Next** button opens the very next element no matter if it is optional or completed during this session.

When unchecked, the **Back** button skips any element that is optional but opens all previous required elements that are completed or not. When checked, the **Back** button opens the previous element no matter if it is optional or required.

The user is required to complete any optional or required element when selecting the **Next** button when trying to move forward. Selecting the **Back** button doesn't require the element to be completed to open a previous element.

Note: When this parameter has been formatted in the User Settings screen, these selections only affect the end-user's profile and follow that end-user to any computer when loading DRM Plus with their VistA access/verify codes.

The Requirements parameter allows the end-user to keep the Element Requirements Panel open when selecting any element from the Exam tab, or the definitions from the OHA or Occlusal screens.

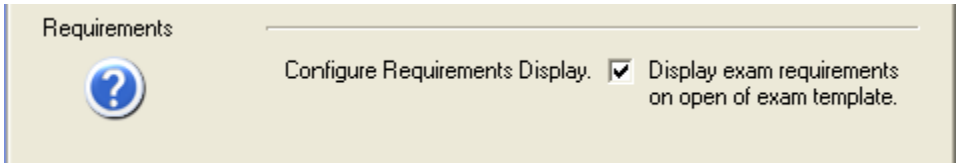


Figure 66: Requirements

It is checked by default, and displays the Elements Requirements whenever an element is open.

When unchecked, the end-user must select the **Done** button and then close/reopen DRM Plus. The end-user must then open the Element Requirements Panel manually.

The **Requirements icon** button, located in the upper right corner of the element screen, can be clicked, and will display the Element Requirements Panel.

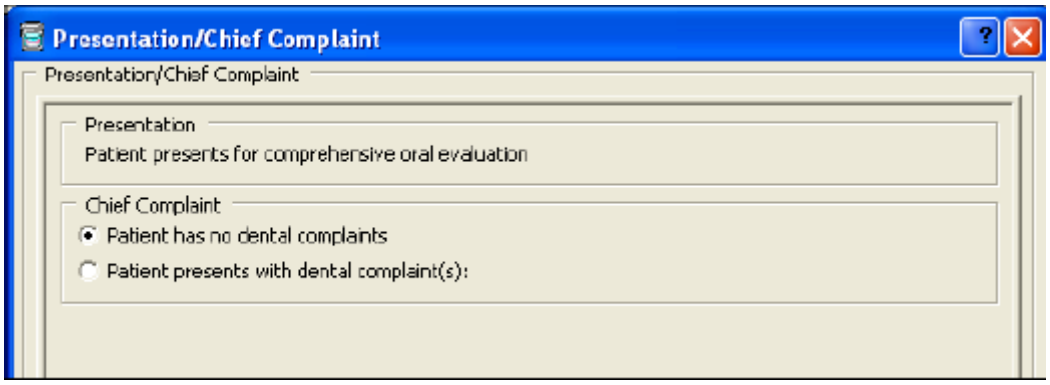


Figure 67: Presentation/Chief Complaint Screen

Administrative Toolbox

There is an administrative function. For more information, please see the DRM Plus administrative guide or speak to a local DRM Plus administrator.

Provider Add/Edit

This is an administrative function. For more information, please see the DRM Plus administrative guide or speak to a local DRM Plus administrator.

Ancillary Tool Functions – ADA Website

This American Dental Association website is only available if the DRM Plus administrator formats this in the administrator's Ancillary applications and parameters. Some users may not have permission to access the Internet or have to enter/re-enter a user name/passcode. Please see the DRM Plus administrator for more details.

Extract History File

This is an administrative function. For more information, please see the DRM Plus administrative guide or speak to a local DRM Plus administrator.

New Extract History File

This is an administrative function. For more information, please see the DRM Plus administrative guide or speak to a local DRM Plus administrator.

Reports

When this option is selected, the Report Selection screen appears.

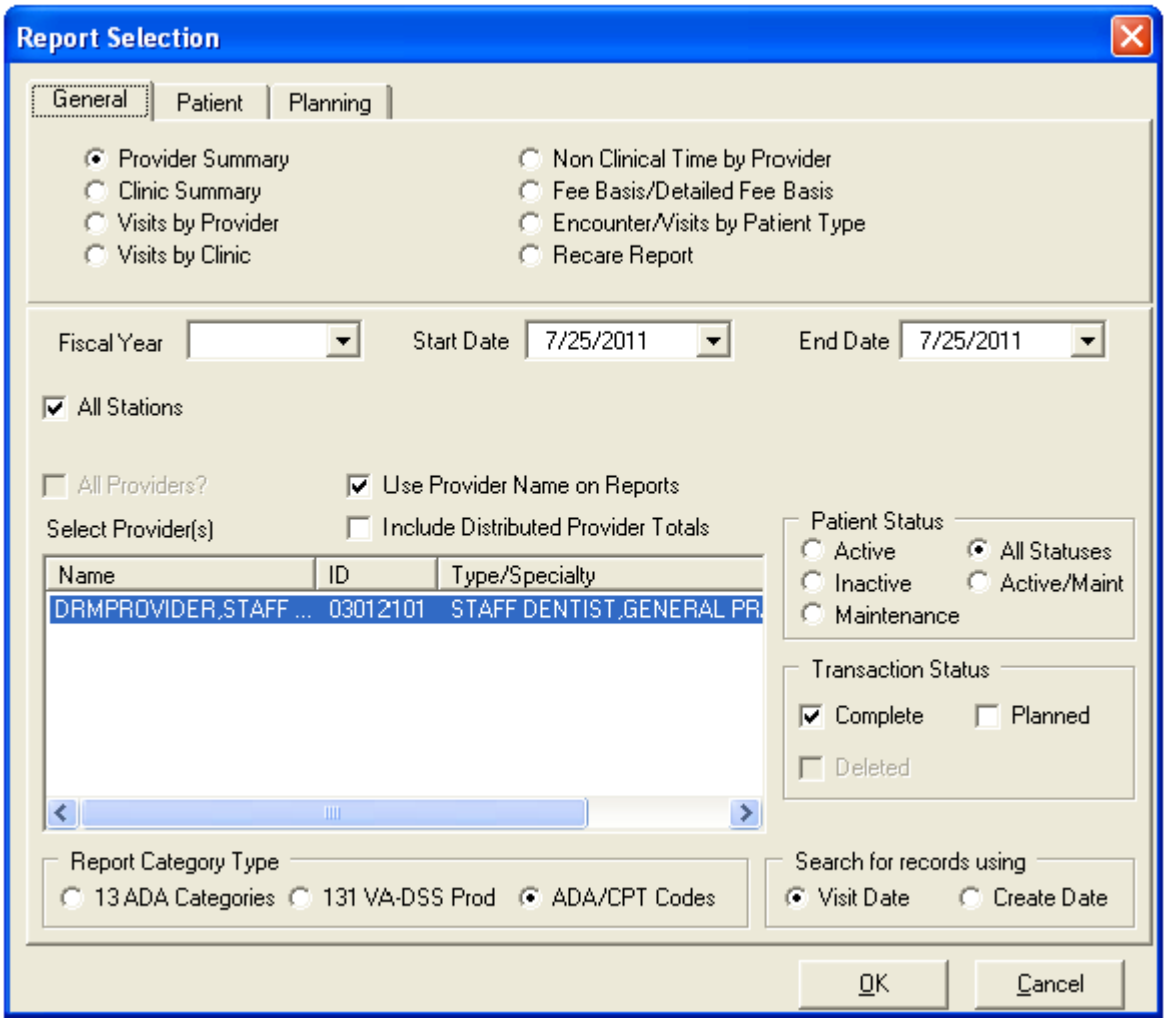


Figure 68: Report Selection Screen

The screen has three tabs: General, Patient and Planning.

General

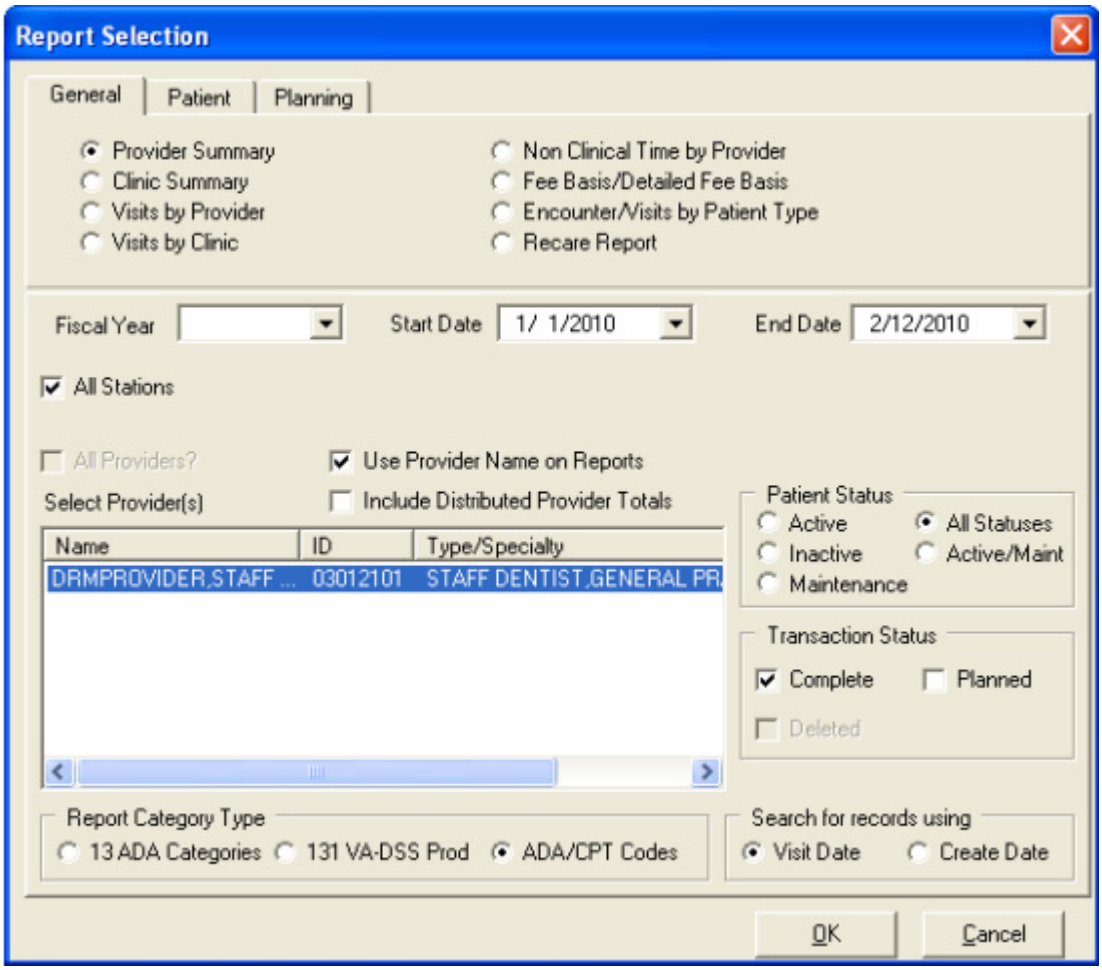
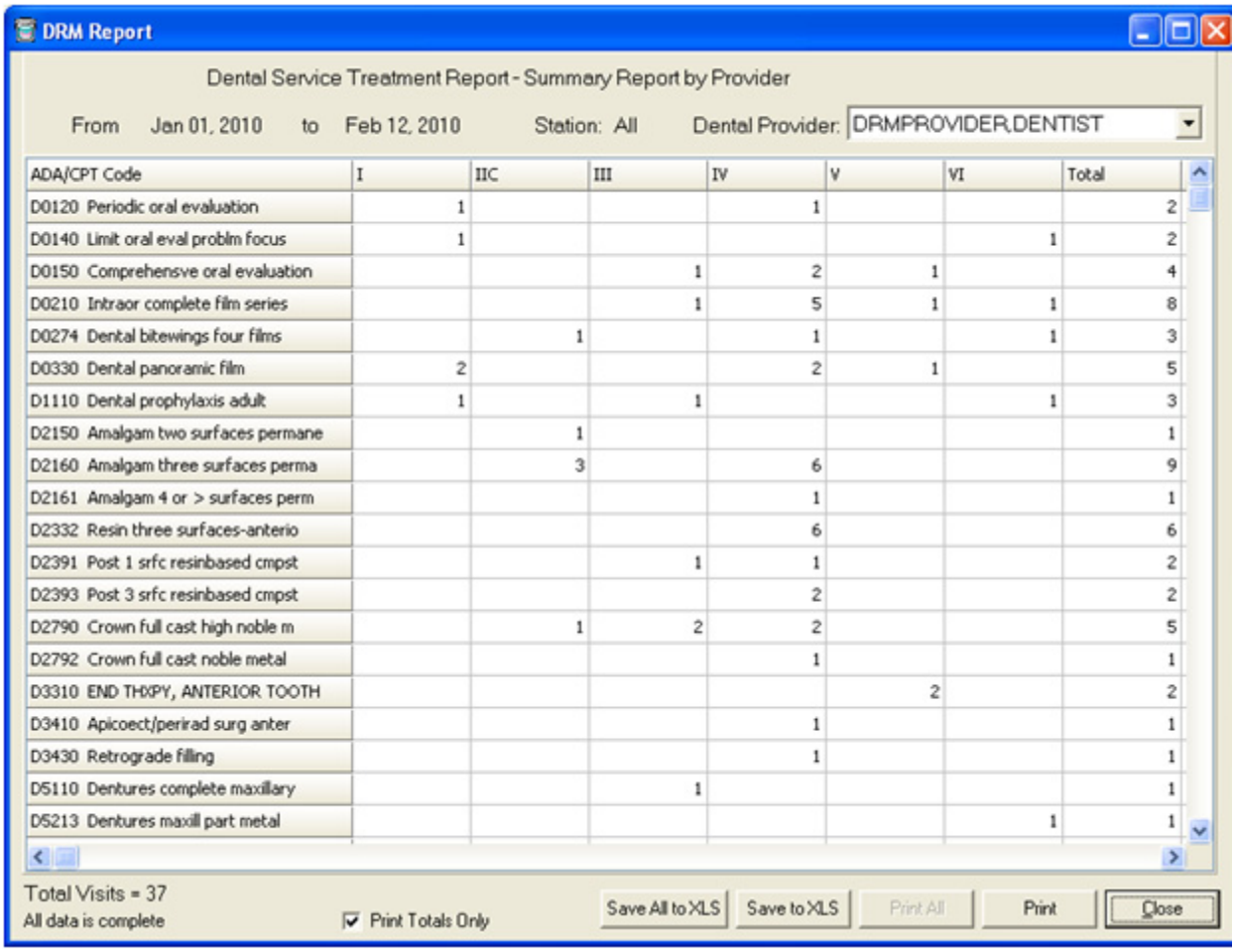


Figure 69: General Tab

To create a report:

1. Choose the desired report type.
2. Select the Fiscal Year or the Start Date and End Date.
3. Use the checkbox to indicate whether the provider name and the distributed provider totals should be included in the report.
4. Choose a patient status.
5. Indicate what the transaction status is.
6. Pick the report category type.
7. Choose the progress note date type that will be represented on the report.
8. Click the **OK** button to generate the report. The report screen appears.



ADA/CPT Code	I	IIC	III	IV	V	VI	Total
D0120 Periodic oral evaluation	1			1			2
D0140 Limit oral eval problm focus	1					1	2
D0150 Comprehensve oral evaluation			1	2	1		4
D0210 Intraor complete film series			1	5	1	1	8
D0274 Dental bitewings four films		1		1		1	3
D0330 Dental panoramic film	2			2	1		5
D1110 Dental prophylaxis adult	1		1			1	3
D2150 Amalgam two surfaces permane		1					1
D2160 Amalgam three surfaces perma		3		6			9
D2161 Amalgam 4 or > surfaces perm				1			1
D2332 Resin three surfaces-anterio				6			6
D2391 Post 1 srfc resinbased cmpst			1	1			2
D2393 Post 3 srfc resinbased cmpst				2			2
D2790 Crown full cast high noble m		1	2	2			5
D2792 Crown full cast noble metal				1			1
D3310 END THXPY, ANTERIOR TOOTH					2		2
D3410 Apicoect/perirad surg anter				1			1
D3430 Retrograde filling				1			1
D5110 Dentures complete maxillary			1				1
D5213 Dentures maxill part metal						1	1

Figure 70: DRM Report Screen

This screen has options to save an Excel file (Save to XLS) or close. Some of the options may not be available with every report type.

Eight report types are accessible through this tab:

- Provider Summary: Summary counts of procedures by Station/Provider and Dental Classification.
- Clinic Summary: Summary counts of procedures by Station and Dental Classification.
- Visits by Provider: Detailed listing of procedures by Station/Provider.
- Visits by Clinic: Detailed listing of procedures by Station.
- Non-Clinical Time by Provider: Total days by provider for time applied to Education, Administration, Research and Fees (for local dental use only).
- Fee Basis/Detailed Fee Basis: Total amount authorized and number of cases by Dental Classification (for local dental use only).
- Encounters/Visits by Pat Type: Summary counts of encounters/visits by patient type.
- Recare Report: List of patients with recare dates. Only accessible by a DRM Plus Administrator.

Click the corresponding radio buttons to select the desired report types. Use the checkboxes to customize these reports.

Note: Selecting multiple reports from the General tab while the Report Selection screen is displayed requires the selection of the Report radio button first followed by the selection of the Fiscal Year every time even if the same fiscal year is desired for multiple reports.

Patient

Use the Patient tab to run a report on any patient and view a list of visits. The patient is only used for report generation; changing patients in DRM Plus is not allowed.

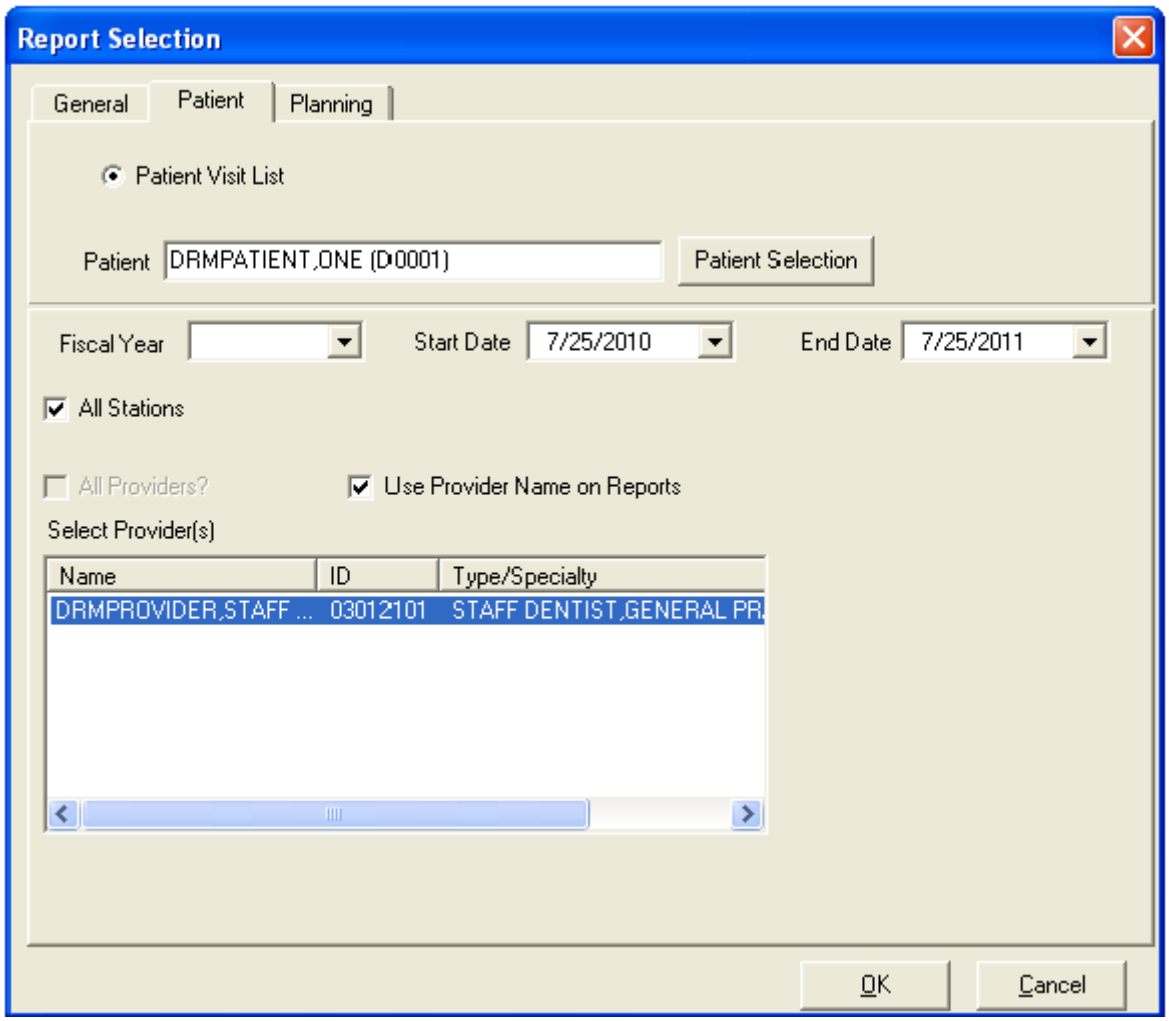


Figure 71: Patient Tab

1. Click the **Patient Selection** button to select a patient. The program automatically defaults to the patient whose record is currently opened in DRM Plus.
2. The Patient Selection screen appears.

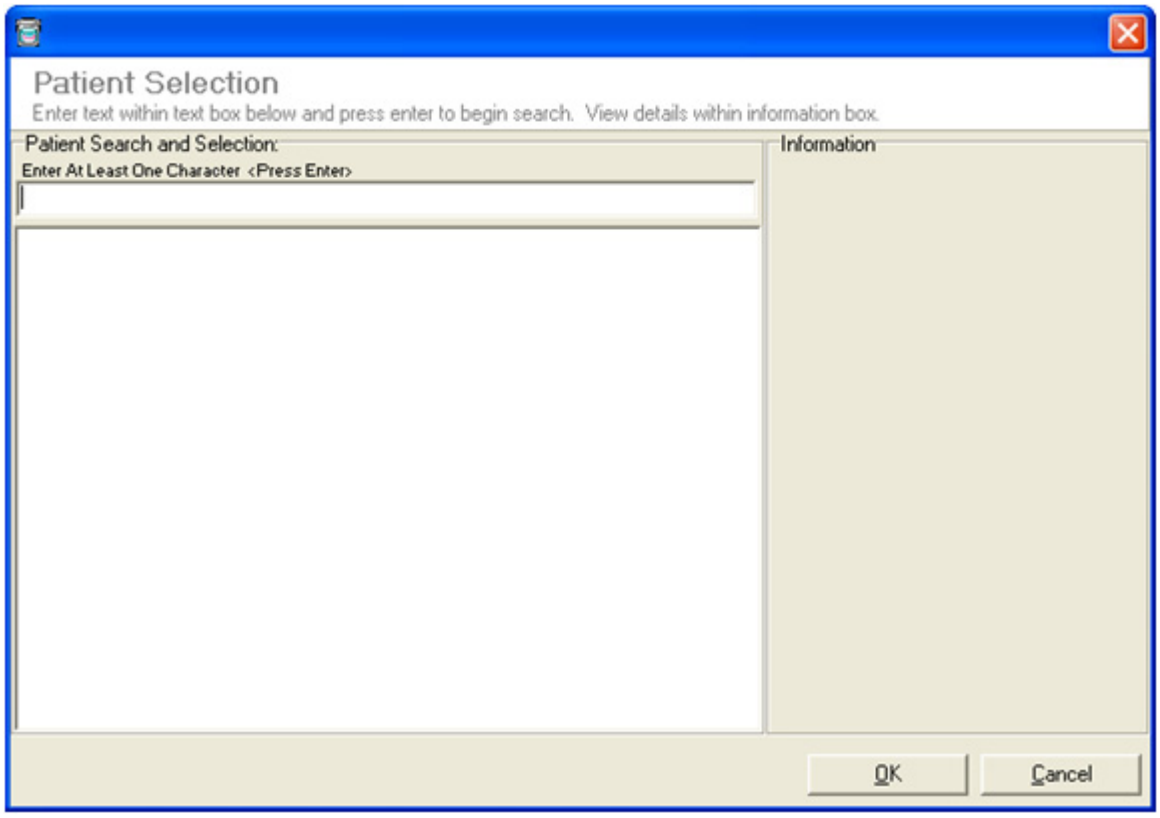


Figure 72: Patient Selection Screen

3. Type a patient name into the text box and press the <**Enter**> key. Partial names are acceptable.
4. Select the desired patient from the results box and click the **OK** button.
5. The selected patient's name now appears on the Patient tab.
6. Choose the date and select other information to be included or excluded using the checkboxes on the patient tab.
7. Click the **OK** button.
8. The DRM Report Screen appears. Save to an Excel file, print or close.

Planning

Use the options in this tab to run planning reports, active patients by provider or unfiled data by provider.

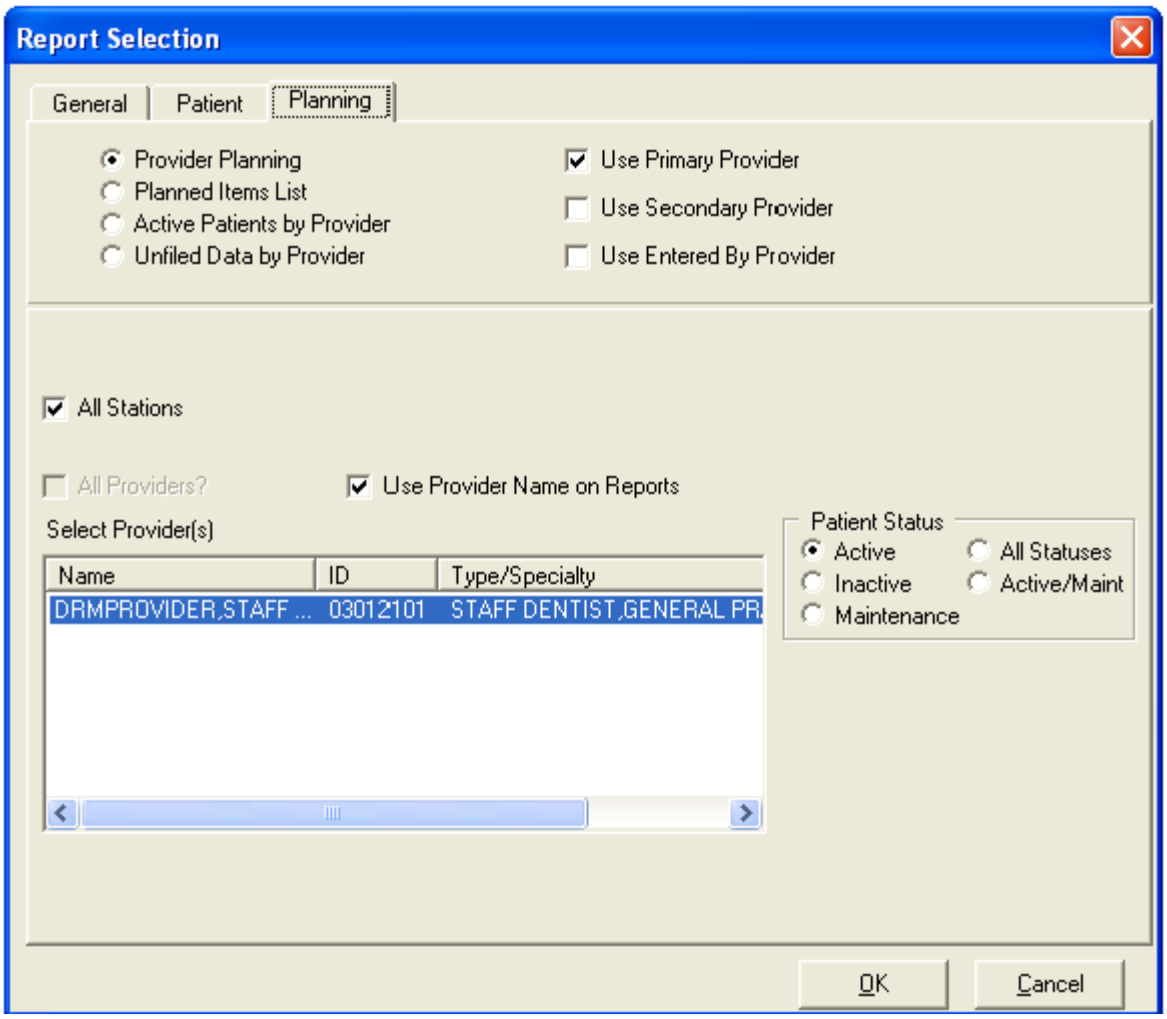


Figure 73: Planning Tab

1. Select the type of report.
2. Use the checkboxes to indicate provider information.
3. Choose a patient status.
4. Click the **OK** button.
5. The DRM Reports screen appears. Print or save the results to Excel.

Note: The Primary/Secondary provider option is utilized for these reports: Provider Planning, Planned Item List and Active Patients by Provider.

Unfiled Data by Provider Report

The Unfiled Data by Provider report displays a list of patients who have unfiled data for providers. Unfiled data is data that resides in a temporary scratch pad-type area, and is only visible by the provider the data is saved to.

This data is not part of the patient's chart record, and should be filed to completion in a timely manner. Unfiled data becomes inactive after eight days; the saved data will be viewable but no longer available to be filed.

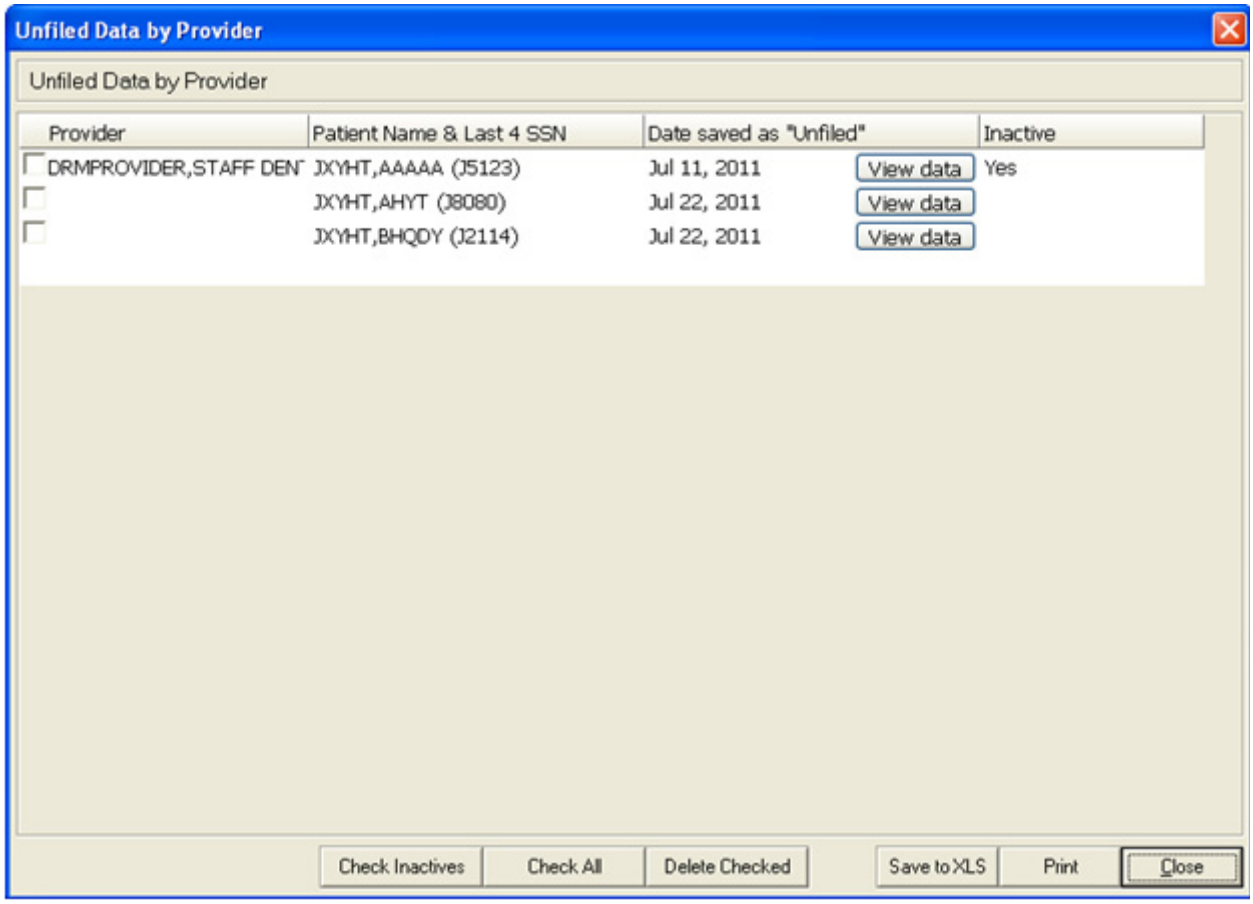


Figure 74: Unfiled Data Report

After selecting an Unfiled Data report, the provider will need to select the **View data** button which will allow the user to display the data that was saved as unfiled data on that patient.

The TX Note Preview screen opens and displays the save unfiled data. This displays the unfiled data saved by this provider or by some other provider who sent it to this provider on a specific patient.

The provider may print this unfiled data, especially if the data was made inactive either by the unfiled data now saved over the 8-day limit, or if a DRM Plus administrator used the Clean Slate option on this patient's chart. An example of inactive unfiled data would have a "Yes" listed in the Inactive column. There is no way for DRM Plus to reload this inactive data back into the patient's chart, so the provider is required to re-enter the data manually with another encounter.

The provider may delete any unfiled data by selecting the checkbox under the provider and then selecting the **Delete Checked** button. The **Check Inactives/Uncheck Inactives** button allows the provider to select/unselect all the inactive unfiled data reports. The **Check All/Uncheck All** button allows the provider to select/unselect all the check boxes in the Unfiled Data report.

The following dialog is an example of unfiled data saved on a patient. The user may print the unfiled data by selecting the **Print** button or close the screen by clicking the **OK** button.

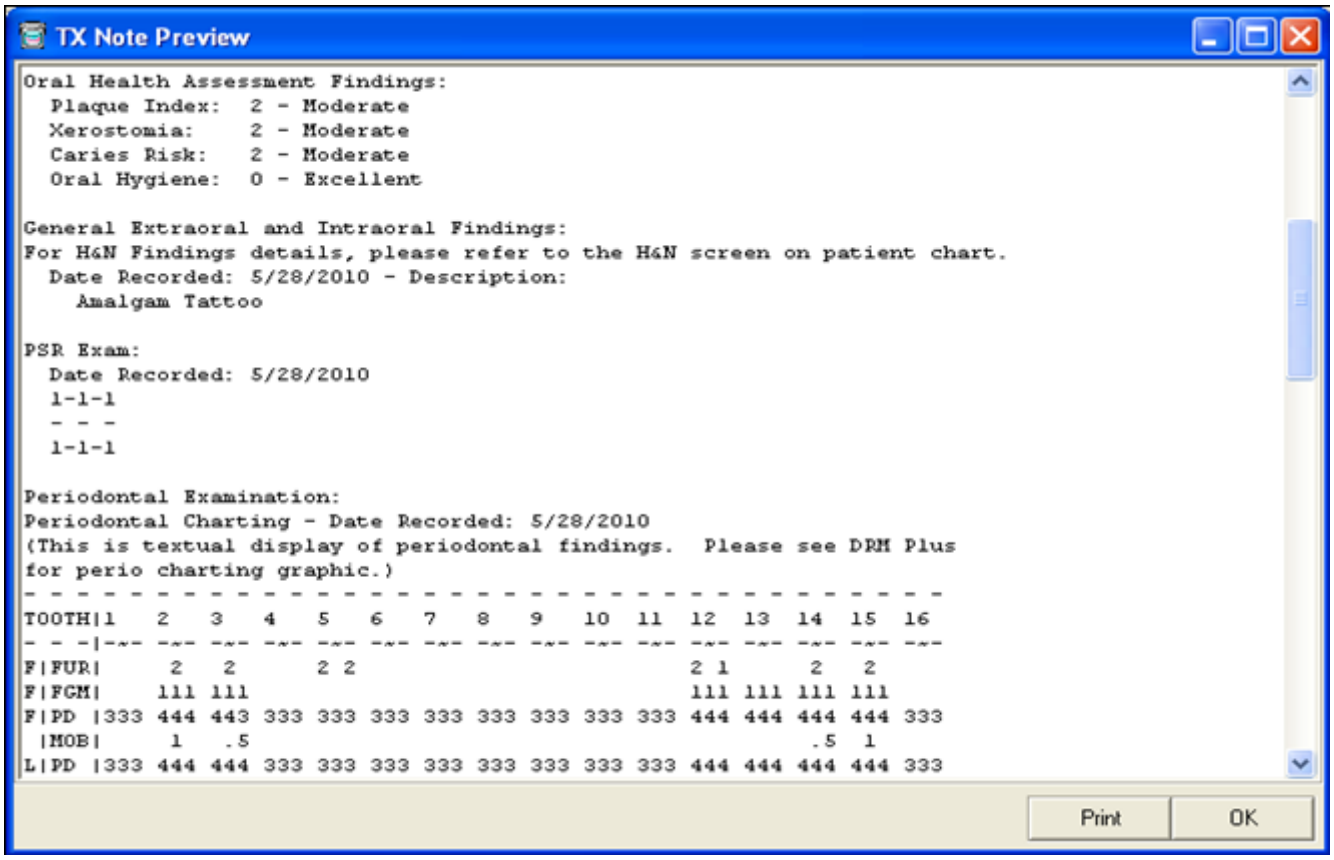


Figure 75: TX Note Preview

Non-administrative end-users are able to delete, view and print the active/inactive unfiled data for all their respective patients when accessing this report. The Unfiled Data by Provider report only allows a non-administrative provider to view their own saved unfiled data and NOT of other providers.

The following dialog is the new screen that allows the provider to load, view (non-load) or delete any unfiled data when opening the DRM Plus chart for a patient. This screen now has a third button that allows the provider to delete unfiled data before it is loaded into this patient's chart. The provider is not able to view the unfiled data when they select this **Delete** button option from this screen.

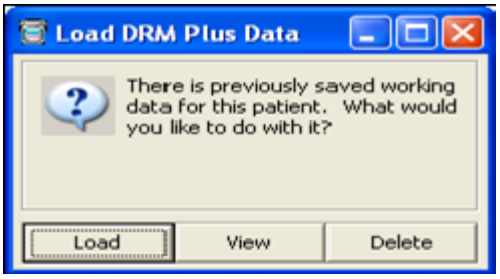


Figure 76: Load DRM Plus Data Screen

There are two ways to view the unfiled data before the provider deletes this data. The first is to select the Load option and go to the Unfiled Data report located from the Tools menu / Reports option / Planning tab / Unfiled Data by Provider report selection.

The second way to view unfiled data when the provider can't remember exactly what was saved as unfiled data is to select the **View** button. This option takes the user directly to the Unfiled Data by Provider report; however, it did not load the unfiled data. If the user wants the unfiled data loaded and filed, then they must close the report and select the **Refresh Patient Chart** under the File menu.

This action brings up the screen again and allows the user to select the **Load** button as the patient's chart reopens. Then they are able to file the encounter. The following screen displays after selecting the **View** button stating the same steps.

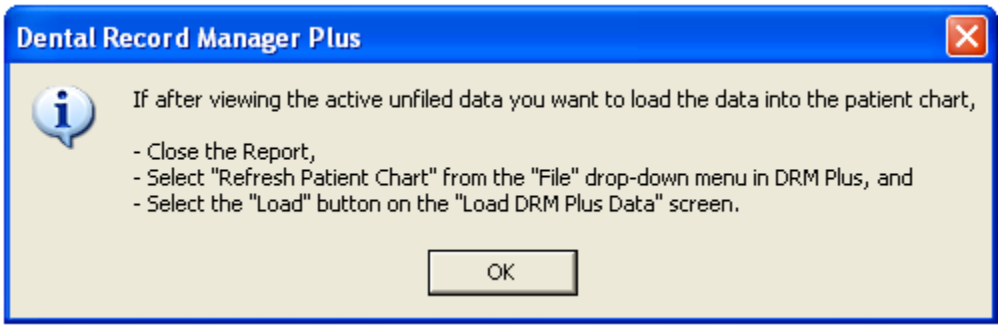


Figure 77: View Data Steps

If the Load or View was selected upon entry into the patient's chart and the provider wants to delete the unfiled data after viewing the data, just use the **Delete Checked** button in the Unfiled Data by Provider report. If the **Load** button was selected,then the user will also need to select the Refresh Patient Chart from the File menu.

Note: VistA dental patients that are configured as test patients with the first three or five digits of the SSN begin with a zero are NOT allowed to be saved or stored as unfiled data in any DRM Plus report. Those dental patients will not have any unfiled data displaying in the Unfiled Data by Provider report found in DRM Plus.

Unfiled Data becomes inactive after eight days. The end-user receives a screen message on the ninth day after saving data whenever they enter the patient's chart. This message provides options to either view or delete the inactive unfiled data.

A screen appears when the patient's chart has inactive unfiled data present from the end-user who saved the unfiled data, or from another DRM user with access to the patient.

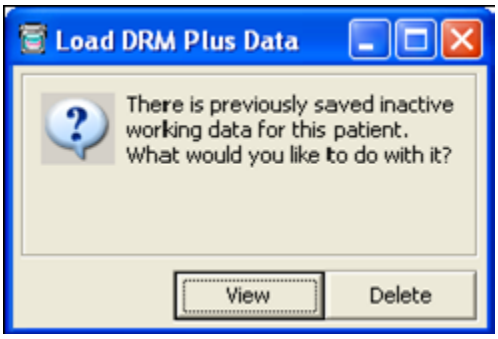


Figure 78: Previously Saved Inactive Data

The **View** button takes the user directly to the Unfiled Data Report, where they can view, print or delete the inactive data. There is no way to load inactive unfiled data into the patient's chart except to re-enter all the data manually.

The **Delete** button deletes the patient's inactive unfiled data from the VistA scratch pad.

Service Reports

Use this tool option to select and create a service report.

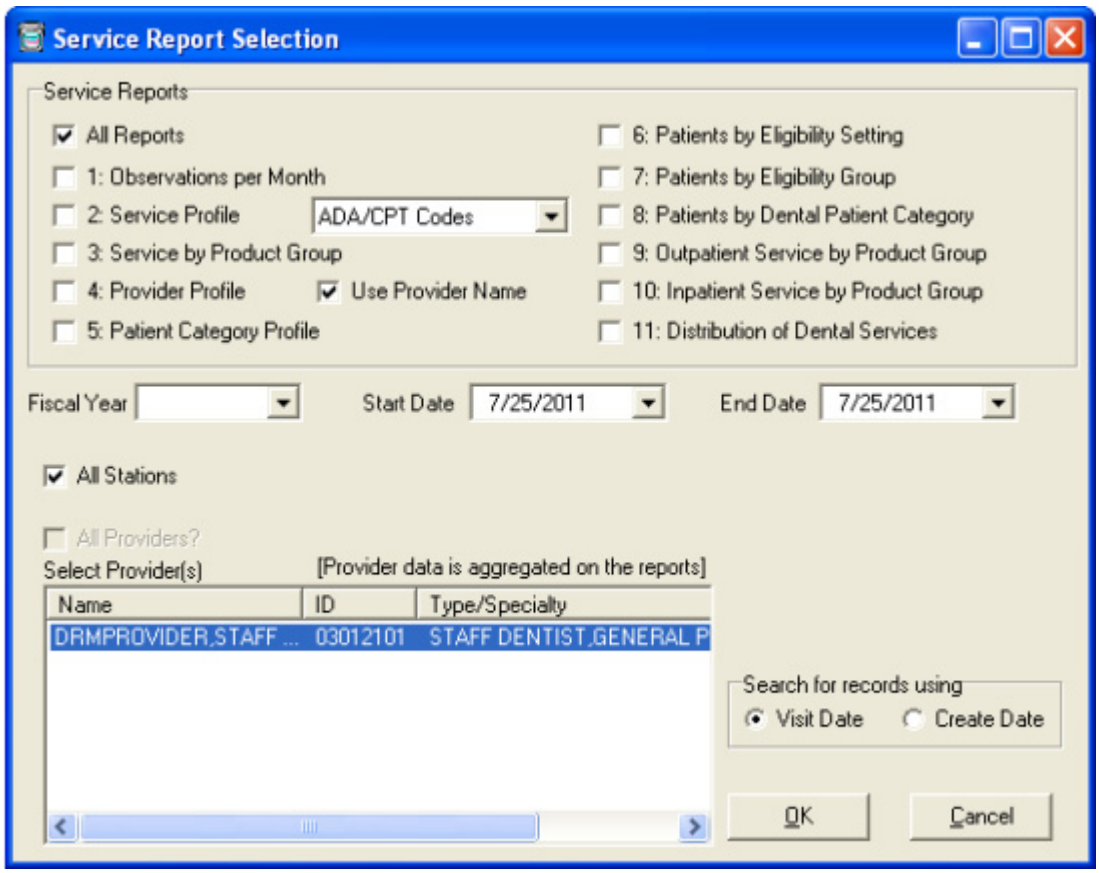


Figure 79: Service Report Selection Screen

1. Choose the desired type of service report.
2. Set the fiscal year or date range, if applicable.
3. Select the progress note date type that will be represented on the report.
4. Click the **OK** button.
5. The Service Reports screen appears with the results.

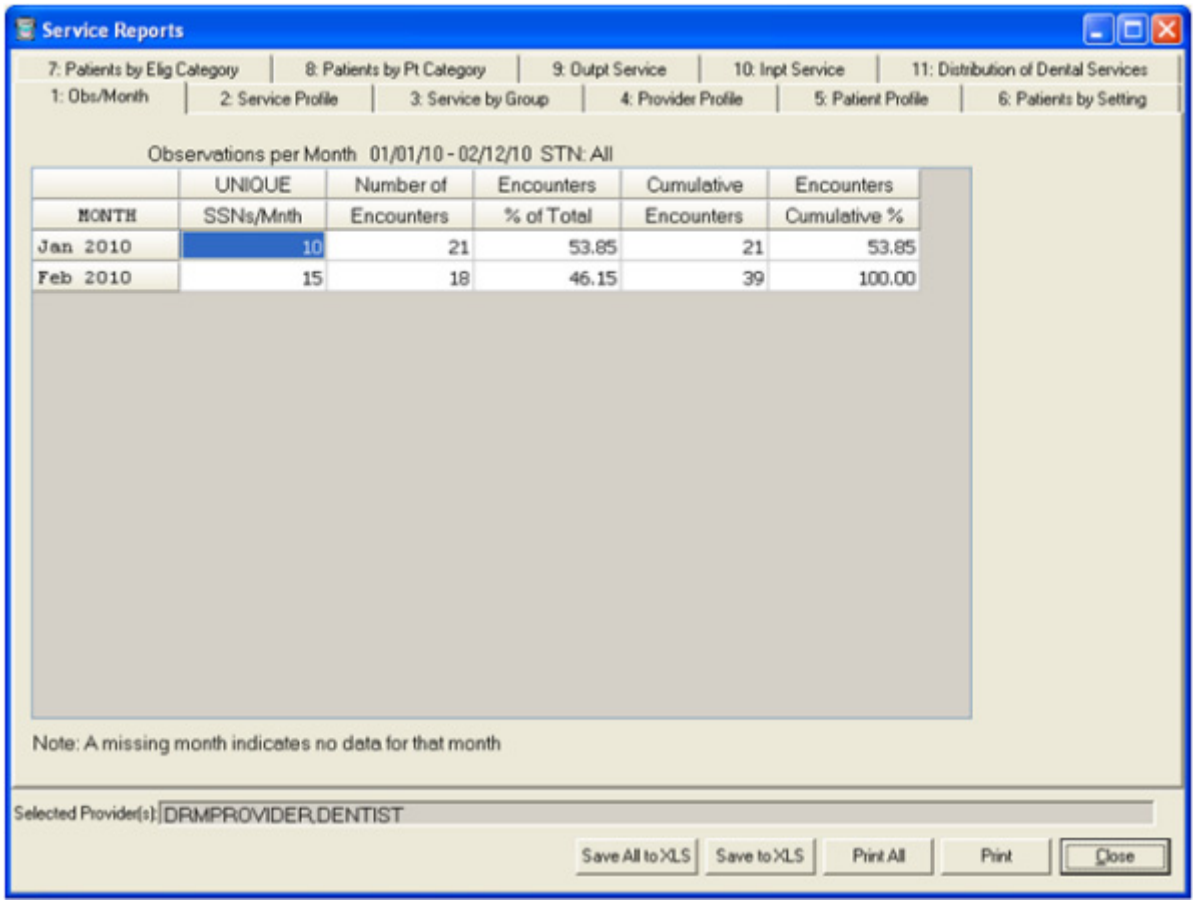


Figure 80: Service Reports Screen

6. If more than one report, or all report options are checked on the Service Reports Selection screen, the reports appear in tabs on the Service Reports screen.
7. Save the report to Excel or print.

Help

Use the Help menu to access more information on DRM Plus. There are five options: Contents, Version Release Notes, Last Broker Call, VA Intranet Website and About.

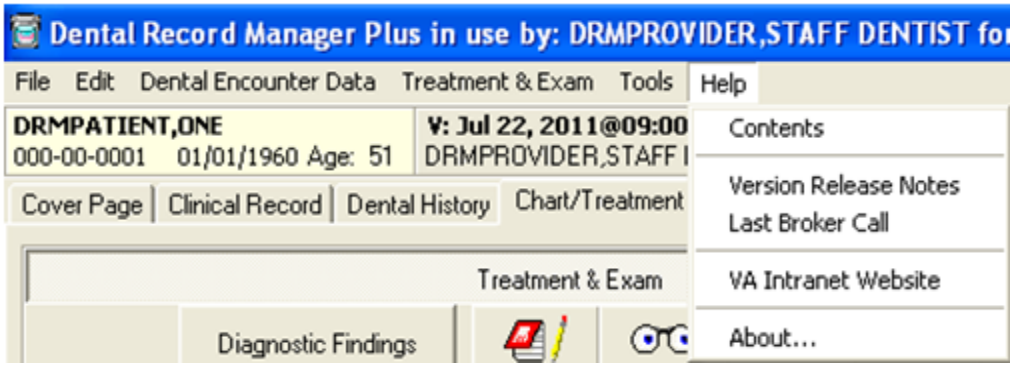


Figure 81: Help Menu

Contents

Use the contents to find information on using DRM Plus.

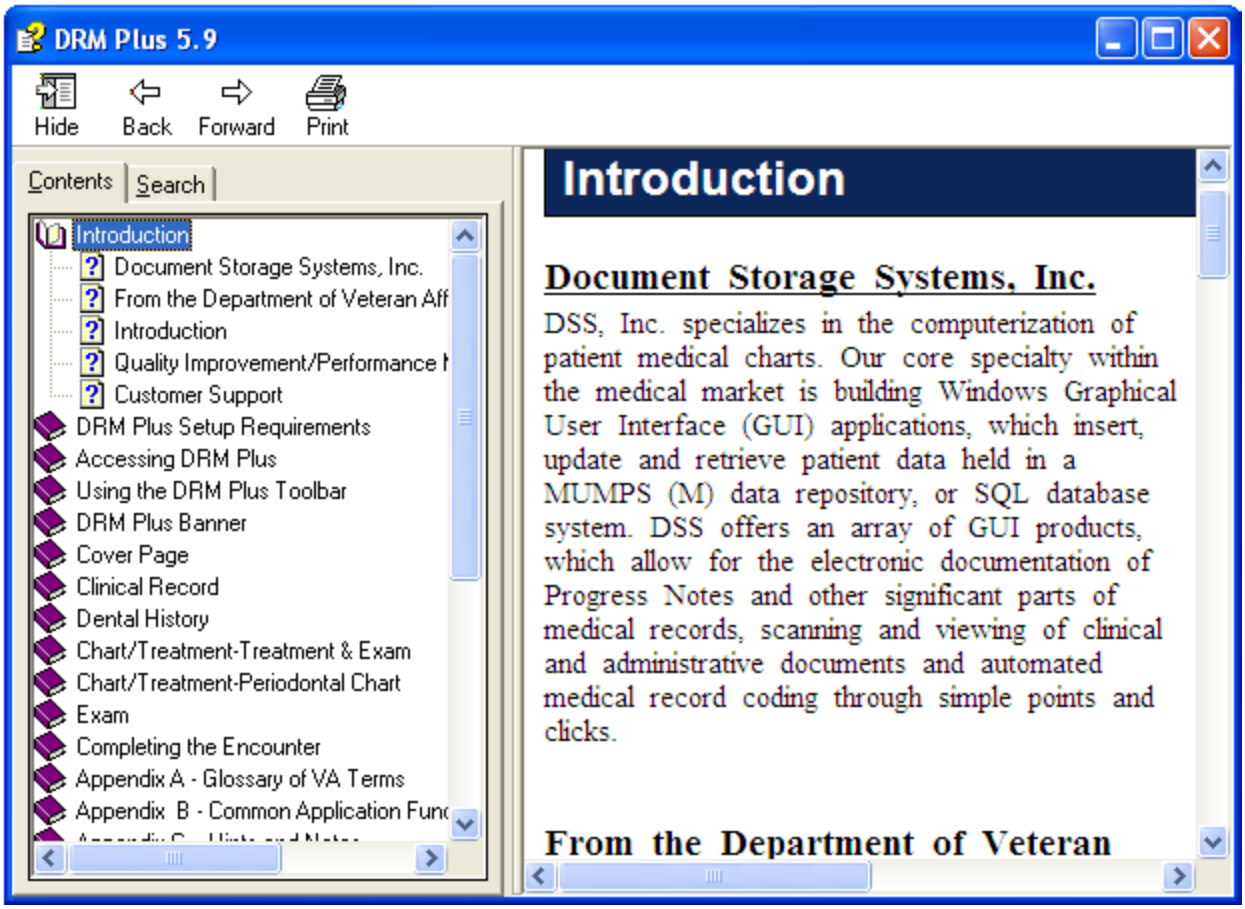


Figure 82: DRM Plus Contents

Version Release Notes

Choosing this option allows the user to see what was introduced in the current version of DRM Plus.

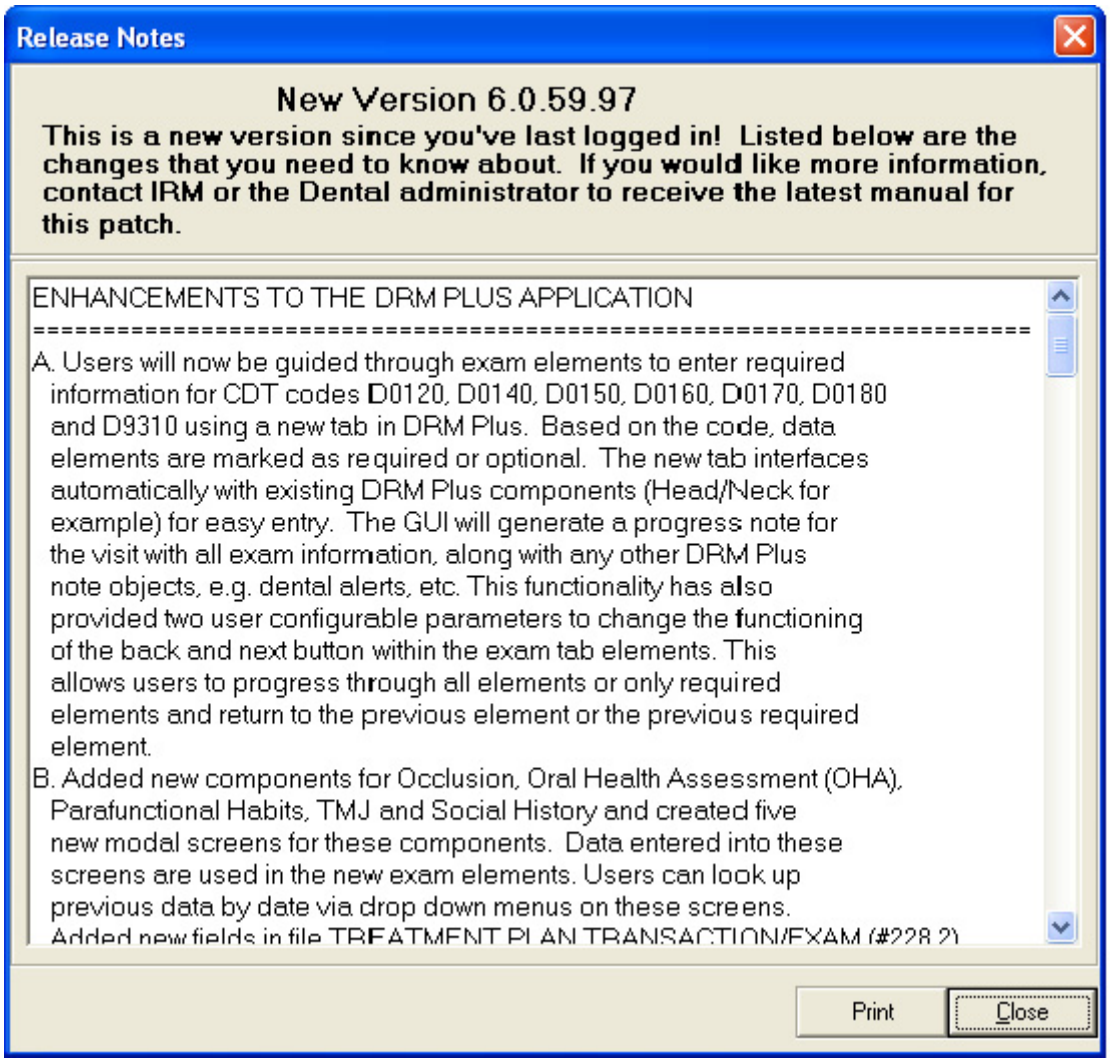


Figure 83: Release Notes

Last Broker Call

Select this option to see the last broker call.

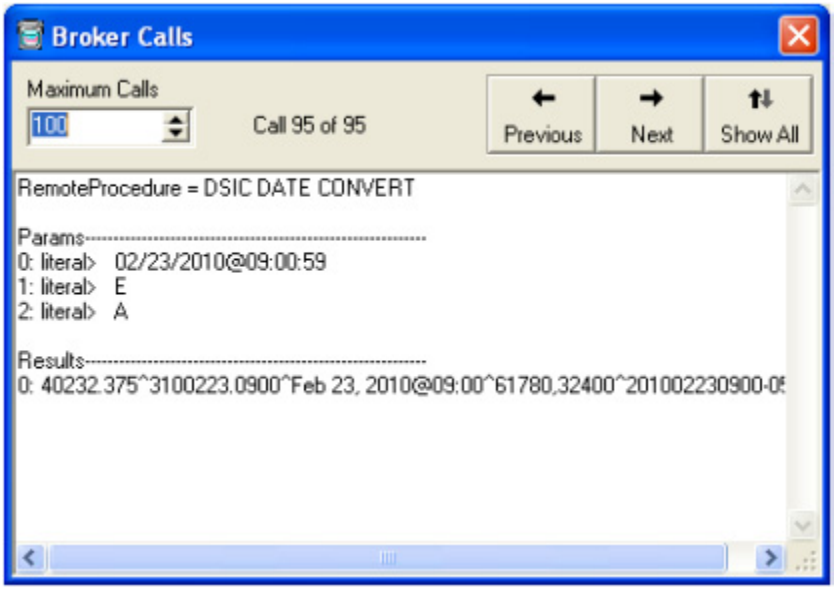


Figure 84: Broker Call Screen

Use the **up and down arrows** next to the Maximum Calls text box to adjust how many broker calls will be retrieved. Use the **previous and next arrows** to scroll through the broker calls. Use the **Show All** button to scroll through the list of broker calls.

VA Intranet Website

Select this option to access the VA Intranet website.

Note: Clicking this option connects the user to the VA Intranet website, where additional dental-related information can be obtained. This includes the latest DRM Plus manuals.

