ExitCare®

ExitCare®

Basic User Manual

Version 7.9.1.7

Elsevier's ExitCare

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Welcome

Elsevier's ExitCare® offers Patient Education Solutions, including the ExitCare® Discharge Information System and the ExitMeds™ Prescription Writing and Drug Information Systems!

If You Need Further Assistance

You can access the ExitCare in-program user manual by clicking **Help/Options** in the sidebar and then **Help**; or find it online at http://exitcare.com/support/training/. Visit our Resource Center at http://elsevierresources.com/exitcare/ to view and download resources. For further help, including how to access our online in-service videos, please contact us at support@exitcare.com or 800-694-6669, extension 2.

Program Overview

The ExitCare software is quick and easy to use, yet comprehensive in what it offers clinicians. Program features include the ability to automatically import patient information; the freedom to add custom information to patient education documents; and a full electronic archive that preserves all patient information printed. We strongly recommend learning and using the program fully. This approach provides the clinical facility with the best results both for the patient and for the management of this information.

Customizable Features

Many features in ExitCare can be customized to save you time. Examples include macros, additional note phrases, shortcuts, drug defaults, and documents. Many features are available for every non-Administrator user who has an ID and password; others are granted by the ExitCare Administrator. If you do not have rights to work with certain features, contact your ExitCare Administrator with your request.

ExitCare Training

Elsevier's ExitCare offers live, web-based training to reinforce overviews, including webinars on Basic, Super User, Administrator, and specialized topics. In-service videos can be viewed online. On-site classes are available for purchase. For more information, please contact support@exitcare.com or 800-694-6669, extension 2.

Formatting Used in this Manual

Generally, the pattern used for formatting in this manual is as follows:

- **Boldface**: Click referenced item
- Underline: Other important items or areas on a screen
- *Italics:* Introductions and emphasis in text

In addition, a wide left-hand margin is provided for those who wish to put this document in a three-ring binder.

Your Feedback

We value your feedback. If you have requests for additional document titles, questions, or suggestions for improvement to the program, please contact us at support@exitcare.com or 800-694-6669, ext. 2.

Basic Steps for Using ExitCare

A. Entering Patient Information

1. Launch and log in to ExitCare.

2. If a drug allergy imported from another system is not recognized by ExitCare, the Unknown Allergy Drug Name window will display allowing you to make a connection to a drug allergy that exists in ExitCare's database.

a. Click the drop down arrow to the right of the imported allergy, and search for a match for the corresponding drug in the ExitCare drug database. *Note that several strength and form options may be associated with one drug name. In those cases, if an appropriate match is found, it is sufficient to select any drug from that set of drugs as long as the chosen drug has the same active ingredients as the allergy.*

b. Click on an appropriate match and click the **OK** button. *Note that, if available, you can check the* Save for future automatic linking *checkbox, and ExitCare will make a connection between the two items in the future for any user, and for any patient. In other words, if the unrecognized drug is imported again, it will display in ExitCare as the drug selected by the user in this instance. If the box is not checked, this will be a one-time connection for this patient.*

c. When all connections have been made, click the **Done** button on the Unknown Allergy Drug Name window.

3. Enter patient information on the Patient Information | Current Patient screen.

a. If your computer system imports patient demographic data via the Patient Lookup tab: Click on its tab (or you can have ExitCare start on this tab), and then double-click on a patient.

b. If entering manually: Fill in the Patient Information fields with at least the patient's first and last name.

c. If using an HIS that imports patient demographic information: view the Current Patient screen and fill in any fields that did not import.

More information on the Patient Lookup tab can be found later in this manual. For further information, please see the in-program user manual: click **Help** under the Help/Options group on the sidebar menu.

4. The patient's weight and height can be imported or entered. These data can assist in confirming that appropriate medication strengths and dosages are being selected when writing scripts. *Note that these values are for informational purposes only*, and do not restrict a user's ability to write a script based on the patient's weight and height, nor does ExitCare include a dose calculator based on weight and height.

5. Click the down arrow in the Patient Diagnosis section and select one or more diagnoses. *The diagnoses will assist you in selecting patient education documents on the Choose Title(s) screen.* The Patient Diagnosis search window is one of the search windows or screens you will see within ExitCare. There are at least three ways you can locate information on these search screens: 1) scroll using the scroll bar; 2) click once on a line where the words are (highlight the line) and start typing; or, 3) search using the search box. Note the two radio buttons ("…Begins With" and "…Contains") controlling the results of the search. You can add a diagnosis not in the list by clicking the "**Add a diagnosis**…" button. It will be listed on the patient's Signature and Summary pages, but it will not assist in finding documents on the Choose Title(s) screen.

Please Note: In addition to users manually selecting diagnoses on the Patient Diagnosis window, your EHR may import patient diagnoses into ExitCare along with other patient information. If the EHR imports a diagnosis via a taxonomy code, such as SNOMED or ICD, the diagnosis will display, along with certain imported text-based diagnoses and manually-selected diagnoses, on the Choose Title(s) screen, but not on the Patient Diagnosis search window. If your EHR imports a diagnosis via text, you will see the diagnosis after clicking the drop down arrow in the Patient Diagnosis section on the Current Patient screen. Only imported text-based diagnoses for which ExitCare has a match in its database will display on the Choose Title(s) screen.

6. As needed, click the down arrow in the Drug Allergies section and check any relevant boxes. Note that several strength and form options may be associated with one drug name. In those cases, if an appropriate match is found, it is sufficient to select any drug from that set of drugs as long as the chosen drug has the same active ingredients as the patient's drug allergy. Selected drug allergies will be added to a patient's information set and will appear in the Drug Allergies frame in ExitMeds. To add a custom allergy not found in the full allergy list, click on **Add an allergy not in the list.** *Note the allergy will not be checked against any drugs, and will not be permanently added to the allergy list, but is for reference purposes for that patient only. Your ExitCare Administrator can add new items to the drug allergy list via the Options System.*

7. You can record the patient's triage/admit date and discharge date and time in the fields at the bottom of the left-hand column. The Signature Page and the Patient Summary Page will display the admission date, and the discharge date and time. There are settings in the Options System that can be set to require the Admission Date and/or the Discharge Date/Time fields to be filled in manually by the user, or to make these fields not appear on the Current Patient screen. If the settings are chosen so that the dates are not required to be filled in, and the date and time are left blank by the user, ExitCare will fill in the current data in these fields when the Print/Fax/Email button is clicked.

