DENT*1.2*59

QUICK START

GUIDE

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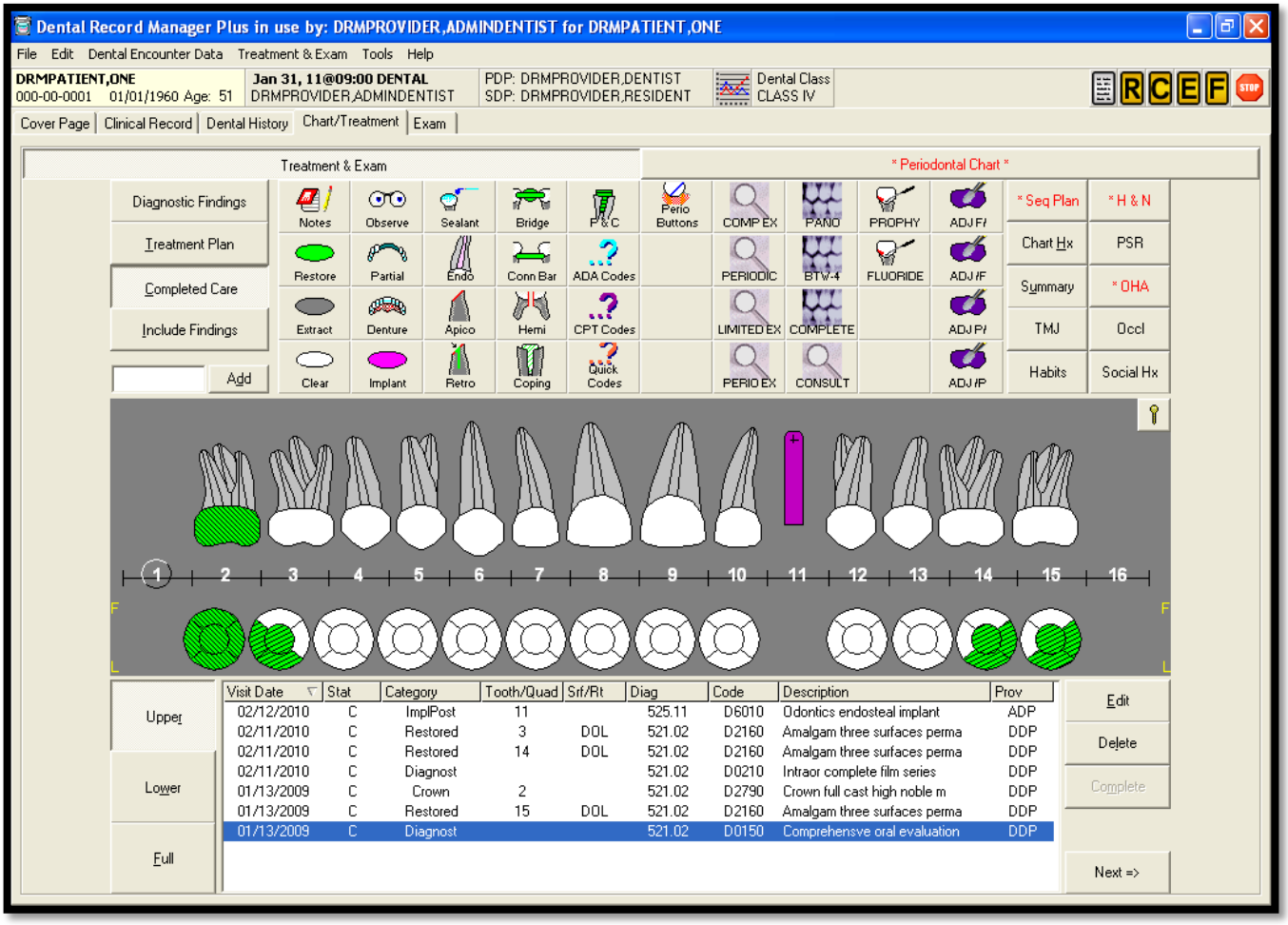
This document details a list of enhancements and fixes for the Dent*1.2*59 (DRM Plus P60.59 GUI), including screen shots and tips where appropriate. It was developed as a quick start guide for DRM Plus end-users to be able to know and understand the changes in this patch.

Enhancements to the DRM Plus Application for Patch 60.59

New Exam Tab

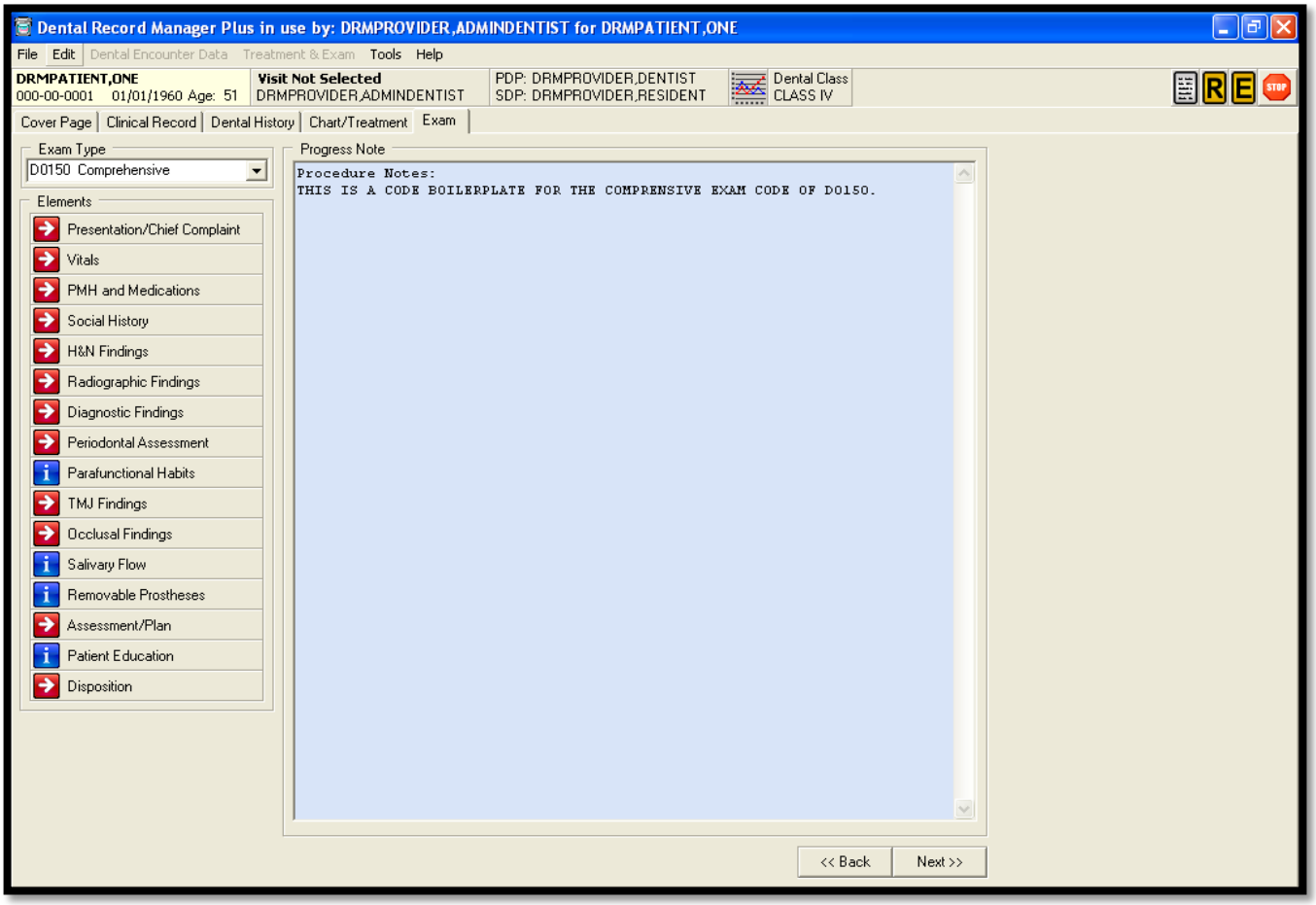
Providers have the ability to file required data using a national standard exam style format for each exam/consult code (D0120, D0140, D0150, D0160, D0170, D0180 and D9310) in conjunction using the new Exam tab in DRM Plus. Mandatory elements for each exam/consult code and requirements for each element are based on the user's procedure 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).



Entering the exam/consult procedure will activate the Exam tab and will display 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 would be by using the drop down menu located on the Exam tab. Another way to change the exam/consult procedure would be 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 will trigger all the elements on the Exam tab with the required icon or an optional icon. Each element will display the completed icon when satisfied for that exam/consult code. The provider will need to enter the required data into the element for this exam/consult code to display the completed icon whether that icon is optional or required. Some elements automatically pull data from other screens when entered during this session from the Chart/Treatment tab. That imported data may satisfy some or all requirements of the element. There is other optional information in each element that may be entered if desired by the provider.

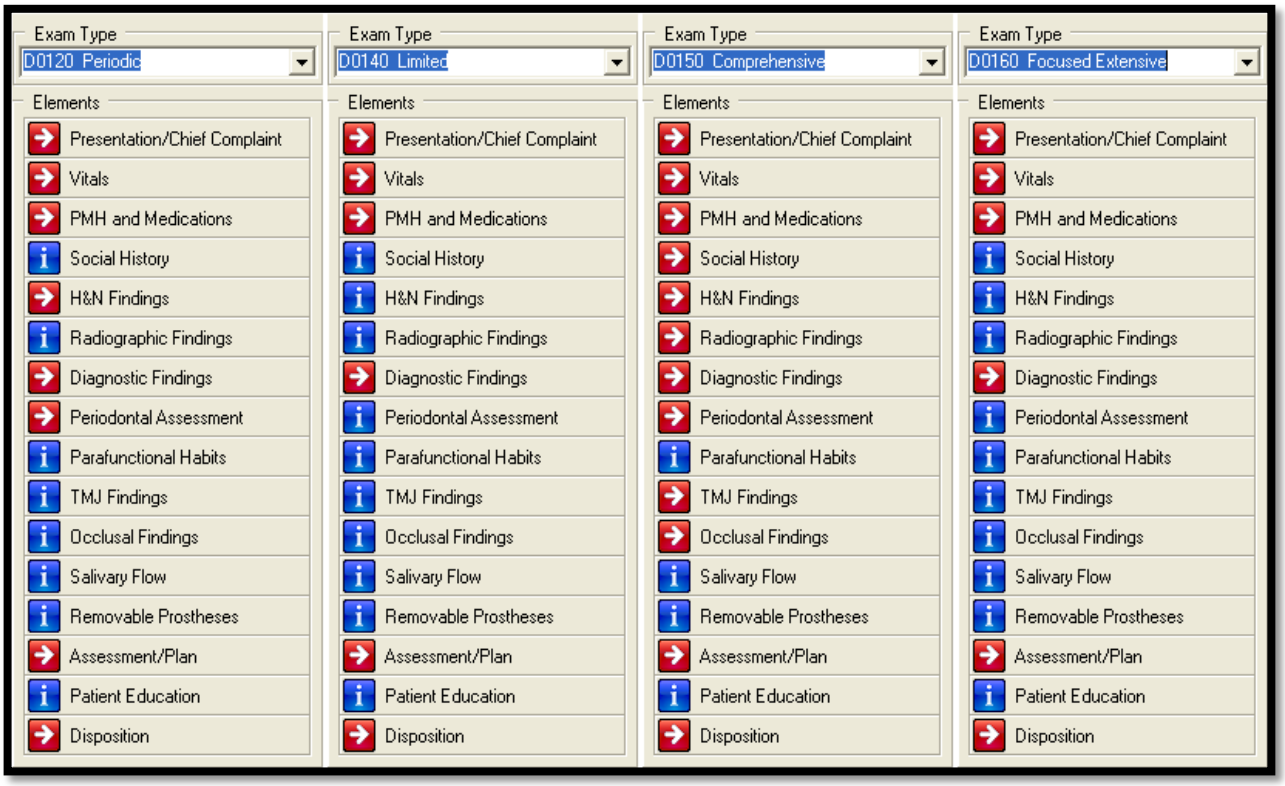
In the following dialog the D0150, comprehensive exam, was selected from the Treatment & Exam/Completed Care view screen. The D0150 procedure code is being entered as completed treatment with today's dental encounter into the patient's chart. Then selecting the Exam tab displays the following dialog with the D0150 Comprehensive displayed in the Exam Type drop-down menu. Twelve of the sixteen elements will require data entry by the provider when selecting the D0150, comprehensive exam.



The seven exam/consult codes will have a different set of required and optional elements activated when that specific exam/consult code is selected. The blue window will display the viewable exam template that has been entered at any given point during this session. This allows the provider to review what has been entered or imported in all sixteen elements before completing the encounter for this patient.

The Back button located on the Exam tab screen will return the end-user to the Chart/Treatment tab. The Next button located on the Exam tab will allow the end-user to proceed to the Filing Options screen which is the next screen when completing the encounter. This Next button also will open the highest listed required element if that element hasn't been completed. The Back/Next buttons located on each element screen will only move backward or forward to other element screens depending on the provider's parameter selection.

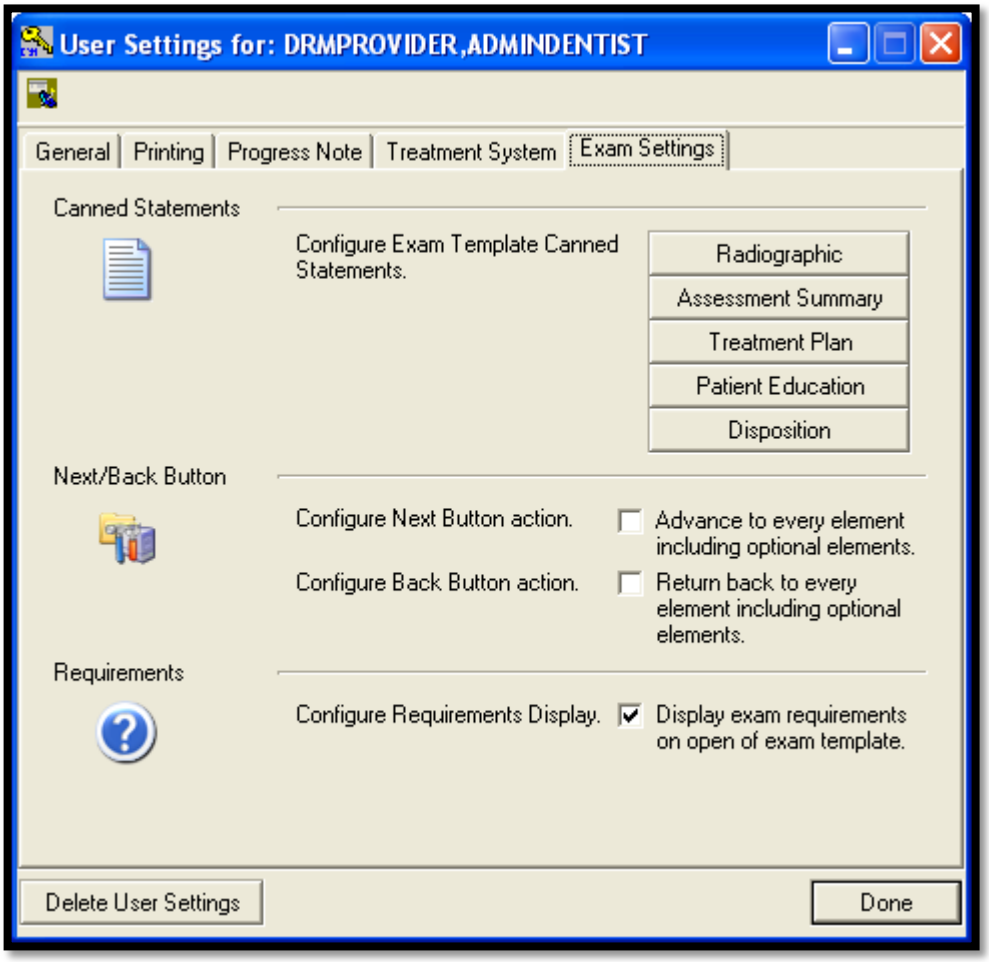
The following two dialogs display the required/optional elements for all seven CDT/CPT codes that will be affected by the national exam template when filing completed treatment with one of these procedure codes.



Parameter User Settings for the Non-admin and Admin End-Users

Canned Statements (pre-defined statements)

There will be three new parameter settings for every end-user of DRM Plus which affects the new exam templates. They are the Canned Statements, Next/Back Button and the Requirements parameters. To add/delete/edit these three parameters the end-user will need to select the Tools menu, User Options and then the Exam Settings tab. The Canned Statements parameter allows the addition of more pre-defined statements by the end-user to four elements. All local providers are an end-user when using this parameter accessed by the User Options whether they are a non-admin or administrative user. The User Settings parameters will only affect the single end-user and not any other provider of DRM Plus associated with the local VistA server.

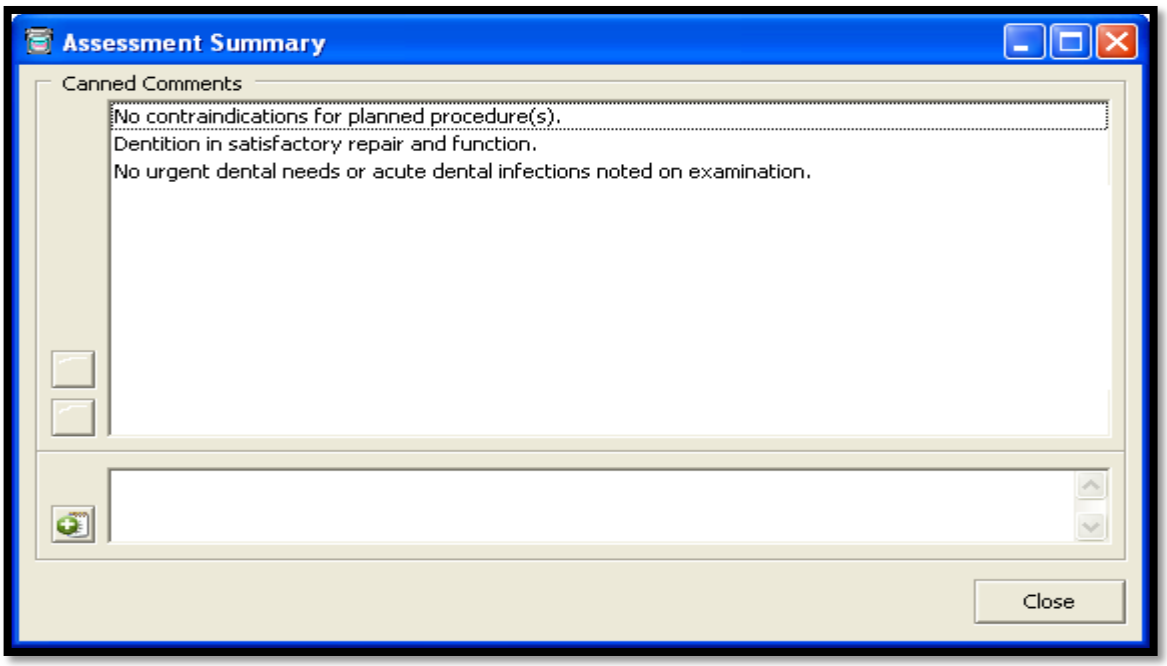


The five categories from the Exam template associated with pre-defined statements are Radiographic, Assessment Summary and Treatment Plan which are located in the same element, Patient Education and Disposition. There is a maximum of twelve pre-defined statements allowed per category which may be entered. The local DRM Plus administrator has priority of entering pre-defined statements system wide and over all end-users when using their administrative settings parameter which is not displayed here.

The end-user may add as many pre-defined statements as they would like up to a maximum of twelve in total. When any of these element categories have the maximum number of pre-defined statements allowed and if the DRM Plus administrator would add another pre-defined statement from the administrative settings parameter; this would result in removing the last pre-defined statement entered by the end-user. This will only affect those end-users that have a total of 12 entered and displayed for that specific pre-defined statement category.

To add an end-user pre-defined statement (admin or non-admin) from User Options,

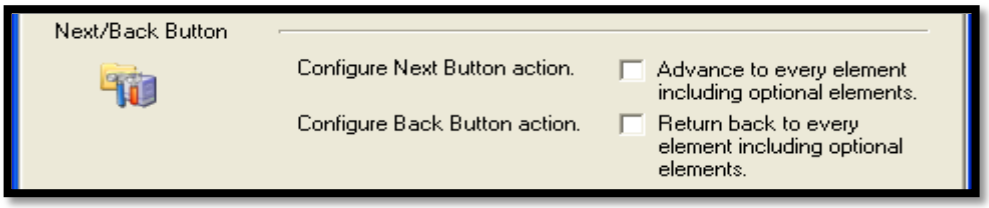
1. Select one of the five pre-defined statement buttons such as Assessment Summary.
2. Type or copy/paste a pre-defined statement in the lower text box.
3. Click the green Add [+] button.
4. Click OK on the pop-up that confirms the new pre-defined statement addition.



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.

Next/Back Button Located on Element Screens

The Next/Back Button parameters on the User Setting's dialog will initially default as unchecked. This 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. 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.



When the parameter is unchecked the Next button will skip any element that is optional or has been completed and satisfied with new data this session from the Chart/Treatment tab. When the element is opened the user will be required to complete the requirements of the element before selecting the Next button. The Back button will move up to the previous element that was required by the exam code selection even if that element was completed or not. Selecting the Back button doesn't require the element to be completed to move to the previous required element.

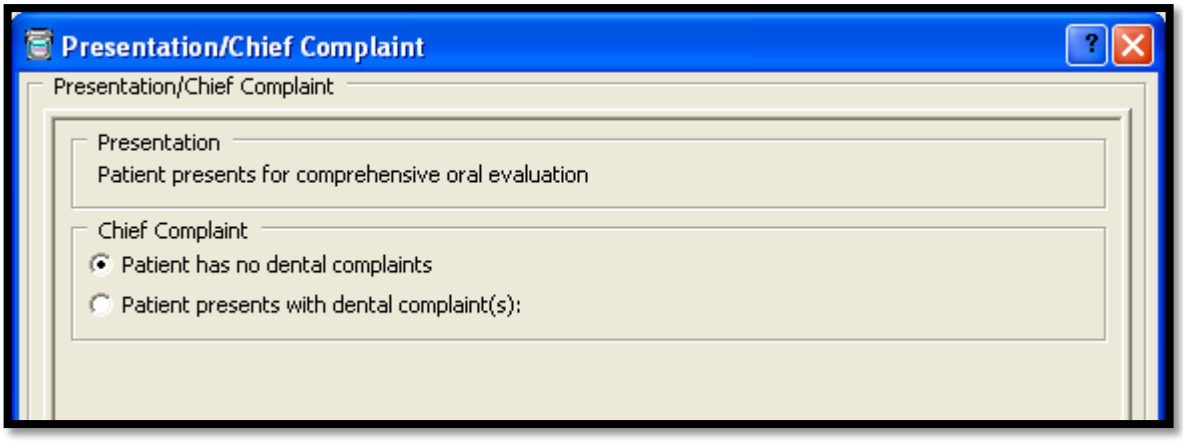
When either parameter is checked and saved by selecting the Done button from the User Settings screen; the Next/Back button selected from any Exam tab element will move to the very next element whether it is required or optional. The same basic rules apply as before when using the Next button requires the element's completion in order for the user to move to the next element. When using the Back button the user will be allowed to move to the previous element without completing the requirements.

The Back button will always make the user return to the element where the Back button was selected first so that element may be completed or canceled. These two parameters only affect the end-user's profile and will only follow that end-user to any computer when loading DRM Plus with their VistA access/verify passwords.

Element Requirements Panel Extended Screen

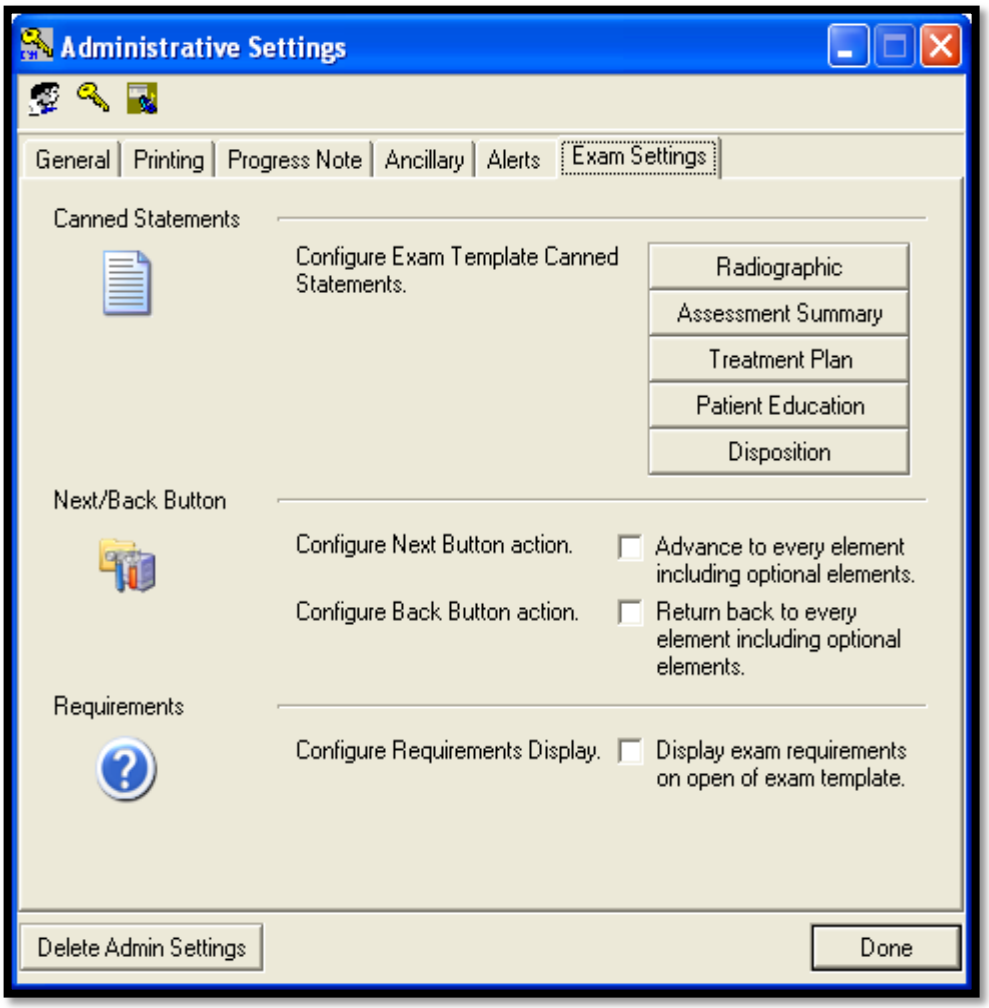
The Requirements parameter on the User Setting's dialog will initially default as checked. This parameter setting allows the end-user to keep the Element Requirements Panel open when selecting any element from the Exam tab or the definitions from the OHA or Occlusal screens. When the parameter is checked on the User Settings screen; the Element Requirements Panel will be displayed all the time when any element is opened.

When this parameter is unchecked, the user will need to select the Done button and then close/reopen DRM Plus; the provider will be required to open these panels manually. The end-user may select the Requirements icon button located in the upper right corner of the element screen displayed in the following dialog. This action will display the Element Requirements Panel. The end-user will need to select the Requirements icon button again to close the Element Requirements Panel.



Parameter Administrative Settings by the DRM Plus Administrator

The Administrative Settings parameter allows the DRM Plus administrator to add/delete system wide all the national and local admin pre-defined comments. This parameter may be accessed from the Tools menu, Administrative Toolbox and then the Exam Settings tab by only DRM Plus administrators.



The parameter allows the creating of pre-defined statements by the DRM Plus administrator that will import to all end-users accounts using the local VistA system. The five pre-defined statement buttons are Radiographic, Assessment Summary and Treatment Plan which are located in the same element, Patient Education and Disposition. There will be two to four national pre-defined statements pre-developed for these five categories.

There is a maximum of twelve pre-defined statements allowed per comment field by any end-user. The DRM Plus administrator has priority of entering pre-defined statements at anytime and may add/delete a national or local admin pre-defined statement by following the same steps described when entering with the User Settings. The DRM Plus administrator may only view the national pre-defined statements or those entered by the DRM Plus administrator with this parameter. The pre-defined statements entered by any end-user's User Settings parameter will not be viewable in this screen which includes any DRM Plus administrator entries from their own User Settings parameter.

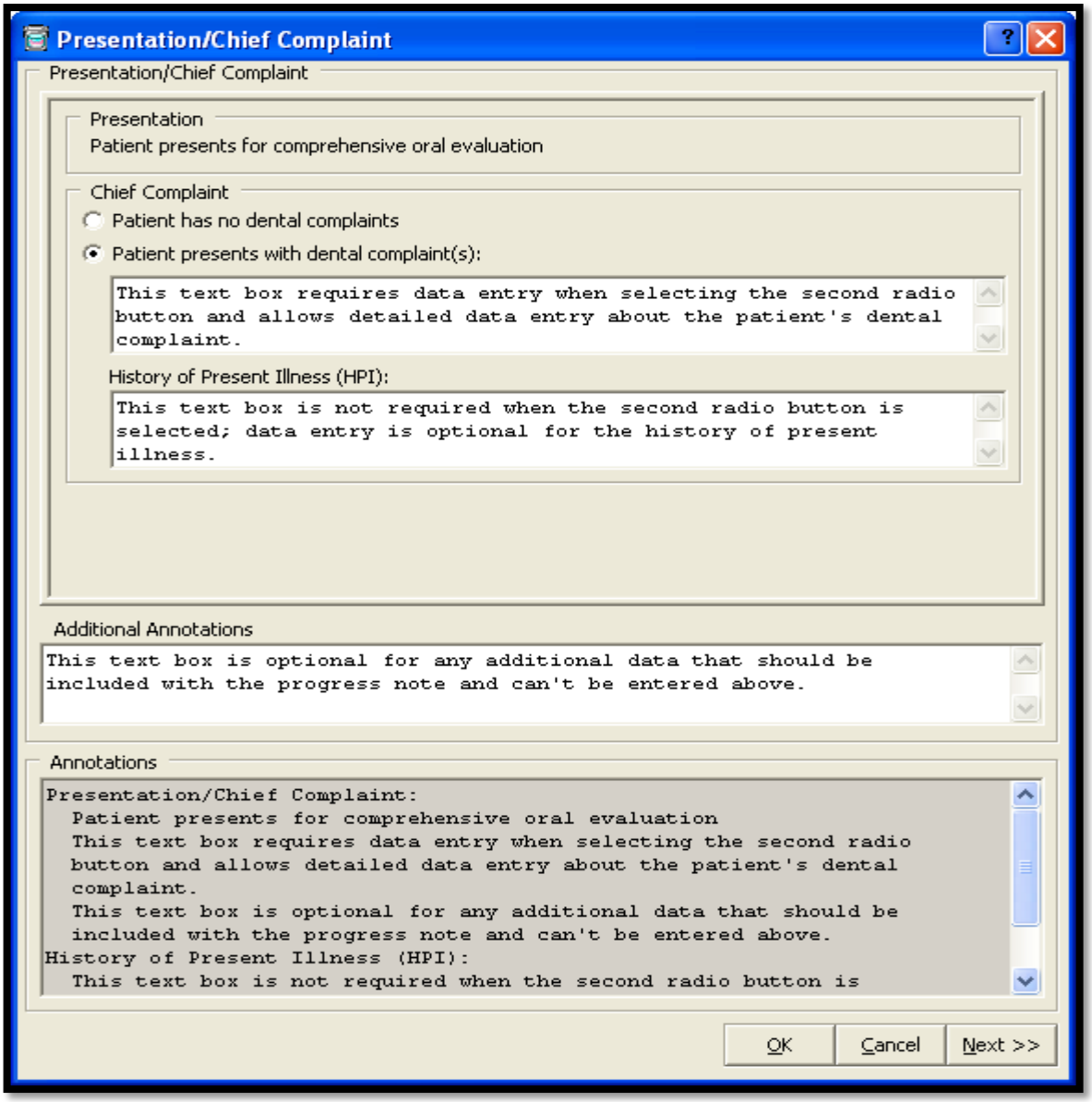
The DRM Plus administrator may delete or rearrange the sequencing of any national or administrator pre-defined statements entered by this parameter. Highlight the pre-defined statement and use one of the two buttons on the left side of the screen to delete or rearrange the sequence of this pre-defined statement. The end-user may not delete or rearrange any of these admin pre-defined statements; they will always be listed at the top in every user's list.

The Next/Back Button and the Requirements parameter from the Administrative Settings screen will not affect the entire local VistA system or any other end-user functionality but will only result in changing the admin end-user functionality. This action will result in the same outcome when editing the User Settings screen.

Presentation/Chief Complaint Element

This section and the next 15 sections will display the D0150, comprehensive oral evaluation, as the exam code displayed on the dialogs. The Presentation/Chief Complaint element is required for all seven exam/consult procedures 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 will open 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.

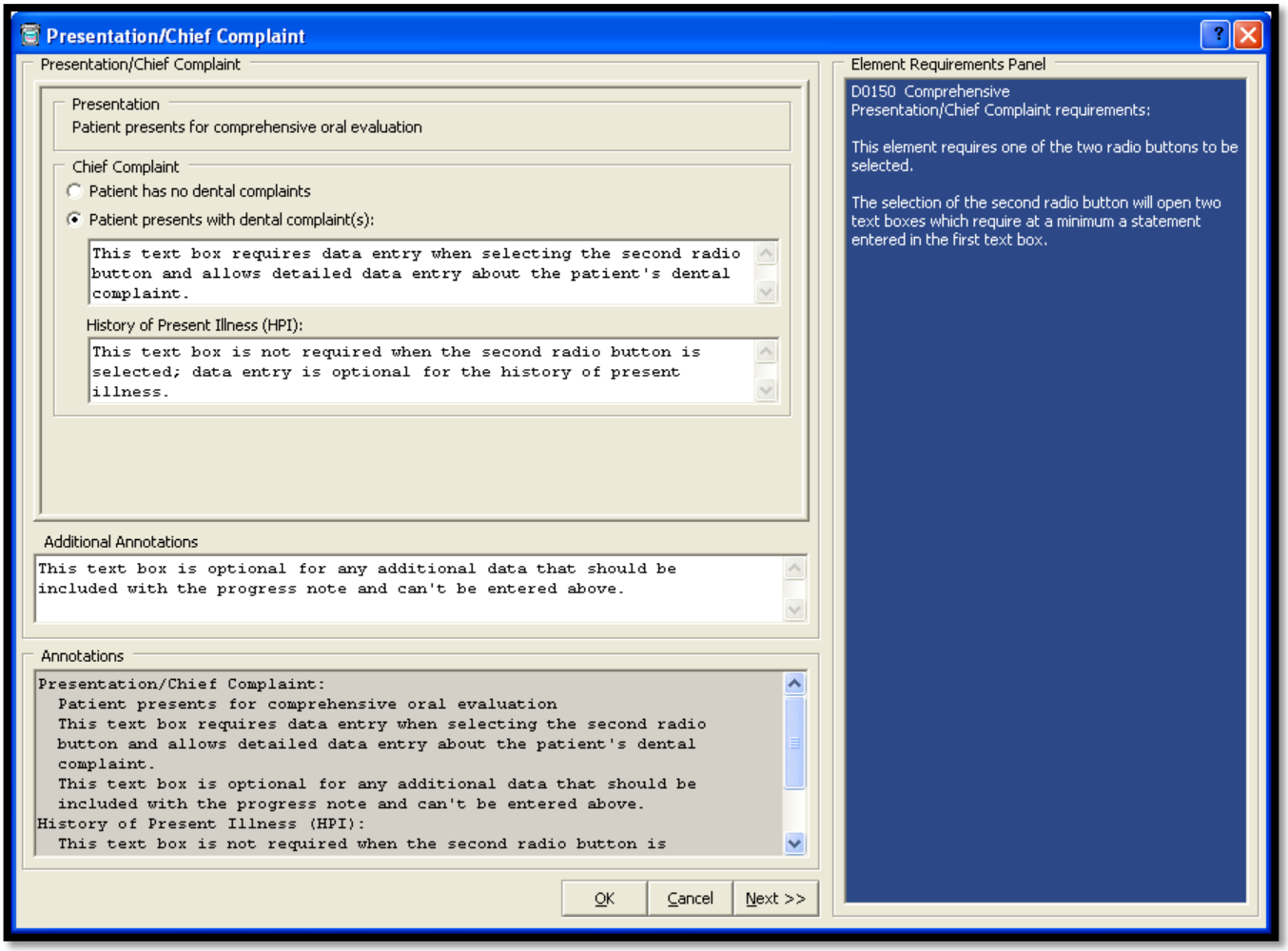
The Additional Annotations is an optional text window which allows the provider to enter additional information about the patient's chief complaint. This text window has the right click functionality of Import text files if desired. The Annotations is a view only window that captures everything that is entered in this element. The OK button will save data entered after all requirements have been meet and close the element. The Next button allows the provider to move to the next required element for this exam type depending on the parameter the end-user has selected in their User Settings.