About

This screen contains information on the DRM Plus application currently in use at the facility, including the version number.

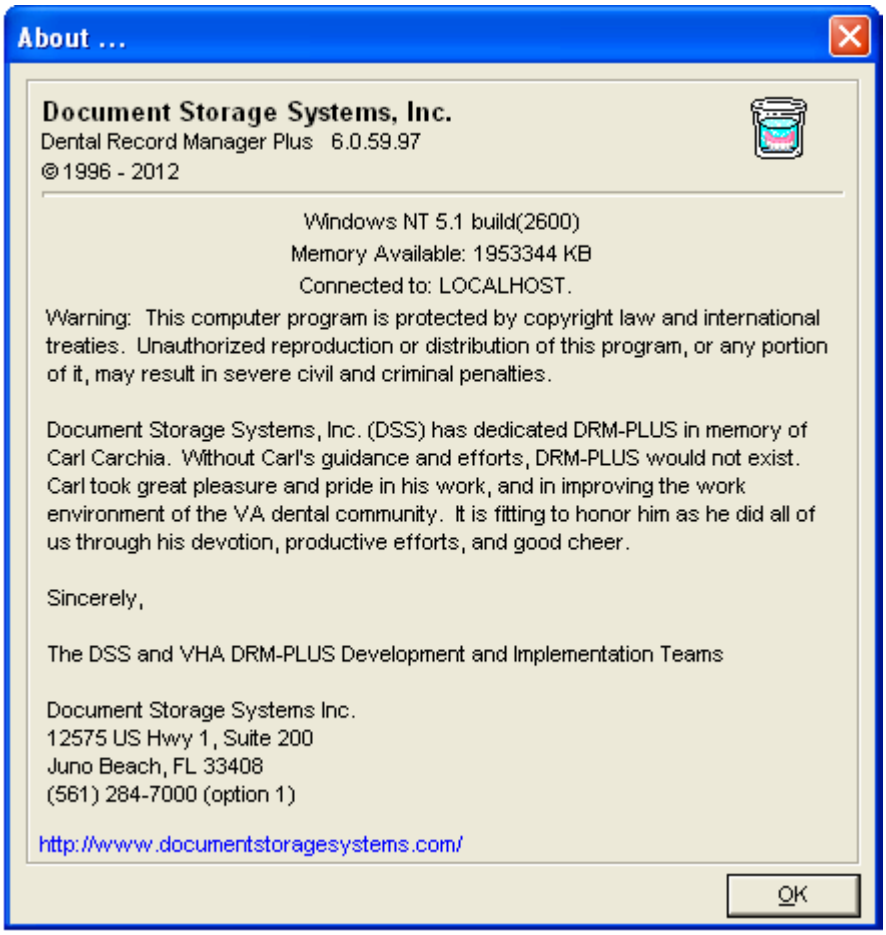


Figure 85: DRM Plus About Screen

DRM Plus Banner

The DRM Plus Banner contains vital information about the patient, providers, and also coding standards and alerts.

Figure 86: DRM Plus Banner

Patient Information

Patient information is displayed on the far left side of the DRM Plus banner.

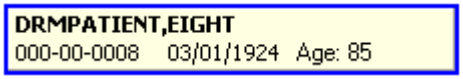


Figure 87: Patient Information

The patient information area shows the patient's first and last name, social security number, date of birth and current age. Click the **patient information** section of the banner to open the Patient Inquiry screen.

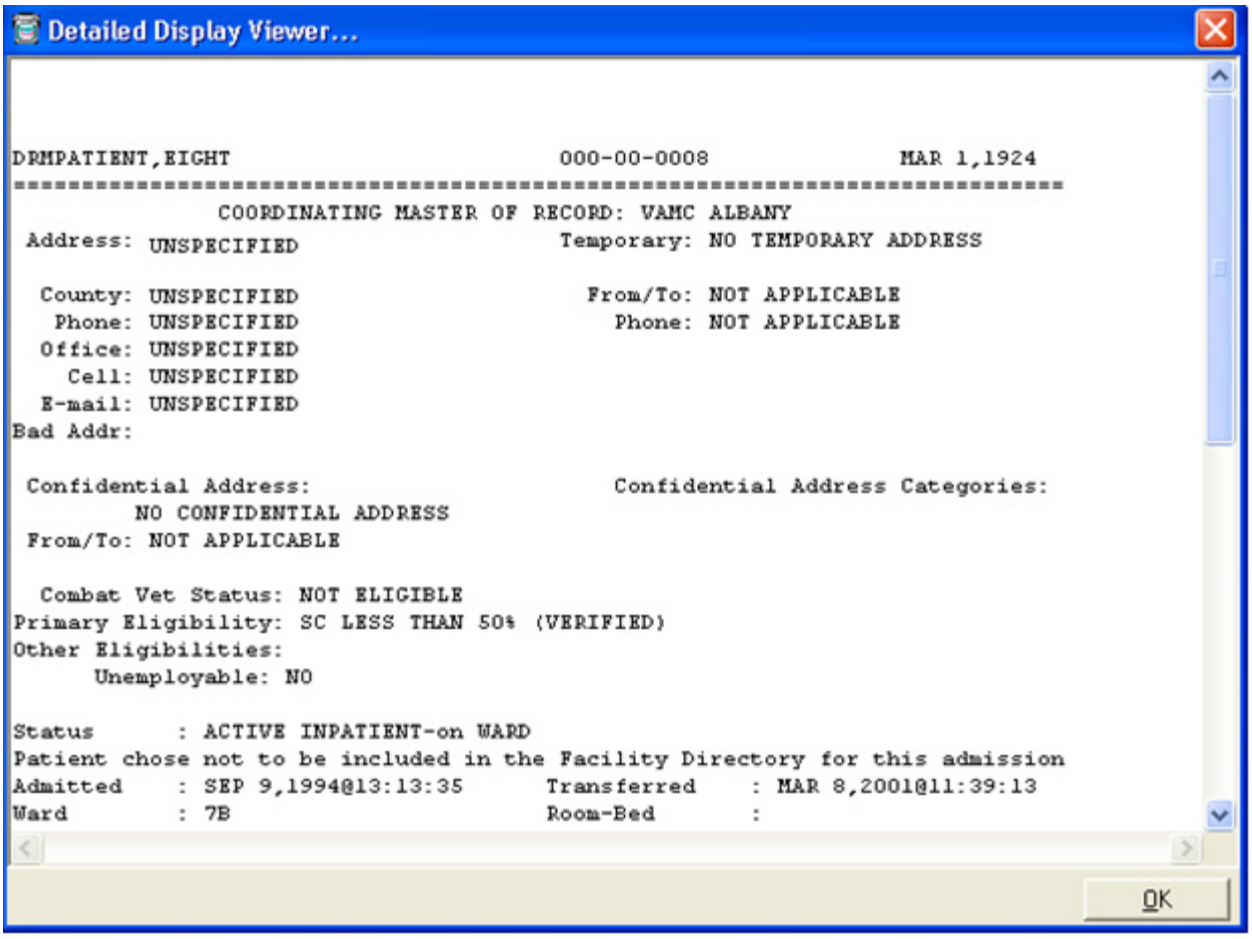


Figure 88: Patient Inquiry Screen

The Patient Inquiry screen contains more detailed information about the patient, including: address, phone number, means test information, status and admissions information.

Visit Information

Visit Information is displayed on the banner in the second box from the left. It contains information on the current encounter. A scheduled appointment will automatically fill the field when the provider enters data into DRM Plus on the same day of the appointment.

Figure 89: Visit Information

To change visit or provider information, click on this area of the banner. The Provider and Location for Current Activities screen appears.

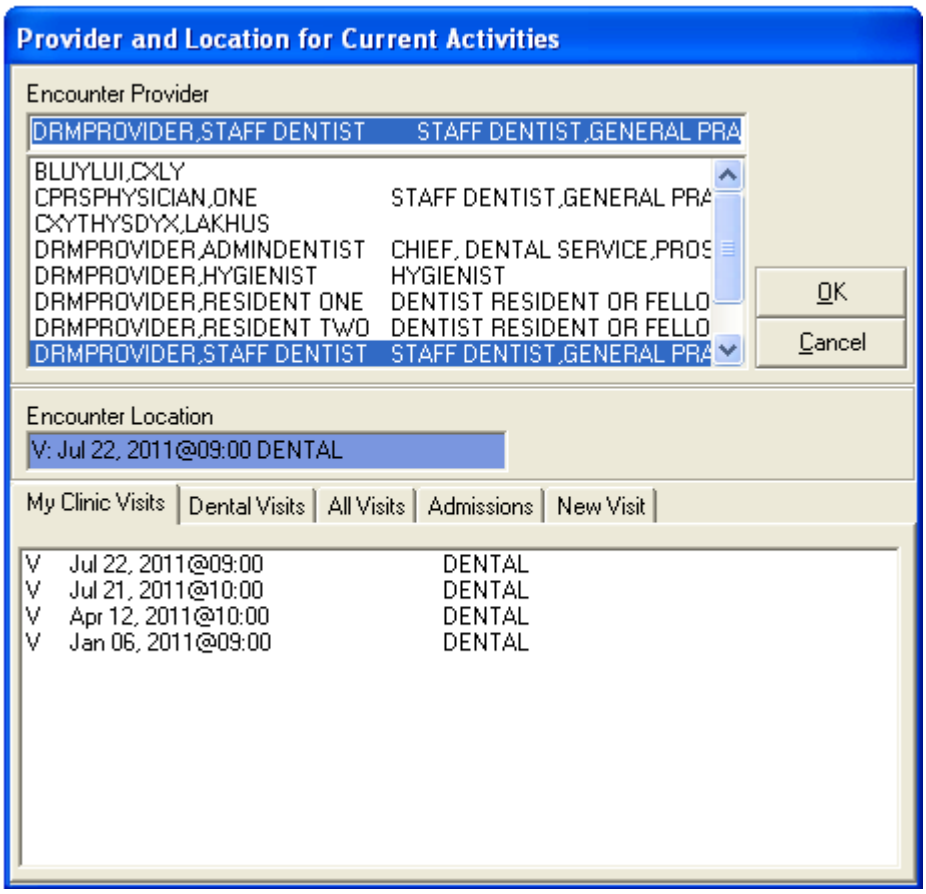


Figure 90: Provider and Location for Current Activities Screen

Select the provider in the top part of the screen and the correct appointment information in the bottom part of the screen. The information in the banner changes to reflect the adjustments made on this screen. For more information on navigating this screen, see the section of this manual entitled Dental Encounter Data, under the chapter entitled Using the DRM Plus Drop-Down Menus.

Dental Provider Information

This section of the banner displays information on the primary and secondary dental providers.

Figure 91: Dental Provider Information

Only a DRM Plus administrator or a user that has this Administrator parameter option can change a patient's Primary or Secondary dental provider information. This information only affects DRM Plus reports.

Note: The Primary Dental Provider and/or the Secondary Dental Provider can be set with an entry of "Fee Basis" in DRM Plus. The Fee Basis provider does not exist in VistA. This is a "Free text" entry and, therefore, most reports in DRM Plus do not recognize the Fee Basis provider.

Dental Class Information

This section of the banner contains information on the patient's dental class.

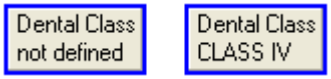


Figure 92: Dental Class

Click this section of the banner to go to the DRM Plus Cover Page tab. However, only a DRM Plus administrator or a user that has this Administrative parameter option can change a patient's dental class. See the chapter of this manual entitled Cover Page for more information.

Clean Slate

This section of the banner when present will be located between the Dental Class and the Icons which are to the far right on the banner. The Clean Slate is only a viewable window that displays the most recent date when a clean slate was performed on this patient's chart. Clean Slate may only be done by a DRM Plus administrator or a provider given that Administrative parameter.

Figure 93: Clean Slate

Clean Slate functionality has been added to clear the graphical portion of the Treatment & Exam screens in DRM Plus and delete all planned treatment for the selected patient. The new clean slate can be restored for this patient at any time until a new encounter has been filed on this patient's chart.

Icons

The icons located on the right side of the banner show patient flags, alerts and provide an easy way for the user to look up coding standards.

Figure 94: DRM Plus Banner Icons

Coding Standards

The first icon is the Coding Standards icon  . Clicking this icon produces the General Coding Standards screen.

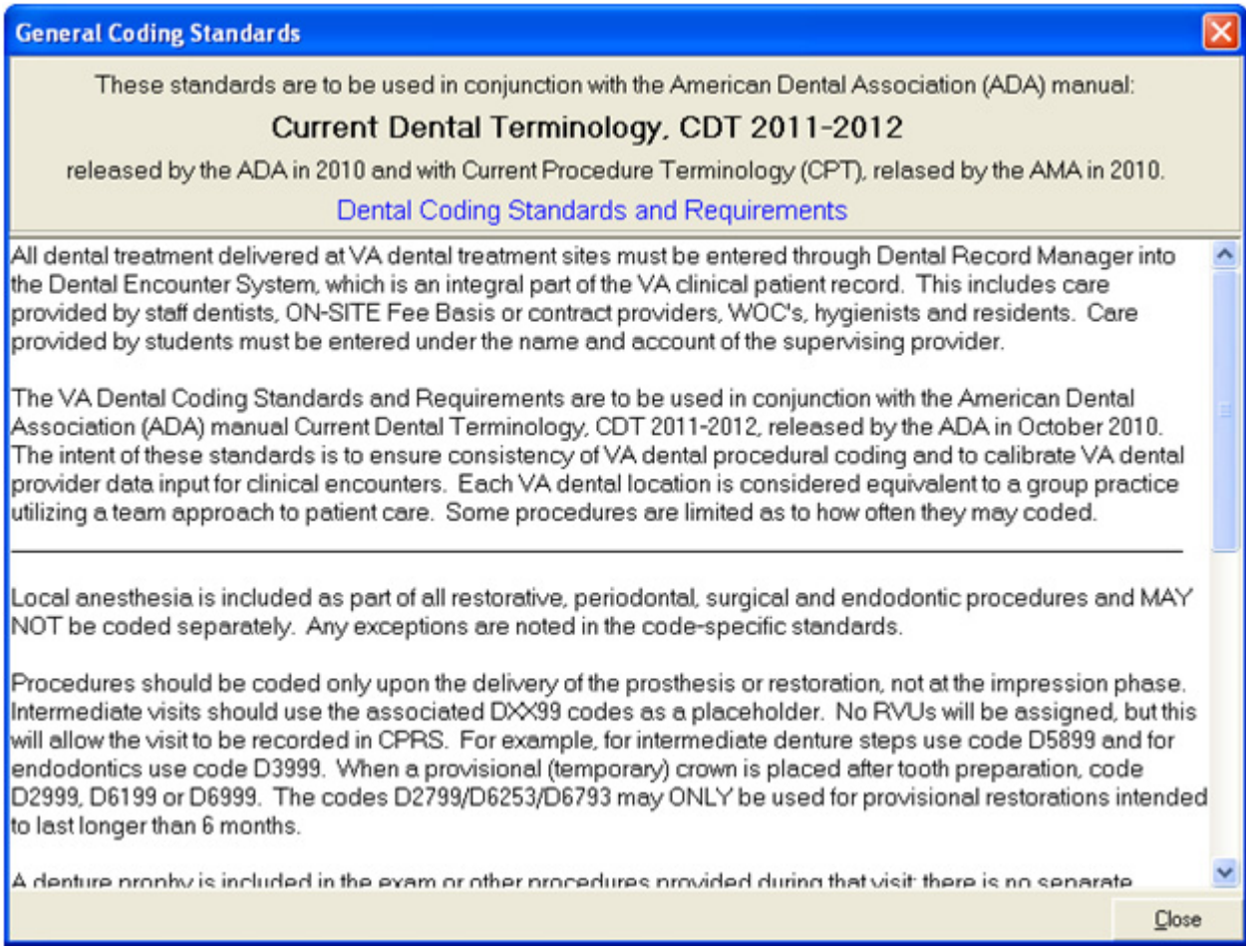


Figure 95: General Coding Standards Screen

This screen contains dental coding standards and requirements as approved by the VA Dental Coding Committee. Go directly to the ADA Dental Coding Standards and Requirements by clicking the hyperlink. Some sites may not allow access to the Internet while others require an additional sign-in.

Patient Flags

There are four possible patient flags that can appear in DRM Plus, including: Clinical Reminders, Consult, Exam Monitor and Fluoride Monitor.

Clinical Reminders

The Reminders icon  appears on the right side of the DRM Plus banner when there are Clinical Reminders due for the selected patient, listed on the CPRS Cover Page tab screen in the Clinical Reminders window. Providers must still process Clinical Reminders using CPRS.

Clicking this icon displays a DRM Plus informational screen, stating that the selected patient has Clinical Reminders due.

Figure 96: Clinical Reminders Due

The Clinical Reminders icon should only display if the current provider is responsible for and may resolve the Clinical Reminder(s) listed. If Clinical Reminder(s) appearing in the list cannot be resolved by the provider, contact the local IRM (Clinical Reminder Support personnel) for assistance.

Consult

The Consult icon  appears when the patient has an incomplete consult in their chart. Click the icon. The Clinical Record tab appears with Consultations selected. For more information, see the chapter of this manual entitled Clinical Record.

Exam Monitor

The Exam Monitor icon  appears when the patient is due for a monitored exam. The icon only appears if the patient meets certain class restrictions. Clicking this icon produces a screen, which reveals when the patient last received a qualifying exam.

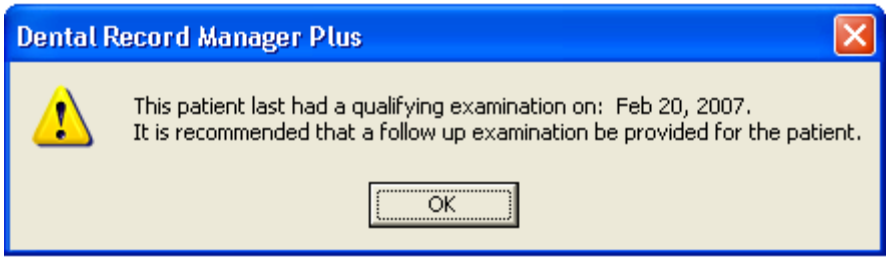


Figure 97: DRM Plus Exam Information Screen

Click the **OK** button. The DRM Plus Cover Page tab appears. For more information, see the chapter of this manual entitled Cover Page.

Fluoride Monitor

The Fluoride Monitor icon  appears when the patient is due for a fluoride intervention. Clicking this icon will appear, which explains why the patient is at risk and needs intervention.

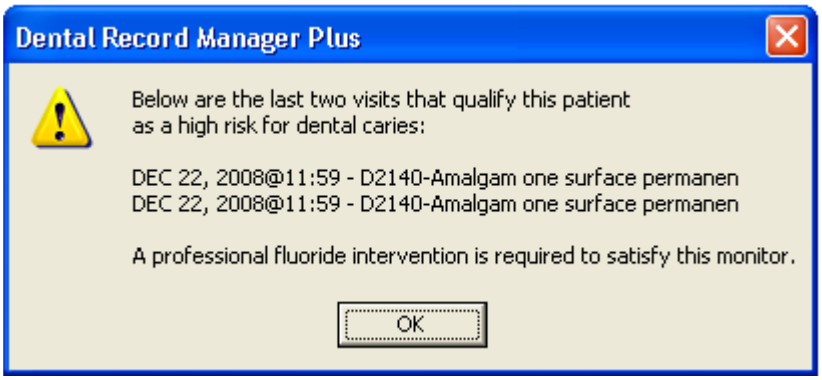


Figure 98: Fluoride Intervention Monitor Screen

Click the **OK** button. The DRM Plus Cover Page tab appears. For more information, see the chapter of this manual entitled Cover Page.

Alerts

The DRM Plus Alerts icon 

shows if the patient has any associated alerts. It can also be used to add alerts to the patient's chart in DRM Plus.

To add an alert:

1. Click the **Alert** icon.
2. The Dental Alert screen appears.

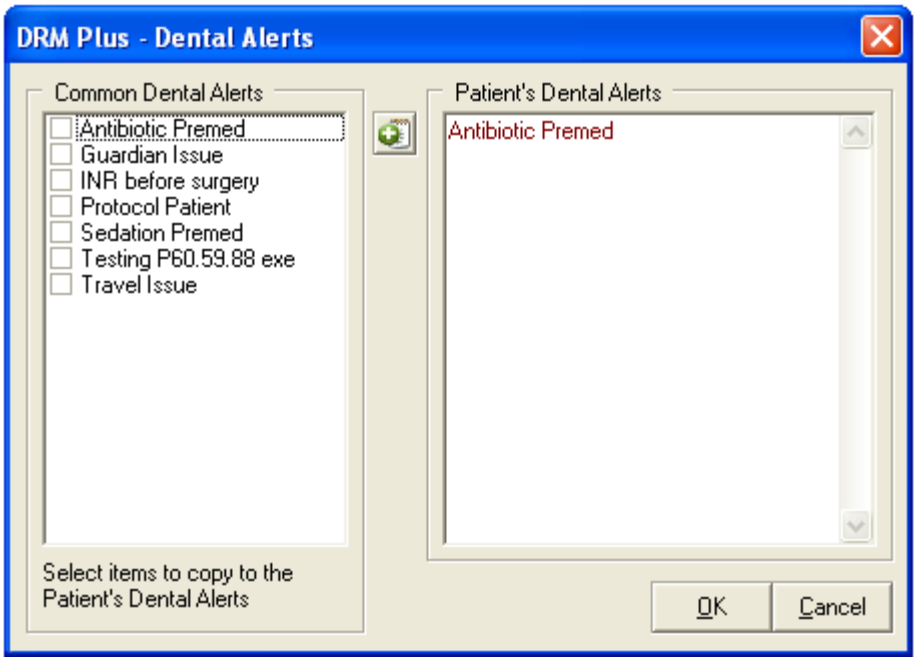


Figure 99: Dental Alerts Screen

3. Click the desired **Common Dental Alerts** on the left side of the screen.
4. Click the **right arrow** button.
5. The selected alert(s) appears on the right side of the screen.
6. Alternatively, type the alert directly into the Patient's Dental Alerts area of the screen.
7. Click the **OK** button.

The alert icon changes when patient alerts are present, and appears as a stop sign 

.

To view the alerts:

1. Click the **alerts** icon.
2. The patient's Dental Alerts screen appears.

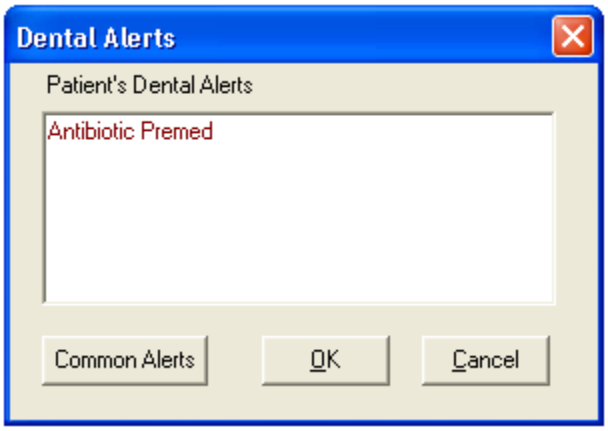


Figure 100: Patient's Dental Alerts Screen

3. Click the **Common Alerts** button.
4. The Dental Alerts screen appears. From here, more dental alerts can be added or the alert can be erased by putting the cursor into the Patents Dental Alerts field and deleting the text.
5. Click the **OK** button to finish.

Cover Page

The DRM Plus Cover Page tab displays important patient information. The tab has 8 major sections: Dental Eligibility, Demographics, Case Management, Recent Dental Activity, Fluoride Monitor Prescription Date, Dental Alerts, Notes and Planned Care.

Note: Dental Eligibility is a DRM Plus Administrative Function. Please contact a DRM Plus administrator for more information about this option.

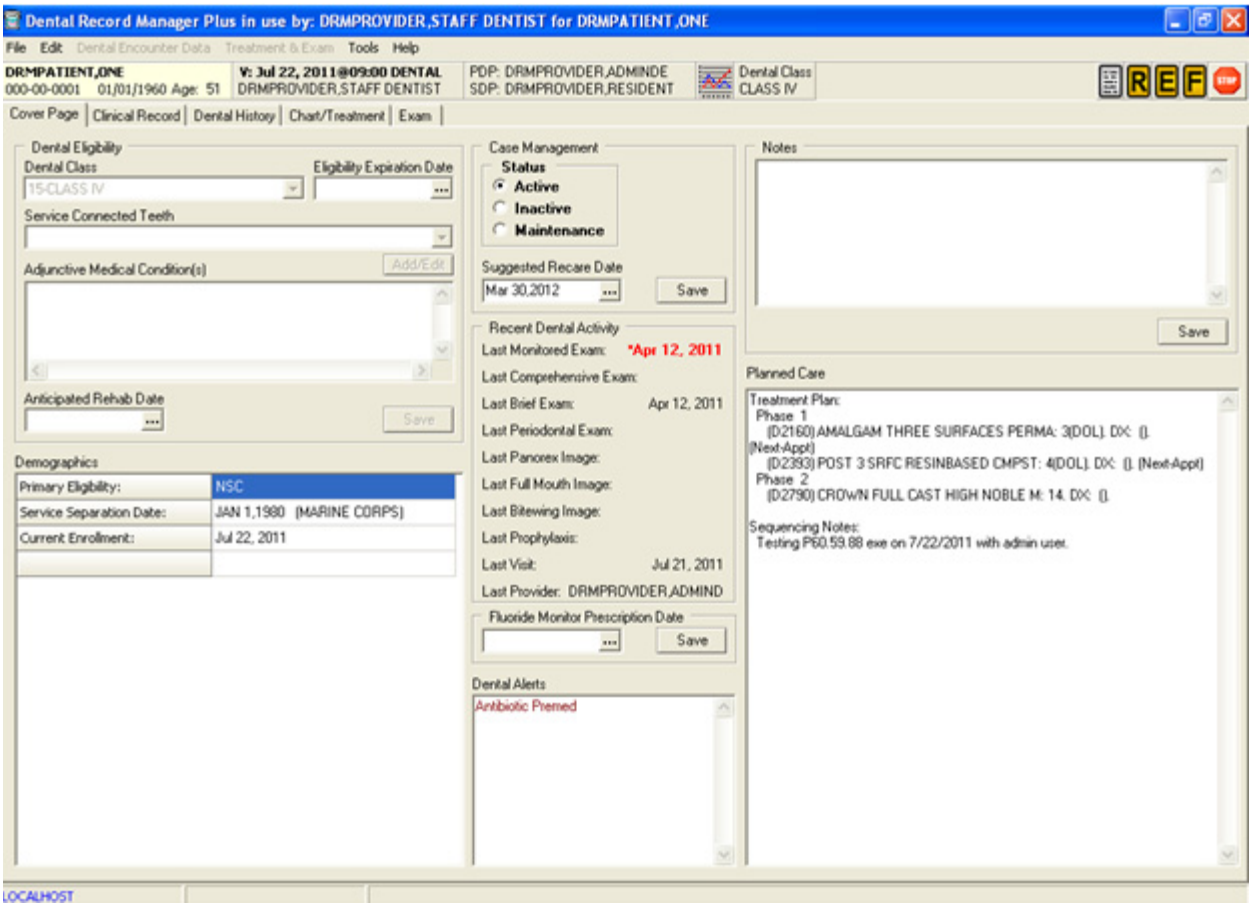


Figure 101: DRM Plus Cover Page Tab

Dental Eligibility

The patient's dental class, eligibility expiration date, service connected teeth, adjunctive medical conditions and anticipated rehab date are displayed in this area.

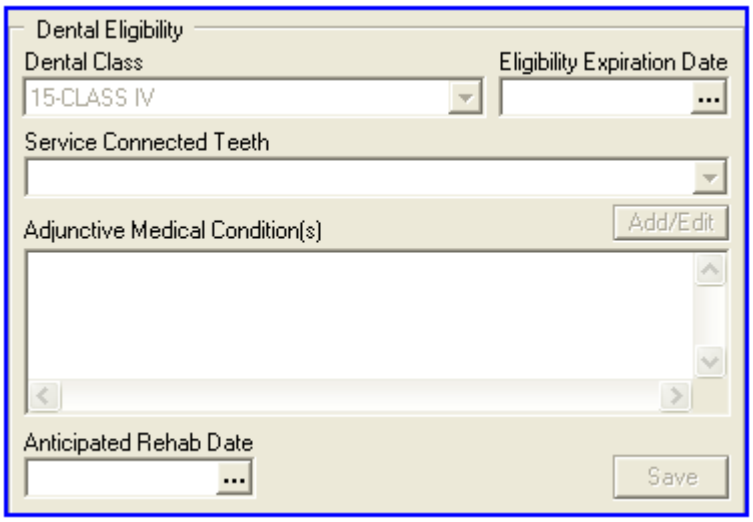


Figure 102: Dental Eligibility

Dental Class

Dental Class can only be changed by a DRM Plus administrator or user who has been given this Administrative parameter option.

Eligibility Expiration Date

Eligibility Expiration Date can only be changed by a DRM Plus Administrator or user who has been given this Administrative parameter option.

Service Connected Teeth

Service Connected Teeth can only be changed by a DRM Plus administrator or user who has been given this Administrative parameter option.

Adjunctive Medical Condition(s)

Adjunctive Medical Conditions can only be changed by a DRM Plus administrator or user who has been given this Administrative parameter option.

Anticipated Rehab Date

Anticipated Rehab Date can only be changed by a DRM Plus administrator or user who has been given this Administrative parameter option.

Demographics

Patient demographic information is located here and is imported from VistA. The fields cannot be updated or changed in DRM Plus.

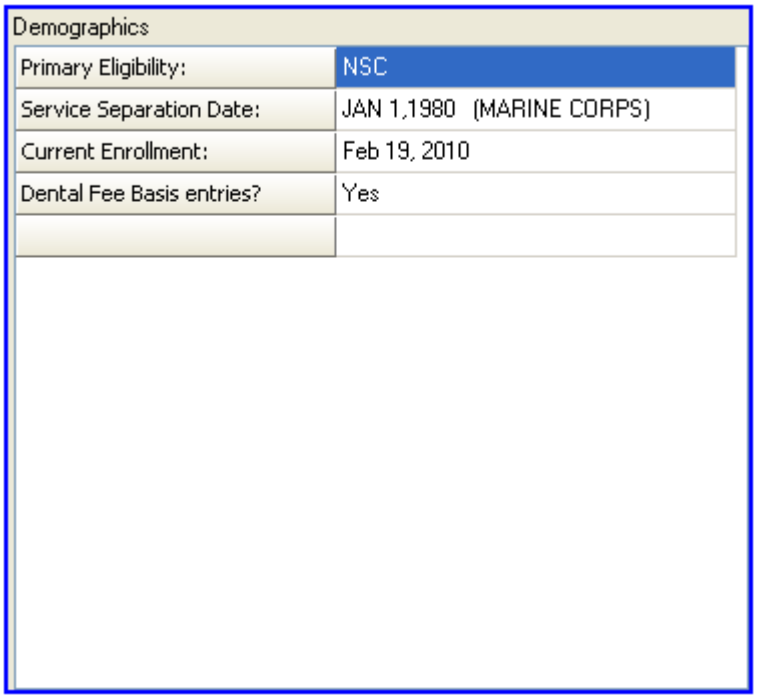


Figure 103: Demographics

Case Management

Use the Case Management (Disposition) fields to adjust the patient's status and file suggested recare dates. Click the **Save** button to update any new changes.

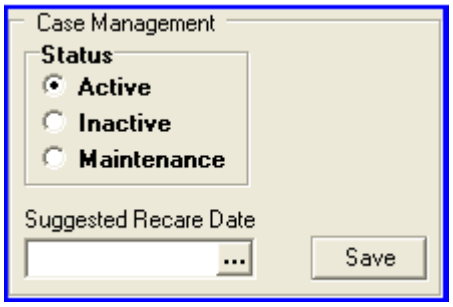


Figure 104: Case Management

Status

Change the status of the patient by clicking the appropriate radio button.

Suggested Recare Date

1. Click the **ellipses [...]** button to display a calendar screen.
2. Select the desired date form the menu and click the **OK** button.
3. Click the **Save** button to file the data.

Recent Dental Activity

This section displays dates, if applicable, of when specific completed procedures were last performed on the patient. Procedure codes that activate the date in this section may be viewed by hovering the mouse cursor over the recent dental activity description.

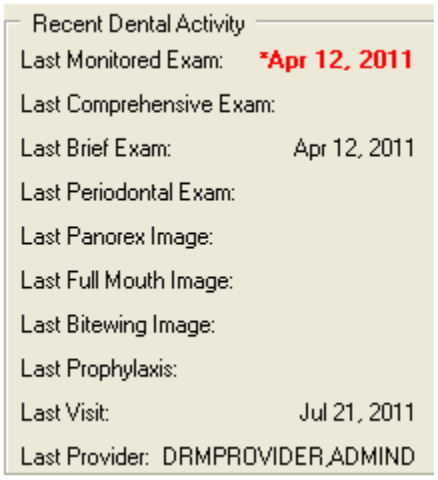


Figure 105: Recent Dental Activity

Fluoride Monitor Prescription Date

Add a Fluoride Monitor Prescription Date here.

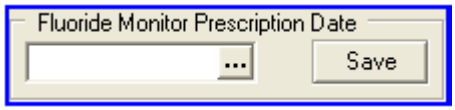


Figure 106: Fluoride Monitor Prescription

1. Click the **ellipses [...]** button.
2. Select a date from the calendar screen and click the **OK** button.
3. Click the **Save** button to file the date.

To delete the prescription date:

1. Click **the date** to place the cursor in the field.
2. Delete the date.
3. Click the **Save** button to file.

The field is active regardless of whether or not the patient has a Fluoride Monitor.

Note: No future dates are allowed for Fluoride Monitor Prescriptions. The field is active regardless of whether or not the patient has a Fluoride Monitor.

Dental Alerts

The patient's Dental Alerts, if any, are listed here.

Figure 107: Dental Alerts

Please see the section of this manual entitled Alerts under the chapter entitled DRM Plus Banner for more information.

Notes

Add general notes in this text box. These notes are not imported into the Progress Note.

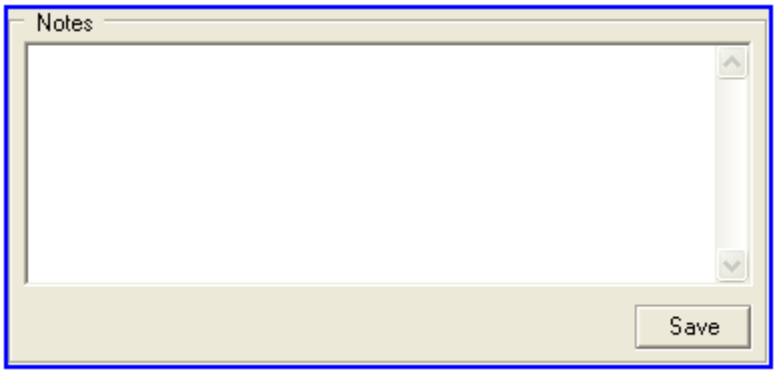


Figure 108: Notes

1. Place the cursor in the text box and begin typing.
2. Click the **Save** button to file the notes.
3. A screen appears showing that the information is saved. Click the **OK** button.

Planned Care

The treatment plan for the patient, if applicable, is displayed here. It cannot be edited on this page.

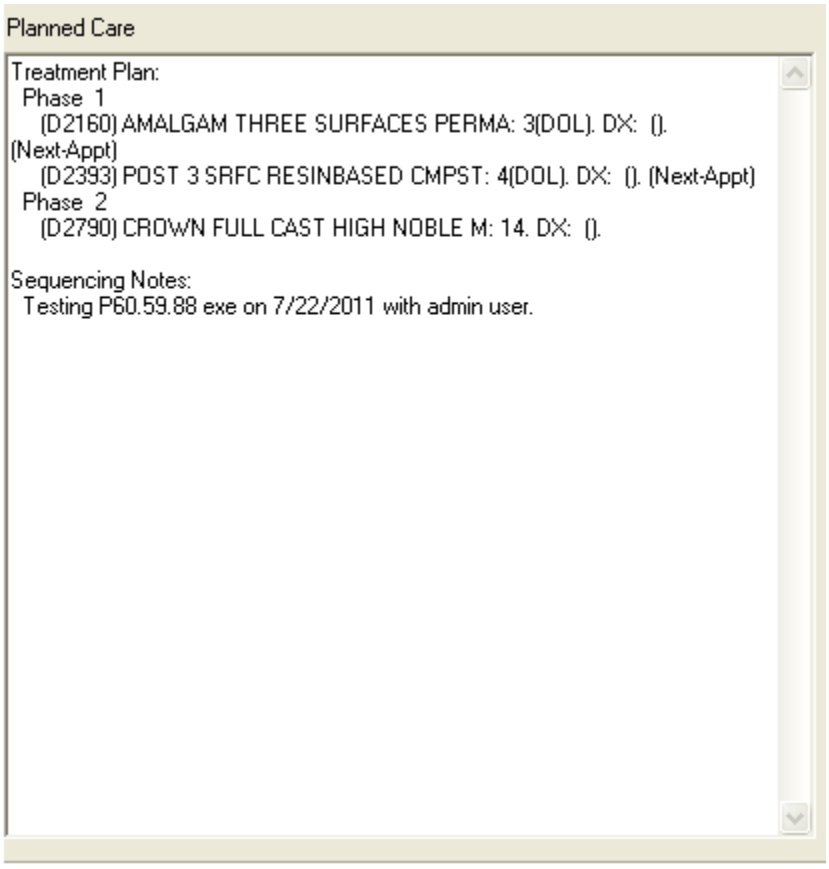


Figure 109: Planned Care

Please see the section of this manual entitled Treatment Plan under the chapter entitled Chart/Treatment-Treatment & Exam for more information.

Clinical Record

The Clinical Record tab allows access to various areas of the patient's record. From here, view Problems, medications, Vital Signs, Radiology, Allergies, Lab Results, Postings, Immunizations, D/C Summaries, Consultations, Health Summary and Notes.

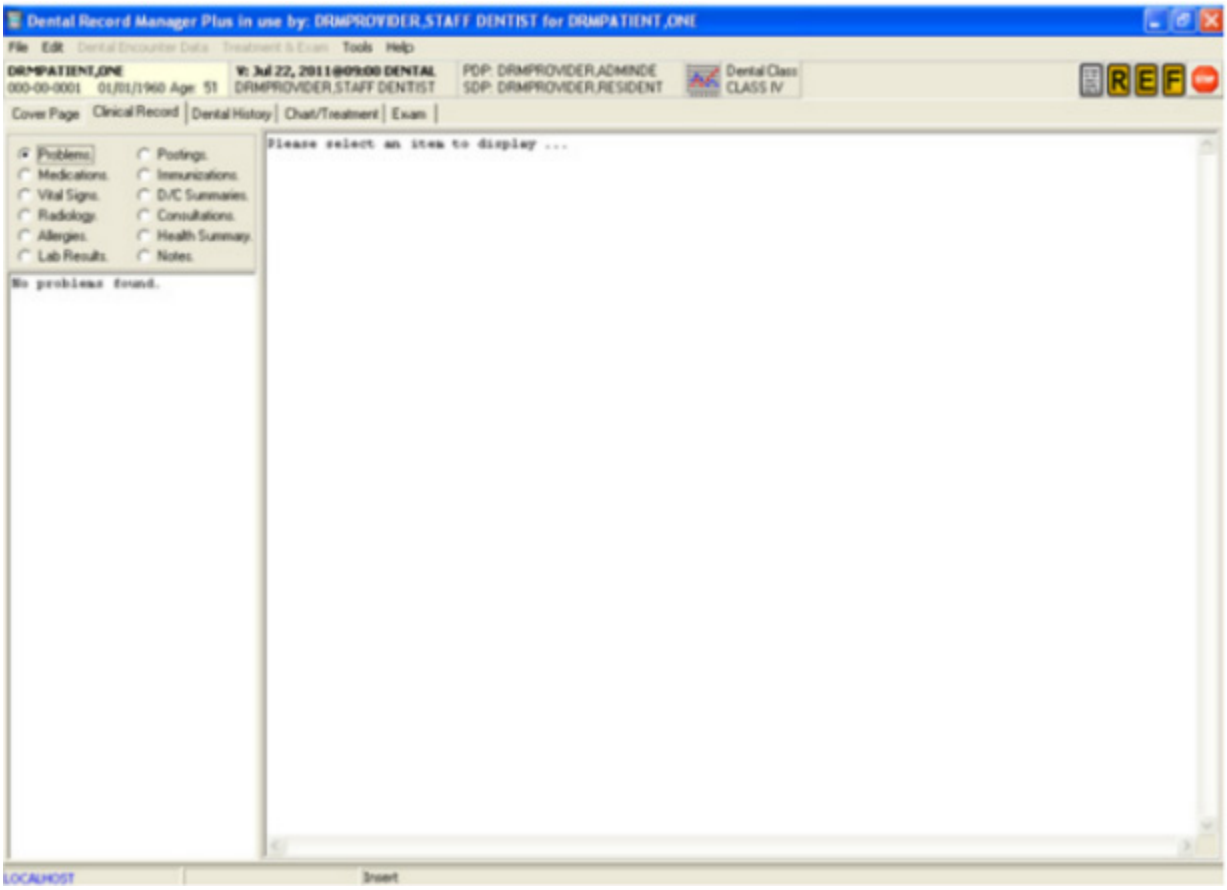


Figure 110: Clinical Record Tab

1. Click the **radio button** that corresponds to the type of clinical record to be viewed.

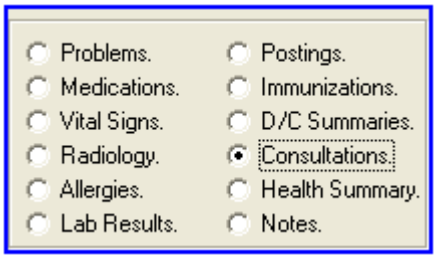


Figure 111: Clinical Record Types

2. A list of entries, corresponding to the selected clinical record types, appears in the area below the list of clinical record types.

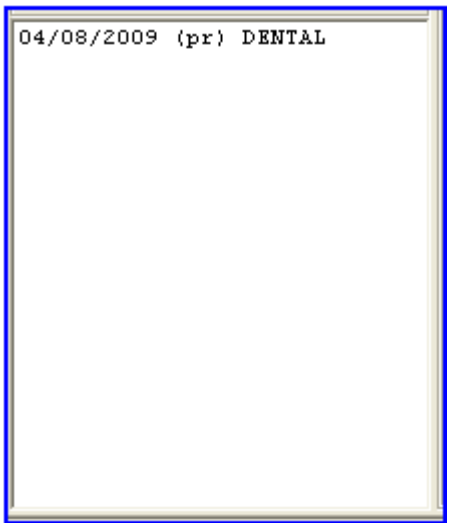


Figure 112: Clinical Record Entries

3. Select an entry. Details for the entry appear on the right side of the screen.

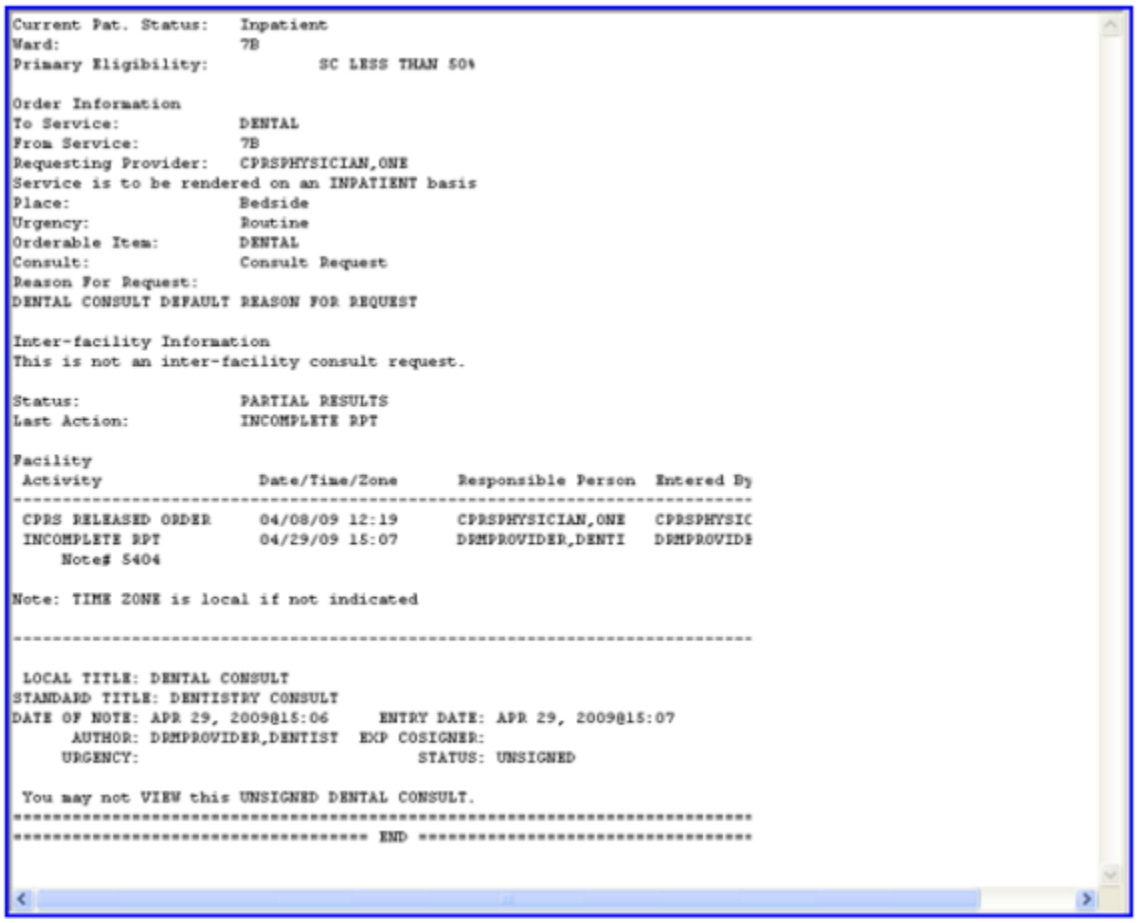


Figure 113: Clinical Record Entry Information

Problems

Click the **Problems radio button** to view a list of active problems previously entered.

To inactivate a problem:

1. Select the problem from the list that should be inactivated.
2. Right-click in the entries area directly below the list of radio buttons.
3. The Inactive Highlighted Problem menu appears.

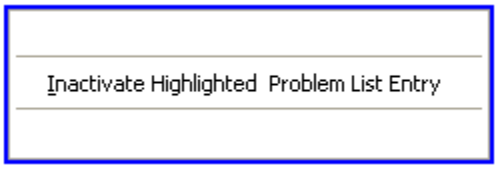


Figure 114: Inactivate Highlight Problem Menu

4. Select the option to inactivate the problem.
5. A screen appears confirming the inactivation. The description on the right side of the page will now list the problem as inactive.

Use CPRS or DRM Plus (see File Data Option Screen section under the chapter entitled Completing the Encounter) to reactivate the problem.

Consultations

Selecting the **Consultations** radio button displays a complete list of consults. They appear with the abbreviated notation of the consult status included in the listing. Consults can be filtered by status, service or date range.

To filter Consultations by status, service or date range:

1. Click the **Consultations** radio button. Consultations, if present, will appear in the entries area.
2. Right-click in the entries area. The filter menu appears.

Figure 115: Consultations Filter Menu

3. Select the desired filter from the menu.
4. Consults filtered by status, service or date range will have a drop-down menu to filter the consults into smaller sub-views.
5. The consultation sub-view list appears on the entries portion of the screen.

Note: Highlighting any consult from the list will result in this consult displaying on the right side of the Clinical Record tab screen.

Notes

Selecting the **Notes** radio button reveals a listing of all completed notes (the default listing). Right-clicking in the note window, where all notes are listed, brings up an option box.

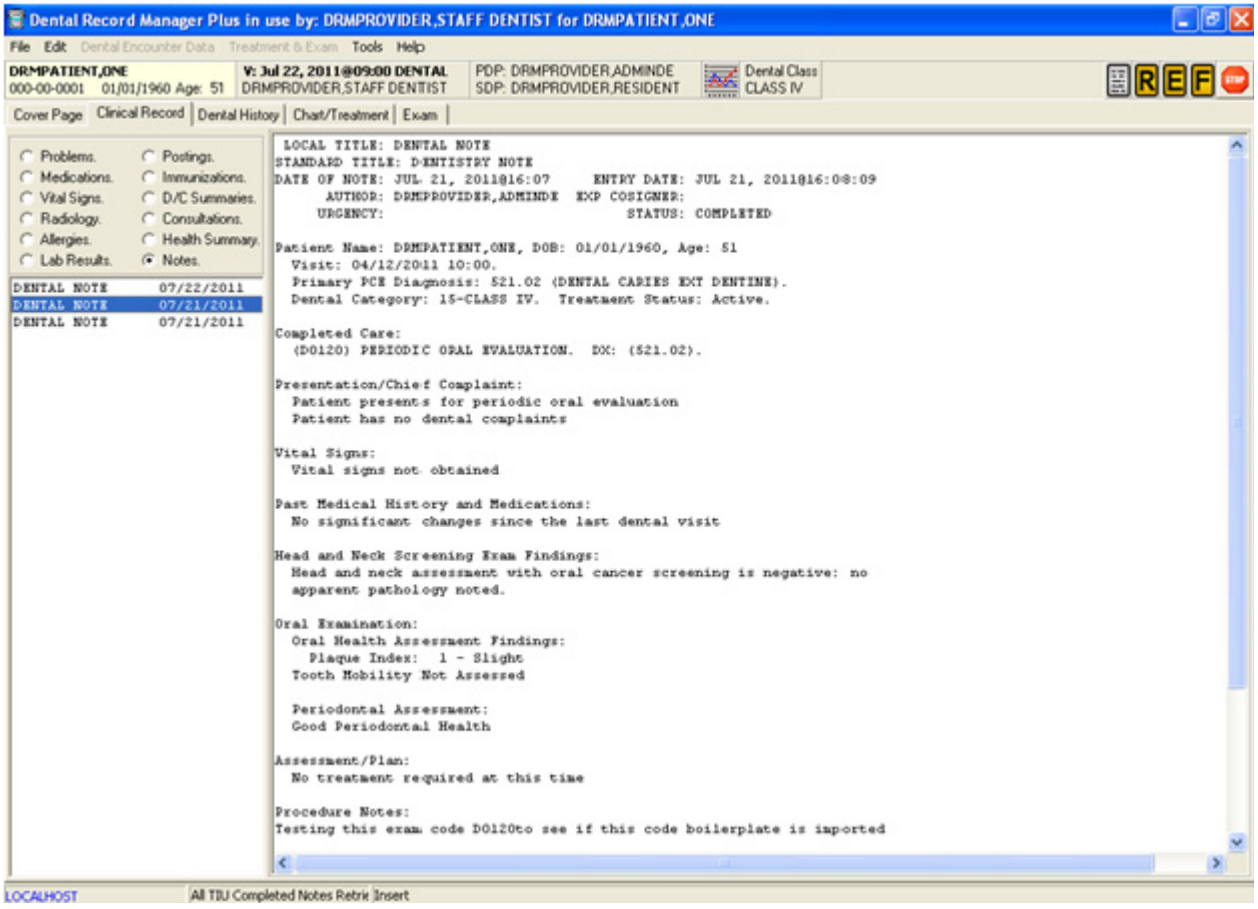


Figure 116: All TIU Completed Notes List

Select the TIU Filters option to filter the list of TIU notes by the listed criteria.

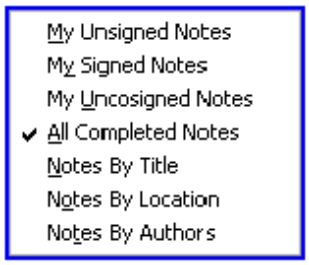


Figure 117: TIU Filters

Open the desired note. Right-click the list of notes again to view the functions available for the selected note.

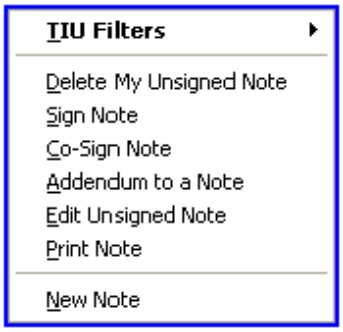


Figure 118: Note Functions Menu

The functions available coincide with the Action menu options, as seen on the Notes tab in CPRS, and works similarly. The note functions can be selected with a left click.

Adding a New TIU Note

To add a new TIU note for informational purposes only, without an ADA procedure code:

1. Select the **New Note** option from the Note Functions Menu.
2. The Set Progress Note Title screen appears.

Selecting the New Note option brings up the appropriate Set Progress Note Title screen.

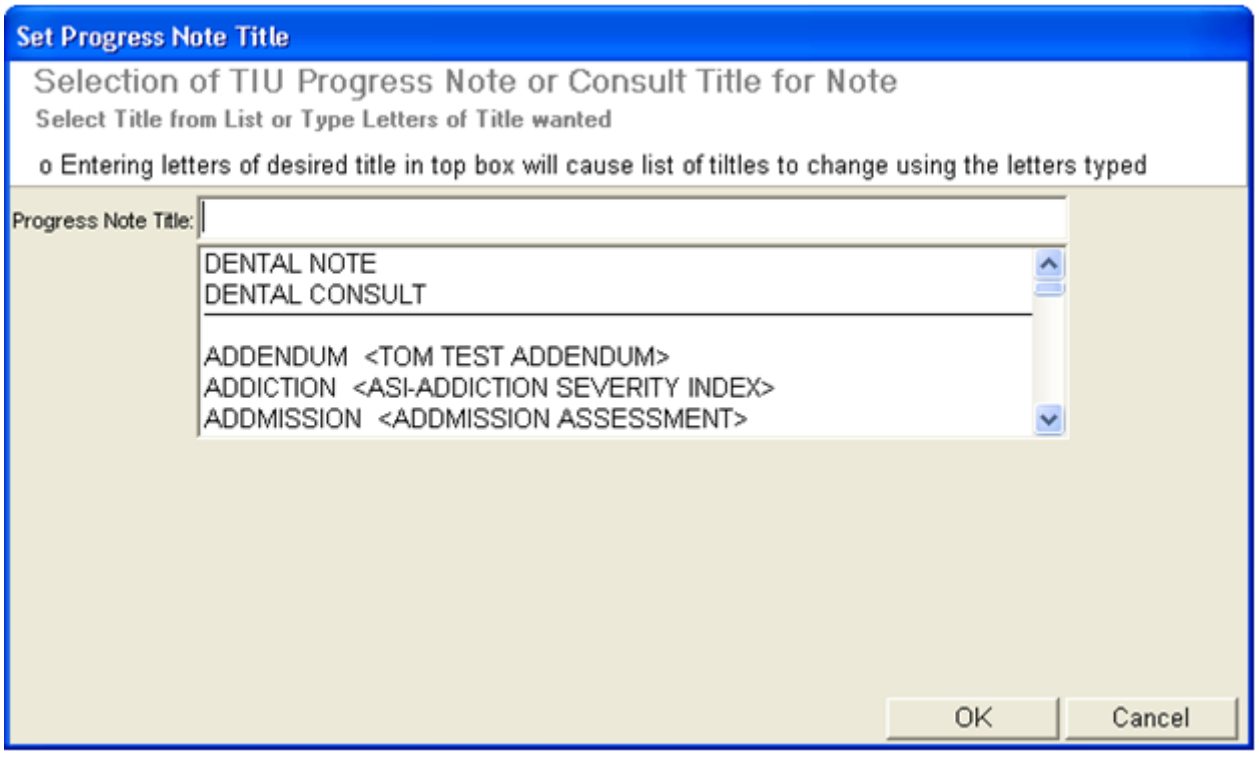


Figure 119: Set Progress Note Title Screen

3. Select the TIU Note Title from the list on the Set Progress Note Title screen. Note Information appears on the screen.

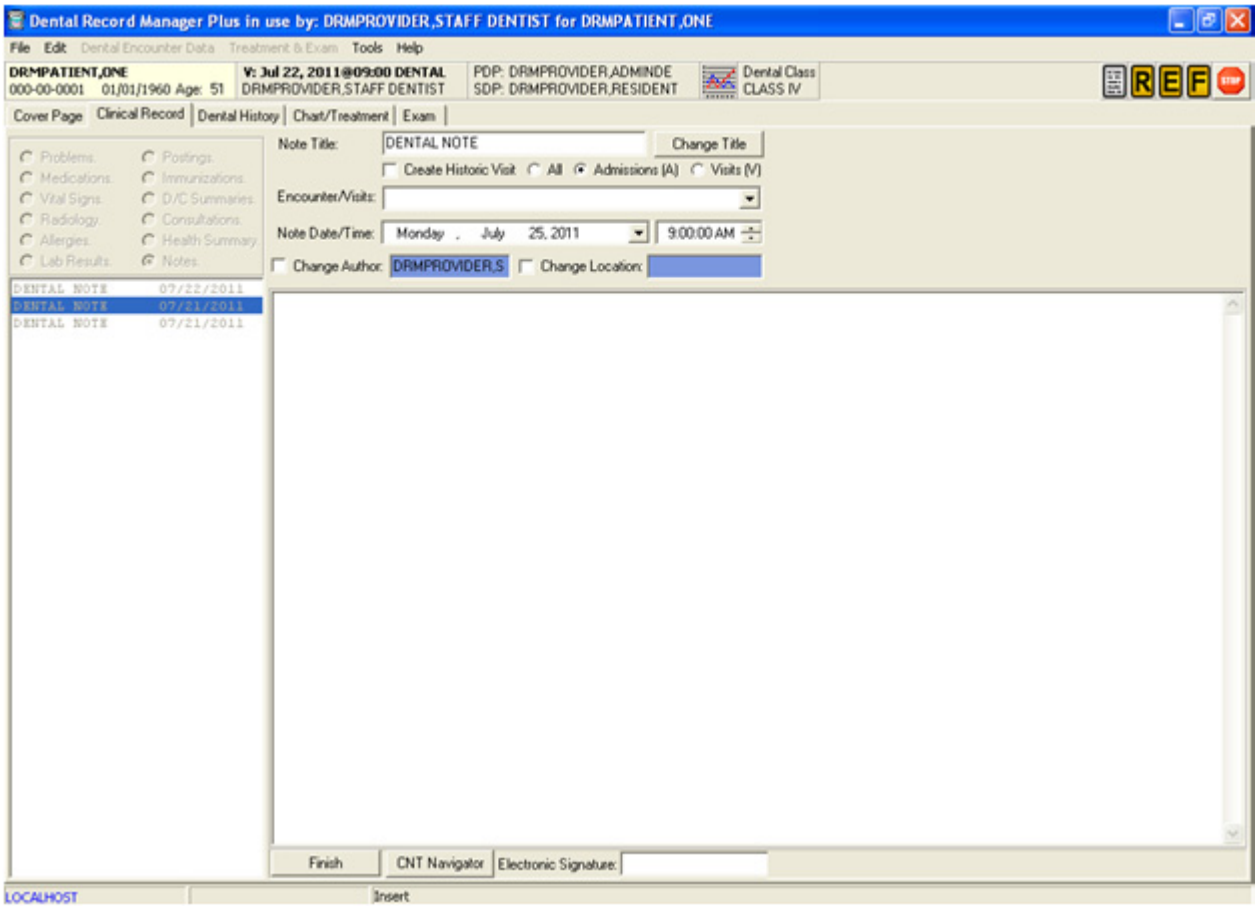


Figure 120: New TIU Note Without any Procedures

4. Use the tools to create a historic visit or select a scheduled visit by using the drop-down menu.
5. Enter notation directly into the note.
6. Enter the Provider's electronic signature and click the **Finish** button to complete the note.

Note: Historical notes may be entered using this option.