8. Enter the Primary Attending, Follow-up, and if needed, Oversight Caregiver information by selecting from the lists found by clicking on the magnifying glass icons, or by typing in the information. *You may need to click the* Clear Search *button on the* Choose Caregiver *screens to make the caregiver lists display.* Select by clicking, or type in, the Primary Follow-up Time.

B. Patient Education Documents

1. Click **Choose Title(s)** in the sidebar to go to the document (or "title") selection screen.

2. If one or more ExitCare diagnoses were selected in Part A, step 5 or imported from another system (HL7 interface or command line with an EHR), click the **+/–** button displayed under the Documents by Diagnosis tab to expand or contract the document list. Highlight (click once on) a document name. *Note the information boxes on the right, and click the Preview Highlighted button at the top of the screen if desired.* You can use the same search and browse functions described in section A 5. Select one or more documents by checking the boxes to the left of the document name.

Please Note: Only documents selected under diagnoses with a corresponding coding standard, such as SNOMED or ICD, will support the Patient-Specific Education Resources Core Measure for Meaningful Use (MU) Stage 2. Please contact CMS or MU experts within your healthcare institution if you have questions regarding attestation requirements for Stage 2 MU Core Measures. Users of the ExitCare Report System can refer to the *ExitCare Administrator Manual* for information on MU Stage 2 reporting done in ExitCare.

3. If a gender or date of birth was entered on the Current Patient screen, click the **Documents by Age/Gender** tab to preview and select suggested documents based on the patient's age or gender. The same search, browse, preview, and selection functions can be used on this tab that are available on the Documents by Diagnosis tab. If both the date of birth and the gender are entered on the Current Patient screen, then only documents for that gender and age group are shown. The age groups are:

- Newborn: birth to 1 month
- Infant: 1 - 23 months
- Preschool: 2 - 5 years
- Child: 6 - 12 years
- Adolescent: 13 - 18 years

- YoungAdult: 19 - 24 years
- Adult: 19 - 44 years
- MiddleAged: 45 - 64 years
- Aged: 56 - 79 years
- OlderAged: 80 years of age and older

Additional Information:

- Although there is overlap in some age groups, the groupings comply with Infobutton age ranges.
- Since there are some age range overlaps, more than one instance of a document will display under this tab when dates of birth within these overlaps are entered on the Current Patient screen.
- If two instances of documents are displayed due to the age range overlap, documents with the same name are identical, regardless of the age group with which they are associated.
- If only a gender is entered on the Current Patient screen, then all associated ages are shown for that gender under this tab. If an age range is not associated with a document, that age range will not display.
- If only a date of birth is entered on the Current Patient screen, then Male, Female, and "Undifferentiated" documents will be shown for that age group.

4. The **Document by Category** tab provides additional documents from which to choose and more search capabilities. You can browse and search within the categories on the left. You can set the radio buttons to search for titles to begin with the characters entered in the search box, for titles that contain the characters entered in the search box, or to search within the text of **all** the documents. Alternatively, you can search by key words associated with the documents.

Highlight (click once on) a document name or an entry with asterisks. *Note the information boxes on the right, and click the Preview Highlighted button at the top of the screen if desired.*

An entry with an asterisk (for example, AACA*) is not the name of the document, but rather a shortcut that points to the document to which it is attached. Because not everyone calls each document by the same name, ExitCare has shortcuts with a single asterisk to assist in locating the documents. Whether you highlight or check the box for a shortcut, the name of the document that it points to appears in the box on the upper right of the screen.

You can also create your own shortcuts and then connect them to documents of your choosing; see the ExitCare *Super User Manual* for details. Shortcuts that users have created are identified with two asterisks.

Checking the Hide Shortcuts check box removes shortcuts from the screen as long as the box is checked. *Checking or unchecking the check box removes all previous document selections you have made on this screen*, so it is advised that you check the box before selecting documents.

Document names with two per cent signs ("%%") at the end indicate that the documents were created by someone at your facility, rather than provided with the ExitCare program.

Also note that when you switch tabs the Search box field is reset.

5. To select a title, check the box to its left. When finished, click **Done**. If you wish to select a single title only, you can double-click it to complete the process.

For more information on using the Choose Title(s) screen, please see the in-program ExitCare User Manual *by clicking **Help/Options** | **Help**.*

6. Under the Macros group in the sidebar menu, click **Load.** Double-click a macro name. For additional information, see the section on using macros later in this manual.

Under the Documents tab, document and form tabs are listed under the yellow information bar. The documents and forms will print in order from left to right. You can rearrange the print order by clicking, dragging, and dropping tabs on other tabs to set the print order of your choosing. In addition, if diagnoses were imported, or added by the user, a message displays under the individual document and form tabs pertaining to the document's or form's relationship to one or more of the diagnoses.

7. As needed, add Additional Attending and Follow-up Caregivers and times on the Questions tab of appropriate patient education documents. Click the **Add a Caregiver** or **Add a Follow-Up** buttons.

8. Add Additional Notes as needed for each document by typing them in or selecting from the user-created list, found by clicking on **Lookup Notes**. The Expand button will increase the size of the Additional Notes window.

9. For documents with question mark icons on their tabs, fill in the fields in the right-hand, Custom Document Questions section. If you do not wish to enter answers for these questions, you may select the No Fields option discussed in Section J on Language & Font Size. If that option is chosen, in most cases the document will suggest a conservative value or that the patient will be informed of this additional information. In some cases, a blank will be deliberately left to fill in. If the No Fields option is not selected and answers are not provided for Custom Document Questions, blank spaces will appear where the answers would otherwise display on the document. Also note that with drop down lists, answers can also be typed in in the field to the left of the "down" arrow.

10. From the View Document tab you may, if granted the rights, click on the **Edit** button and edit the document. In addition, certain fields on this screen can be clicked and edited without clicking the Edit button.

11. Clicking on the View Patient Comprehension Questions tab allows you to view the available "patient comprehension" questions for that particular patient education title. If there are no patient comprehension questions available for that title, the tab for that page will be inactive. These questions are tools to test a patient's comprehension of the patient education document you have provided. They are designed to both test the patient's comprehension and reinforce the important points of the document. Whatever the topic or number of questions, all answers are true except for question 4. You may document in your patient chart that the patient comprehension test was given and record the results. There is also room on the form to document results and actions taken to re-educate the patient. It is suggested that you use this tool to work with the patient to ensure their understanding of the important points, which is designed to improve patient compliance in their own care plan.