Element Requirements Panel

The extended dialog displays the element called Presentation/Chief Complaint extended with the Element Requirements Panel for the D0150 exam code. This panel will help when the user may not understand what the requirements or the minimal requirements for this element maybe. The requirements are determined after the respective Exam code has been selected. The parameter loads defaulted to keep this requirements panel open all the time. When the user disengages this parameter then there will be a Requirements icon button [?] in the upper right corner on each element screen where the user may select to view the requirements.

The blue panel window will list textual clues about the requirements for this element when selecting the D0150 exam code. Selecting the Requirements icon button [?] will open/close the requirements panel and this doesn't matter if this parameter is checked/unchecked in the User Settings.



Every element's requirements panel will list its distinct requirements associated with the exam code that was selected in Completed Care view screen. The textual information for some elements when selecting the Requirements icon will state that this whole element is optional for this exam code with the minimal requirement if new data is desired to be entered.

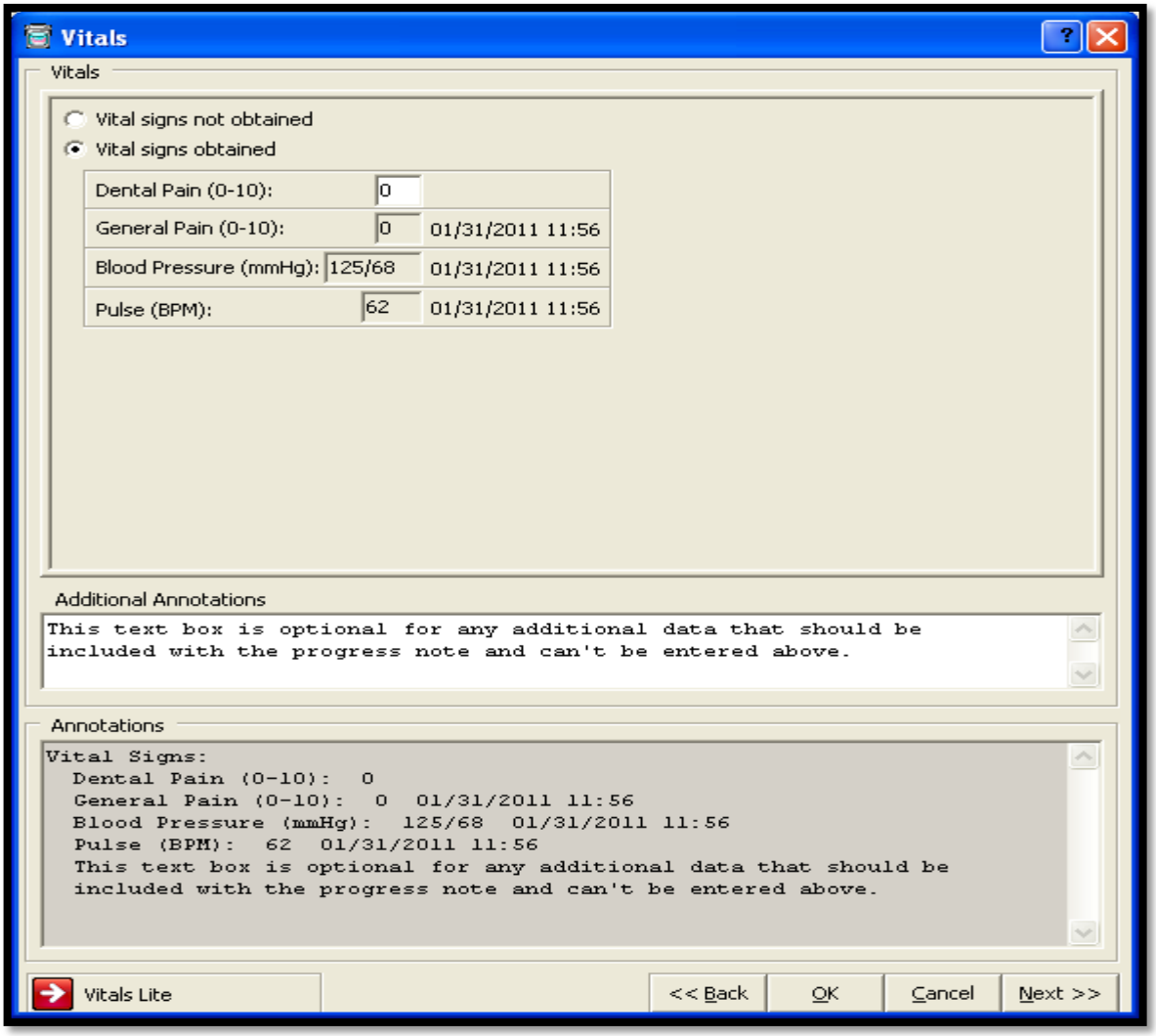
The element's Requirements panel has a parameter located on the User Settings screen that will initially load defaulted for the end-user to keep the screen displaying all the time when an element is selected.

Vitals Element

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 will default to any vitals that have been entered during a 24 hour range of the visit date importing data from the Vitals Lite package. The Visit/Date for the encounter also has to be entered in DRM Plus for this feature to work. If no vitals have been entered in Vitals Lite during this 24 hours range then the four vital entries in the element will have a text box that allows data to be entered manually. When entered manually there will be no date attached to the vitals sign entry. Dental Pain is the only required vital sign entry when selecting the second radio button and entering the vitals sign by either method.

The Vitals Lite screen for entering today's vitals maybe opened using Vitals Lite button which is found on the DRM Plus banner or the Vitals Lite button located in the lower left area of the Vitals element screen.

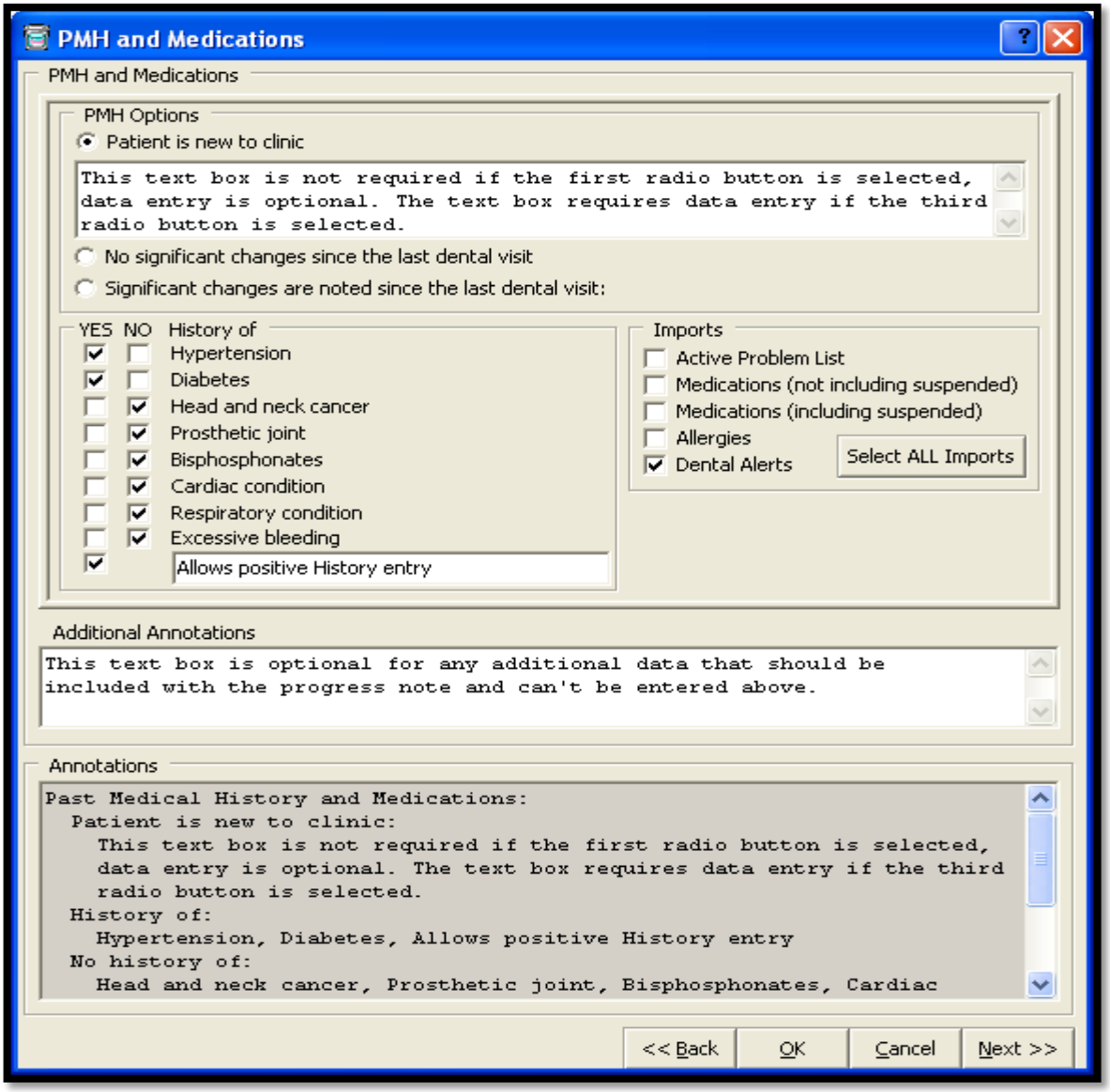
The Additional Annotations is an optional text window which allows the provider to enter additional information about the patient's vitals. This text window has the right click functionality of Import text files if desired. The Annotations is a view only window that captures everything that is entered in this element. The OK button will save data entered after all requirements have been meet and close the element. The Next/Back 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. Only the vital sign Dental pain will be saved as unfiled data for this element and no BP, pulse or general pain vital signs that were entered during the session maybe saved as unfiled data.



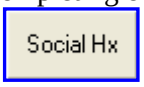
PMH (Past Medical History) and Medications Element

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 will open an optional text box to enter additional information if the patient is new to the clinic. The selection of the third radio button will open a required text box to enter any significant changes noted since the last dental visit. The eight positive/negative check box conditions, one free text positive condition or the five Imports check boxes 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 the VistA Fileman database.

The Additional Annotations is an optional text window which allows the provider to enter additional information about the patient's past medical history. This text window has the right click functionality of Import text files if desired. The Annotations is a view only window that captures everything that is entered in this element. The OK button will save data entered after all requirements have been meet and close the element. The Next/Back 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.

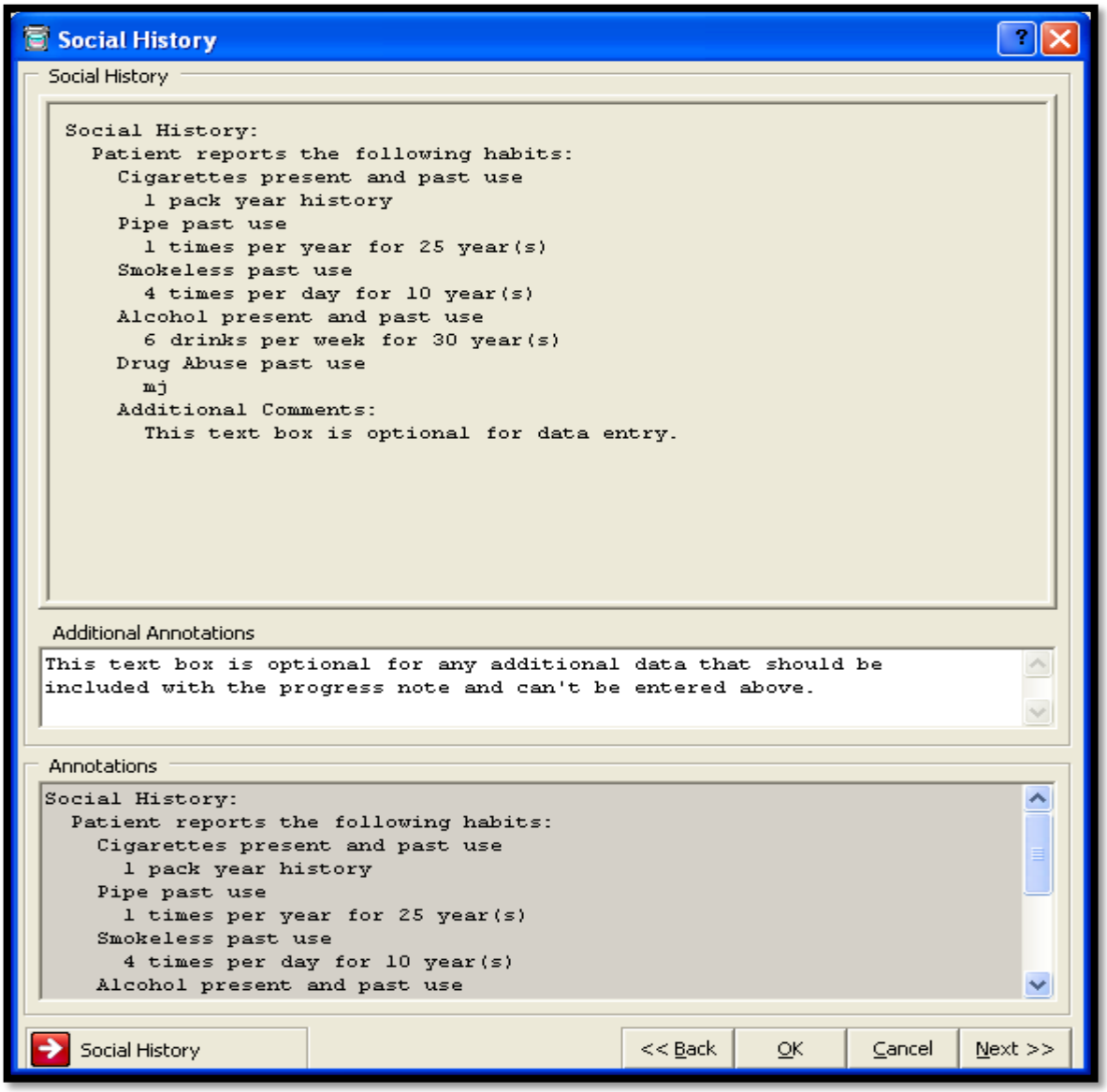


Social History Element

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 maybe opened with the specialty button 

located on the Chart/Treatment tab or 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. The new functionalities for the Social History screen are explained in greater detail in a later section of this QuickStart Guide.

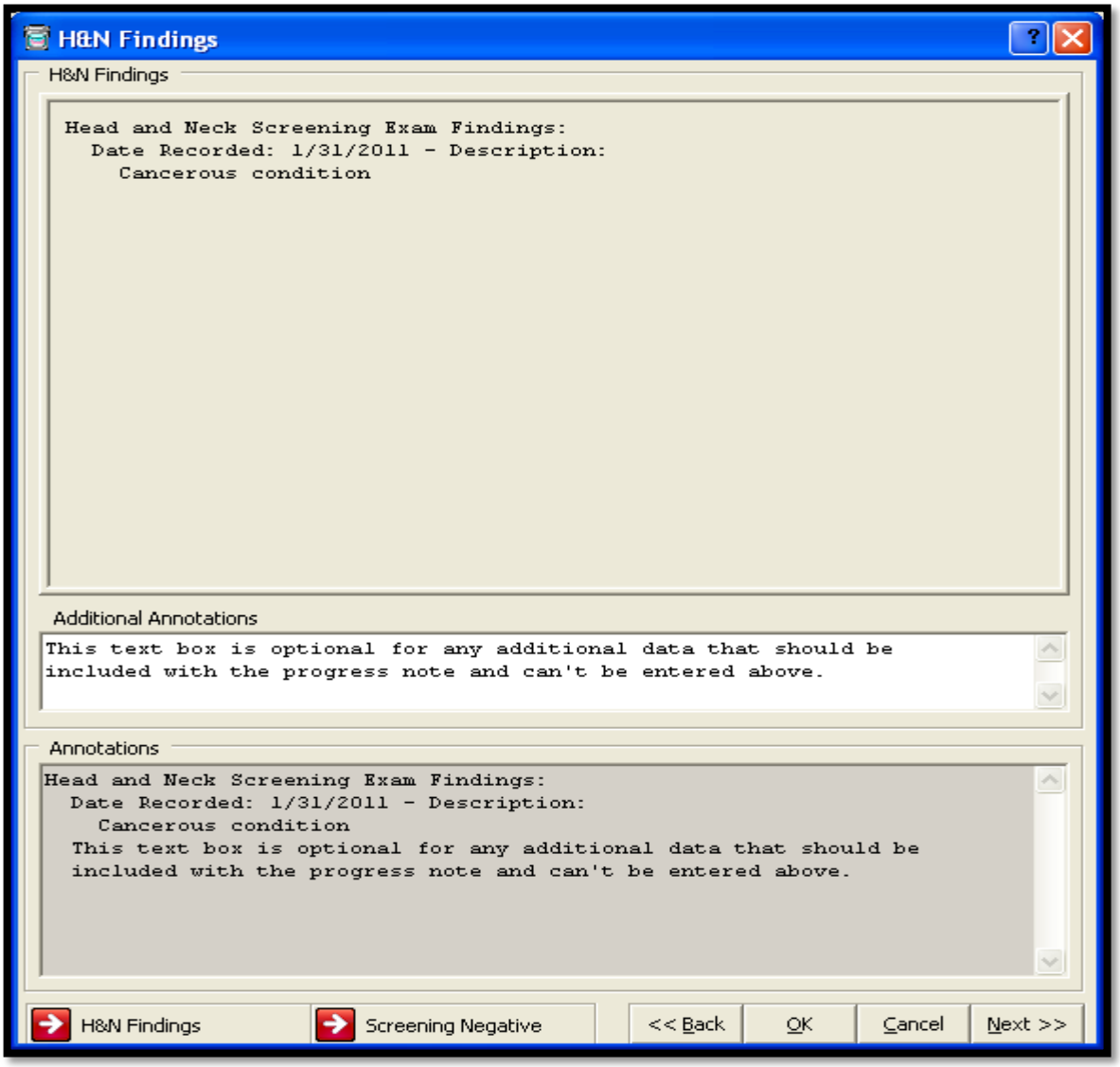
The Additional Annotations is an optional text window which allows the provider to enter additional information about the patient's social history. This text window has the right click functionality of Import text files if desired. The Annotations is a view only window that captures everything that is entered in this element. The OK button will save data entered after all requirements have been meet and close the element. The Next/ Back 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.



H&N (Head and Neck) Findings Element

The H&N element is required for the D0120, D0150 and D0180 exams. This element will require a new H&N finding or historical entry using the H&N Findings screen. This element will import data entered from the H&N Findings screen or will be blank if nothing has been entered during this session. When blank after selecting one of the three required exam codes will require the provider to enter a new H&N finding. The H&N Findings screen maybe opened with the specialty button from the Chart/Treatment tab or it is also located in the lower left area of this screen. The Screening Negative button on this element's screen will allow a new screening negative entry directly into the element and import it into the H&N Findings screen for the patient's permanent record.

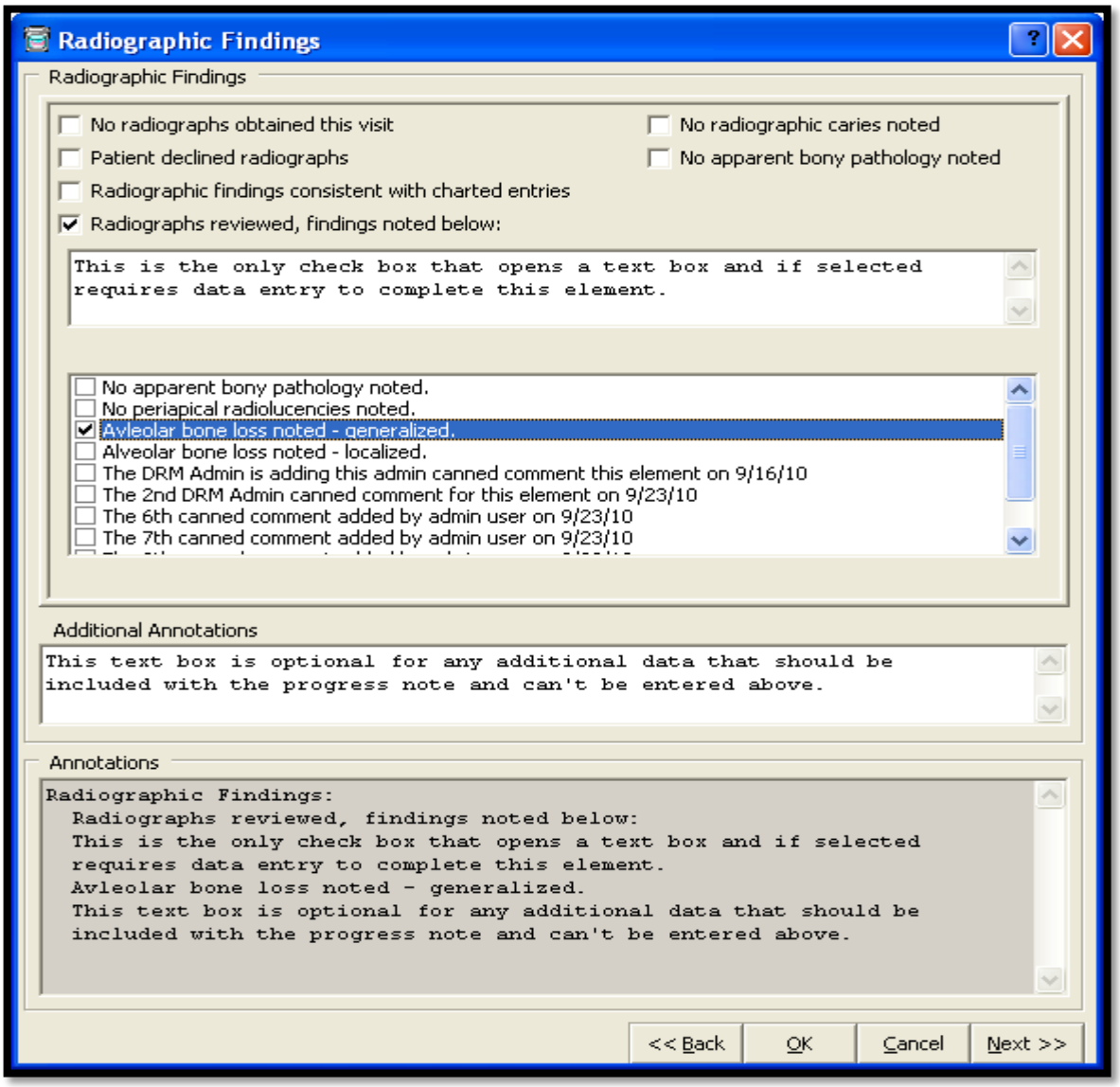
The Additional Annotations is an optional text window which allows the provider to enter additional information about the patient's H&N finding. This text window has the right click functionality of Import text files if desired. The Annotations is a view only window that captures everything that is entered in this element. The OK button will save data entered after all requirements have been meet and close the element. The Next/Back 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. The new functionalities for the H&N Findings screen are explained in greater detail in a later section of this QuickStart Guide.



Radiographic Findings Element

The Radiographic Findings element is required for the D0150 and D0180 exams. The radiographic element will require at least one selected check box from the top six options. The provider may select any combination of the top six check boxes for the patient's progress note. The fourth check box down the left column requires some data entry in the text box or at least one per-defined statement to satisfy the requirements. This screen will also allow the user to select up to twelve pre-defined statements on radiographic findings. The selections in the pre-defined statement window will have three national radiographic finding statements pre-loaded. All twelve radiographic finding pre-defined statements maybe created locally. The local facility may add/delete all twelve by the DRM Plus administrator, who has priority, and the rest added/deleted by the end-user.

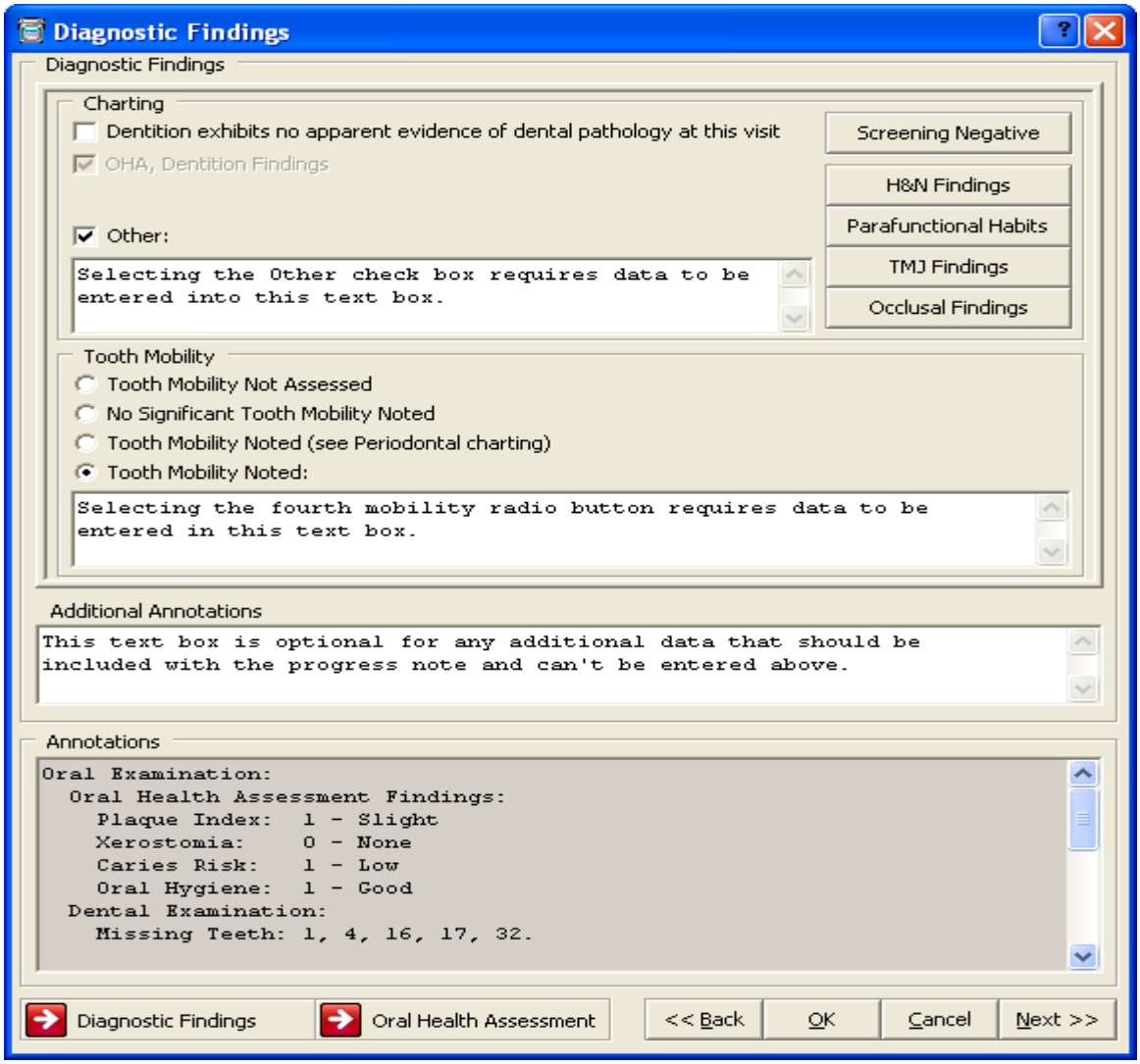
The Additional Annotations is an optional text window which allows the provider to enter additional information about the patient's radiographic findings. This text window has the right click functionality of Import text files if desired. The Annotations is a view only window that captures everything that is entered when using this element. The OK button will save data entered after all requirements have been meet and close the element. The Next/Back 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.



Diagnostic Findings Element

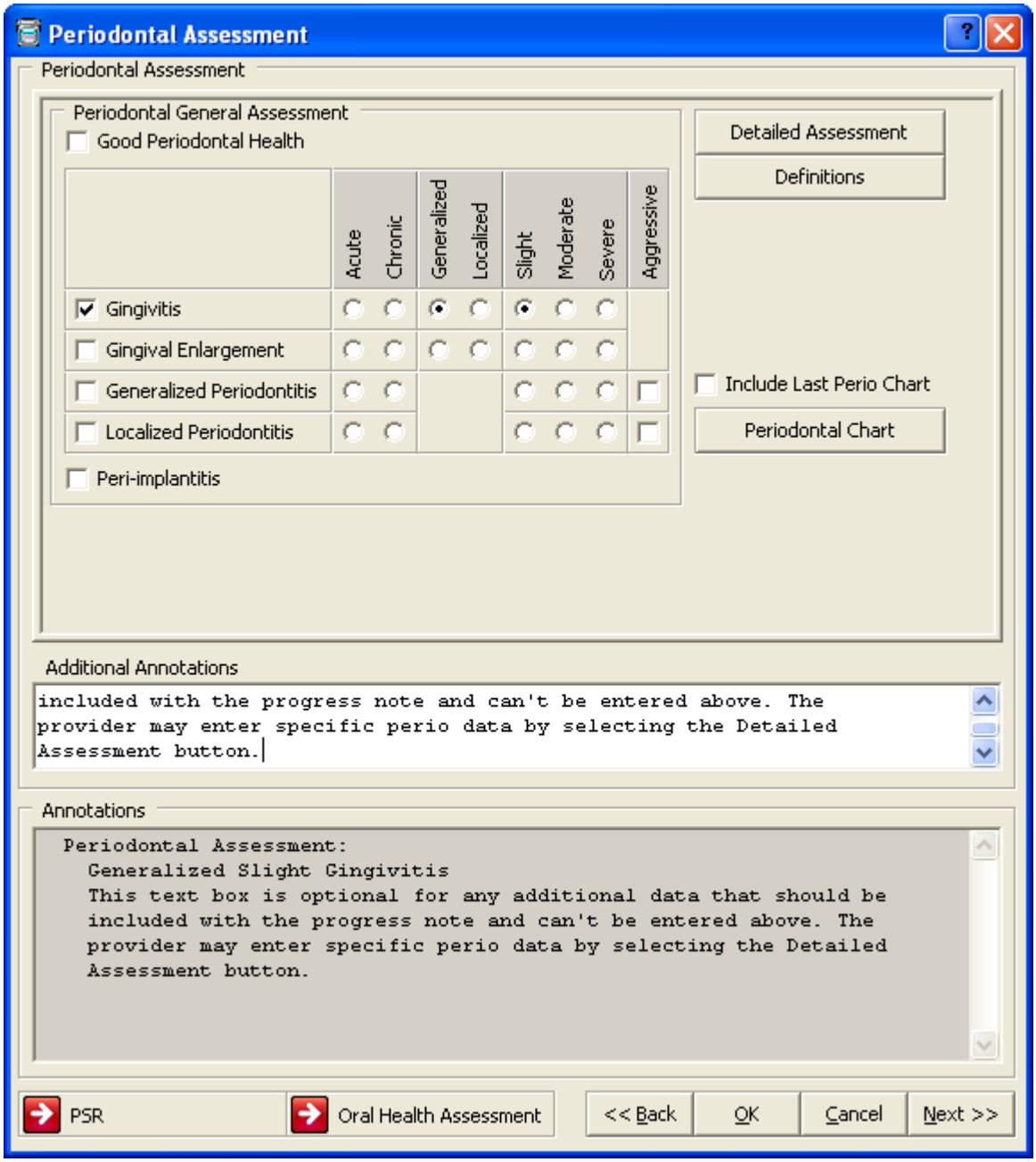
The Diagnostic Findings element is required for all seven exam/consult procedures. The D0150 exam requires an entry in Diagnostic Findings screen or the first check box of no apparent pathology. The other six exam/consult codes require as appropriate for new and updated findings. This element requires at least one of the three check boxes to be required for the six exam/consult codes other than the D0150 exam. The second check box will only display after data is entered from another Chart/Treatment findings screen that satisfies this option. The D0180 exam requires an Oral Hygiene entry from the OHA screen. The D0120 and D0150 exams require a Plaque Index entry from the OHA screen. One of the four Tooth Mobility radio buttons is also required for a D0120 and D0150 exams. Informational pop-ups will inform the user of any missing requirements for a specific exam code. The NFT, no functional teeth, check box when selected in the OHA screen will bypass all requirements in this element for all exam/consult procedures. The OHA screen maybe opened from the Chart/Treatment tab or selecting the OHA button in the lower left area of this screen.

The Additional Annotations is an optional text window which allows the provider to enter additional information about the patient's diagnostic findings. This text window has the right click functionality of Import text files if desired. The Annotations is a view only window that captures everything that is entered in this element. The OK button will save data entered after all requirements have been meet and close the element. The Next/Back 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.