Adding a New TIU Note Addendum

Creating an addendum to a previously completed TIU Note to provide additional information, or to clarify any issues, does not require entering an ADA procedure code. This type of addendum can be done from DRM Plus in the Clinical Record screen or in the CPRS GUI. An addendum that adds an ADA procedure to a signed note requires passing information to VistA PCE/DES and requires entering an ADA code through the Completed Care entry process.

To record a Note Addendum without an ADA procedure code:

1. Select the **note to be appended** from the list of notes.
2. The note appears in the viewer.
3. Right-click the area where the notes are listed to view the Note Functions menu.
4. Select **Addendum to a Note** from the menu. Only signed notes can have an addendum.

5. Type the note directly into the note viewer. Right-click in the viewer to import information or cancel.

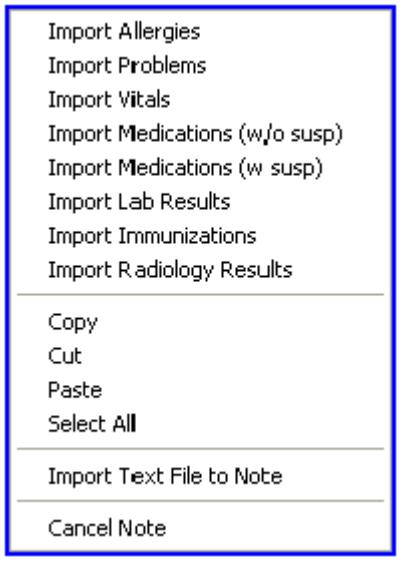


Figure 121: Viewer Right-Click Menu

6. Enter the provider's Electronic Signature and click the **Finish** button to add the addendum.
7. A confirmation screen appears. Click the **OK** button.

Note: If Addendum to a Note is selected in error, right-click the appended note and select the Cancel Note option.

Dental History

The Dental History tab displays all dental completed care information for each tooth and non-tooth entry filed in DRM Plus.

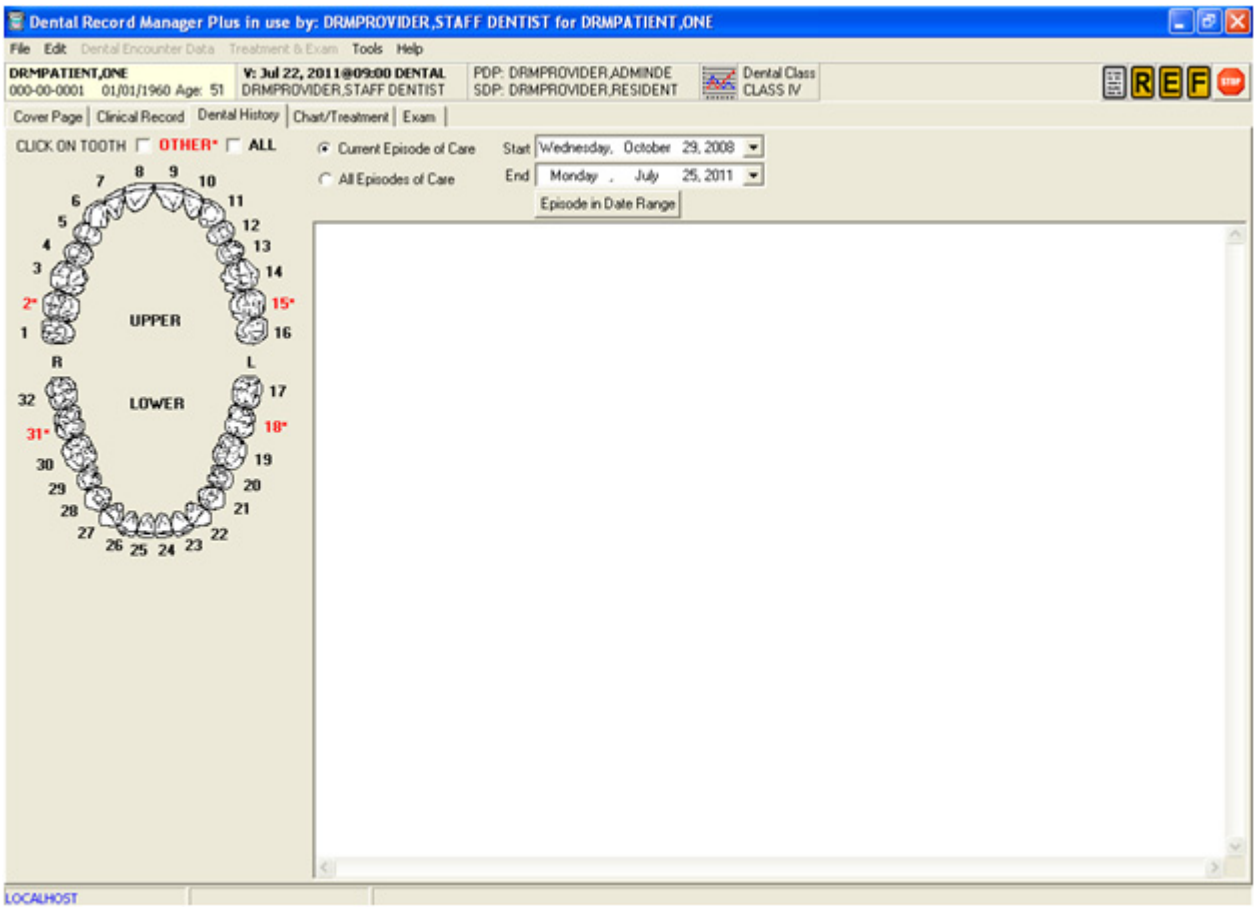


Figure 122: Dental History Tab

Viewing Dental Information By Tooth

To view dental information by tooth:

1. Click a **tooth** in the tab diagram. Teeth numbered in red with an asterisk have information associated with them. When a tooth is selected, it is colored red in the diagram.

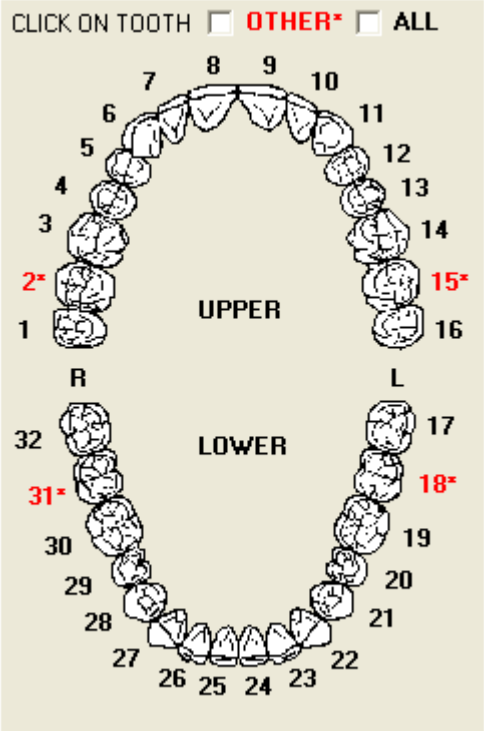


Figure 123: Dental History Teeth Diagram

2. Information about the selected tooth appears on the right side of the screen.
3. To deselect a tooth, click it again. The tooth turns white and the information about the tooth is removed from the right side of the screen.

Viewing Other Dental History Information

To see dental history that is not listed by tooth, select the **Other** checkbox. The information displays on the right side of the screen.

Viewing All Dental History Information

To see all dental history associated with this patient, mark the **All** checkbox. The information displays on the right side of the screen.

Viewing Dental History Information By Episode of Care

To view a patient's dental history by episode of care:

1. Choose whether to view the current episode of care or all episodes of care by selecting the appropriate radio button.

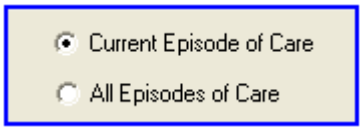


Figure 124: Episode of Care Radio Buttons

2. Select the **tooth** or **teeth** to be viewed, or click the **Other** or **All** checkboxes.
3. The information appears on the right side of the screen.

Episode in Date Range

To view a patient's dental history information by date:

1. Click the **start** and **end** drop-down arrows.

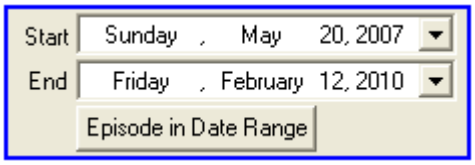


Figure 125: Episode in Date Range

2. Use the calendar screen to choose the desired start and end dates.
3. Click the **Episode in Date Range** button. The results appear on the right side of the screen.
4. Select the **tooth** or **teeth** or the **Other** or **All** checkboxes to view the desired information.

Chart/Treatment-Treatment & Exam

There are two main sections to the Chart/Treatment tab: Treatment & Exam and Periodontal Chart.

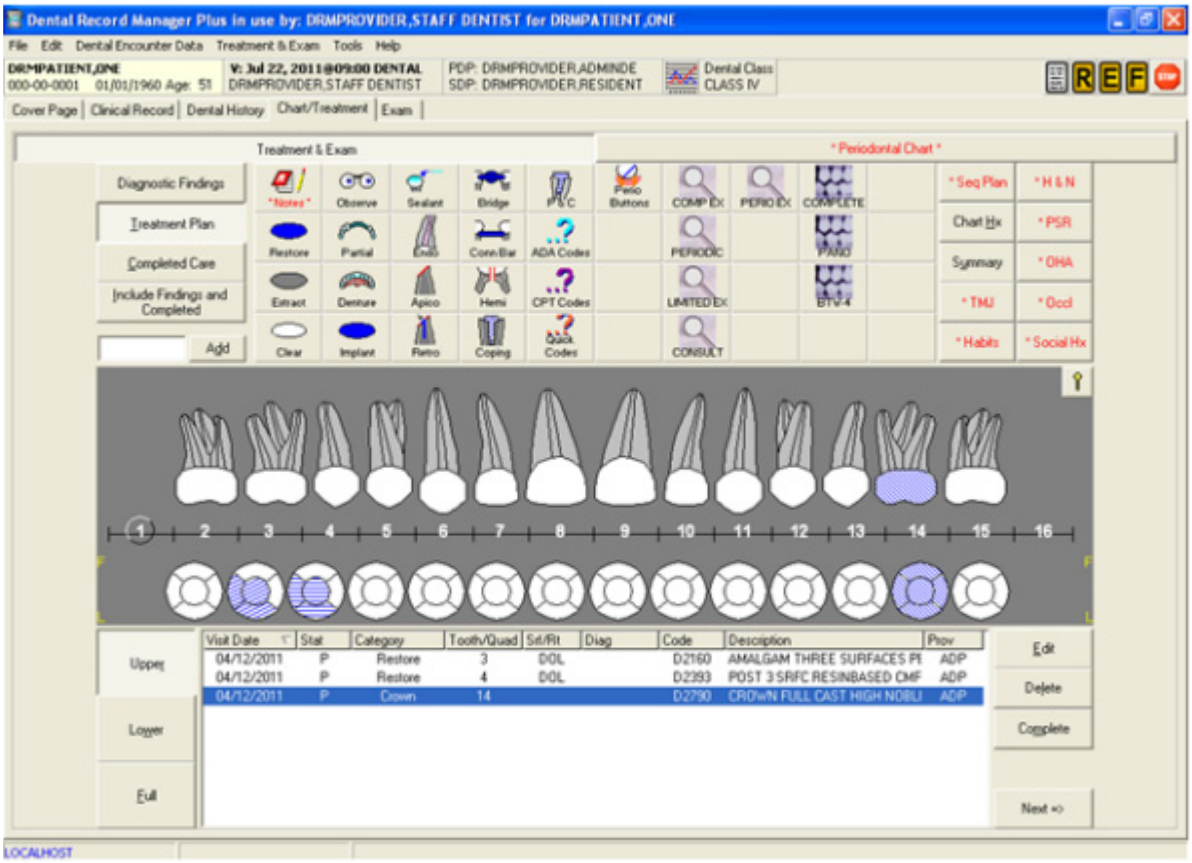


Figure 126: Chart/Treatment Tab Displaying Treatment & Exam Screen

The Treatment & Exam screen has several important component views. On the upper left side of the screen, the user will find: the Diagnostic Findings, Treatment Plan and Completed Care views, with corresponding icons. These tools are used to enter information on diagnostic findings, create treatment plans, view previously completed care or enter dental procedures/diagnoses on today's encounter. The **Include "..."** button allows the user to view information from a combination of the aforementioned views on one screen.

Figure 127: Diagnostic Findings, Treatment Plan, Completed Care and Include Buttons

The Seq Plan (Sequencing), Chart Hx (History), Summary, TMJ, Habits (Parafunctional), H&N, PSR, OHA (Oral Health Assessment), Occl (Occlusion) and Social Hx (History) buttons are on the upper right side of the screen.

Figure 128: Treatment & Exam Specialty Buttons

The center of the screen is occupied by a graphic display of all the teeth. Use the visual representation in combination with the Diagnostic Findings, Treatment Plan and Completed Care buttons and icons to enter information about the patient. There is also a key button on the right side of the display, that shows which conditions the various colors, patterns and symbols represent.

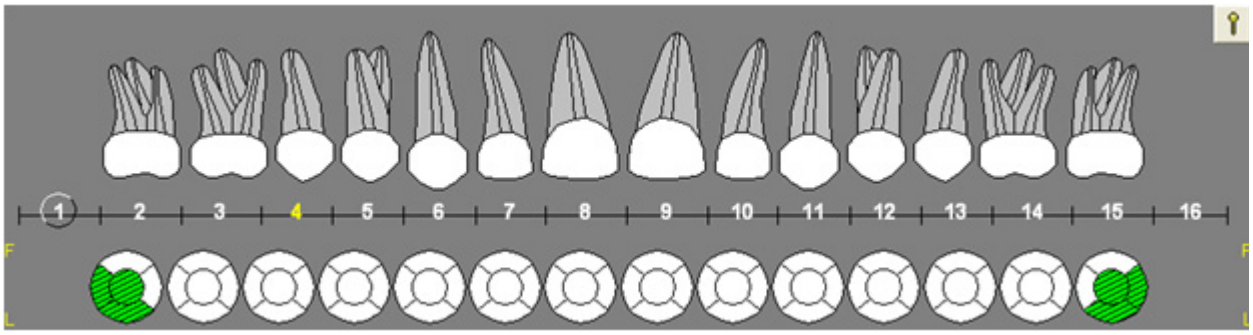


Figure 129: Completed Care Graphic Display

The lower portion of the screen has buttons to change the view in the graphic display. Additionally, the transaction table, which shows detailed information entered into Diagnostic Findings, Treatment Plan and the Completed Care view screens. There are tool buttons to the right of the transaction table, which allow the user to **Edit**, **Delete**, **Complete** from the Treatment Plan or click **Next**, to move on to updating the progress note. Toggle between the teeth of the upper and lower arch by clicking the **Upper** and **Lower** buttons to the left of the transaction table on the bottom section of the screen. The Full button allows the user to only view the two arches.

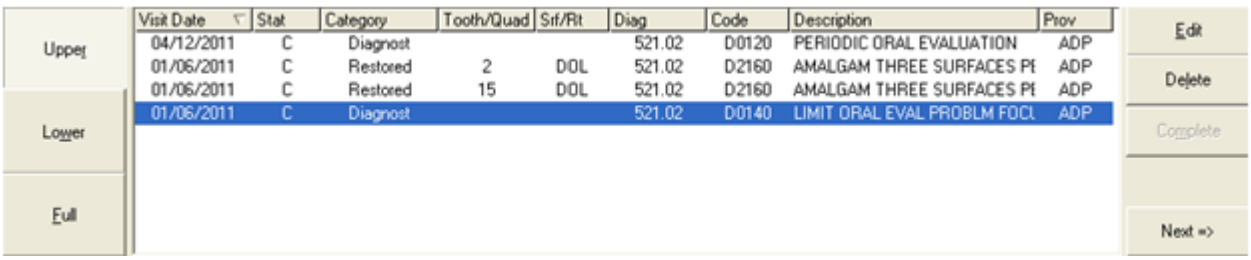


Figure 130: Completed Care Transaction Table

Diagnostic Findings

1. Click the **Diagnostic Findings** button on the left side of the screen.
2. Select the desired finding from the icons to the right of the Diagnostic Findings button.

Figure 131: Diagnostic Findings Button Active with Icons

3. Click the **tooth/area** of the tooth in the graphic display. Use the **Upper** and **Lower** buttons on the left side of the text display to view the arch and the previous diagnostic findings on the upper and lower arches.

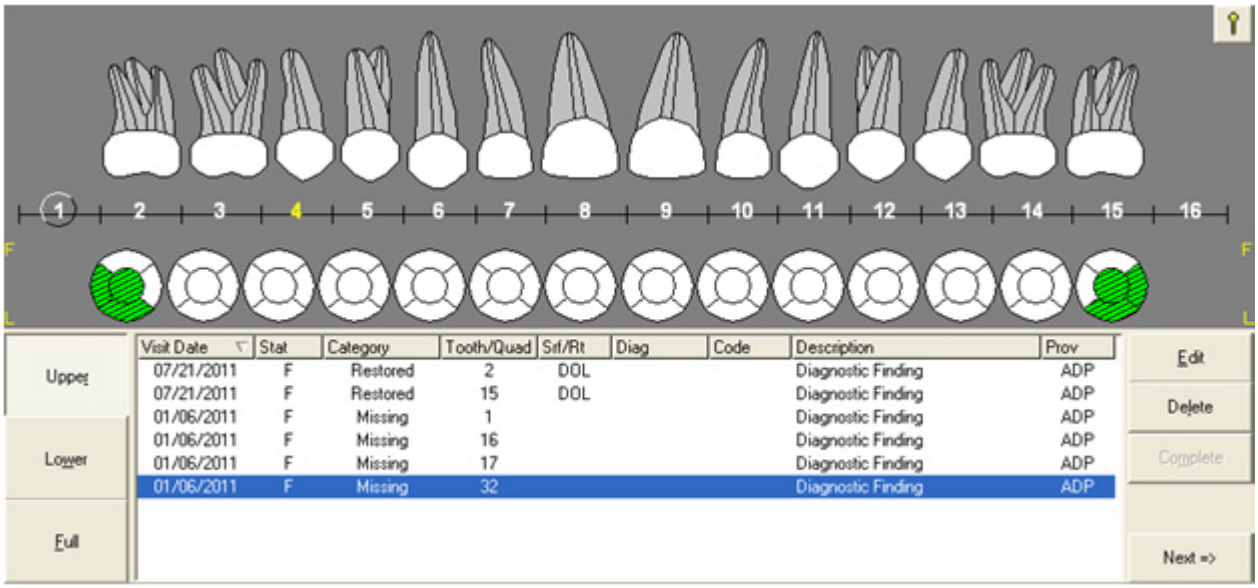


Figure 132: Diagnostic Findings Graphic and Transaction Table View Screen

4. The finding appear in both the text and graphic display. Click the **Key** button in the upper right corner of the graphic display to see how various findings are displayed in the graphic.
5. Use the **Clear** icon to remove any finding entered during today's encounter only. Click the **Clear** icon and then click the desired finding on the graphic to remove the finding from both the graphic and the transaction table.

Note: The Stats column in the transaction table will have an F when the transaction is "Finding".

Editing Diagnostic Findings Description

Diagnostic Findings descriptions that have been entered, but for which no progress note has yet been filed, can be edited. To edit a diagnostic finding description:

1. Select the finding by highlighting it in the transaction table.
2. Click the **Edit** button to the right of the transaction table.
3. The Edit Transaction screen appears.

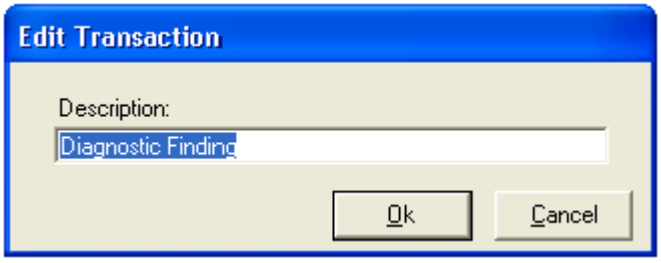


Figure 133: Edit Transaction Screen

4. Enter the new description in the text box. Note that only the description can be edited. The other information, such as Visit Date, Tooth/Quad or Category cannot be edited with this button.
5. Click the **OK** button. The edited information appears in the transaction table.

Deleting a Diagnostic Finding

Diagnostic Findings that have been entered, but for which no progress note has yet been filed, can be deleted. To delete a diagnostic finding:

1. Select the diagnosis by highlighting it in the transaction table.
2. Click the **Delete** button on the right side of the transaction table.
3. The diagnosis is deleted.

Note: If the user attempts to delete a finding that has already been filed with an old encounter, the item will be removed from the graphic display, but will remain in the transaction table with a line through it. The DRM Plus administrator may delete the finding from the graphic and the transaction table, unless the transaction has previously been deleted by a non-DRM Plus administrator.

Note: Clicking a transaction table column heading will sort the table. Generally in ascending order dependent on the current view. Clicking the column heading a second time returns the table to the original descending view. This functionality works the same for all three Treatment & Exam transaction table views.

Treatment Plan

Entering a Treatment Plan

There are multiple ways to enter a treatment procedure for a patient: by adding the code directly utilizing the **Add** button with text box or by selecting the icon that corresponds to the treatment and choosing the tooth from the graphic display. Use the ADA Codes, CPT Codes, Quick Codes Icon and personal Speed Code Icons as additional ways to enter treatment for the patient.

Rules for entering a procedure code for a planned item in the Treatment Plan view include:

1. Always use a standard icon, first four columns and P&C, if one is available first.
2. When no standard icon is available, use the ADA Codes, CPT Codes, Quick Codes or a Speed Code Icon.
3. The **Add** button with text box may be used interchangeably with Rule 2.
4. Always enter transactions in the same order they are performed on the patient.

Figure 134: Treatment Plan Button Active and Icons

To enter a planned treatment using the Add button and text box:

1. Click the **Treatment Plan** button. Notice that the Add text field and button are active.
2. Type a word or procedure code into the Add text box and click the **Add** button.
3. The Code Details screen appears if the procedure code is tooth or quadrant related.

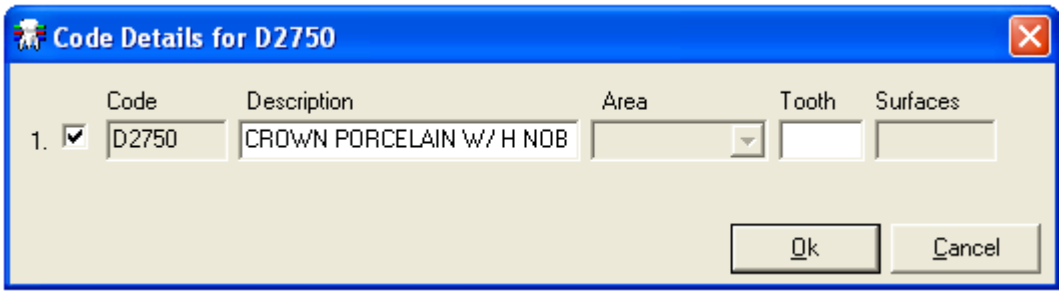


Figure 135: Code Details Screen

4. Enter the Tooth number and, if applicable, the area or surface modifiers and click the **OK** button. The graphic display and the text display adjust to reflect the addition.

Note: When surface modifiers are required for a procedure code, they must be entered using Upper-Case letters (M, O, D, F, B, L and I). When root modifiers are required for a procedure code, they must be entered using lower-case letters (r, b, l, d and m).

To enter a planned treatment using the standard Treatment Plan icons:

1. Click the **Treatment Plan** button.
2. Click the **icon to the right** that corresponds to the desired treatment plan.
3. Click the **appropriate tooth, area**, and/or **surface**.
4. As in Diagnostic findings, toggle between the upper and lower arch by clicking the **Upper** or **Lower** button on the left side of the display.
5. The graphic and transaction table display the new addition.

To enter a planned treatment using the ADA Codes icon or the CPT Codes icon:

1. Click the desired icon.

Figure 136: ADA, CPT and Quick Codes Icons

2. The Code Search screen appears for the ADA Codes icon selection.

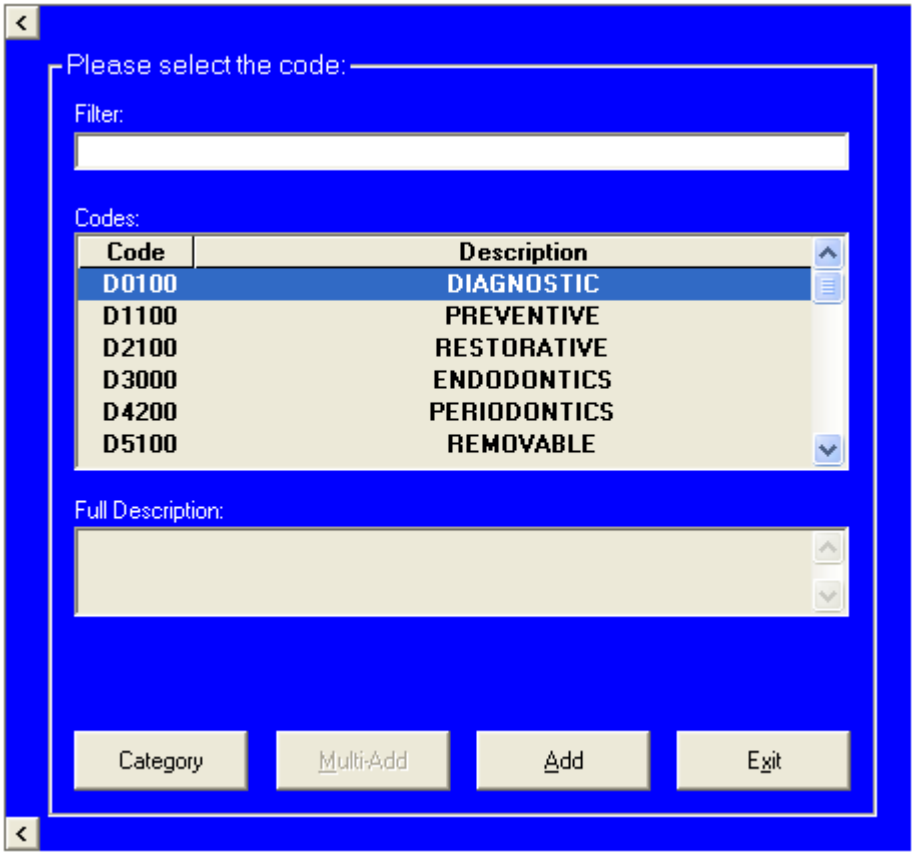


Figure 137: CPT Procedure Code Search Screen

3. Type the code into the filter, or use the scroll bar to search for a code.
4. A description of the highlighted code appears in the Full Description text box.
5. Click the **Category** button to return to the list of categories at the top of the scroll sheet. Click the **Multi-Add** button to add multiple codes on the same tooth.
6. When the desired code is highlighted, click the **Add** button.
7. If the code needs to be attached to a specific tooth and surface modifier, the Code Details screen appears.

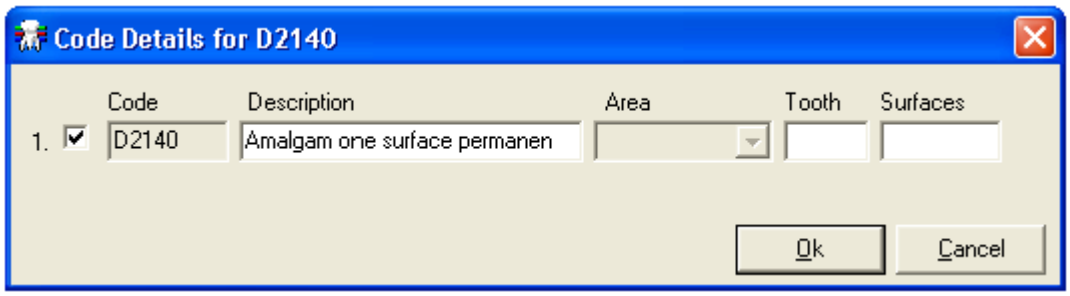


Figure 138: Code Details Screen

8. Fill in the fields with the requested information and click the **OK** button.
9. The Treatment Plan Code screen appears if the parameter is activated.

10. Select the treatment procedure on the left side of the screen (default is all selected) and the diagnosis code(s) on the right side. If the correct diagnosis code does not appear, use the Additional Diagnosis Code Search to find a different diagnosis code.
11. Click the **OK** button. The information appears in the transaction table on the graphic chart.
12. To undo any graphical entry on today's encounter, use the **Clear** icon as described in the section of this chapter entitled Diagnostic Findings.

To enter a treatment using the Quick Codes icon is similar when adding with the ADA Code Icon. To enter a treatment using the personal Speed Code icons, see the section later in this chapter, entitled Perio Buttons.

Editing a Treatment Plan Description

1. Click the desired entry in the transaction table.
2. Click the **Edit** button. The Edit Transaction screen appears.

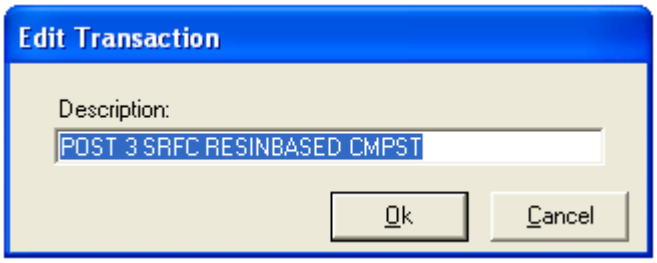


Figure 139: Edit Transaction Screen

3. Enter the new description in the text box.
4. Click the **OK** button.
5. The Description is changed in the transaction table. Note that the Code, Category and other information cannot be changed with the **Edit** button.

Every DRM Plus user is allowed to delete any planned item, no matter who entered it. The planned entry will be removed from the graphic and transaction table in the Treatment Plan and Sequencing screens.

Completing a Treatment Plan

1. Select the planned procedure to be completed from the transaction table.
2. Click the **Complete** button.
3. The ICD-9 Diagnosis Code screen appears.

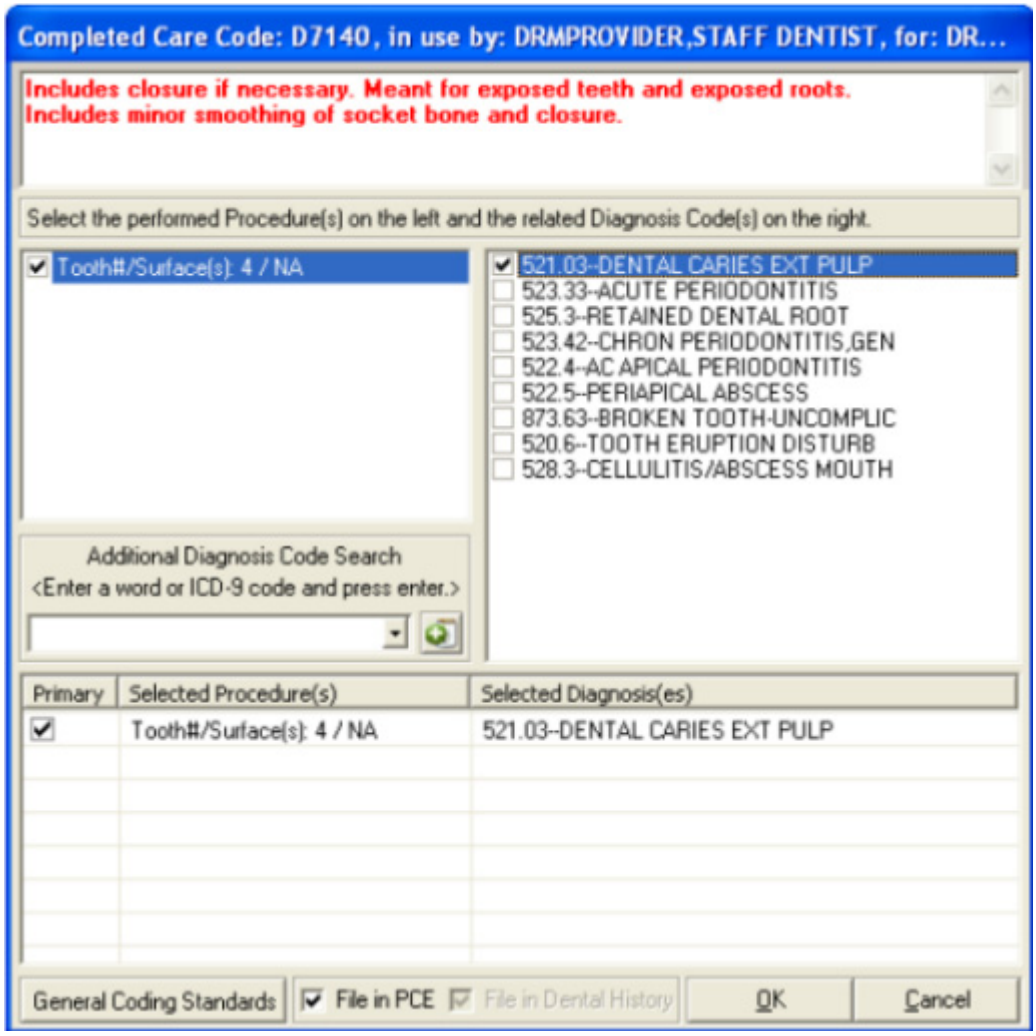


Figure 140: ICD-9 Diagnosis Code Screen

4. Select the treatment procedure on the left side of the screen (default is all selected) and the diagnosis code(s) on the right side of the screen. If the correct diagnosis code is not listed, use the Additional Diagnosis Code Search to find a different diagnosis code.
5. Notice the File in PCE checkbox. If the Completed Care treatment is not to be filed in PCE, uncheck this box.
6. Click the **OK** button.
7. The planned procedure is removed from the transaction table and is now part of Completed Care for the patient.

Note: The PCE checkbox option should only be used by advanced users. Changing this option will effect the data being sent to VistA PCE. Do not change this checkbox unless the user does not want the data to be sent to VistA PCE.

Note: Treatment Plan procedure codes can be designated with or without a related diagnosis. The parameter change for the end user to acquire this functionality is Tools menu/ User Options/ Treatment System tab and checking the top checkbox.

Completed Care

Click the **Completed Care** button to see all treatments that have been previously completed in the VA for the patient, or entering any new completed treatment for today's visit.

Figure 141: Completed Care Button Active Icons

The rules for entering a procedure code for a completed treatment in the Completed Care view include:

1. Always use a standard icon, first four columns and P&C, if one is available first.
2. When no standard icon is available, use ADA, CPT and Quick codes, or a Speed Code icon.
3. The Add button and corresponding text box may be used interchangeably with rule 2.
4. Always enter transactions in the same order they are performed on a patient.

Entering Completed Care

There are several ways to enter Completed Care. Planned treatments, which are complete (see Completing a Treatment Plan), will appear in the Completed Care transaction table. Completed Care can also be entered manually:

1. Click the **Completed Care** button.
2. Select the desired associated standard icon.
3. Choose the appropriate tooth/area on the graphic display.
4. Complete the ICD-9 Diagnosis Code screen.
5. The entry appears in the transaction table.
6. To undo any graphical entry on today's encounter, use the **Clear** icon as described in the Diagnostic Findings section of this manual.

Completed care can also be entered through the Add button and text box and the ADA, CPT and Quick Codes icons, as well as the Speed Code icons. For furthur information on these functions, see the Treatment Plan section of this manual.

Editing Completed Care Description

Completed Care description can only be edited if it has not yet been made a part of the progress note. To edit a completed care entry:

1. Choose a completed care entry from the transaction table.
2. Click the **Edit** button.
3. The Edit Transaction screen appears.

Figure 142: Edit Transaction Screen

4. Type the new description into the text box.
5. Click the **OK** button. Note that only the description can be edited.

Deleting a Completed Care

1. Click the desired entry in the transaction table.
2. Click the **Delete** button.
3. The treatment is removed from the graphic and transaction tables.

DRM Plus users are not allowed to delete any previously entered completed care. This can be performed only by DRM Plus administrators.

Include "Completed"/Include "Findings and Completed"/Include "Findings"

This button can be used in conjunction with the other buttons to include more than one type of information on the display. When the Diagnostic Findings button is active, and the associated information is displayed in the graphic and transaction tables, clicking this button adds the Completed Care information to the display. If the Treatment Plan button is active, and the associated information is displayed, clicking this button adds the Diagnostic Findings and the Completed Care information to the graphic and transaction tables. Finally, when the Completed Care button is active, and the associated information is displayed, clicking this button adds the Diagnostic Findings.

Perio Buttons Icon

The Icon table includes the Perio Buttons Icon. Click this icon to see the second set of speed codes associated with perio mode, if entered by the user. For furthur information, please see the Speed Codes section of this manual, in the Using the DRM Plus Drop-Down Menus chapter.

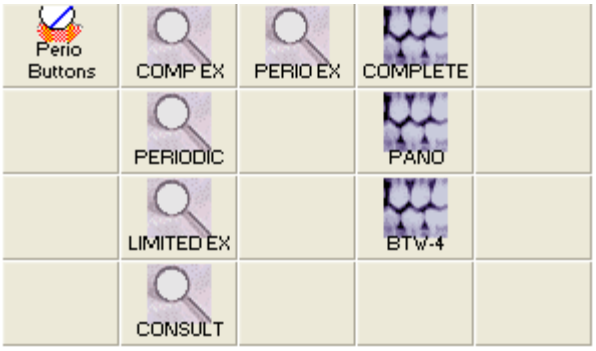


Figure 143: Perio Button and Icons

This option is only available while Treatment Plan or Completed Care are active, but not with Diagnostic Findings.

Click the desired icon to add it to the Treatment Plan. If these buttons are clicked when Completed Care is active, the ICD-9 Diagnosis Code screen appears, which allows the selection of diagnosis codes, that are mapped to that procedure code, to be entered.

To change the location of the speed code icon:

1. Click one of the blank icons where the speed code icon is to be moved.
2. The Configure Button screen appears.

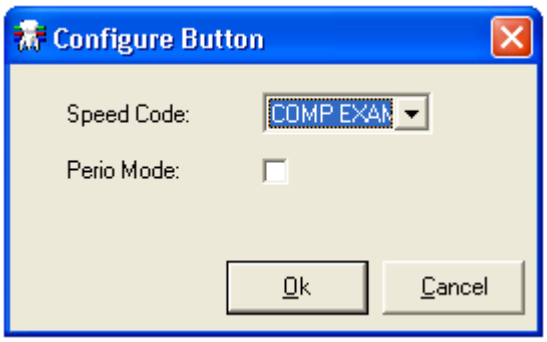


Figure 144: Configure Button Screen

3. Use the drop-down menu to assign the speed code.
4. Use the Perio Mode checkbox to link the speed code icon with the Perio Buttons icon.
5. Click the **OK** button. The old speed code icon location is cleared and the speed code icon is now in the new assigned icon location.

Seq Plan/Sequencing Button

Use sequencing in combination with the Treatment Plan function to organize when to perform specific planned treatments. Planned treatments can also be deleted or completed from this screen.

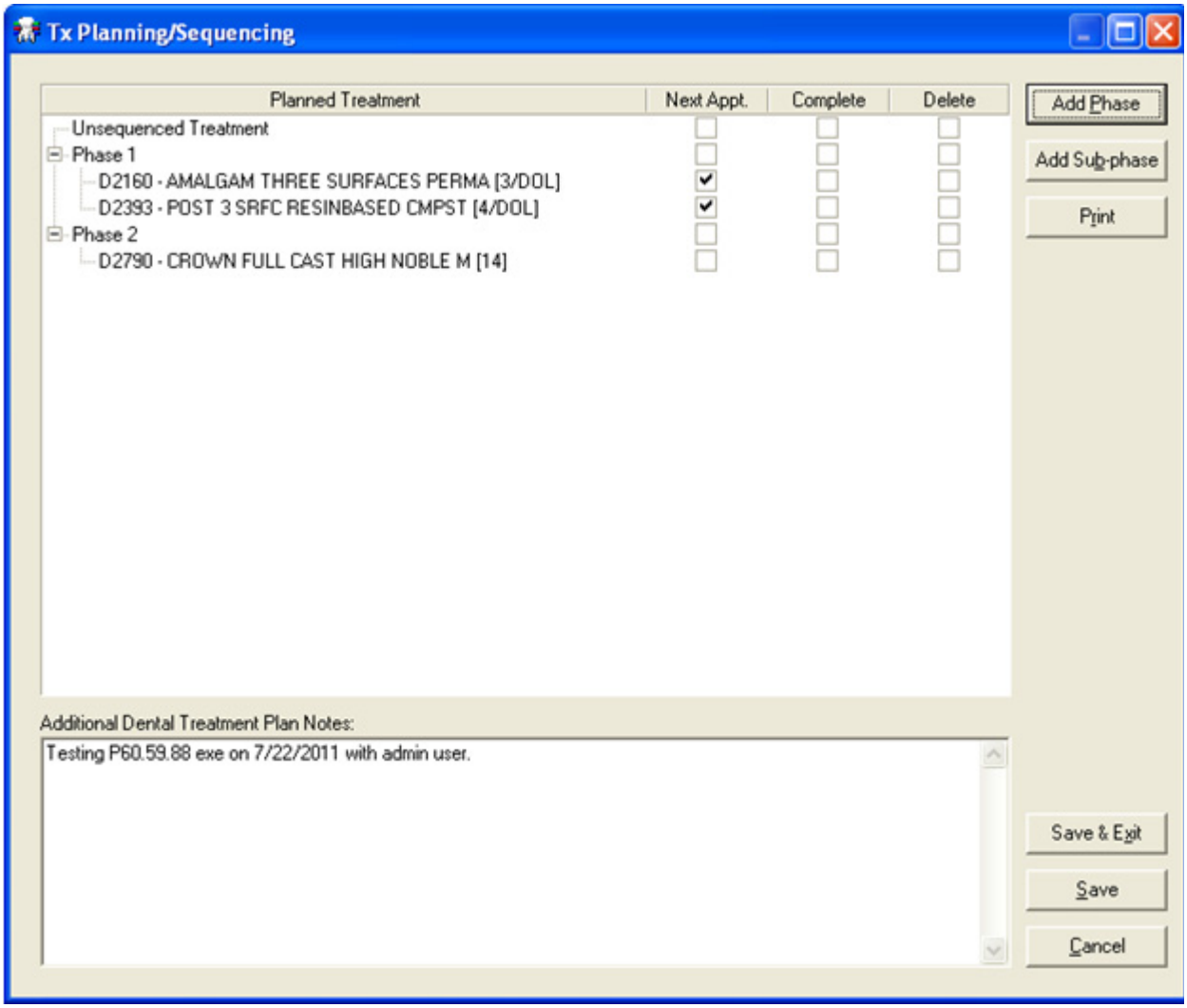


Figure 145: Tx Planning/Sequencing Screen

Plan a Treatment Sequence

1. Click the **Seq Plan** (Sequencing) button.
2. The Tx Planning/Sequencing screen appears.
3. Information from the Treatment Plan transaction table is on the screen. use the Add Phase and Add Sub-phase buttons to add a new phase and/or sub-phase. Highlight the desired phase listed in the screen to add the sub-phase under this desired phase.
4. Change the sequence of the planned treatments by dragging and dropping them into the correct phase.
5. If the planned treatment is to be completed at the next appointment, click the corresponding check-box.

6. Add Additional Dental Treatment Plan Notes in the text box.
7. Click the **Save and Exit** button if only planned items have been added or sequenced for this patient. This option requires that no new data may be entered as completed transactions, Perio, H&N or any other modal at the same time for the option to work.
8. Click the **Save** button to save the progress in sequencing and keep working on this encounter.

Note: Always enter planned treatment in the same order they are performed on a patient.

Note: The Save and Exit button from the Sequencing screen will file any changes and minimize DRM Plus. Any new planned entries added will have the same Visit Date as the latest Progress Note filed on this patient. The most recent dental encounter must have an Active status for this feature to work.

Complete a Planned Treatment in the Sequencing Screen

1. Click the **Seq Plan** (Sequencing) button.
2. The Tx Planning/Sequencing screen appears.
3. Choose the planned treatment that is to be completed by checking the corresponding checkbox in the Complete column.
4. Click the **Save** button.
5. The Completed Code Care screen appears. See the Completing a Treatment Plan portion in the Treatment Plan section of this chapter for further information.

Deleting a Planned Treatment in the Sequencing Screen

1. Click the **Seq Plan** (Sequencing) button.
2. The Tx Planning/Sequencing screen appears.
3. Choose the planned treatment that is to be deleted by checking the corresponding checkbox in the Delete column.
4. Click the **Save** button.
5. The planned treatment is deleted from the Sequencing screen, the transaction table and the graphical chart on the Treatment Plan screen.

History Button

Click the **History** button to see a completed care chart of the patient's dental history. The transaction table includes the text details of the Visit Date, Stat, Category, Tooth/Quadrant, Surface/Root modifiers, Codes, CPT Description and Providers initials.

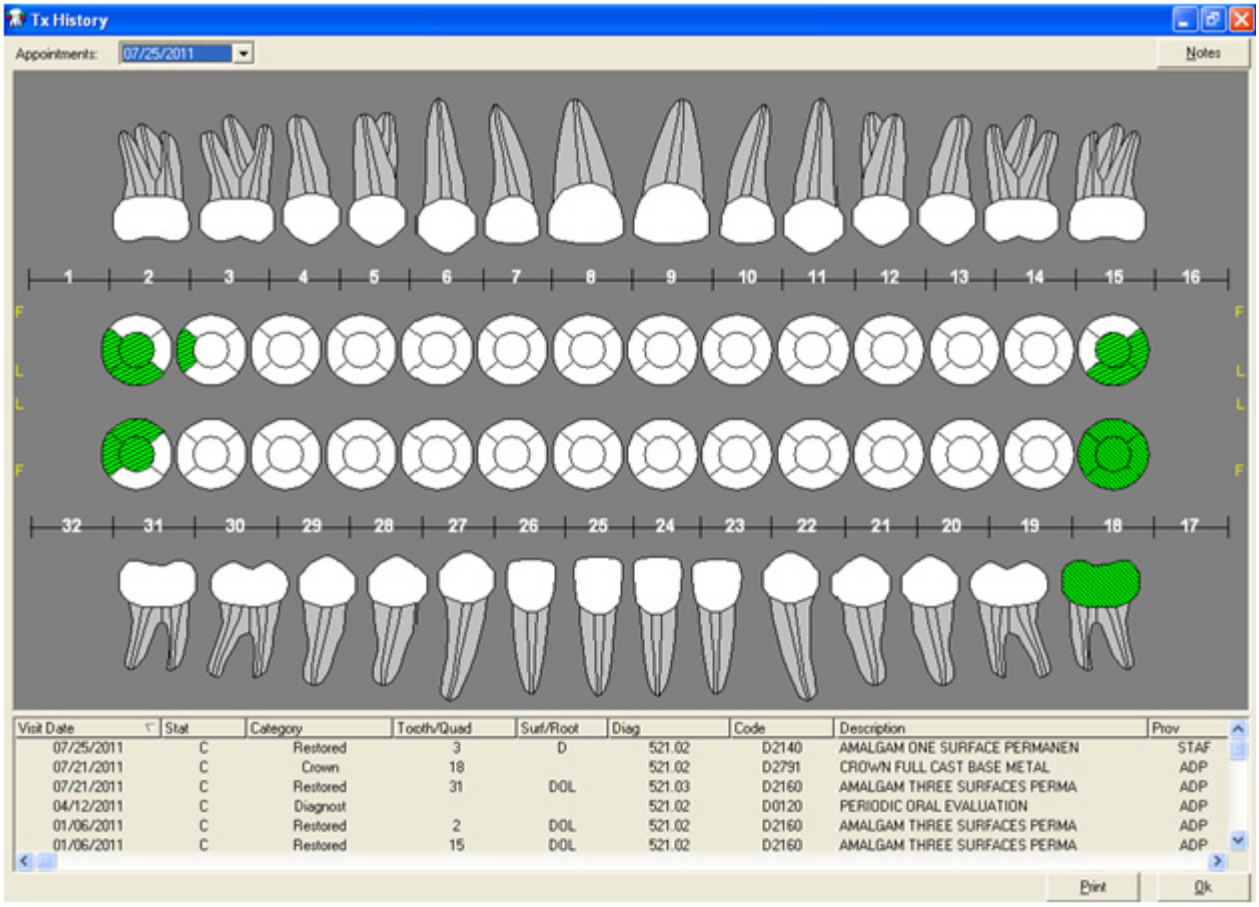


Figure 146: Tx History Screen

Use the Appointments drop-down menu to see the patient's history by different appointment dates. View tooth notes on the patient's file by clicking the **Notes** button tied to the note's appointment's date.

Note: To display any past tooth-specific note, click the **History** button**.** Continue by clicking the drop-down arrow of the Appointment field, in the top left corner of the History screen, and selecting the appropriate date the tooth-specific note was entered. Once the date is selected, the tooth numbers in the graph will display in yellow. Once the desired tooth is found, click the **Notes** button. Then use the drop-down arrow to select the tooth-specific note of interest and view its contents.

Summary Button

Click the **Summary** button to view a summary of a patient's chart. Periodontal information appears in the summary as well.

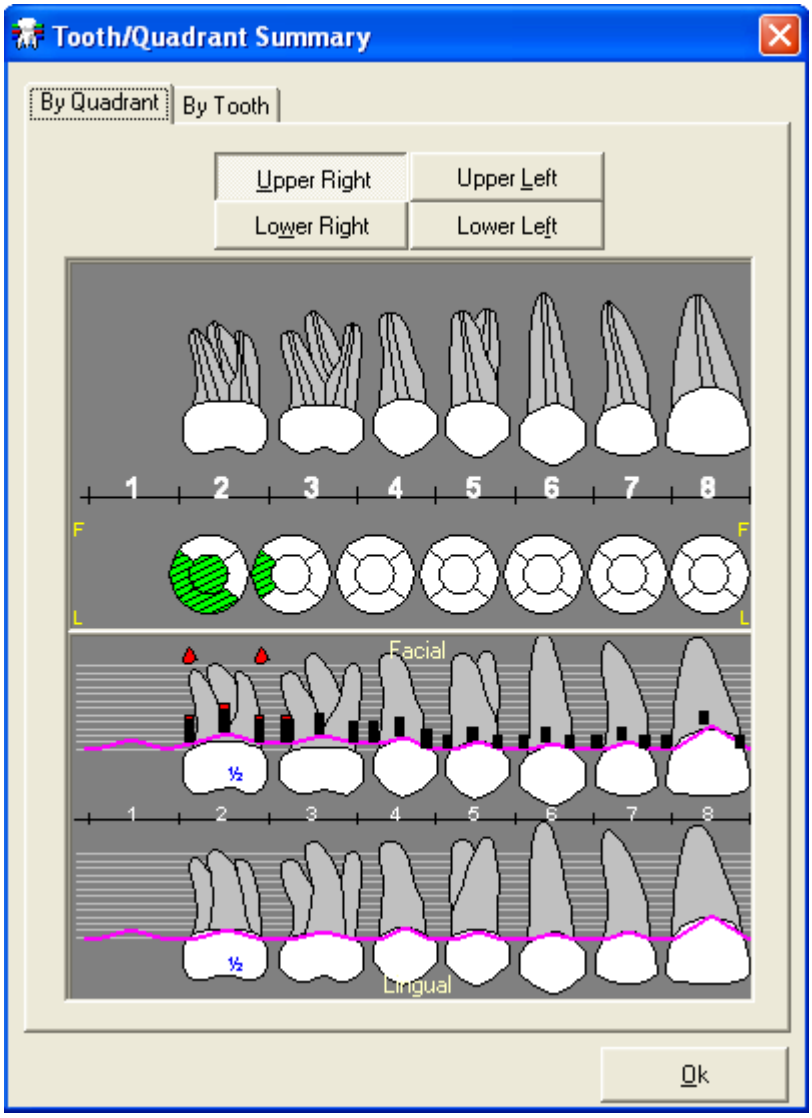


Figure 147: Tooth/Quadrant Summary Screen

Use the tools on the screen to view the information by quadrant or by tooth.

Note: On the Treatment & Exam screen, with the following views: Diagnostic Findings, Treatment Plan, or Completed Care, clicking the **Summary** button displays the history of the selected primary view. The upper half of the window shows the summary of the primary view that is active when the Summary button is selected. Only the activated primary view, with all of its entries, is displayed in the Restorative top window. The lower half of the screen displays Periodontal summary, which includes the latest exam in Periodontal history with filed Diagnostic Findings and Completed Care; however, not including surfaces or roots.

H&N Button

Use the functions in the H&N (Head and Neck) button to enter and view diagnostic information on the patient's head and neck.

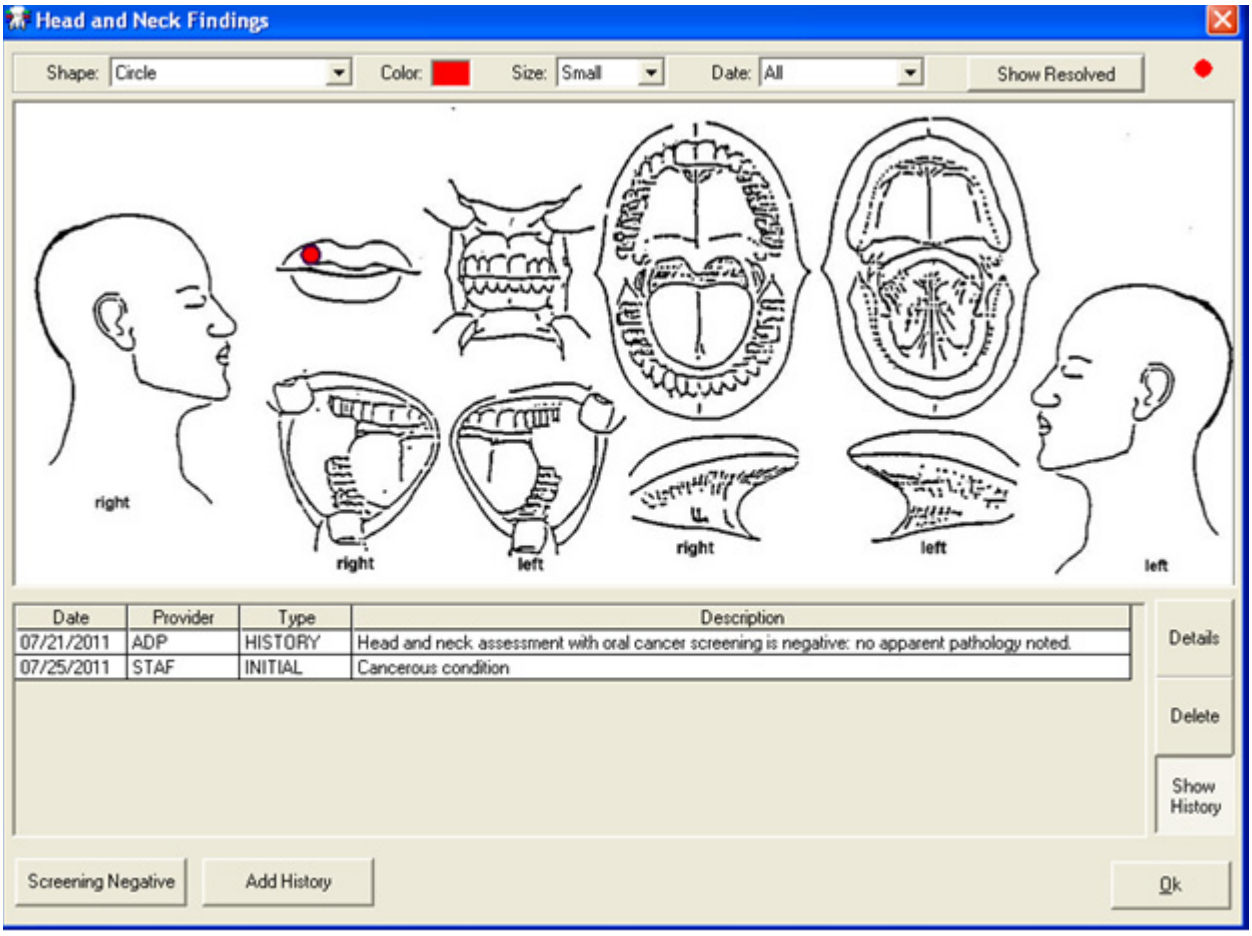


Figure 148: Head and Neck Findings Screen

To enter a finding:

1. Select the graphic shape that best represents the finding by using the **Shape** drop-down menu.
2. Select the contrasting color for the finding by clicking the **Color** box. A visual list of possible colors appears.
3. Select the size of the graphic by using the **Size** drop-down menu.
4. The date box defaults to Today, which is required for new data entries. After the first filed progress note entry of H&N, the date box defaults to All. The user may click the drop-down arrow and highlight a previous exam to view the entries on a previous date.
5. Click the **graphic** to show where the lesion is located on the patient.
6. The H&N Detail screen appears.

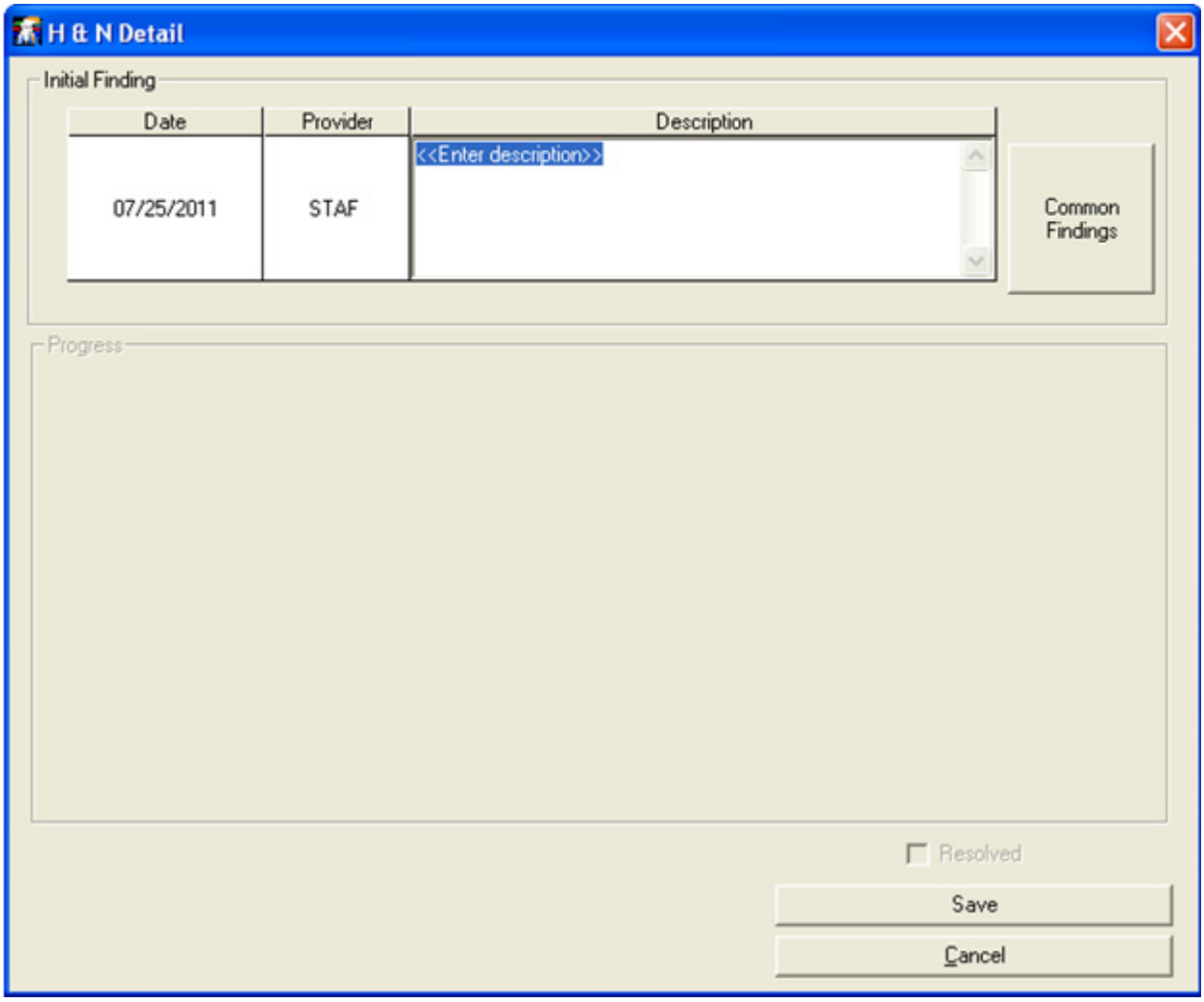


Figure 149: H&N Detail Screen

7. Enter the description of the lesion in the Description column, or click the **Common Findings** button to see a list of commonly appearing lesions and add the description to the finding.
8. Click the **Save** button. The finding appears on the H&N transaction table.