C. Drug Information Sheets

1. If you need to add drug information sheets without prescriptions, there are two options to begin:
- **a.** Under a document's Questions tab, click the **Add Drug Information Sheet** button; OR
- **b.** Click the **Drugs** tab, and then click the **+** button in the Drug Information Sheets Without Scripts frame in the upper right-hand corner of the Drug Summary tabbed screen.

2. Locate the information sheets of your choice by scrolling; highlighting a row and then typing within the list of drugs; or searching using the Search box.

3. Select the information sheets by checking the box before each title.

4. You may preview the selected sheets by clicking the **Preview Drug Information Sheets** tab. Click **Close Preview** to return to the drug information sheet list.

5. Click **OK** when finished.

The Print Drug Sheet feature under the ExitMeds group on the sidebar operates differently than this screen. Please see the section on this sidebar feature later in this manual.

D. Excuse Forms

Click **Add Excuse Form** on the sidebar menu and enter the necessary information via the Questions tab.

E. Drugs: New Scripts Tab

*There are three ways to get medication data into ExitCare. The first is through an HL7 interface where medication data entered into another system could be sent to ExitCare and made available for the current patient. A second way is through the historical records of the current patient. If medication data for the current patient was entered into ExitCare on a previous visit, you can restore this data for this visit via the Drug History tab; please see Section F for details. The third way that drug data can be entered into ExitCare is the system that we use to write new prescriptions, explained below. Note that in order for the **Drugs** tab to be accessed, a patient's first and last name must be entered on the Current Patient screen.*

1. Options to begin include:
- **a.** Under a document's Questions tab, click the **Add Default RX** button. If one or more appropriate drug defaults exist for this document, select it from the pop up window and then click **OK**; OR
- **b.** Under a document's Questions tab, click the **Add RX/OTC** button; OR
- **c.** Click the **Drugs** tab at the top of the screen, and then click the **New Script** tab.

2. To enter drug or other information on the New Script tab after completing step 1b or 1c above:
- **a.** Scroll; highlight and type; or use the search box to find a desired medication in the ALL DRUGS list or the user Favorites list. Click or double-click, respectively, on an item name to select it.
- **b.** If no match is found, click the **Add Custom Drug** button, and manually enter the necessary data on the pop-up window and in the Drug Information section.

3. If a drug default exists for a drug:
- **a.** Click on the default of your choice to populate the Drug Information fields on the right of the screen.
- **b.** Once populated, verify or change any details in the Drug Information fields.

4. If a drug default does not exist for a drug, complete the fields in the Drug Information section. Starting with the RX and OTC buttons, select or type in the content for the required fields. *If any of the fields, including drop down fields, do not display the needed data, it can be typed in.* The next field will activate after the previous one is filled in. If desired, check **Include Drug Information Sheet**.

5. In the Additional Instructions box, type in any instructions; or click **Instructions Lookup** for a library of additional instructions. Make selections and click **Add Selected**.

6. Click a button in the lower right (**New RX, Stop Taking,** etc.) to classify the medication data. This facilitates the medication reconciliation process.

Additional Information:

- Custom drugs added with the Add Custom Drug button will be added to the patient's record, but not to the ALL DRUGS list. Your ExitCare Administrator can add the drug to the list via the Options System. Also note that drugs added via the Add Custom Drug button or to the list via the Options System will not be checked for drug-to-drug interactions nor for drug allergies, for any patient.
- To save custom-created drug information sets (drug defaults) for future use, please see the section titled *Drug Defaults* in this manual.
- To make your own Favorites drug lists, please see the section titled *Drug Favorites (Personalized Drug Lists).*
- To save drug defaults attached to specific patient education documents, please see the section titled *Drug Defaults for Specific Documents (Document-Level Drug Defaults)*.

F. Drugs: Drug Summary Tab

*The Drug Summary tab allows you to review and reconcile medications entered for the current patient. In order for the **Drugs** tab to be accessed, a patient's first and last name must be entered on the Current Patient screen.*

In the upper right corner of the screen you can add a drug information sheet to the print list without entering a prescription. To do so, click the **+** button in the Drug Information Sheets Without Scripts frame.

Above the Drug Summary grid are three buttons. The first button takes you to the New Script tab. The second button allows you to delete a drug from the grid; simply click the row of drug data, and then click **Delete Selected**. To check for drug interactions or allergies, click the **Check Interactions / Allergies** button.

If the patient states that they are not on any medications, check the box next to **Patient stated they are not on any pre-visit drugs.** *Once checked, the documentation printed for both the chart and the patient will state that the patient claimed they were not on any medications.*

The five small icons to the right of the "Patient stated…" checkbox are related to ways to report or export the medication data listed in the table below. There are two types of printed medication documents available on this screen. The first icon allows you to set up the page for printing. The second icon lets you preview the two available documents. The first is an Input Form which allows a physician to specify the drug status of each medication on paper, so someone else can input the data into ExitCare. Along the left-hand side of this document, the physician can check the box of the appropriate drug status for each medication; two blank rows are at the top of the form if they desire to add any additional medications. The second document is a Status Report that shows the status of each medication at any point in time. The Input Form and the Status Report are for use by your facility's staff, and are not the medication reconciliation document which is given to the patient.

The third icon allows you to print either document. The fourth icon lets you export the data from the table as a spreadsheet. The final icon allows you to export the data as an HTML file.

You can display, hide, or move the columns of data on the Drug Summary page clicking the small icon at the top left corner of the table, next to the **Status** column. You can also click and drag the column headers. Once you have optimized the table, you can save the layout as your default for the future by clicking on **Save Grid Layout**. You can also sort the list of medications in the Drug Summary table by clicking on any column heading.

To change the status of any medication, click the down arrow in the Status column. You can also change details of medications by clicking the row of data in the main part of the grid, and then edit the available options in the Drug Information section of the screen. Click **Save** after editing each drug's data. *Note that changing*

medication fields (such as Dose or Frequency) on the Drug Summary page will trigger the Drug Status to display "Changed" only for drugs listed as "Take as Previously Directed."

If you try to print the final set of documents for the patient, and any medications are still classified as "Pre-Visit," you will get a warning notice. For an inpatient, you could be printing the instructions for today's teaching, and are not yet prepared to reconcile their pre-visit meds. In this case you can click on "Continue to Print Screen" and print the documents you need. If you choose to print a medication reconciliation document with meds still classified as "Pre-Visit", a warning will print on the patient documentation letting them know that some drugs have not been reconciled.

In order to print out a medication reconciliation document or any scripts for a patient, a primary caregiver must be listed on the Patient Information | Current Patient screen.