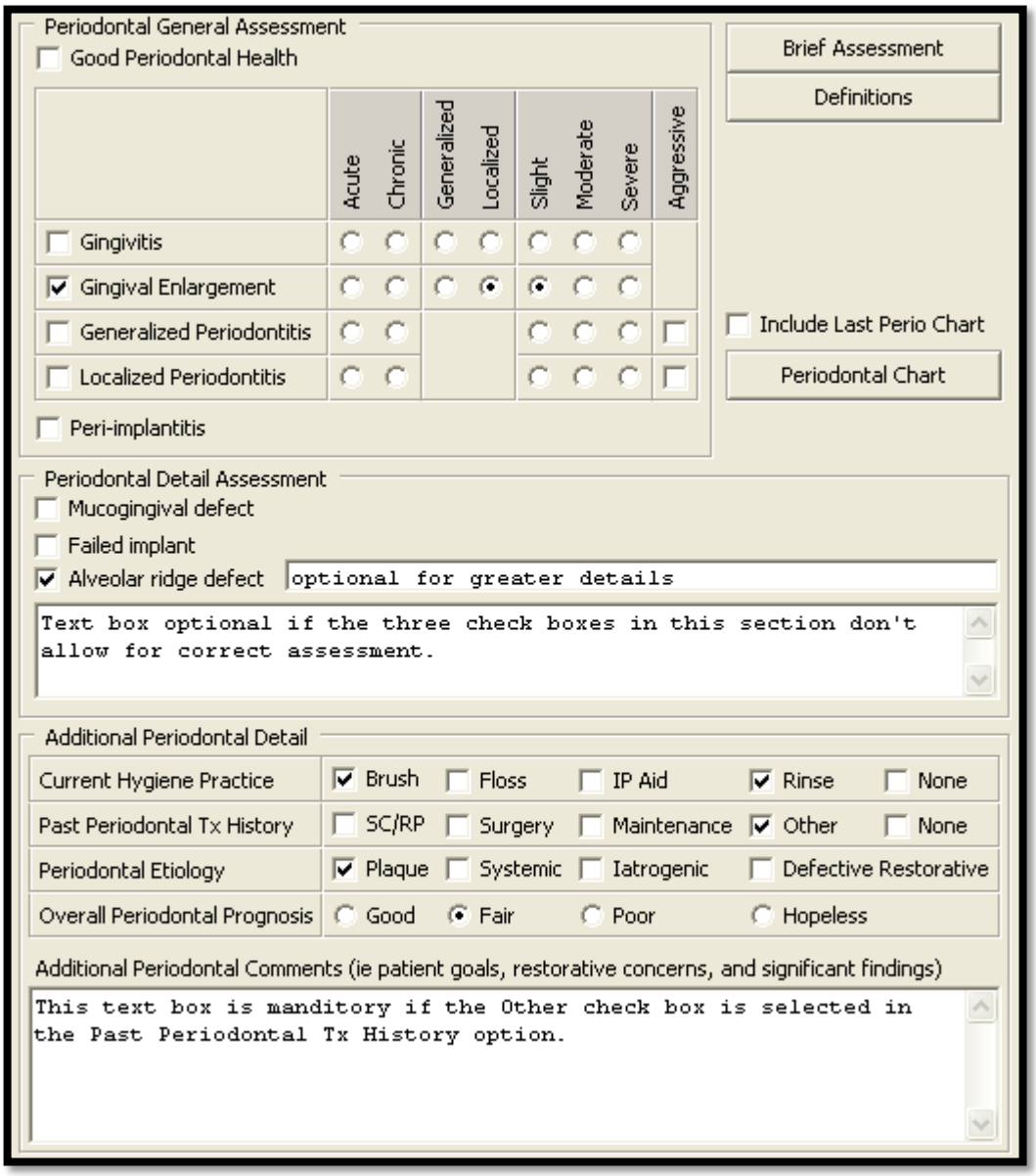
Periodontal Assessment Element

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 Include Last Perio Chart check box will default as unchecked and if the provider would like to import the last filed Periodontal Chart into this element. The Include Last Perio Chart check box when selected will satisfy the requirements for this Periodontal Assessment element for the D0140, D0160, D0170 and D9310 procedures. When any 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 statement. The NFT, no functional teeth, check box 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.



The Additional Annotations is an optional text window which allows the provider to enter additional information about the patient's periodontal assessment. This text window has the right click functionality of Import text files if desired. The Annotations is a view only window that captures everything that is entered and imported when using this element. The OK button will save data entered after all requirements have been meet and close the element. The Next/Back 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.

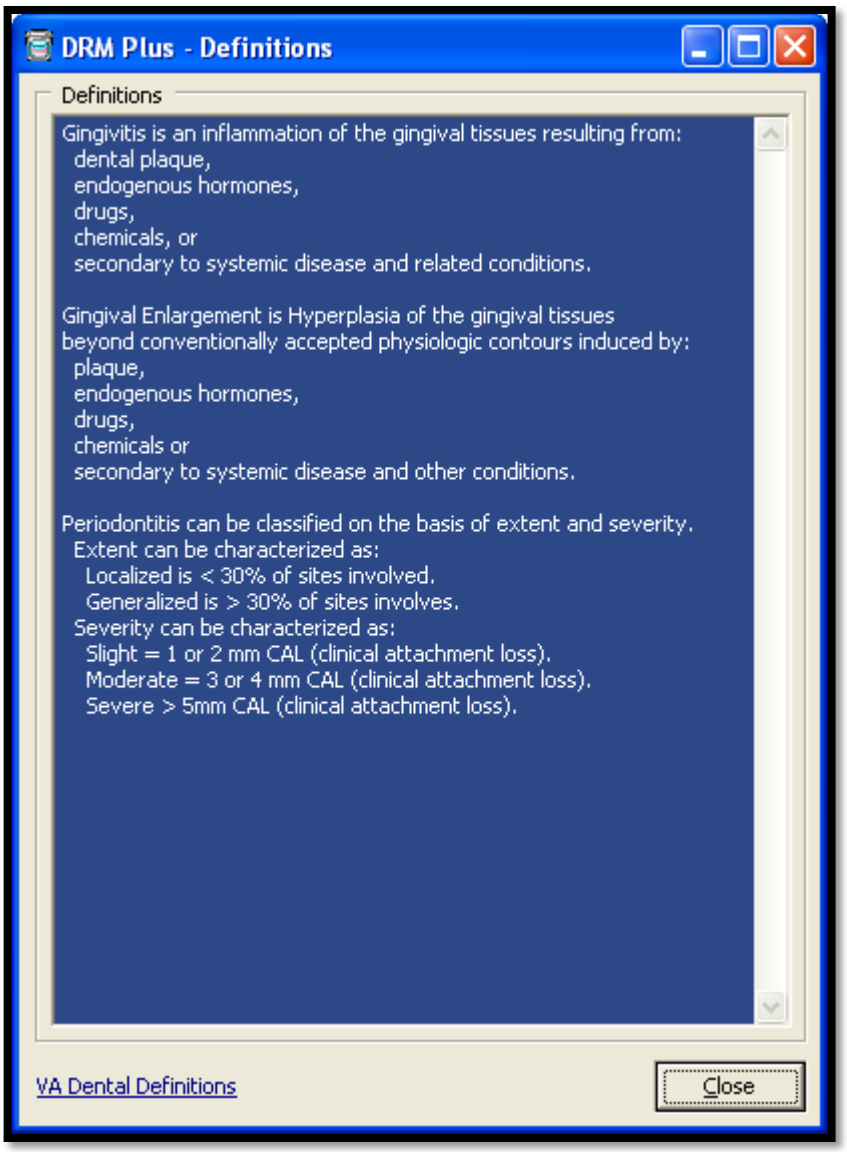
The D0180 exam requires one selection from the Periodontal General Assessment section as well. The Periodontal Detail Assessment section is optional and has optional text boxes with each selection if more descriptive detail is needed. The D0180 exam also requires the first four rows in the Additional Periodontal Details to have at least one selection. The last Additional Periodontal Comments text box is optional in this section. When the Other check box is selected from the Past Periodontal Tx History row it will require data entry in the Additional Periodontal Comments text box.



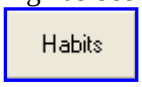
The D0180 exam code will not allow the user to select the Brief Assessment button from this screen.

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 will allow access to that chart to enter any new findings this session.

The following dialog displays the VA Office of Dentistry perio definitions.

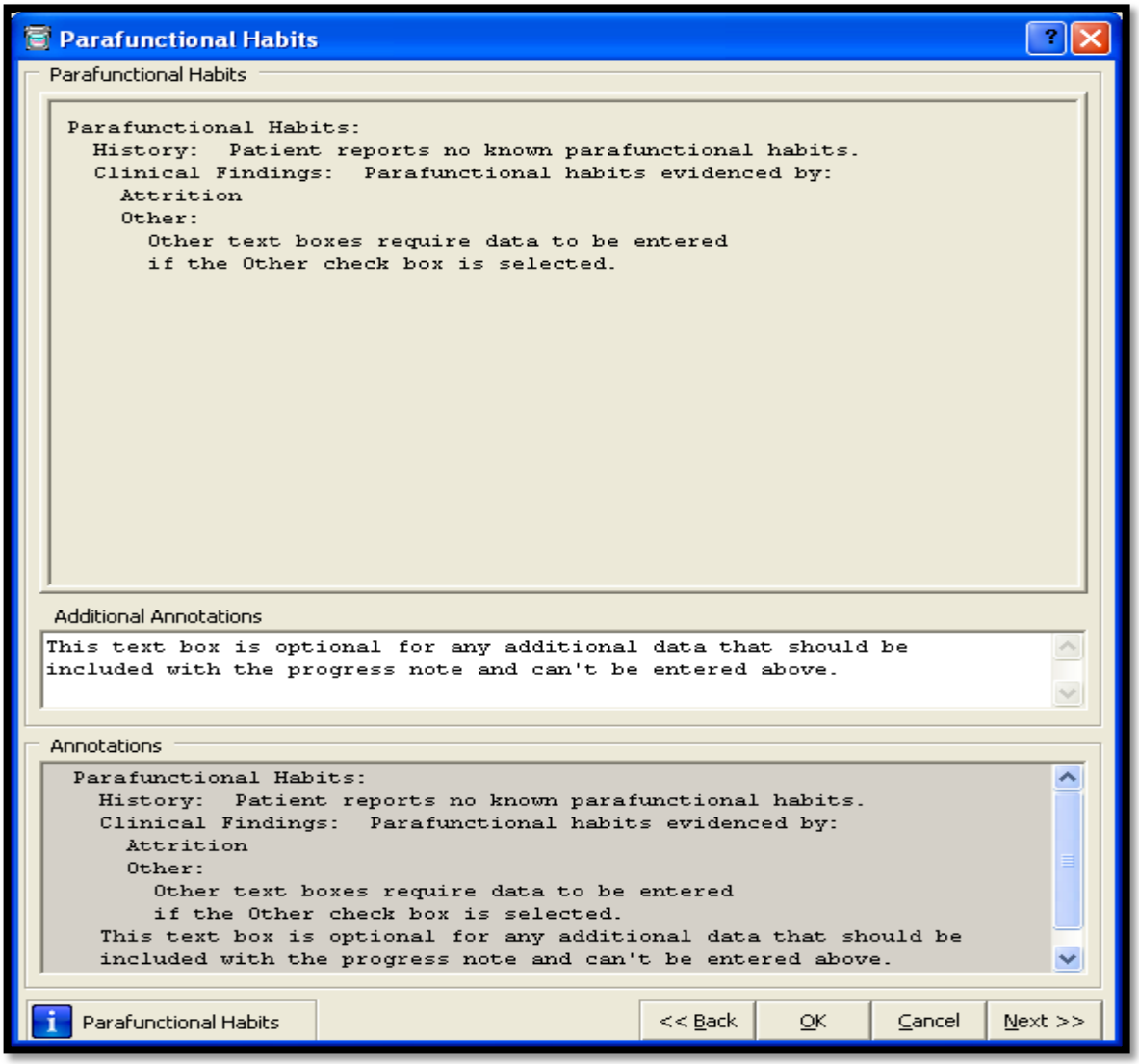


Parafunctional Habits Element

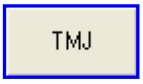
The Parafunctional Habits element is optional for all seven exam/consult procedures. This element will import data entered this session from the Parafunctional Habits screen or will be blank if nothing has been entered in that screen. The Parafunctional Habits screen maybe opened with the specialty button 

from the Chart/Treatment tab or from the lower left corner of this element's screen. The minimal requirement to enter a new Parafunctional Habit finding is to select at least one history or one clinic finding from the screen. The new functionalities for the Parafunctional Habits screen are explained in greater detail in a later section of this QuickStart Guide.

The Additional Annotations is an optional text window which allows the provider to enter additional information about the patient's parafunctional habits. This text window has the right click functionality of Import text files if desired. The Annotations is a view only window that captures everything that is imported when using this element. The OK button will save data entered after all requirements have been meet and close the element. The Next/Back 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.

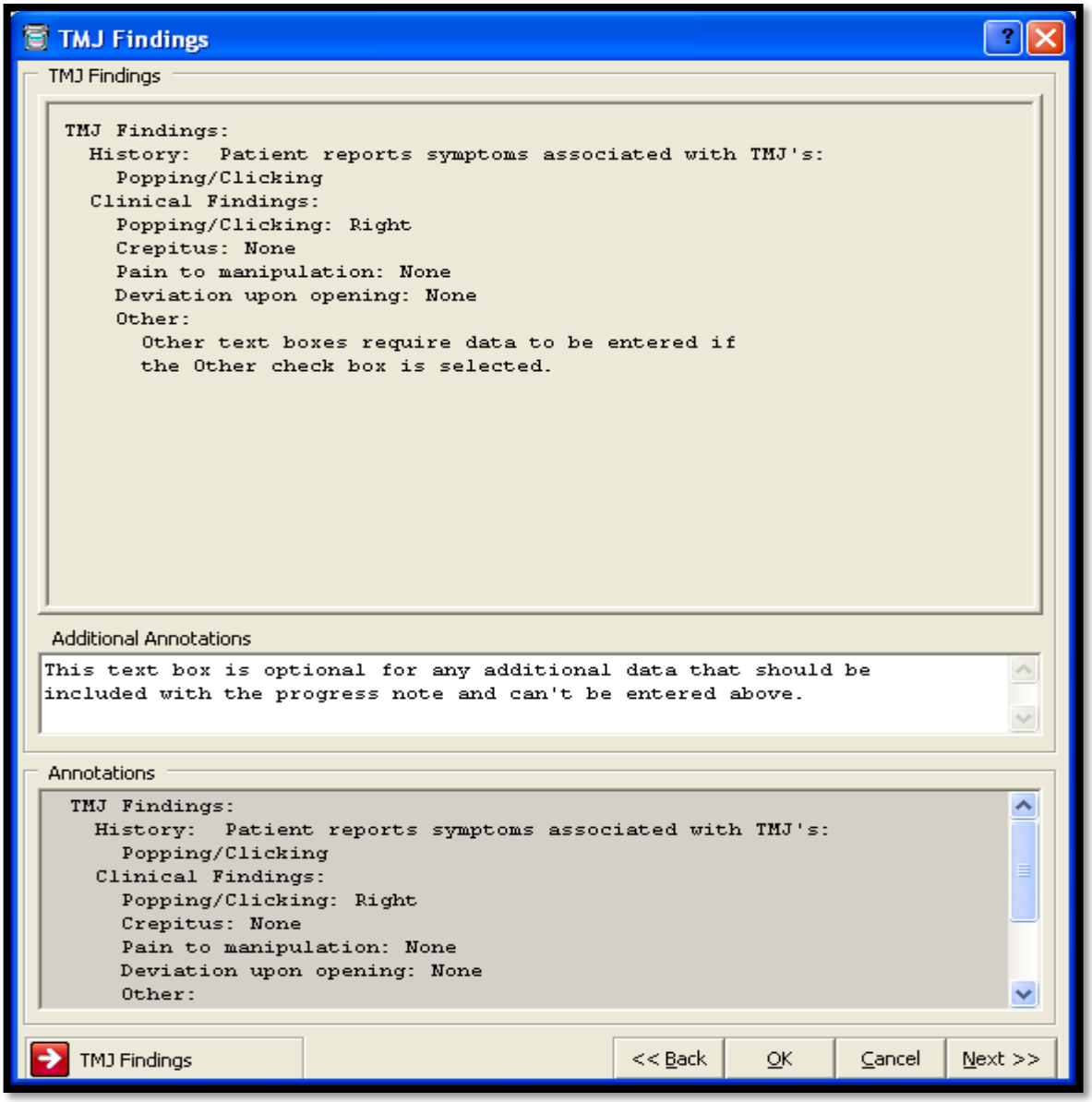


TMJ Findings Element

The TMJ Findings element is required for both the D0150 and D0180 exams. This element requires new TMJ findings entered from the TMJ screen when selecting one of the two required exams. The TMJ screen maybe opened with the specialty button 

from the Chart/Treatment tab or one is located in the lower left corner of the element's screen. The minimal requirement to enter a new TMJ exam finding is to select at least one historical or one clinical finding from the TMJ screen. The new functionalities for the TMJ screen are explained in greater detail in a later section of this QuickStart Guide.

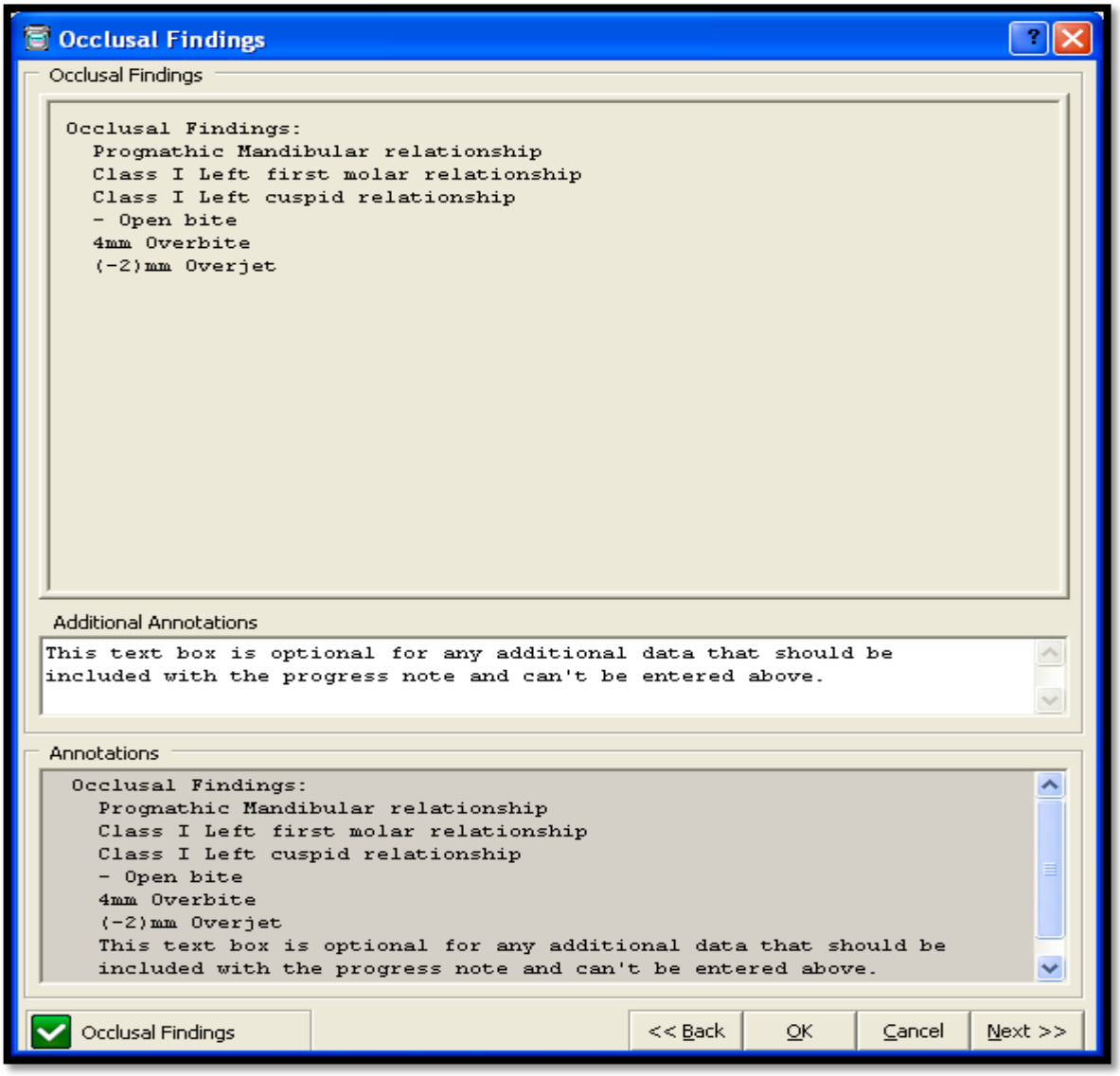
The Additional Annotations is an optional text window which allows the provider to enter additional information about the patient's TMJ findings. This text window has the right click functionality of Import text files if desired. The Annotations is a view only window that captures everything that is entered in this element. The OK button will save data entered after all requirements have been meet and close the element. The Next/Back 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.



Occlusal Findings Element

The Occlusal Findings element is required for the D0150 and D0180 exams. This element requires Occlusal Findings entered from the Occlusion screen when completing one of the two required exams. This element will import data entered from the Occlusion screen. The Occlusion screen maybe opened with the specialty button Occl from the Chart/Treatment tab or at the lower left corner of this element's screen. The Clinical Findings drop-down menu option Mandibular relationship is the only required field. Data from the last filed Occlusion exam will import into the screen when a new exam is selected. This will require the provider to add and/or remove the correct data. The new functionalities for the Occlusion screen are explained in greater detail in a later section of this QuickStart Guide.

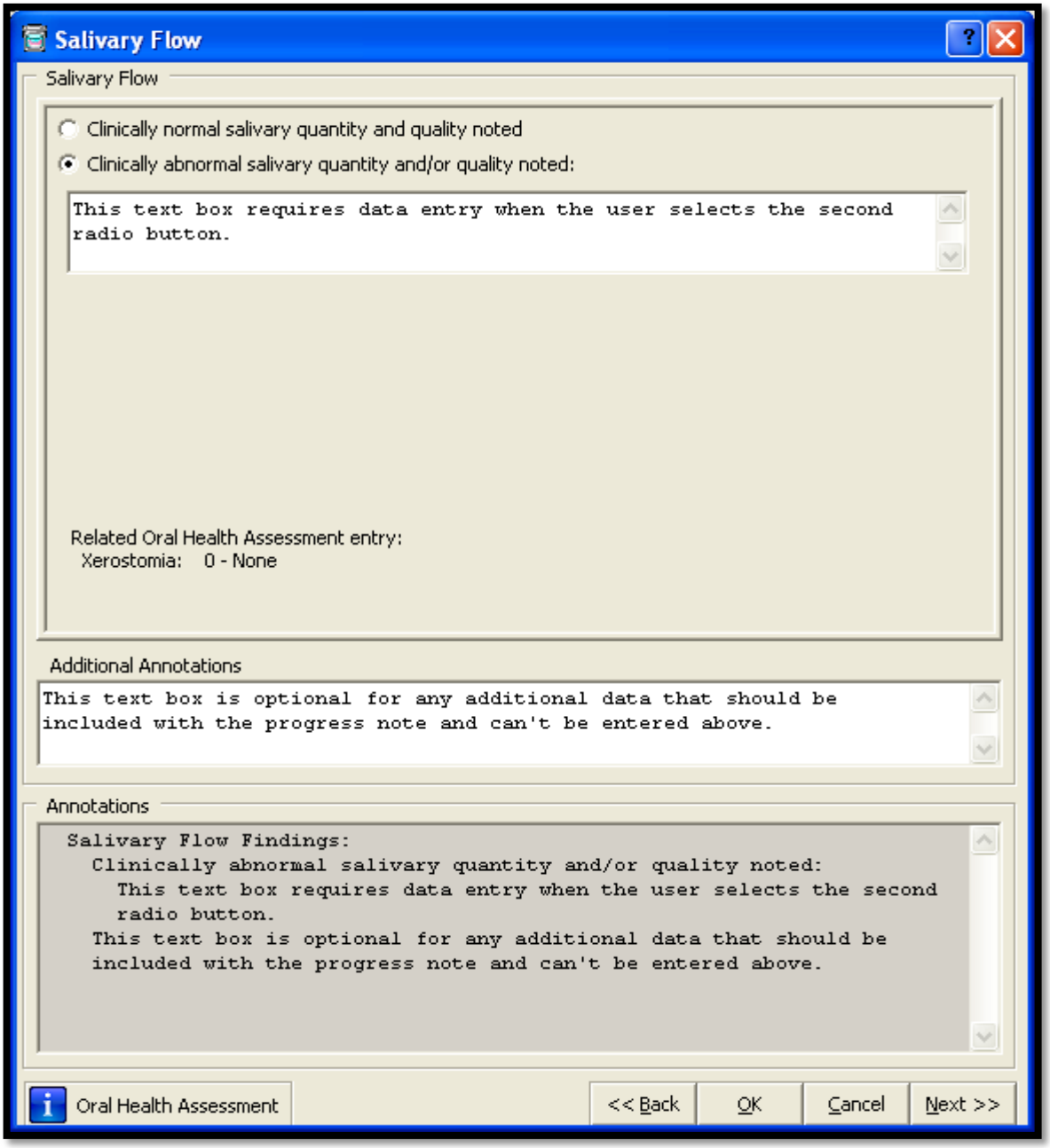
The Additional Annotations is an optional text window which allows the provider to enter additional information about the patient's occlusal findings. This text window has the right click functionality of Import text files if desired. The Annotations is a view only window that captures everything that is entered in this element. The OK button will save data entered after all requirements have been meet and close the element. The Next/Back 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.



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 will import for viewing on this Salivary Flow element screen if entered from the OHA screen during this session.

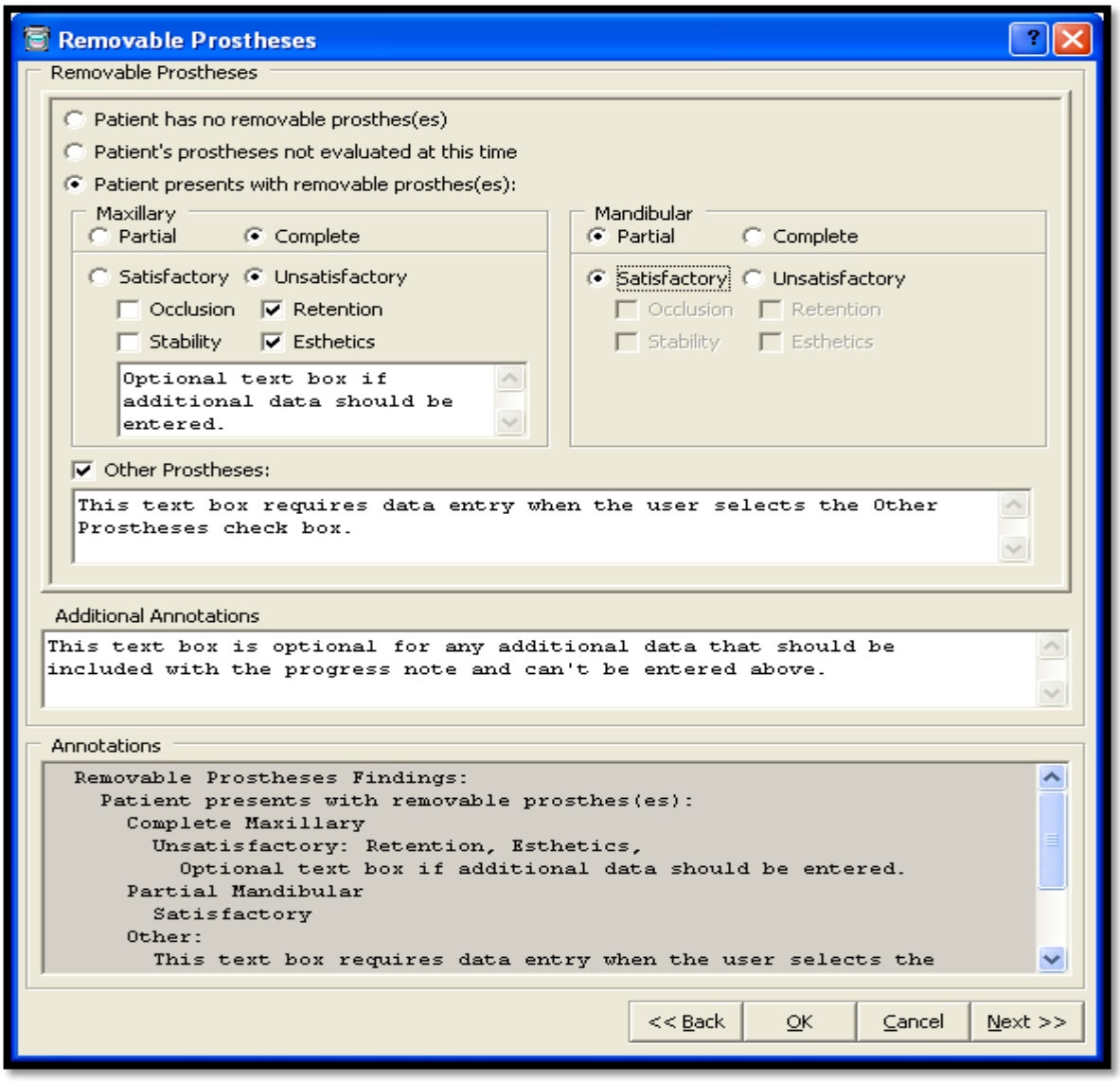
The Additional Annotations is an optional text window which allows the provider to enter additional information about the patient's salivary flow. This text window has the right click functionality of Import text files if desired. The Annotations is a view only window that captures everything that is entered when using this element. The OK button will save data entered after all requirements have been meet and close the element. The Next/Back 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.



Removable Prostheses Element

The Removable Prostheses element is optional for all seven exam/consult procedures. This element requires one of the top three radio buttons to be selected when entering data. The selection of the third radio button will allow the selection of another radio button listed in a maxillary or mandibular column. Only one selection of a maxillary or mandibular radio button is allowed which is followed by another selection of a satisfactory or unsatisfactory radio button. When selecting the unsatisfactory option there may be up to four possible descriptive words for selection or a text box to enter something that may not be listed. The check box Other Prostheses opens a required text box for any other prostheses that should be added in the progress note for the patient.

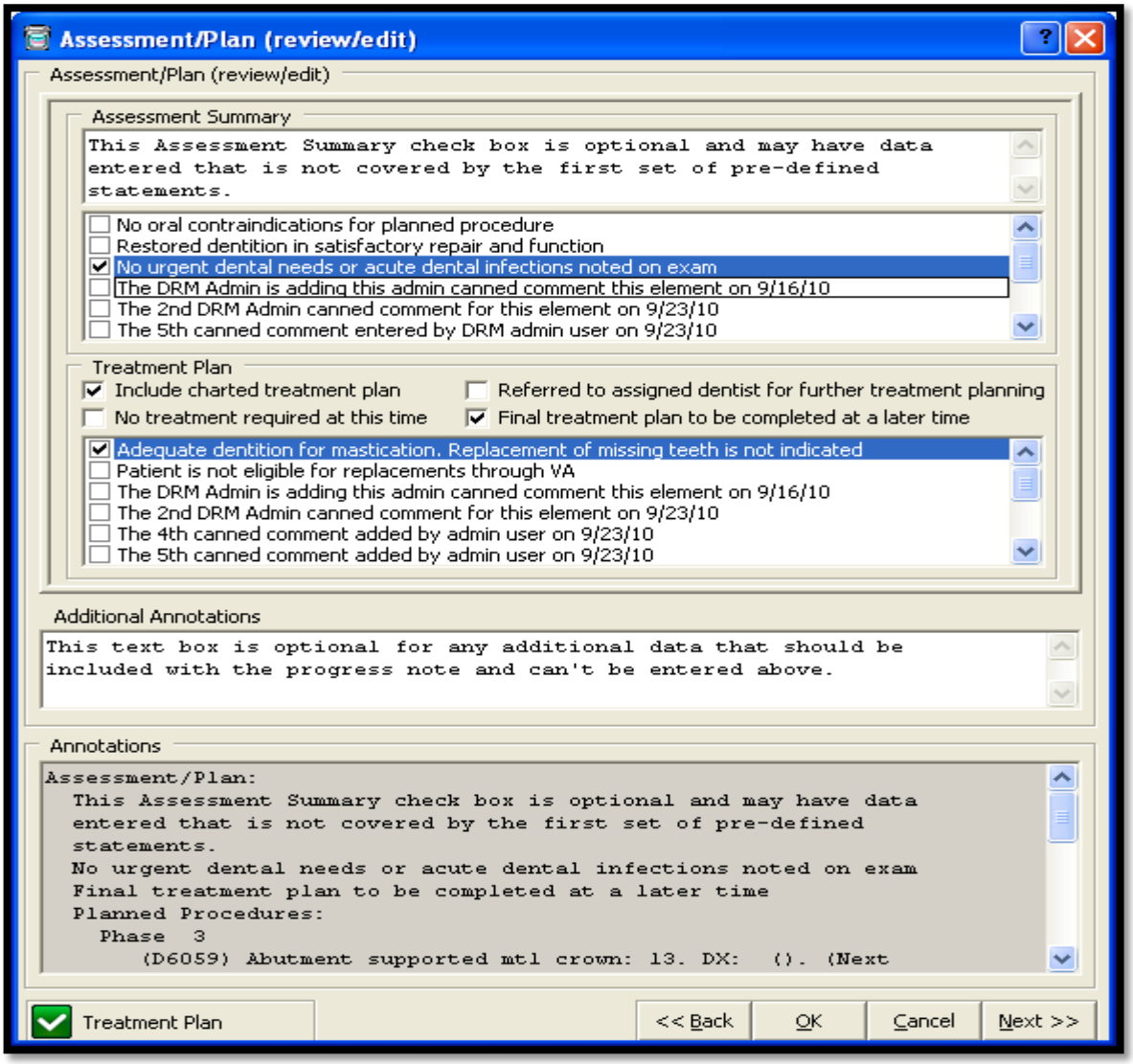
The Additional Annotations is an optional text window which allows the provider to enter additional information about the patient's removable prostheses. This text window has the right click functionality of Import text files if desired. The Annotations is a view only window that captures everything that is entered when using this element. The OK button will save data entered after all requirements have been meet and close the element. The Next/Back 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.



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 check boxes or only one pre-defined statement to be selected to complete the element. The first check box, Include charted treatment plan, will load automatically and import the patient's newly entered and/or past planned treatment. The selections in the pre-defined statement windows will have three/two national assessment/plan statements pre-loaded. All twelve assessment pre-defined statements or planned pre-defined statements maybe created locally. The local facility may add/delete all twelve by the DRM Plus administrator, who has priority, and the rest added/deleted by the end-user.