To add new details of a finding:

1. Click the desired finding in the H&N transaction table and click the **Details** button.
2. The H&N Detail screen appears with progress information to be entered.

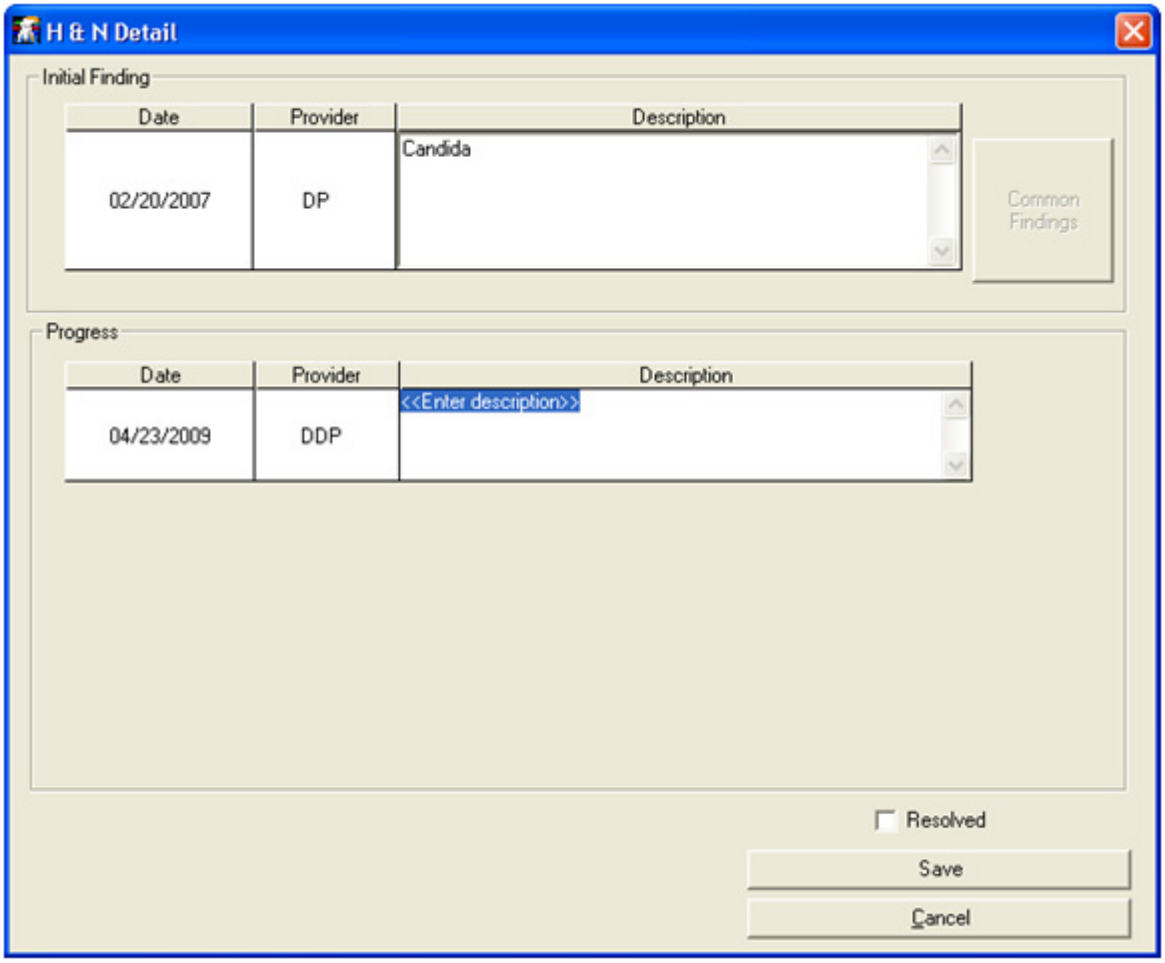


Figure 150: H&N Detail Screen with Progress Description Activated

3. Enter information in the Description column of the Progress area.
4. Click the **Save** button to save the entered information and return to the H&N screen.

To delete a lesion:

1. Highlight the entry on the H&N transaction table.
2. Click the **Delete** button.
3. A screen confirming that the entry is to be deleted appears. Click the **OK** button. Note that this screen only appears if the entry is made during this encounter.
4. The entry and the mark on the H&N graphic is removed.

Note: Clicking the **Delete** button deletes the highlighted entry(s) during the same day the H&N transaction was entered. Deleting any filed H&N transaction by any DRM Plus end-user results in a line through the entry, and it remains in the transaction table.

PSR Button

Click the **PSR** button to view the PSR screen. Use this screen to view past PSR information if present, or to enter new PSR information.

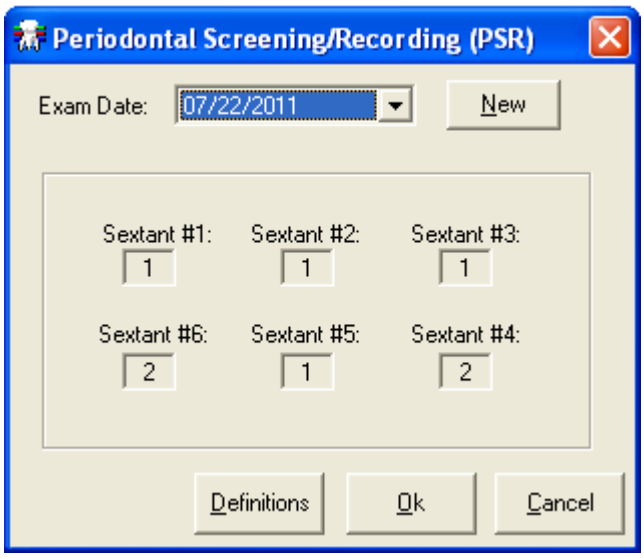


Figure 151: Periodontal Screening/Recording Screen

Use the Exam Date drop-down menu to view past Periodontal Screening information.
To enter new information:

1. Click the **New** button. All the Sextant text boxes are 0, or the value from the previous exam.
2. Enter the desired national dental value in each Sextant text box. Entering a "*" requires a number added with the symbol to be saved (i.e. "3*").
3. Click the **Definitions** button to view PSR definitions of national dental values.
4. Click the **OK** button to complete.

Note: The PSR modal allows two providers to enter a PSR exam on the same day; however, it only displays the last PSR exam that was entered on that day. The first entered PSR exam is only viewable in the progress note of the provider that filed the encounter. The second provider's filed note has a different header, which includes the word "modified" in the PSR exam of the progress note.

OHA (Oral Health Assessment) Button

The specialty **Plaque** button was combined with **Xerostomia**, **Caries Risk** and **Oral Hygiene** to create the **OHA** button. This also applies to the **Plaque** button on the Periodontal Chart screen.

To enter new findings in the OHA screen, click the **New** button. Today's date is imported into the Date field on the screen. Today's date is the date of entry or the create date for this finding; when reloaded and filed as unfiled data, it retains the date from when the finding was originally entered.

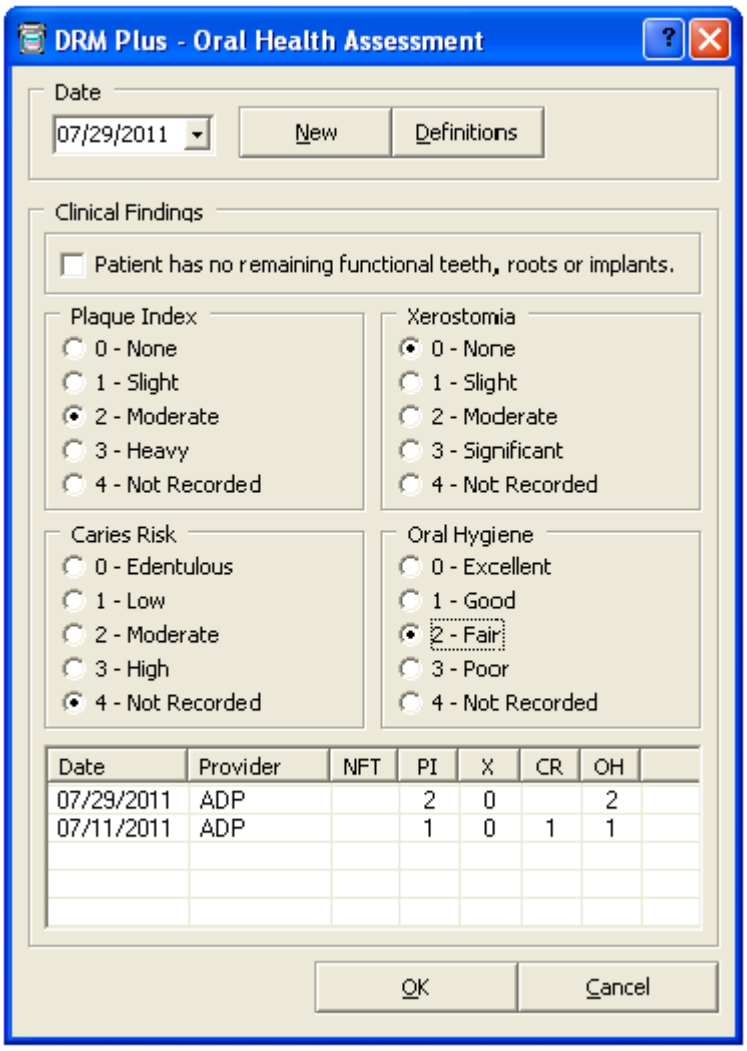


Figure 152: Oral Health Assessment (OHA) Screen

The NFT checkbox option, listed as "Patient has no remaining functional teeth, roots or implants" may be selected in the event the patient meets these criteria and no findings can be entered in the Diagnostic Findings chart.

Checking this box automatically completes the Diagnostic Findings element and the Periodontal Assessment element when filing any exam/consult code during a dental encounter. It also automatically selects the 0-Edentulous radio button in the Caries Risk section.

The radio buttons default to “4 - Not Recorded” in all four fields. This selection does not import any clinical finding into the progress note, nor displays in the transaction table of the OHA screen. The provider has the option of selecting the **appropriate radio button** (0-3) for each of Plaque Index, Xerostomia, Caries Risk and Oral Hygiene, or simply leaving the default setting.

The entry or create date, provider’s initials and each field value entered is captured in the transaction table at the bottom of the screen. The provider has to enter at least one value (between 0-3) in one of the four fields to save and file an oral health assessment.

The Definitions button has the American Dental Association definitions for field values when entering Plaque Index, Xerostomia Risk and Caries Risk. The rest of the Xerostomia and Caries Risk definitions may be viewed using the scroll bar on the right side of the screen.

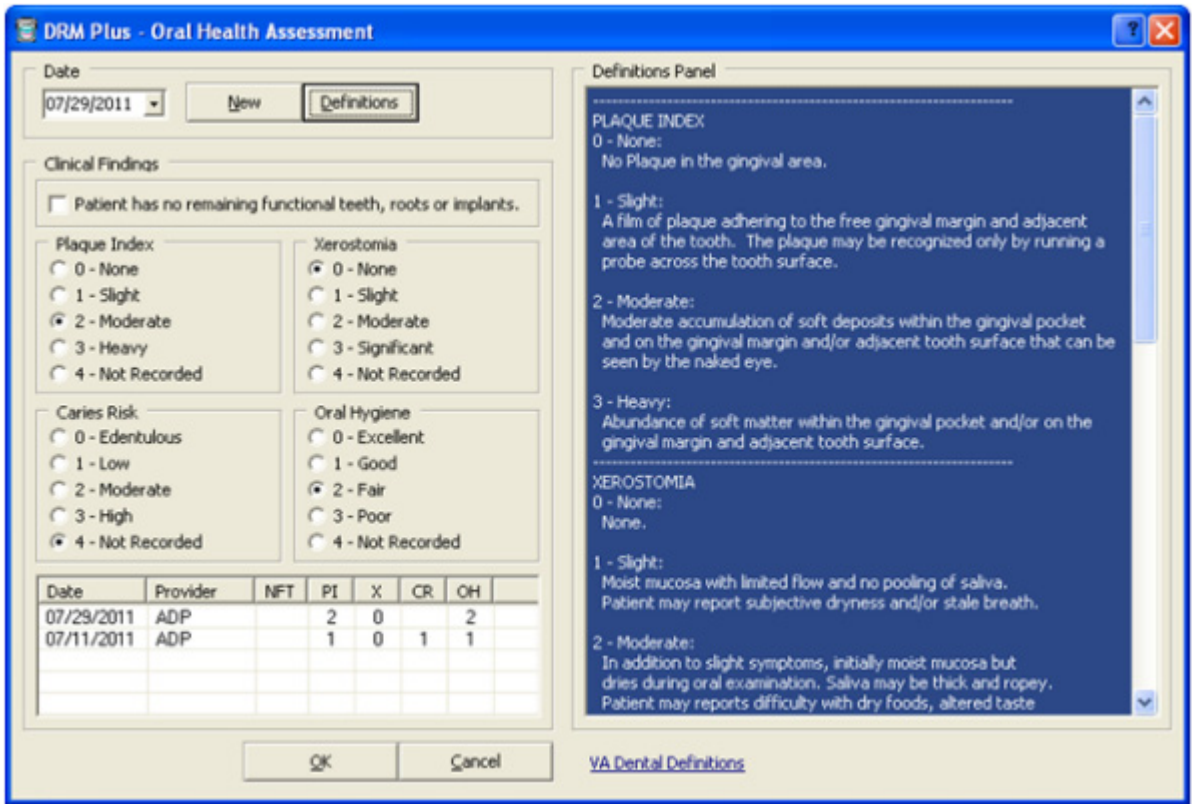


Figure 153: OHA Definitions Showing Plaque Index and Xerostomia Risk

The OHA (Oral Health Assessment) Definitions Panel is displayed in the previous screen. The Definitions panel maybe automatically expanded due to the parameter selection that is defaulted when first loaded. The user may change this parameter by going to Tools menu, User Options, Exam Settings and uncheck the Requirements.

At the bottom of the OHA Definitions panel is the Internet link for possible newer ‘VA Dental Definitions' which displays any new definition updates that have been changed for these findings.

Note: The Plaque definitions have been reprogrammed and only allows whole number entries. Most Plaque values filed before the loading of the new exam template patch retain the decimal value, if entered with one, and are located in the PI column of the new OHA transaction table.

TMJ Button

The new specialty button **TMJ** functions similar to the **OHA** button when entering a new exam. Click the **New** button and today's date imports into the Date field. Today's date is the date of entry or the create date for this finding; and when filed as unfiled data retains the same date when the finding was originally entered.

At least one entry in either the History or Clinical sections from this TMJ screen requires data to be selected in order to save. When selecting the **second History radio** button 'Patient reports symptoms associated with TMJ's:' allows multiple checkbox selections and at least one is required for this option to save.

The text windows found below the Other checkbox in History or Clinical Findings only opens if the checkbox has been selected and each requires a text entry. The Other text boxes allow an unlimited text field.

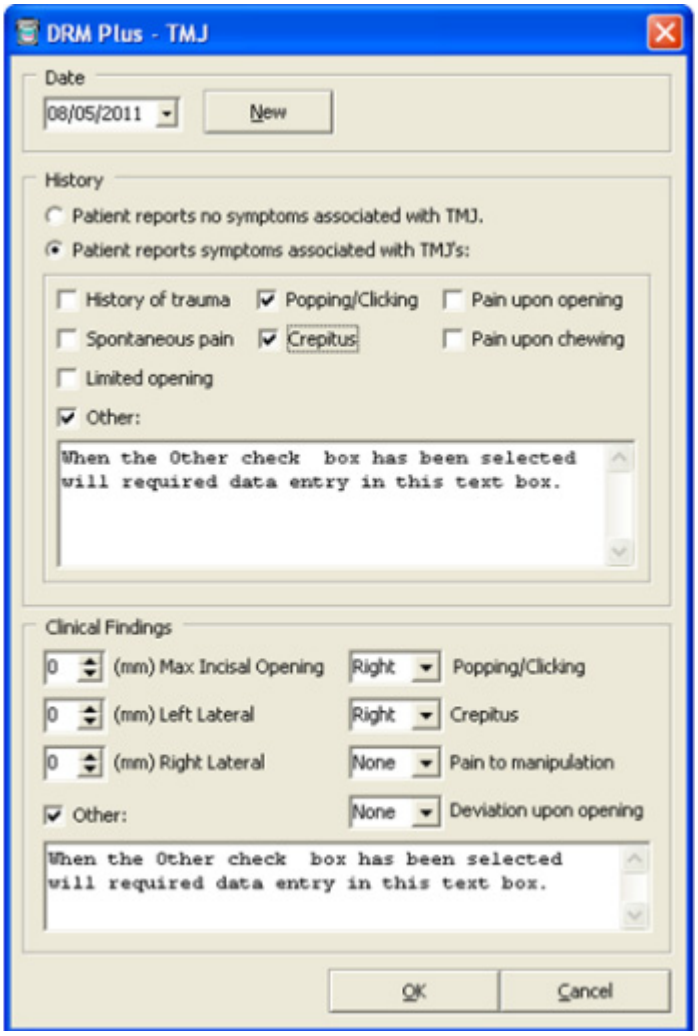


Figure 154: TMJ Screen

The Clinical Findings section has three numerical fields to enter a millimeter value and four drop-down menu options in selecting popping/clicking, crepitus, pain to manipulation and deviation upon opening. The Other checkbox allows an unlimited text field for additional text information if selected.

The minimal requirement to enter a new TMJ finding is the selection of only one historical or clinical finding from this screen.

Occl (Occlusion) Button

The new specialty button **Occl (Occlusion)** functions different than the other new modals when entering a new occlusion finding. Click the **New** button and today's date imports into the Date field. When there is previously filed data present then all that filed data is imported into the new exam. The user needs to add/delete any new occlusion findings and click the **OK** button to save. Today's date is the date of entry or the create date for this finding; and when filed as unfiled data retains the same date when the finding was originally entered.

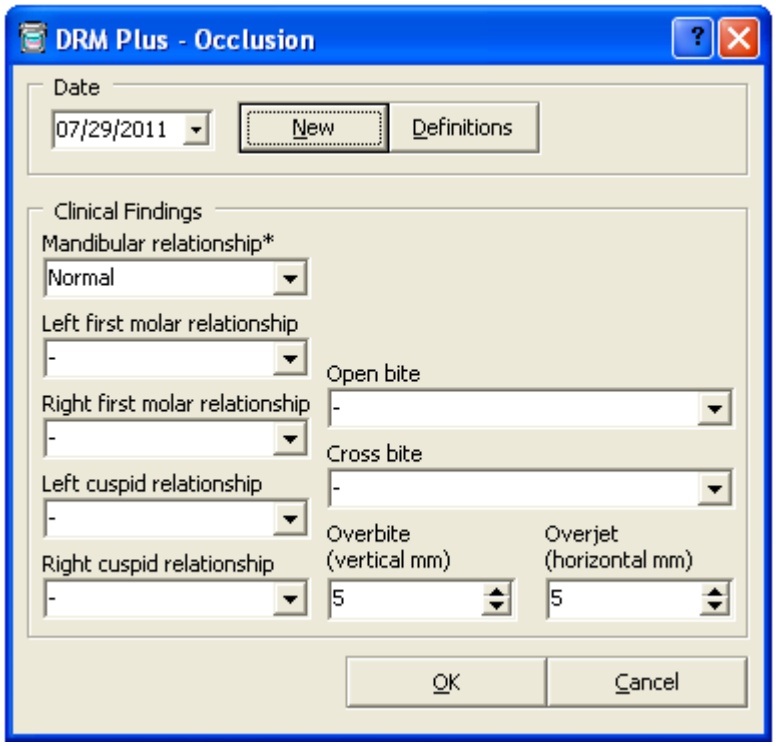


Figure 155: Occlusion Screen

The Clinical Findings drop-down menu option Mandibular relationship* is the only required (*) field on this screen. The six other drop-down menu options and the two numerical box selections are optional entries.

The Definitions panel displays the Angle's Classification definitions. These Angle's Classifications are for the selections displayed in the left bottom four drop-down menus. The Definitions panel maybe reduced to display only the OHA screen by selecting the **Definitions** button.

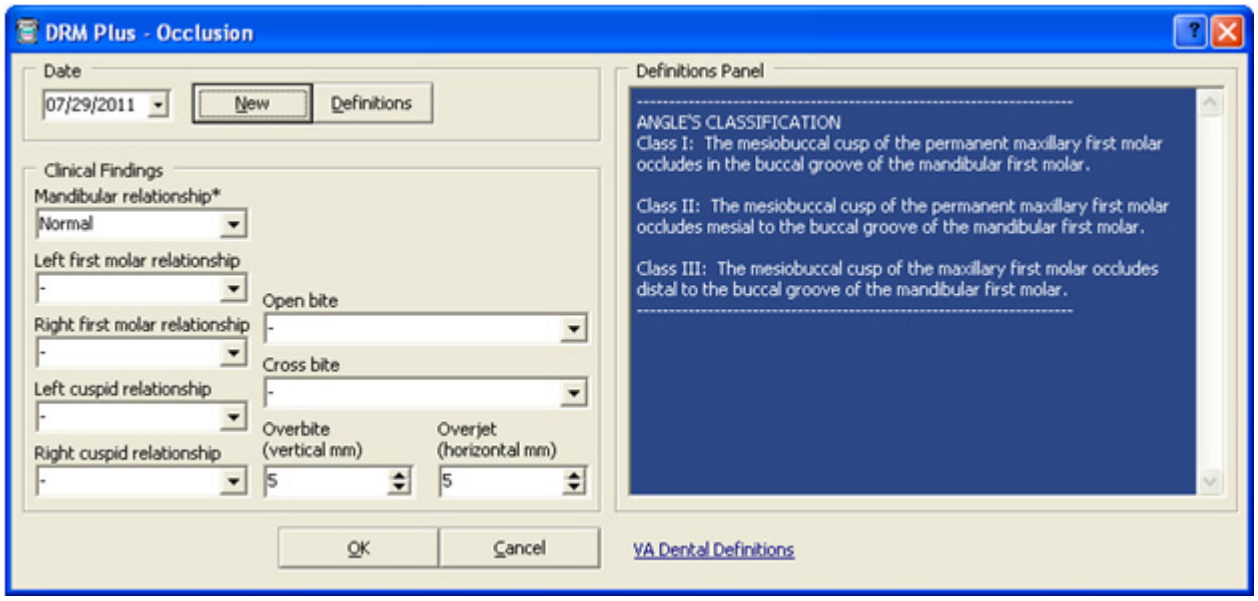


Figure 156: Occlusion Angle's Classification Definitions

The Definitions panel maybe expanded due to the parameter selection that is defaulted when first loaded. The user may change this parameter by going to the **Tools** menu, clicking **User Options**, then **Exam Settings** and finally unchecking the **Requirements**.

At the bottom of the Occlusion Definitions panel is the Internet link for possible newer 'VA Dental Definitions', which displays any new definition updates that have been changed for these findings.

Habits (Parafunctional) Button

The new specialty button, **Parafunctional Habits,** functions similar to the **OHA** button when entering new data. Click the **New** button and today's date imports into the Date field. Today's date is the date of entry or the create date for this finding; and when filed as unfiled data retains the same date when the finding was originally entered.

The History and Clinical Findings fields each have two radio buttons for selection. When the second radio button is selected in each field, multiple options become active for selection. The Other checkbox allows an unlimited text field for additional text information.

The minimal requirement to enter a new parafunctional habit finding is to select only one historical or clinical finding from the Parafunctional Habits screen.

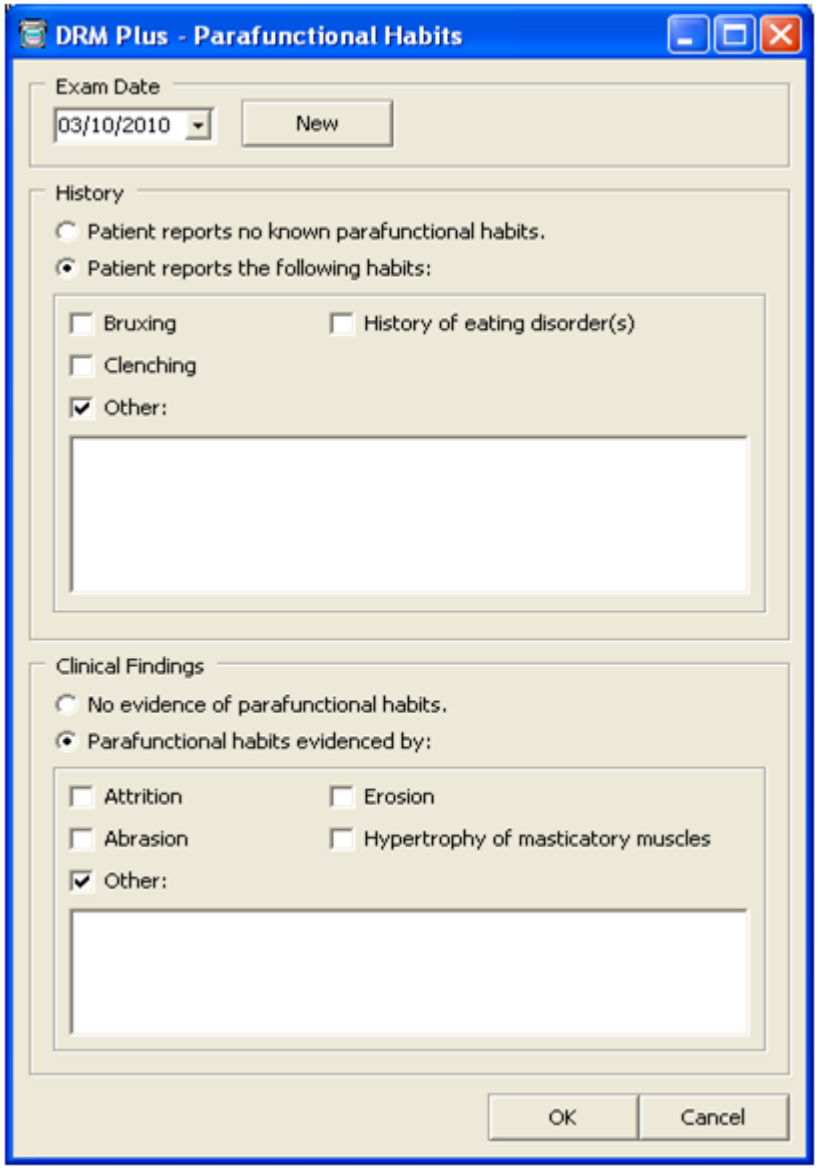


Figure 157: Parafunctional Habits Screen

Social Hx (Social History) Button

The new specialty button, **Social History**, functions similar to the **OHA** button when entering new data. Click the **New** button and today's date imports into the Date field. Today's date is the date of entry or the create date for this finding; and when filed as unfiled data retains the same date when the finding was originally entered.

The minimal requirement is the selection of one of the two History radio buttons. When selecting the second radio button then at least one checkbox option is required to save the new historical data.

Any combination of checkboxes maybe selected for Present/Past. The tobacco and alcohol drop-down options are per day, per week, per month and per year except for the cigarettes. The cigarettes have only the drop-down options of pack year history, per day, and per week. The text box with the Drug Abuse selection is optional when one of the checkboxes is selected. The bottom text box is optional and allows an unlimited text field of formation if selected to enter data about eating disorders, dietary concerns, piercings, etc.

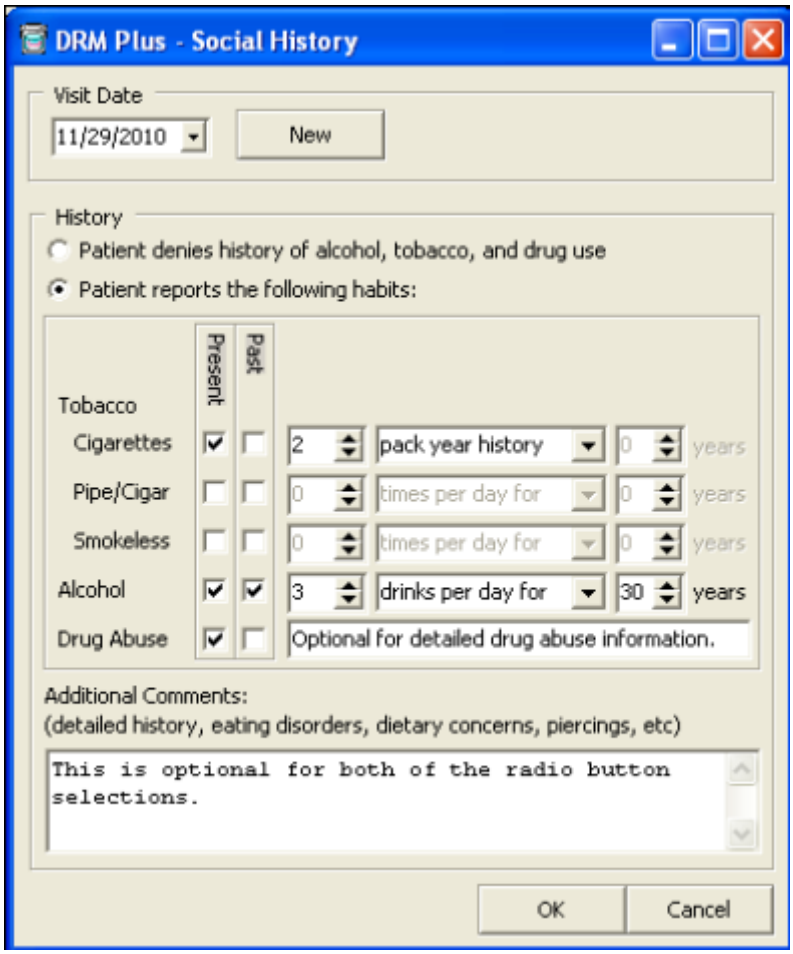


Figure 158: Social Hx (History) Screen

Note: All five of the new modals work like the PSR screen except for one major difference. The major difference in functionality of the new modals is that they allow the provider to clear the exam selection findings during the present session for any of the five new modals by opening that screen and selecting the **Cancel** button.

Filing Multiple Exams to Same Modal Same Day

The following functionality occurs with the new modals when two providers or the same provider files two TIU notes during the same day. The second filing allows the provider to enter new data or edit the previously filed data. This is the functionality for all five new modals that work and display the same as the PSR and Periodontal Chart exams. This functionality only allows the last exam filed during one calendar day to remain in the historical date drop-down field of that screen.

The first provider (HYP) may file an exam in the OHA modal and that data will display in the screen for every other user of DRM Plus to review.

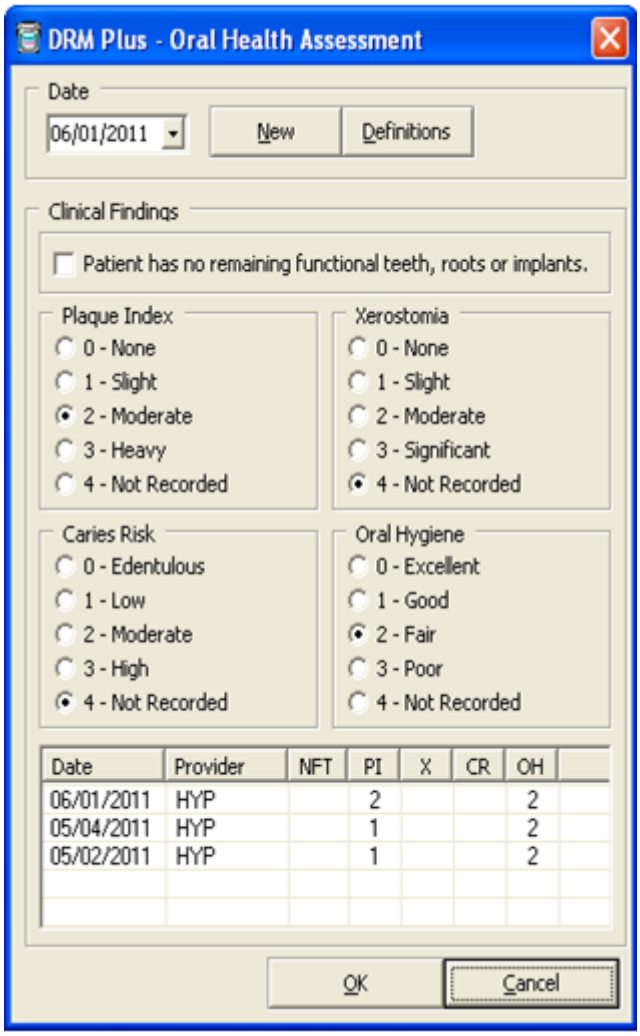


Figure 159: Provider HYP Filed OHA Data First

When the second provider (ADP) filed an edited OHA exam data during the same calendar day; the second provider had to modify the first provider's filed OHA exam. This edited or modified exam, after it has been filed, is the only one present for the local clinical providers when they open this DRM Plus patient's chart.

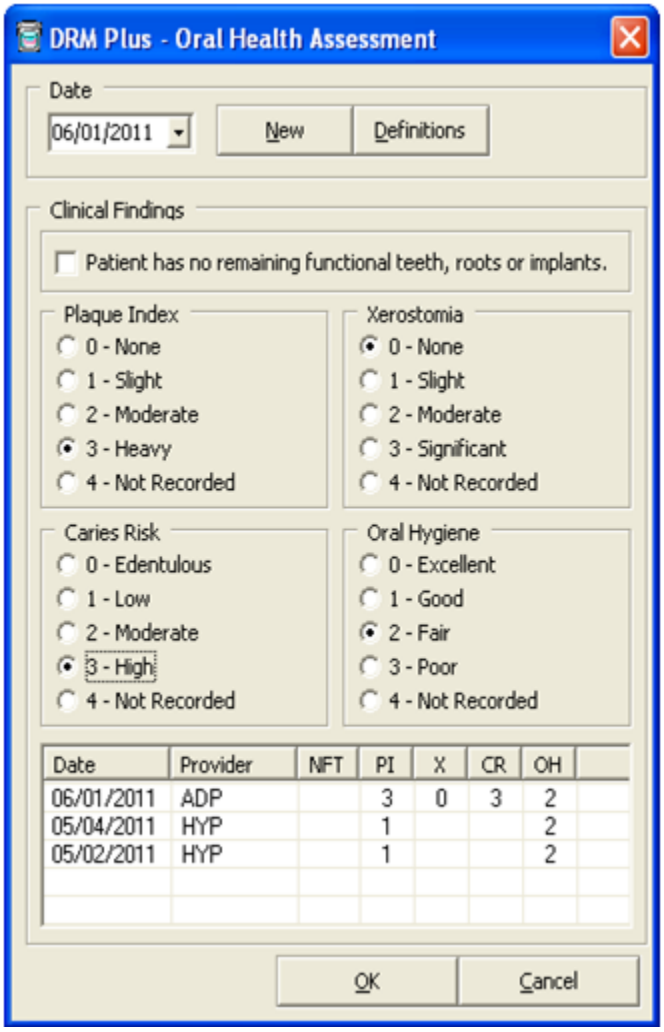


Figure 160: Provider ADP Edited and Filed OHA Data Second

Note: The first provider's exam is only present in their filed TIU note.

Note: The OHA is the only new modal that displays the date and the provider's initials filed with the exam data.

Chart/Treatment-Periodontal Chart

Enter periodontal information on the patient from the Periodontal Chart screen, within the Chart/Treatment tab.

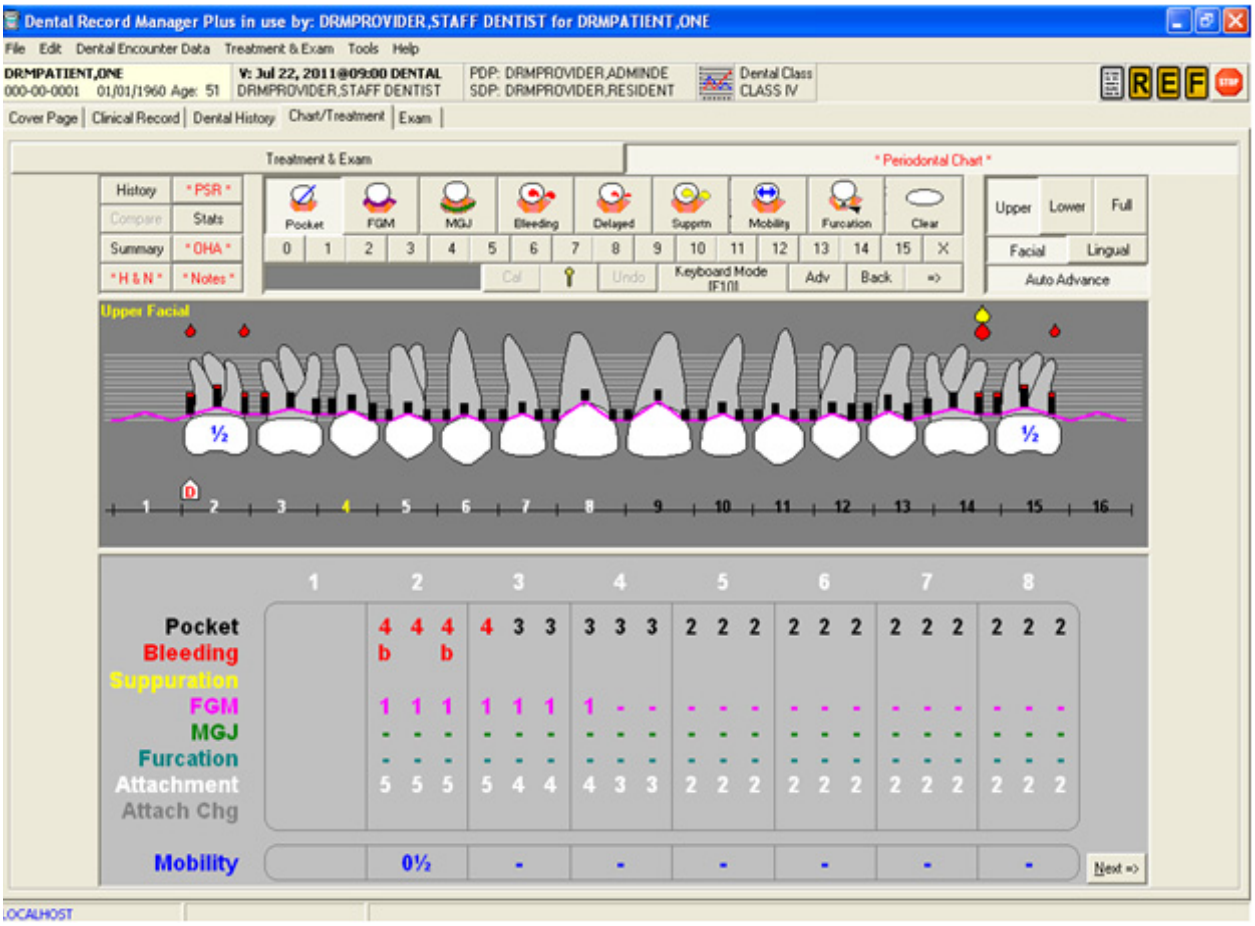


Figure 161: Periodontal Chart Screen

The upper left side of the screen shows the **History**, **Compare**, **Summary**, **H&N**, **PSR**, **Stats**, **OHA** and **Notes** buttons. The top center of the screen displays various periodontal condition-specific icons. Use these to mark periodontal findings on the patient's chart.

Use the options on the upper-right side of the screen to adjust the view of the tooth/arch graphic.

The center of the screen features the tooth/arch graphic. Clicking various areas in combination with the condition-specific icons located in the top center of the screen enters information into the patient's chart.

The bottom of the screen shows text (only a quadrant is viewable depending where the cursor shield 

is located) of the periodontal information entered using the graphic and the condition-specific icons in the top center of the screen.

Note: The Perio Chart allows two providers to enter perio data on the same day; however, it only displays the last perio data that was filed on a given day. The first entered perio data is only viewable in the progress note of the provider that filed the first encounter.

History and Compare Buttons

Clicking the **History** or the **Compare** button displays similar screens.

Use the Compare function to see two periodontal charts for a patient.

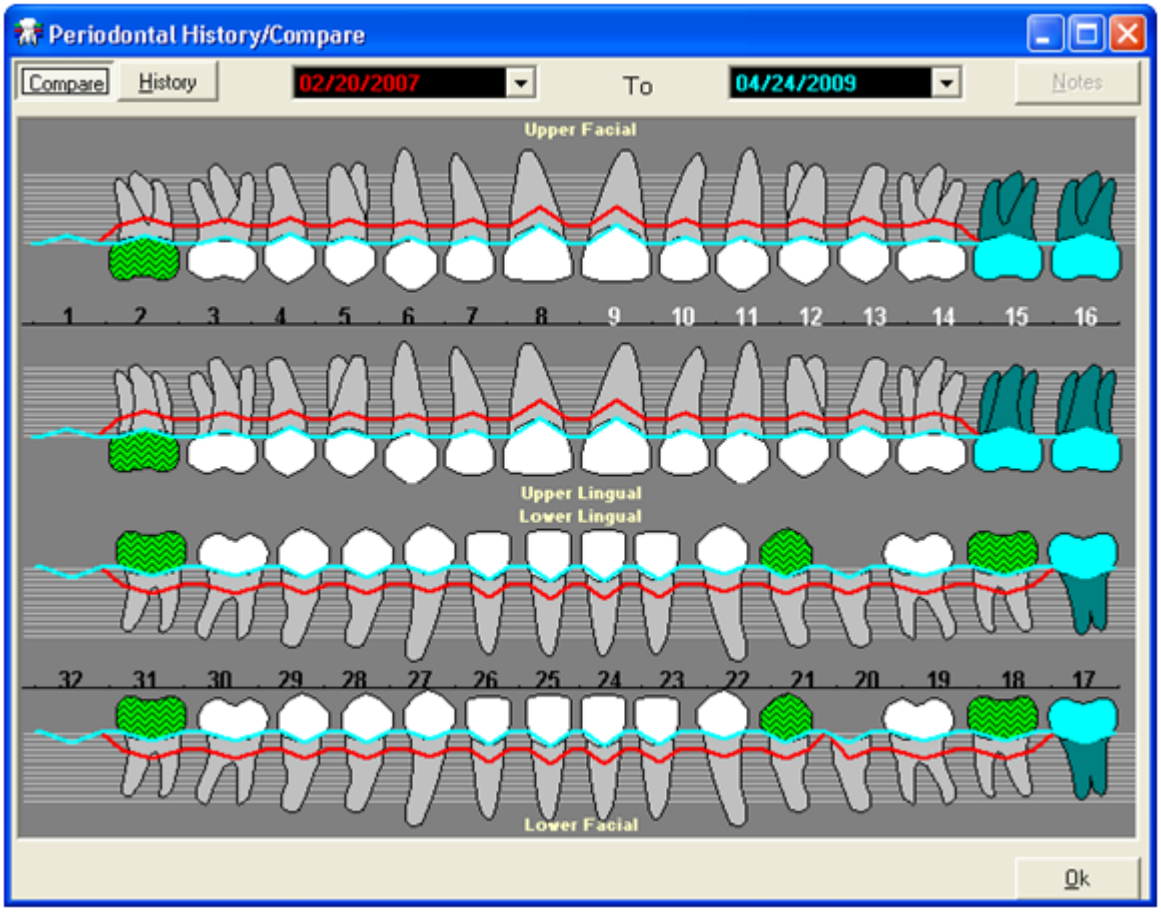


Figure 162: Periodontal History/Compare Screen -- Compare Viewable

The information is color-coded. The data from the first date is displayed in red, while the data from the second date is displayed in blue. Use the drop-down menus to change the dates.

Click the **History** button to view a graphic of the patient's history.

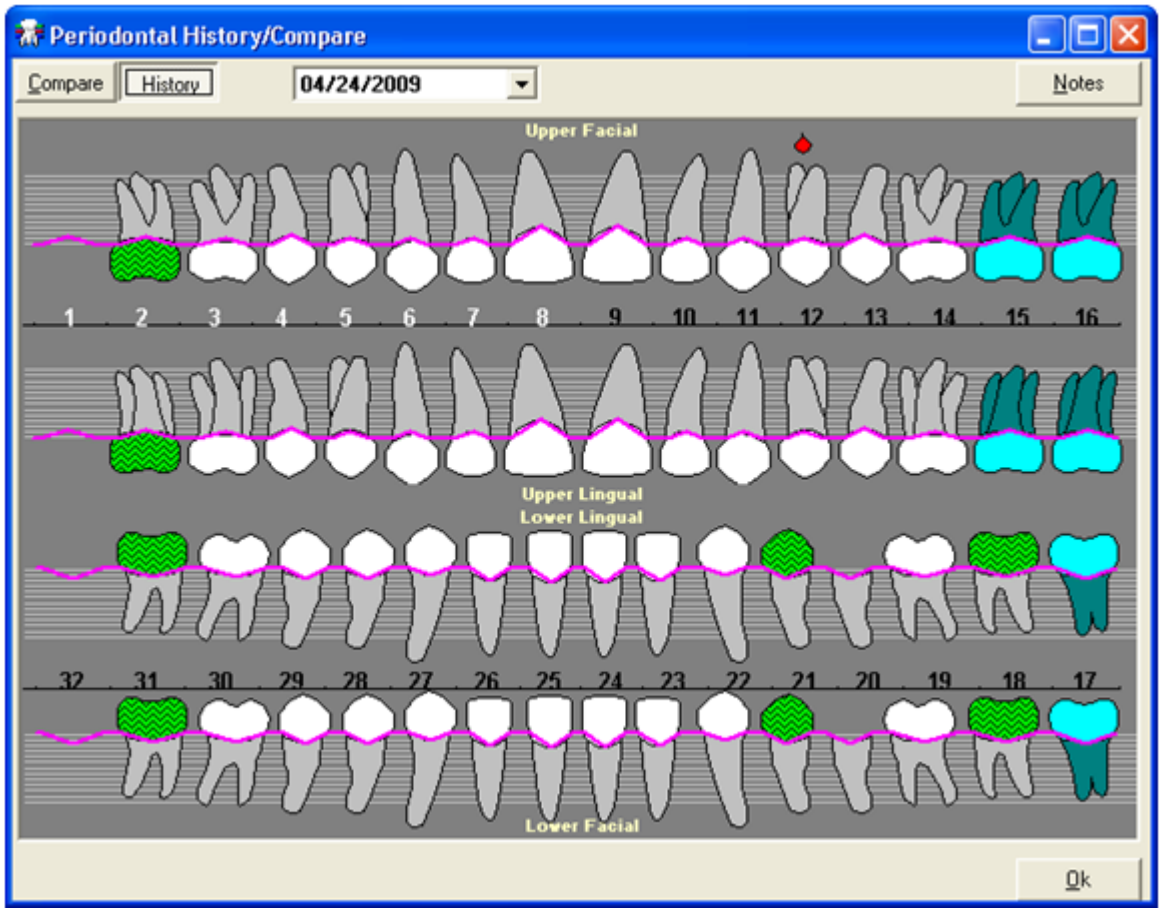


Figure 163: Periodontal History/Compare Screen -- History Viewable

Use the drop-down menu to change the date. Use the **Notes** button to view previously entered notes concerning the patient's periodontal history.

Summary Button

See the Summary Button section in the Chart/Treatment-Treatment & Exam chapter of this manual.

H&N Button

See the H&N Button section in the Chart/Treatment-Treatment & Exam chapter of this manual.

PSR Button

See the PSR Button section in the Chart/Treatment-Treatment & Exam chapter of this manual.

Status Button

Use the Stats function to view the patient's total number of periodontal warning levels.

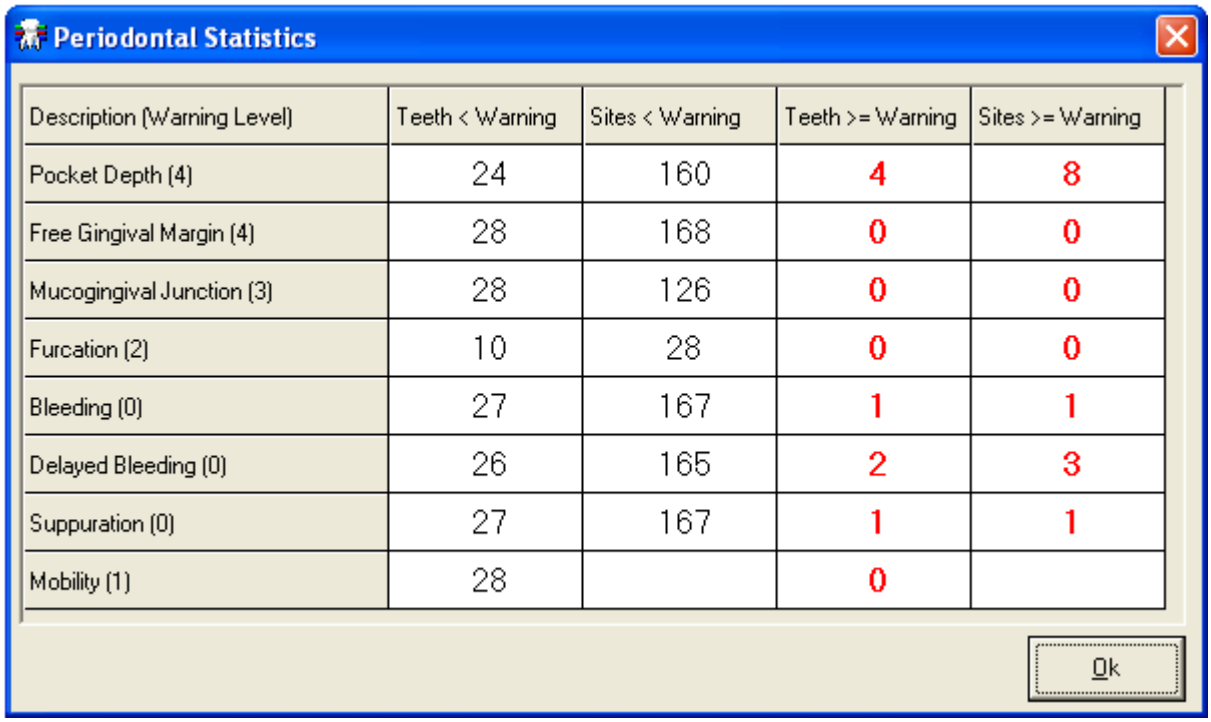
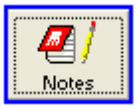


Figure 164: Periodontal Statistics Screen

OHA (Oral Health Assessment) Button

Please see the OHA Button section in the Chart/Treatment-Treatment & Exam chapter of this manual.

Notes Button

Use the Notes button 

to enter general patient notes or tooth specific notes into the chart.

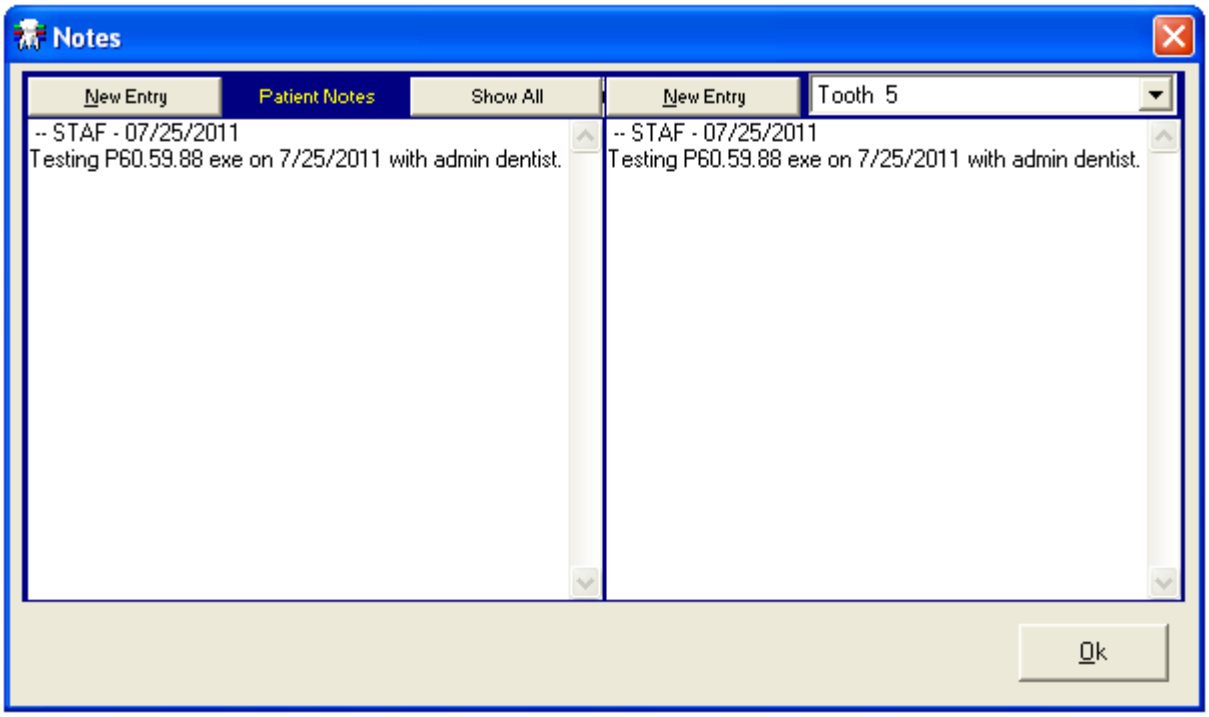


Figure 165: Notes Screen

Choose between creating a more general note on the patient by using the tools on the left side of the screen, or a note about a specific tooth on the right side of the screen.

- To create a new note, click the **New Entry** button.
- To view all general patient notes in the patient's chart, click the **Show All** button.
- To make an entry about a specific tooth, use the drop-down menu on the right side of the screen to select a tooth before making a new entry.

To view any tooth-specific note that has been entered during the past year into the patient's chart, click the **History** button. View the note by clicking the selected history's **Notes** button, according to the appropriate visit date. Note that this is the same screen that appears if the **Notes** icon is clicked on the Treatment & Exam screen.

Entering Periodontal Information

The condition-specific icons in the top center of the screen work in combination with the tooth/arch graphic.

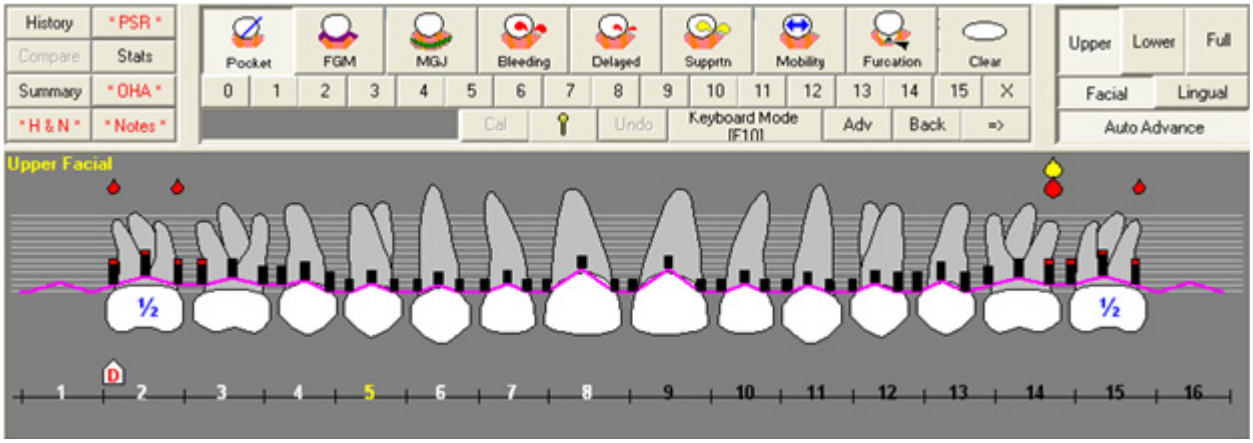


Figure 166: Periodontal Icons and Periodontal Graphical Chart

To enter periodontal information:

1. Click the desired condition-specific icon (Pocket, FGM, Bleeding, Mobility, etc.).
2. On the graphic, the cursor shield  is the graphical pocket location for perio data entry.
3. Click the desired number below the list of condition icons (if applicable). Bleeding, Delayed Bleeding and Suppuration don't require any clicks on a number.
4. Use the buttons on the top right of the screen to view different areas of the tooth/arch, or to change the view.
5. The condition and location appears on the graphic and on the transaction table below the graphic. The transaction table only displays a quadrant of the upper/lower arch.

Note: Only one Periodontal Chart exam is allowed to be completed in a Progress Note per day, per patient. When a second exam is completed during the same day, the Periodontal Chart history only saves the second exam. Progress Notes in VistA TIU still have all the data entered.

Other Tools

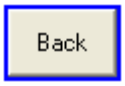
The last line of buttons in the top center of the screen features several tools.

 Displays keyboard shortcuts.

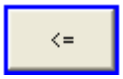
Undoes the last action performed on the screen. This action is limited to the last nine actions performed.

Switches the program to Keyboard mode.

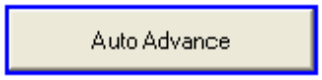
Moves the cursor shield on the graphic forward due to the direction of the arrow.



Moves the cursor shield on the graphic back due to the direction of the arrow.



Shows the direction the cursor shield will move on the graphic. The direction of advancement depends on the orientation of this button.



When this button is active, the cursor shield automatically moves in the way designated for the perio exam entry of the condition-specific icons. It does not allow Bleeding, Delayed Bleeding, or Suppuration, to automatically move.

The auto exam sequence is a parameter adjustment that may be redesigned by each provider. For more information, see the Treatment & Exam/Show Configuration/Periodontal section of the Using the DRM Plus Drop-Down Menus chapter of this manual.

Exam

Providers have the ability to file required data using a national standard exam style format for each exam/consult code (D0120, D0140, D0150, D0160, D0170, D0180 and D9310) in conjunction using the new Exam tab in DRM Plus. Mandatory elements for each exam/consult code and requirements for each element are based on the user's exam/consult code selection. Initially each element will be marked with required or optional icon. The new Exam tab interfaces automatically with existing DRM Plus components (i.e. Head & Neck) for easy data entry. The Exam tab when activated will generate a progress note associated with a specific visit containing the entire exam or consult's required information, along with other DRM Plus note objects (i.e. dental alerts, etc).

To proceed into the Exam tab, the user is prompted to select one of the six exams or consult procedure codes from the Chart/Treatment tab's Completed Care screen.