G. Drugs: Drug History Tab

*The Drug History tab allows you to review certain medication data previously entered into ExitCare during past visits. The top of the screen is automatically filled in with the data on the current patient. If some of the data varies on each visit, you may need to clear that cell of data before searching the history. In order for the **Drugs** tab to be accessed, a patient's first and last name must be entered on the Current Patient screen.*

1. Click the **Search** button to display the patient's history. The table displays drugs that were classified on the Drug Summary screen during previous visits as "New" or "Take as previously directed." If the patient has been at your facility numerous times and you just want to see the last entry for each medication, you can check the **Hide Duplicates** check box. This screen allows you to easily review and document meds the patient is currently taking, as well as helps you identify drug seeking patients.

2. To export a drug from this list into the Drug Summary table, check the box to the left of the drug name and click on the **Add as New, Add as Current,** or **Add as Pre-Visit** buttons at the bottom of the screen.

H. Drugs: Patient Medication Schedule Tab

*This screen displays a list of all medications that have been classified as either "New" or "Take as previously directed." Here you can create a patient medication schedule for these drugs. In order for the **Drugs** tab to be accessed, a patient's first and last name must be entered on the Current Patient screen.*

On this screen, check boxes with checks in them will create empty boxes in the printed schedule for the patient to check after taking his or her medications. Empty boxes on this screen will put marks in the schedule, indicating that the patient does not need to take the medications for that instance.

1. For drugs that are to be taken more than once a day: In each row of medications, click the far right (**duplication**) button to create additional rows in the schedule for that medication. *For example, if the drug is to be taken three times a day, click the copy button twice.* Uncheck boxes for any instances the patient does not need to take their medications.

2. Using the button under the Time column, set the times to take the medications.

3. Repeat steps 1 and 2 for any other medications listed.

4. To add additional weeks, click the **Add Another Week** button. If the medication is not to be taken for any day of the final week, uncheck boxes for the relevant days in the last week.

If you need to start over, or have added a drug and need to refresh the view with new drug information, you can reload the form by clicking on **Recreate Patient Medication Schedule**.

I. Drugs: Drug Interactions/Allergies Tab

*The Drug Interactions/Allergies screen allows you to check for drug-to-drug interactions and patient drug allergies. In order for the **Drugs** tab to be accessed, a patient's first and last name must be entered on the Current Patient screen.*

1. Enter all drugs to which the patient is allergic on the Current Patient screen; see Section A above. If you check the box there to indicate that the patient is not allergic to any drugs, both the documentation later printed for the chart, as well as the documentation for the patient will clearly state that the patient has confirmed that they have no drug allergies. If patient-specific drug allergy information is available from the registration system, the allergies can automatically be entered into ExitCare when importing the patient.

2. If you have entered medications, and there are either drug interactions or allergies found, you will automatically be taken to the Drug Interactions/Allergies screen when you click the Print/Fax/Email icon. To manually access this screen, either click the **Check Interactions / Allergies** button on the Drug Summary tab, or click the **Drug Interactions/Allergies** tab under the main Drugs tab.

3. The top half of the screen lists drug-to-drug interactions at four severity levels. ExitCare Administrators can establish a threshold for drug interactions so you would only be notified for certain level of interactions. If you wish to know more about a particular interaction, click the drop down arrow under the Severity Description or the Interaction columns.

4. The bottom half of this screen is where interactions to the patient's allergies are listed.

5. If you do not wish to approve a medication on this page, either go back to the Drug Summary page and delete the drug; or shut down ExitCare (which will save your work) and remove the drug from the drug data imported into ExitCare. Restart ExitCare to proceed.

6. If you wish to approve all medications in spite of interactions, click the **Approve All** button; this approves all interactions and allergies on this screen. On the right-hand side is the name of the person who is the logged-in user when the boxes have been checked off, approving the medication regimen in spite of the interactions. The name of this person will be documented later on the Patient Signature Page for the chart.

Additional Information:

- ExitCare will not give access to the Print/Fax/Email screen as long as there are interactions or allergies listed that have not been approved.
- Drugs added for a patient via the Add Custom Drug button or to the list via the Options System are not able to be checked for drug-to-drug interactions nor for drug allergies, for any patient.
- Custom allergies added for a patient or via the Options System are not able to be checked against drugs for reactions.
- Because of the above, users will need to approve any custom drugs and/or allergies when on the Drug Interactions/Allergies screen.

J. Language & Font Size

To change the language and font size of your selected document, click **Language/Size**.

For patient education documents and forms with question mark icons on their tabs: If you do not wish to select answers for the fields on the right side of the screen under the Questions tabs, select the No Fields option for the language of your choice. Generally, the "No Fields" versions do not have Question/Answer fields within the documents, but instead, ExitCare provides text with conservative words or values, or that the patient will be informed of this additional information. However, some of the "No Fields" versions of the documents have underlined blank spaces which allow for a manual method to fill in, such as an agency telephone number. Also note that the Excuse Form *does* retain its fields (check boxes and calendars) when a "No Fields" version is chosen on this screen.

When you choose a language other than English, you can print a duplicate set of information in English. To do so, select the check box for documents, or for forms, or both. The check boxes also appear on the General Print Settings screen if you forget to check them here. Also note that changing languages does not change other information such as Additional Notes you may have entered; only the main body of the document is changed.

K. Print/Fax/Email: Printing

Click **Print/Fax/Email** and confirm or make choices. If you want to return to the current patient record without printing, click the **Close** button.

When you come to the screen shown under the General Print Settings tab, you might only need to click one of the Print buttons along the bottom of the screen. However, this screen also allows you to select which documents are going to print, as well as the print quantity of each one. You may select which items you want to print by checking or unchecking the individual items listed. *If a box is unchecked a document will not print and it will be removed from the Signature Page.* To not print a document but have it listed on the patient's Signature Page, keep its box checked and change the print count of the document to zero (0). You can also adjust the print count to print multiple copies of a document either by clicking on the print count and typing in the new count, or by clicking the arrows directly above the document listings. You can click and drag items within lists to change the print order within that list. If you need to print additional documents that have been added after the original documents have been printed, you can print just the new documents by deselecting the original documents on this screen, or by leaving the boxes checked and changing the print count to zero (0), depending on your need to have it listed on the Signature Page. This can be helpful where a particular document was previously printed, given to the patient and is still available to the patient. To change printers for the current print job, click the drop down arrows for the Prescription printer and the Main printer, and make a selection. **Note that once you print, ExitCare creates an entry in the archive which cannot be changed.**

L. Print/Fax/Email: Delivering Patient Documents Electronically

In addition to printing (discussed in Section K), you can also select to provide an electronic copy of all documents except prescriptions to the patient. This feature assists in satisfying one of the Meaningful Use Core Measures.

