

Recertification may be necessary to provide further attestation that the patient is still eligible for home health services.

## Recertification Visit

On a Recertification Visit, several tiles on the charting page indicate required. While not all tiles require documentation, it may require you to review and edit as necessary.

### ➤ Getting Started

**STEP 1:** Log into Netsmart Homecare.

**STEP 2:** Locate the patient on the **Today** screen and tap the **Patient's name** or **Visit Type**.

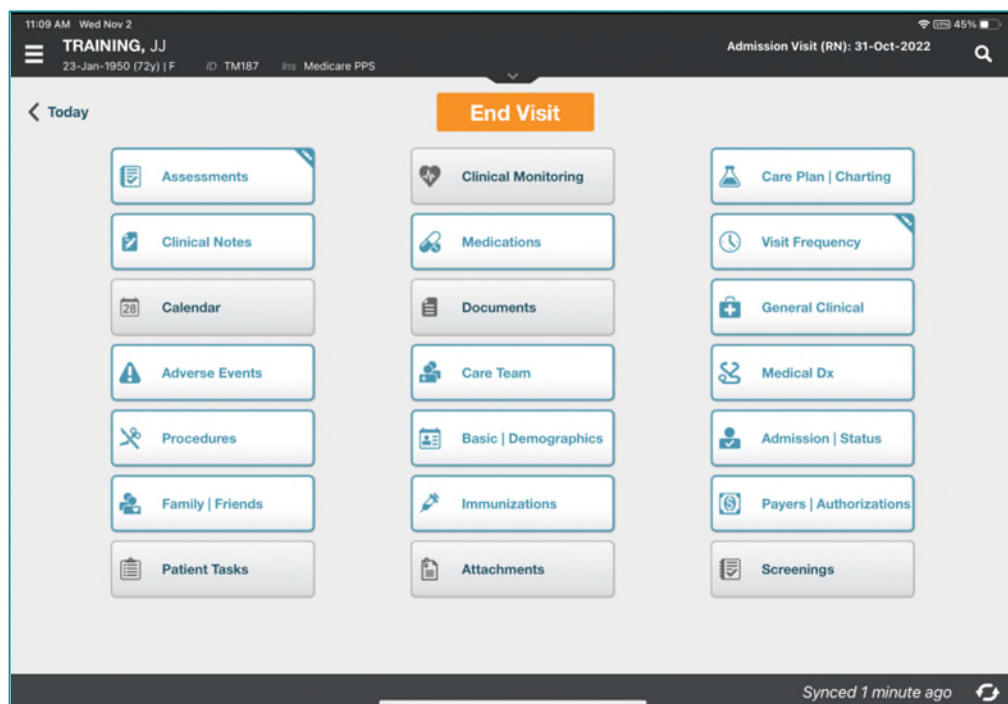
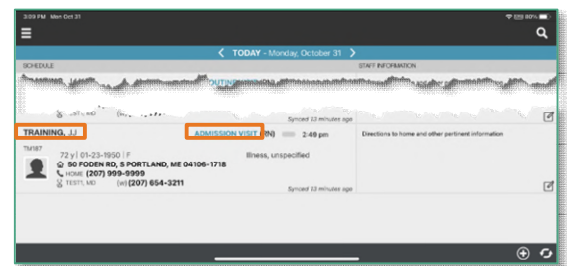
**STEP 3:** Tap **Sync** in the bottom right-hand corner.

**STEP 4:** From the charting page, tap **Start Visit**.

- This logs the current time as the start time for the visit type in the **Time Entry** screen.

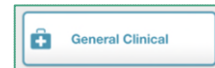
**STEP 5:** The highlighted tiles display, indicating required documentation.

- Some tiles may display highlighted, this is to assist users who are still using the laptop for documentation.
- As a reminder, the intake assessment can be viewed prior to starting the visit by selecting **Attachments** prior to selecting start visit.



➤ **Visit Documentation**

**STEP 1:** Tap **General Clinical**.



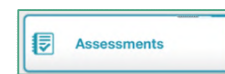
- The navigator displays on the left. Tap the applicable item to review, update, and add as applicable.
- Select the < **back arrow** to save the information and return to the charting page.