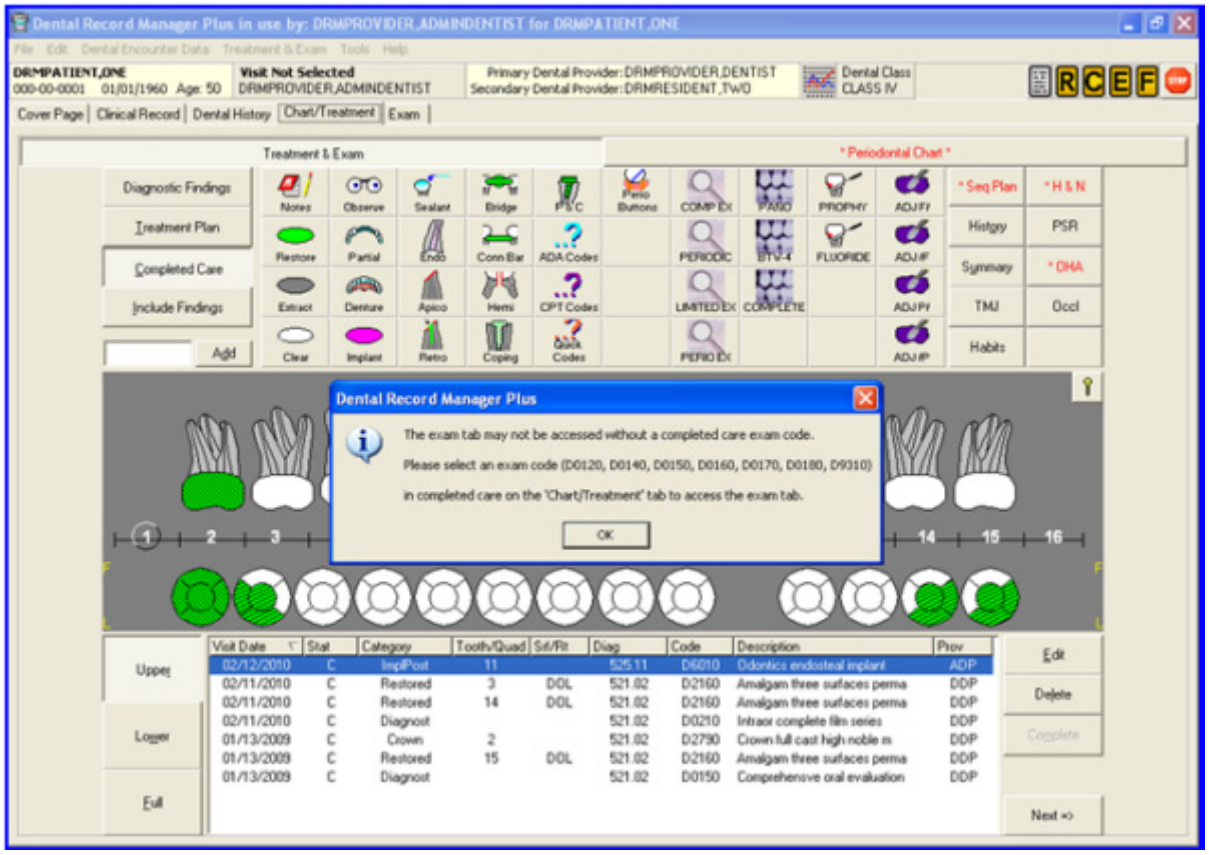


Figure 167: Exam Message

Entering the exam/consult procedure activates the Exam tab and displays the procedure in the Exam Type drop-down menu. One way to change the exam/consult procedure after selecting it and determining it was incorrect is to use the drop-down menu located on the Exam tab. Another way to change the exam/consult procedure is deleting the procedure from the Completed Care view screen and entering a new one.

Selecting the exam/consult code from the Completed Care view screen triggers all of the elements on the Exam tab with a required icon or optional icon . When these elements are satisfied, a completed icon will display. Some elements automatically pull data from the modals when entered from the Chart/Treatment tab.

Note: Users may enter additional optional information in each element, if desired, for the selected exam/ consult code.

In the following example, the D0150, comprehensive exam, was selected from the Treatment & Exam/ Completed Care view screen. Upon selecting the Exam tab, D0150 Comprehensive displays in the Exam Type drop-down menu. Twelve of the sixteen elements requires data entry by the provider when selecting the D0150, comprehensive exam.

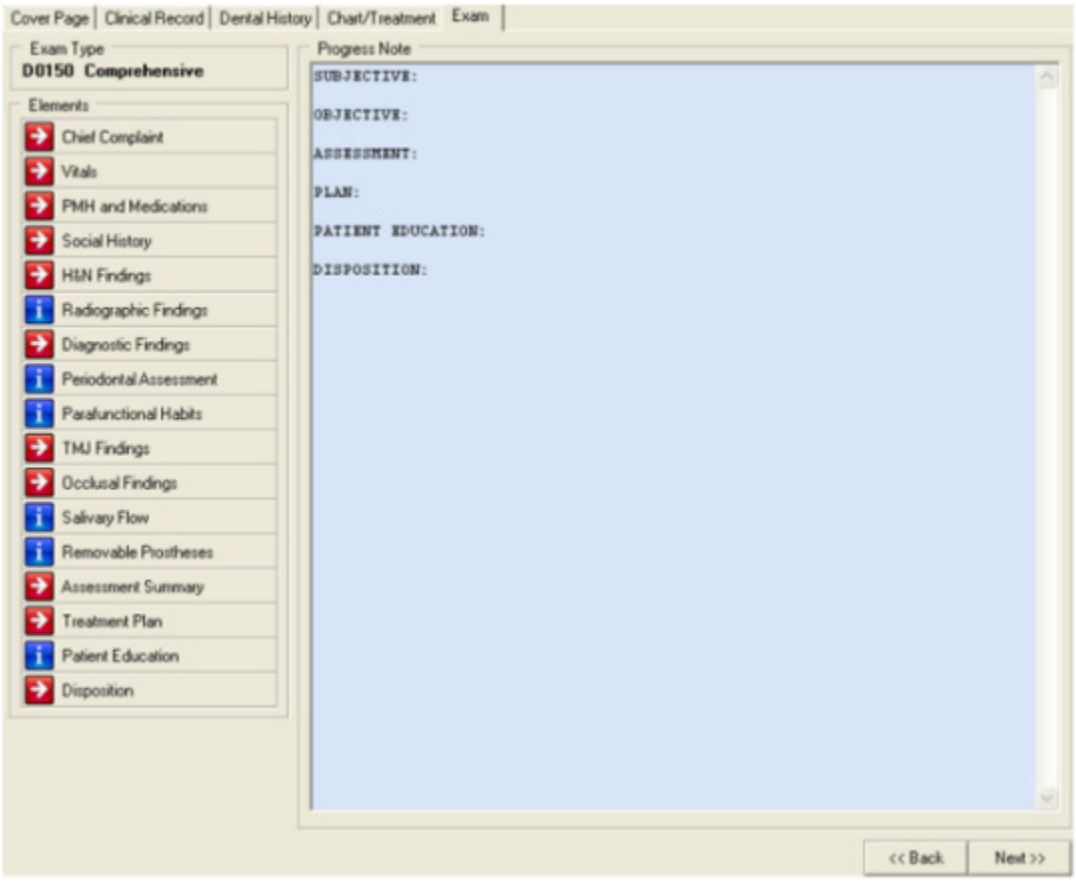


Figure 168: Exam Tab

The seven exam/consult codes each have a different set of required and optional elements activated when selecting a specific code. The dialogue found in each element section that follows are those that would display if the user selected D0150, comprehensive exam, during a session.

The **Back** button located on the Exam tab screen returns the end-user to the Chart/Treatment tab.

The **Next** button located on the Exam tab allows the end-user to proceed to the Filing Options screen which is the next screen when completing the encounter. This **Next** button also opens any required element if that element hasn't been completed.

The **Back/Next** buttons located on each element screen only moves backward or forward to other element screens. The buttons allow the provider to move to the next required element for this exam type depending on the parameter the end-user has selected. Usage of the **Back** button is not dependent on the element's completion.

Exam Elements

Presentation/Chief Complaint Element

The Presentation/Chief Complaint element is required for all seven exam/consult procedure codes and will automatically open when the Exam tab is selected. The presentation of the exam/consult code is automatically imported and displayed at the top of the element. This element requires one of the two radio buttons to be selected. The selection of the second radio button opens two text boxes which require a text entry only in the first text box intended for the dental complaint of the patient. The second text box (optional text entry) allows data entry for the history of patient's present illness.

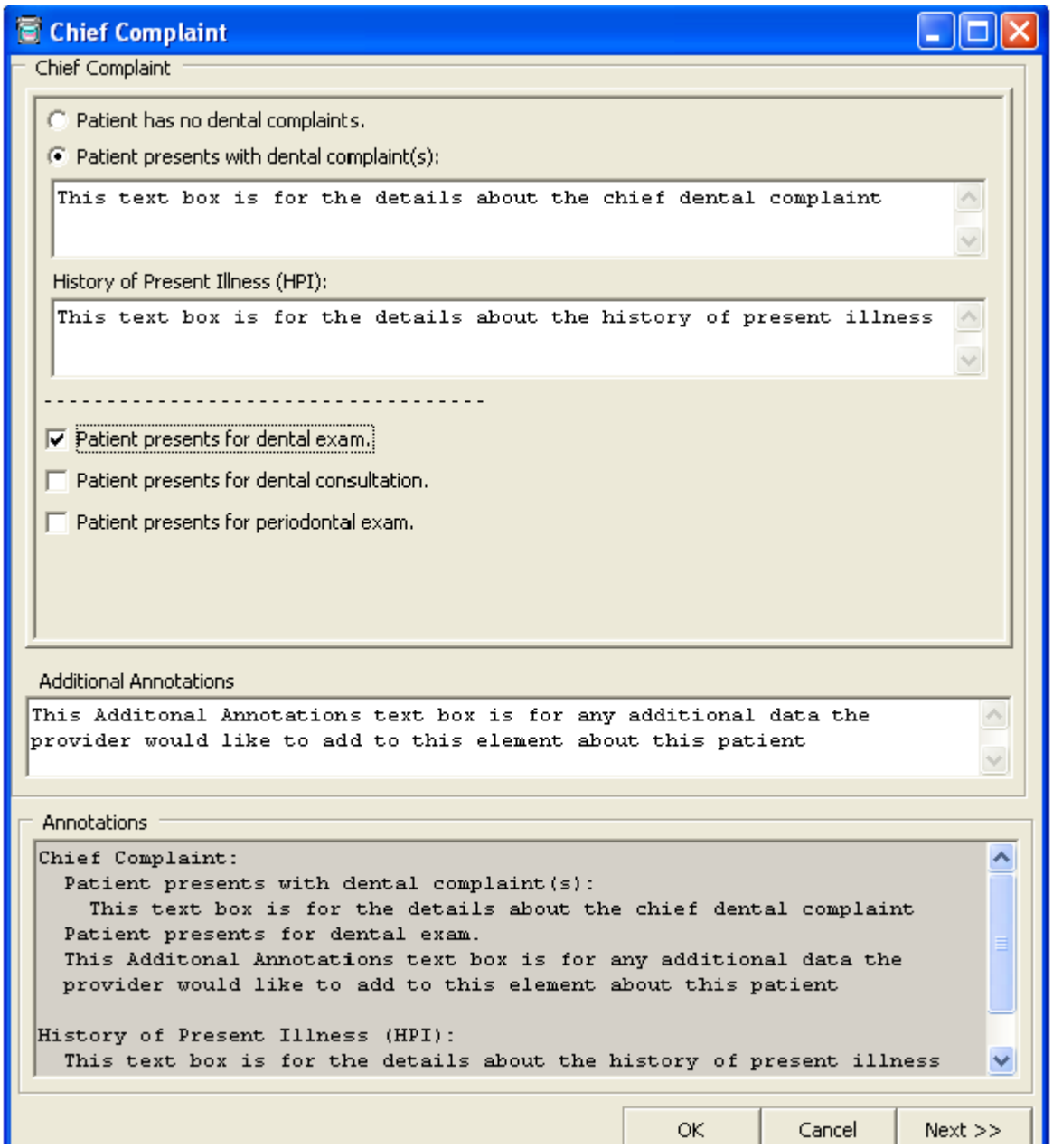


Figure 169: Chief Complaint

The following information is the same with all 16 elements except the Presentation/Chief Complaint does not have a **Back** button and the Disposition does not have a **Next** button.

The Additional Annotations is a free text window, which allows the provider to enter additional information about the patient's chief complaint. It offers right click functionality of import .txt files if desired.

The Annotations is a view-only, and captures everything entered into this element.

Select the **OK** button to save all required information entered and close the element or to move to the next required element, depending on the selected parameter, click the **Next** button.

The **Back** button moves to the previous required element, depending on the selected parameter, and is not dependent on the element's completion.

Vitals Elements

The Vitals element is required for all seven exam/consult procedures. This element requires one of the two radio buttons to be selected. The **second radio button** defaults to any vitals that have been entered, using Vitals Lite, during 24 hours of the visit date. The Visit/Date for this encounter also must be entered in the banner for this feature to work. Entering the Visit/Date should be the first action taken when opening any patient's chart for a new encounter.

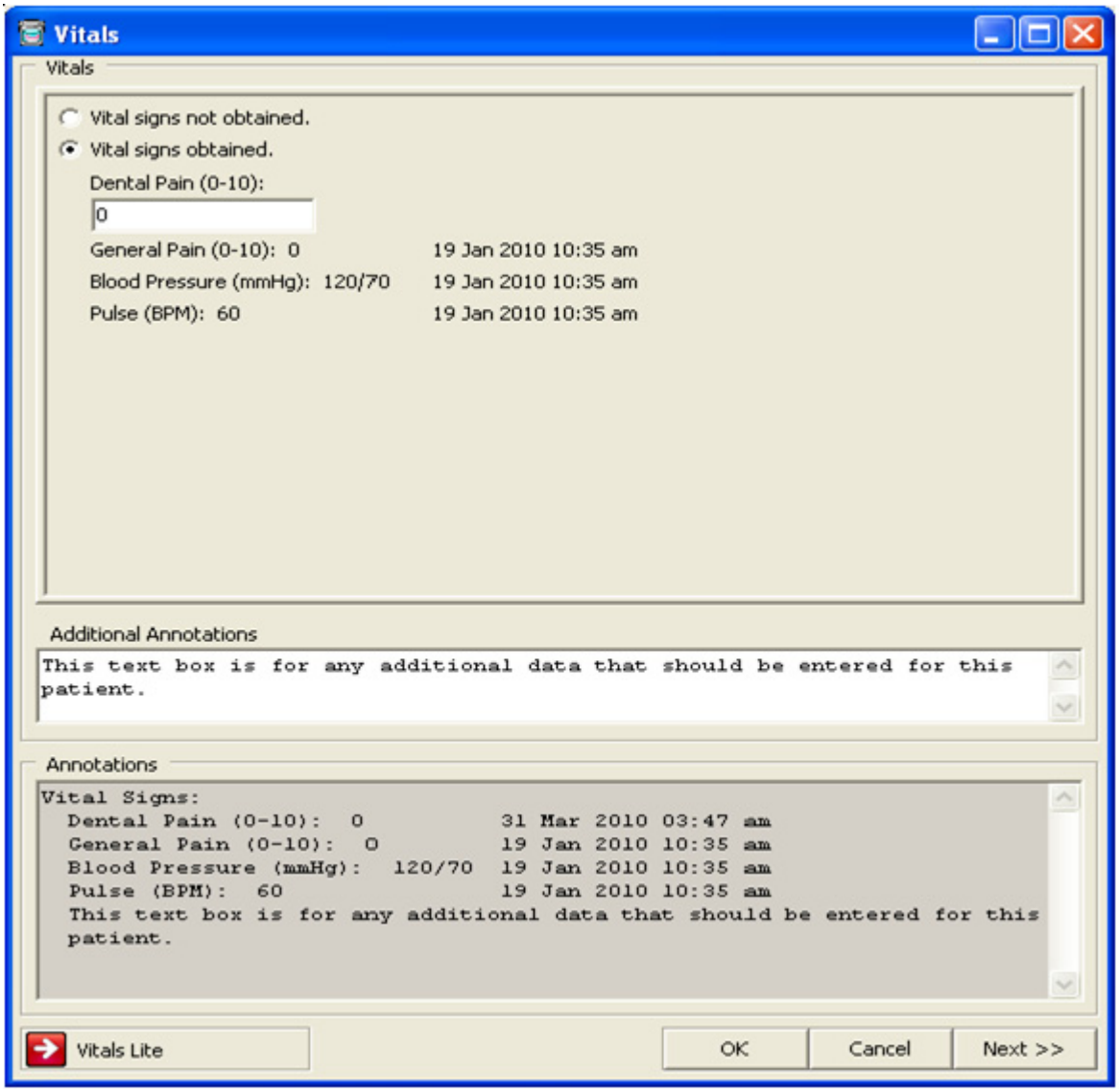


Figure 170: Vitals Element

If no vitals have been entered using Vitals Lite, the information can be entered manually; however, no date is attached to these entries. Dental Pain is the only required vital sign.

To enter today's vitals, click the Vitals Lite  button, found on the DRM Plus banner. The user can also click the **Vitals Lite** button in the lower left portion of the Vitals element screen.

Specific vitals information can be entered into the Additional Annotations free text window. Right-click in this window to import text files, if desired. All information entered into the Vitals element appears in the read-only Annotations window. Once the element is complete, click the **Next** button to move to the next element or the **OK** button to close the element. The **Back** button moves to the previous required element, depending on the selected parameter, and is not dependent on the element's completion.

Note: The only vital sign, Dental Pain, may be saved as unfiled data for this element.

PMH (Past Medical History) and Medications Element

The PMH element is required for all seven exam/consult procedures. This element requires one of the three radio buttons to be selected. The selection of the first radio button opens an optional text box to enter additional information if the patient is new to the clinic. The selection of the third radio button opens a required text box to enter any significant changes noted since the last dental visit.

The eight positive/negative checkbox conditions, one free text positive condition or the five Imports checkboxes are optional entries of patient information for this element. The user may select one import such as the patient's medications or use the Select ALL Imports button to import all four previously filed medical histories about the patient which is being stored in a VistA Fileman database.

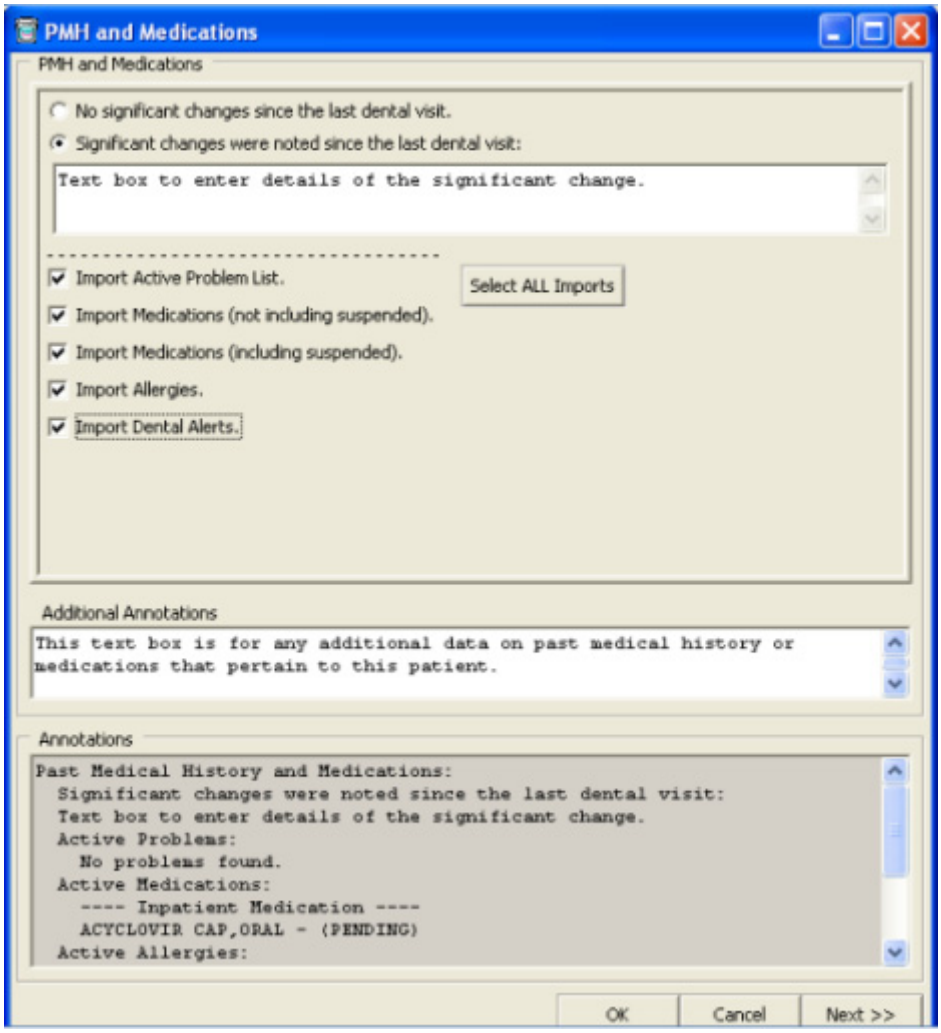


Figure 171: PMH Element

The Additional Annotations is a free text window, which allows the provider to enter additional information about the patient's chief complaint. It offers right click functionality of import .txt files if desired. The Annotations is a view-only, and captures everything entered into this element.

Once the element is complete, click the **Next** button to move to the next element or the **OK** button to close the element. The **Back** button moves to the previous required element, depending on the selected parameter, and is not dependent on the element's completion.

Social History Element

The Social History element is required for the D0150 and D0180 exams. This element requires new Social History findings entered with the Social History screen when completing one of the two required exams.

The Social History screen may be opened with the specialty button located on the Chart/Treatment tab or by the Social History button located in the lower left corner of this screen. The minimal requirement to enter a new Social History entry is to select at least one historical finding from the Social History screen.

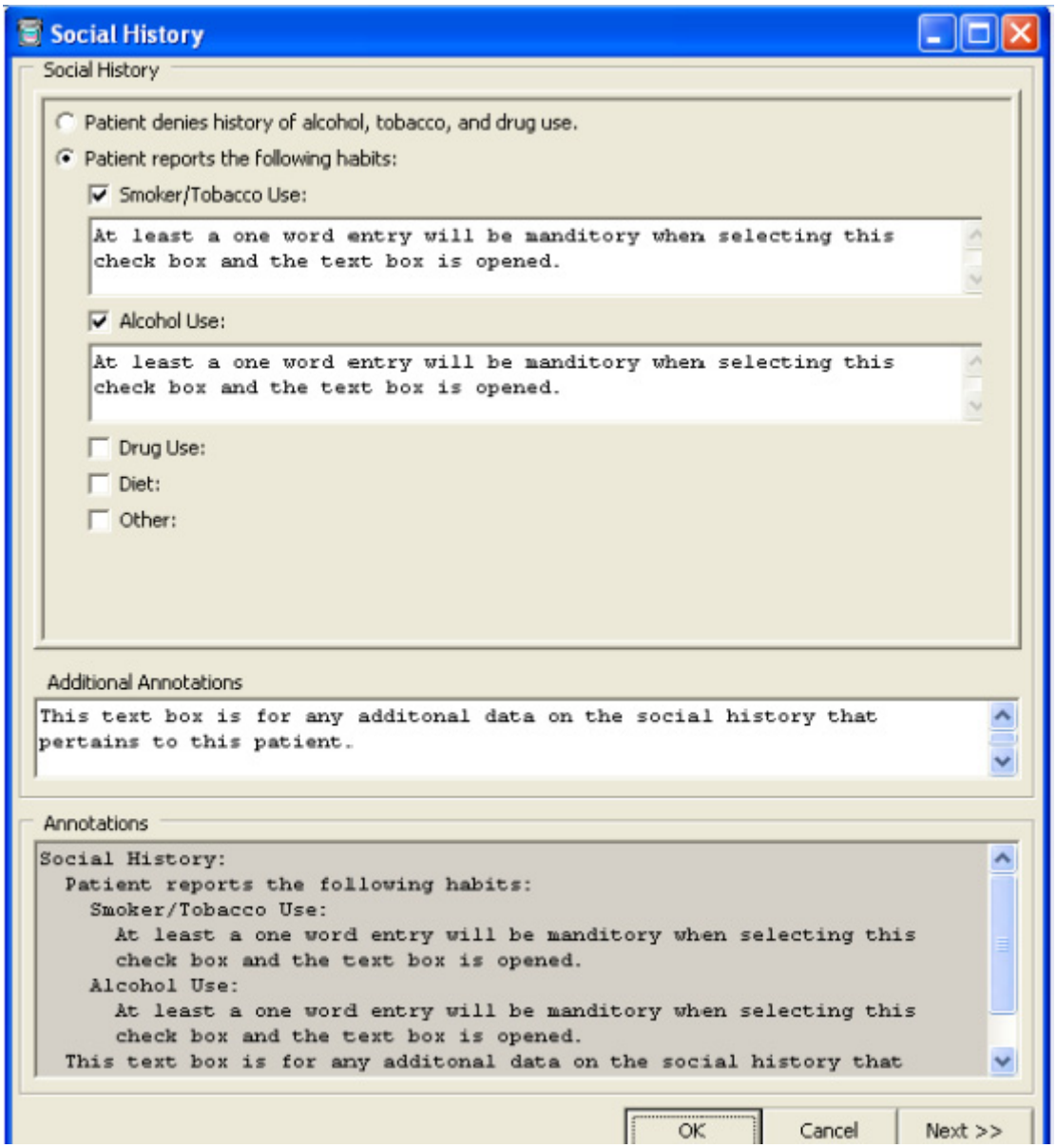


Figure 172: Social History Element

Additional information regarding the patient can be entered into the Additional Annotations window. Right-click in this window to import text files, if desired. All information added to this element appears in the read-only Annotations window. Once this element is complete, click the **Next** button to move on to the next element.

H&N (Head and Neck) Findings Element

The H&N Findings element is required for the D0120, D0150 and D0180 exams. This element requires a new H&N finding or historical entry using the H&N Findings screen. This element imports data entered from the H&N Findings screen. The Screening Negative button on this element's screen allows a new screening negative entry directly into the element and imports it into the H&N Findings screen for the patient's permanent record.

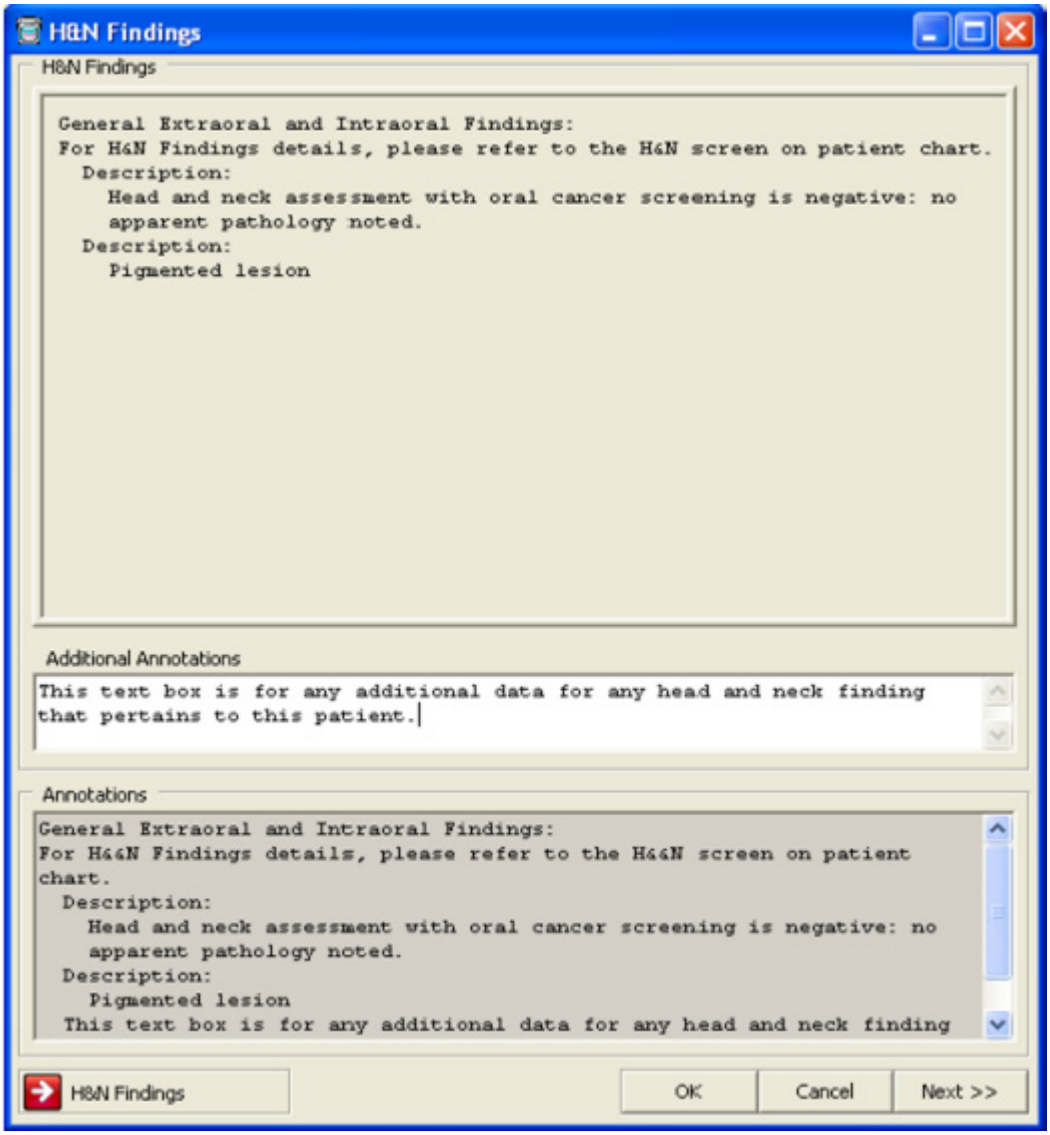


Figure 173: H&N Findings Element

The H&N Findings screen can be accessed either by clicking the specialty button from the Chart/Treatment tab, or simply clicking the **H&N Findings** button in the left bottom corner of this element. Once the H&N findings are added to this element, additional information regarding the patient can be entered in the Additional Annotations free text window. Right-click in this window to import text files, if desired.
All information entered into this element appears in the read-only Annotations window. Once the element is complete, click the **Next** button to move on to the next element.

Radiographic Findings Element

The Radiographic Findings element is required for the D0150 and D0180 exams. The radiographic element requires at least one selected checkbox from the top six options. The provider may select any combination of the top six checkboxes for the patient's progress note. The fourth checkbox down the left column requires some data entry in the text box or at least one per-defined statement to satisfy the requirements.

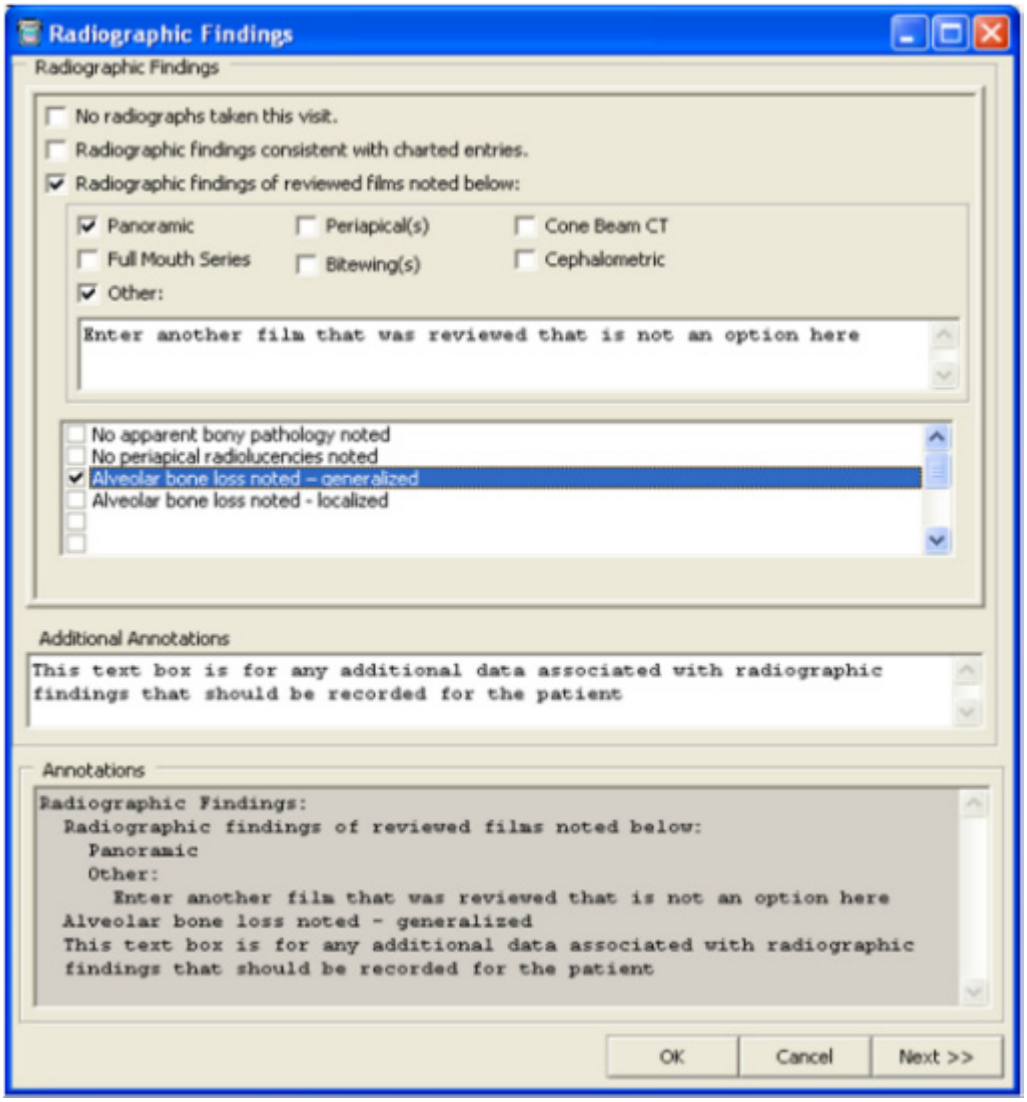


Figure 174: Radiographic Findings Element

Up to 12 pre-defined statements on radiographic findings can be selected from this screen. The checkboxes found in the pre-defined statements window have three national radiographic findings statements preloaded; however, all 12 statements can be created locally.

The DRM Administrator has priority over all other users and may add or delete all twelve, if desired. Additional information regarding the patient can be added in the Additional Annotations free text window. The user can right-click to import a text file, if desired. All information entered into this element appears in the Annotations read-only window. Once the element is complete, click the **Next** button to move on to the next element.

Diagnostic Findings Element

The Diagnostic Findings element is required for all seven exam/consult procedures. All exam/consult codes require as appropriate for new and updated findings. The second checkbox only displays after data is entered from another Chart/Treatment findings screen that satisfies this option. Informational screens inform the user of any missing requirements for a specific exam code.

The NFT, no functional teeth, checkbox when selected in the OHA screen bypasses all requirements in this element for all exam/consult procedures. The OHA screen may be opened from the Chart/Treatment tab or by selecting the **OHA** button in the lower left area of this screen.

- D0120: Requires a Plaque Index entry from the OHA screen. Also requires the selection of a Mobility radio button, as it pertains to the patient.
- D0150: Requires at least one entry from the Diagnostic Findings screen or the first checkbox of no apparent pathology selected. Requires a Plaque Index entry from the OHA screen. Also requires the selection of a Mobility radio button, as it pertains to the patient.
- D0180: Requires an Oral Hygiene entry from the OHA screen.

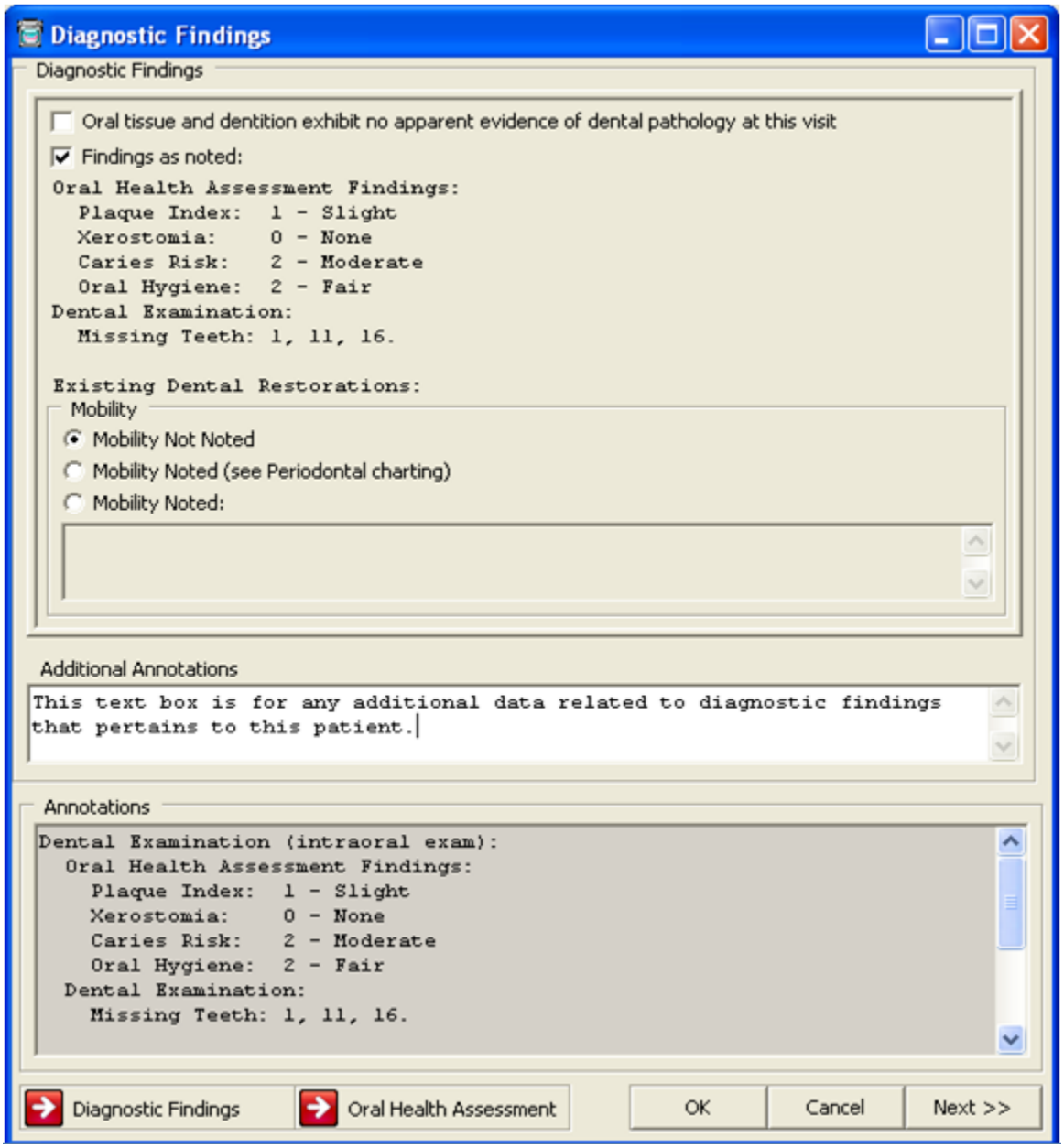


Figure 175: Diagnostic Findings Element

The user can enter any additional information regarding the patient into the Additional Annotations free text window. Right-click in this window to import a text file, if desired. All information entered into this element appears in the read-only Annotations window. Once the element is complete, click the **Next** button to move on to the next element.

Periodontal Assessment Element

The Periodontal Assessment element is required for the D0120, D0150 and D0180 exams. The D0120 and D0150 exams required at least one selection from the Periodontal General Assessment section. The **Detailed Assessment** button allows the user to enter additional perio data; however, this is optional for the D0120 and D0150 exam codes.

The checkbox, Include Last Perio Chart, defaults as unchecked if the provider would like to import the last filed Periodontal Chart into this element. The checkbox, Include Last Perio Chart, when selected satisfies the requirements for this Periodontal Assessment element for the D0140, D0160, D0170 and D9310 procedures.

When any new perio data has been added to the perio chart this session that data will import into this element and satisfy the same four exam/consult procedures as stated in the previous paragraph.

The NFT, no functional teeth, checkbox when selected in the OHA screen will bypass all requirements for the D0120, D0150 or D0180 exams in the periodontal element. The user may access the Periodontal Chart screen, OHA screen or PSR screen using the buttons found on this Periodontal Assessment element screen.

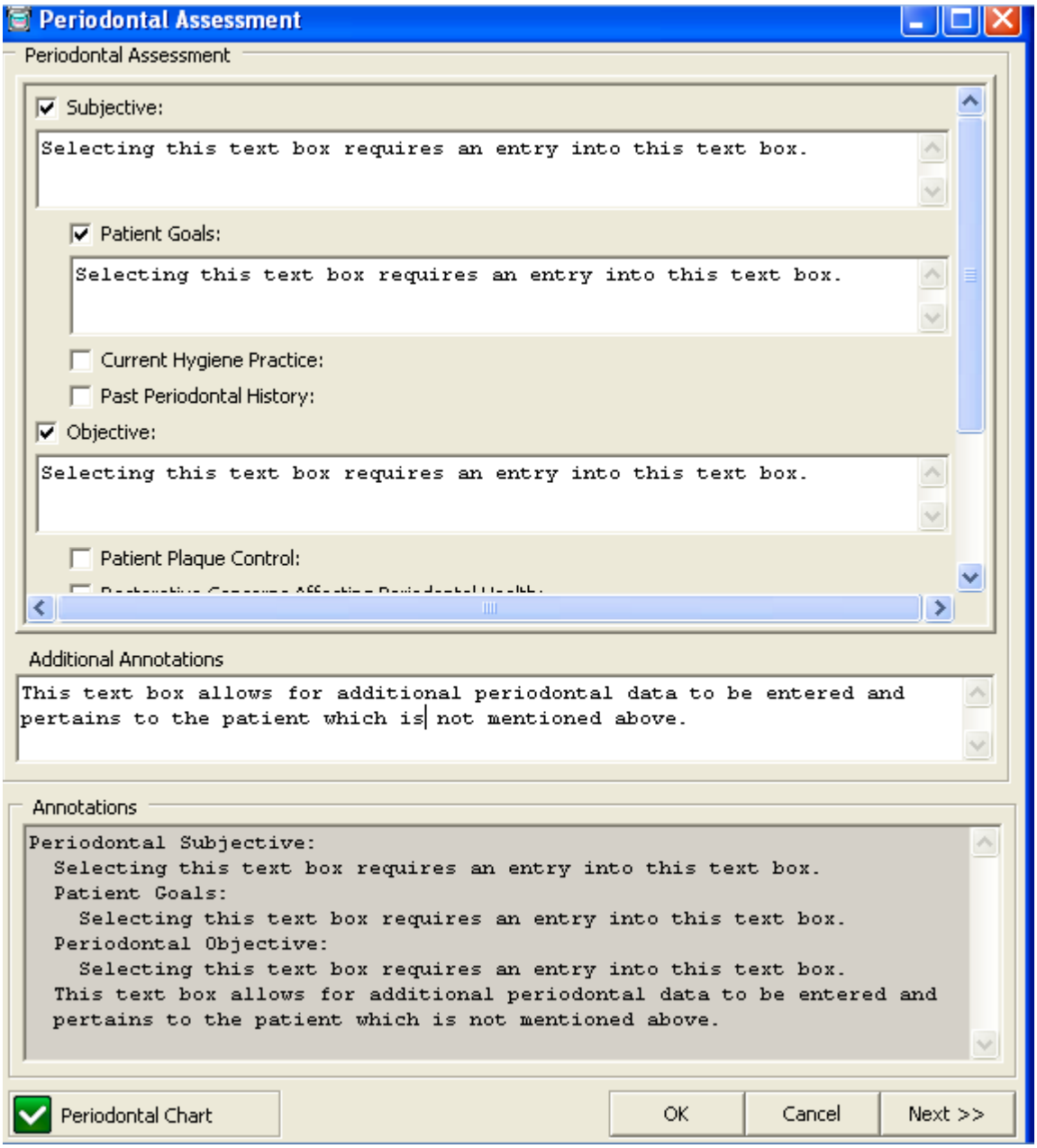


Figure 176: Periodontal Findings Element

The D0180 exam requires one selection from the Periodontal General Assessment section as well. The Periodontal Detail Assessment section is optional and has optional text boxes with each selection if more descriptive detail is needed.

The D0180 exam also requires the first four rows in the Additional Periodontal Details to have at least one selection. The last Additional Periodontal Comments text box is optional in this section. When the Other checkbox is selected from the Past Periodontal Tx History row, it will require data entry in the Additional Periodontal Comments text box.

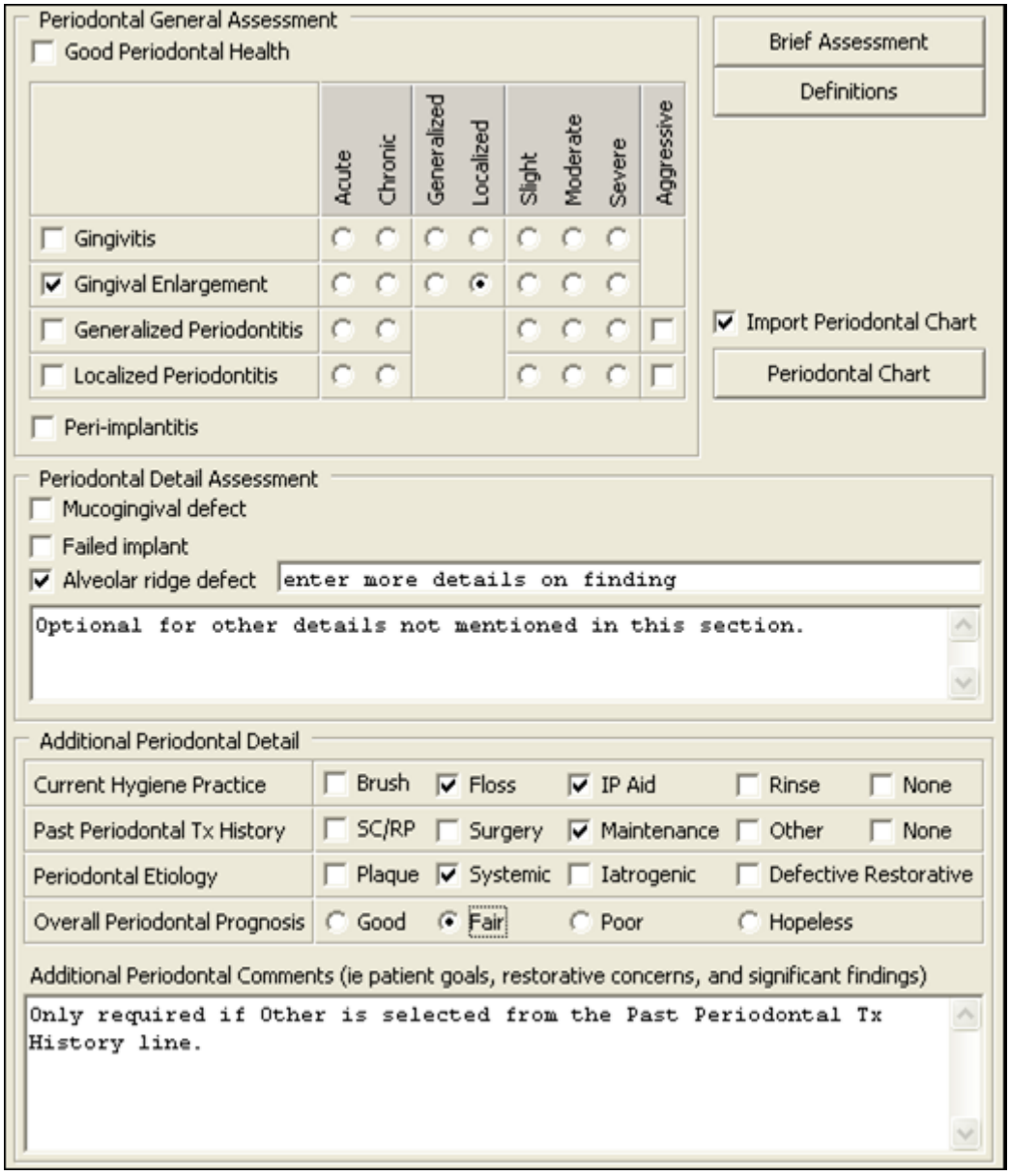


Figure 177: Periodontal General Assessment

Note: The D0180 exam code does not allow the user to select the **Brief Assessment** button from this screen.

Additional information regarding the patient may be entered into the Additional Annotations free text window. The user may right-click in this window to import a text file, if desired. All information entered into this element appears in the read-only Annotations window. Once this element is complete, click the **Next** button to move on to the next element.

The provider may open the OHA screen or the PSR screen using the buttons in the lower left area of this screen or the Chart/Treatment tab to enter an OHA finding or a PSR exam. The Periodontal Chart button on the middle right side of this screen allows access to that chart to enter any new findings this session. The following dialog displays the VA Office of Dentistry perio definitions.

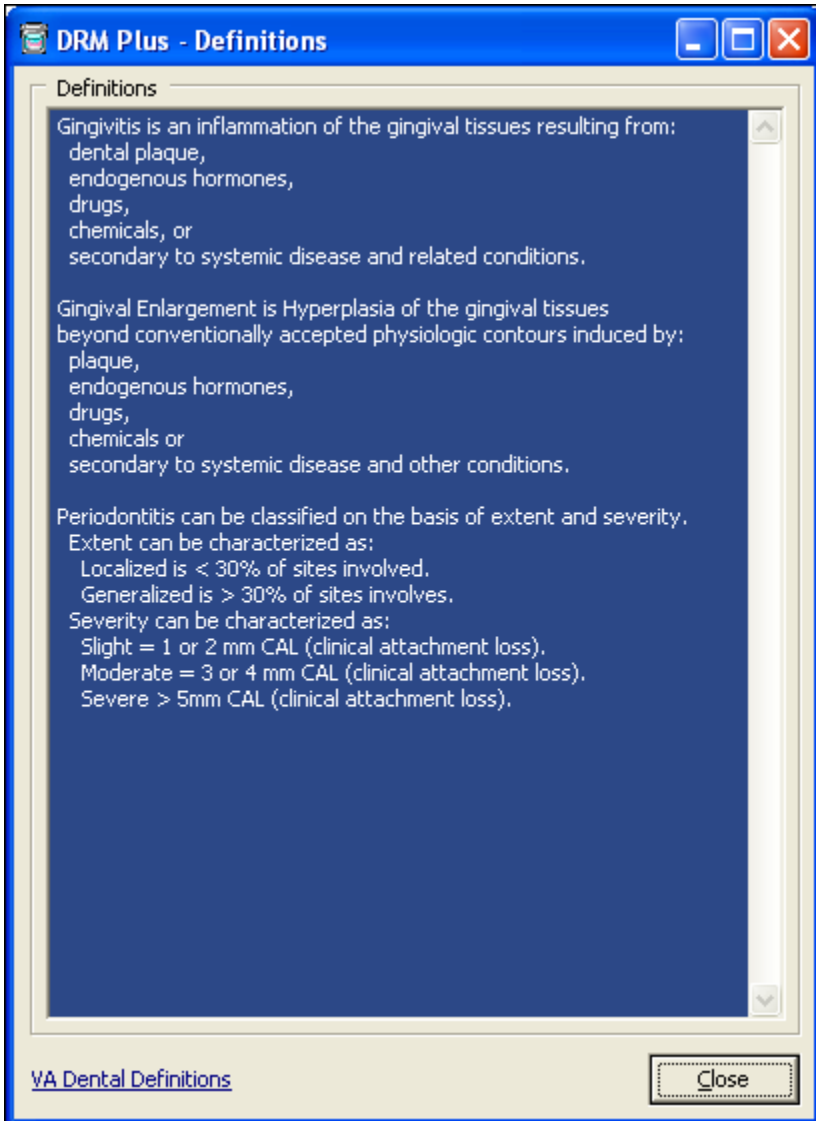


Figure 178: VA Dentistry Definitions

Parafunctional Habits Element

This element is optional for all seven exam/consult types. It imports all data entered this session from the Parafunctional Habits screen, or simply is left blank. The Parafunctional Habits screen can be opened by clicking the specialty button from the Chart/Treatment tab, or by clicking the **Parafunctional Habits** button in the bottom left portion of this element.

The minimal requirement to enter a new Parafunctional Habit finding is to select at least one history or one clinical finding from the Parafunctional Habits screen.

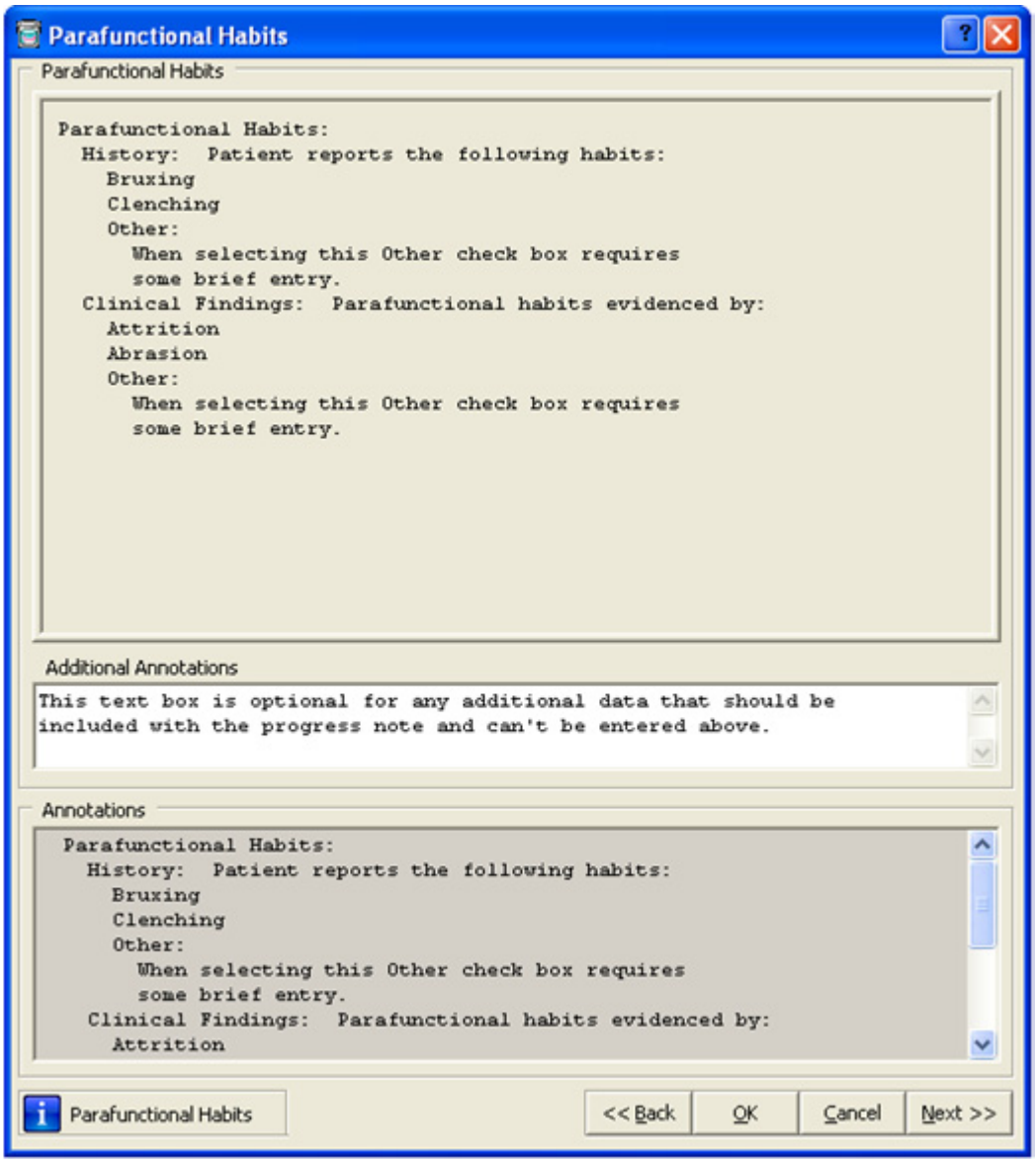


Figure 179: Parafunctional Habits Element

Additional information regarding the patient may be entered into the Additional Annotations free text window. The user can right-click in this window to import a text file, if desired. All information entered into this element appears in the read-only Annotations window. Once this element is complete, click the **Next** button to move on to the next element.

TMJ Findings Element

This element is required for the D0120, D0150 and D0180 exams. It requires new TMJ Findings entered from the TMJ screen, which can be opened either by clicking the **TMJ specialty** button from the Chart/ Treatment tab, or the **TMJ Findings** button located in the bottom left portion of this element.

The minimum requirement to enter a new TMJ exam finding is to select at least one historical or clinical finding from the TMJ screen. Additional information regarding the patient can be entered into the Additional Annotations free text window. The user can right-click in this window to import a text file, if desired.

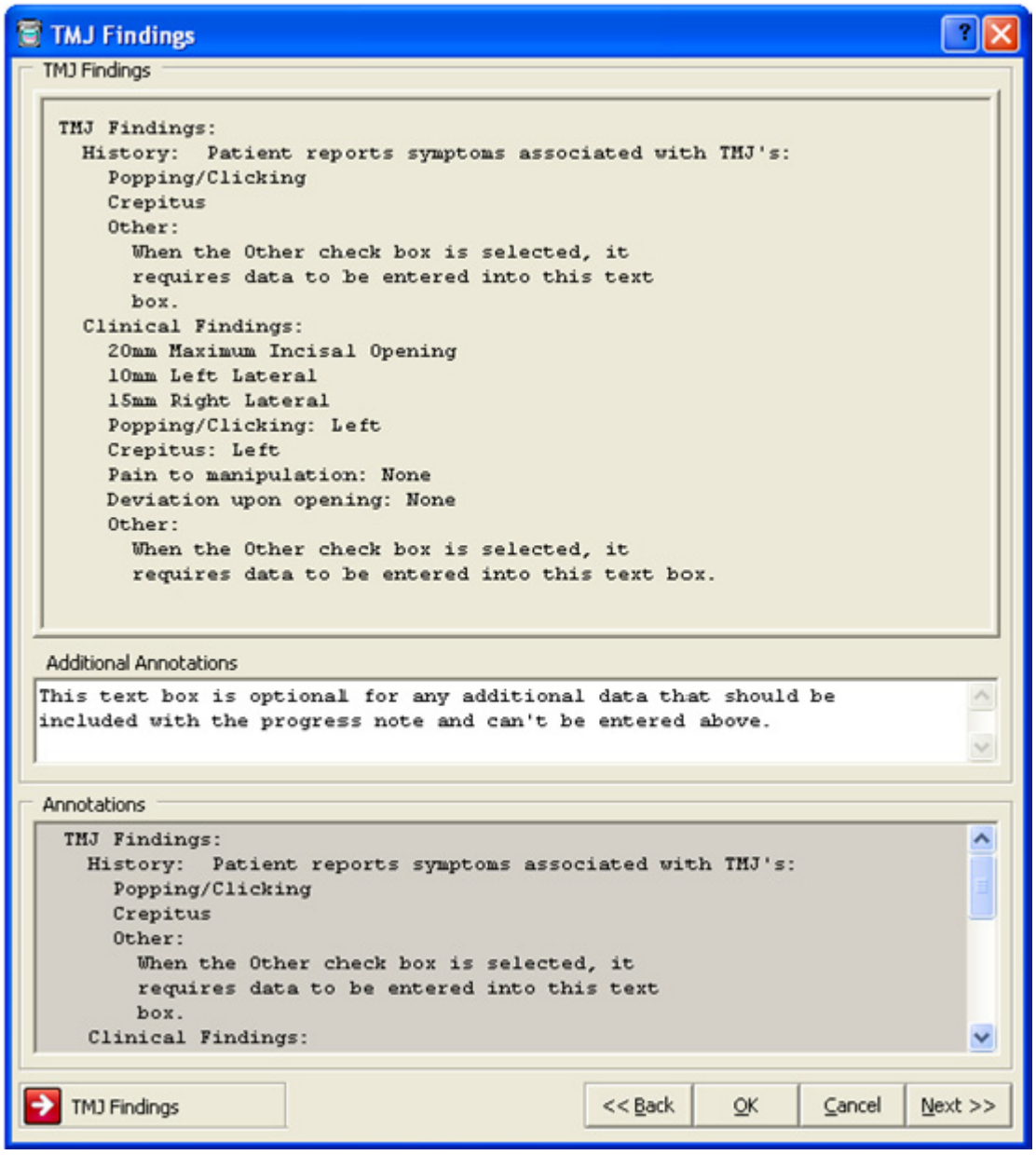


Figure 180: TMJ Findings Element

All information entered into this element appears in the read-only Annotation window. Once the element is complete, click the **Next** button to move on to the next element.