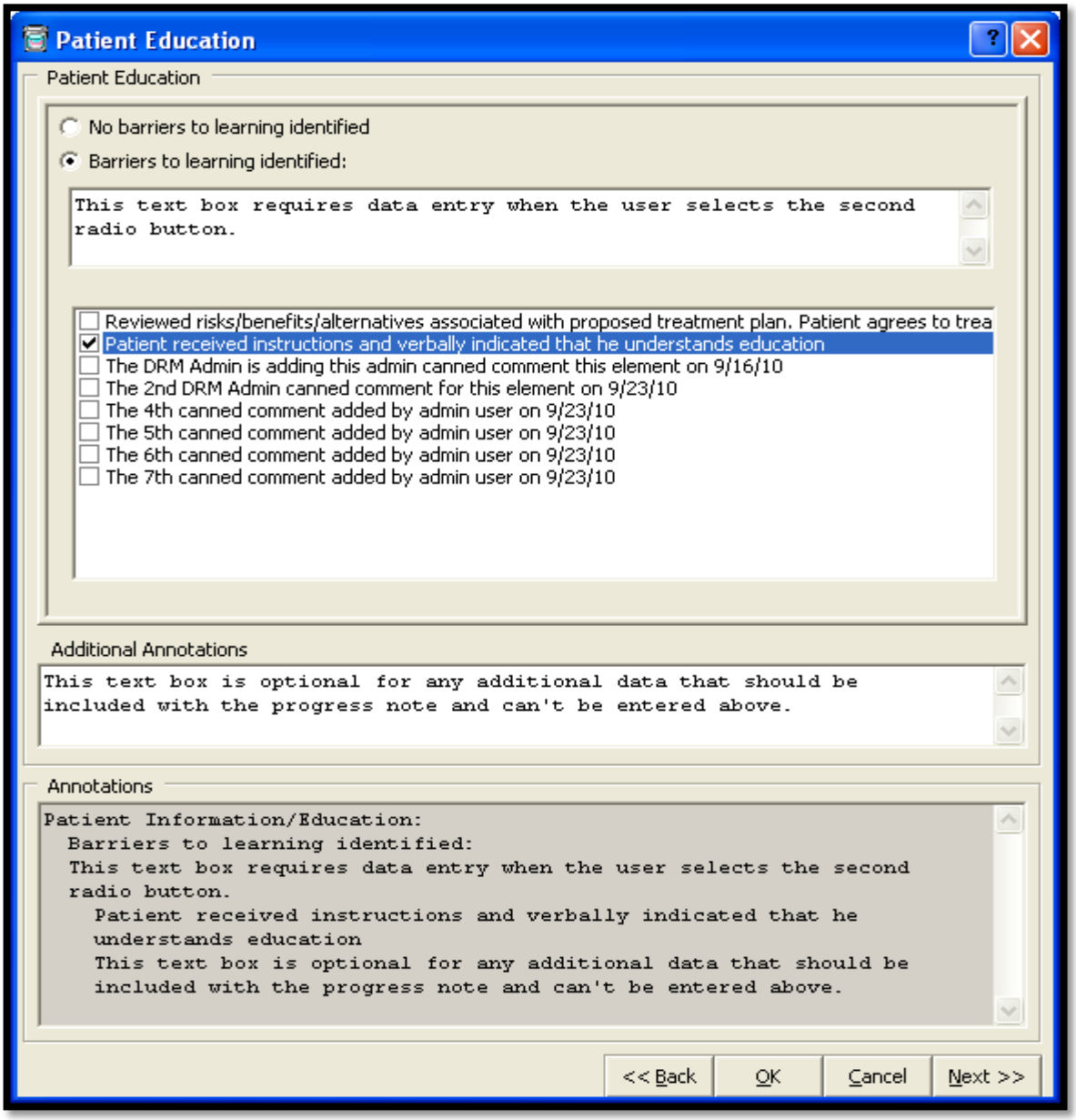
The Additional Annotations is an optional text window which allows the provider to enter additional information about the patient's planned treatment. This text window has the right click functionality of Import text files if desired. The Annotations is a view only window that captures everything that is entered in this element. The OK button will save data entered after all requirements have been meet and close the element. The Next/Back 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. The element will import incomplete when saved as unfiled data and then reloads. The provider will be 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 will open a text box that requires some type of entry or one pre-defined statement selected. The selections in the pre-defined statement window will have two national patient education statements pre-loaded. All twelve patient education pre-defined statements maybe created locally. The local facility may add/delete all twelve by the DRM Plus administrator, who has priority, and the rest added/deleted by the end-user.

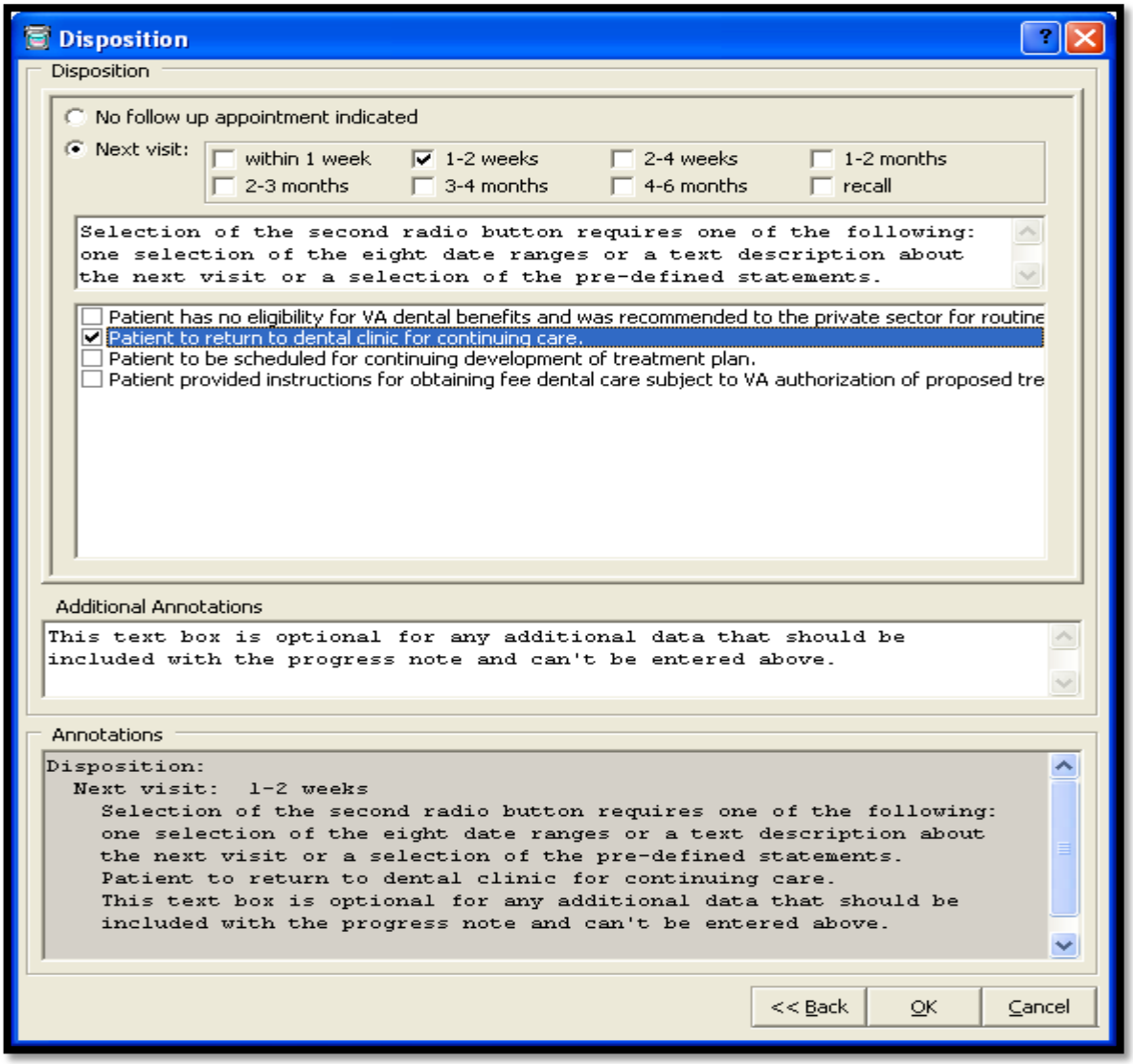
The Additional Annotations is an optional text window which allows the provider to enter additional information about the patient's education. This text window has the right click functionality of Import text files if desired. The Annotations is a view only window that captures everything that is entered when using this element. The OK button will save data entered after all requirements have been meet and close the element. The Next/Back 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.



Disposition Element

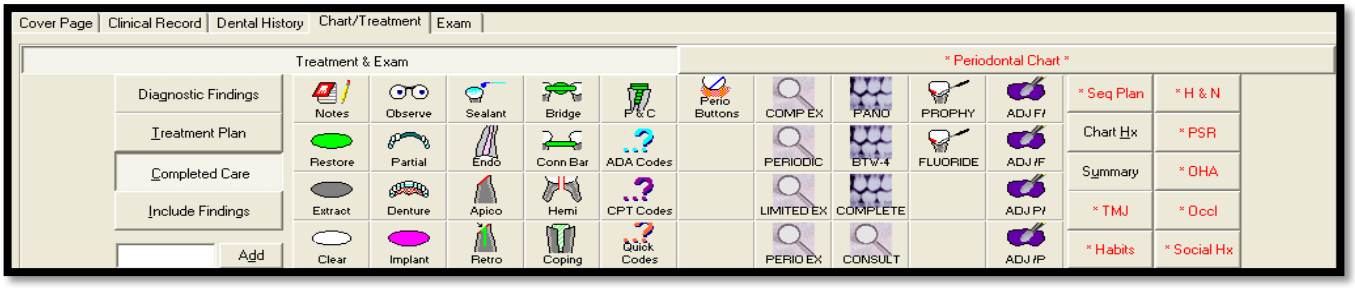
The Disposition element is required for all seven exam/consult procedures. This element requires one of the two radio buttons to be selected when entering data. The selection of the second radio button will require at least one of the following: one selection of the eight data ranges, a text description about the next visit typed in the text box or one selection from the pre-defined statements. The selections in the pre-defined statement window will have four national disposition statements pre-loaded. All twelve disposition pre-defined statements maybe created locally. The local facility may add/delete all twelve by the DRM Plus administrator, who has priority, and the rest added/deleted by the end-user. The Next Appointment check boxes if selected in the Sequencing screen will import automatically into the Annotations view window of this element.

The Additional Annotations is an optional text window which allows the provider to enter additional information about the patient's disposition. This text window has the right click functionality of Import text files if desired. The Annotations is a view only window that captures everything that is entered in this element. The OK button will save data entered after all requirements have been meet and close the element. There is no Next button present in this element. Usage of the Back button is not dependent on the element's completion. Clicking the OK button will save the data, close the Disposition screen and display the pre-viewable note. The exam template note is only editable from each individual element screen or when the user has moved to the progress note screen.



New Specialty Exam Buttons

This patch adds five new specialty exam buttons which are OHA (Oral Health Assessment), TMJ, Occl (Occlusion), Habits (Parafunctional Habit) and Social Hx (Social History) to the Chart/Treatment screen. This introduces five new screens that allow new data to be entered and filed with any dental encounter. These screens will also import data into the new exam template when an exam/consult code is completed during the current session when new findings are added to any of the specialty screens. Providers may also look up previous filed data after opening the screen and selecting the Date from a drop-down menu on each of these five specialty screens.



The Date field found on these five specialty screens will display the actual date the findings were entered or created. For example; if these findings were saved as unfiled data on a different date than the actual visit date for the patient's encounter, the Date field would display the entry date of the unfiled data which is the create date of those findings and it would not display the visit date.

OHA (Oral Health Assessment) Button

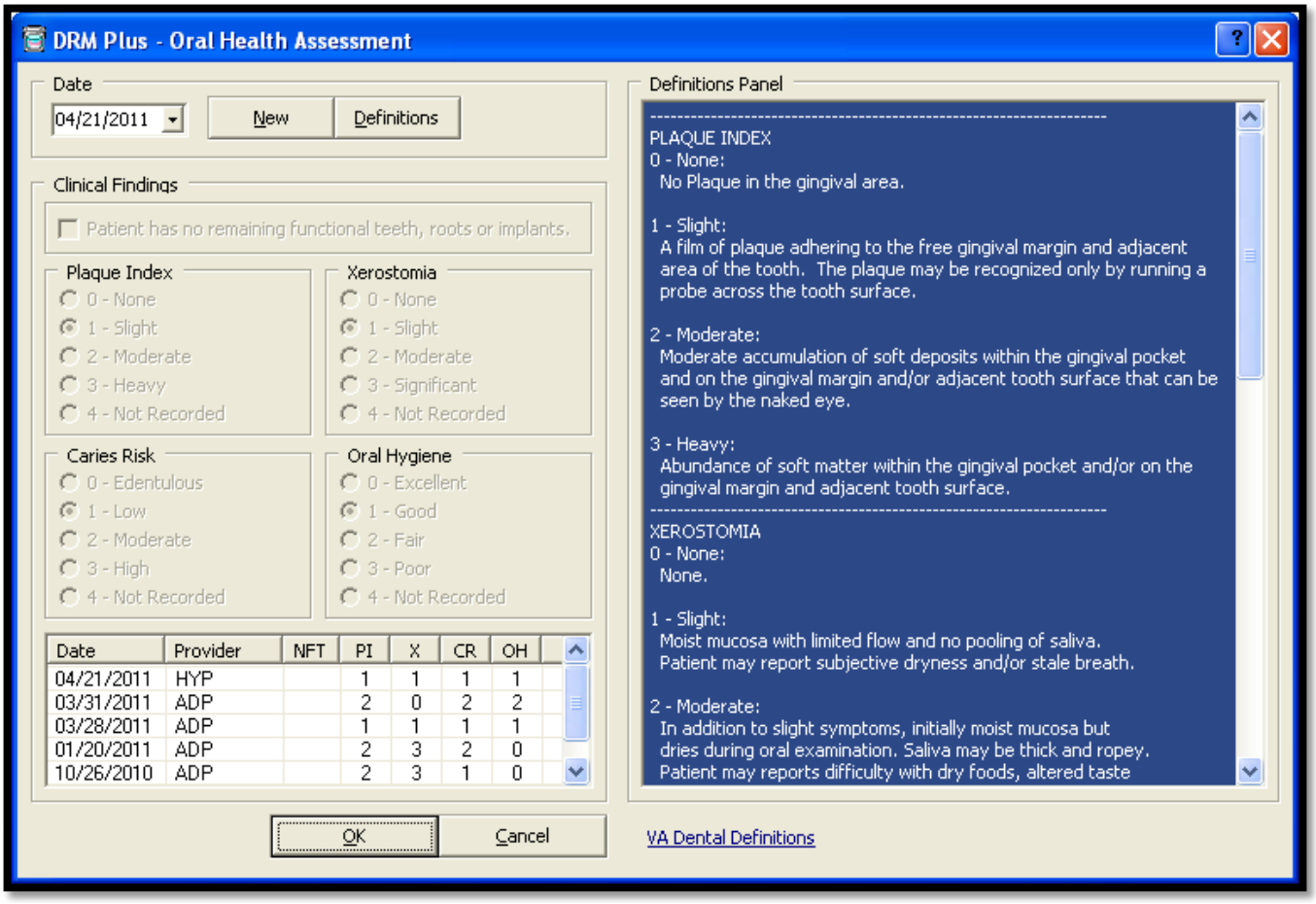
The specialty button Plaque was combined with Xerostomia, Caries Risk and Oral Hygiene where all four may allow new findings entered after selecting the OHA button. The same is true with the old Plaque button located on the Periodontal Chart screen in previous versions.

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

The NFT check box option listed as 'Patient has no remaining functional teeth, roots or implants' maybe selected when the patient has no functional teeth and there is no possible way to enter any findings on the Diagnostic Findings chart. This descriptive statement is established as the clinical definition for an edentulous patient by the VA Office of Dentistry. Selecting this check box will automatically complete the Diagnostic Findings element and the Periodontal Assessment element when filing any exam/consult code during a dental encounter. This check box selection will also automatically select the 0-Edentulous radio button in the Caries Risk section.

The Definitions Panel has the American Dental Association definitions for field values when entering Plaque Index, Xerostomia Risk and Caries Risk. The following dialog displays the definitions for Plaque Index and some of the Xerostomia Risk. The rest of the Xerostomia and Caries Risk definitions may be viewed using the scroll bar on the right side of the screen. There are no national definitions for the Oral Hygiene values.

The OHA (Oral Health Assessment) screen is displayed in the following dialog. The Definitions panel is 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.

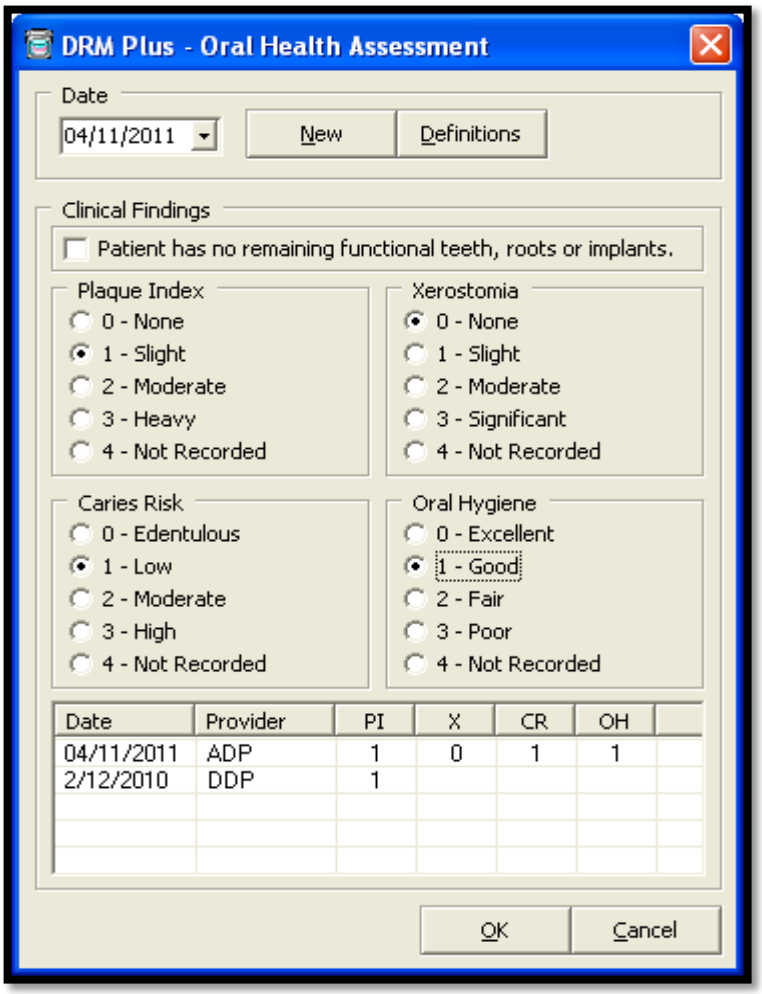


To enter new findings in the OHA screen, click the New button, today's date will be imported into the Date field on the screen. Today's date is the date of entry or the create date for this finding; when reloaded and filed as unfiled data will retain the same date when the finding was originally entered.

The radio buttons will default with the 4 -Not Recorded radio button in all four fields. The 4 -Not Recorded selection will not import as a clinical finding into the progress note or display in the transaction table of the OHA screen. The provider has the option of selecting the (0 – 3) radio buttons for each field of Plaque Index, Xerostomia, Caries Risk and Oral Hygiene or leaving it defaulted at the 4 -Not Recorded option.

The Definitions panel maybe reduced to display only the OHA screen by selecting the [?] icon which is next to the red [X] icon located in the upper right corner of this screen.

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



The entry or create date, provider's initials and each numeric value from the radio button selection will be captured in the transaction table at the bottom of the screen. The provider may only enter one value between (0 – 3) in one of the four fields to save and file an oral health assessment. The value 4 -Not Recorded will not be saved in the table when viewing any previous exams however will be viewable by the position of the radio button. The provider may save the data after selecting the OK button with at least one of the four exams with a (0-3) selection.

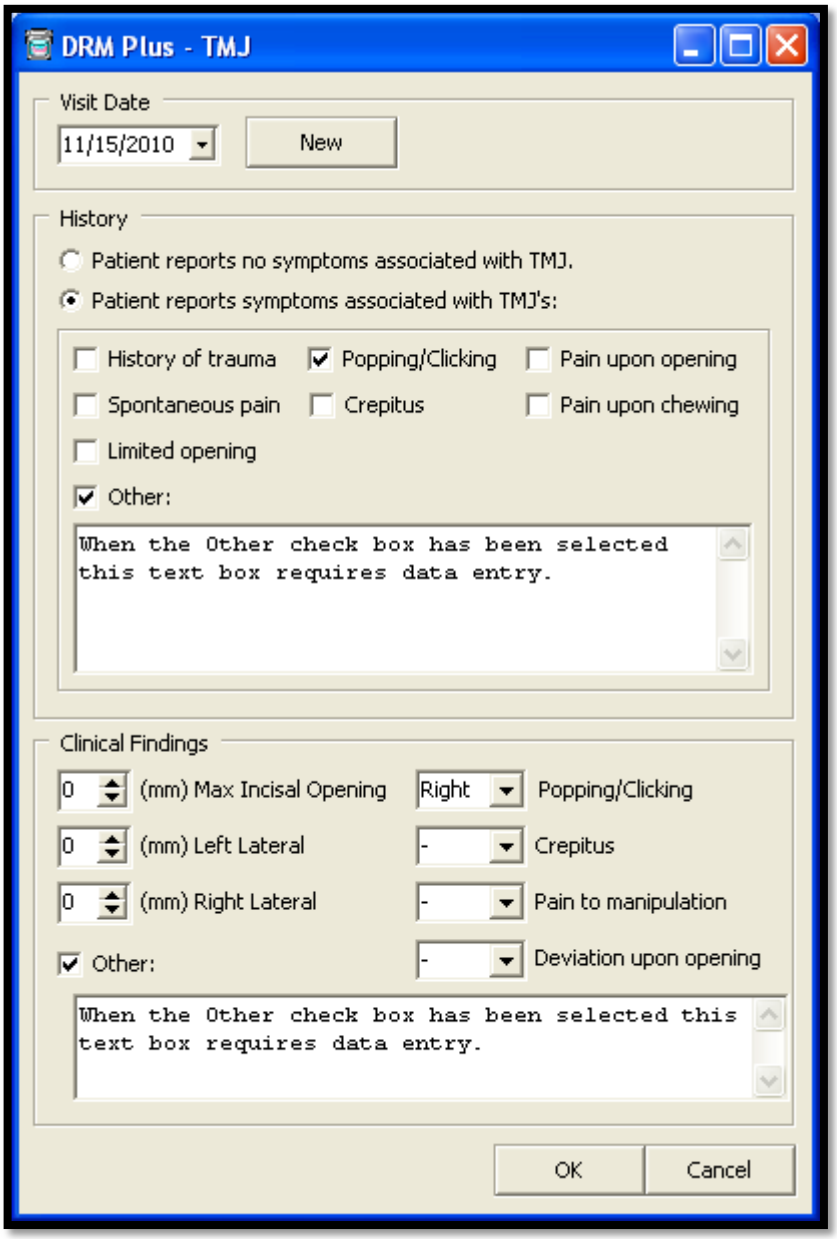
The five new modal allow the provider to clear the exam selections during the session for any modal by opening that screen and selecting the Cancel button. The Cancel button will clear all data entered during this session however it will not remove any data that has been filed with a TIU note today or in the past.

TMJ Button

The new specialty button TMJ functions similar to the OHA button when entering a new exam. Click on the New button and today's date will import 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 will retain 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 check box selections and at least one will be a required for this option to save.

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



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 check box allows an unlimited text field for additional text information if selected.

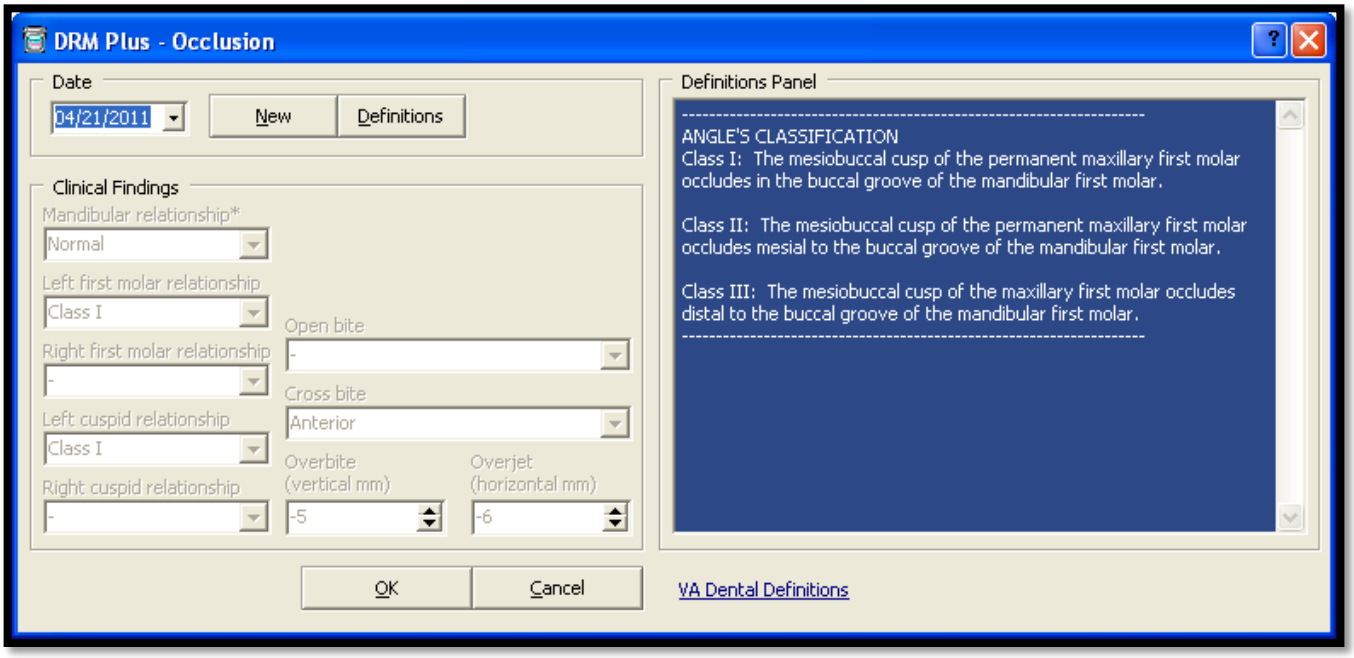
The minimal requirement to enter a new TMJ exam finding is to select only one historical or one clinical finding from the TMJ screen.

Occl (Occlusion) Button

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

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 Tools menu, User Options, Exam Settings and uncheck the Requirements.

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 [?] icon which is next to the red [X] icon located in the upper right corner of this screen.

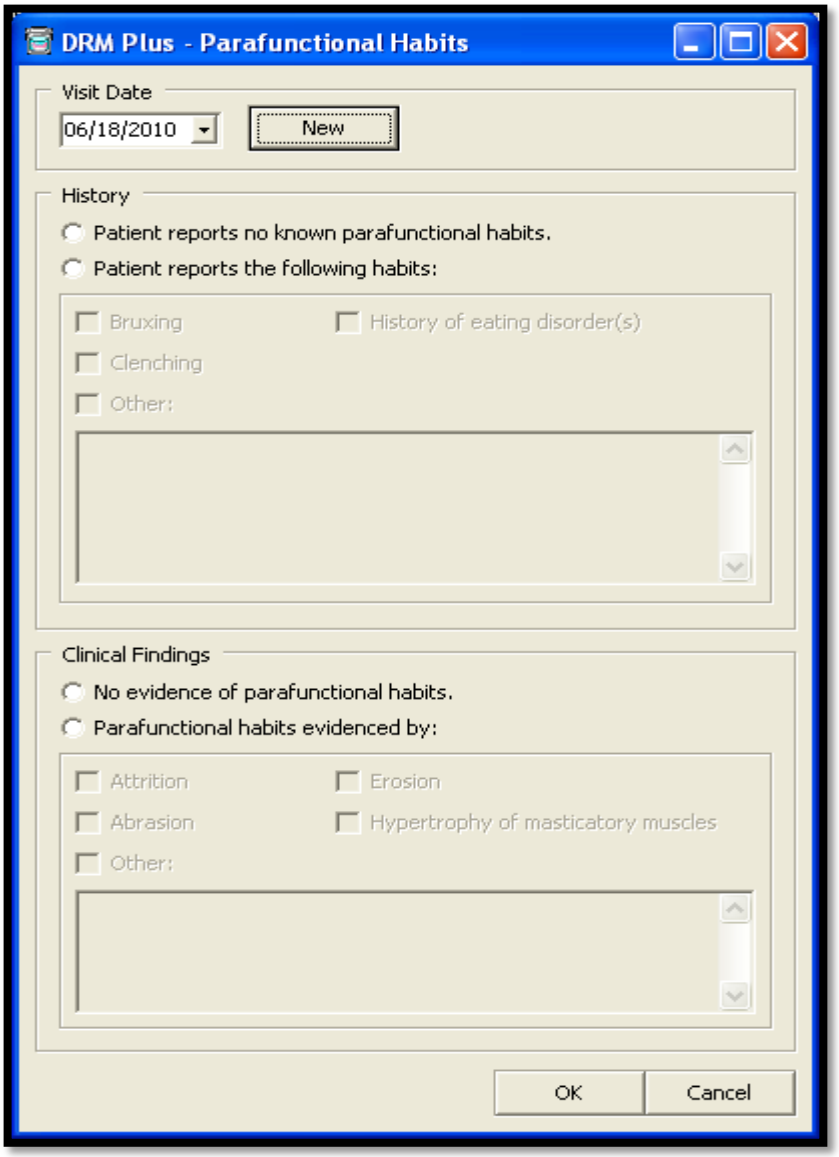
At the bottom of the Occlusion Definitions panel is the internet link for possible newer 'VA Dental Definitions' which will display any new definition updates that have been changed for these findings.

Habits (Parafunctional) Button

The new specialty button Parafunctional Habits functions similar to the OHA button when entering new data. Click on the New button and today's date will import 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 will retain the same date when the finding was originally entered.

At least one entry in either the History section or the Clinical Finding section from this Parafunctional Habits screen requires data to be entered in order to save. When the second radio button is selected in each field then multiple options become active for selection and selecting at least one option is required to save the data. The Other check boxes require an entry in the unlimited text field if selected.

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

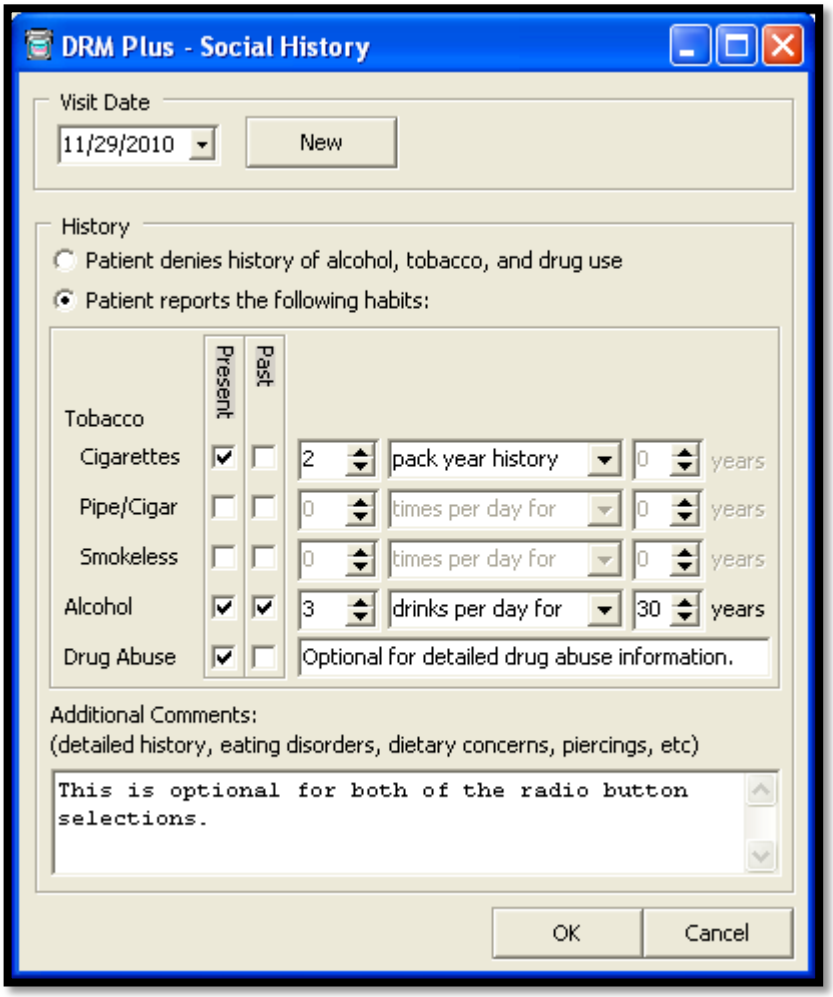


Social Hx (Social History) Button

The new specialty button Social History functions similar to the OHA button when entering new data. Click on the New button and today's date will import 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 will retain 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 check box option will be required to save the new historical data.

Any combination of check boxes 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 check boxes 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.

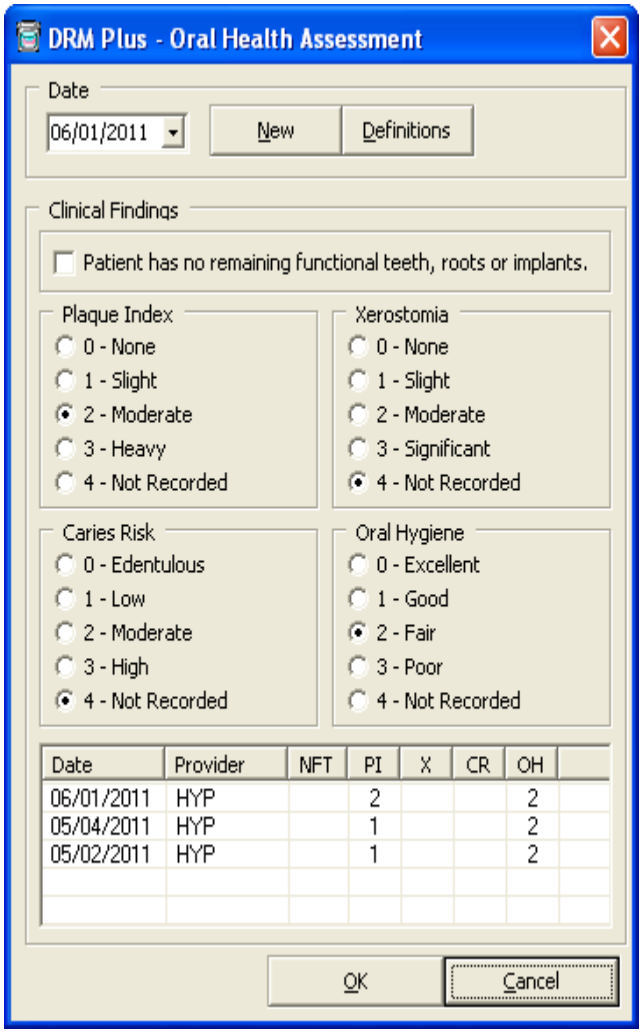


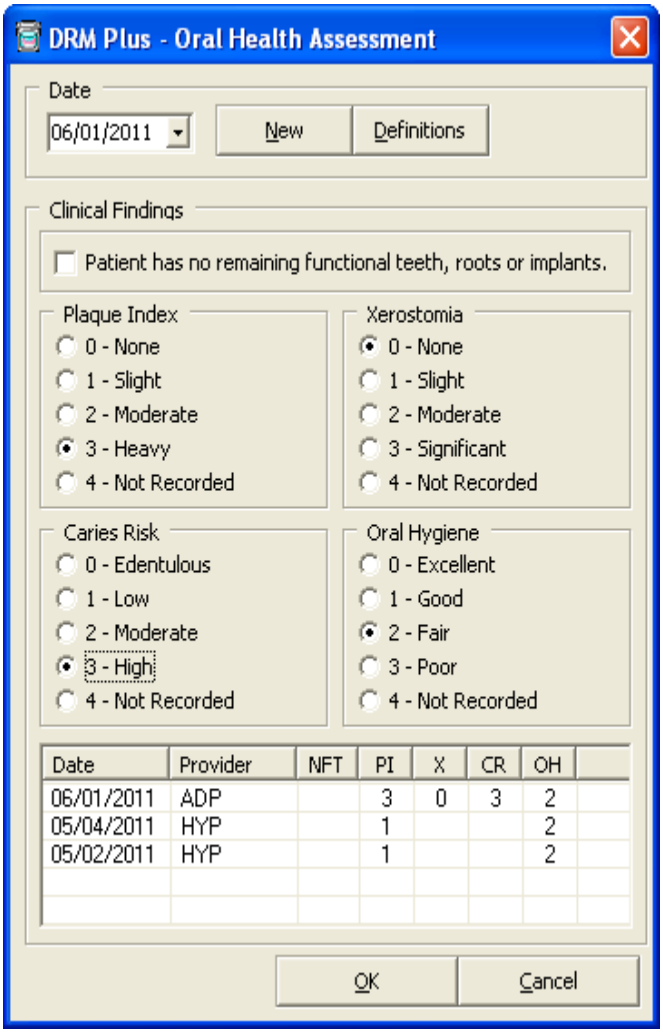
Note: All five of the new specialty screens work like the PSR screen except for one major difference. The major difference in functionality of the new specialty screens is that they will allow the provider to clear the exam selection findings during the present session for any of the five new modals 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 will only allow 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.