**STEP 2:** Tap **Medications**.



- Toggle between active and discontinued medications to display in the navigator.
- Adding medications:
  - If pending medications display, tap **Pending Medications** and swipe left to include or exclude. Continue until all medications are added and update the details for the medications, as applicable. Activate any medications that have been discontinued.
  - Tap **+** **Add** to add any additional medications.
    - Toggle between **Medications** and **Kits**.
    - Start typing the medication name in the search box, scroll and select the appropriate medications. Continue until all medications are entered and select **Next**.
    - Enter the details for all medications and select **Done**.
- Tap the three dots and select **Drug-Drug** to run the Drug/Drug interactions.
- Select the < **back arrow** to save the medications and return to the charting page.

**STEP 3:** Tap **Assessment**.



- The assessments completed for the patient display on the left.
  - Tap **+** **Add**.
    - Select the **Template** and **Visit Type**.
  - Complete the required fields in the assessment as indicated by the orange outlines.
    - To activate a section, tap the three dots in the lower right while in the assessment and select **Show Details**.
    - Tap the applicable dithered section in the navigator to the left and tap the three dots and select **Activate**.
    - Indicate if this is for this assessment only or all future assessments.
      - If necessary, activate additional dithered sections as necessary.
  - Tap the three dots in the lower right-hand corner to view the predictive modeling for the patient, show the HIPPS scores, and to manually validate the assessment, if needed.
  - Select the < **back arrow** to save the status and return to the charting page.
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**STEP 4:** Tap **Care Plan/Charting**.

- Navigate between care plan editing and compact charting, along with the active and discontinued care plans, as necessary.
  - Active Care plans display on the left. If there are active care plans, discontinue them.
- Tap **Add** to add a Recertification Care Plan.
  - You must be on Care Plan editing for add to display.
- Complete the required care plan charting as indicated by the orange outlines.
- Tap the < **back arrow** to save the care plans and return to the charting page.



**STEP 5:** Tap **Visit Frequency**.

- Active visit frequencies display in the navigator to the left.
- Tap + **Add**.
- **Verbal Start of Care (VSOC)** is located at the top, enter the **date** and **sign**.
  - **Lupa Threshold** will display under the VSOC.
- Complete the fields applicable for the discipline, entering the high and low number of visits.
  - The certification period displays at the top of the navigator.
  - Check **Cert/Recert** and **Do Not Create End Order**.
- Enter any PRN visits for the patient.
- Select the < **back arrow** to save the information and return to the charting page.



**STEP 6:** Tap **Care Team**.

- The disciplines display on the left in the navigator.
- Locate your discipline and ensure that your name is the **Admitting Clinician** and for your discipline if you will continue to see the patient.
- Enter code status, infections, alerts, precautions, and other known information.
  - Use capital letters, such as VAX, to search easily.
- Select the < **back arrow** to save the information and return to the charting page.



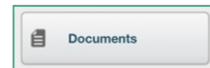
**STEP 7:** Tap **Clinical Note**.

- The clinical notes completed for the patient display on the left.
  - Navigate between **Active** and **All** clinical notes as necessary.
    - Notes with an end date are under **All**, while notes without an end date are under **Active**.
- Tap **Add** to add a new clinical note.
- Utilize the applicable note template and ensure that all required documentation is complete.



- Tap the < **back arrow** to save the information return to the charting page.

**STEP 8:** Tap **Documents**.



- The navigator displays with the different document types.
- Tap **Active Orders**.
  - Confirm the **certification, plan of care** and **all appropriate information** is present.

**STEP 9:** Tap **Calendar**.

- Select **+Add** and tap **Visit** or **Activity**.
  - For a **non-recurring visit**, select the **visit type**.
  - For **recurring visits**, the **number of visits** and **frequency** (days, weeks) also need to be completed.
  - For an **activity**, complete **Resource Type, Date, and Activity**.
    - Do not enter a Start Time or Duration for an activity.
    - Use **Clear** if those fields populate. This keeps the activity on the tablet.
- Select **Done** to add visit (s) to the schedule.

A rectangular button with a light orange background and a thin orange border. The text "End Visit" is written in a bold, dark font.

**STEP 10:** Tap **End Visit**.

- This logs the current time as the end time for the visit type in the **Time Entry** screen.
- If required documentation stills needs to be completed, select the required documentation from **Open Charts** and complete the documentation.