Using the "**Request for electronic copy…**" drop down list, you can choose to provide the patient's documents via non-encrypted or encrypted email; or you can create a PDF file of the documents which can be given to the patient on a flash drive, burned onto a CD, etc.. Everything printed for the patient will be delivered to the patient electronically except for prescriptions.

Using the drop down list you can also choose to note on the Patient Signature Page that documents were provided by other electronic means outside of ExitCare, such as through the facility's own EHR system; or, that the patient requested, but you were unable to provide, an electronic copy of the documents. The default selection is that the patient did not request an electronic copy of the documents.

If a patient requests an electronic copy of their documents:

1. Select the desired method of delivery from the "**Request for electronic copy…**" drop down list on the General Print Settings screen. If choosing to email the documents, the patient's email address will need to be entered on the Current Patient screen.

2. When you click one of the Print buttons on any of the Print/Fax/Email screens, the documents will print and be delivered to the patient or the selected option will be documented on the Patient Signature Page.

M. Print/Fax/Email: Faxing and Emailing to Caregivers and Pharmacies

In addition to printing (discussed in Section K), you can also fax or email the Patient Signature Page and patient comprehension questions to a follow-up caregiver; and fax or email unsigned prescriptions to a pharmacy.

Under the Fax/Email Information tab, each follow-up caregiver and/or pharmacy you have selected will be listed for you to confirm the fax numbers or email addresses. You also have the option to add information to the fax or email, so you can convey test results or other information to the follow-up caregiver – information that is not documented on the handouts given to the patient. If multiple providers are listed in the top section of the screen, you can choose to send or not send the data by checking or un-checking their respective boxes. The data will only be sent if a check mark is next to the name.

For faxing, ExitCare uses the standard Microsoft Windows® operating system faxing solution. To track or verify any faxes, you would need to go to that application. ExitCare only prepares the fax and sends it to the Microsoft Windows® operating system fax server. ExitCare has no ability to manage faxes after they have been sent to the Windows® operating system.

Two options exist for e-mailing from ExitCare:

- After ECCS is installed, you can utilize your existing email server to send emails from ExitCare. ExitCare's email functionality is SMTP-based, provided through ECCS.
- You can also use a MAPI-compliant e-mail application on each workstation to allow ExitCare to send e-mails.

N. Print/Fax/Email: Print Preview

Click the **Print Preview** tab to preview your documents and forms. To return to the main print screen, click the General Print Settings tab. At any time, you can click on one of the buttons along the bottom of the screen.

O. New Patient

Click **New Patient** to close the patient record and begin a new one. This will save all patient information (including documents and drugs) to the Recent Patients list.

Selected Features

Patient Lookup Screen

The Patient Lookup screen allows users to search for patient records that have been recently saved in ExitCare ("Recent Patient records"). For customers whose computer systems transmit patient information into ExitCare (via an HL7 interface or otherwise), the Patient Lookup screen gives users one place to search for: a) records ready to import via an HL7 interface; and b) records that that have been recently saved in ExitCare ("Recent Patient records").

The Patient Lookup screen is opened by clicking on the **Patient Lookup** tab next to the Current Patient tab, or by clicking on **Patient Lookup** in the History group on the sidebar.

If you had previously prepared an instruction set for a patient, and had filled in at least the First Name and Last Name fields on the Current Patient screen and saved your work, you may retrieve all of your customized patient data by double-clicking on the patient's row of information within the Patient Lookup screen.

There are several ways to save patient records to the Patient Lookup screen. They include clicking:

- the Patient Lookup tab
- the Save Patient to Patient Lookup List button (the green diskette button)
- the New Patient icon
- The Logout icon
- The Shutdown icon

On the General Print Settings screen, clicking the following buttons will save records to the Patient Lookup tab:

- Print, Clear Patient and Minimize
- Print and Logoff
- Print and Shutdown
- Print and Clear Patient

By default the Patient Lookup screen displays patient demographic records from the department to which the workstation was assigned. There are two search options that users may choose that permit the display of records from the entire facility: a) checking the box for Search all recent patients in facility before searching will display recent patient records from within the entire facility; or b) checking the box for Show all patient imports displays patient records available to be imported for the first time, from within the entire facility.

An easy way to locate records is to click on the blank space under a column header and begin typing. For example, clicking in the space directly under the last name field column and then typing "Sm" displays all the records whose last name starts with "Sm."

See the in-program ExitCare User Manual *(**Help/Options | Help**) for much more information on the Patient Lookup screen.*

Archive History Lookup

The Patient Archive screen allows authorized users to search the ExitCare archives for records and retrieve them. Archived records are created whenever you print documents with one or more of these fields filled in on the Current Patient screen: ID Number; Medical Record Number; First Name; Last Name.

Common uses of the archive screen include quick look up of caregiver instructions when patients call back a day or two after their visit asking “What did my doctor tell me to do?”, or “When did my Excuse Form say to go back to work?”; or to recall the information months or years later if the information is needed for legal purposes. Such archived documents can be viewed or printed (if the user has the security rights to do so), but no changes can be made to these historical records.

ExitCare discharge instructions can be created to include a patient ID and/or medical record number. ExitCare uses this ID or record number, made up of any combination of letters, numbers, or other keyboard symbols, for this feature. You may use your own patient ID or medical record numbering system. You may search for a patient’s discharge information records based on patient ID or medical record number, or first and/or last name. Using a percent symbol (%, a “wild card”) in the number and name fields will return a list of all patients in that archive location.

Clicking on the Patient Archive icon in the History group on the sidebar, or clicking on the Archive History Lookup tab under the Patient Information tab brings you to the Patient Archive screen. If patient information (first name, last name, patient ID, or medical record number) is on the Current Patient screen when clicking either the afore-mentioned icon or tab, that information will populate their respective fields at the top of the Patient Archive screen. You may need to click the Search button in order to make the patient record display in the table.

You may also specify a date range and, if applicable, specify the facilities pertinent to the search.

Using the Diagnosis Filter, you may also search for records containing specific diagnoses. These searches can be conducted with or without patient name, ID, or MR Number data. Please see the section below for more information on the Diagnosis Filter.

After setting up your search, click the **Search** button. To open a record for viewing, click on the "+" sign to the left of the patient's Visit Start Date, or double click the patient's row of information.

Using the Diagnosis Filter
To search for patient archive records by diagnoses, click the Diagnosis Filter **drop down arrow**. Find and select the desired diagnoses, and click the **OK** button.