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 will be the only one present for the local clinical providers when they open this DRM Plus patient's chart.

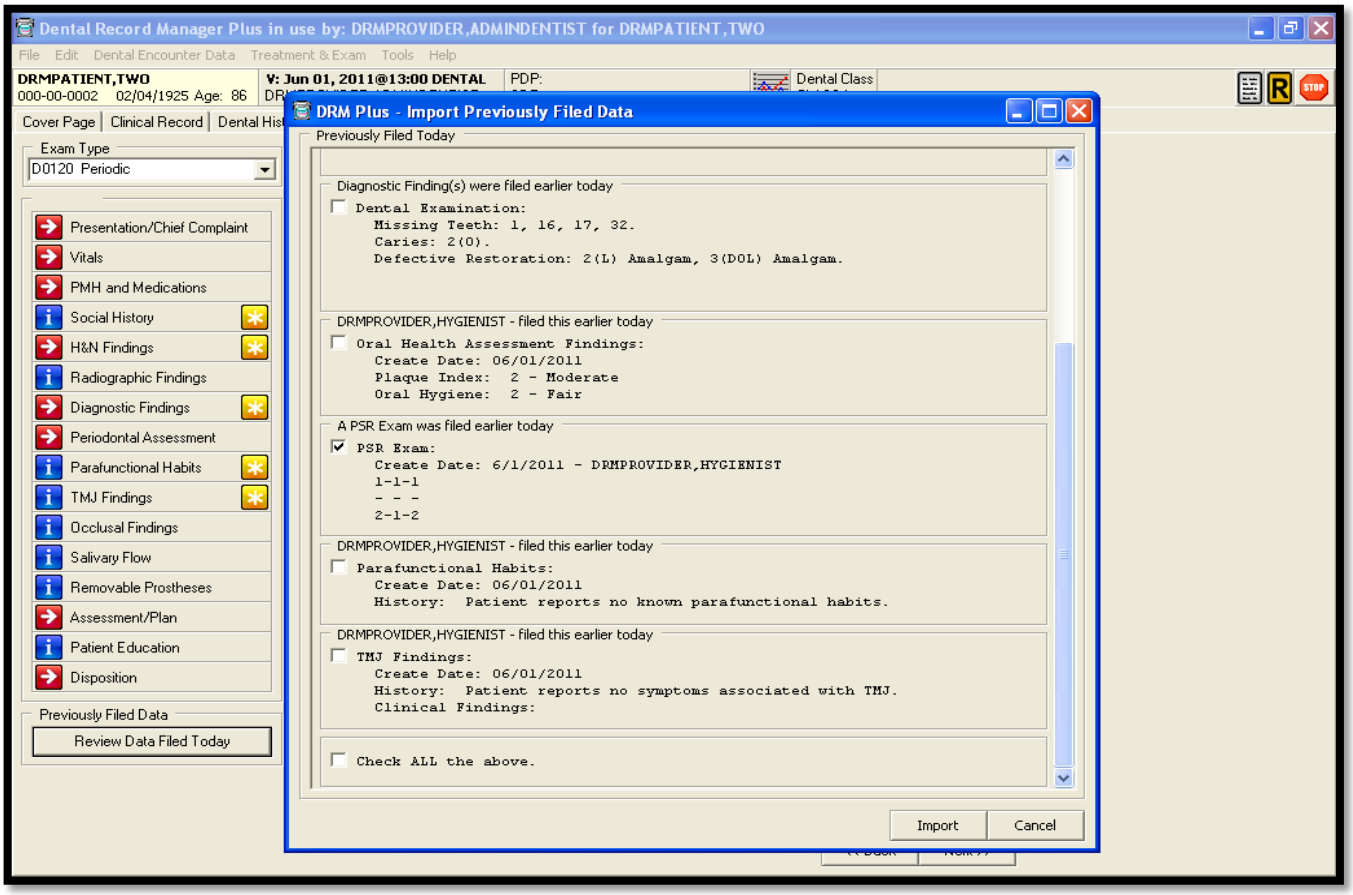
The first provider's exam will only be present in their filed TIU note.

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

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 will allow 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 check boxes of any or all previously filed data today will import that data into their present exam template session. There is a 'Check ALL the above' check box at the bottom of the screen which will allow all today's filed data to be imported into this new TIU note. After selecting the desired check boxes the provider will select 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.



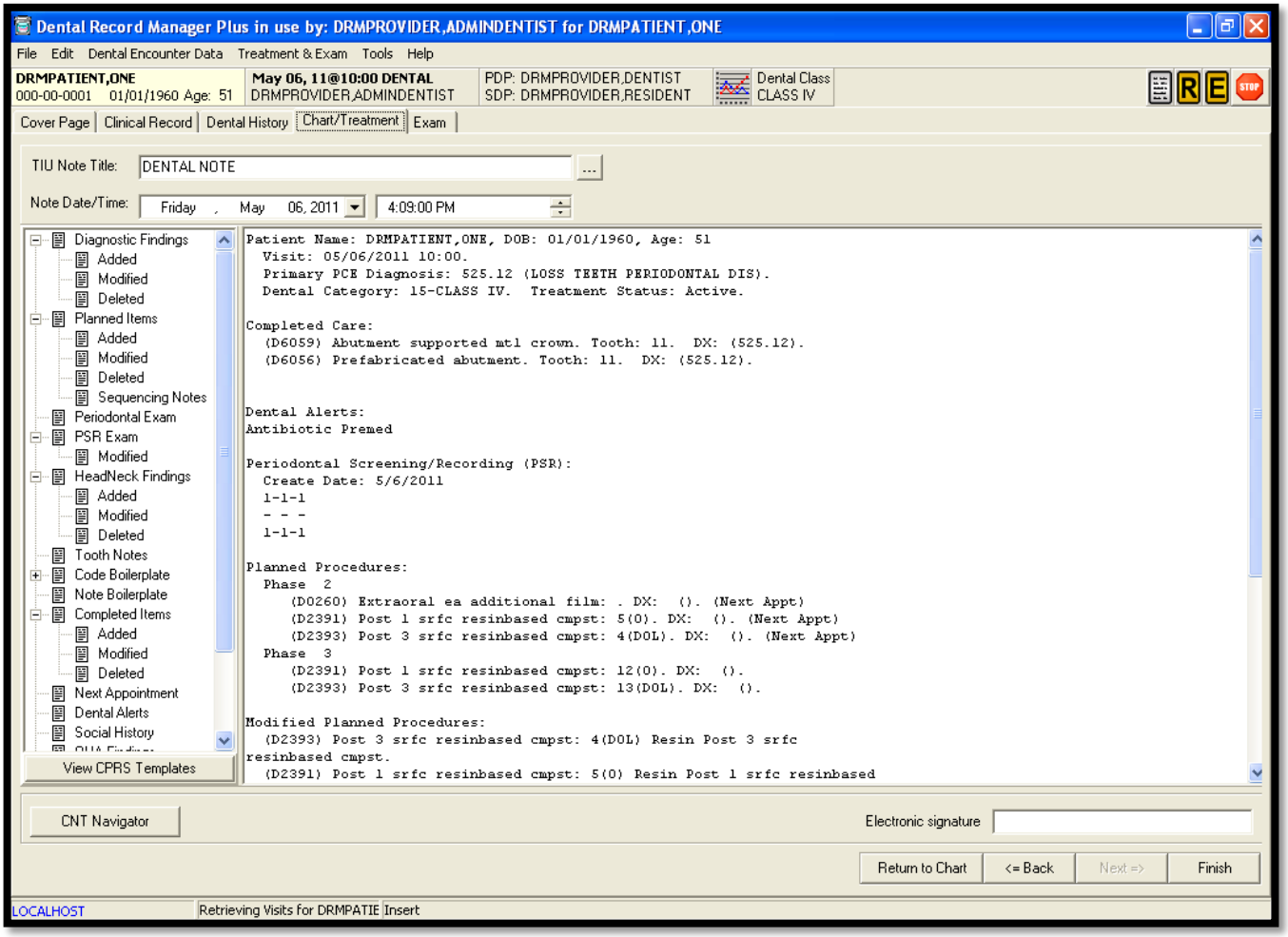
The icon on the right of the element button will display when there was previously filed data today and that data is associated with the element. The Diagnostic Findings element will inform the provider when the icon is displayed and there may have been one or any combination of diagnostic findings, 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 will only display 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.

New Return to Chart Button on the Completing Encounter Screens

The last three screens when completing an encounter for any patient; this includes the Filing Options screen, the Service Connections screen and the Progress Note screen will now have a new Return to Chart button. The Return to Chart button allows the user to go from that screen back to the Chart/Treatment screen with one click.

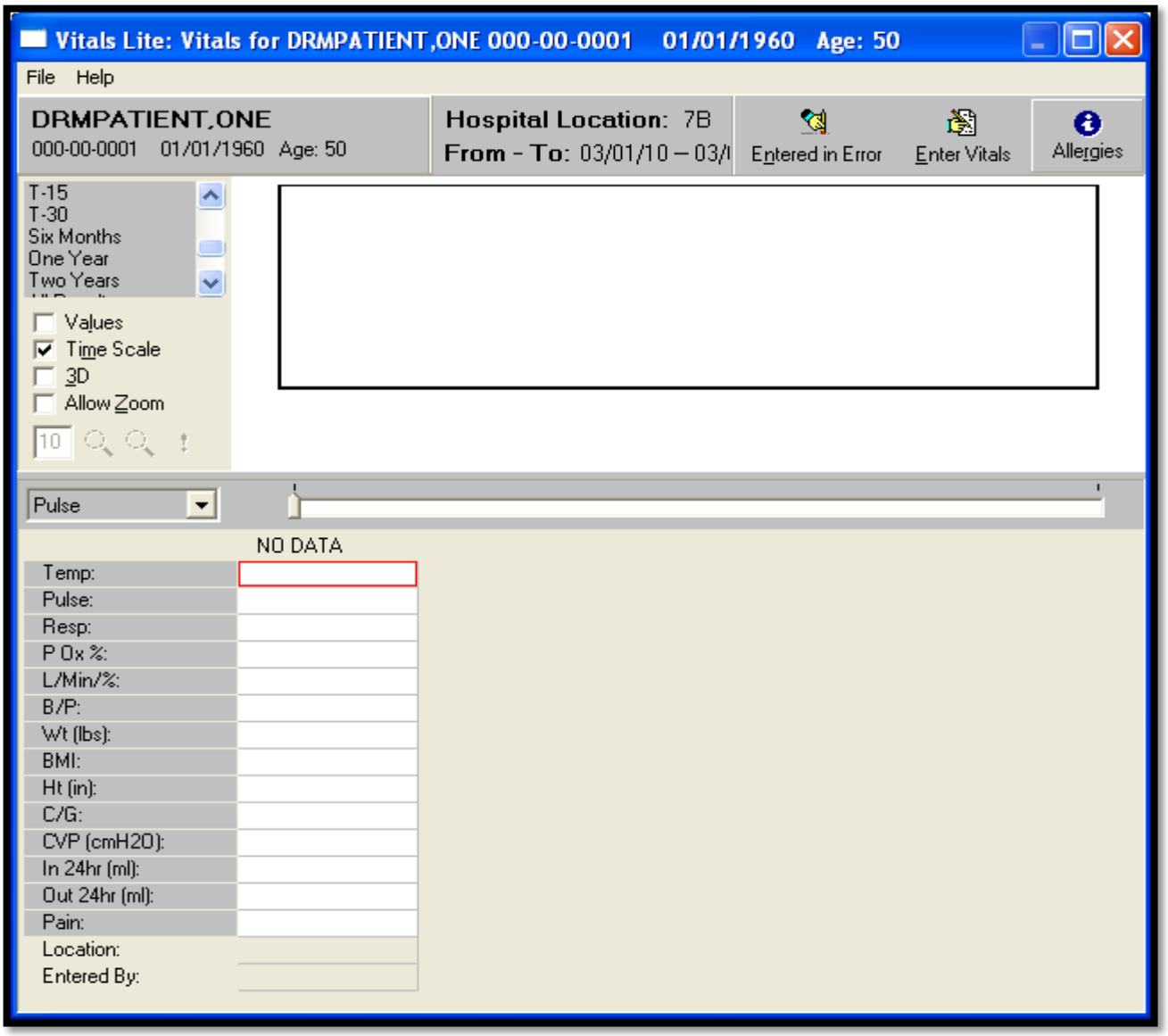
This will help the provider save time by eliminating multiple Back clicks when selecting the Return to Chart button. This jumping screen process will only work in the backward direction when filing a note. Jumping forward requires encounter data to be entered per screen and this data will not be saved when the provider is going back and forth.



Vitals Lite Application Accessed from DRM Plus

This patch gives access to the Vitals Lite application which is available now from the banner in DRM Plus, or the button on the Vitals element on the Exam tab or an option selection from the Tools menu. The Vitals Lite allows providers to record patient's vitals and opens the same application accessed from the CPRS GUI. The Vitals Lite icon location in the banner is between the Dental Providers and the Dental Class information.

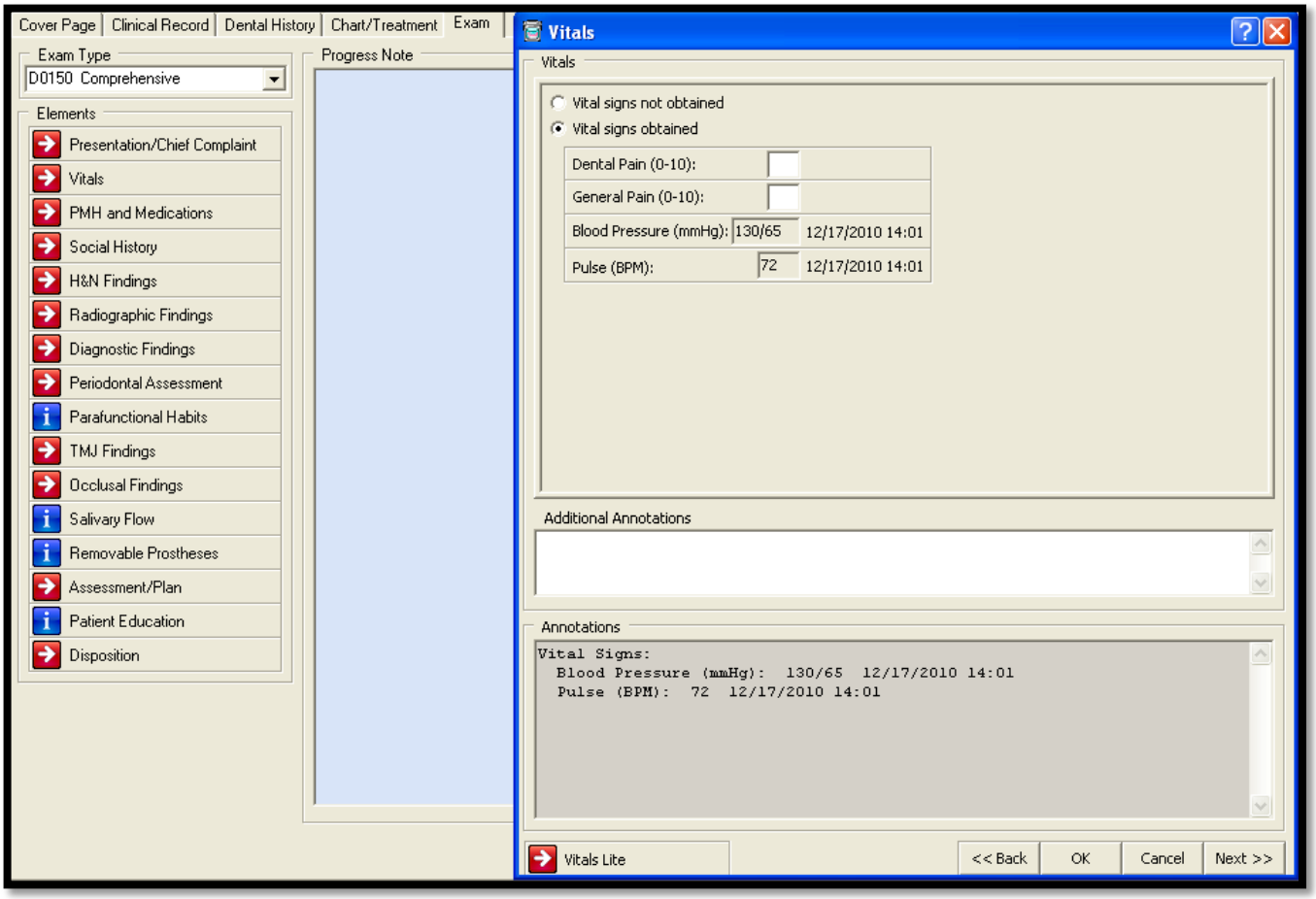
Click on the Vitals Lite button in the banner and the Vitals Lite application for that patient will open.



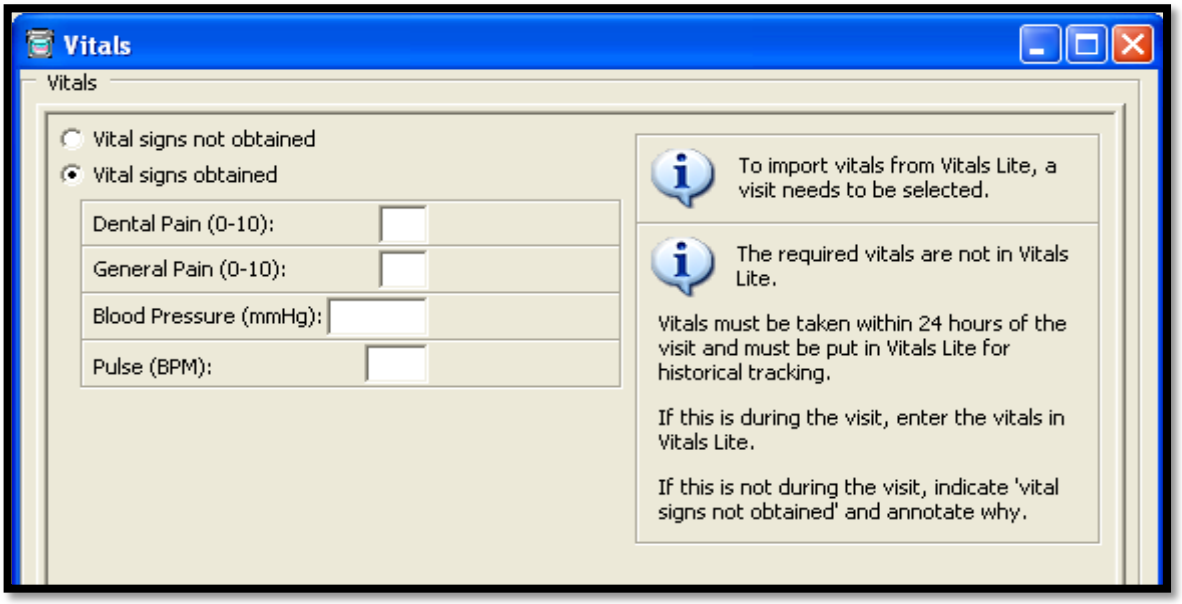
The Vitals Lite screen will be available for the provider to enter today's vitals for the dental patient and stored in the VistA database. All captured patient's vitals will be viewable using the CPRS GUI or the DRM Plus GUI.

The Vitals Lite button which is also found in the Vitals element from the Exam tab has a different appearance. Clicking the Vitals Lite button located in the lower left corner of the element's screen will bring up the Vitals Lite screen to enter today's vitals for the current patient selected in DRM Plus.

Vitals entered from the Vitals Lite package can **NOT** be imported into the Vitals element in the Exam tab until a Visit date/time has been selected for this encounter in DRM Plus. Also the vitals will only import into the Vitals element if it was entered during a 24 hour window before or after the Visit date/time of the patient's encounter. Only the Vitals Lite package allows historical tracking of any vitals taken and recorded for the patient by any DRM Plus provider.



If the Visit date/time is **NOT** selected and the user selects the second radio button then the vitals may only be added manually in DRM Plus. The only required field to be entered in the Vitals element is the Dental Pain. General Pain, Blood Pressure and Pulse are optional entries and are not required.



Note: Dental Pain is the only field that is saved as unfiled data for any patient if entered and saved.

New Clinical Reminders Icon on DRM Plus Banner

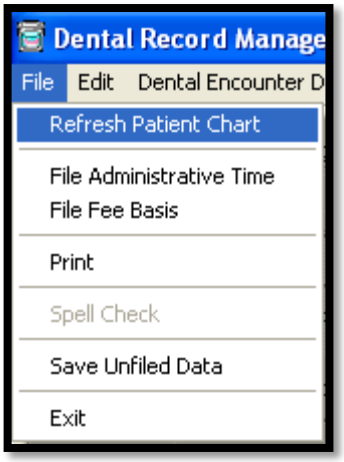
The Reminders icon appears on the right side of the DRM Plus banner when there are Clinical Reminders that are due for the selected patient that are listed on the CPRS Cover Page tab screen in the Clinical Reminders window. Providers must still process Clinical Reminders using CPRS.

Clicking on the Reminders icon will display a Dental Record Manager Plus informational screen stating that the selected patient has 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, please contact local IRM (Clinical Reminder Support personnel) for assistance.

New Refresh Patient Chart Option under File Menu

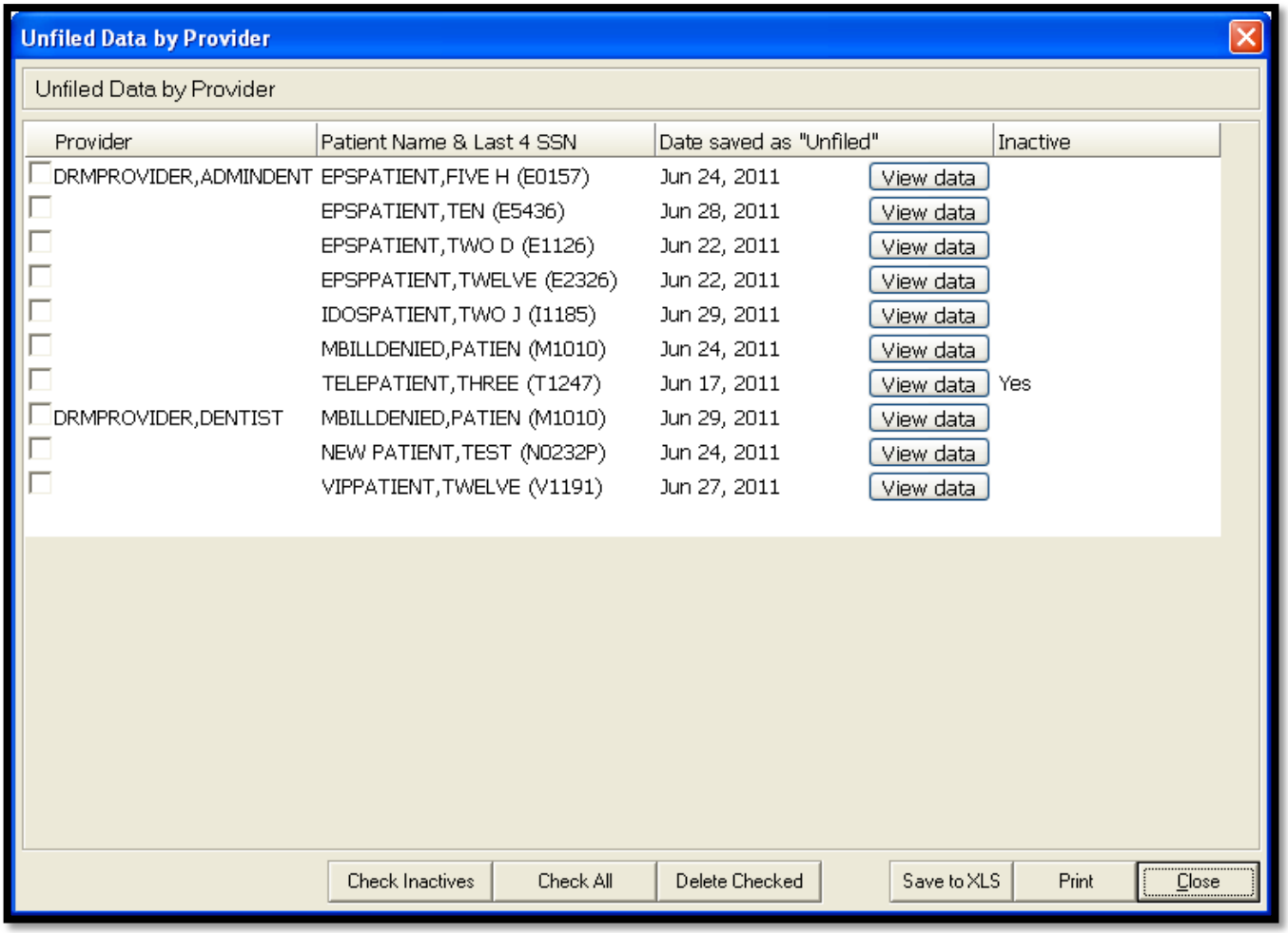
The Refresh Patient Chart option now allows users in DRM Plus to refresh the patient's chart when working in DRM Plus. The location of Refresh Patient Chart is the first option under the File menu. The functionality will require the provider to decide if they want to save any new data entered before this action as unfiled data.



New Changes to Unfiled Data Report and Save Unfiled Data Menu Option

This patch introduces changes made to the Unfiled Data Report for providers with/without the DRM Administrative privilege in DRM Plus. DRM Plus administrators will be able to delete all active/inactive unfiled data for all patients saved by any provider. The report also allows the DRM Plus administrator to view and print the details for any active/inactive unfiled data entry list from the report.

All non-administrative providers may delete, view and print the details for any active/inactive unfiled data with this report option that they have saved to themselves. They will not be able to view other provider's unfiled data.

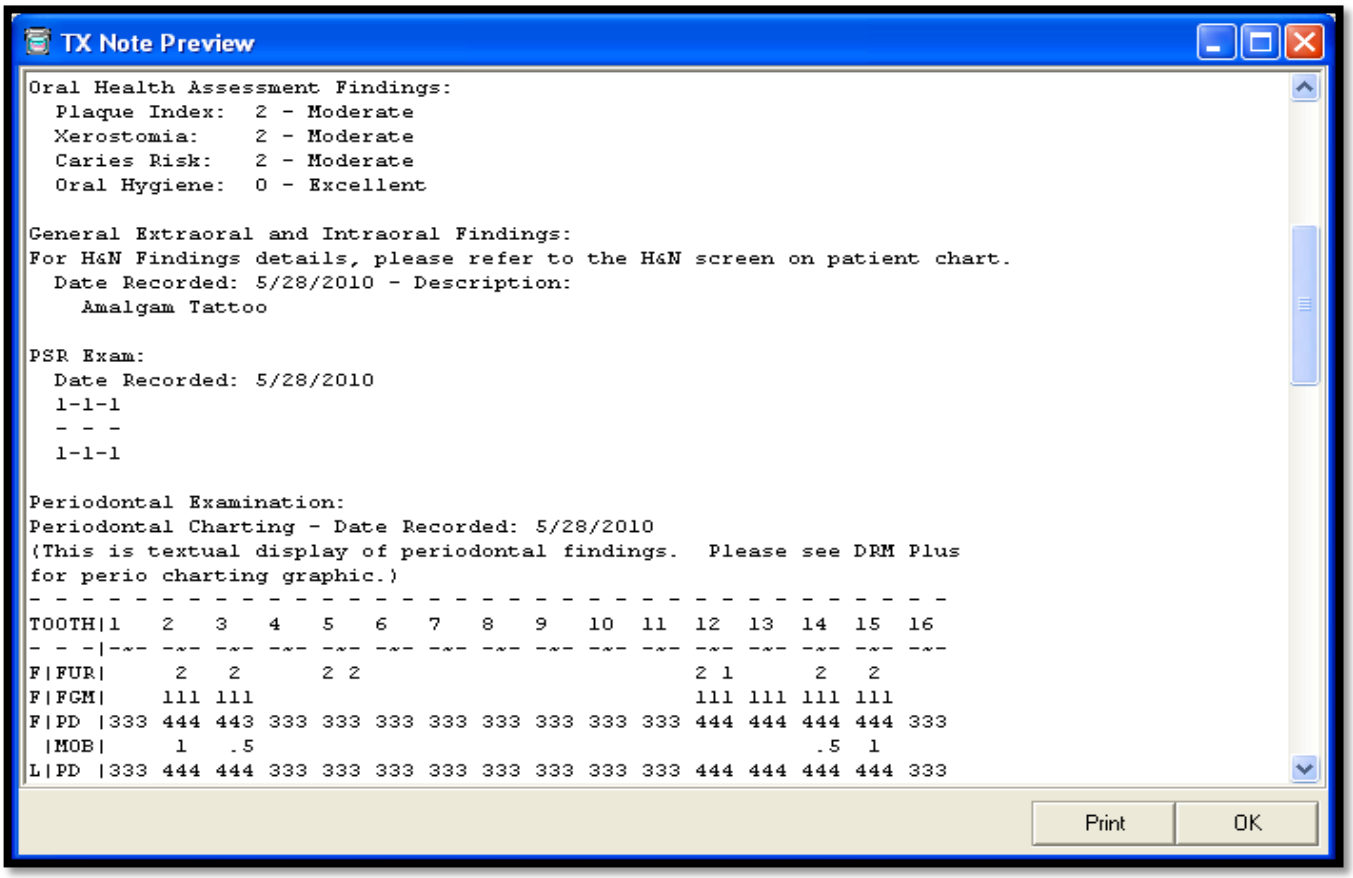


After selecting the Unfiled Data report the provider will need to select the View data button which will allow the user to display the data that was saved as unfiled data on that patient. When the View data button is selected for an unfiled data entry the TX Note Preview screen opens and displays the save unfiled data. This will display 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 will be no way for DRM Plus to reload this inactive data back into the patient's chart so the provider will be required to re-enter the data manually with another encounter.

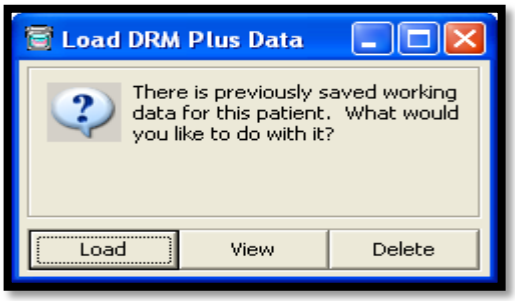
The provider may delete any unfiled data by selecting the check box under the provider and then selecting the Delete Checked button. The Check Inactives/Uncheck Inactives button allows the provider to select/unselect all the inactive unfiled data reports. The Check All/Uncheck All button allows the provider 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.



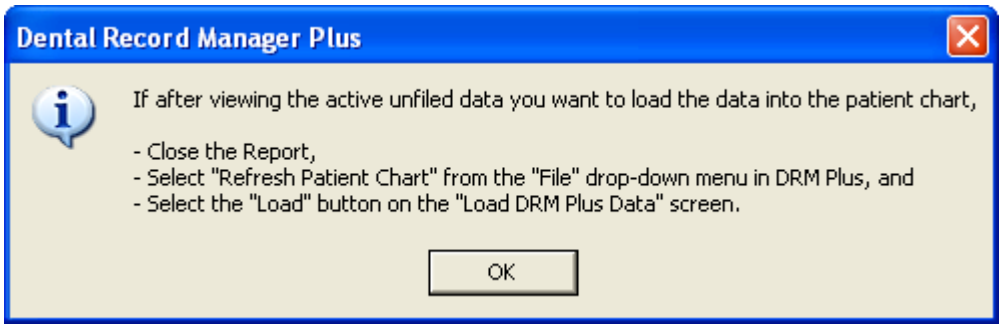
Non-administrative providers will be able to delete, view and print the active/inactive unfiled data for all their respective patients when accessing this report. The Unfiled Data by Provider report only allows a non-administrative provider to view their own saved unfiled data and **NOT** of other providers.

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



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 will take the user directly to the Unfiled Data by Provider report however it didn't load the unfiled data. If the provider has decided he would want the unfiled data loaded and filed then he will have to close the report and select the Refresh Patient Chart under the File menu. This action will bring up the pop-up again and allow them to select the Load button as the patient's chart reopens and then they are able to file the encounter. The following pop-up will display after selecting the View button stating the same steps.



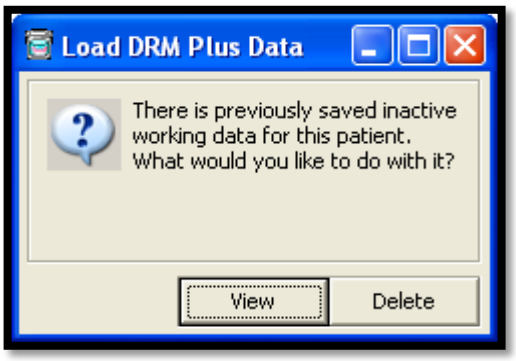
If the Load or View was selected upon entry into the patient's chart and the provider wants to delete the unfiled data after viewing the data, just use the Delete Checked button in the Unfiled Data by Provider report. If the Load button was selected then the user will also need to select the Refresh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

All active unfiled data on the ninth day after being saved will automatically become inactive. The provider will get a pop-up on the ninth day when they enter that patient's chart and will be given only two options to view or delete that inactive unfiled data. The View button will take them directly to the Unfiled Data Report where they will be able to view, print or delete that inactive data. There is no way to load inactive unfiled data into the patient's chart except to re-enter all the data as new into the patient's chart today that was present in the unfiled data report. The Delete Checked button will delete the inactive unfiled data.

The following dialog displays the pop-up when the patient's chart has inactive unfiled data present for the provider who saved the unfiled data or was sent unfiled data from another DRM user for this patient.