Occlusal Findings Element

This element is required for every D0150 and D0180 exam. Occlusal Findings must be entered into, and imported from the Occlusion screen when completing one of these exams. The Occlusion screen can either be opened by clicking the **Occl** specialty button from the Chart/Treatment tab, or by clicking the **Occlusal Findings** button in the bottom left corner of this screen.

From the Clinical Findings drop-down menu, click **Mandibular relationship**. This is the only required field. All data from the last filed Occlusion exam imports into the screen when a new exam is selected, which will require the provider to remove and/or add correct data.

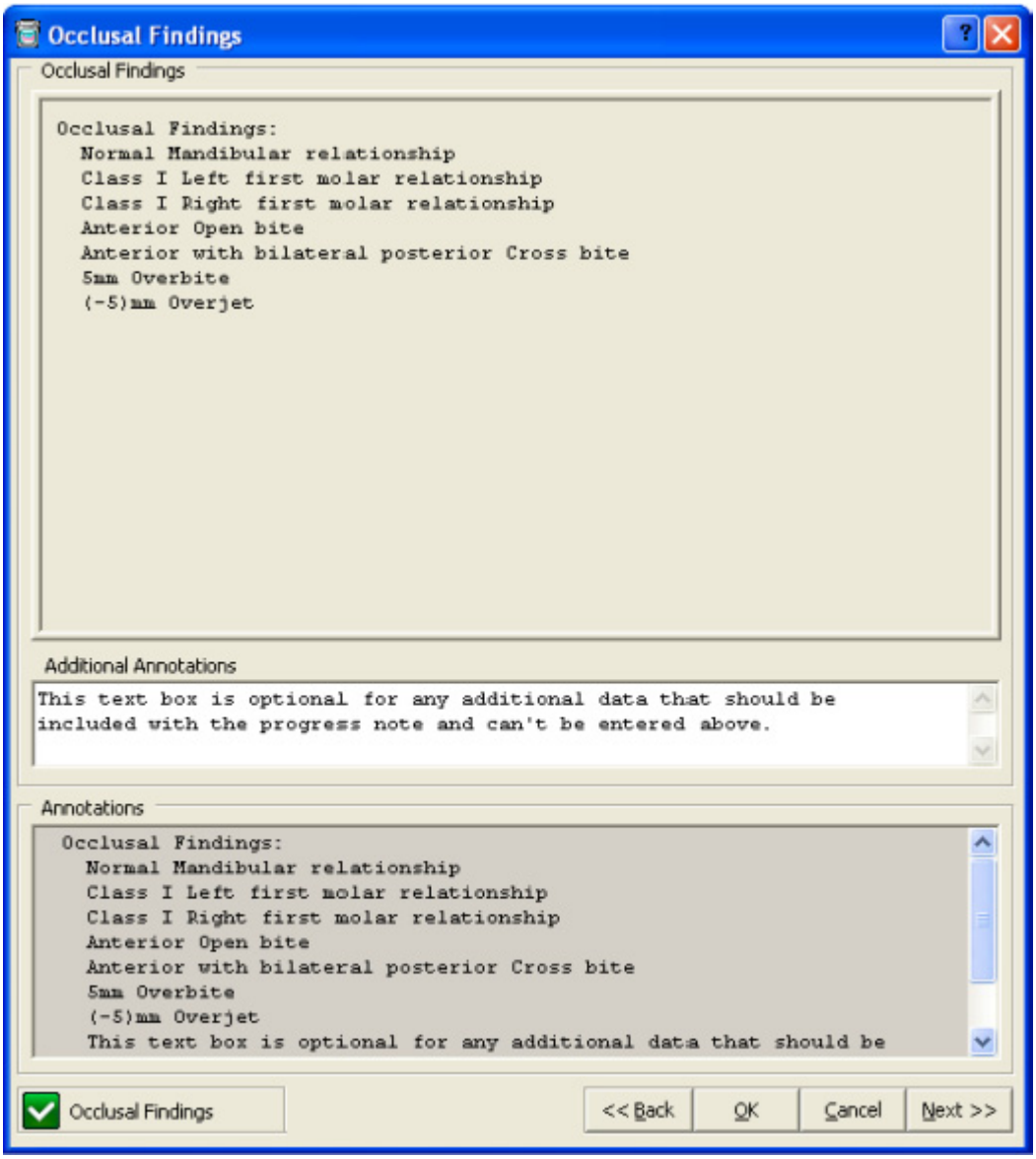


Figure 181: Occlusal Findings

The user can enter additional information regarding the patient into the Additional Annotations free-text window. This window offers right-click functionality to import text files, if desired. All information entered into this element appears in the read-only Annotations window. When the element is complete, click the **Next** button to move on to the next element.

Salivary Flow Element

The Salivary Flow element is optional for all seven exam/consult procedures. This element requires one of the two radio buttons to be selected when entering data. The second radio button option requires a statement entered in the text box.

The Xerostomia value and description imports for viewing on this Salivary Flow element screen if entered from the OHA screen during this session.

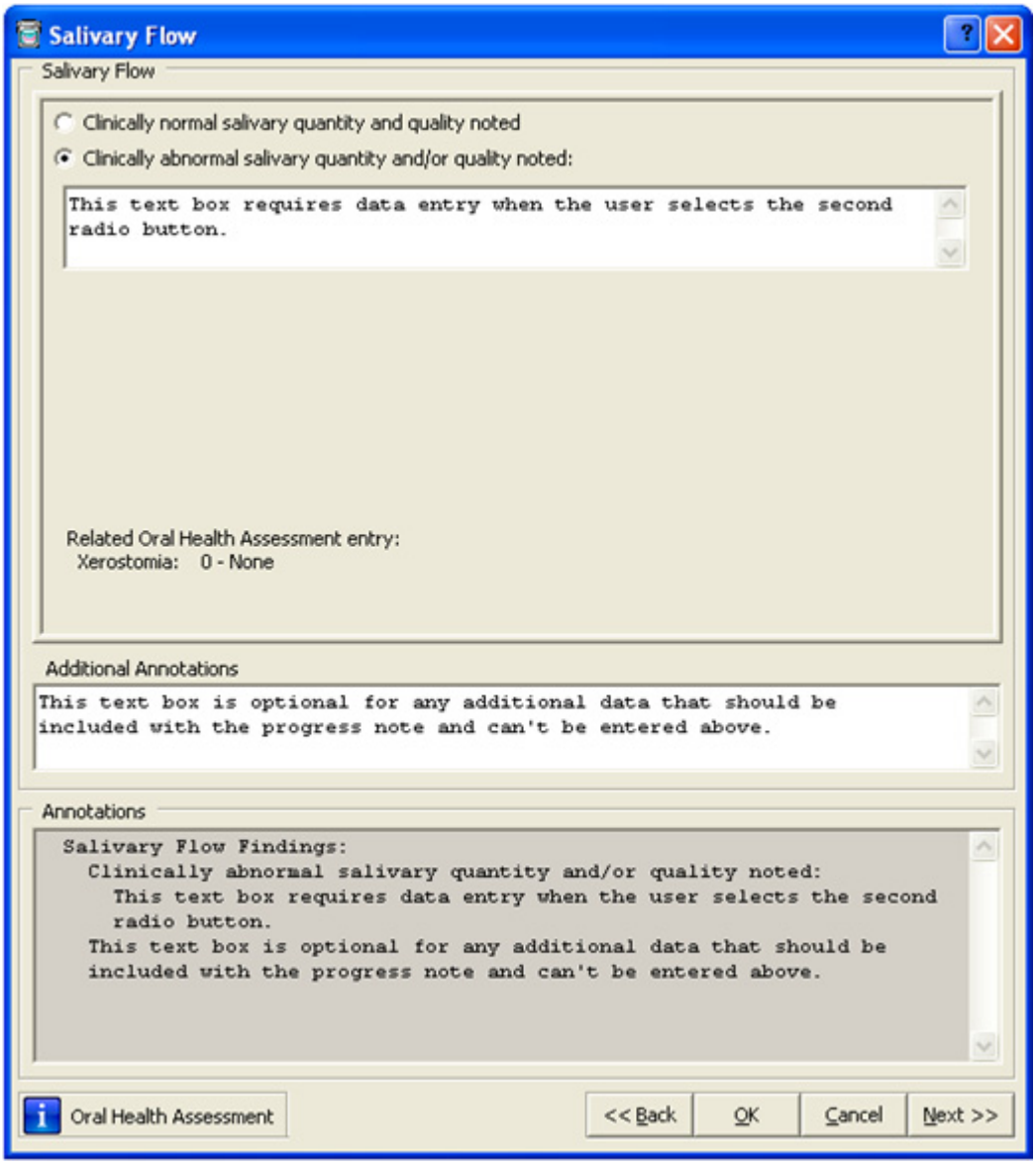


Figure 182: Salivary Flow

The user can enter additional information regarding the patient into the Additional Annotations free text window. This window offers right-click functionality to import text files, if desired. All information entered into the element appears in the read-only Annotations window. Once the element is complete, click the **Next** button to move on to the next element.

Removable Prostheses Element

This element is optional for all seven exam/consult types. This element requires one of the top three radio buttons to be selected when entering data. If the user selects the third, **Patient presents with removable prosthes(es):** button, the user must then select must select one of either the Maxillary or Mandibular radio buttons: **Partial** and **Complete**. Only one is required and, once selected, will open two more radio buttons: **Satisfactory** and **Unsatisfactory**.

If the user selects **Unsatisfactory**, four checkboxes (Occlusion, Retention, Stability, Esthetics) and a text box will become active. The user should check any box pertaining to the patient, and note any additional prostheses in the text box.

The checkbox Other Prostheses opens a required text box for any other prostheses that should be added in the progress note for the patient.

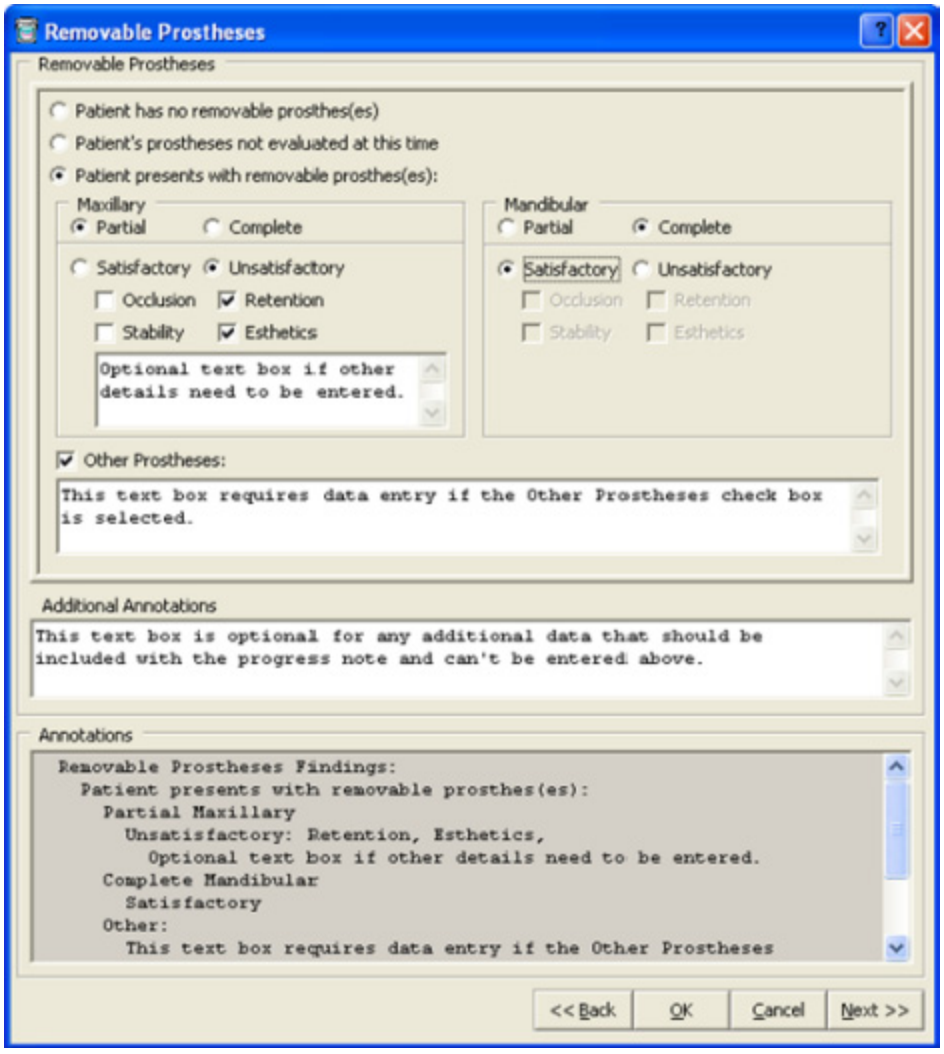


Figure 183: Removable Prostheses

The user may enter any additional information regarding the patient into the Additional Annotations text window. This window offers right-click functionality to import text files, if desired. All information entered into the element appears in the read-only Annotations window. Once the element is complete, click the **Next** button to move on to the next element.

Assessment/Plan Element

The Assessment/Plan element, comprised of an assessment and planned section, is required for all seven exam/consult procedures. The top assessment section is optional for the completion of this element.

The Treatment Plan section requires one of the four checkboxes or only one pre-defined statement to be selected to complete the element. The first checkbox, Include charted treatment plan, loads automatically and imports the patient's newly entered and/or past planned treatment.

Up to 12 pre-defined statements for the Assessment Summary and 12 Treatment Plan statements can be selected from this screen. The checkboxes found in the pre-defined statement windows will have three national assessment and three national planned statements pre-loaded; however, all 12 statements from either can be created locally.

The DRM Administrator has priority over all other users and may add or delete all 12, if desired.

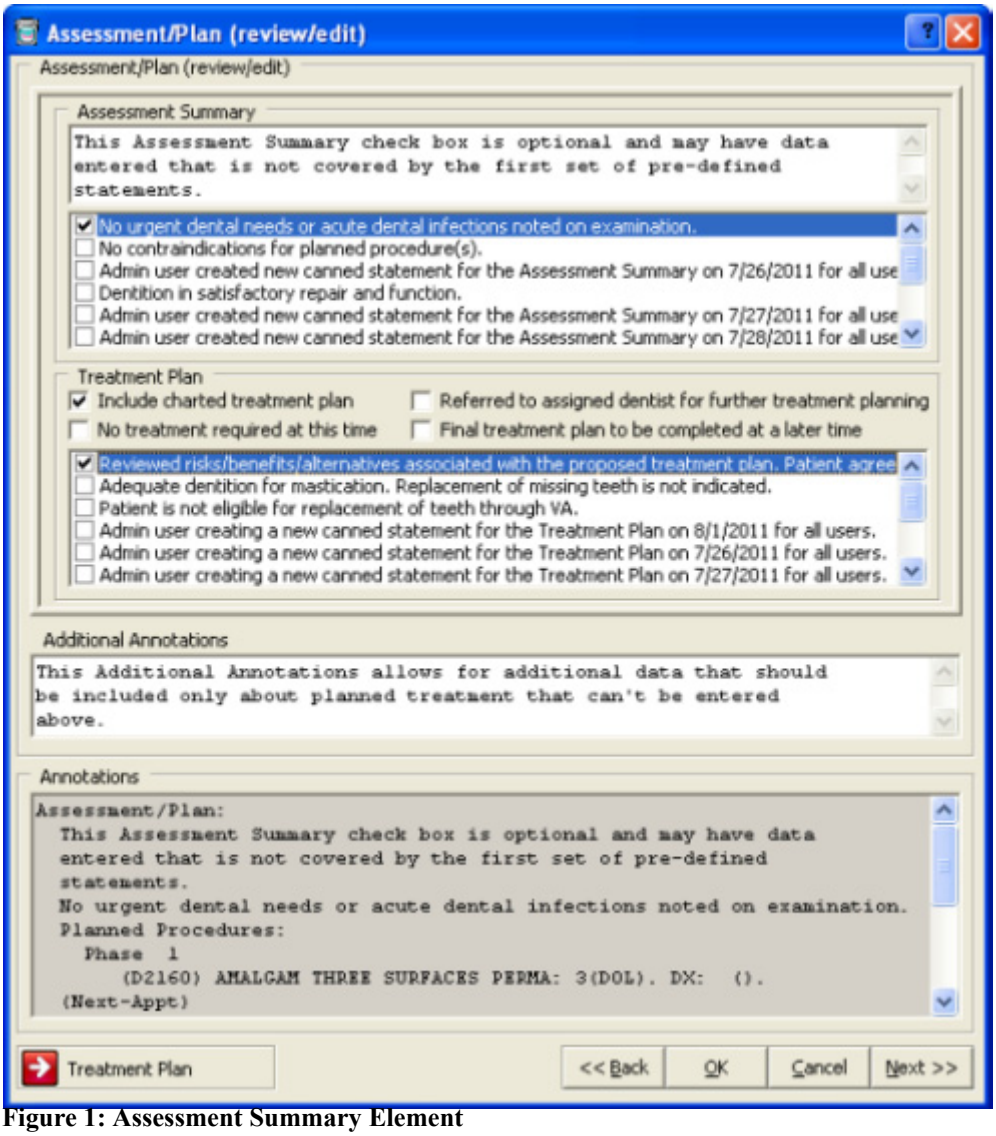


Figure 1: Assessment Summary Element

The user may enter additional information regarding the patient into the Additional Annotations free text window. This window offers right click functionality to import text files, if desired. All information entered into this element appears in the read-only Annotations window. Once the element is complete, click the **Next** button to move on to the next element.

Usage of the **Back** button is not dependent on the element's completion.

The element imports incomplete when saved as unfiled data and then reloads. The provider is required to review/edit this element again at this time.

Patient Education Element

The Patient Education element is optional for all seven exam/consult procedures. This element requires one of the two radio buttons to be selected when entering data. The selection of the second radio button opens a text box that requires specific information regarding the patient or one pre-defined statement may be selected.

Up to12 pre-defined statements on patient education can be selected from this screen. The checkboxes found in the pre-defined statements window have two national patient education statements pre-loaded; however, all 12 statements can be created locally.

The DRM Administrator has priority over all other users and may add or delete all 12, if desired.

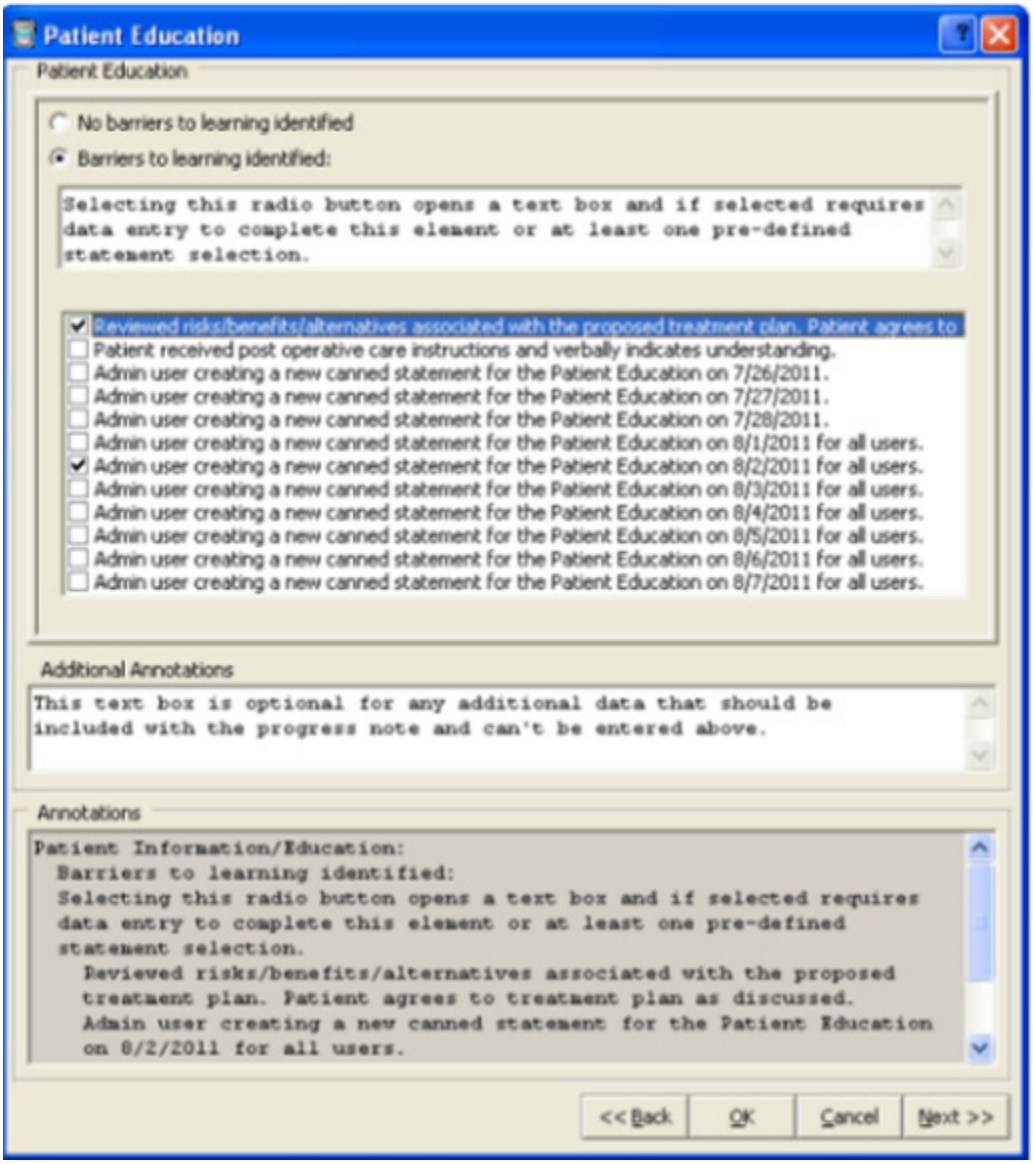


Figure 184: Patient Education

The user may enter additional information regarding the patient into the Additional Annotations free text window. This window offers right click functionality to import text files, if desired. All information entered into this element will appear in the read-only Annotations window. Once the element is complete, click the **Next** button to move on to the next element.

Usage of the **Back** button is not dependent on the element's completion.

Disposition Element

The Disposition element is required for all seven exam/consult procedures. This element requires one of the two radio buttons to be selected when entering data. The selection of the second radio button requires at least one of the following: one selection of the eight data ranges, a text description about the next visit typed in the text box or one selection from the pre-defined statements.

The Next Appointment checkboxes, if selected in the Sequencing screen, will import automatically into the Annotations view window of this element.

Up to 12 pre-defined statements on disposition can be selected from this screen. The checkboxes found in the pre-defined statements window will have four national disposition statements pre-loaded; however, all 12 statements can be created locally.

The DRM Administrator has priority over all other users and may add or delete all 12, if desired.

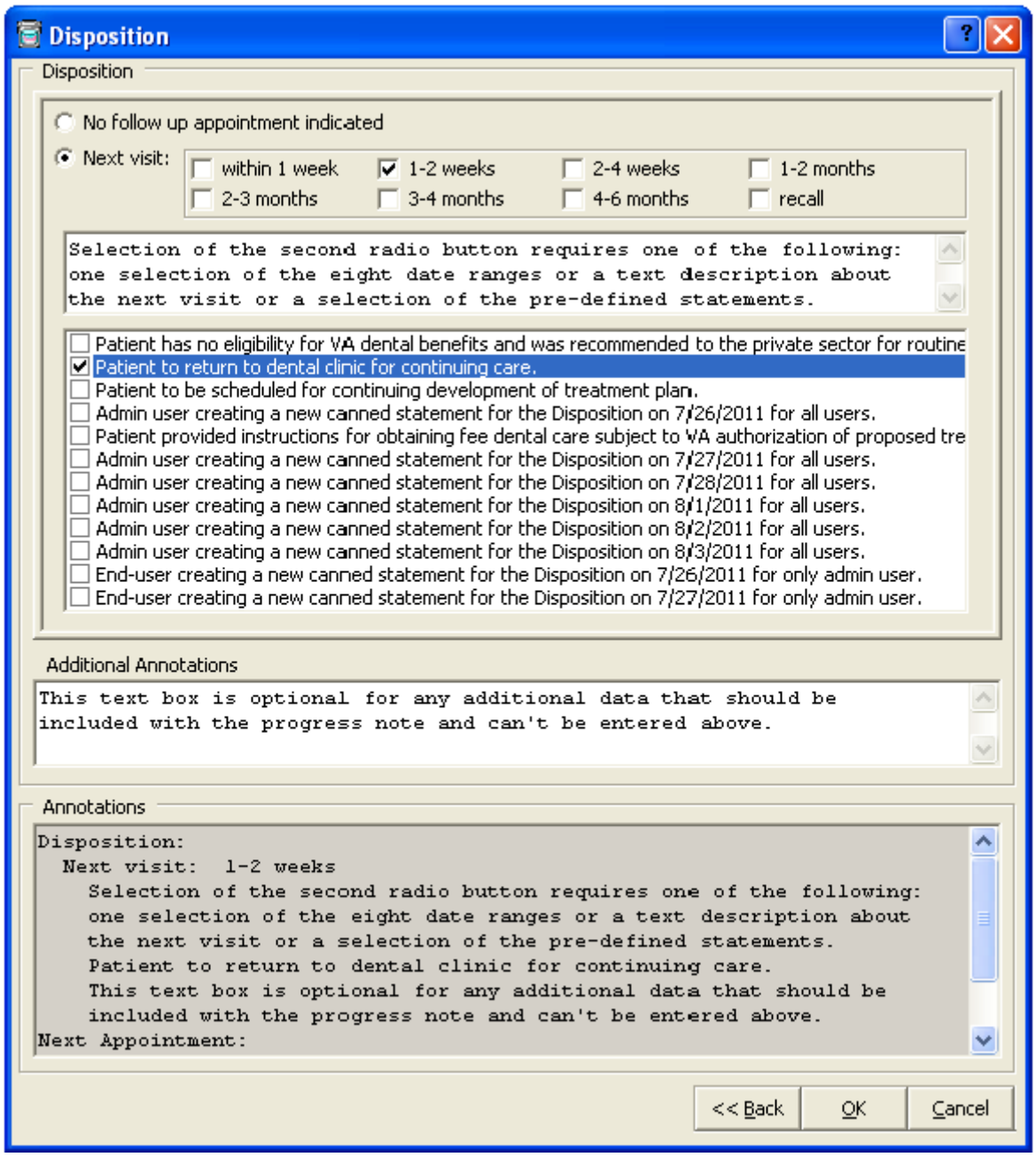


Figure 185: Disposition

The user may enter additional information regarding the patient into the Additional Annotations free text window. This window offers right click functionality to import text files, if desired. All information entered into this element appears in the read-only Annotations window. Once the element is complete, click the **Next** button to move on to the next element.

Usage of the **Back** button is not dependent on the element's completion.

New Import Previously Filed Data Screen

When any provider has filed patient dental data previously today in any of the following screens: Social History, OHA, TMJ, Parafunctional Habits, Occlusion, Diagnostic Findings, Head and Neck Findings, PSR Exam or Periodontal Chart then that data maybe imported by a second provider entering an exam today as well. The second provider after selecting an exam code and then selecting the Exam tab will have the following Import Previously Filed Data screen display. This screen allows the provider an option to import this data into his exam template to satisfy some possible requirement from the exam code that they may have selected.

Selecting the checkboxes of any or all previously filed data today imports that data into their present exam template session. There is a 'Check ALL the above' checkbox at the bottom of the screen which allows all today's filed data to be imported into this new TIU note. After selecting the desired checkboxes, the provider selects the **Import** button to incorporate this data into the current exam template. When none of the data should be imported into the current exam template then select the **Cancel** button.

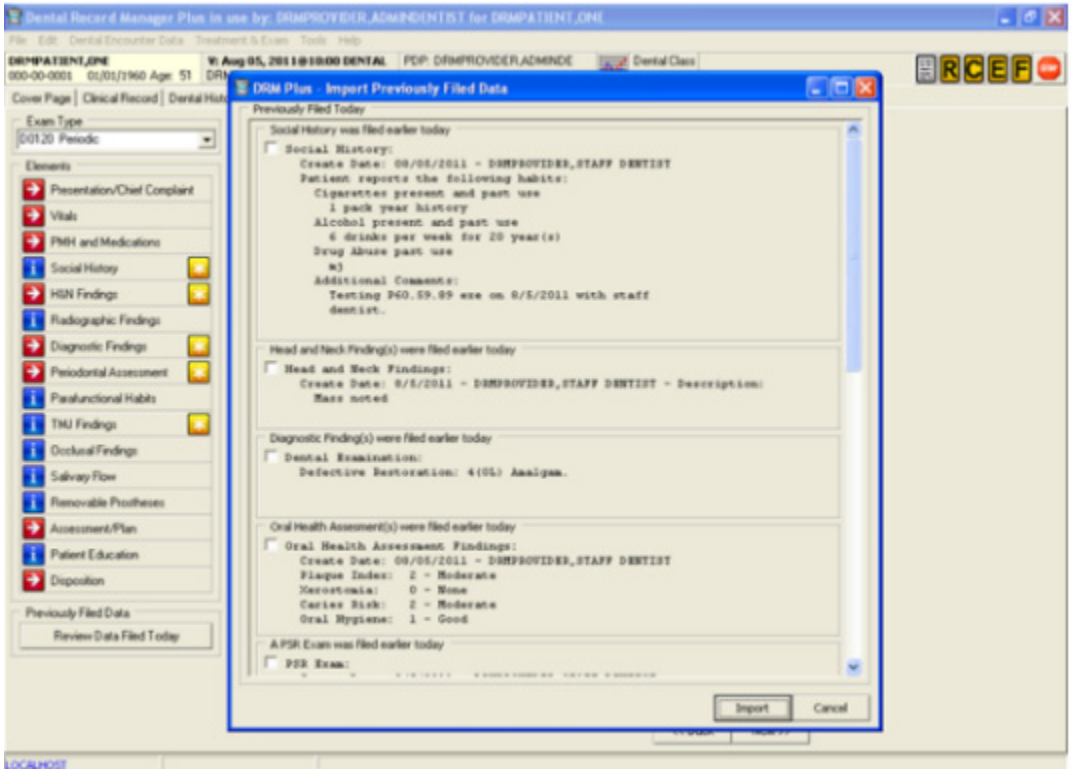


Figure 186: Import Previously Filed Data

The  icon on the right of the element button displays when there was previously filed data today and that data is associated with the element. The Diagnostic Findings element informs the provider when the  icon is displayed and there may have been one or any combination of diagnostic findings, OHA or PSR filed earlier today by another provider.

Below the element icons located on the left side of the Exam tab will be a new Review Data Filed Today button. This button only displays when data was filed to TIU earlier today by any provider for this patient. This button allows the provider to open the Import Previously Filed Data screen to make edits or corrections after the provider has reevaluated what was filed previously today.

Completing the Encounter

Click the **Next** button, located in the bottom right corner of both the Periodontal Chart and Treatment & Exam screens, to begin completing the encounter with the patient. If the provider/visit/date was not selected from the banner when the patient's chart was opened, clicking the **Next** button will bring up the Provider and Location for Current Activities screen. However, if no procedure code has been entered in completed care for the patient, the File Data Options screen will appear, which is explained later in this chapter. In addition, if the system sees possible duplicate procedure codes, the Potential Duplicate Transaction screen appears.

To complete the patient encounter:

1. Click the **Next** button on the bottom right corner of either the Treatment & Exam or Periodontal Chart screens.
2. The Provider and Location for Current Activities screen appears. For further information, see the Dental Encounter Data section in the Using the DRM Plus Drop-Down Menus chapter of this manual.

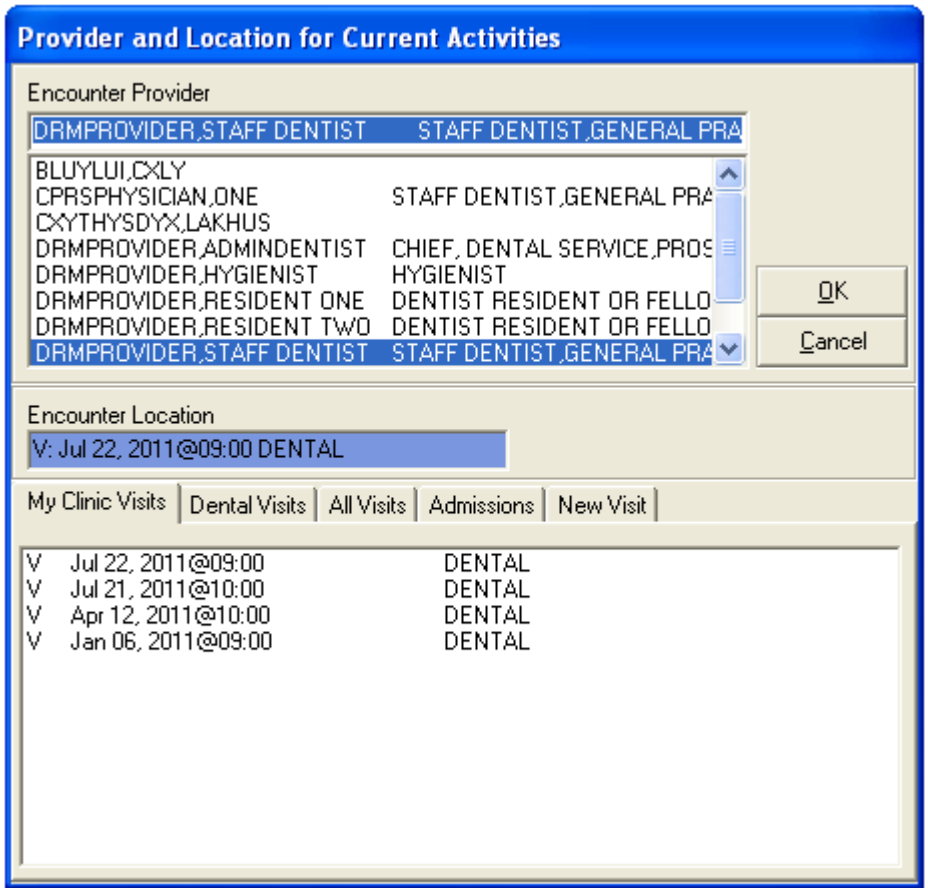


Figure 187: Provider and Location for Current Activities Screen

3. Select the provider from the Encounter Provider list. The program automatically defaults to the provider currently logged in.
4. Select the desired visit from any of the tabs on the bottom of the screen.

5. Click the **OK** button.
6. The Filing Options screen appears.

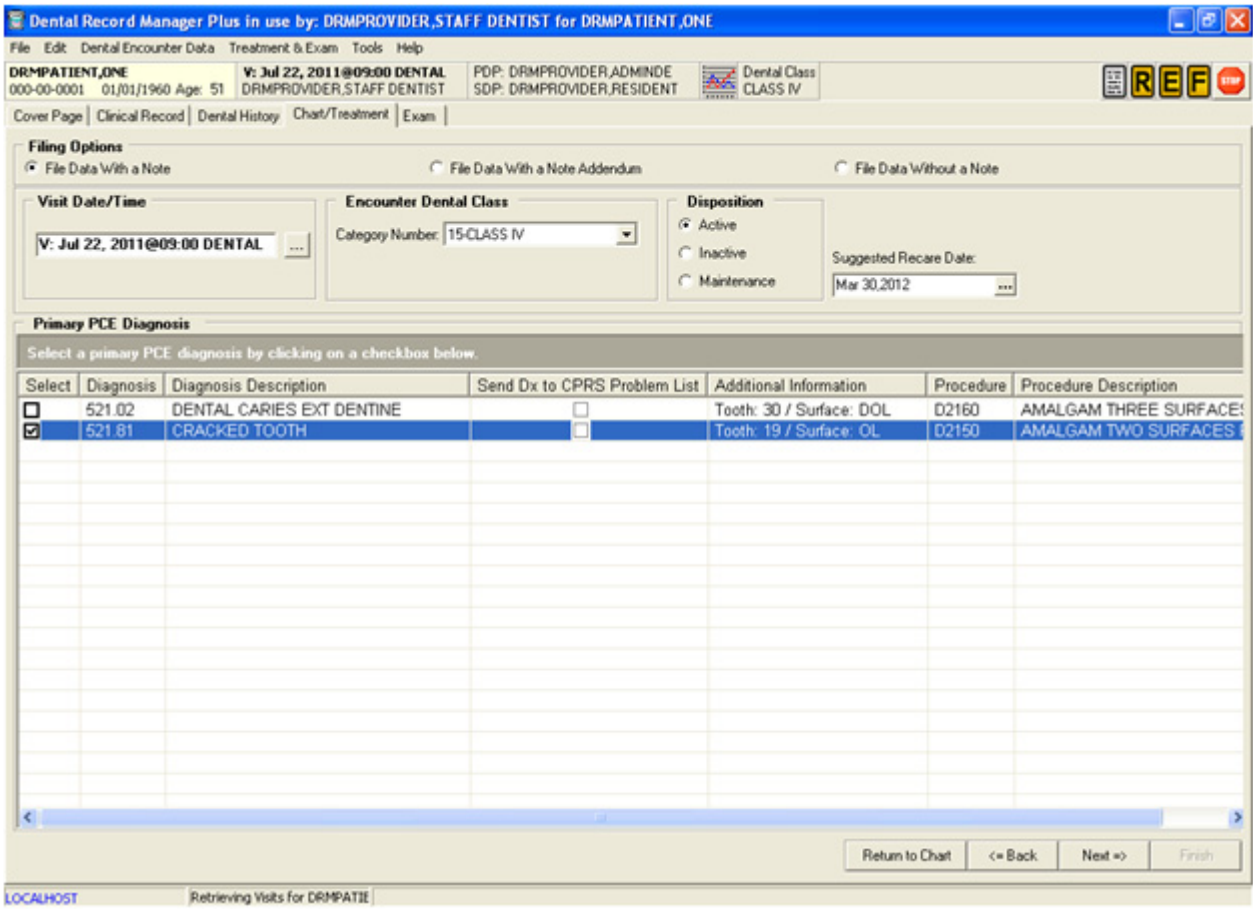


Figure 188: Filing Options Screen

7. Select the correct Filing Option. The information displayed in the Visit Date/Time, Encounter Dental Class, and the Disposition is defaulted but can be changed. Select the Suggested Recare Date if applicable to the patient.
8. Select the Primary PCE Diagnosis for the encounter, unless there is only one, which will be defaulted.
9. Provider may select the diagnosis to be sent to the patient's problem list.
10. Click the **Next** button.
11. The Dental Class Discrepancy screen may appear, if the Encounter Dental Class and Cover page Dental Class don't match. This will not stop the user from completing the encounter.
12. The Service Connection screen appears.

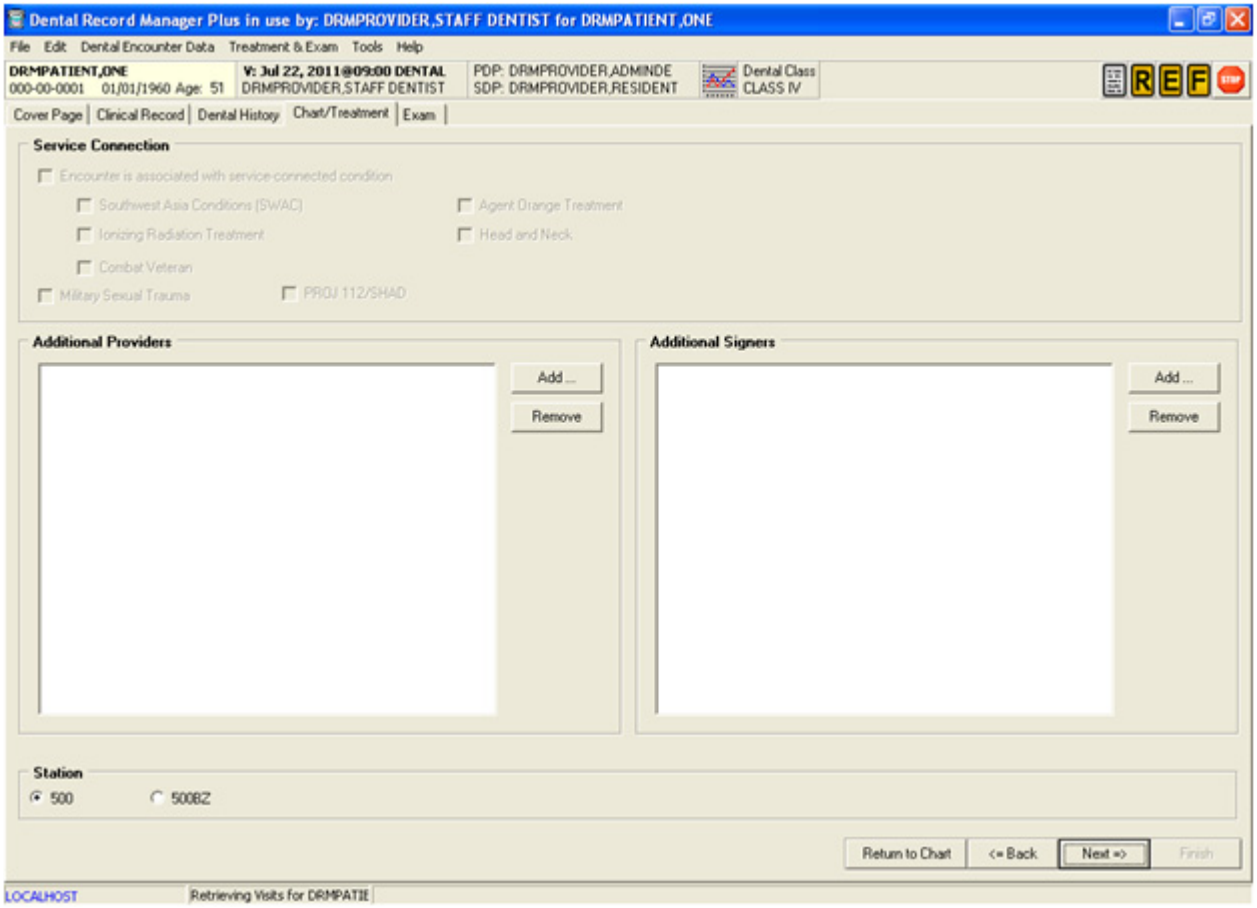


Figure 189: Service Connection Screen

13. Enter the locally required information on this screen. Please see the section of this manual entitled Service Connection Screen for more information.
14. Enter the optional information of Additional Providers or Additional Signers on this screen. Please see this section of this manual entitled Additional Providers/Additional Signers, found later in this chapter, for additional information.
15. Select the appropriate facility (station) by clicking the appropriate radio button.
16. Click the **Next** button.
17. The Set Progress Note Title screen appears. Note that this screen does not appear if the File Data with Note Addendum or File Data Without Note options were selected from the Filing Options screen.

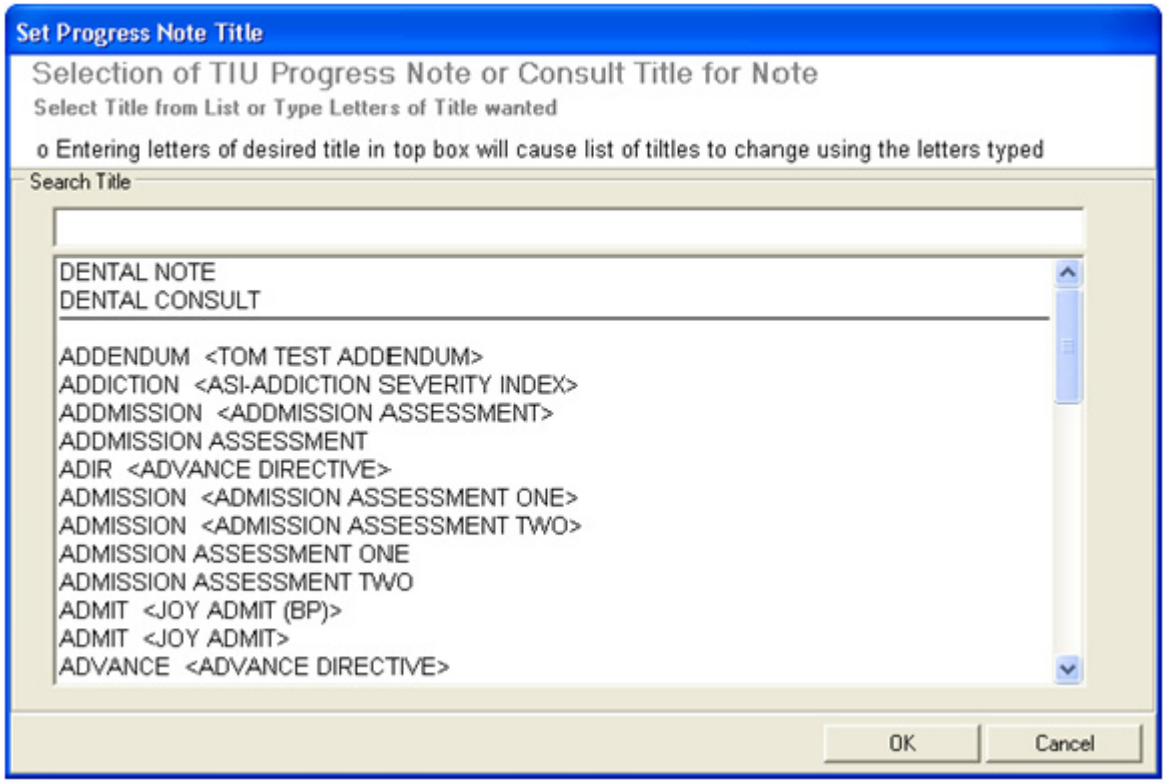


Figure 190: Set Progress Note Title

18. Search for the Title using the Search box, or use the scroll bar to select the desired title from the list. Default TIU note titles at the top of the list are set in the CPRS Tools menu/Options/Notes tab/ Document Titles button.
19. Click the **OK** button.
20. The Progress Note screen appears.

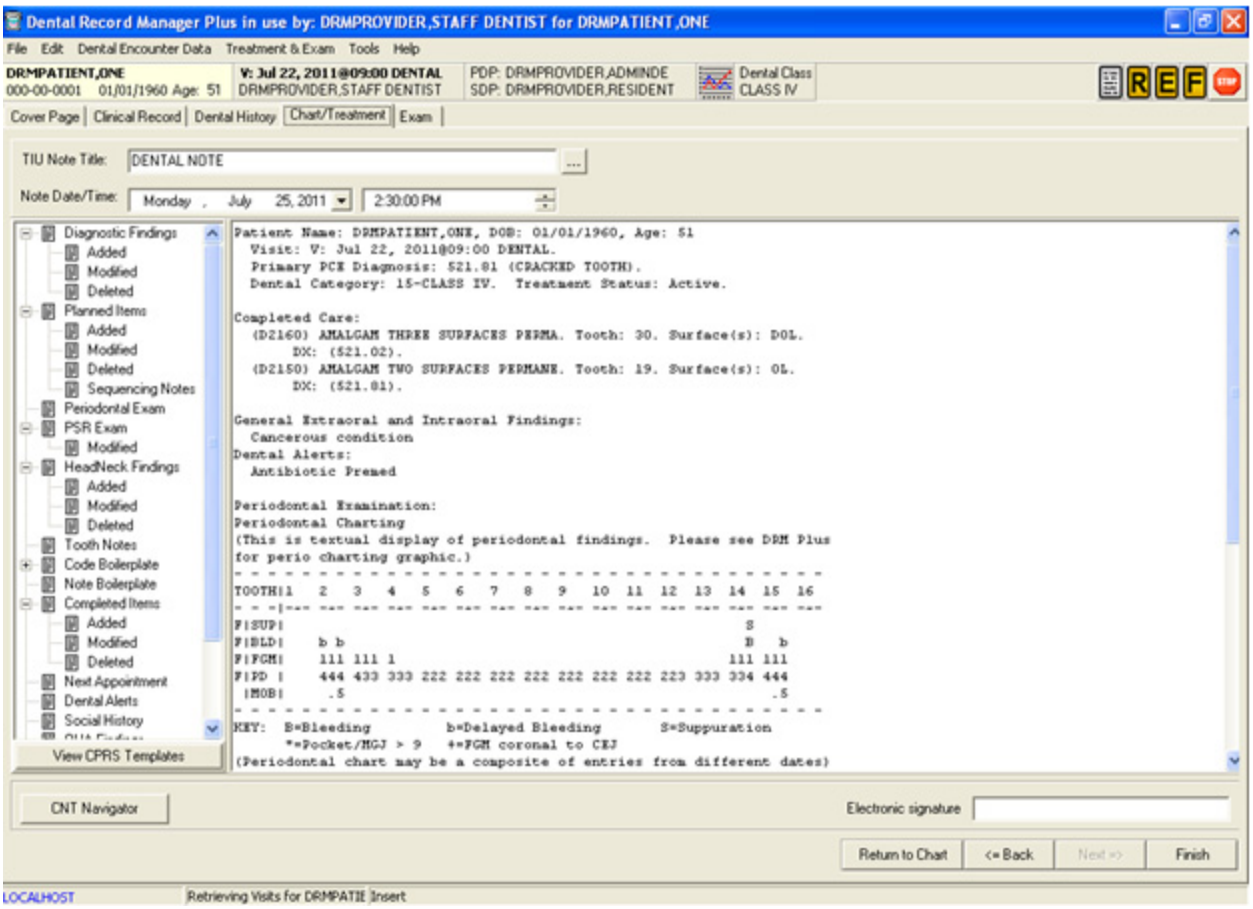


Figure 191: Progress Note Screen

21. Ensure the information on the screen is correct. Enter the electronic signature and click the **Finish** button. An electronic signature is not required to file the note as unsigned. See the Electronic Signature section later in this chapter for more information.
22. The Change Provider screen appears.

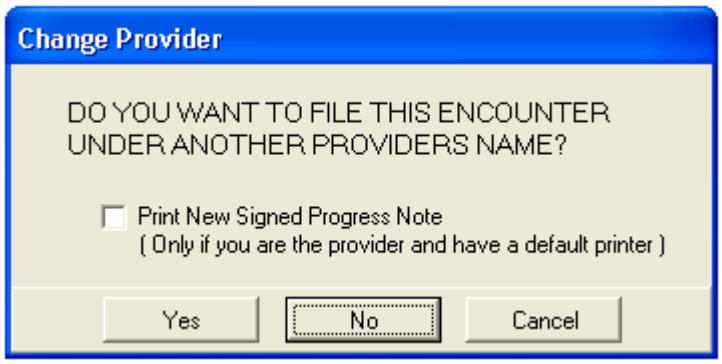


Figure 192: Change Provider Screen

23. Click the **Yes** button to change the provider. The Search for Provider screen appears. If **No** is selected, a screen appears. See step 25.

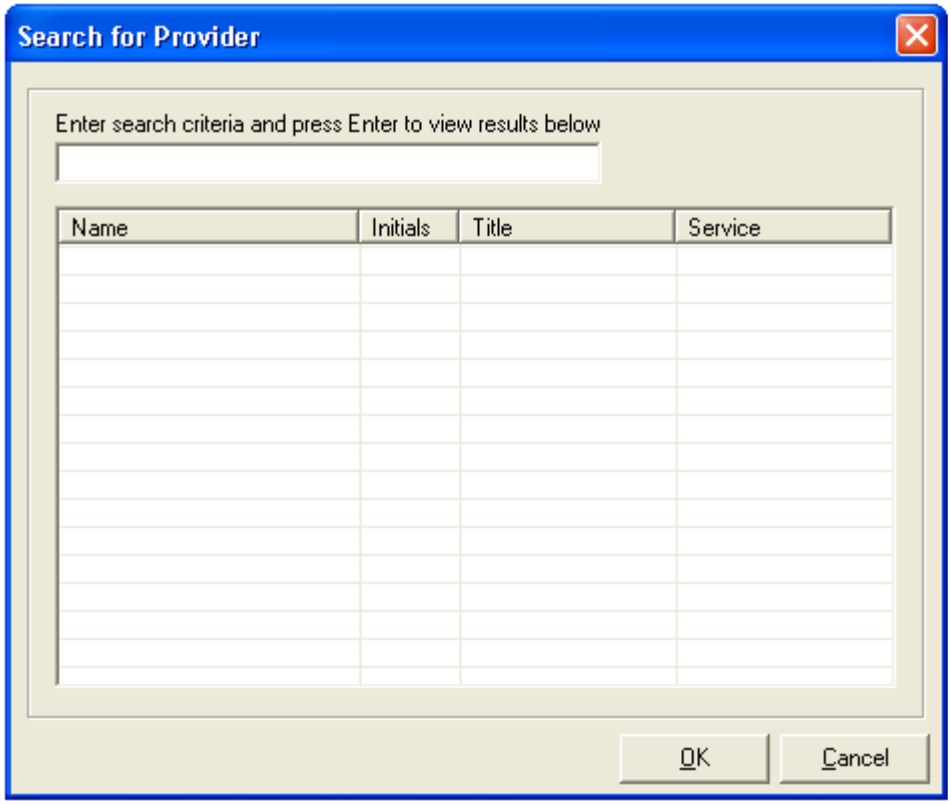


Figure 193: Search for Provider Screen

24. Enter the search information and press the <**Enter**> key. Select the provider from the list and click the **OK** button.
25. A screen appears saying that the encounter record has been created.

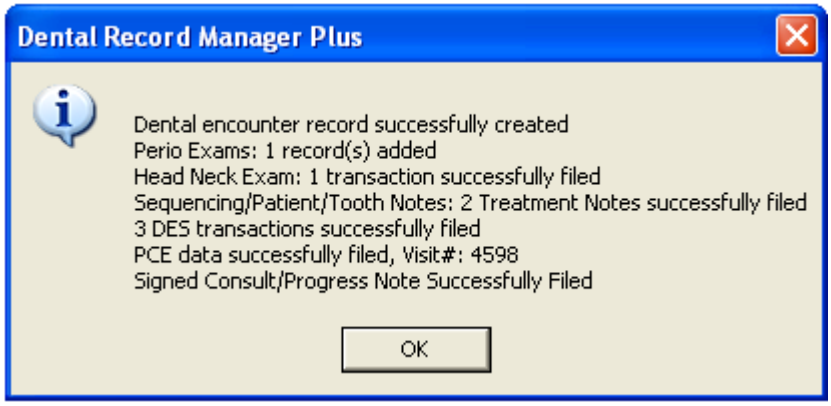


Figure 194: DRM Plus Screen

26. Click the **OK** button. The DRM Plus screen minimizes, and the CPRS main screen remains open, unless it has timed out.

Potential Duplicate Transactions Screen

If the system detects that a possible duplicate transaction exists, the Potential Duplicate Transactions screen appears, when the Next button on the Treatment & Exam or Periodontal Chart screens is clicked.

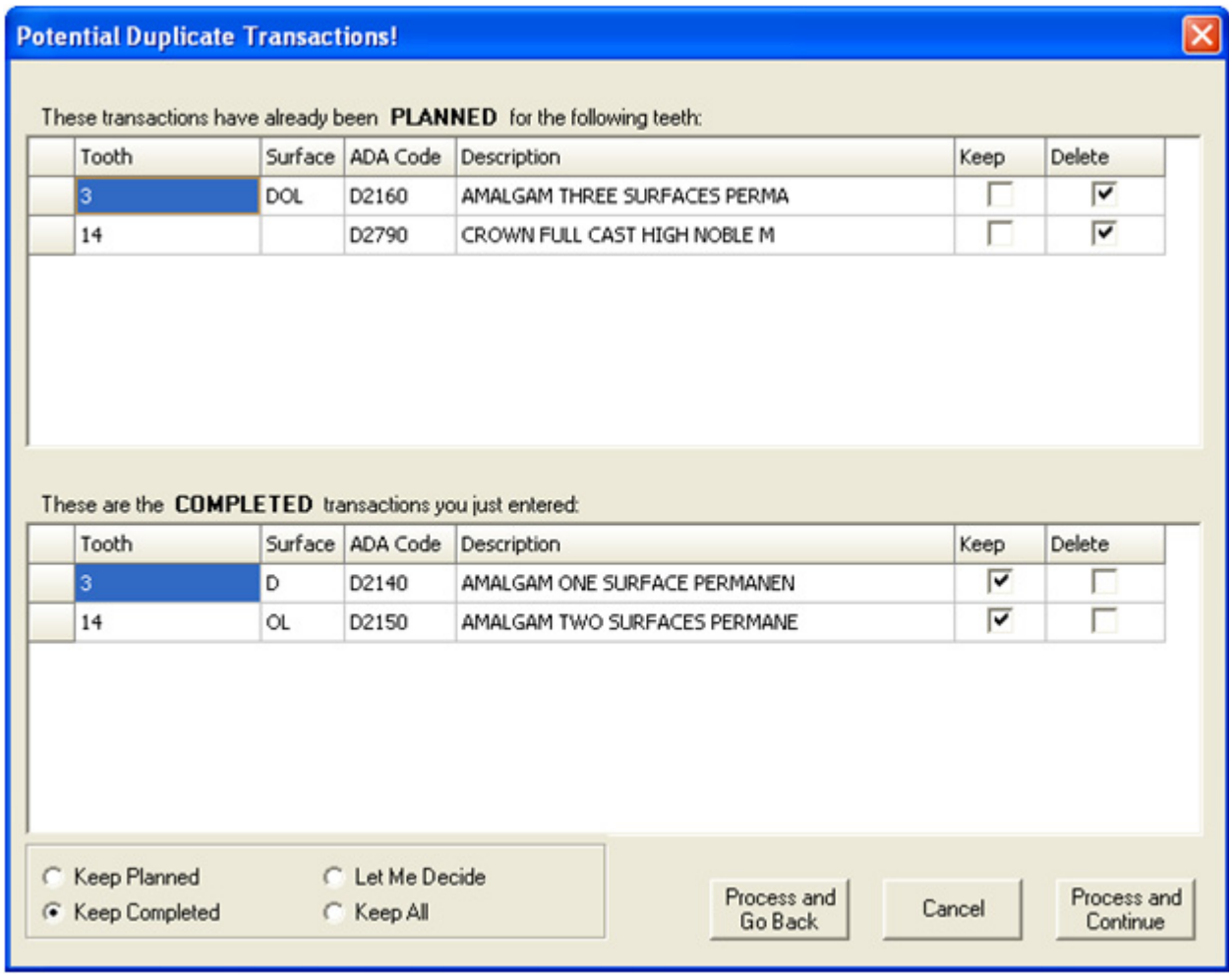


Figure 195: Potential Duplicate Transaction Screen

A list of planned transactions for a tooth, along with the procedure code and the description, are listed in the top portion of the screen. Completed transactions taken during this encounter are listed in the bottom portion of the screen, with elements that match other planned transactions for the same tooth.

The radio buttons on the lower left portion of the screen designate which information will be kept or discarded. The **Keep Planned** radio button keeps the planned transaction and deletes the conflicting completed transaction entered during the encounter. The **Keep Completed** radio button keeps the completed transaction entered during this encounter and deletes the planned transaction. The **Let Me Decide** radio button clears all checkboxes and allows for picking and choosing among the planned and completed transactions. The **Keep All** radio button allows all conflicting procedure codes that are planned and completed to be processed.

After clicking the desired radio button and selecting, if necessary, which transactions will be kept and/or discarded, click either the **Process and Go Back**, **Cancel** or **Process and Continue** button to continue

completing the encounter. **Process and Go Back** will process the procedure codes and return to the Treatment & Exam or Periodontal Chart screen, depending. **Cancel** will bring up the Periodontal Chart or Treatment & Exam screen without processing any information. **Process and Continue** will process the procedure codes and continue updating the progress note. The Filing Options screen appears. Continue closing the encounter from this point, as outlined in the previous chapter.

Note: The system will not present a user with the Potential Duplicate Transactions screen when the potential duplicate is a tooth-related radiographic procedure.

File Data Option Screen

If no procedure code has been entered as complemented treatment on the Completed Care screen and the user clicks the **Next** button, the File Data Options screen will appear.