Click **Search** to obtain your results.

Click a Diagnoses column cell to see all the diagnoses for a patient. The figure below shows an example after clicking in a cell.

For longer diagnoses, such as in the second example shown below, you can further expand the size of the cell by grabbing the upper- or lower-left corner of an open Diagnoses cell and dragging it.

An entry in a Diagnoses cell stating "Unknown Description ..." will display if an EHR imports an ICD-9, ICD-10, ICD-11, CPT, LOINC, or SNOMED diagnosis code that is not in the ExitCare database. In addition, these diagnoses will *not* display under the Documents by Diagnosis tab on the Choose Title(s) screen.

Note that the Diagnosis Filter list displays ***all*** diagnoses for all patients for whom records have been printed, whether or not documents related to the diagnoses were selected and then printed.

The Diagnosis Filter list and the Diagnoses cells in the table below it show diagnoses that were:

- imported, whether code- or text-based, with the patient's record
- manually selected by the ExitCare user from the Patient Diagnosis list on the Current Patient screen
- manually typed by the user on the Custom Diagnosis pop up window

If no diagnoses were imported, selected, or typed in for a patient, the Diagnoses cell in the patient's row of data will be blank.

In order for a patient row of data to display in the table created by clicking the Search button, when working with the patient's record outside of the Archive screen, it is required to print using the Print/Fax/Email screen. Each Diagnoses cell in the table displays all diagnoses that were assigned to a patient at the time of printing, whether or not documents related to the diagnoses were selected and then printed.

For patients who have more than one print job per visit: Once a diagnosis--whether imported by an EHR, or manually selected, or typed in by a user--is added to a patient's record, the diagnosis will display in the patient's record after a print job is done, even if it is removed later during that same visit. A “visit” is defined as a stay that generates a patient record with a unique Patient ID number, MR Number, first name, and/or last name.

Please see the rest of the Patient Archive section below for more information on using the other features on the Patient Archive screen. Please see the Diagnosis Report section in the *Administrator Manual* for information on generating diagnosis reports.

Searching for and Finding Names in the Patient Archive List
Alternatively, to look up a patient record, key in a patient’s ID number, Medical Record (MR) Number, or first and last name. Wildcards are: an underscore (“_”) represents a single character in your search string; and a percent sign (“%”) represents any series of characters (do not use the quotes shown here).

For example, searching for last name "Ander%" will show all names in the list that start with "Ander", such as Anders, Anderson or Andersen. Searching for "Anders_n" will show all names that include all the letters shown, with any value in the underscore symbol position, such as Anderson or Andersen.

You may also click in the blank space under a column header and begin typing. For example, clicking in the space directly under the last name field column, typing "Sm," and then hitting the "Enter" key displays all the records whose last name starts with "Sm." As you type more letters, the results become closer to what you are typing.

Finally, you may also click within the list in the column of data you want to search by and then start typing. For example, clicking with the last name field column and then typing "Sm" takes you to the first name starting with "Sm."

Working With the List
You may scroll through the list of patients, which is **sorted** by whichever column header you click on, except for the Diagnoses column header. Click on a column heading to switch between ascending or descending order sorting for that column.

You may also **filter** the list by clicking on the "down" arrow within the column heading by which you want to filter the list. Doing so will allow you to choose a filter value for that column. This will have the effect of only showing the items in the list which match that filter. To remove the filtering by a particular column value, click the arrow again and choose "All" from the drop down list, or uncheck the previously-checked box(es) in the list.

You may select which column headers display by clicking the Column Selector box (the leftmost rectangle in the row of headers) and then select or deselect the headers of your choice. Please see the figure below.
You may then arrange the column headers in the order of your choosing by dragging and dropping them within the header row.

Once you have your grid list customized with the look you want, as an individual logged in user you may save that layout by clicking on the **Save Grid Layout** button on the lower left of the screen. The next time you log on as that user, the grid will appear in the configuration you saved.

Detail Tab
Under the Detail tab the entire discharge information package will be presented as it had been printed, including all of the different elements, and in as many copies as were originally printed. Note the rows to view different elements, which, depending on what was printed, include Documents, Forms, Scripts, Drug Information Sheets, Signature Page, Medication Summary, Medication Schedule, and Patient Summary Page. Also note that the original Print Date/Time is listed (as "Detail Date/Time"), as well as the user name (under "Detail User") logged in when it was originally printed.

To see each element printed for the patient, click on the magnifying glass icon in the row of the element you wish to view. After doing so, you can print that element by clicking the Print button in the lower right corner of the screen. A dialog box will open to select a printer; click OK to execute the print job. You can save that element as a PDF file by clicking the Save as PDF button. Click the **Done** button to return to the Archive Lookup screen.

If you want to add or edit a note ("annotate the record") to a Patient Archive record for any reason (e.g., you printed a set of information for a patient that contained an error, so you corrected the error and then reprinted the set and gave that to the patient), you may do so by clicking the ellipsis button (the button with the three periods) on the far right of each row of data. A dialog box will open allowing you to enter the note and attach it to that record. The annotation will appear in the “Detail Notes” column of data for that record.

Demographic History Tab
If one or more elements of the patient's demographic data, as well as the user who saved the data, have changed between separate print sessions for the patient, ExitCare will display a new row displaying the changed data. It will also display a question mark to the right the plus or minus button as an indicator that the demographic data have changed, allowing you to detect that fact before opening up the patient record.

Table Processing Icons
The icons in the upper left of the screen, shown below, are for: page setup; print preview; printing; collapsing the table; expanding the table; exporting as a spreadsheet; and exporting as an HTML file, respectively. You can print or export the patient information table showing either the grid of the Detail tab or of the Demographic History tab.

Attach File/Scan Image
You can attach images or PDF files to patient archive records, and can scan documents and images and attach them to patient archive records. Highlight (click once on) the patient record to which the scan will be attached.

You can also highlight an individual element, although either way, the attachment will be added to the record in general and not to the individual element. Then click on "Attach File/Scan Image."

To attach a PDF file: select the "Attach PDF" option. Browse for your file and select it. Enter a description for the attachment, and click OK. It will then display as a new Detail Type as "User Imported," and your description will display under the "Detail Name" column.

To scan in an image: Select the "Attach Image/Scan" option after clicking on "Attach File/Scan Image." Select "Scanner" in the upper left hand corner of the pop-up window. Select "Acquire Pages."