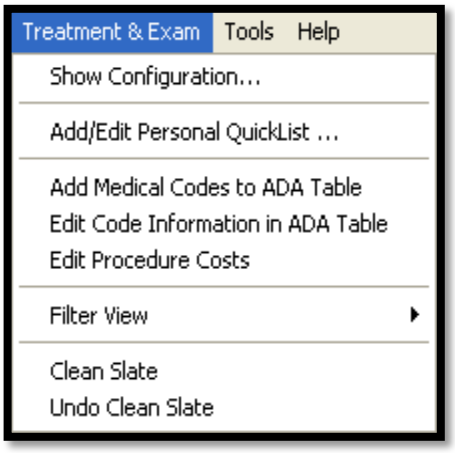


New Clean Slate Functionality

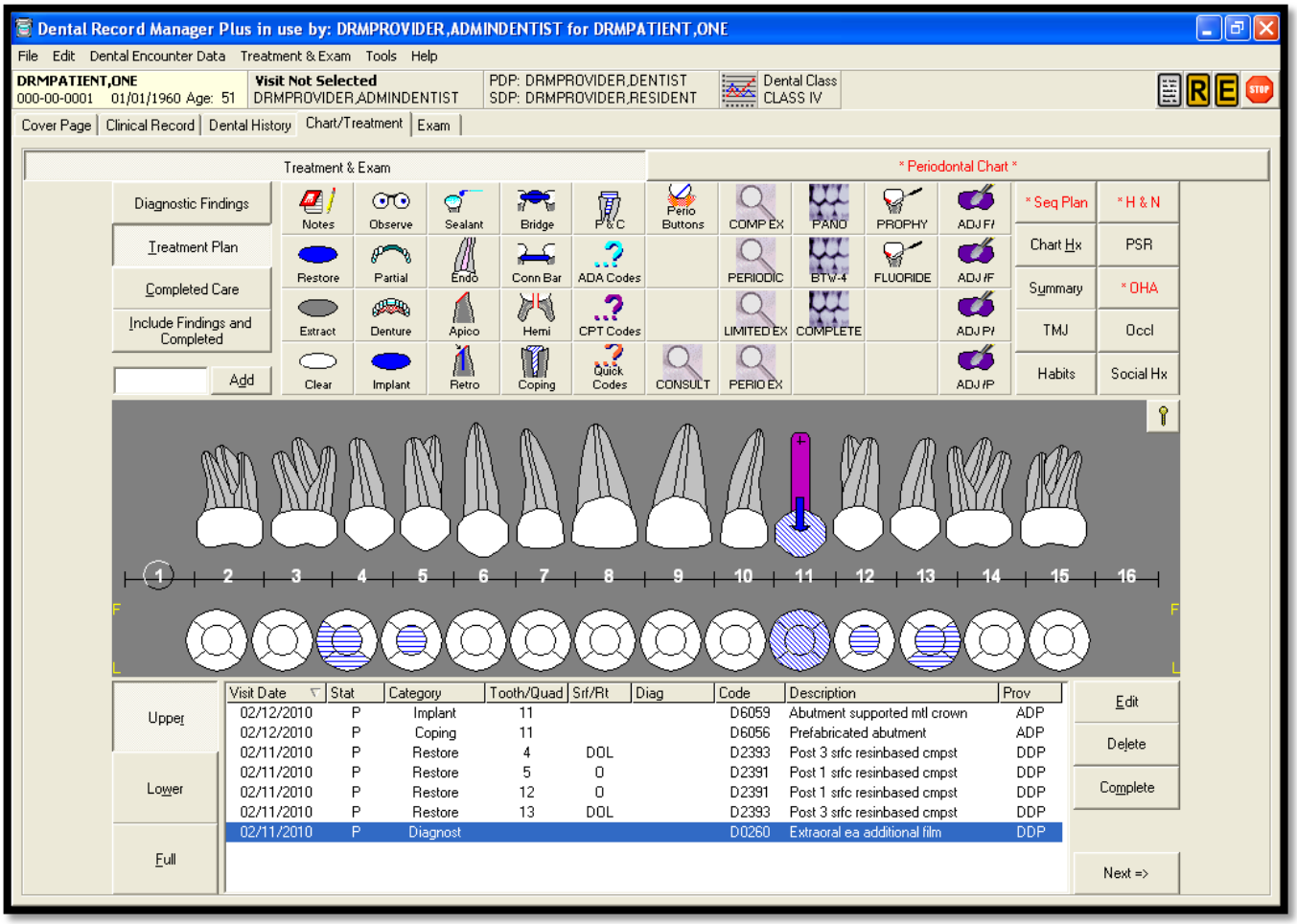
Clean Slate Option

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. The deleted planned treatment may never be recovered, only reentered and filed on the patient's chart. Clean Slate also inactivates all saved unfiled data entered during this session and all previous unfiled data saved by all providers for this patient. Clean slate removes all graphics on the three Treatment & Exam screens, but leaves the historical transactions in both tables of the findings and completed screens.

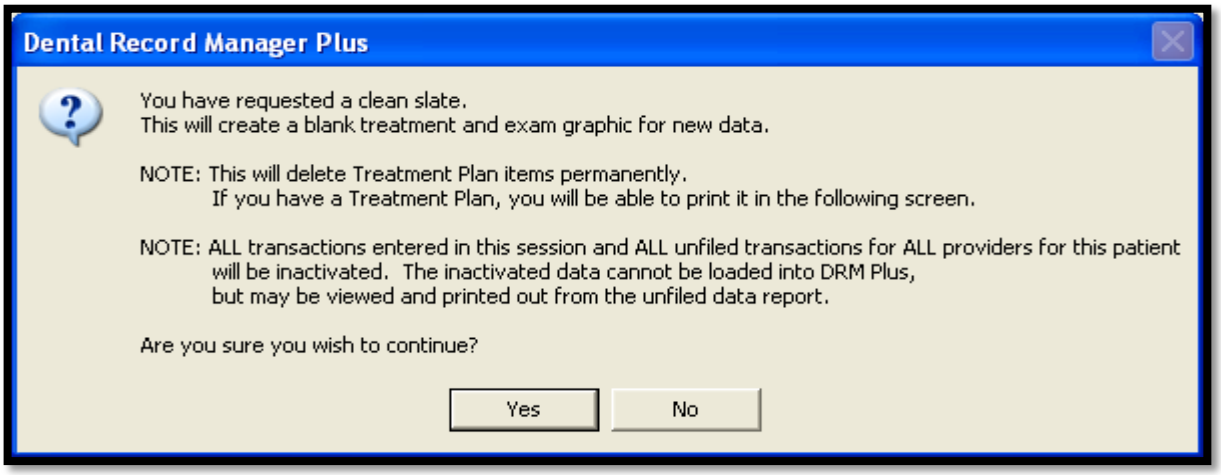
The menu options of Clean Slate and Undo Clean Slate will be found under the Treatment & Exam menu. Only end-users who have the Administrative Key for clean slate are allowed to use this new function.



The following dialog displays the planned treatment for the selected patient. This patient has extensive findings and completed treatment which have been filed previously on the DRM Plus patient chart.

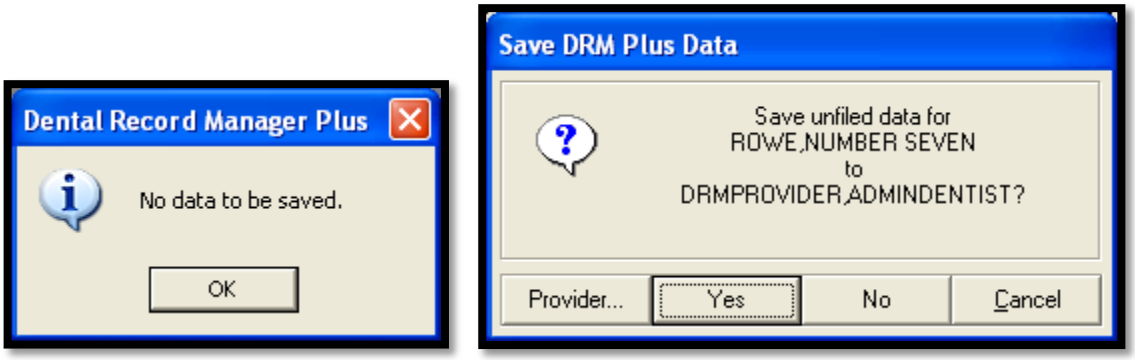


Selecting the Clean Slate option under the Treatment & Exam menu will bring up the follow pop-up informing the DRM Plus admin-user that planned treatment will be deleted permanently. All current graphics will be removed from the exam (findings) and completed treatment screens. All transactions entered during this session will be saved as inactivated unfiled data. All unfiled transactions from all providers saved on this patient will be inactivated.

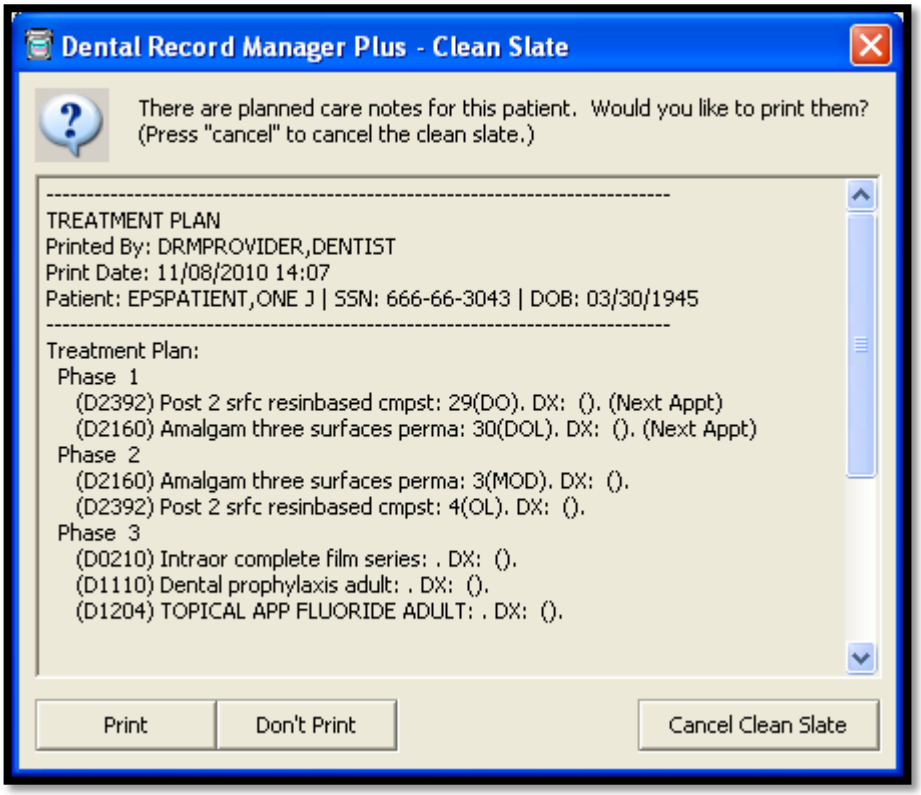


The next pop-ups may or may not display to the admin-user. The first pop-up, Dental Record Manager Plus will only display if there was any unfiled data that was saved for this patient by any provider in the past. This unfiled data will be inactivated if the admin-user completes the clean slate.

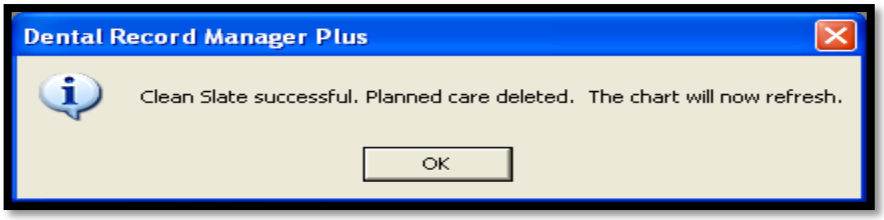
The Save DRM Plus Data pop-up will display which allows the administrator to save new transactions as unfiled data if just entered but those transaction will be inactivated when completing the clean slate. When the No option is selected from this 'Save DRM Plus Data' pop-up during this process will require the user to answer No again on the same pop-up after the clean slate has recycled.



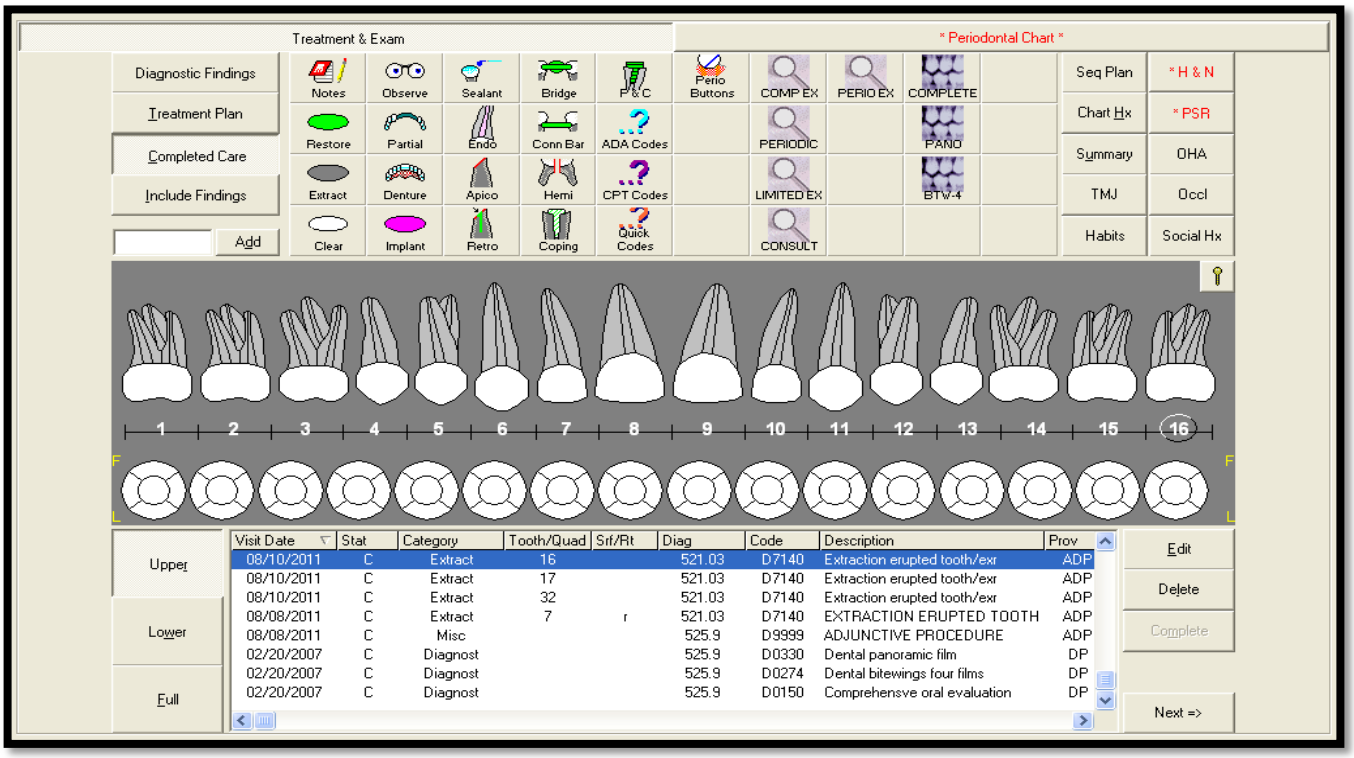
The next pop-up, which will always display, has a message asking if the admin-user would like to print the planned treatment. Select the Print button if the admin-user is concerned about re-entering the planned treatment because the planned treatment will be deleted and can't be recovered. When this is another provider's treatment plan then the planned treatment should be printed and given to that provider to follow-up on the planned treatment for this patient. That provider will have to reenter and file the planned treatment on this patient's chart.



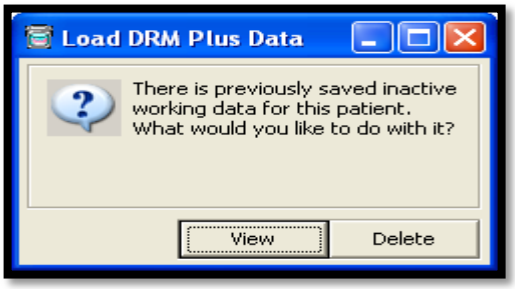
The following pop-up will display to inform the clean slate was successful, click the OK button.



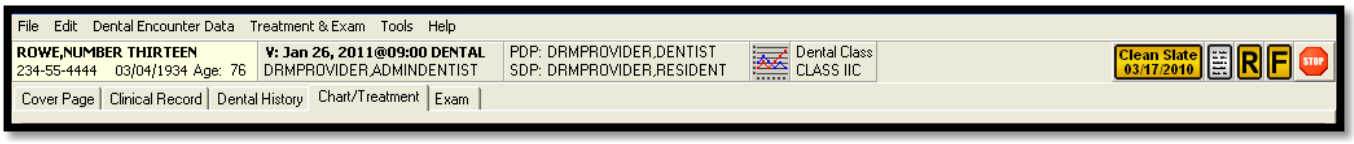
The chart displays no graphics for completed treatment and exam findings. All the historical transactions in the tables for both the completed treatment and exam findings will still be present. The next dialog displayed shows that the Seq Plan button is no longer active representing that all planned treatment has been deleted; graphical and transactional.



This following pop-up will display when an admin-user saved unfiled data during the clean slate process. It will also display for any provider opening this patient's chart after the clean slate has been completed and there was previous saved unfiled data for this patient by that provider. It will inform the provider that the patient now has inactive unfiled data. All end-users may delete the unfiled data using the pop-up by selecting the Delete button or select the View button and view/print/delete the inactive unfiled data from the Unfiled Data report.



The Clean Slate will have an icon in the banner showing the last clean slate date done on this patient's chart. This icon will be permanently on this patient's chart however will be updated with a current date when another clean slate is performed on this patient's chart.

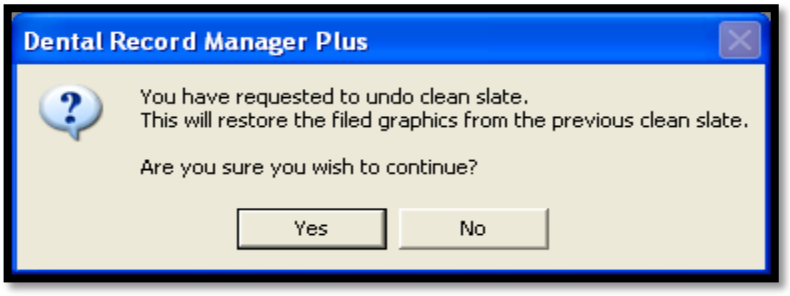


Note: The Clean Slate option may not be used for any filed completed transaction corrections or any encounters filed incorrectly on a dental patient. These still have to be deleted by the DRM Plus Administrator using the line item deletion function or the complete encounter deletion function.

Undo Clean Slate Option

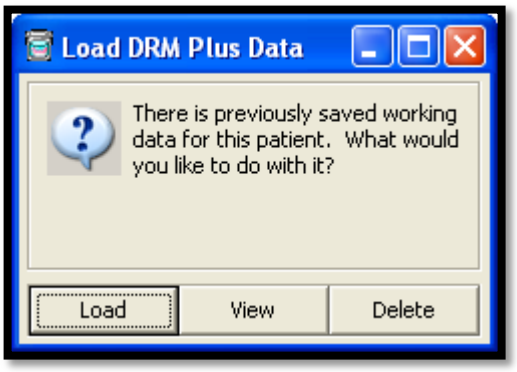
The Undo Clean Slate option under the Treatment & Exam menu allows the Administrative Key holder to undo the clean slate until there has been a new encounter filed to VistA on this patient's chart. This means that all historical graphics of completed treatment and findings will return to the chart if the clean slate was done on this patient. The planned treatment will never be able to be restored back into DRM Plus until the provider manual reenters the planned data and files a new encounter on the patient's chart.

Select the Undo Clean Slate option under the Treatment & Exam menu and the following pop-up will display.

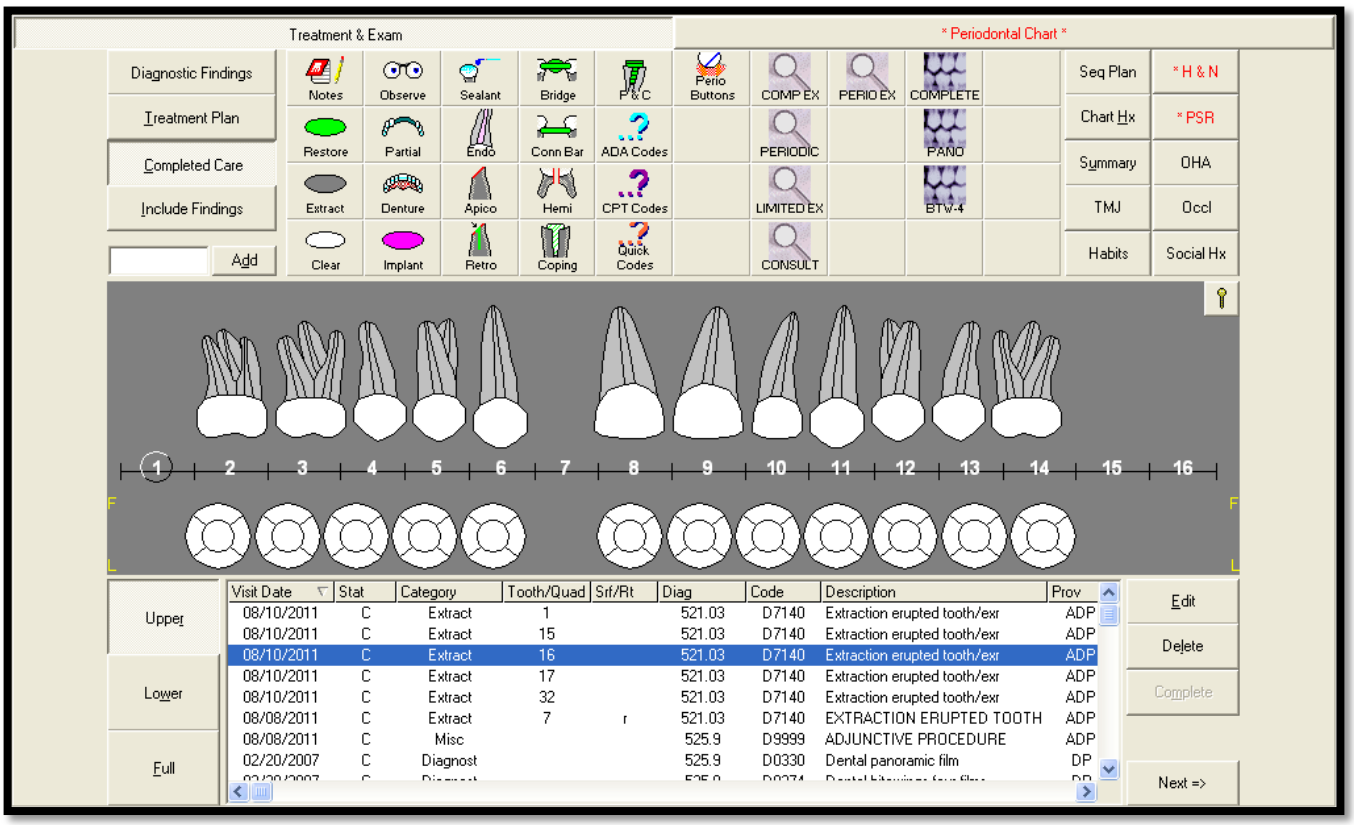


After clicking the Yes button the following pop-up will display.

While the DRM Plus patient's chart is getting refreshed after activating the Undo Clean Slate option and if there was inactive unfiled data that had not been deleted then the following pop-up will display. This pop-up reactivates the unfiled data and allows the same options when loading saved unfiled data into the patient's chart.



The correct date range of historical completed treatment graphics and exam findings graphics will import into the patient's chart. The following dialog displays the return of all the graphics in completed care.



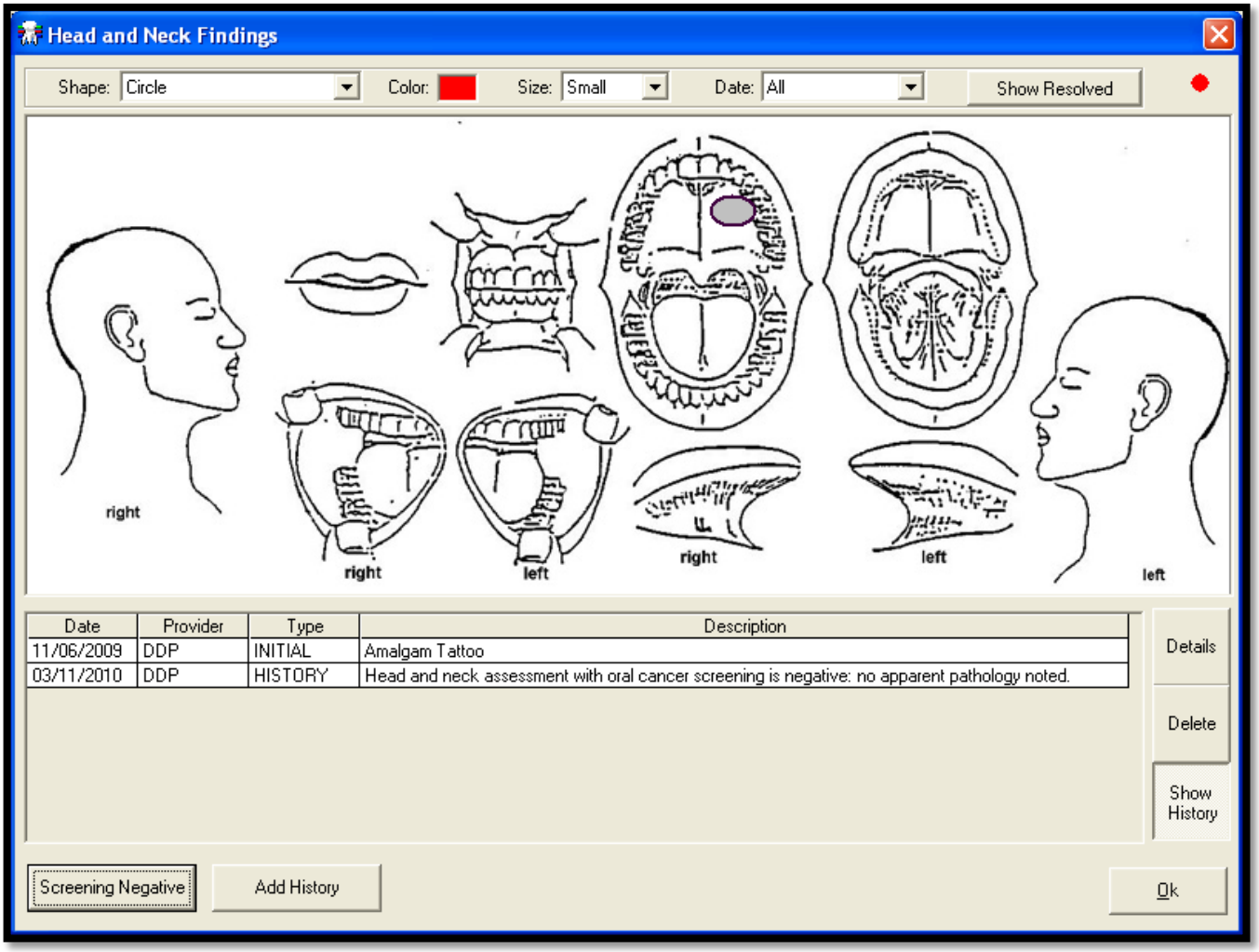
The planned treatment was permanently deleted during the clean slate process and there is no way it can be recovered. Therefore if the clean slate was done on the wrong patient then it should be a good idea to print out the planned treatment when using the clean slate option.

Note: Saved unfiled data for this patient maybe recovered if the administrator completed a clean slate option for this patient's chart and then immediately, before any other provider accesses this patient and files an encounter, selects the undo clean slate option before the inactive unfiled data is deleted.

New Historical H&N Information May Now be Entered

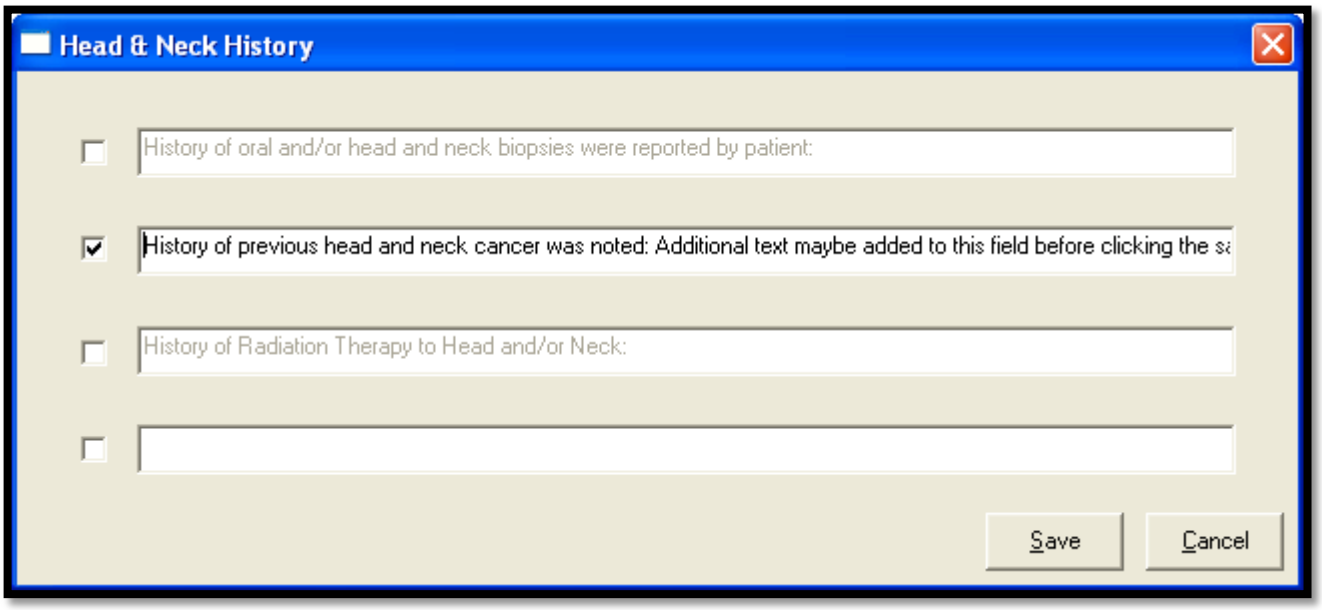
There are three new buttons located on the H&N screen: Screening Negative, Add History and the Show History button. The Screening Negative button, when selected will enter a national standard description stated as: Head and neck assessment with oral cancer screening is negative: no apparent pathology noted.

The Type, third column in the transaction table, will be labeled History when entering a screening negative or historical entry. Any previously filed History entry will not be able to be edited using the Details button. All History entries may be hidden using the Show History button which is defaulted as active on/display when opening the H&N screen.

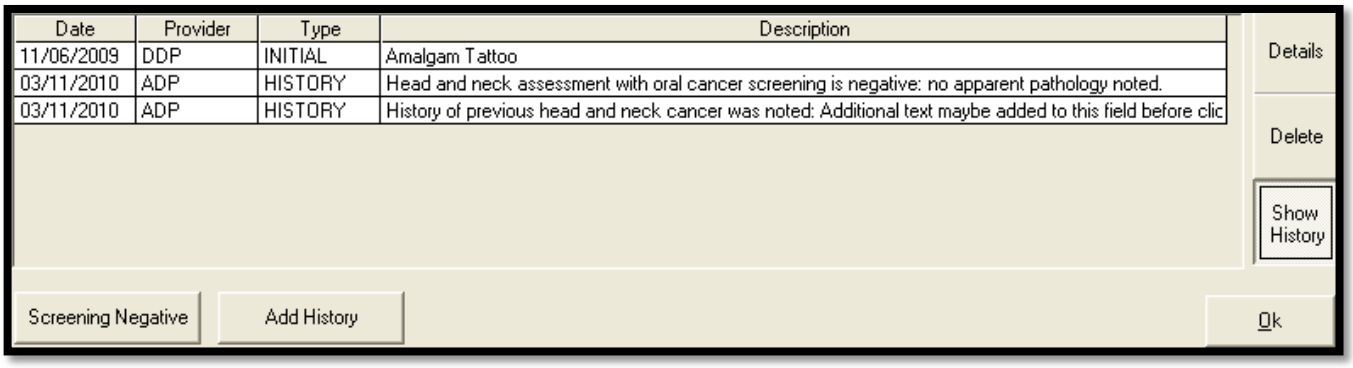


The Add History button will open the Head & Neck History screen allowing four different historical statements that may be entered by the provider. The provider may select one or all four options for a historical entry in H&N transaction table.

Click the check box(s) for every historical entry that is desired and then add text if desired after the standard statement before saving. The fourth option allows the provider to free text the entire H&N historical statement. Click the Save button to enter this historical statement into the H&N transaction table.



Clicking the Save button will automatically import this finding into the transaction table as a History entry in the Type column. Any of these four historical entries from the Add History button may be edited using the Details button however only during the same session they are filed. These Add History statements will not be editable after they have been filed on the patient's chart.



All History entries may be hidden using the Show History button which is defaulted as active on/display when opening the H&N screen.

Note: There is also a Screening Negative button in the H&N Findings element located on the Exam tab, exam template. When this button is selected it will import this negative historical statement to the Head and Neck Findings screen. This process allows the exam template entry to be captured as a permanent record for this patient's chart.

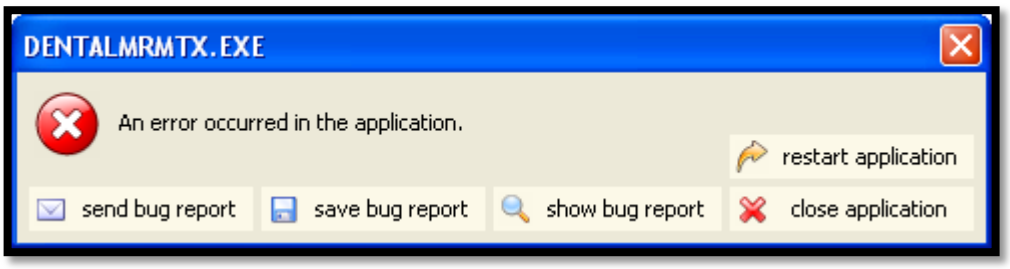
New Error Reporting Functionality

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.

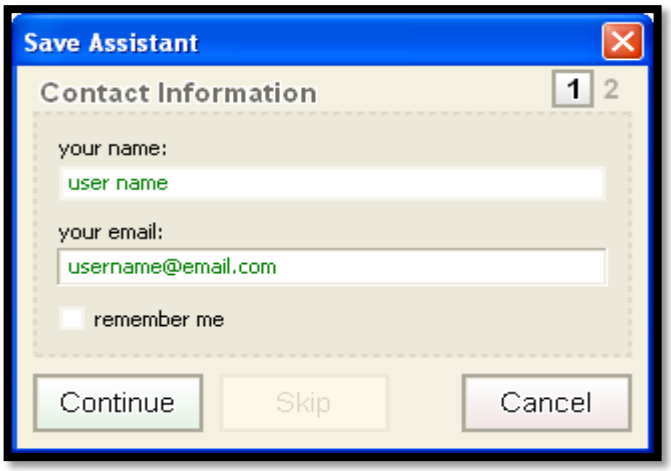
In order to be prepared to use this tool if an error occurs while using DRM Plus, please review the following directions:

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.