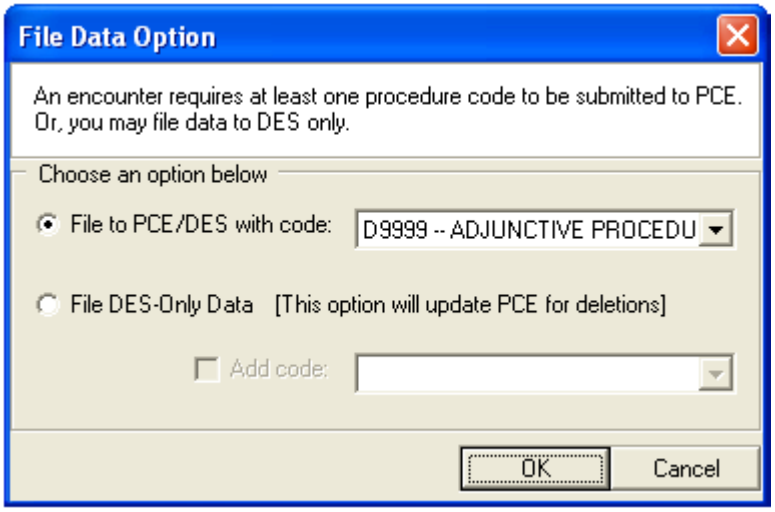


Figure 196: File Data Option Screen

Click the appropriate radio button to designate whether the data is to be filed to PCE/DES with a procedure code, or to file to DES-Only data.

File to PCE/DES with Code

To file data to PCE/DES with procedure code:

1. Click the corresponding radio button on the File Data Options screen.
2. The program defaults to D4999 if entering this screen from the Periodontal Chart and D9999 if entering from Treatment & Exam.
3. If the default procedure codes are incorrect, click the **code** drop-down menu and select the desired procedure code.
4. Click the **OK** button.
5. The ICD-9 Diagnosis Code screen appears.
6. Fill in the information on the ICD-9 Diagnosis Code screen. For further information, see the Completing a Treatment Plan section of this manual in the Chart/Treatment-Treatment & Exam chapter of this manual.

7. The Provider and Location screen appears. For further information, see the Dental Encounter Data section in the DRM Plus Drop-Down Menus chapter of this manual.

File to DES-Only Data

To file to DES-Only Data:

1. Click the **File to DES-Only Data** radio button.
2. If a procedure code is desired (not required), check the Add Code check box and use the drop down menu to select a procedure code.
3. The ICD-9 Diagnosis Code screen appears. See the Completing a Treatment Plan section, in the Chart/Treatment-Treatment & Exam chapter of this manual, for further information.
4. The Provider and Location screen appears. Please see the Dental Encounter Data section, in the Using the DRM Plus Drop-Down Menus chapter of this manual, for further information.

Filing Options Screen

The filing options screen is divided into 6 main sections: Filing Options, Visit Date/Time, Encounter Dental Class, Disposition, Suggested Recare Date and Primary PCE Diagnosis & Send DX to CPRS Problem List.

Filing Options

Use the Filing Options radio buttons to choose how the encounter will be filed.

Figure 197: Filing Options

The options are: File to Data with a Note, File Data With a Note Addendum and File Data without a Note. The File Data Without a Note creates no TIU progress note.

Visit Date/Time

Adjust the Visit Date/Time using this function. The program will default to whatever was entered on the Provider and Location for Current Activities screen.

Figure 198: Visit Date/Time

To change the visit date and time:

1. Click the **ellipses (...)** button.
2. The Provider and Location for Current Activities screen appears.
3. Choose the correct provider and appointment from the Provider and Location for Current Activities screen and click the OK button. For further information, see the Dental Encounter Data section in the Using DRM Plus Drop-Down Menus chapter of this manual.

Encounter Dental Class

Use the drop-down menu to change the Category Number/Encounter Dental Class for this encounter.

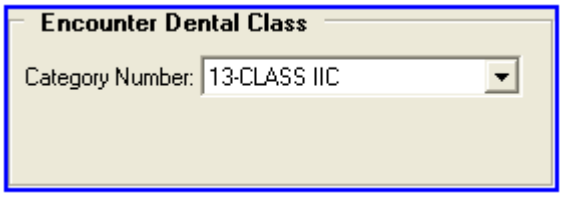


Figure 199: Encounter Dental Class

Disposition

Use the radio buttons to change the patient's Disposition or Case Management status.

Figure 200: Disposition

Suggested Recare Date

Use the **ellipses (...)** button to add/change the suggested recare date.

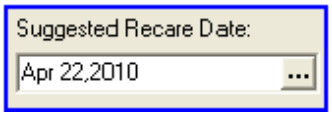


Figure 201: Suggested Recare Date

Clicking the **ellipses (...)** button opens the Select Date/Time screen.

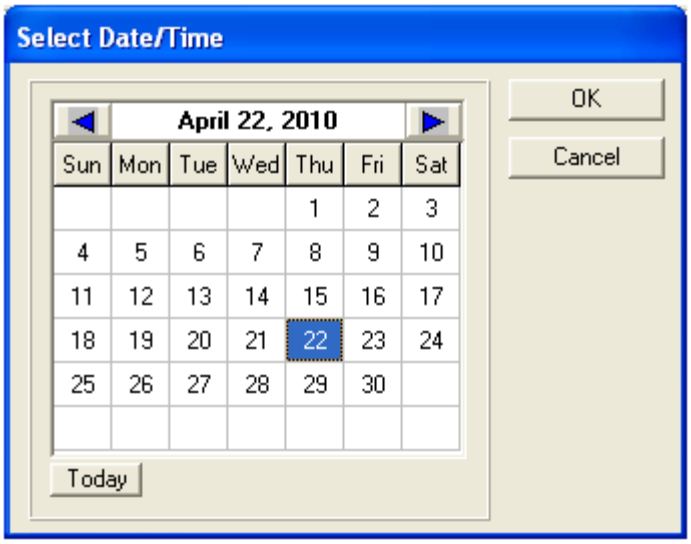


Figure 202: Select Date/Time Screen

Select the date from the calendar and click the **OK** button.

Primary PCE Diagnosis & Send Dx to CPRS Problem List

This area features a list of the diagnosis codes with descriptions, selections to send diagnosis to CPRS problem list, procedure codes with descriptions and additional information.

Select the Primary PCE Diagnosis by clicking the checkbox under the Select column in the Primary PCE Diagnosis window. If there is only one diagnosis, or many of the exact same diagnosis, the selection will be checked by default. All encounters require only one primary diagnosis filed to VistA PCE.

Select diagnoses to send Dx to CPRS Problem List by clicking the checkbox in that column.

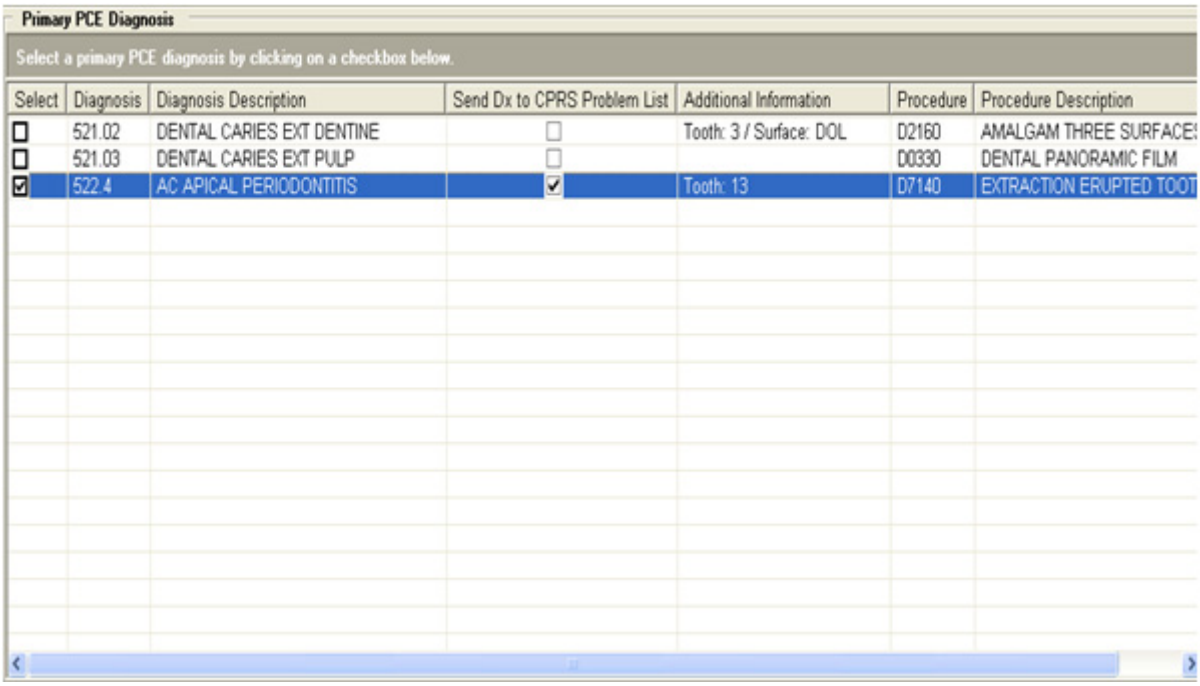


Figure 203: Primary PCE Diagnosis Window

Service Connection Screen

The Service Connection screen has four main areas: Service Connection, Additional Providers, Additional Signers and Station.

Service Connection

Use the checkboxes to denote service connection, if applicable.

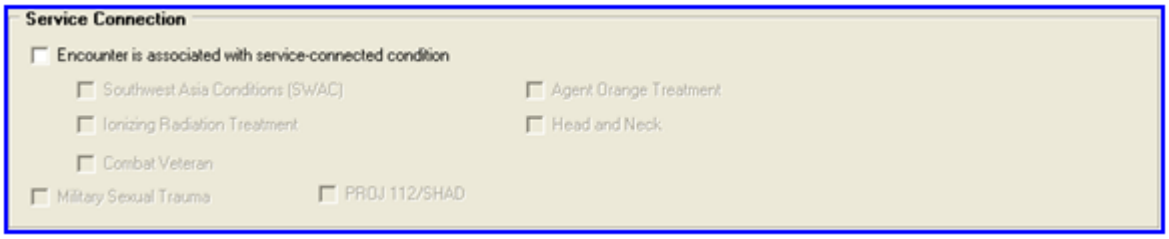


Figure 204: Service Connection

Additional Providers/Additional Signers

Add or remove providers from this patient encounter by using the tools in this area.

Figure 205: Additional Providers/Additional Signers

To add a provider or signer:

1. Click the **Add** button.
2. The Search for Provider/Search for Signer screen appears.

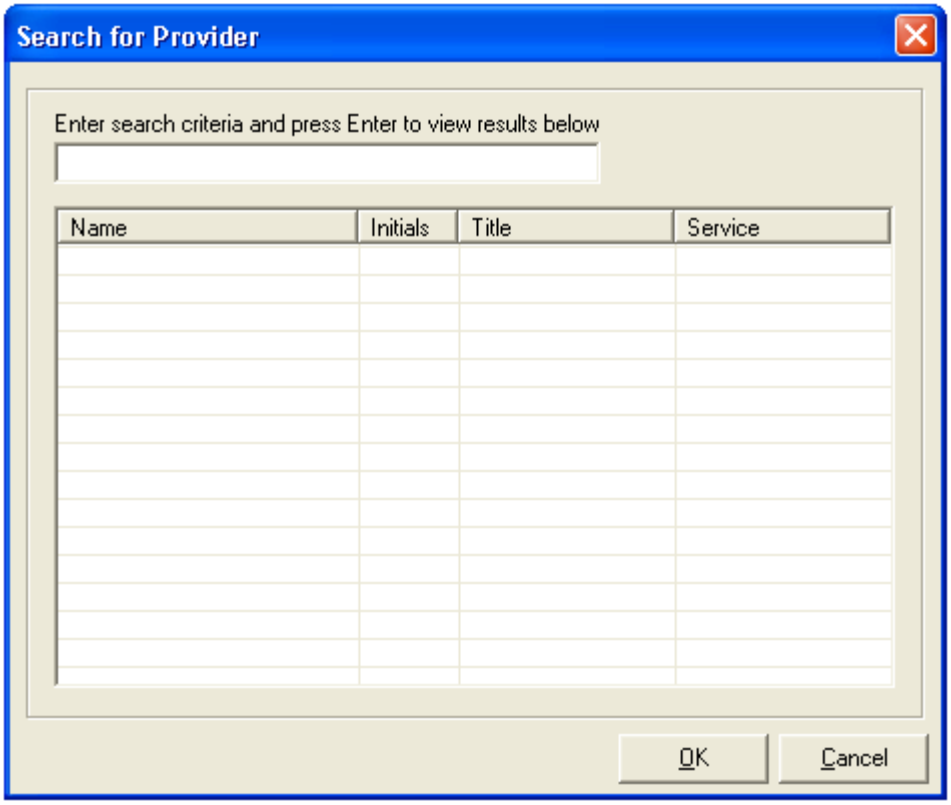


Figure 206: Search For Provider Screen

3. Enter the name into the text box and press the <**Enter**> key.
4. Select the correct name from the results and click the **OK** button.
5. The provider appears on the main screen. Repeat as necessary.

To remove a Provider/Signer:

1. Highlight the provider or signer name.
2. Click the **Remove** button.
3. A confirmation screen appears. Click the **Yes** button.
4. The name is removed from the Additional Provider list.

Station

Select the appropriate facility (station) by clicking the appropriate radio button, if applicable.

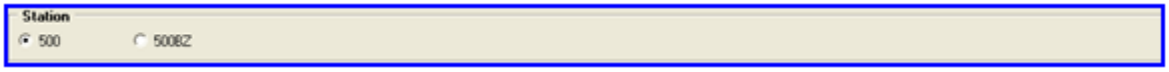


Figure 207: Station

Progress Note Screen

The Progress Note screen has several major areas and functions. This is the final major screen in completing an encounter with the patient, and has different incarnations depending on how the transaction is filed: With a Note, With a Note Addendum, or Without a Note. The following screen results when the transaction is filed using the With a Note option.

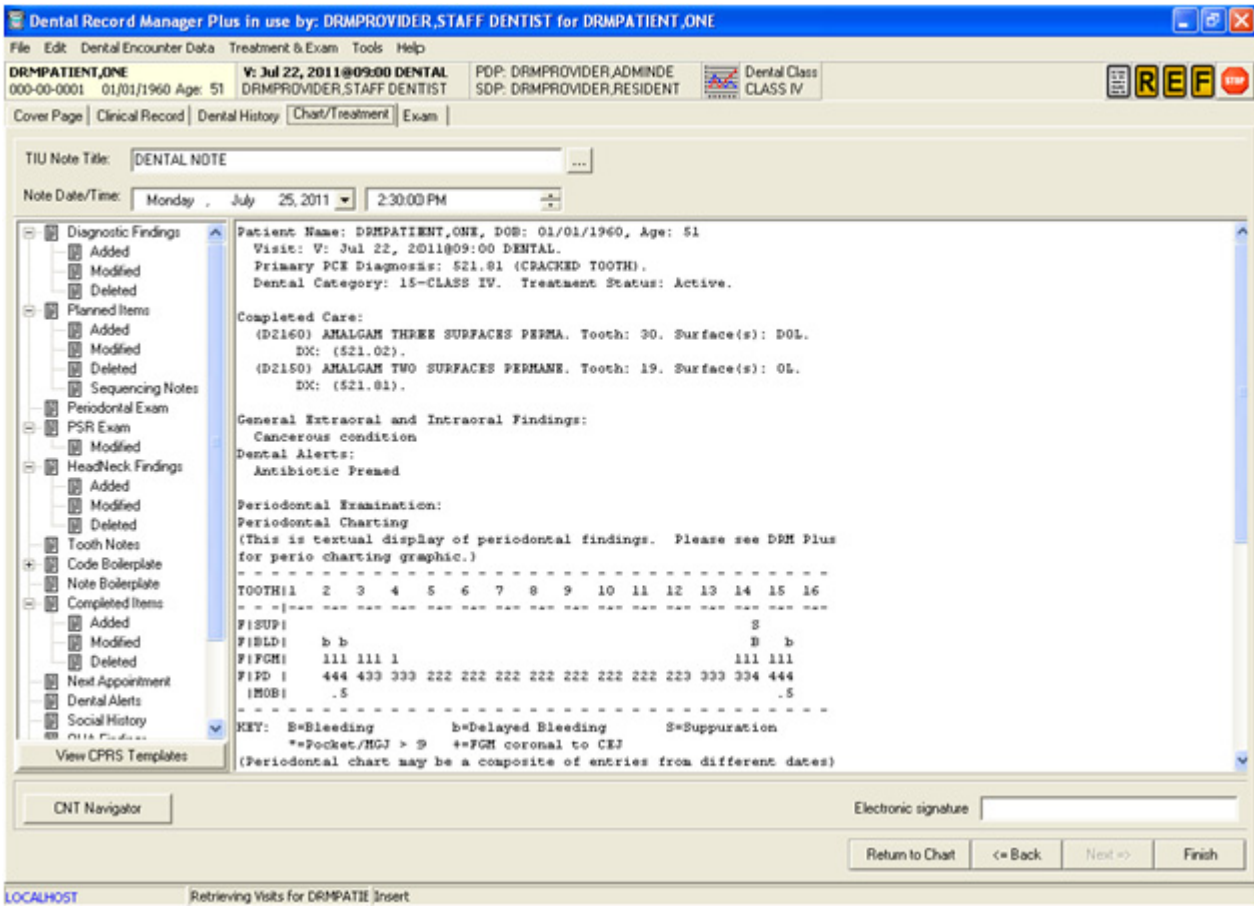


Figure 208: Progress Note Screen

Use the **ellipses (...)** button to change the TIU Note Title here if needed. Use the **up** and **down** arrows to change the Note Date/Time if desired. From this screen, the user can also: view and/or import DRM Plus objects, view and import CPRS templates, launch CNT Navigator (DSS product clinical note templates), view the patient's progress note, import VistA medical information and add an electronic signature.

Viewing/Importing DRM Object/Progress Note

To view/import DRM objects:

1. View the DRM object in the tree on the left side of the screen.
2. Double-click the DRM object and it appears in the viewer on the right side of the screen. The DRM object imports where the cursor is positioned.
3. Information can be added or deleted by typing directly into the progress note on the right side of the screen.

Viewing/Importing CPRS Templates

To view/import CPRS templates:

1. Click the **View CPRS Template** button**.**
2. The shared/personal templates tree, if expanded, appears on the left side of the screen. Functionality of CPRS templates in DRM Plus is the same as in CPRS.
3. Click the **View DRM Plus Object** button to return to the DRM Plus Objects tree.

Importing VistA Medical Information

To import VistA medical information into the patient's progress note:

1. Right-click in the progress note area.
2. The Import Menu appears.

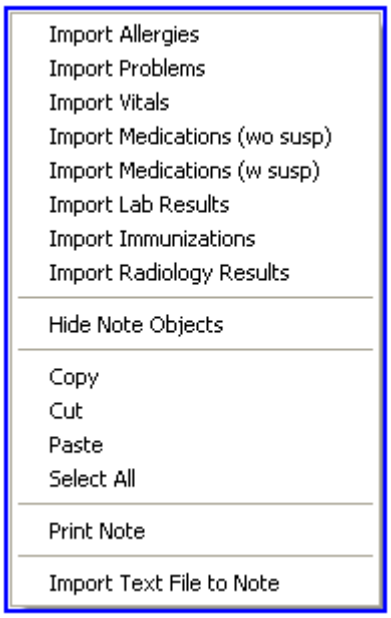


Figure 209: Import Menu

3. Choose the information that is to be imported from the top half of the menu.
4. The information appears in the progress note where the cursor was positioned.

Other Options in the Import Menu

Hide Note Objects: Hides or closes the objects tree on the left side of the screen and enlarges the progress note viewer.
View Note Objects: Undoes Hide Note Objects.
Copy: Copies selected text in the progress note.
Cut: Cuts selected information in the progress note.
Paste: Pastes information into the progress note.
Select All: Selects all text in the progress note.
Print Note: Prints the progress note.
Import Text File to Note: Navigate to a text file to import into a note. See the User Options section in the Using DRM Plus Drop-Down Menus chapter of this manual for more information on automatically setting the location for this text file.

Accessing Dental CNTs

Click the **CNT Navigator** button to access Dental CNTs. These are DSS product clinical note templates. The Dental CNTs may not be mapped for DRM Plus at the user's site, which would require IRM assistance. Please see the CNT Navigator section, further in this chapter.

Electronic Signature

Enter the Electronic Signature and click the **Finish** button to complete the progress note. Clicking the **Finish** button without entering an electronic signature leaves the patient progress note status: unsigned.

Progress Note Addendum

When the File Data With Note Addendum option has been chosen, the progress note screen appears slightly different. The functions are the same as in the previously shown Progress Note screen with the additions of selecting the Note Categories, and the Note Display.

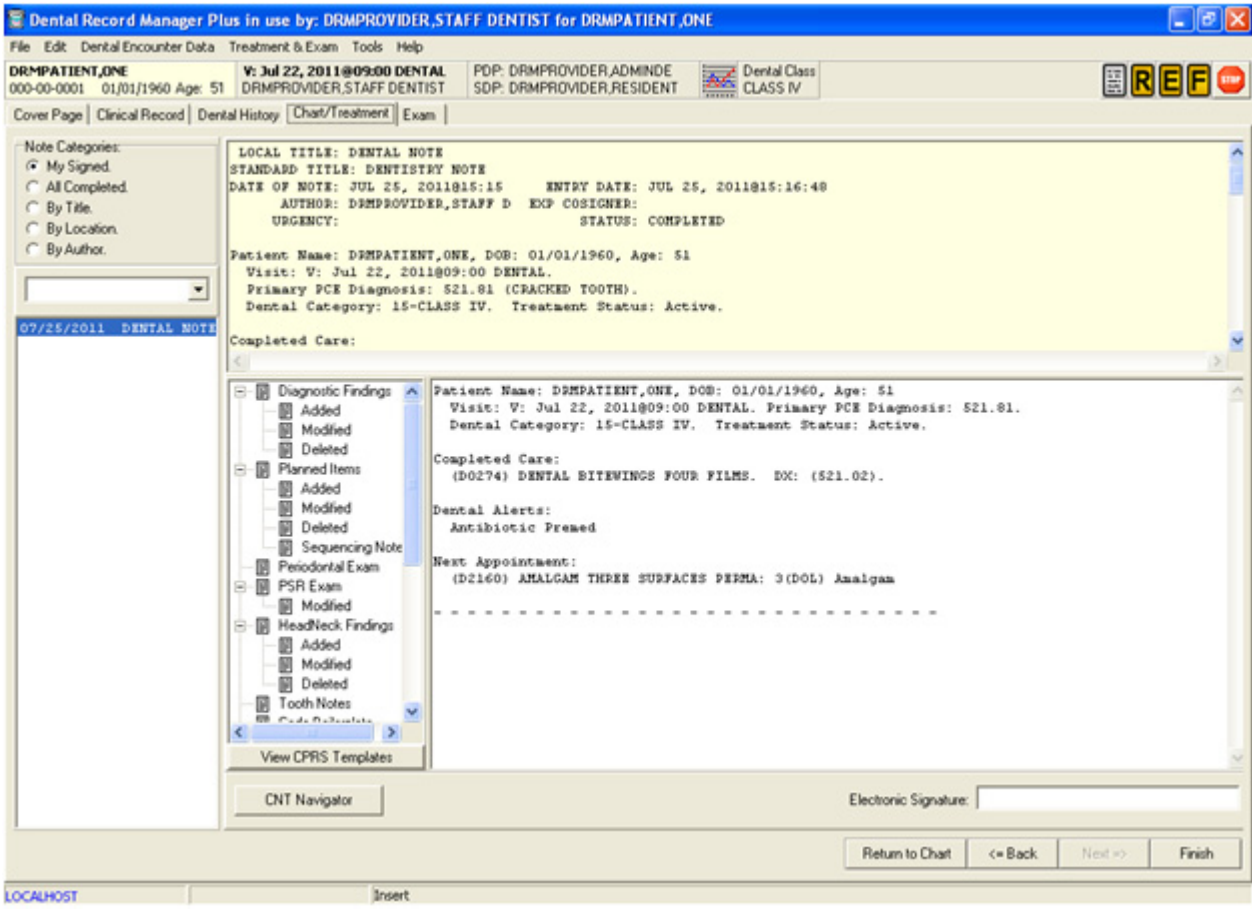


Figure 210: Progress Note Addendum Screen

The notes associated with the selected note categories appear in the white space below the note categories area. Use the drop down menu below the note categories screen to filter the results. Click a primary note to view details in the upper right area of the screen.

Select a category/note to finish the process of filing the encounter with a note addendum, which is displayed in the lower right area of the screen.

CNT Navigator

Clicking the **CNT Navigator** button brings up a directory of clinical note templates in use, as a tool, to assist the user in writing a note, or adding additional information to a note. The CNT Navigator button is located on the bottom left side of the Progress Note screen. These are Document Storage Systems (DSS) product clinical note templates, and may not function unless they are mapped correctly, which requires IRM assistance.

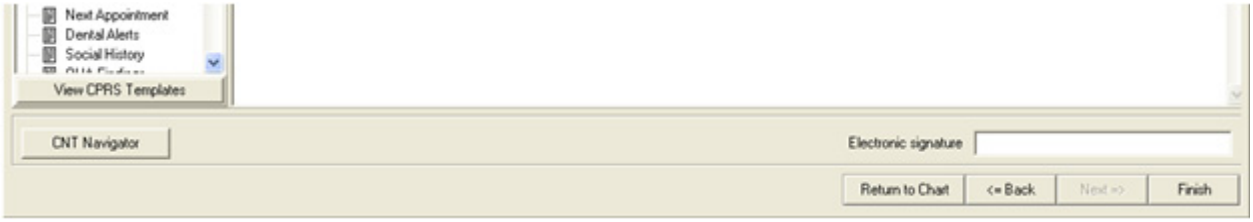


Figure 211: CNT Navigator button

Using the mouse, point and click to select pre-determined text in the development of a note. Free text type within the CNT, if the pre-determined text or statement does not contain the necessary verbiage.

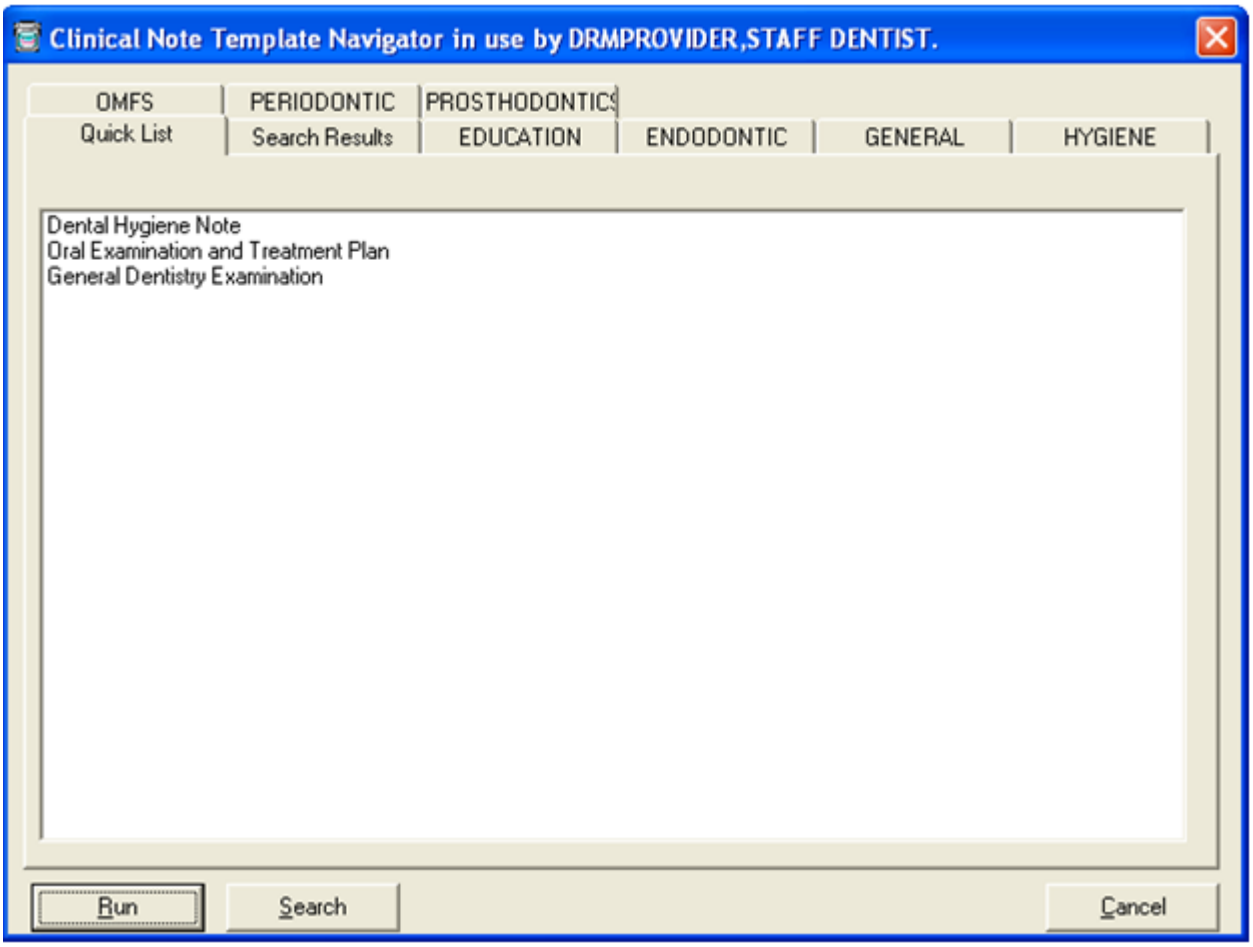


Figure 212: Using the CNT Navigator

To access a CNT:

1. Click any of the tabs.
2. A listing of CNTs specific to the selected tab appears. Either double-click the desired template, or click once to select it and then click the **Run** button.

Navigating Within CNTs

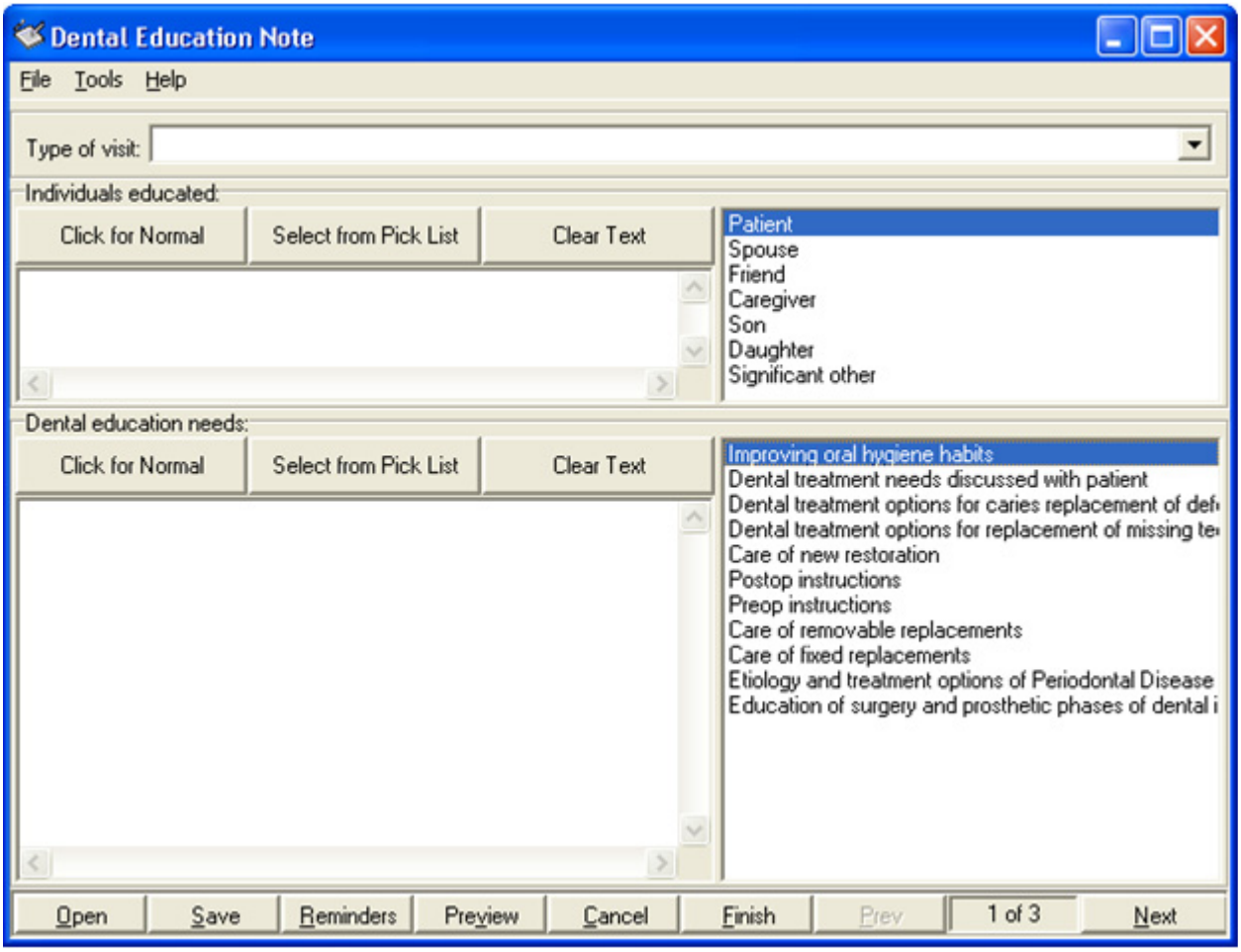


Figure 213: Navigating Within CNT

To navigate within a CNT:

1. Point and click within the windows, tabs, drop-down arrows, checkboxes and radio buttons. Each navigational method provides the user with a different method of entering or selecting information.
2. Preview the note by clicking the **Preview** button.
3. Click the **Return** button to continue writing the note.

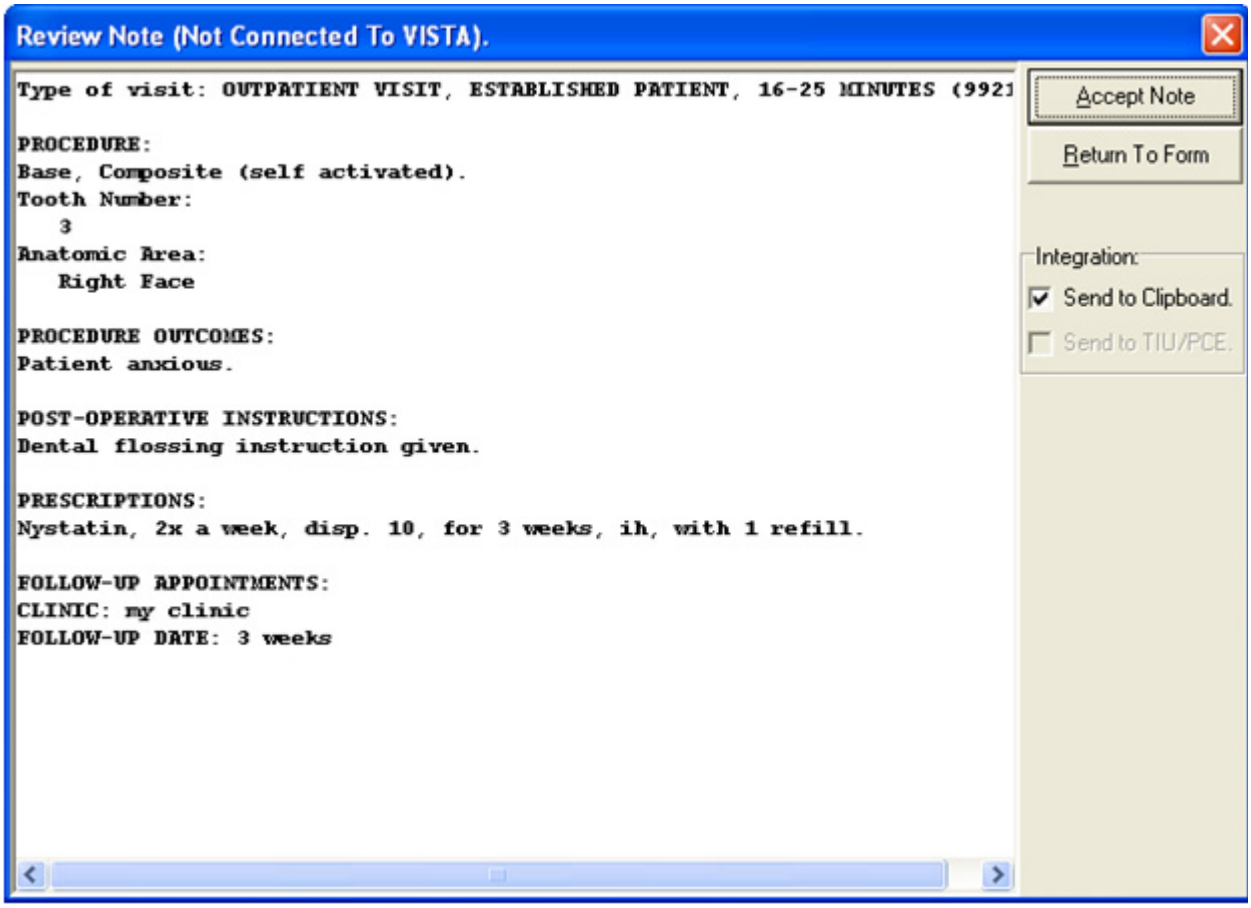


Figure 214: Preview Note

When the note is complete, click the **Finish** button. Then click the **Accept Note** button.

Consult Notes

The option to complete a consult comes after the service connection screen, during the process of completing a patient encounter, when the Set Progress Note Title screen appears.

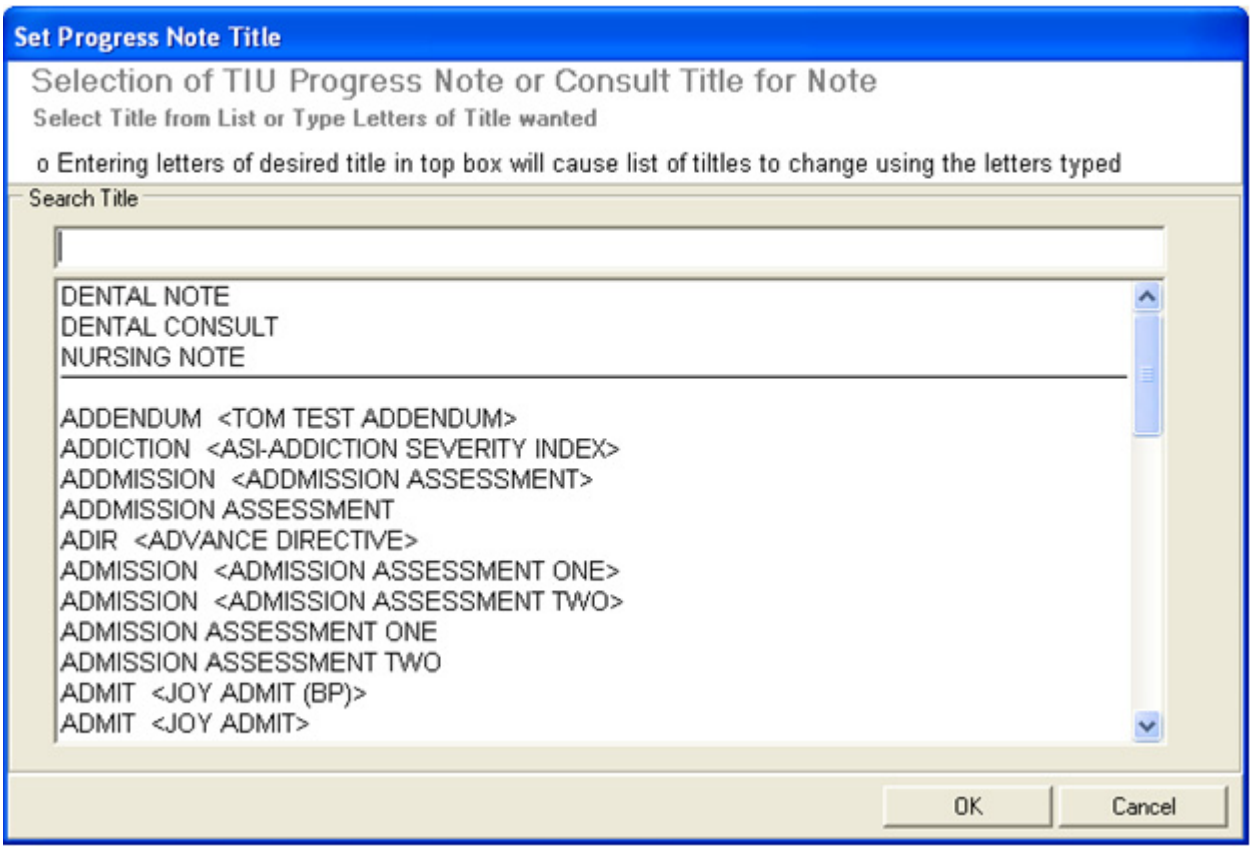


Figure 215: Set Progress Note Title Screen

To complete the consult:

1. Choose the consult title from the Set Progress Note Title screen.
2. The patient's pending consults appears on the screen.

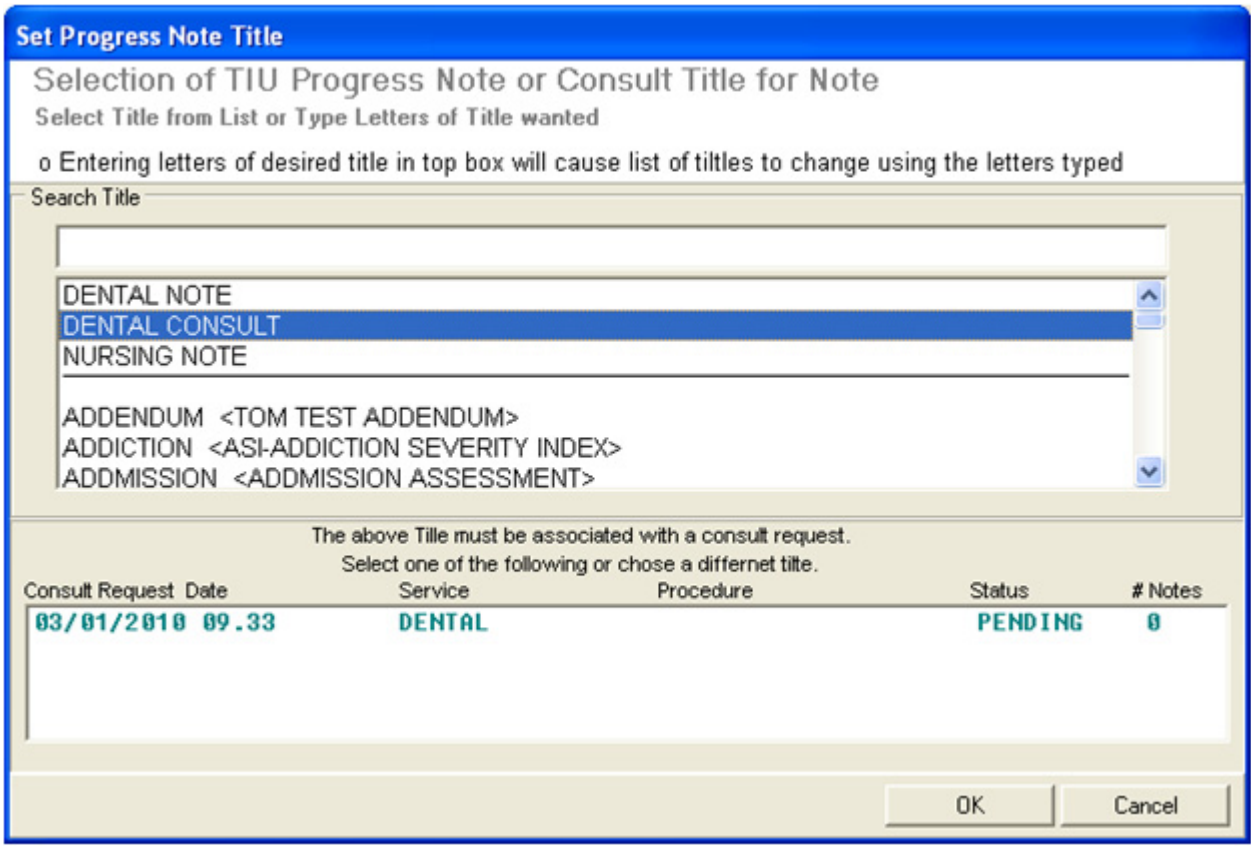


Figure 216: Set Progress Note Title with Consult Requests

3. Select the consult from the list.
4. The consult is added to the progress note on the Progress Note screen. Once the electronic signature is entered on the Progress Note screen, the consult will be complete.

Resident Filing as Cosigners or Distributed Providers

A 2006 VA Directive stated that residents are users with a Person Class of V030300, or V11550 or V115600. Residents are required to have a distributed provider (attending) to complete the encounter with the patient. Since most sites require residents to enter a cosigner for the note, the cosigner will default as the distributed provider in PCE. If there is no cosigner required for the resident, or the user filing data to a resident, they must enter the distributed provider before filing.

To add a distributed provider:

1. Click the **Finish** button.
2. The Change Provider screen appears.

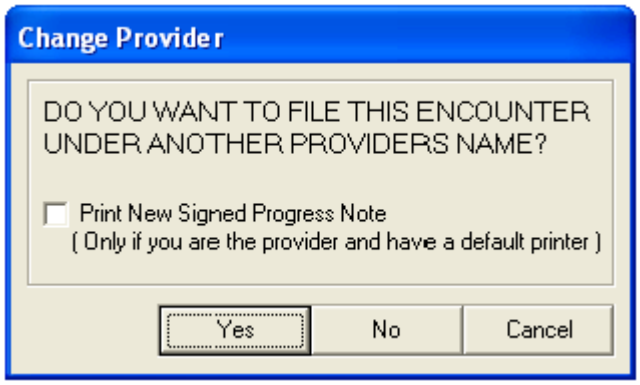


Figure 217: Change Provider Screen

3. Click the desired response (Residents will click the **No** button).
4. The Search for Cosigner Provider screen or the Search for Distributed (PCE Primary) Provider screen appears.

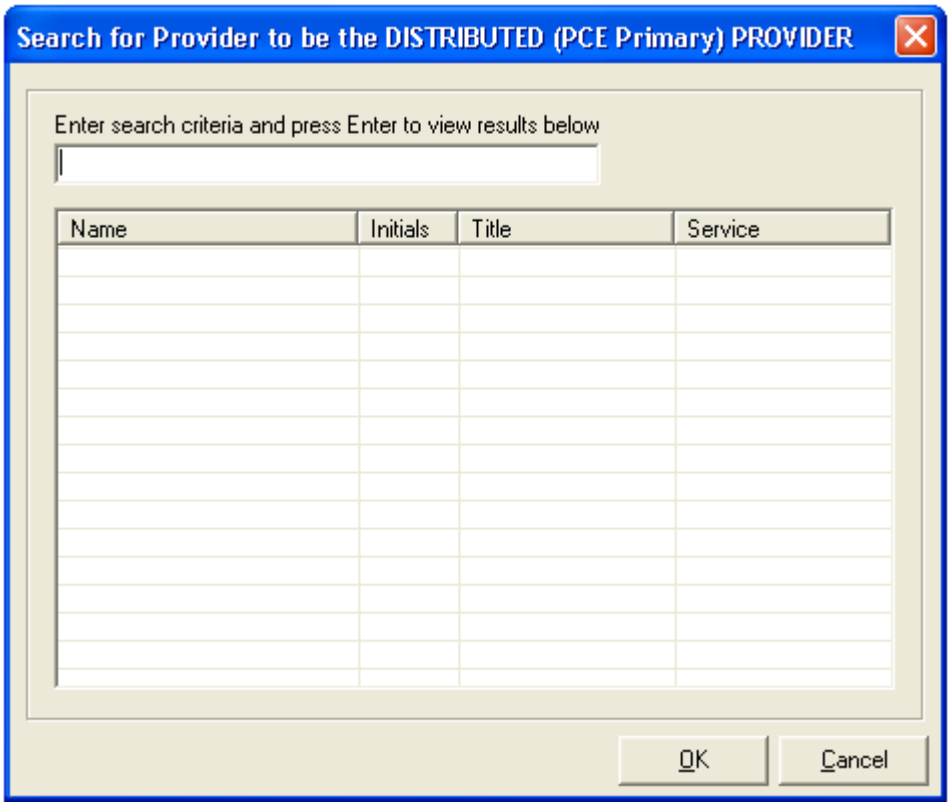


Figure 218: Search for Distributed Provider Screen

5. Enter the search terms in the text box and press the <**Enter**> key.
6. Choose the provider from the search results and click the **OK** button.
7. An information screen appears confirming that the information was field.

Note: VA Dental gives credit/RVU time to the residents actually performing the procedures, all of which is filed to DES; to meet the VA requirement that the attending (distributed) gains credit for, requires this to be filed in PCE.

When the visit is filed to PCE, the resident will become the secondary provider, and the distributed provider will become the primary provider for the visit. All procedures and diagnoses will be assigned to the resident.

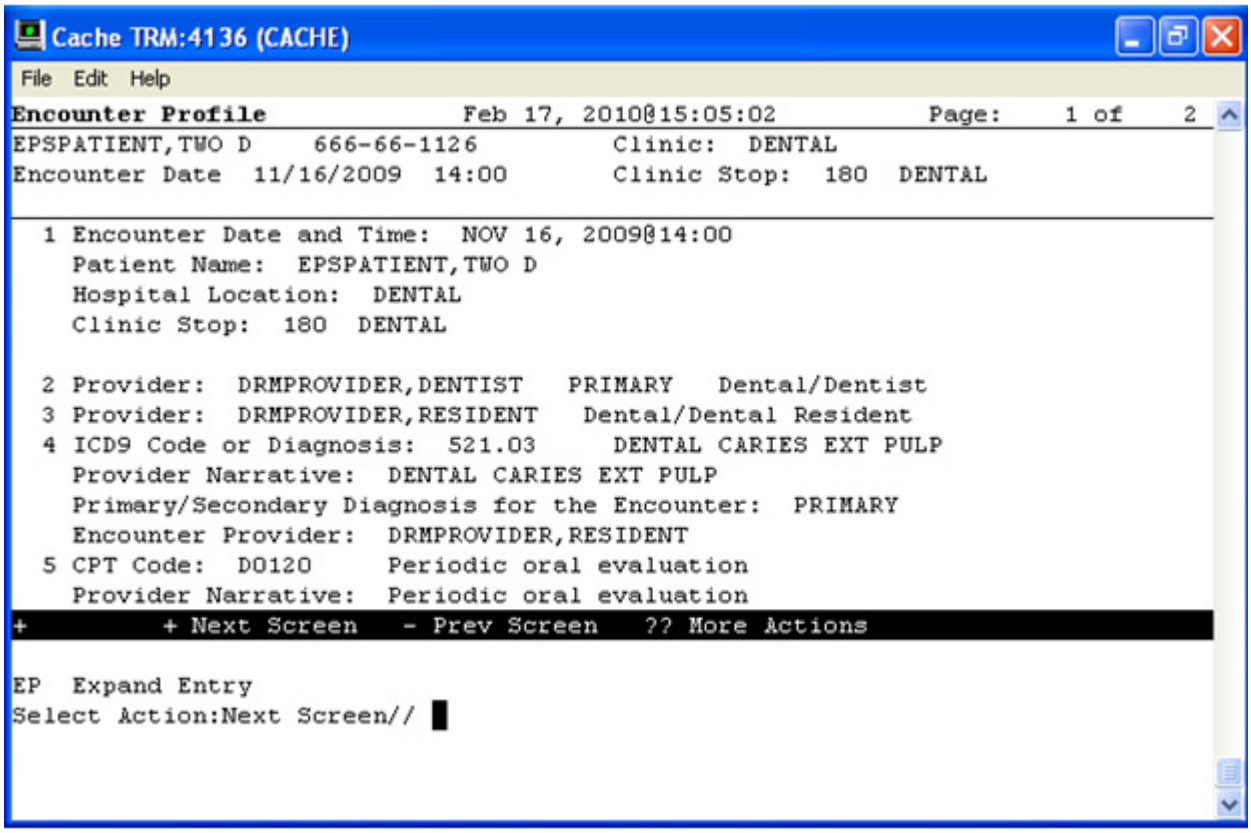


Figure 219: PCE Encounter Information in VistA

Appendix A – Glossary of VA Terms

ADPAC	Automated Data Processing Applications Coordinator
AICS	Automated Information Collection System, formerly Integrated Billing, the program that manages the definition, scanning and tracking of Encounter Forms.
APPOINTMENT	A scheduled meeting with a provider at a clinic; an appointment can include several encounters involving other providers, tests, procedures, etc.
CBOC	Community Based Outpatient Clinic
CC	Coordinating Committee
CFO	Chief Financial Officer
CHECKOUT PROCESS	Part of the Medical Administration (PIMS) appointment processing. The checkout process documents administrative and clinical data related to the appointment.
CIO	Chief Information Officer
CIR	Corporate Information Repository
CIRN	Clinical Information Resource Network
CLINICIAN	A doctor or other provider in the medical center authorized to provide patient care.
CNT	Clinical Note Template (Used to format TIU Notes)
CPR	Cardiopulmonary Resuscitation
CPRS	Computerized Patient Record System
CPT	Common Procedure Terminology
CQI	Continuous Quality Improvement
DAS	Dental Activity System (also called AMIS)
DES	Dental Encounter System (also called DES)
DHCP	Decentralized Hospital Computer Program (See: VistA)
DNR	Do Not Resuscitate
DOD	Department of Defense
DRG	Diagnostic Related Group

DSS	Decision Support System
DSS	Document Storage Systems, Inc.
DVA	Department of Veteran Affairs
EDI	Electronic Data Interchange
ELC	Executive Leadership Council
EMR	Electronic Medical Record
ENCOUNTER	A contact between a patient and a provider who has responsibility for assessing and treating the patient at a given contact, exercising independent judgment. A patient can have multiple encounters per visit.
ENCOUNTER FORM	A paper form used to display and collect data pertaining to an outpatient encounter, developed by the AICS package.
EPISODE OF CARE	Many encounters for the same problem constitute an episode of care. An outpatient episode of care may be a single encounter, or can encompass multiple encounters over a long period of time.
FEMA	Federal Emergency Management Agency
FIM	Federal Independence Measure
FRP	Federal Response Plan
GAF	Global Assessment of Functioning
GPRA	Government Performance and Results Act
GUI	Graphic User Interface
HEALTH SUMMARY	A Health Summary is a clinically-oriented, structured report that extracts multiple kinds of data from VistA and displays it in a standard format.
HR **IGA**	Human Resources Office of Intergovernmental Affairs
INPATIENT VISIT	Inpatient encounters include the admission of a patient to a VAMC and any clinically significant change related to treatment of that patient.
IOM	Institute of Medicine
ISDA	Intensity Severity Admission Discharge (criteria)
IT	Information Technology
JCAHO	Joint Commission on the Accreditation of Healthcare Organizations
LAN	Local Area Network

M V V	Mission Vision Values
MAC	Management Assistance Council
MCCR	Medical Care Cost Recovery
MDS	Minimum Data Set
NHCU	Nursing Home Care Unit
OERR	Order Entry Results Reported
OSHA	Occupational Safety & Health Administration
OUTPATIENT ENCOUNTER	Outpatient encounters include scheduled appointments and walk-in unscheduled visits
OUTPATIENT VISIT	The visit of an outpatient to one or more units or facilities located in or directed by the provider maintaining the outpatient health care services (clinic, physician's office, hospital medical center) within one calendar day
PACS	Picture Archiving and Communications System
PAI	Patient Assessment Instruction
PCE	Patient Care Encounter
PI	Prevention Index
PM	Performance Management
PROCEDURE	A test or action done for or to a patient that can be coded with the CPT coding process
PROVIDER	The entity which furnishes health care to a consumer
PSA	Patient Service Area
PTSD	Post Traumatic Stress Disorder
RM	Risk Management
RPM	Resource Planning Methodology
SD	Standard Deviation
SMI	Seriously Mentally Ill
SSC	Shared Service Center
TIU	Text Integrated Utility
TQI	Total Quality Management
UM	Utilization Management

UNC	Universal Naming Convention. Used in place of Drive letters
VA	Department of Veteran Affairs
VAVS	Veterans Administration Voluntary Service
VHA	Veterans Healthcare Administration
VISN	Veterans Integrated Service Network
VISIT	The visit of a patient to one or more units of a facility within one
VistA	Veterans Information System Technology Architecture, the new name for DHCP
VSO	Veterans Service Organization

Appendix B – Common Application Functions

Microsoft Windows tools are used in DRM Plus. Left-clicking, right-clicking, double-clicking, drop-down arrows, radio buttons, checkboxes, text boxes, highlighting and scroll bars are used throughout DRM Plus. Certain buttons and clicking options are common to most screens and are discussed below.

OK: Clicking the **OK** button is used to finalize a selection or end a process. The open screen is closed, and the user is moved to another screen.

Cancel: Clicking the **Cancel** button cancels the action taken on a screen and returns the user to the previous screen.

Next: Clicking the **Next** button moves the user to the next screen.

Back: Clicking the **Back** button moves the user to the previous screen.

Add: Clicking the **Add** button adds a selected item to a function.

Edit: Clicking the **Edit** button allows the user to edit a selection.

Delete: Clicking the **Delete** button allows the user to delete a selection.

Reset: Clicking the **Reset** button resets changed settings to their original settings.

Finish: Same as the **OK** button.

Browse Buttons: Clicking the **browse** buttons moves the user to a previously-programmed selection screen.

Radio Buttons: Clicking a **radio** button displays a dot in the button, designating a specific option. Only one radio button is allowed for selection in a group.

Checkboxes: Clicking a checkbox works the same as a radio button; however, multiple selections can be added from one group.

Text Boxes: Clicking in a textbox allows the user to type text into the box.

Drop-Down Arrows: Clicking these arrows displays a menu of selections.

Selection Arrows: Clicking these arrows allows a selected item to be moved from one dialogue box to another.

Search Boxes: Typing selection criteria in a search box causes the criteria to be matched to a master file. Matches are displayed, allowing the user to highlight the desired selection for further action. DRM Plus requires the user to press the <Enter> key after entering the criteria.

Sorting: Clicking a Transaction table column heading will sort the table, usually in ascending order, depending on the current view. Clicking the column heading a second time returns the table to its original view.

Highlighting: Clicking an item will result in its being highlighted, and selected for the next action to be completed.

Shift Key: Generally, holding the <Shift> key down allows for selection of multiple consecutive items in Windows applications.

Control Key: Generally, holding the <Control> key down allows for selection of multiple items in Windows applications.

Keyboard Use: When a letter or a button name is underlined (Add or Speed Code) the user may use the keyboard to activate the button. The action required is to press and hold the <Alt> key, then press the underlined letter.

Appendix C – Hints and Notes

Save Unfiled Data

If the user has entered any data and attempts to close DRM Plus, or switch to a different patient, DRM Plus will display a screen prompting the user to save the current patient's entries. Clicking the **Yes** button initiates the save unfiled data function.

When the user has saved unfiled data and no longer needs this data for the patient, there are only two options to eliminate this saved, unfiled data. The first is to select the **Delete** button when opening the patient, and the dialogue screen will ask the user if they want to load saved data. The section option is to delete the saved unfiled data from the Unfiled Data by Provider report.

Dental Class Displayed on Banner

The patient's Dental Class appears in the banner area, only if the information was entered on the Cover Page in the Dental Eligibility/Dental Class field by a DRM Plus administrator. As soon as the Dental Class is selected, it appears in both fields: the Dental Class field on the Cover Page tab screen, and the Dental Class box in the DRM Plus banner.