Three selections under the "Simple Mode" tab on the right hand side of the screen will appear. The first gives the ability to select what the document should be scanned as. The next set of options lets you control the output type and size, along with the ability to adjust the cropping frame and make a few image corrections. When you are ready, click "Scan" and this will begin scanning the document.
After the scan is complete, the program will show the image that was scanned. Click "OK." It will then prompt for a description to be entered. Once entered, select "OK."

Once attached, a message stating "Attachment Saved" will appear. Select "OK."

To view the scanned image, expand the patient record that file was saved under. Under "Detail Type" there will be an entry titled "User Imported," with your description as the name. Select the magnifying glass on the far left side to view the document.

For more information on the Archive screen, please see the in-program ExitCare User Manual *(**Help/Options | Help**), or our video on the Archive screen.*

Sidebar Menu

Most program control and function buttons appear in the sidebar menu on the left of the screen. There are five button groups: General, Macros, ExitMeds, History, and Help/Options. Most of the features in the General group have been previously discussed. Logout will log out a user but keep ExitCare running; Shutdown will close down the program completely. The Macros group is discussed in the next section.

The ExitMeds group has three options:

- Create Prescription which brings you to the New Script tab under the main Drugs tab
- Refill Script which brings you to the Drug History tab under the main Drugs tab
- Print Drug Sheet which allows you to select drug information sheets for immediate printing. *Note that the Print Drug Sheet feature on the sidebar prints drug sheets with no connection to a patient's name. Drug sheets printed from the sidebar menu will not be part of the patient's record, nor will there be any archive record created. This feature can be useful if, for instance, a patient's relative requests a drug information sheet for himself or herself.*

The History group provides access to the Patient Lookup tab and the Patient Archive screen. Please see their sections above.

Functions in the Help/Options group:

- The Options menu. Many features are available to users who have a login ID and password.
- If users are given the rights to change their own passwords, Change Password will be active

- Help launches the in-program *ExitCare User Manual*
- About provides basic "About" software information
- Your ExitCare Administrator will most likely use Check for Updates. In addition, a notice may display at the bottom of the screen when an update is available (whether it displays or not is determined by your ExitCare Administrator. If your ExitCare Administrator does not use ExitCare on a daily basis, and you see the update notice and you do not have permission to update, please notify your Administrator so that he or she can perform the update.

Macros: Using

The Macro system is a powerful tool that provides you with the ability to use "sets" of information, which could include educational documents, prescriptions, excuse forms, languages, and any special notes. ***Macros can greatly reduce the time it takes to generate a set of documents and prescriptions.***

1. After entering patient information and selecting any documents on the Choose Title(s) screen, click on **Load** within the Macros group on the sidebar. A list of all macros available to the logged-in user will be presented. *Information about the contents of the highlighted macro will display in the Highlighted Macro Information box in the upper right of the screen.*

2. Select the macro by either double-clicking on the name of the macro, or by checking the box next to the macro and clicking **Done.**

After loading the macro, you can change answers in fields on the Questions tabs; add or remove documents, drugs, or drug information sheets; edit drug fields, and so on. If the Save button is not clicked, the macro will not be changed for the next user.

Macros: Creating

1. Select a diagnosis from the Patient Diagnosis dropdown list.

2. On the sidebar, click **Choose Titles**.

3. Select the documents for your macro set; then click **Done**.

The tabs for the patient education documents are listed in alphabetical order under the yellow information bar. The documents will print in order from left to right. You can rearrange the print order by clicking, dragging, and dropping document tabs on other document tabs to set the print order of your choosing.

4. Add any additional notes in the Additional Notes field, and answer any questions presented under Custom Document Questions. *Additional Caregiver information is not saved in the macro.*

5. Add necessary drugs and drug information sheets. You will need to enter a patient first and last name on the Current Patient screen before going to the Drugs tab. However, patient information (and doctor information) is not saved in the macro. In a macro, drugs can be saved with a status of either New or This Visit (In Hospital).

6. If needed, click **Add Excuse Form** in the sidebar. Fill in any additional notes, and complete the information under Custom Document Questions. O*n forms like Work or School Excuse forms, if two days from today is selected for the return to work date, for example, then whenever this macro is used in the future, it will add two*

days to the current date at that time. Also note that any forms selected (such as the Excuse Form) are not included in setting the document print order and will print separately.

7. Click on **Language/Size** to customize as required.

8. When all customization is complete, click on **Save** under the Macros group. Enter a name for the macro, and make your selections for facility, department, or current user.

9. Click the **OK** button to save the macro. Click **OK** on the information dialog box.
Your macro will preserve the document order each time it is used. If needed, you can rearrange the document order in two places: under the Documents tab by clicking and dragging the document tabs on top of each other; and on the General Print Settings screen under the Document Name group by clicking and dragging the document names.

Macros: Modifying

You can update existing information in a macro, or create a new macro by editing an existing macro.

A. To edit and overwrite an existing macro (*edits made will appear each time the new macro is selected)***:**

1. Click **Load** in the Macros group in the sidebar menu.

2. Locate the macro name on the list. Load it to the main screen by double-clicking the display line or by placing a check mark in the box next to the macro name and clicking the **Done** button.

3. Make modifications to the documents or prescriptions contained in the macro. *Examples include removing or adding documents to the set, modifying answers to custom document questions, removing or adding additional notes, and modifying or adding prescriptions to the document set.*

4. Click on **Save** within the Macros group, then **OK**.

B. To create a new macro by modifying an existing macro: *This will create a second version of a macro with different preferences shown (e.g., two macros for the same diagnosis with one for a patient that smokes and one for a non-smoking patient; or two macros for the same diagnosis with one in English and a matching set in Spanish).*

1. Click **Load** in the Macros group in the sidebar menu.

2. Locate the macro name on the list. Load it to the main screen by double-clicking the display line or by placing a check mark in the box next to the macro name and clicking the **Done** button.

3. Make your modifications to the documents or prescriptions contained in the macro.

4. Click the **Save As** icon within the Macros group in the sidebar menu.

5. In the Select Datalevel pop up window, enter the title for the macro.

6. Make your selections for facility, department, or current user. Click **OK,** then **OK** on the information dialog box.

7. The new macro can be verified by clicking on **Load** in the Macros group in sidebar menu.

Macros: Deactivating and Reactivating

ExitCare provides a way to remove unwanted macros from the Macro list.

A. Deactivating a Macro

1. In the sidebar menu, click the **Help/Options** group header, then **Options**.

2. Click **Document System**, then **Macros**.

3. Working on the Active Items tab, place a check mark next to the macro to be deactivated. To choose the entire macro library, click the **Select All** button.