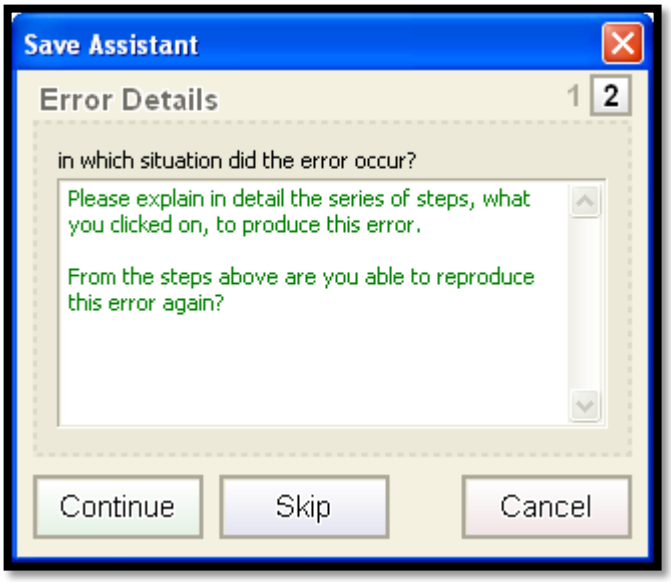
As soon as the DENTALMRMTX.EXE error screen appears, please select the **'send bug report'** button (first button from the left) as displayed:



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

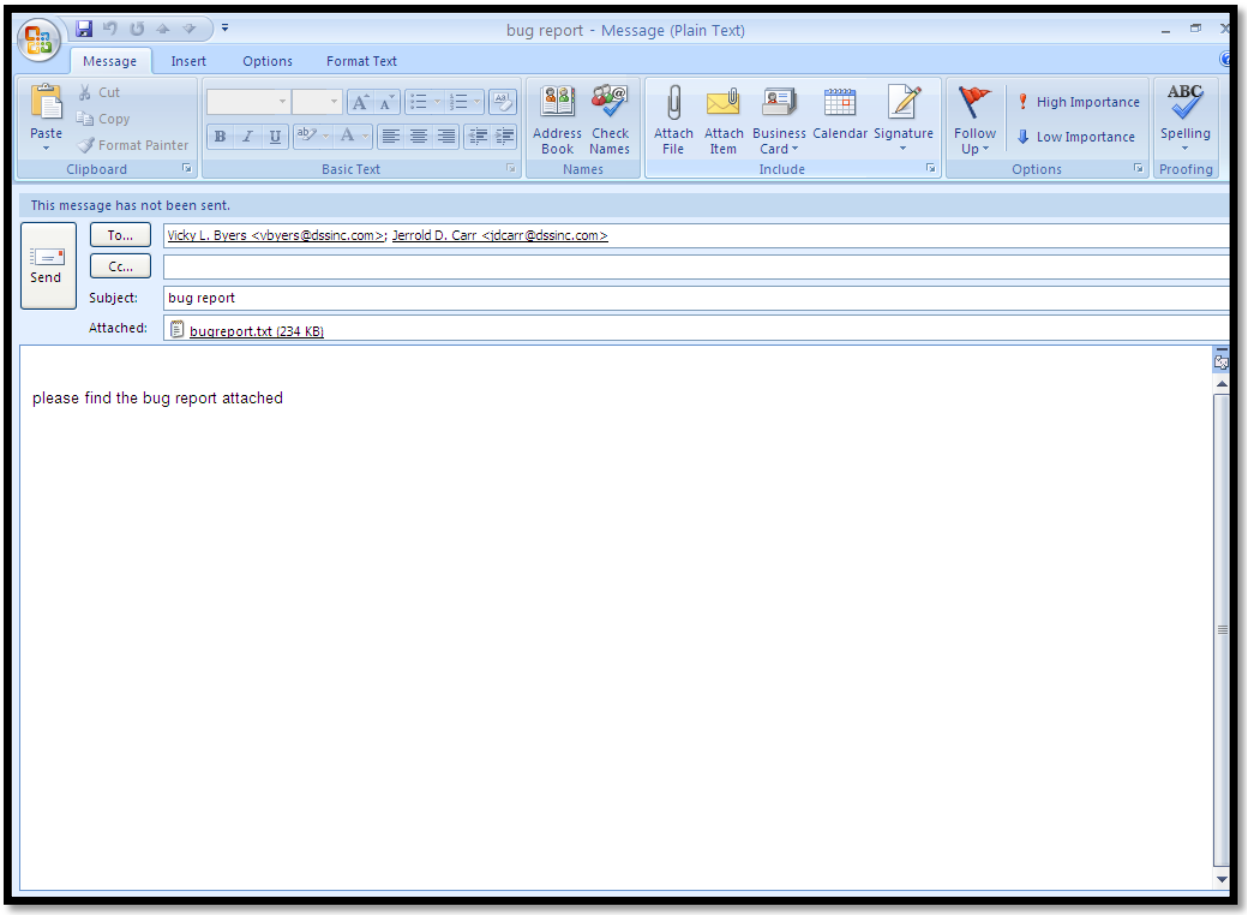


The Save Assistant Error Details screen will immediately appear. Please add information in the in the Error Details screen providing as much information as possible. If known, please list every click that occurred prior to the error message. The more details listed; the easier it will be to reproduce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



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:

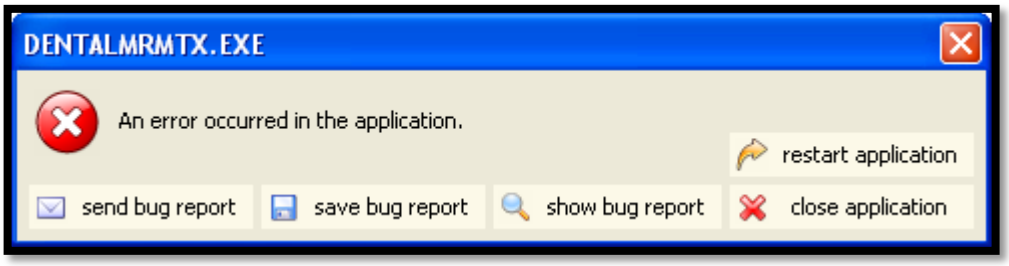


Please enter the name and location (include city and state) of the VA dental clinic where the error occurred. For example, if the error occurred at the Daytona Beach Dental Clinic, please enter Daytona Beach, Florida and do not enter Gainesville, Florida, even though Daytona Beach is a Gainesville satellite 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. Please 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.

Select the Send button from the email screen.

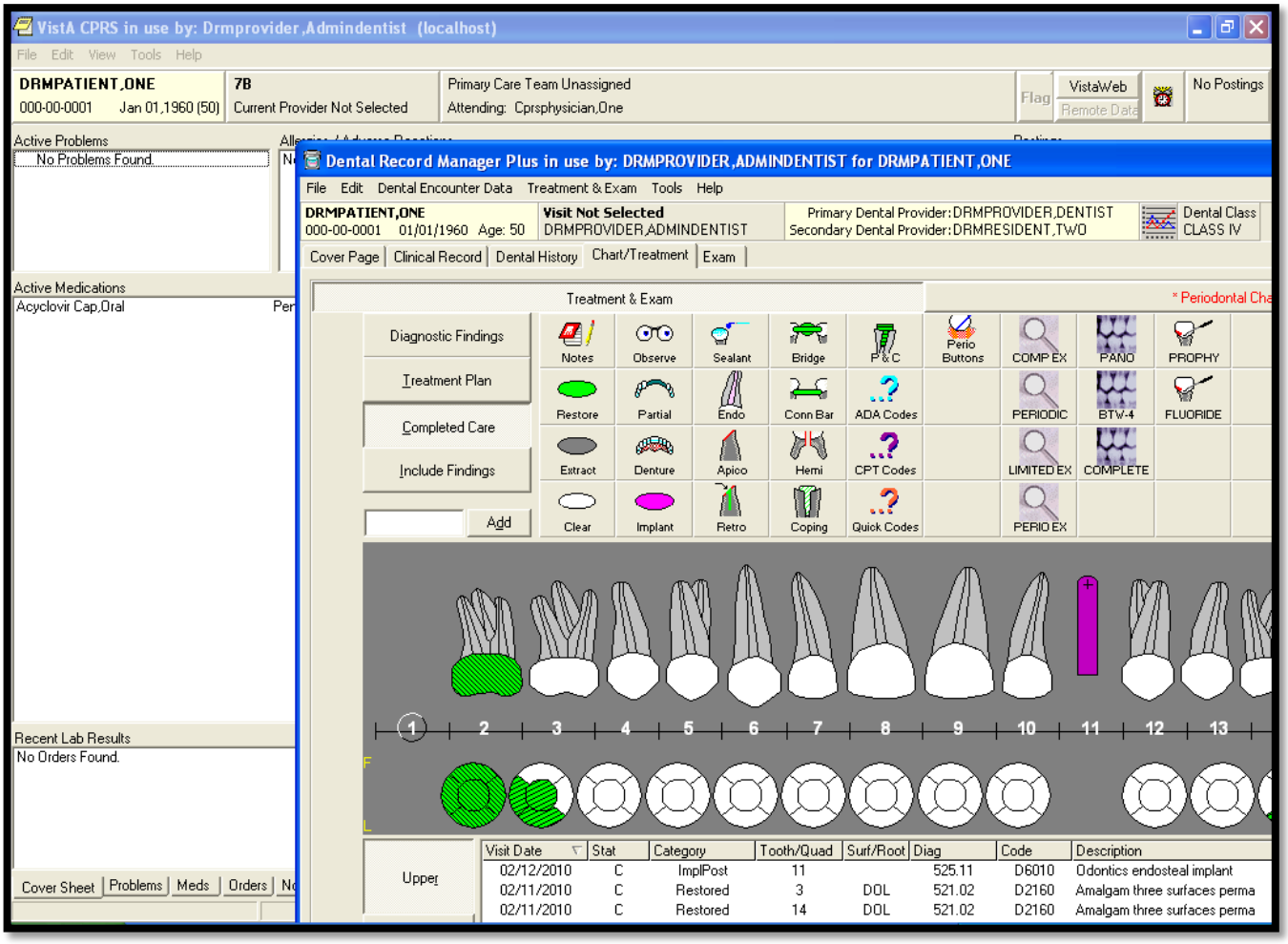
Select the 'close application' button (bottom button on the right) from the DENTALMRMTX.EXE screen. This will close the MADEXCEPT tool and DRM Plus.



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

DRM Plus Doesn't Maximize With the First Load of P60.59

DRM Plus will no longer be maximized with the initial load of the new P60.59 executable. This functionality was changed to allow the window position to be saved. Once DRM Plus is restored and loaded a second time it will return to the previous position that was saved on the very initial loading.

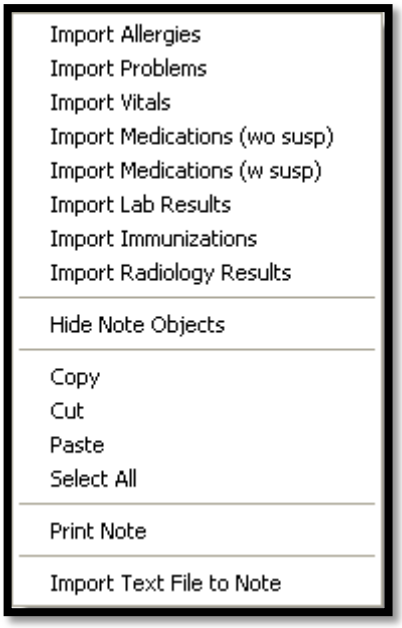


Drag the DRM Plus screen so one can click the maximize button on DRM Plus. Once the end-user has set the window position by maximizing or resizing the screen then DRM Plus will always open to that window position. The provider may reset their window position at any time.

Suspended Medications will Import into DRM Plus

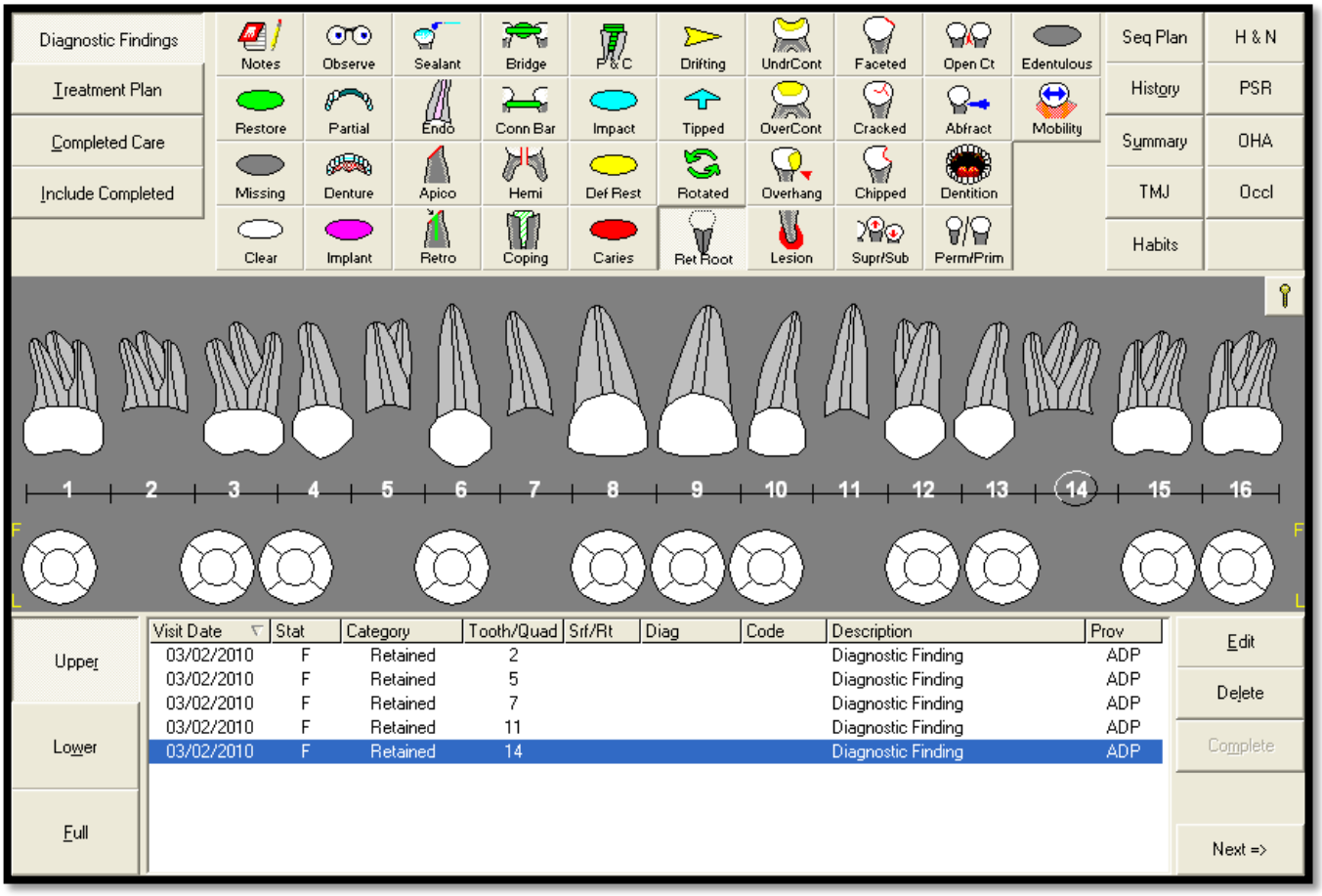
Suspended medications as well as active medications may display and/or import into any progress note created in DRM Plus. There will be two options listed detailing w/wo suspended meds.

The right click feature is shown below when the provider is displaying the progress note screen whether filing a note or a note addendum using the Chart/Treatment tab. The feature is also present when filing a note or a note addendum using the Clinical Record tab however when filing a note using this process allows no procedure codes to be filed with the encounter.

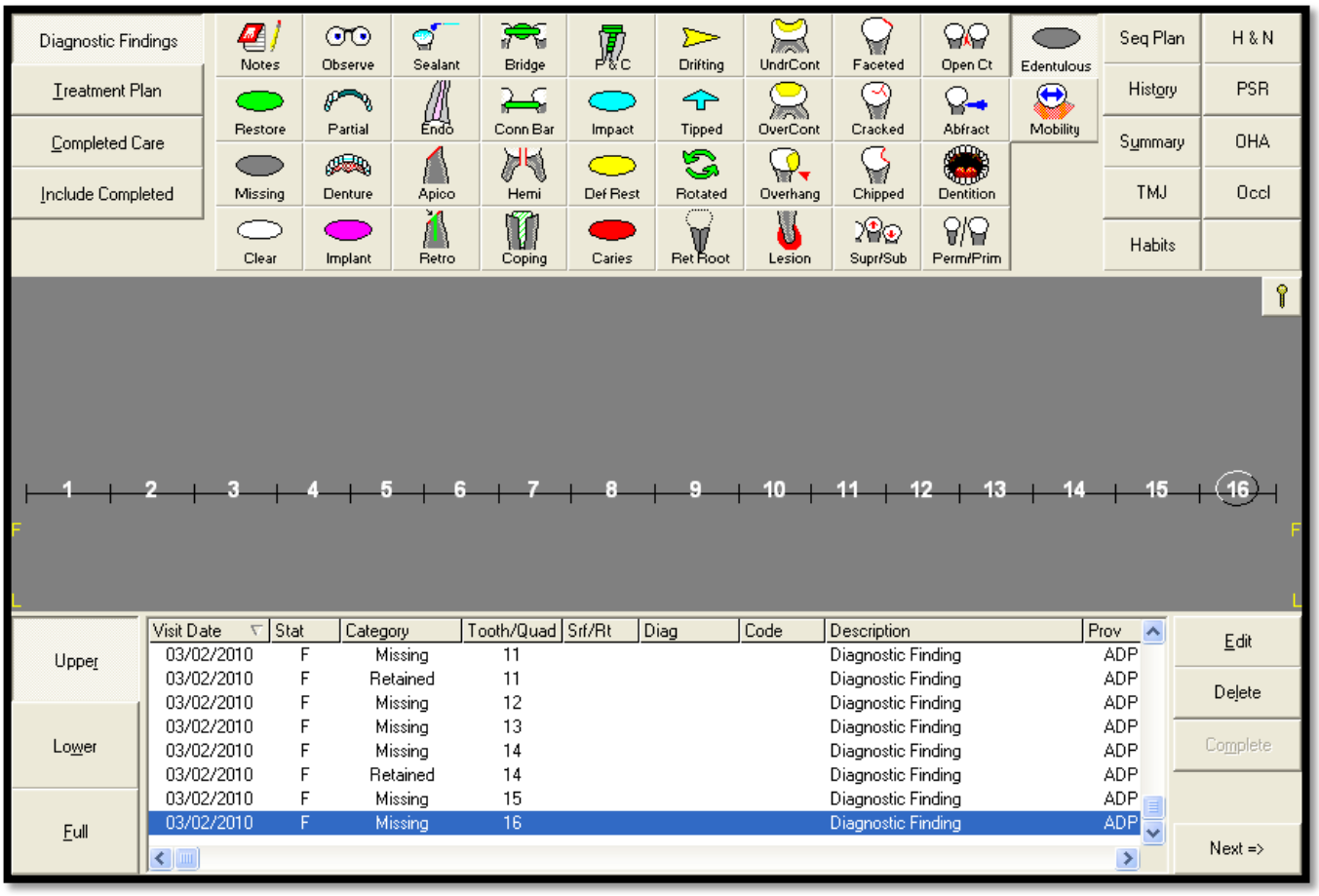


Edentulous Icon Removes Retained Roots

DRM Plus allows the edentulous button to remove retained roots. In the following dialog there are many retained roots present in the graphics/transaction table of the upper arch.



Click the Edentulous Icon and then click on one of the teeth or roots in the upper arch. The entire arch is cleared with Missing listed in the Category of the transaction table and a tooth number modifier present for either the missing tooth or missing retained root.

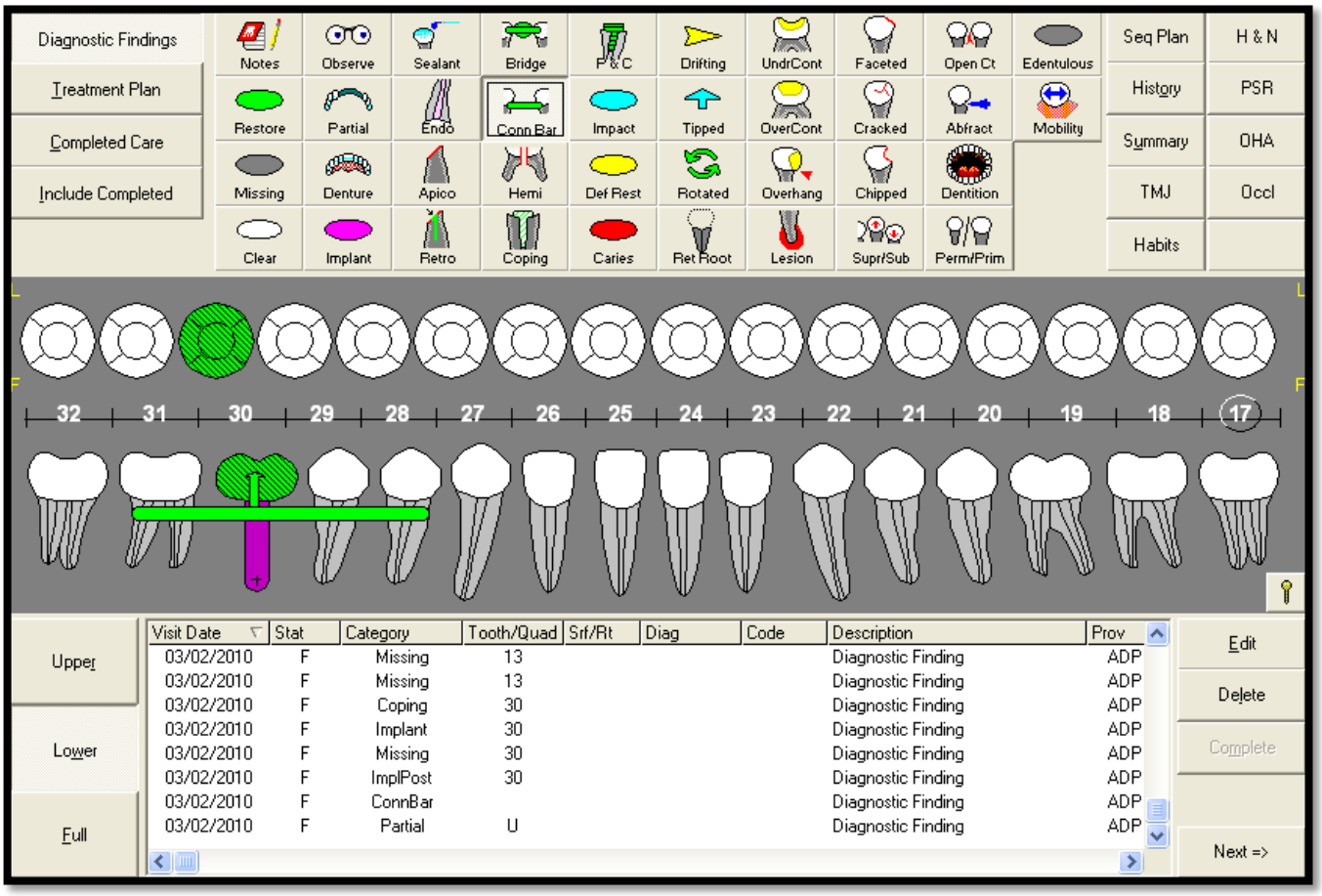

Diagnostic Findings
Treatment Plan
Completed Care
Include Completed
Notes
Observe
Sealant
Bridge
P & C
Drifting
UndrCont
Faceted
Open Ct
Edentulous
Restore
Partial
Endo
Conn Bar
Impact
Tipped
OverCont
Cracked
Abfract
Mobility
Missing
Denture
Apico
Hemi
Def Rest
Rotated
Overhang
Chipped
Dentition
Clear
Implant
Retro
Coping
Caries
Ret Root
Lesion
Supr/Sub
Perm/Prim
Seq Plan
H & N
History
PSR
Summary
OHA
TMJ
Occl
Habits
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
F
F
L
L
Upper
Lower
Full
Visit Date
Stat
Category
Tooth/Quad
Srf/Rt
Diag
Code
Description
Prov
03/02/2010 F Missing 11 Diagnostic Finding ADP
03/02/2010 F Retained 11 Diagnostic Finding ADP
03/02/2010 F Missing 12 Diagnostic Finding ADP
03/02/2010 F Missing 13 Diagnostic Finding ADP
03/02/2010 F Missing 14 Diagnostic Finding ADP
03/02/2010 F Retained 14 Diagnostic Finding ADP
03/02/2010 F Missing 15 Diagnostic Finding ADP
03/02/2010 F Missing 16 Diagnostic Finding ADP
Edit
Delete
Complete
Next =>

Connector Bar is Single Transaction in Diagnostic Findings

DRM Plus shows the connector bar to be a single transaction in the Diagnostic Findings screen. This patch removed the selection of abutments and pontics for each tooth when entering a connector bar for an exam finding. The connector bar selection is a single transaction and not modified with a selection of a tooth or arch.

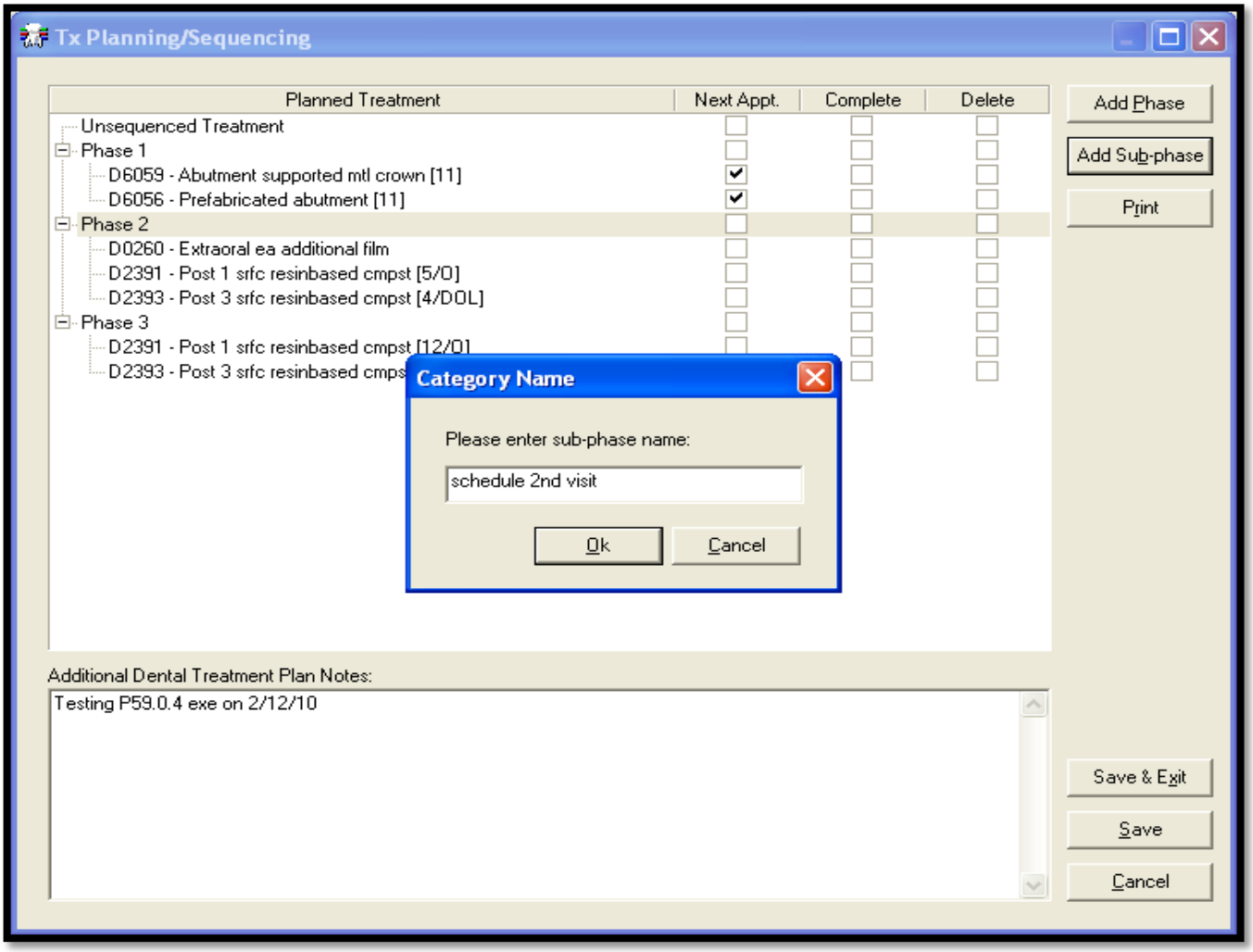
This functionality works now for all three view screens of Diagnostic Findings, Treatment Plan and Completed Care. Place the mouse on the first tooth location and drag to the final tooth location. When entering a connector bar for the Treatment Plan screen or the Completed Care screen the CDT/CPT Procedure Code Selection screen will be displayed 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.

The following dialog displays a single connector bar in the transaction table when enter in the Diagnostic Findings view.

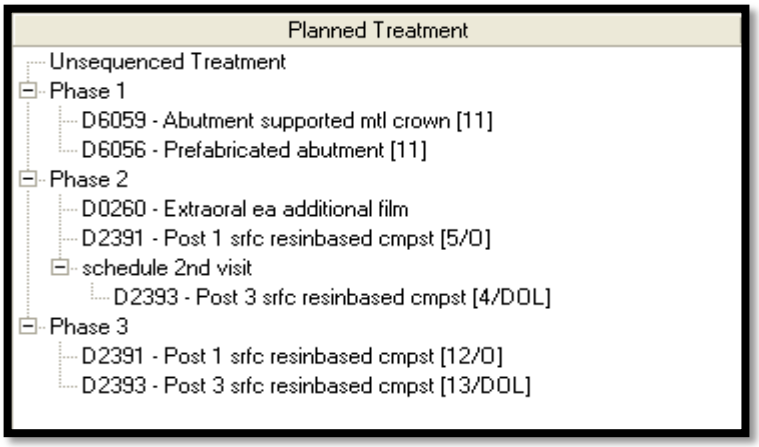


Corrected Length of Sequencing Sub-phase Pop-up to 20 Characters

The category name for the sub-phase will only allowed 20 characters to be entered; the pop-up has been corrected to only allow 20 characters to be entered for the sub-phase.



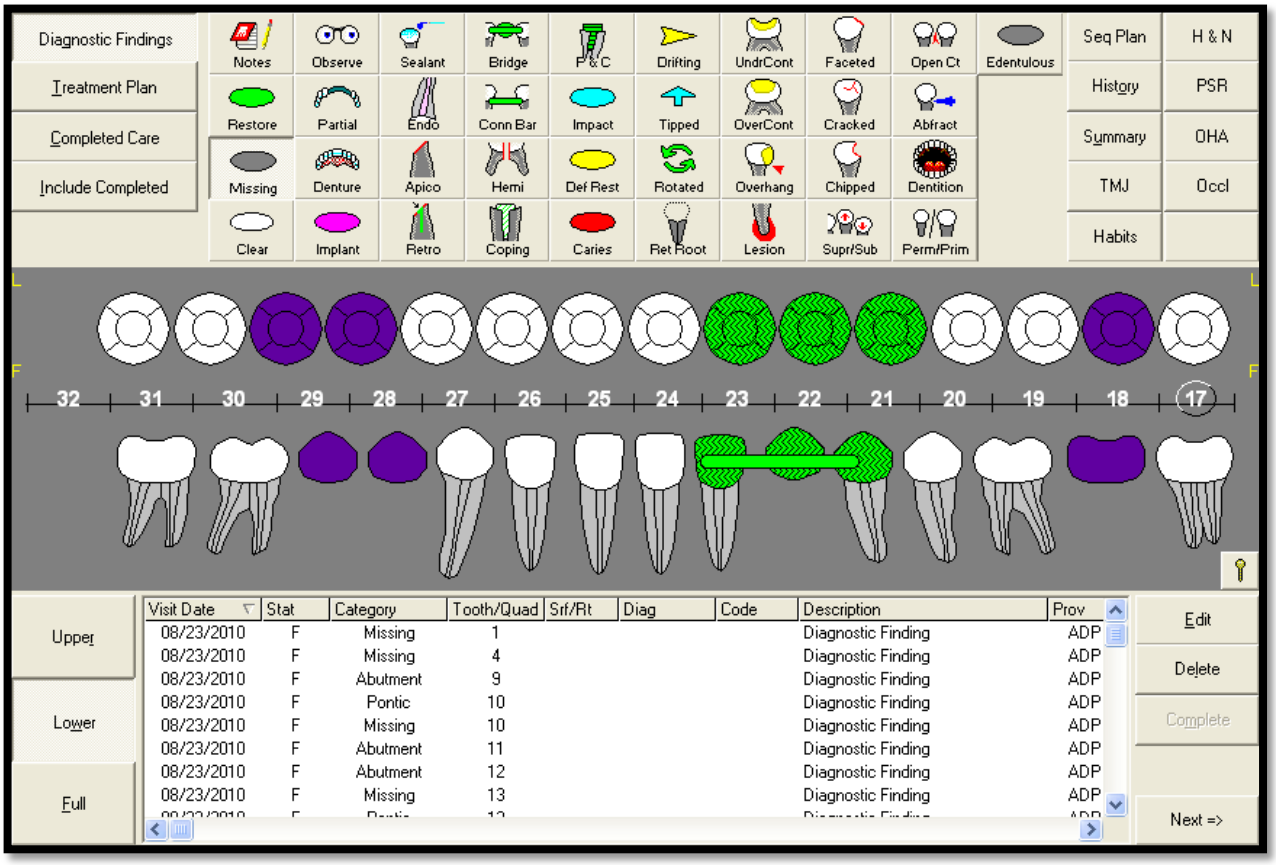
The example shows 'schedule 2nd visit' as a new sub-phase under the Phase 2 entries.



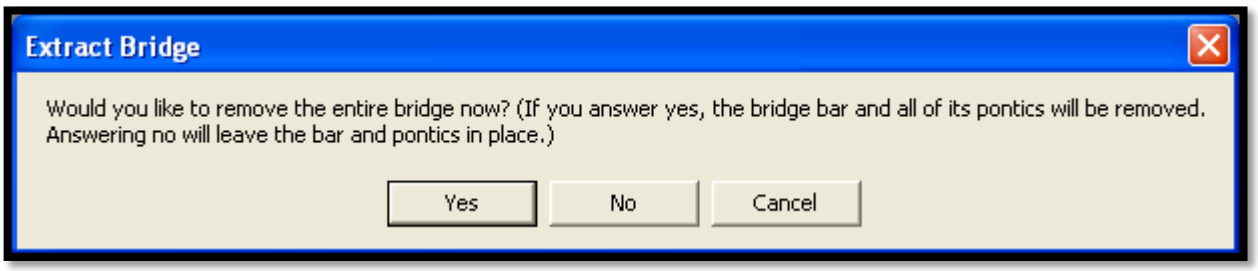
Missing Icon Now Removes Dentures, Partials, Bridge, Connector Bar

The Missing icon from the Diagnostic Findings view screen will now allow removal of dentures, partials, bridge bars/pontics or connector bar of any previous filed entry in Diagnostic Findings. There are no restrictions for this function so all users of DRM Plus may use this new functionality. When removing a denture or partial just select the Missing icon and then the denture or partial in the graphics. The graphic of the old finding will be removed in Diagnostic Findings and the removed listing will be entered in the transaction table as a new finding.

Removing a bridge bar and pontics is a little more complicated. The following dialog has a previously filed bridge with one pontic displayed in Diagnostic Findings view screen. Select the Missing icon and click on any part of the present filed bridge graphics to remove the graphics and enter a removed transaction in the table.