Diagnostic Findings

The Diagnostic Findings are not updated automatically from Completed Care entries for any encounter. Any Completed Care entries that are filed need to be entered as Diagnostic Findings during a patient's future dental examination.

Always mark teeth missing in Diagnostic Findings before entering Partials, Dentures, Implants or Bridge findings. DRM Plus works best when missing teeth or endentulous arch(es) are entered before any other findings. Dentition is always entered first on a new patient before any dental data is entered in DRM Plus, if the patient is a juvenile.

Diagnostic Findings may be deleted after the encounter has been filed by any end user. If this happens after the encounter has been filed, the findings deleted will be removed from the graphic; however, the text entry will remain in the transaction table with a line through it. An administrator of DRM Plus has the ability to completely remove any Diagnostic Finding entry from the transaction table, unless the entry was already deleted by an end user.

Treatment Plan

For implant procedures entered in the Treatment Plan screen, and if a related Diagnostic Finding of Missing has not been entered, DRM Plus will not allow this corrective planned treatment procedure to be entered.

It is recommended to use the Include Findings and Completed button to temporarily combine screens of the treatment plan with the Diagnostic Findings and not use the automatic Include option in DRM Plus. The automatic Include option is the original default in DRM Plus when the end user is viewing a Treatment Plan, and the screen of Diagnostic Findings is included. End users may edit this parameter by accessing the Treatment & Exam menu/ Show Configuration option / Tx & Exam tab / Display Defaults drop-down menu and removing the check marks in the checkboxes.

Multi-Add Screen

Small buttons [<] and [>] have been added to the CPT Procedure Codes screen and multi-add screen to enable the user to move the screen to the other half of the graphic chart. This may be necessary to see what is beneath, especially when entering multi-add codes.

Missing teeth display as white text on a blue background. This can help the user visualize the mouth while entering multi-add codes. The missing teeth are still selectable if needed for the procedures partial, denture, implant or bridge.

Ranged Codes

Certain codes, designated as Ranged Codes, used for multiple teeth procedures, mostly in the prosthetics area, have been restricted and can only be used with hard coded DRM Plus icons. These icons are Partial, Bridge, Conn Bar and some Denture procedure codes. These icons are only found with the Treatment Plan and Completed Care view screens. When the user utilizes other options for selecting these CPT procedure codes, when using the ADA codes icon or the Add box, the ranged codes are grayed out and cannot be selected.

Speed Codes

Speed Codes do not have Multi-Add or Suggestion Links functionality. Multi-Add and Suggestion Links functionality work with the Quick Codes icon, ADA Codes icon, CPT Codes icon, using the Add box to select a procedure code. Some of the DRM Plus standard icons allow multi-add functionality. Speed codes are only used with the Treatment Plan and Completed Care view screens for selecting a procedure code.

Speed Codes that include codes violating Coding COmpliance rules need to be edited or deleted.

Sequencing Screen

There is a maximum of nine phases which may be added to the Planned Treatment for one patient. There are an unlimited number of sub-phases possible in each phase.

Ranged codes, mostly prosthetics, move as a block when one code is highlighted, by left-clicking on the item, holding, and dragging to the proper phase.

End users are able to re-size and move the Sequencing screen in all directions. DRM Plus allows the users to drag and drop multiple procedures at one time by pressing the <**Shift**> and <**Ctrl**> keys.

Users may add or modify the Treatment Plan and Sequencing screen and file the changes without having to click the **Next** button and create a progress note as long as no new completed transactions, perio, PSR or Head & Neck data are entered. In addition, the most recent dental encounter must have an Active status for this feature to work. Clicking the **Save and Exit** button from the Sequencing screen files any changes made, and minimizes DRM Plus. Any new planned entries added will have the same visit date as the latest progress note filed for the patient.

If the completed care screen is set as the display default in DRM Plus, completed care transactions completed from the sequencing screen may require a refresh for those transactions to appear in the completed care screen. Selecting the **Diagnostic Findings** button or the treatment plan button and then reselecting the **Completed Care** button refreshes the application.

Completed Care

Completed procedures that have been filed as signed Progress Notes can only be deleted by a DRM Plus administrator. If end users don't have this Administrative parameter option and highlight an entry in the transaction table of Completed Care, then click the **Delete** button, a screen will appear, stating that the transaction cannot be deleted. When a DRM Plus administrator deletes any entry from DRM Plus, appropriate procedures must be followed to correct any associated entry filed in VistA TIU.

In those rare cases where pre-existing charted care does not allow the user to click and select a procedure code via the graphic chart, the user may enter the desired code via the ADA Codes icon.

If one or more of the procedures entered with multi-add functionality require an assignment of a different ICD-9 diagnosis code, unselect the procedure code by clicking the procedure code located on the upper left side of the ICD-9 Diagnosis Code Dialog screen. The deselected procedure code no longer appears highlighted, and is also removed from the table at the bottom of the screen, indicating that it will not file with the selected ICD-9 diagnosis code. Click the **OK** button at the bottom of the screen, and the remaining procedure code(s) recycles and appears highlighted in the ICD-9 Diagnosis Code Dialog screen for the user to assign an ICD-9 diagnosis code. This process of recycling continues until all procedure codes added with the multi-add functionality have an ICD-9 diagnosis code assigned by the user.

Periodontal Chart

The **History** button maintains all graphical entries from previous perio examinations; therefore, any prior perio exam graph may be viewed with the **History** button, selected from the Periodontal Chart screen. The Periodontal History/Compare screen may be vertically extended to view any data that is not visible.

To use the Furcation icon, the cursor shield must be positioned at the root location where an entry in the graphics would be appropriate.

The **X** button located at the end of the pre-defined measurement scale results in a null entry in the transaction table for the Pocket, FGM, MGJ, Mobility and Furcation icons. This null entry only works when the specific icon is active for Pocket, FGM, MGJ, Mobility and/or Furcation. The null entry remains as a "**-**" mark in the transaction table, and no entry in the Progress Note.

If the error is recognized immediately, the **Undo** button may be clicked. Otherwise, place the cursor shield on the pocket where the incorrect value was entered. If the value is for Pocket, FGM, MGJ, Mobility or Furcation, the incorrect value can be replaced by entering the correct value.

A zero entry results in no graphical view; however, it results in a zero entry in the transaction table and Progress Note, because it is a measurement. If no recording should be present for a given icon, a null entry can be created by clicking the **X** button. If the incorrect entry is for Bleeding, Delayed Bleeding or Suppuration, click the identical icon again to remove the graphic display and the transaction table entry.

When perio data is imported into the Progress Note, it has each tooth displayed with each surface and condition shown in the vertical column, under the tooth number. The key at the bottom of the progress note explains certain symbols. There may be a statement at the bottom of the perio data, which informs other providers that this Progress Note contains perio data from the current exam, as well as data that has not changed from at least one previous exam. If the Clear icon was used at the beginning of the exam, then only data from this current exam is imported into the note.

Warning levels can be changed by the end-user and then displayed. The pocket depth warning level should be the same for the perio chart graphics, and for the pocket depth warning level listed on the Statistics tab. The Pocket Depth warning level on the Statistics tab must be the same as the Pocket Depth warning level in the Periodontal tab. Both of these tabs are found by utilizing the Configuration option from the Treatment & Exam menu.

Completing the Encounter

Entering data in the Encounter Dental Class drop-down menu will have category numbers 1-8 displayed for inpatients, and numbers 9-22 for outpatients.

Selecting any Service Connection checkbox sends the flag to PCE for the encounter.

DRM Plus is now aligned with CPRS for patients who are Combat Veteran service connected. If appropriate, the Combat Veteran option will default to a check (Yes) in DRM Plus. To remove the check (change to No), click the checkbox to the left of the Combat Veteran field. The check is removed.

VistA has co-signature functionality, and is checked by CPRS and DRM Plus. Both GUIs also have additional signer functionality. Additional signers are not required, but may be added to a Progress Note by a provider. Do not confuse additional signers with co-signers. Co-signers are built into VistA by facility management based on business rules. If the software detects that a co-signer is required, a screen will display, requesting a co-signature. A provider may need a co-signer for one or all Progress Notes.

Since most sites require residents to enter a co-signer, the co-signer defaults as the distributed provider in PCE. If there is no co-signer (i.e. no note exists when using File Data Without a Note, or the resident is not required to have a co-signer) then the resident, or user filing resident data, must enter the distributed provider prior to filing. When the encounter is filed to VistA PCE, the resident becomes the secondary provider and the distributed (attending) provider becomes the primary provider for the encounter. All procedures and diagnoses are assigned to the distributed provider in VistA PCE.

VA Dental wants to give credit/RVU time, etc. to residents who actually perform the procedures, and all of this is filed to VistA DES; however, to meet the VA requirement that gives credit for the encounter to the attending (distributed), requires this to be filed in VistA PCE.

DRM Plus users may import a TIU Note Boilerplate into a patient progress note. If the Note Boilerplate parameter is set with a check mark, an informational screen displays when selecting a TIU Note or Consult title, if that title has a note boilerplate associated with it. The informational screen allows a user to select Yes or No to the question of importing the note boilerplate. If this parameter is not set with a check mark then the note boilerplate imports into the patient progress note without an opportunity to decline this action. This parameter is located under the Tools menu/User Options/General tab/**Other Parameters** button.

CPRS templates will automatically import into a patient progress note if the TIU Note/Consult title selected is associated with a CPRS template and there is no option for the user to decline this template import. When the template appears or opens, complete or fill-in the appropriate information on the template and close or finish it. The information entered on the template will import into the patient progress note. Please note: DRM Plus does not support Reminder Dialog or COM Object CPRS templates.

There are generally two types of progress notes created using DRM Plus: 1. using the Exam tab or 2. not using the Exam tab. A progress note created using the Exam tab sequences DRM Plus objects in the order

designed and approved by the VA Dental Exam Committee. The sequencing of DRM Plus objects in the Note Objects Sequence parameter screen is overwritten by the Exam tab sequence design when the Exam tab is used. Progress notes created without using the Exam tab will sequence DRM Plus objects in the order set by the user in the Note Objects Sequence parameter screen. This parameter is located by selecting the following: Tools/User Options/Progress Note tab/Set Note Sequence button. The Note Boilerplate in the list of Note Objects Sequence parameter screen includes both TIU Note Boilerplates and supported CPRS templates.

All DRM Plus data objects displayed in the left window of the Progress Note screen may be imported into the note automatically. This depends on whether the parameter is activated by the end-user. However, most of the data objects are not allowed to be deselected by the end-user for the automatic importing process. This parameter is located by selecting File menu, User Options, Progress Note tab and then clicking the **Progress Note Data** button.

DRM Plus Code Boilerplates are listed individually with the DRM Plus Objects on the Progress Note screen. DRM Plus users who have created code boilerplates can now import them into a Progress Note by clicking the **desired Code Boilerplate object**, listed with DRM Plus objects. Using the cursor, set the object where it will be sequenced in the Progress Note, then double-click to import the object.

Text files may be created and saved in a preferred directory. Right-click in a Progress Note window and click **Import Text File** to navigate to and open the saved file. The file is then placed in the Progress Note as designated by the cursor placement.

Follow these steps to set up a file for importing:

1. Create a folder in an appropriate directory (usually a server drive).
2. From the Tools menu/ User Options/ click the **Set File Folder** option and navigate to the folder created in step 1. Set the folder by double-clicking it.
3. Create a text file from the Tools menu/ Windows Notepad option and save it as a .txt file in the designated folder from step 1.

If the user clicks the **Finish** button before the provider's electronic signature is entered, the Progress Note will be filed in VistA (PCE, DES and TIU) as an unsigned note, and may be viewed with CPRS. If the electronic signature is entered before clicking the **Finish** button, the Progress Note will be filed as a signed note in VistA (PCE, DES and TIU).

When the user clicks the **Finish** button, a prompt may appear if there are no planned items, and if the patient status is Active. Correctly identifying the patient's status is important for reporting. The end user should click the proper radio button (Active, Inactive or Maintenance) and then click the **OK** button.

Reports – Non-Clinical Time by Provider

The Non-Clinical Time by Provider report displays an approximate numerical unit of days (1 day = 8 hours). Accumulation of less than 4 hours results in rounding down to the nearest whole number day, and accumulation of 4 or greater rounds up to the nearest whole number day.

Code Boilerplates

Multiple boilerplates may be added for a single code, or multiple codes may be associated to the same boilerplate. The user may establish as many boilerplates and related codes as necessary.

If an administrator of DRM Plus creates a code boilerplate in their Administrative Toolbox option, then every user may use the code boilerplate by entering the name of that code boilerplate to their parameter. Enter the name precisely as it was entered by the DRM Plus administrator and click the **OK** button in the end user's User Options. This action imports the administrative code boiler plate to the end user code boilerplates.

Last Broker Call

The Last Broker Call option is used by the IT or ADPAC personnel to document problems. It is not usually accessed by providers.

Recent Dental Activity

This section on the Cover Page tab displays the most recent date for selected types of procedure codes. Hover the cursor over the heading to display all of the ADA procedure codes, which comprise the data for that heading.

- Last Monitored Exam = D0120, D0150 or D0180
- Last Comprehensive Exam = D0150 or D0160
- Last Brief Exam = D0120, D0140 or D0170
- Last Periodontal Exam = D0180
- Last Panorex Image = D0330
- Last Full Mouth Image = D0210
- Last Bitewing Image = D0270, D0272, D0274 or D0277
- Last Prophylaxis = D1110, D1205, D4341, D4342 or D4910
- Last Visit = the last dental visit date
- Last Provider = the provider for the last visit

Appendix D – Icon Definitions

Diagnostic Findings

The following table explains the actions required to enter a Diagnostic Finding:

ICON	CLICK TOOTH	CLICK SURFACE	CLICK ROOT	POP-UP SCREEN	ADDITIONAL COMMENTS
Restore	As many as required	As many as required	No	Material or surfaces	Graphic in green
Missing	As many as required	No	As many as required	Selected Roots	Graphic for roots is outlined
Observe	As many as required	No	As many as required	Selected Roots	Tooth outlined in red
Partial	As many as required	No	No	Cancel or Complete	Graphic allows root condition graphics to show. Graphic in purple.
Denture	Any tooth	No	No	None	Graphic allows root condition graphics to show. Graphic in purple.
Implant	As many as required	No	No	None	Graphic in violet
Sealant	No	As many as required	No	None	Graphic in green
Endo	No	No	Yes	Materials and roots	Graphic color denotes material
Apico	No	No	Yes	Selected roots	Graphic in red
Retro	No	No	Yes	Selected roots and materials	Requires Apico to be present. Graphic denotes material
Bridge					See special instructions

ICON	CLICK TOOTH	CLICK SURFACE	CLICK ROOT	POP-UP SCREEN	ADDITIONAL COMMENTS
Conn Bar					See special instructions
Hemi	No	No	As many as required	Selected roots	Graphic in dark grey
Coping	Yes	No	No	None	Graphic in green
P&C	No	No	As many as required	Selected roots and materials	Graphic in green and denotes material
Impact	As many as required	As many as required	As many as required	Selected surfaces and roots	Graphic in light blue, roots in blue-green
Def Rest	Yes	As many as required	Yes	Selected surfaces, roots and materials	Graphic in yellow, denotes material
Caries	Yes	As many as required	As many as required	Selected surfaces and roots	Graphic in red, root caries initiates description box
Drifting	Yes	No	No	Direction	Graphic is yellow arrow to the left of tooth
Tipped	Yes	No	No	Direction	Graphic is light blue arrow to left of tooth
Rotated	Yes	No	No	Direction	Graphic is green arrow to left of tooth
Ret Root	No	No	As many as required	None	Graphic removes crown
UndrCont	No	As many as required	No	Selected surfaces	Graphic is red and yellow
OverCont	No	As many as required	No	Selected surfaces	Graphic is red and yellow

ICON	CLICK TOOTH	CLICK SURFACE	CLICK ROOT	POP-UP SCREEN	ADDITIONAL COMMENTS
Overhang	No	As many as required	No	Selected surface	Graphic is red and yellow
Lesion	No	No	As many root surfaces as required	Selected roots	Can also click implant. Graphic is a red circle.
Faceted	No	As many as required	No	Selected surfaces	Graphic is red and yellow
Cracked	No	As many as required	As many as required	Selected surfaces and roots	Graphic is red and yellow
Chipped	No	As many as required	No	Selected surfaces	Graphic is red and yellow
Supr/Sub	Yes	No	No	Direction	Graphic is red arrow
Open Ct	Yes	No	No	None	Graphic is red arrow to right of tooth
Abfract	No	Facial or lingual	No	None	Graphic is blue arrows
Dentition	No	No	No	Dentition box	Converts graphic to juvenile. Must be done before other entries
Perm/Prin	Yes	No	No	Dentition Box	Designate selected tooth as primary or permanent
Endentulous	Any tooth	No	No	None	Graphic removes all teeth and roots in arch

Note: Certain Diagnostic Findings or Completed Care procedures, once entered, will appear graphically on all screen views. These items are, if entered from the Diagnostic Findings screen: missing, implant,

impacted, retained root, hemi section, dentition and observe. If entered from the Completed Care screen: extract, hemi section, implant and observe.

Treatment Plan

ICON	CLICK TOOTH	CLICK SURFACE	CLICK ROOT	POP-UP SCREEN	ADDITIONAL COMMENTS
Restore (2)	Yes	As many as required	No	Code Selection box	Graphic in Blue
Extract	Yes	No	Yes	Code Selection Box	Graphic in shadow
Observe	As many as required	No	No	None	Tooth outlined in red
Partial (1)	As many as required	No	No	Cancel or Complete	Graphic allows root condition graphics to show
Denture	Any tooth	No	No	Code Selection box	Graphic allows root condition graphics to show.
Implant	Yes	No	No	Code Selection Box	Graphic in violet, Diagnostic Finding must be Missing
Sealant	No	As many as required	Yes	Code Selection Box	Graphic in blue, no root graphic
Endo	No	No	Yes	Code Selection Box	Graphic in blue
Apico	No	No	Yes	Code Selection Box	Graphic in red
Retro	No	No	Yes	Code Selection Box	Requires Apico to be present. Graphic in blue.
Bridge (1)				Code Selection Box	See special instructions
Conn Bar (1)				Code Selection Box	See special instructions
Hemi	No	No	As many as required	Code Selection Box	See special instructions.
Coping	Yes	No	No	Code Selection Box	Graphic in blue

ICON	CLICK TOOTH	CLICK SURFACE	CLICK ROOT	POP-UP SCREEN	ADDITIONAL COMMENTS
P&C	No	No	As many as required	Code Selection Box	Graphic in blue
Perio Buttons	No	No	No	None	No Graphic. See Speed Code instructions.

(1) Certain codes associated with these icons are defined as Ranged codes. Ranged codes can only be entered by clicking the **Icon** button. The ADA Codes table, QuickLists or Speed Code entries are prohibited to enter these codes.

(2) To designate a root restoration, click the **Restore** icon. Click the **tooth surface** that corresponds to the root surface. Using a tooth note, or the Description edit feature in the transaction table, explain the root restoration.

Note: Certain Diagnostic Findings or Completed Care procedures, once entered, will appear graphically on all screen views. If these items are entered from the Diagnostic Findings screen, they are: missing, implant, impacted, retained root, hemi section, dentition, and observe. If entered from the Completed Care screen, they are: extract, hemi section, implant and observe.

Completed Care

ICON	CLICK TOOTH	CLICK SURFACE	CLICK ROOT	POP-UP SCREEN	ADDITIONAL COMMENTS
Restore (2)	Yes	As many as required	No	Code Selection Box	Graphic in Green
Extract	Yes	No	Yes	Code Selection Box	Tooth is removed. Root graphic in dark gray.
Observe	As many as required	No	No	None	Tooth outlined in red
Partial (1)	As many as required	No	No	Cancel or Complete. Then Code Selection box.	Graphic allows root condition graphics to show. Graphic in purple.
Denture	Any tooth	No	No	Code Selection Box	Graphic allows root condition to show. Graphic in blue-purple.
Implant	Yes	No	No	Code Selection Box	Graphic in violet, Diagnostic Finding must be Missing
Sealant	No	As many as required	Yes	Code Selection Box	Graphic in green. No root graphic.
Endo	No	No	Yes	Code Selection Box	Graphic in pink.
Apico	No	No	Yes	Code Selection Box	Graphic in red.
Retro	No	No	Yes	Code Selection Box	Requires Apico to be present. Graphic in green.
Bridge (1)				Code Selection Box	See Special Instructions
Conn Bar (1)				Code Selection Box	See Special Instructions

ICON	CLICK TOOTH	CLICK SURFACE	CLICK ROOT	POP-UP SCREEN	ADDITIONAL COMMENTS
Hemi	No	No	As many as required	Code Selection Box	Graphic in gray
Coping	Yes	No	No	Code Selection Box	Graphic in green
P&C	No	No	As many as required	Code Selection Box	Graphic in green
Perio Buttons	None	No	No	None	No Graphic. See Speed Code instructions.

(1) Certain codes associated with these icons are defined as Ranged codes. Ranged codes can only be entered by clicking the **Icon** button. The ADA Codes table, QuickLists or Speed Code entries are prohibited for entering Ranged codes.

(2) To designate a root restoration, click the **Restore** icon. Click the **tooth surface** that corresponds to the root surface. using a tooth note, and the Description edit feature in the transaction table, explain the root restoration.

Note: Certain Diagnostic Findings or Completed Care procedures, once entered, will appear graphically on all screen views. These items are, if entered from the Diagnostic Findings screen: missing, implant, impacted, retained root, hemi-section, dentition and observe. If entered from the Completed Care screen, these items are: extract, hemi-section, implant and observe.

Special Descriptions – Bridge Icon

Place the cursor on the first abutment and drag to the second abutment. The Code Selection screen displays, with the lowest number tooth selected, as shown below.

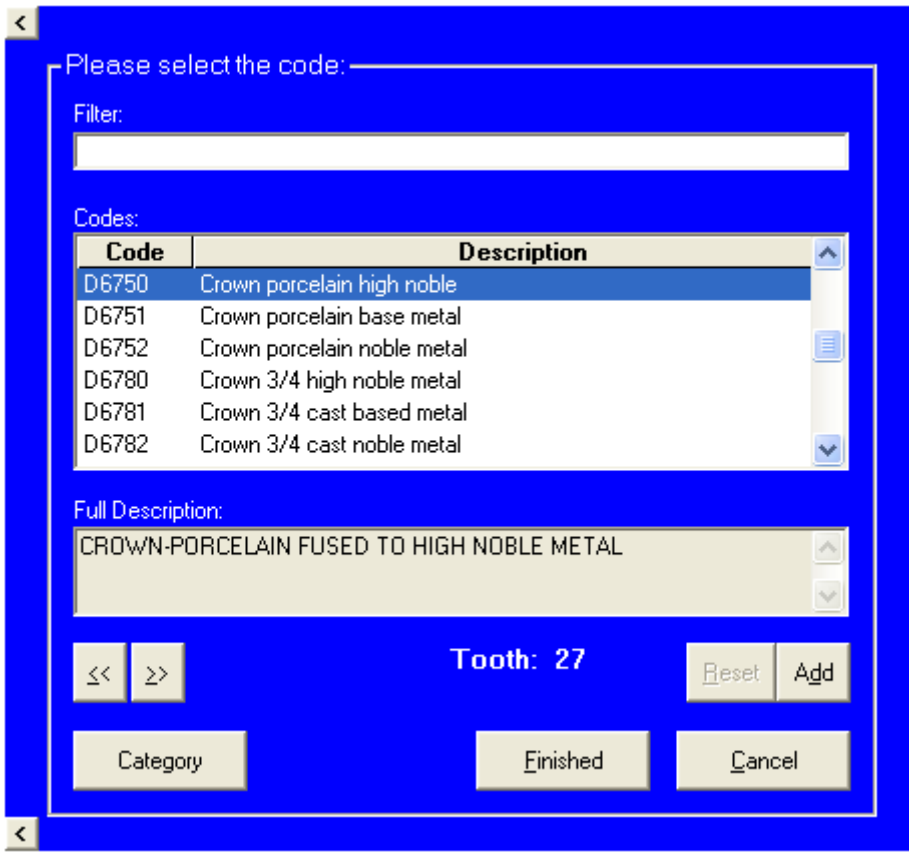


Figure 220: Special Descriptions – Bridge Code

Select the appropriate code and click the **Add** button. The code selection screen moves to the first pontic tooth. Select the appropriate code and click the **Add** button again. Continue this process until all required teeth and codes have been selected. Click the **Finished** button once the selection process is complete.

Note: The << and >> buttons may be clicked to move backward or forward to different teeth for code selection. The **Reset** button, when activated by using the << and >> buttons, clears all previously entered codes for the selected tooth.

Special Descriptions – Conn Bar Icon

This functionality works for all three view screens of Diagnostic Findings, Treatment Plan and Completed Care. Place the cursor on the first tooth location and drag it to the final tooth location. When entering a connector bar from the Treatment Plan screen or the Completed Care screens, the CPT Procedure Code Selection screen will display, with no tooth selected. DRM Plus will default to the correct connector procedure code, depending on what conditions the connector bar was entered on. Click the **OK** button to complete the connector bar entry.

Special Descriptions – Notes Icon

Please see the Notes section in the Chart/Treatment-Periodontal Chart chapter of this manual. This icon works the same for all three Treatment & Exam screen views.

Items to consider on tooth notes:

- Teeth designated as primary shows in the tooth drop-down menu with the appropriate letter not with a number. A tooth designation for Supernumerary teeth is displayed after tooth #32 in the drop-down menu.
- When a tooth-specific note has been entered, the tooth number in the graphical chart on the Diagnostic Findings, Treatment Plan, Completed Care and Periodontal Chart screens will display in yellow.
- Previously entered Notes (tooth/patient note) appear grayed out. The note will appear grayed out if it was saved as unfiled data and DRM Plus is closed and reopened. It also grays out when an assistant saves unfiled data to a provider. When the provider re-opens DRM Plus to complete the Progress Note, they may edit-delete the Note (tooth/patient note) by clicking the **New Entry** button. This activates the grayed out entry so the provider is able to modify or delete the note before the Progress Note is finished.

Appendix E – Using the Keyboard to Enter Periodontal Data

Overview

The Periodontal screen is designed for data entry using the mouse. Data entry using the keyboard is also an option. Clicking the Keyboard Mode key, <F10>, initiates keyboard navigation and data entry on this screen.

Figure 221: Keyboard Mode Button on the Periodontal Chart Screen

When this button is clicked, all of the icons are grayed out and the keyboard is activated. The keyboard functions are described in this section.

Navigating the Periodontal Screen

Use the following key strokes to change the screen views.

Arch Views

The screen moves form the existing view to any of the other views by using the following keys:

U = Upper
L = Lower
N = Lingual
F = Facial
F11 = Full (this screen must be closed by using the mouse)

Cursor Movement

There are four options for moving the cursor to select a Tooth/Surface.

Enter: Moves the cursor one surface in the direction of the higher numbered tooth.
Backspace: Moves the cursor one surface in the direction of the lower numbered tooth.
“>” with or without the <Shift> key: Moves the cursor one surface in the direction of the higher numbered tooth.
“<” with or without the <Shift> key: Moves the cursor one surface in the direction of the lower numbered tooth.

Press the **<A>** key to toggle the Auto Advance function on or off.

Entering Data

Entering data from the keyboard requires the cursor to be placed on the desired Tooth/Surface. The user must then select the desired condition and enter the data values in the appropriate manner.

Note: All numeric values must be entered with two digits (1= 01, 2 = 02, 10 = 10). Entering FGM and Mobility require the values to have a prefix (see below).

K = Pocket: Press the <**K**> key and with the cursor in the correct position, enter a two digit value. Then move the cursor to the next surface.

G = FGM: Press the <**G**> key and with the cursor in the correct position, enter "+" and a two digit value, or just a two digit value. Then move the cursor to the next surface.

J = MGJ: Press the <**J**> key and with the cursor in the correct position, enter a two digit value. Then move the cursor to the next surface.

B = Bleeding: With the cursor in the correct position, press the <**B**> key.

D = Delayed Bleeding: With the cursor in the correct position, press the <**D**> key.

S = Suppuration: With the cursor in the correct position, press the <**S**> key.

O = Mobility: Press the <**O**> key with the cursor in the correct position and enter a two digit value. For a value of 1 1/2, 2 1/2, etc. enter the two digit value preceded by a plus sign "+".

I = Furcation: Press the <**I**> key and with the cursor in the correct position enter a two digit value. Move the cursor to the next surface.

R = Reset: Pressing the <**R**> key resets all values to zero (use this functionality with extreme caution).

Ctrl Z = Undo.

Special Buttons

Viewing the Special Buttons screen requires pressing the following keys:

H = History
C = Compare
M = Summary
E = Head & Neck
P = PSR
Q = Stats

Note: Displaying these screens using the keyboard turns off the keyboard function for these screens. The mouse is required to navigate these screens.

Other Functions

Z = Cal
X = Lock

For convenience, a tear-out of the following Periodontal Keyboard shortcut chart is available on the last page of this manual.

Appendix F – Ranged Codes

Using the graphic icon on the Treatment Plan and Completed Care screens is not only straightforward, it minimizes the potential for errors. Certain codes, designated as Ranged Codes, used for multiple teeth procedures, mostly in the prosthetics area, have been restricted to icon use only for procedure entry. These codes are listed below.

Removable Prosthodontics	Implant Services	Fixed Prosthodontics
5130	6054	6205
5140	6055	6210
5211	6068	6211
5212	6069	6212
5213	6070	6214
5214	6071	6240
5225	6072	6241
5226	6073	6242
5281	6074	6245
5820	6075	6250
5821	6076	6251
5860	6077	6252
5861	6078	6253
	6079	6545
	6194	6448
		6600
		6601
		6602
		6603
		6604
		6605
		6606
		6607
		6608
		6609
		6610
		6611
		6612
		6613
		6614
		6615
		6624
		6634
		6710
		6720
		6721
		6722
		6740
		6750
		6751
		6752
		6780

Figure 222: Ranged Codes

Maxillofacial Prosthetics	Fixed Prosthodontics
5934	6781
5935	6782
	6783
	6790
	6791
	6792
	6793
	6794
	6920

Figure 223: Ranged Codes

Appendix G – Option to Set Dental patients to “Inactive” Status

A new option that IRM may run (or may give as a secondary VistA option to a DRM Plus user) allows the user to check the system for patient activity, and set patients without current encounters to “Inactive” status.

Use the OPTION NAME: DENTV INACTIVE PATIENTS and then select an inactivate date (defaulted to 2 years).

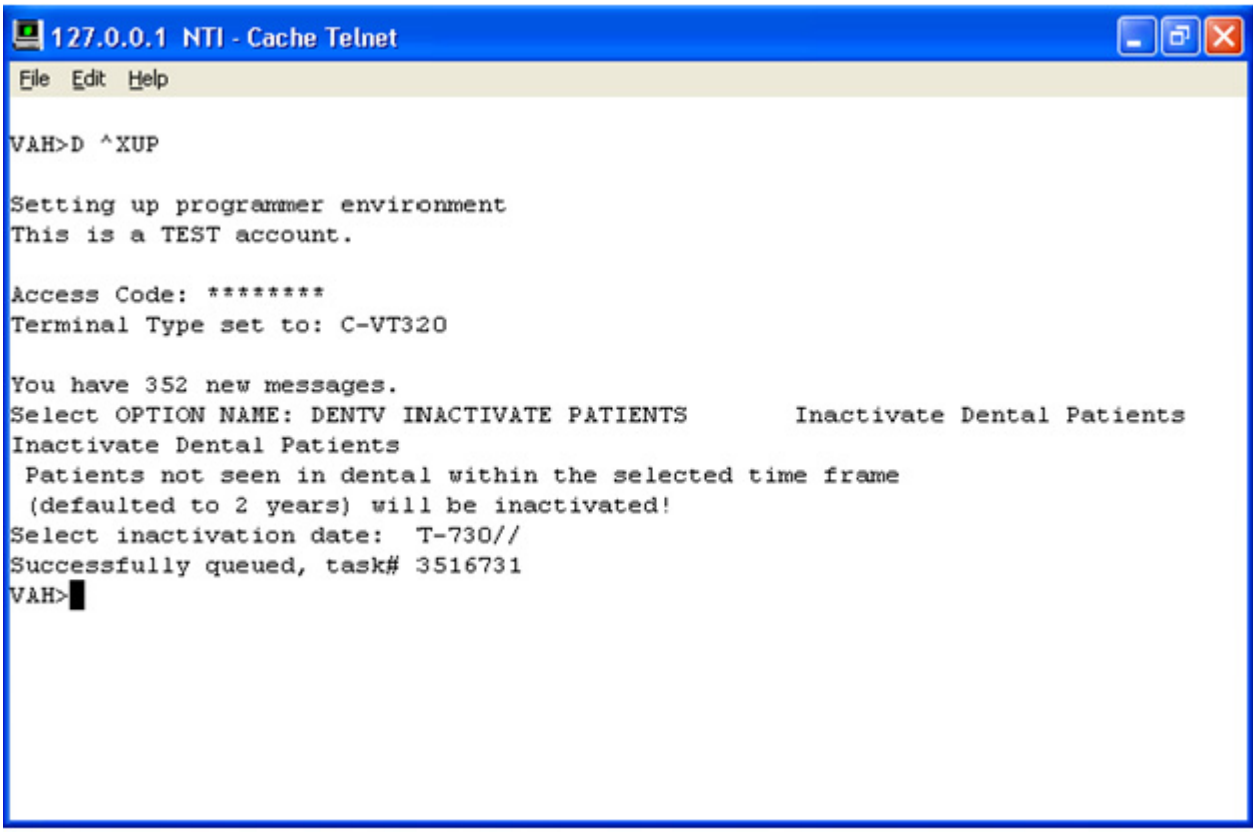


Figure 224: VistA Option to Set an Inactivation Date

Appendix H – How to Map Dental CNTs

Note: These procedures require IRM Assistance. The dental staff should provide these instructions to IRM.

In order to confirm that the CNTs are mapped correctly:

1. Open the \DOCSTORE\Array\dntarray.txt file located on the server to confirm that within the dntarray.txt file, the patch for each CNT is correct:

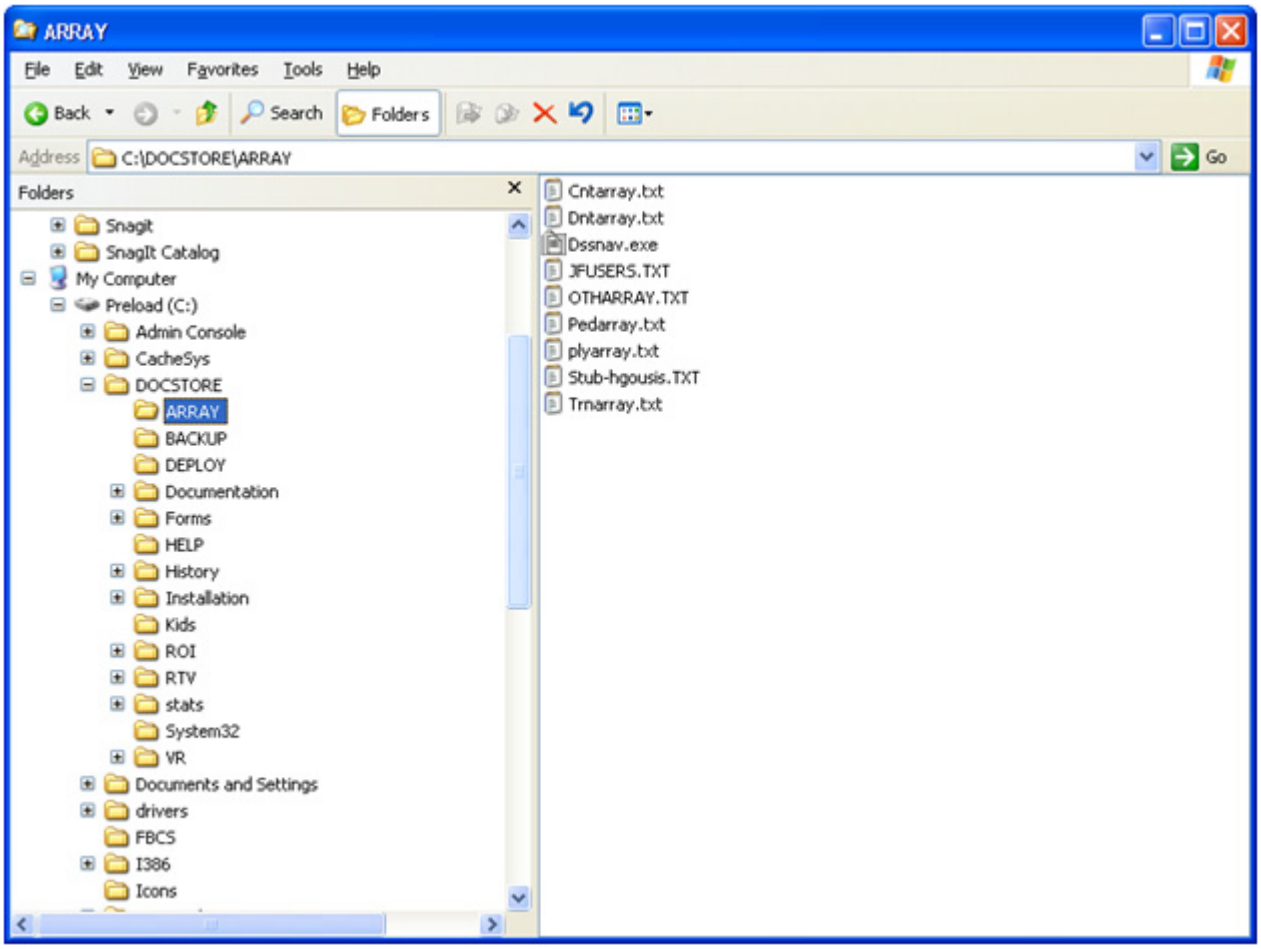


Figure 225: How to Map Dental CNTs

2. Open one of the CNT .ini files within the \DOCSTORE\FORMS directory (i.e. \\vhaserver-name\DOCSTORE\FORMS\160_DENT\04160001\DRMEval)

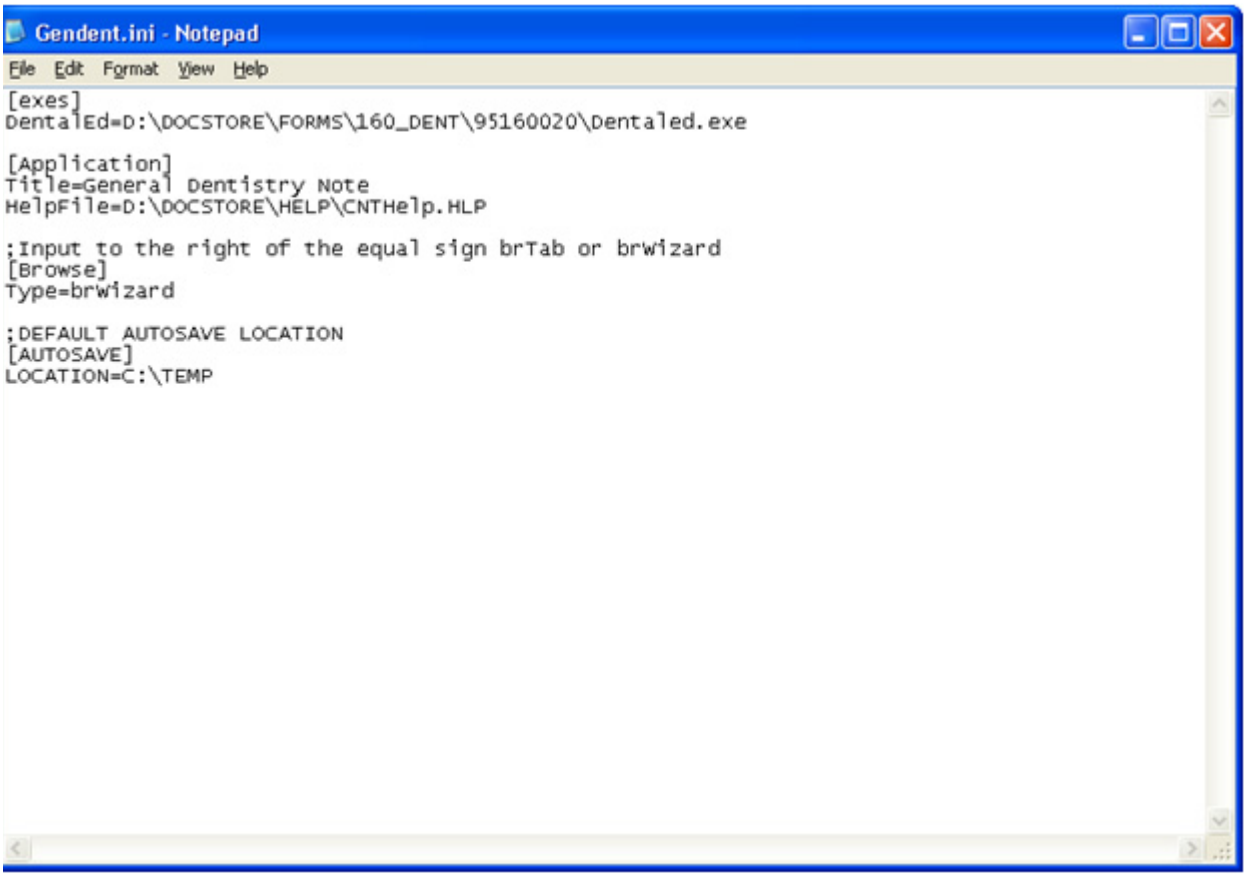


Figure 226: CNT .ini File

3. Confirm that the VHAservername path matches what was in the \Array\dntarray.txt file and is correct.
4. If the VHAservername within any of the \FORMS\160_DENT\########\ini_files does not match the directory shown above (in the ARRAY folder),then each .ini file within the FORMS directory would need to be opened and edited to reflect the correct path.

Appendix I – Recommendations for Coding of Prosthetic Appliance

Coding for prosthetic appliances is to be done at the time when the prostheses are delivered to the patient and/or home care instructions are provided and documented.

Taking workload credit for the undeliverable prosthetic appliances should occur:

- After death.
- After 6 months and 3 attempted telephonic contacts. Attempts to reach patient should occur at a timely interval (i.e. at least one week apart).
- No response to a final letter to patients' last known address.
- CPRS documentation to insure no citation for patient abandonment.

To take workload credit with no associated patient visit (i.e. phone contact):

1. Follow local policies for documentation of telephonic contact. Codes for phone contacts in DRM Plus are listed under the CPT codes (99441, 99442 and 99443).

To file workload credit:

1. Enter codes in Completed Care and then click **Complete the Encounter.**
2. Select a **Visit Date/Time**, creating an addendum. Then select a date form the note to append.
3. Select the **File Data With a Note Addendum** radio button.

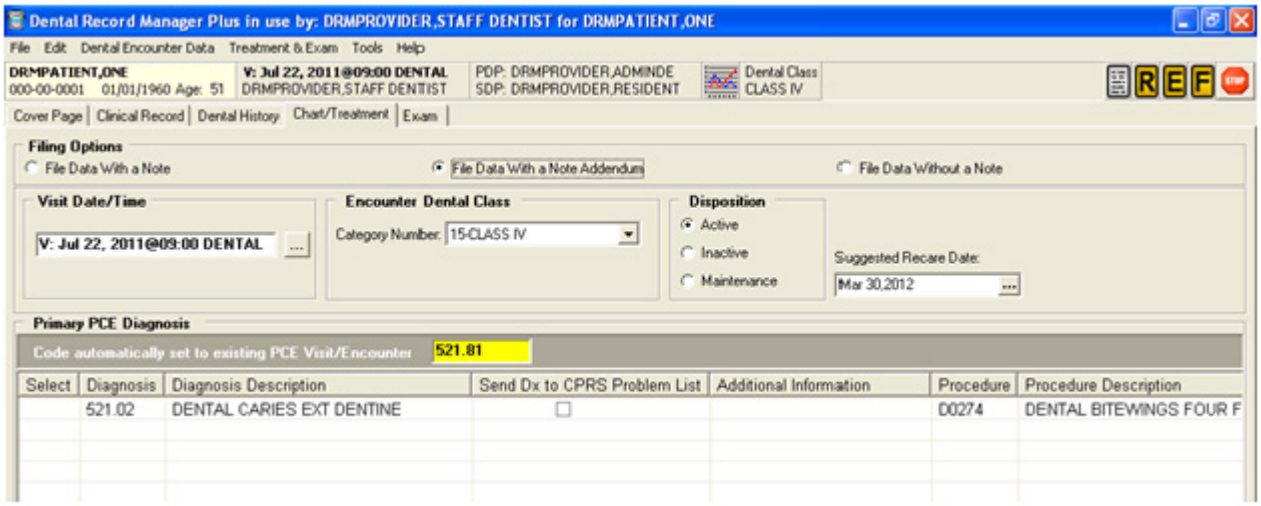


Figure 227: Filing Setting and Visit Selection

4. Complete the Encounter as a Note Addendum.

Appendix J – Business Use of DRM Plus

As important as it is to know how to use DRM Plus, it is equally important to be aware of how to enter codes, fees and similar DRM Plus business considerations.

Entering DRM Plus business information may be viewed in three different components:

- Local policy and practice
- National policy and practice
- National business practice

Adhering to the following guidelines for each is essential and critical to the success of treating our Veterans. Entering valid data can provide important information on the allocation of VA resources on a local and national level, clarify current and future funding issues and determine how to provide even better care to patients.

Review this information carefully. If the user has any questions about this software or the accompanying business policies, contact the local DRM Plus Subject Matter Expert on site. If this person cannot answer the question, s/he will know who to contact to find the correct solution.

Local Policy and Practice

This includes the workflow process addressing the provider's data entries for the following:

- Diagnostic Findings
- Observations
- Approval for proposed Patient Treatment Plans are to be established by the local dental manager.

National Policy and Practice Coding Standards

All completed procedures on site must be entered into the DES through DRM. This includes the following:

- Procedures by staff
- Fee-basis on site
- Sharing on site
- Contract on site
- Residents
- Without compensation
- Students
- Hygienists

For example, if a surgeon goes to the OR and enters the procedure into PCE through the surgery package, or through an encounter, that procedure must be entered into DES through DRM.

Coding standards should be followed in an attempt to calibrate providers, in the event that the same encounters are observed at two separate clinics. This ensures that the encounters are coded the same.

Appendix K – Data Security

As a VA computer user, one of the best and most important ways to contribute to good computer security is to know all data, its level of sensitivity, that it is virus-free, what would happen if it were unavailable, how long it could be done-without, and the effect of another user changing it without approval.

Classifying data involves determining how sensitive and valuable it is, and what protection it needs. Information is classified according to sensitivity, which is based on its need for:

Confidentiality: the information must be kept private as its owner instructs.
Integrity: the information must not be inappropriately changed or destroyed.
Availability: the information must be ready for use, as needed.

The amount of information and the context in which it is found can effect its value. Some information is confidential only at certain times (i.e. contracting or economic forecast information, which is sensitive until its publication or release date, after which it is made public). Current information is generally more valuable than older information.

When protecting data, all employees and contractors have a responsibility to:

- Be familiar with VA security policies, procedures, rules and regulations (i.e. know what to do, how to do it and why).
- The user should ask a supervisor or ISO any questions about these security responsibilities.

The user is responsible for:

- Reporting known or suspected incidents immediately to the ISO
- Using VA computers only for lawful and authorized purposes
- Choosing good passwords and changing them every 90 days. Do not write down or share log-in information with anyone, including Help Desk
- Complying with safeguards, policies and procedures to prevent unauthorized access to VA computer systems
- Recognizing the accountability assigned to the user's UserID and password. Each user must have a unique ID to access the VA systems. Recognize that UserIDs are used to identify an individual's actions on VA systems and the Internet. Individual user activity is recorded, including sites and files accessed on the Internet (recorded as the files go through the firewall)
- Ensuring that data is backed up, tested and stored safely.
- Not generating or sending offensive or inappropriate email messages, graphical images or sound files. Limit distribution of email to only those who need to receive it. Realize that the user is identified as a user of the VA computer systems when logged on to the Internet.
- Using authorized virus scanning software on the workstation or PC and home computer. Know the source before using discs or downloading files. Scan files for viruses before execution.
- Complying with terms of software licenses and only using VA-licensed and authorized software. Do not install single-license software on shared hard drives (or servers).
- Complying with terms of software licenses and using only VA-licensed and authorized software. Do not install single-license software on shared hard drives or servers.

- Knowing data and properly classifying and protecting it, as well as inputs and outputs, according to their sensitivity and value. Label sensitive media, use a screen saver with a password, logoff when leaving the work area, and secure that sensitive information is removed form hard disks sent out for maintenance. Do not send sensitive information over the Internet unless it has been encrypted.
- Learning as much as possible about information security to assist the user's ISO. Numbers alone make users the most important security asset. Compared to one ISO for a system, users offer a chance for numerous eyes and ears to remain alert to potential threats to information systems.

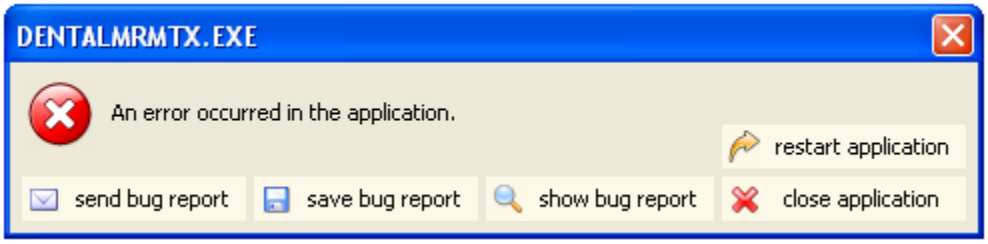
Appendix L -- MADEXCEPT

MADEXCEPT is a new tool that has been added to DRM Plus to assist with error reporting from the field and implementing a fix in the application.

In order to be prepared to use this tool if an error occurs while using DRM Plus, please review the following directions:

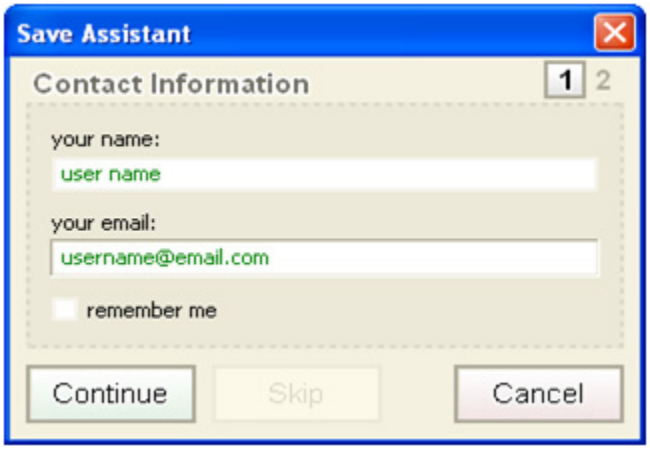
Select all the **OK** buttons from any traditional error screen that may display in DRM Plus. There may be more than one traditional error screen, but no matter how many, select the **OK** button on all. If any informational screen displays asking if the user would like to view the last broker call, select the **No** button from that screen and continue through this process.

As soon as the DENTALMRMTX.EXE error screen appears, select the **'send bug report'** button (first button from the left) as displayed:



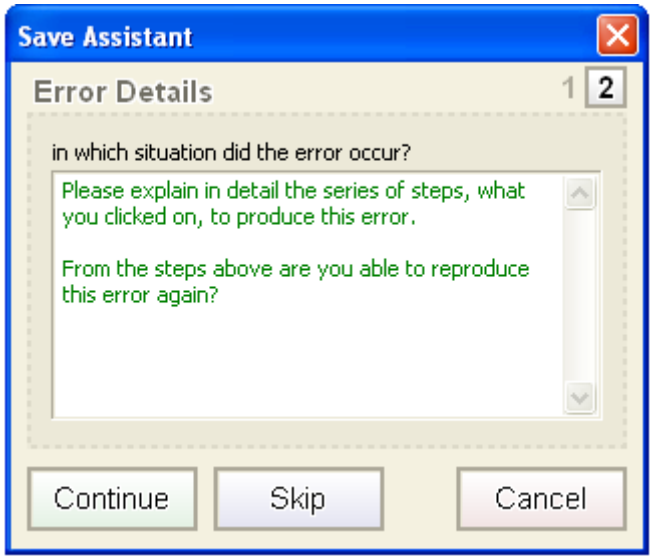
DENTALMRMTX.EXE

After selecting the **'send bug report'** button, the Save Assistant screen will appear. Enter a user name and VA email address and select the **Continue** button on the Save Assistant screen:



Save Assistant

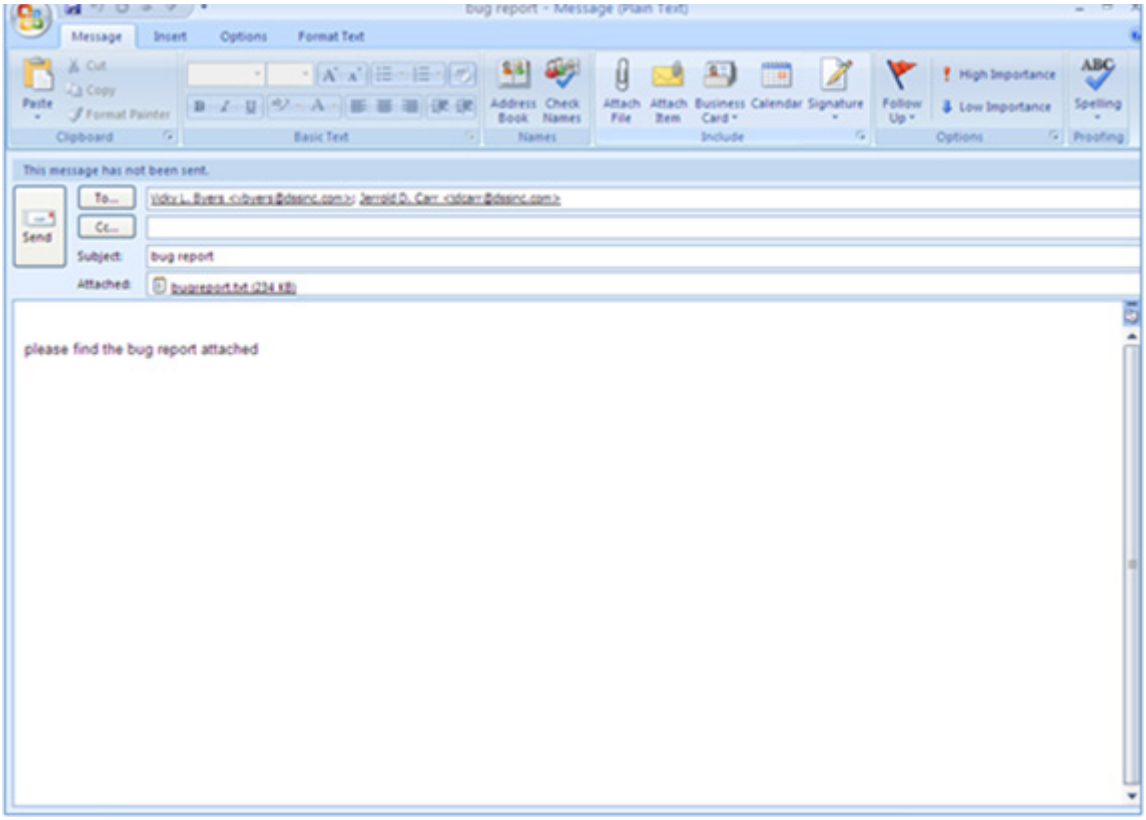
The Save Assistant Error Details screen will immediately appear. Add information in the in the Error Details screen providing as much information as possible. If known, list every click that occurred prior to the error message. The more details listed; the easier it will be to reproduce the error and fix it.



Error Details

Select the **Continue** button from the Save Assistant screen.

The screen that follows will open the users email screen. The example used is MS Outlook. The email address of both Vicky Byers and J.D. Carr and the error/bug report will populate the 'To' field:



Outlook Window

Enter the name and location (include city and state) of the VA dental clinic where the error occurred. For example, if the error occurred at the Daytona Beach Dental Clinic, enter Daytona Beach, Florida and do not enter Gainesville, Florida, even though Daytona Beach is a Gainesville satellite clinic. Also include, if known, the person class or provider type/specialty and the phone number that may be used to contact the person reporting the error. Enter all this data in the email address window.

The user may add any other individuals as recipients (To and CC) in the email address fields as appropriate. Additional information may be included by entering that information in the email address window.

Click on the **Send** button from the email screen.

Select the **'close application'** button (bottom button on the right) from the DENTALMRMTX.EXE screen. This will close the MADEXCEPT tool and DRM Plus.

Note: After an error occurs while using DRM Plus, please reboot the computer before continuing.

Periodontal Keyboard Shortcuts Tear-Out

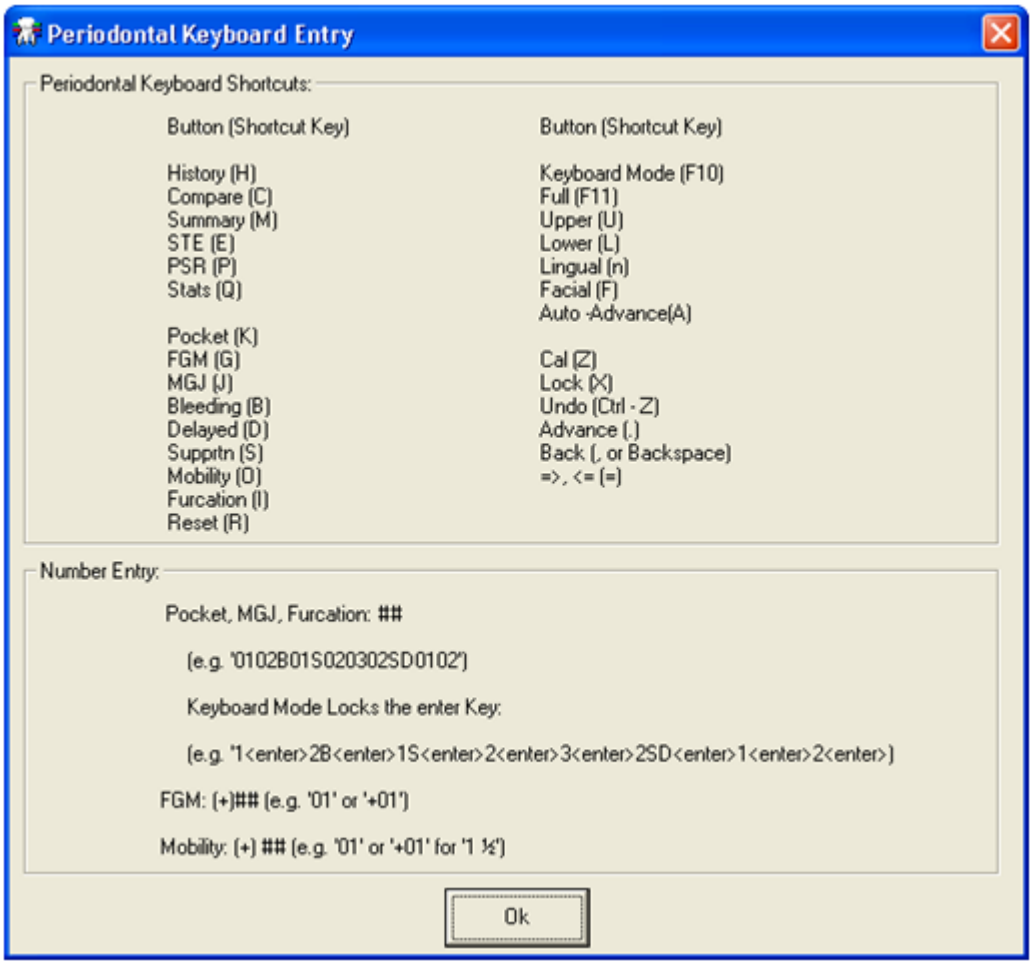


Figure 1: Periodontal Keyboard Shortcuts Tear-out