4. Click the **Deactivate** button.

5. Make your selections for facility, department, or current user.

6. Click **Yes**, then **OK**.

The deactivated macro is now stored on the Deactivated Items tab and can be reactivated at any time in the future if needed.

B. Reactivating a Macro

1. Click **Help/Options**, then **Options.**

2. Click on **Document System**, then **Macros.**

3. Click the **Deactivated Items** tab. Place a check mark next to the macro to be reactivated. To reactivate all deactivated macros, click the **Select All** button.

4. Click the **Reactivate** button.

5. Click **Yes**, then **OK.**

The reactivated macro will now display on the Active Items tab and in the "front end" of the program when Load is clicked under the Macros group.

Additional Note Phrases

Routinely used additional note phrases can be saved to the ExitCare additional note library. This will allow for quick selection of notes that can be added to the bottom of most patient education documents. Use this tool to save time and eliminate the need for manual entry of common note phrases.

1. In the sidebar menu, click **Help/Options**, then **Options**.

2. Click **Document System**, then **Additional Note Phrases**.

3. Click the **Add** button.
4. At the top of the page, enter a title or description for the new note. If it's short enough (50 characters or less), you could even enter the note itself.

5. Type in your note in the large field below. *Note the word processing capabilities indicated by the drop down lists and the buttons at the top of the note field.*

6. You have the option of adding the note to every document by checking the **Add to every document** box.

7. Click **Save.**

8. Select the facility and department to which this note is relevant, or if it is for the current user only. Click **OK**.

Additional Information:

- You can also add notes by first clicking on the **Lookup Notes** button in the Questions tab screen of a document. Next, click the **Edit Notes** button.
- Additional notes or phrases created and saved by either method will be available by clicking on the **Lookup Notes** button in the Additional Notes section under the Questions tab for a selected document.
- For those sites with multiple language needs, consider a numbering scheme for your notes. For example, note number 101E is the note in English, 101S is the identical note in Spanish, and 101P is the identical note in Portuguese. This type of numbering system allows you add notes or phrases to the bottom of documents and only have them translated once. Since the foreign language characters are not available on this screen, it is best to create the translated phrases in a word processing program, and then copy and paste the text into the Additional Note Phrase creation window.
- Once you have created an Additional Note Phrase you can preview it, deactivate it, or, by clicking on **Edit Highlighted**, you can return to the edit screen to modify it. Once notes are deactivated, they can be reactivated by clicking on the Deactivated Items tab, checking the box of the note to be reactivated, and clicking on **Reactivate**.

Drug Favorites (Personalized Drug List)

A logged-in user can make a personalized, Favorites drug list that will appear above the ALL DRUGS list on the New Script tab. When using the Search box, ExitCare will search through both lists.

1. On the New Script screen, enter or select the appropriate items in the Drug Information section; please see Section E, steps 1 through 5, with the exception of step 2b.

2. In the lower right, click the **Save to Defaults** button.
3. You will now see one or more dropdown arrows in place of the Drug Information section. To the right of the drug you are working on, click the dropdown arrow under the Default Level column.

4. Select **Favorite** from the dropdown list.

5. Click the **Save** button in the bottom right of the screen. The item will now display in the Favorites list.

*To delete a Favorite drug, highlight it, and click **Delete Selected Favorite**.*

Drug Defaults

You can save custom-created drug information sets (drug defaults) by following these steps.

1. On the New Script screen, enter or select the appropriate data in the Drug Information section; please see Section E, steps 1 through 5, with the exception of step 2b.

2. In the lower right, click the **Save to Defaults** button.

3. You will now see one or more dropdown arrows in place of the Drug Information section. To the right of the drug you are working on, click the dropdown arrow under the Default Level column. *To create drug defaults associated with documents, please see the section on* Drug Defaults for Specific Documents *in this manual.*

4. Select the **Default Level** (Global, Facility, Global Department, Department, or User) from the drop down list.

5. Click the **Save** button in the bottom right of the screen. The default will now display in the within the ALL DRUGS list.

Additional Information:

- Defaults can be set up for common OTC medications that are routinely prescribed for patients. When doing so, to be able to print scripts, the radio button in the Drug Information section must be set to RX before saving the default.
- To deactivate a default, right-click on it, and make the appropriate choice on the pop-up list.

Drug Defaults for Specific Documents (Document-Level Drug Defaults)

A drug default can be associated with a patient education document. When that document is later selected, the drug can be chosen while on the document's Questions screen.

1. Select documents from the Choose Titles screen or by clicking **Load** under the Macros group.

2. Click on the **Drugs** tab; then click on the **New Script** tab.

3. Enter or select the appropriate data in the Drug Information section; please see Section E, steps 1 through 5, with the exception of step 2b.

4. Click the **Save to Defaults** button (lower right of screen); the drug name and document titles will display at the top of the default window.

5. Click the dropdown arrow to the right of the title to which you wish to connect the drug, and select the **Default Level** (Global, Facility, Global Department, Department, or User) from the list.

6. Click **Save**. The drug will now be available as a default associated with the selected title.

Additional Information:

- To verify that the new drug default is associated with the document, click on the **Documents** tab, the **tab** of the relevant document, and then on the **Add Default RX** button. The Default Scripts window will open and display the added drug default.

- To add the script to the patient record, click in the checkmark box to select the drug. Click the **OK** button. The drug is now added to the medication list that can be viewed on the Drug Summary tab.

Logged In User Settings

Users with their own user ID and password can set: a default category for the Choose Titles screen; a default language in which documents are printed; a starting screen; and, a default search type.

1. Click **Help/Options** in the sidebar; then click **Options**.

2. Click **Logged in User Settings**, then **User Settings**.

3. In the first drop down list, a default category for the Choose Title(s) screen can be chosen; its titles will be shown when the Document by Category screen is displayed. All other categories will display and are selectable on the Choose Title(s) screen, as well. If no choice is made on the User Settings screen, ExitCare defaults to the All Documents category.

4. In the second drop down list, a default print language can be selected. Other languages (if licensed) will also be available and selectable on the Language/Size screen. If no choice is made, ExitCare defaults to English.

5. The third setting allows users to choose which screen displays when the program starts and when the New Patient icon is selected.

6. Under Default Search Type, two choices are provided: Begins with and Contains, the latter providing for a broader search. The choices affect all search boxes that contain these two settings as options.

7. Click the **Save** button.

8. Click the **Exit Option System** button.

Additional Features

Click on **Help/Options | Options** and explore the various features available there. For additional information, please see the ExitCare document titled *Features with Built-In User-Only Rights* and the *Super User Manual.*

Credits