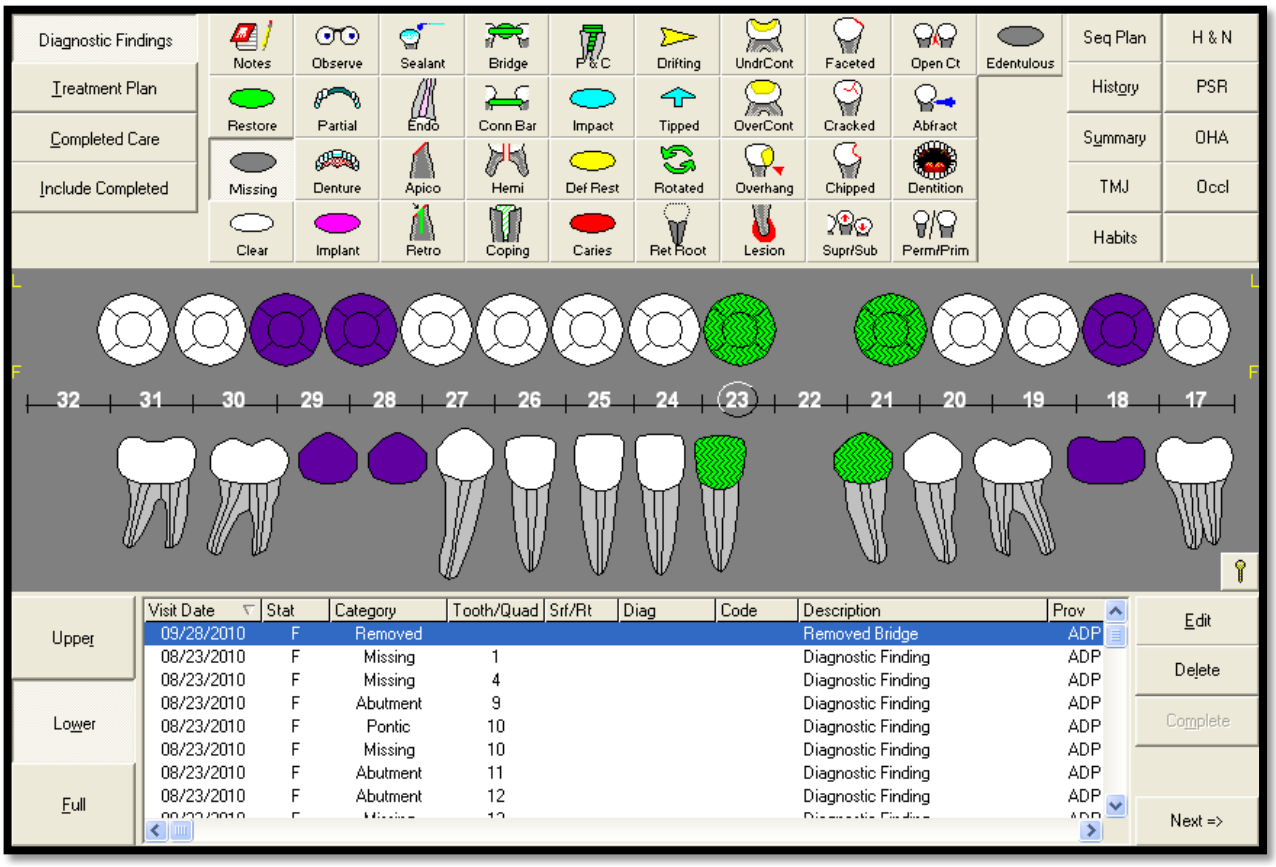
The following Extract Bridge pop-up will display asking the user if they would like to remove the bridge bar and pontics.



- Selecting the Yes button will remove the bridge bar and pontics.

- Selecting the No button will leave the bar and pontics in place however will remove the abutment selected and mark it as missing in the transaction table.
- Selecting the Cancel button will close the pop-up and allow the user to continue their findings charting with no change to the graphics.

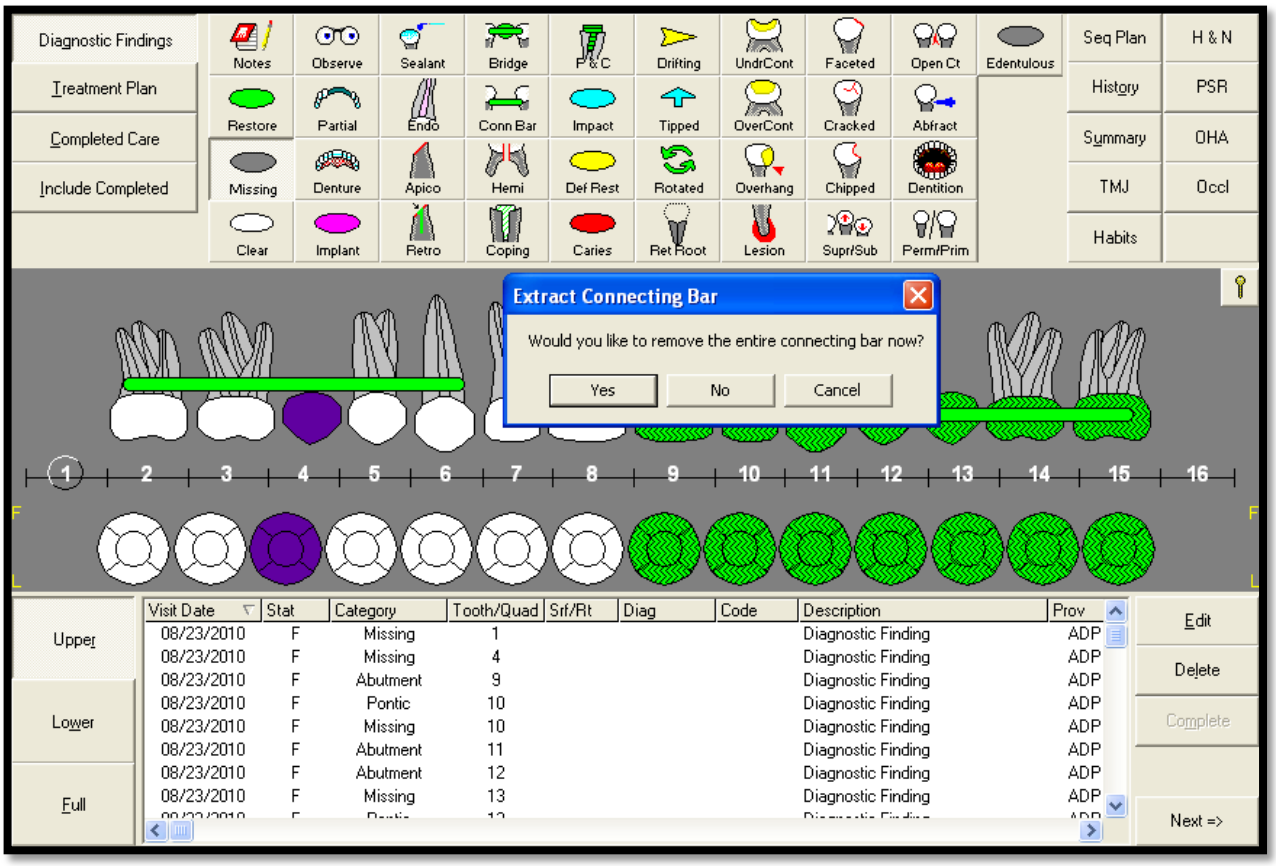
The following dialog displays the removal of the bridge bar/pontic after selecting the Yes button in Diagnostic Findings view screen. The transaction statement will always be a single designation on what was removed.



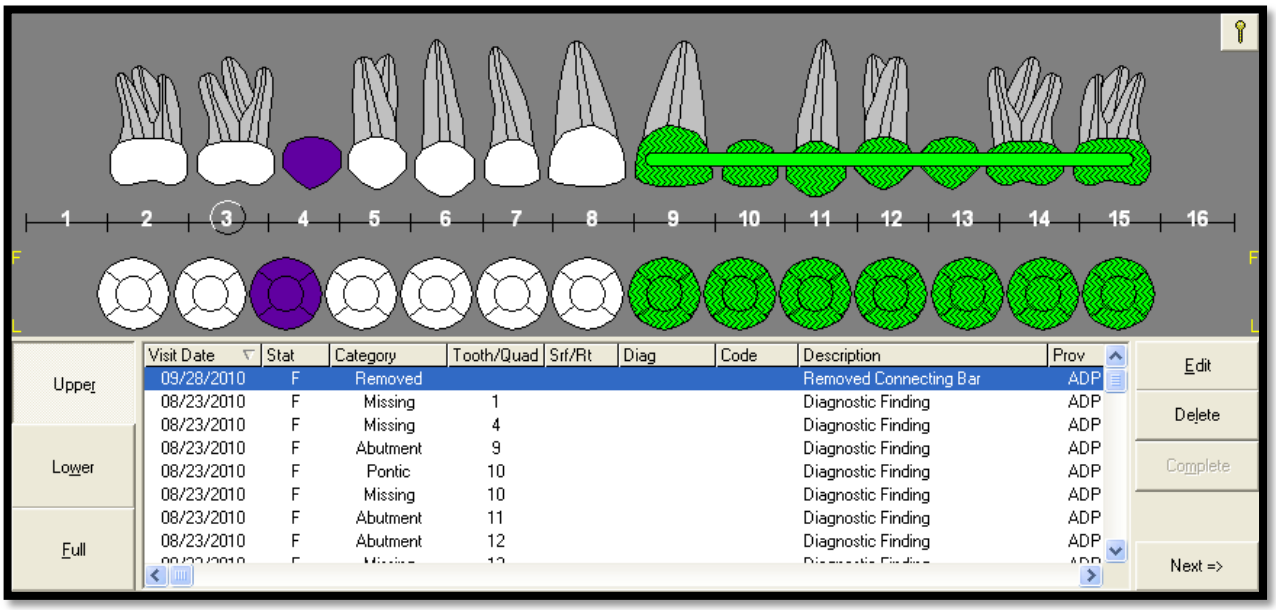
Removing a connector bar is similar to a bridge. The following dialog has previously filed connector bar displayed in the graphics on the Diagnostic Finding view screen. Select the Missing icon and click on any part of the present filed connector bar graphics to remove the graphics and enter a removed transaction in the table.

The following Extract Connecting Bar pop-up will display asking the user if they would like to remove the entire connecting bar.

- Selecting the Yes button will remove the connector bar.
- Selecting the No button will leave the connector bar in place however will enter a new graphic the user selected as missing. This action will allow the user to enter a missing tooth or root(s) if desired.
- Selecting the Cancel button will close the pop-up and allow the user to continue their charting of findings with no change to the graphics.



The following dialog displays the removal of the bridge bar/pontic after selecting the Yes button in Diagnostic Findings view screen. The transaction statement will always be a single designation on what was removed.



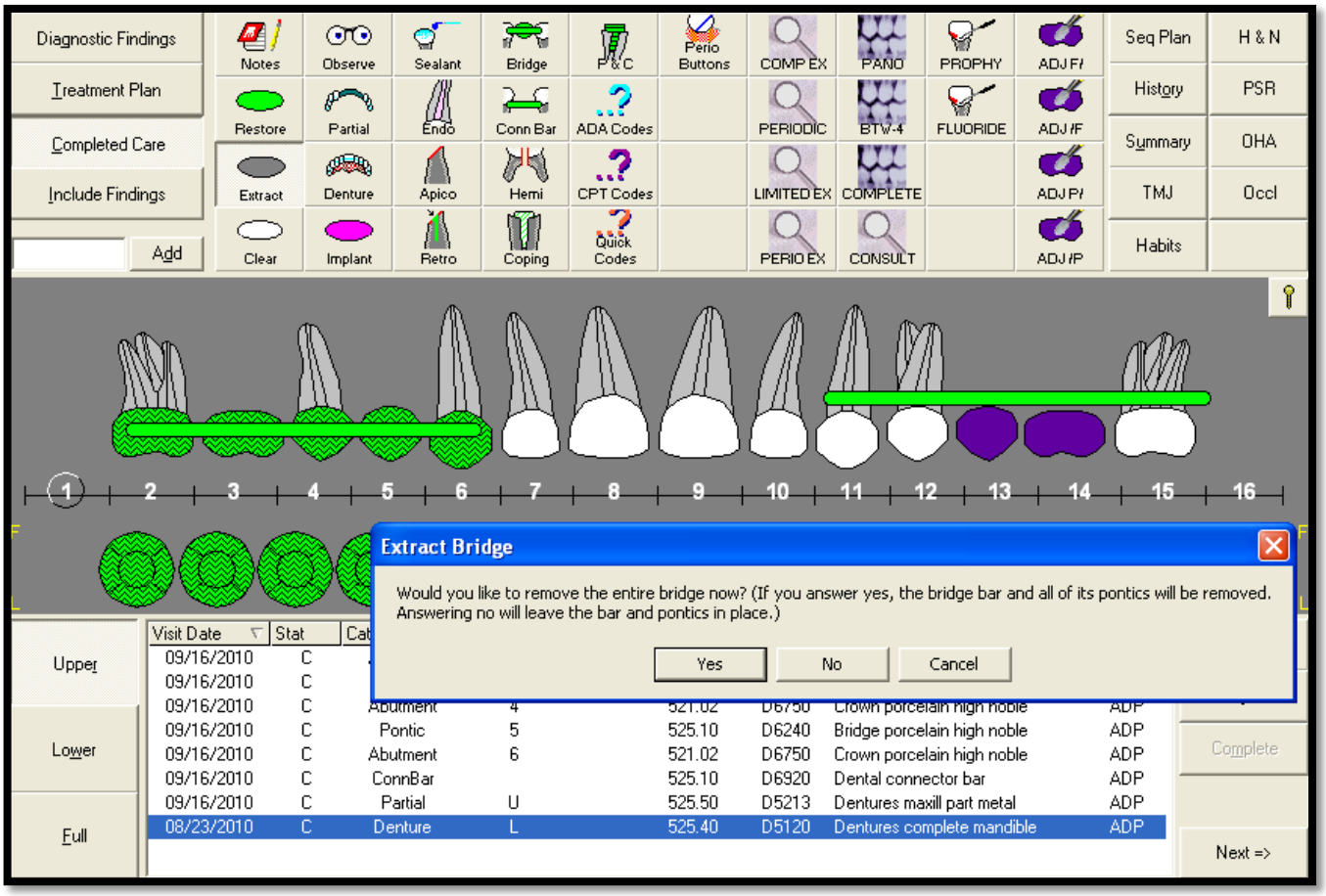
Extract Icon Now Removes Dentures, Partials, Bridge, Connector Bar

The Extract icon from the Completed Care view screen will now allow removal of dentures, partials, bridge bars/pontics or connector bar of any previous filed entry in Completed Care. There are no restrictions for this function so all users of DRM Plus may use this new functionality. When removing a denture or partial just select the Extract icon and then the denture or partial in the graphics. The graphic of the old procedure will be removed in Completed Care screen and will be listed as a new finding for the partial however the denture will be listed as a completed stat of removed.

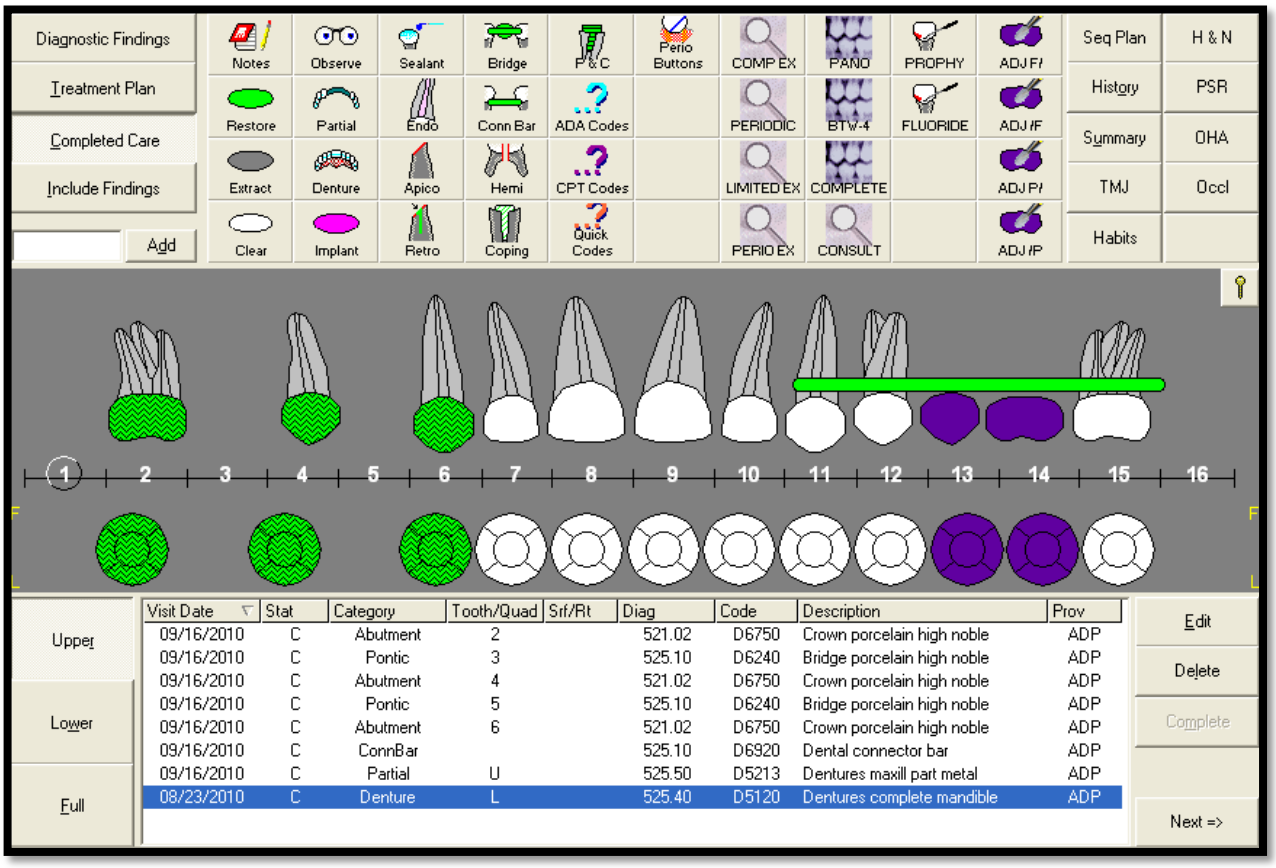
Removing a bridge bar and pontics is a little more complicated. The following dialog has a previously filed bridge with one partial displayed in Completed Care view screen. Select the Extract icon and click on any part of the present filed completed bridge graphics to remove the graphics and enter a removed transaction in the Diagnostic Findings transaction table as a new finding.

The following Extract Bridge pop-up will display asking the user if they would like to remove the bridge bar and pontics.

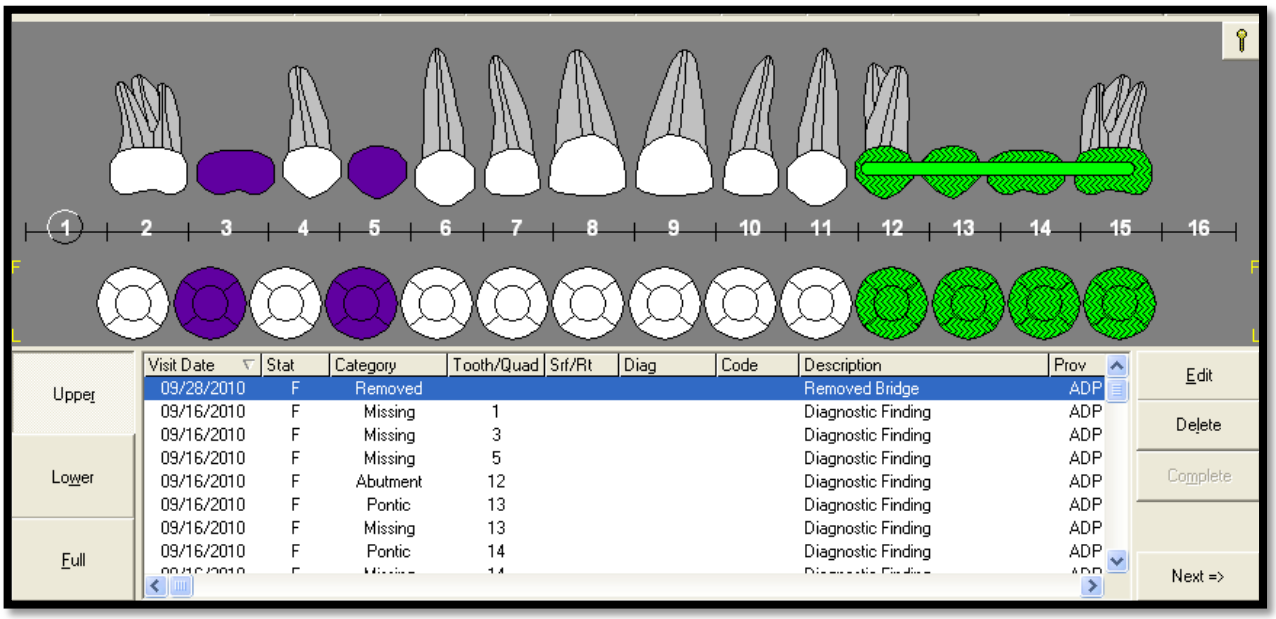
- Selecting the Yes button will remove the bridge bar & pontic graphics and list it as a finding.
- Selecting the No button will leave the bar and pontics in place however will extract the abutment from the graphics and allows the provider to enter a Completed Care extraction in the transaction table.
- Selecting the Cancel button will close the pop-up and allow the user to continue their completed treatment charting with no change to the graphics.



The following dialog displays the removal of the bridge bar/pontic after selecting the Yes button in the Completed Care view screen. The transaction statement will always be a single designation on what was removed and will be entered in the Diagnostic Findings transaction table.



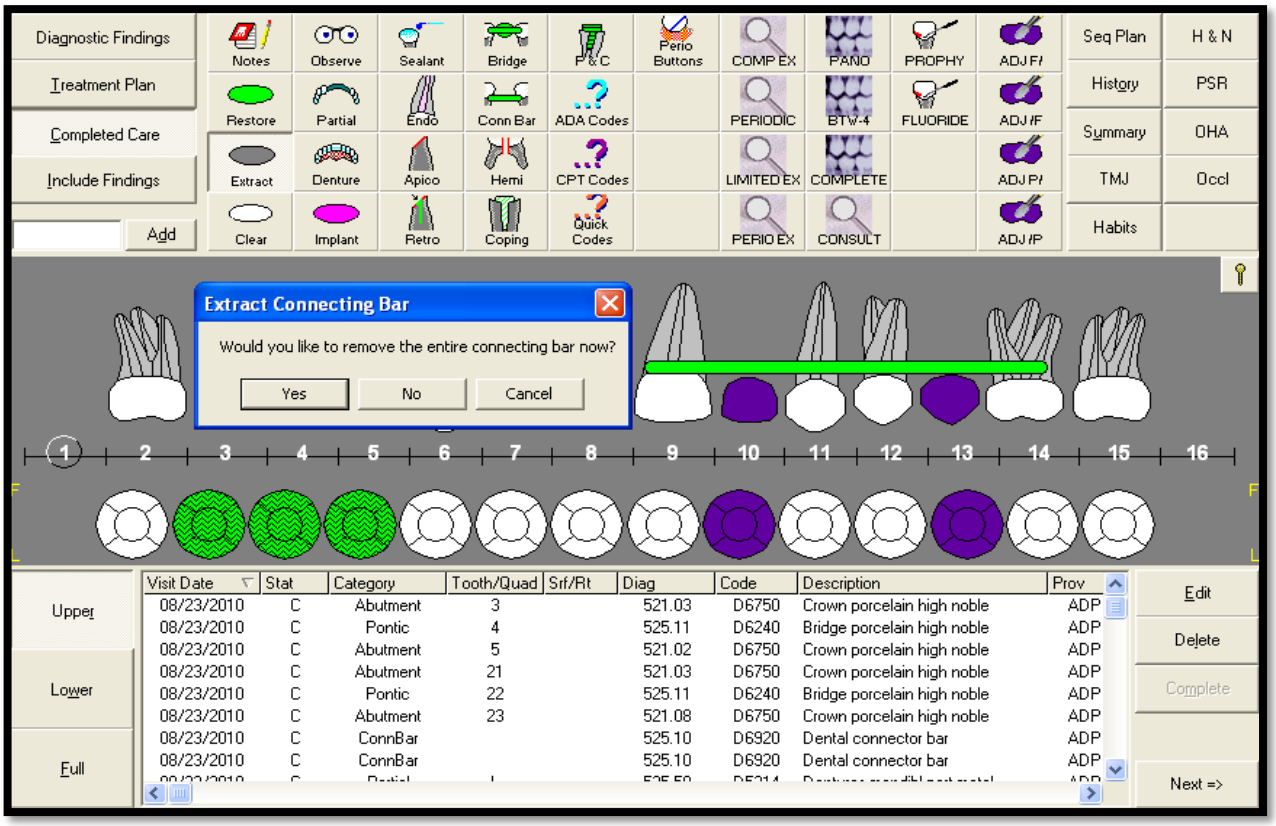
The following dialog displays the Removed transaction statement in Diagnostic Findings transaction table.



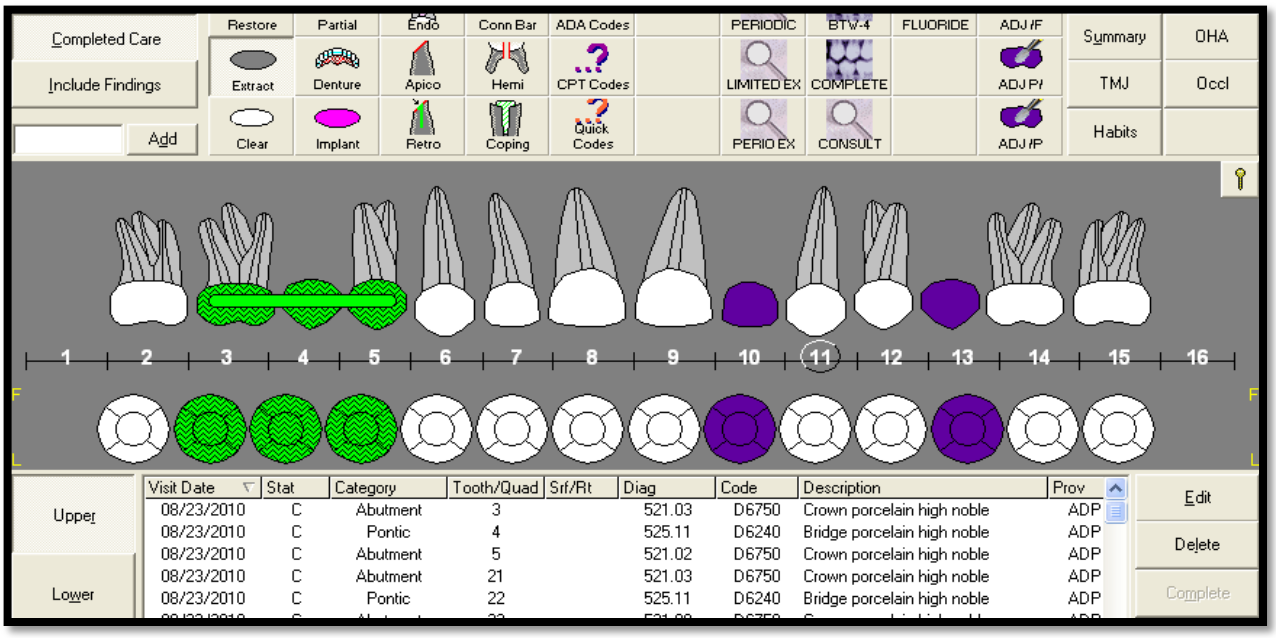
Removing a connector bar is similar to a bridge in the completed care view screen. The following dialog has a previously filed connector bar displayed in the graphics on the Completed Care view screen. Select the Extract icon and click on any part of the present filed connector bar graphics to remove the graphics and enter a removed transaction in the Diagnostic Findings transaction table as a new finding.

The following Extract Connecting Bar pop-up will display asking the user if they would like to remove the entire connecting bar.

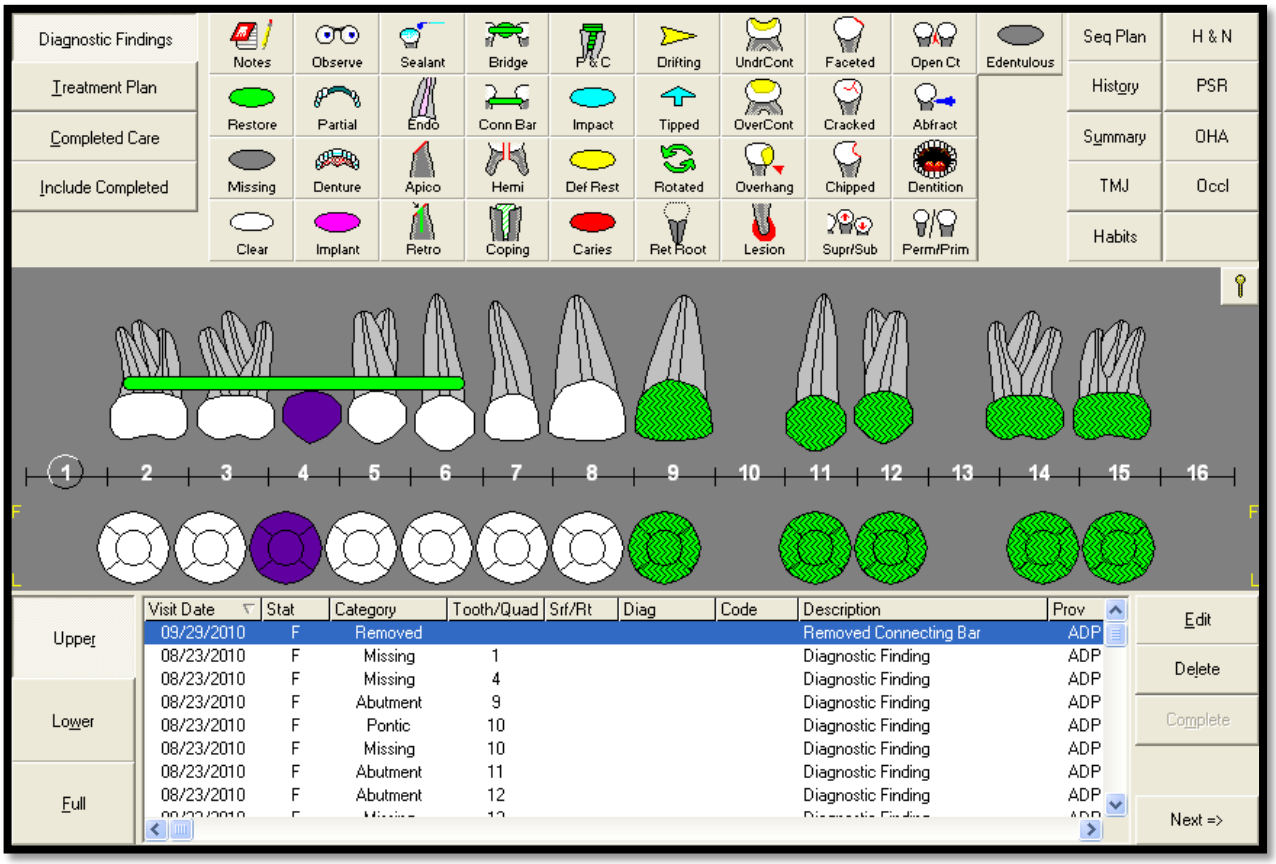
- Selecting the Yes button will remove the connector bar graphics and list it as a finding.
- Selecting the No button will leave the connector bar graphics in place however will enter a new graphic the user may select as extracted. This action will allow the user to enter an extracted tooth or root(s).
- Selecting the Cancel button will close the pop-up and allow the user to continue their charting of completed treatment with no change to the graphics.



The following dialog displays the removal of the connector bar after selecting the Yes button in the Completed Care view screen. The transaction statement will always be a single designation on what was removed and will be entered in the Diagnostic Findings transaction table.



The following dialog displays the Removed transaction statement in Diagnostic Findings transaction table.



Fixes to the DRM Plus Application for Patch 60.59

The following items were addressed from Remedy calls, or from other issue lists.

- Fixed the Provider Summary and Visits by Provider reports when Distributed Providers are included for a search by Create Date. Remedy ticket HD0000000268184.
- Import medications will retrieve active with suspended or active without suspended medications into DRM Plus progress notes/consults based on user selection. Remedy tickets HD0000000286933 and HD0000000321886.
- Missing teeth will only import into the DRM Plus progress note if there are other diagnostic findings, not for every note.
- Removed a trigger for field DATE DELETED (#1.03) in file TREATMENT PLAN TRANSACTION/EXAM (#228.2) that was causing visit dates to be deleted erroneously related to the undelete fix in patch 57. The post install will loop through the file and re-add the visit date for any records missing the VISIT DATE.
- The Fluoride Monitor Prescription Date calendar is holding the date from the previous patient if entered. It now should default to today's date when entering new data. The date can also be cleared.
- Removed rpc DENTV TIU GET TEMPL DATA and replaced with TIU TEMPLATE GET TEMPLATE in DENTV DSS DRM PLUS menu options to comply with ICR 4582. This RPC provides the same functionality. This fix requires TIU*1*252.
- Changed the Provider modal from "desktopcenter" to "screencenter". The window will no longer show up in the middle of two screens when using dual monitors.
- Fixed a whitespace issue in alerts. DRM Plus will no longer record whitespace or any non-visible ASCII character 0-128. Also fixed wrapping in the Alerts pop-up.
- Added functionality to the transaction table to remove any incorrect displays. Moved the "Condition" above aspect, IsJuvenile, Tooth, and IsJuvenile in the component.
- An Implant can be added correctly after transaction is "Invalidated" by a user.
- Removed post and core from graphic when a retained root is removed.
- Removed surface markers when a post and core is added.
- Fixed a problem where the notes for tooth #1 could be deleted without editing the note.
- Fixed labels for periodontal statistics view.
- Added Close button to mesial/distal selection pop-up.
- The current selected icon will remain active after canceling the ADA code selection box.
- Changed the edentulous button to remove retained roots.
- Allow removal of dentures, partials, bridges, and connecting bars using the missing button.
- Changed connecting bar to be a single transaction; removed selection of abutments and pontics for each tooth.
- Added parameter to BeginMulti event which indicates number of transactions forthcoming. This aids in the coordination of events between the component dll and the exe.
- Refresh internal periodontal data when DRM Plus calls Refresh. This prevents the summary view of showing the previous patient's periodontal data.
- The length of the sequencing sub-phase name is limited to 20 characters.
- The ADA Codes, CPT Codes, Quick Codes buttons will be de-selected after the user clicks exit.
- Retro can always be added to a root with an apicoectomy.
- Search results using Add box always show updated matches.
- After searching for a partial code in the Add box and selecting a code, the code will be entered on the current screen, not the user's default screen.
- Panels on the DRM Plus banner have been adjusted so that clicking anywhere on the panel will process the action.
- The Broker History screen was redesigned to include time stamps on RDP calls.

- The Broker History will now include more than 50 calls if a user selects to retrieve more than 50.
- A resident may now enter an addendum on a signed or cosigned note.
- Fixed the manual HL7 resubmission process to only reset Completed transactions.
- Fixed a bug in the VistA DENTV INACTIVATE PATIENTS option where the user could not use ^ to exit the option without processing.
- Transactions that were "undeleted" by the post-install in patch 57 inadvertently had the Visit Date in the transaction deleted preventing the transaction from being "seen" by the exam monitor. A post-install in patch 59 will correct the Visit Date.
- Fixed a bug allowing a D0140 and/or a D0170 to be entered with a D0120 or any other exam code more than once per visit.
- Fixed not being able to delete all of the Adjunctive Medical Codes on the cover page. The problem only occurred when trying to delete all of the codes at the same time.
- Fixed the ability to set an extract folder for non-admin users when they are granted the option to extract history reports.
- The Recare report options have been ghosted out for all non-admin providers, so they cannot run the report. Admin users are only allowed to select the All Provider option.
- Fixed the Dental Alerts header from displaying when no Dental Alerts are imported into the progress note. The header will only import when there are Dental Alerts imported.
- Extracted retained roots will not show up as an additional missing item in the progress note when the corresponding tooth has been previously extracting or designated as missing.
- Fixed an out of bounds error from occurring under certain conditions while completing sequencing transactions.