From the Office of Health Informatics

Home Care and Hospice Recertification Visit

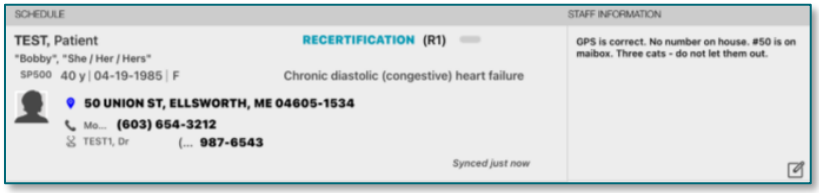
November 12, 2025

Before the new certification period starts, a patient will need a Recertification visit.

Recertification Visit

On a Recertification Visit, several tiles on the charting are highlighted. While not all tiles require documentation, some may require review and edits as necessary.

➢ **Starting and Ending Visit**



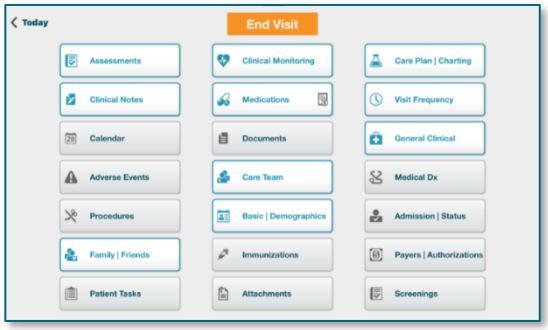
STEP 1: Login to **Netsmart Homecare**.

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 Start time for the visit in the Time Entry screen.

- If **End Visit** is inadvertently tapped, the time can be edited on the **Time Entry s**creen.
- At the end of the visit, tap **End Visit** and obtain a signature. This is done even if the documentation is not completed during the visit.



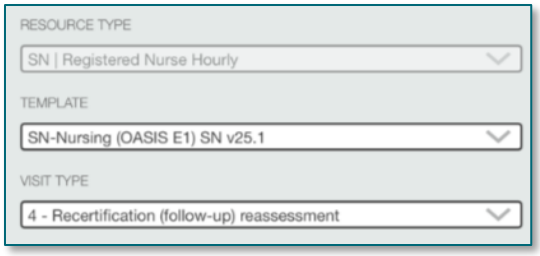
Assessments

The assessments previously completed for the patient display on the left.

➢ **Visit Documentation**

STEP 1: Tap **+ Add**.

STEP 2: The New Assessment template box should auto-populate:



- **Resource Type** – your Discipline
- **Template** – your Discipline (OASIS) or HOPE
- **Visit Type** – 4 Recertification (follow-up) reassessment or Routine Visit **-** for Hospice patients.

STEP 3: Complete the required fields in the assessment as indicated by the orange outlines.

STEP 4: To activate a section:

- Tap the three dots in the lower right in the assessment and select **Show Details.**
- Tap the applicable section on the left then tap the three dots. Select **Activate**.
- Indicate if this is for this assessment only or all future assessments.
- If necessary, activate additional sections.

STEP 5: Select the **< back arrow** to save the status and return to the charting page.

Clinical Monitoring

If Vital Signs, Measurements or Labs (INR or Pulse Ox) are obtained, document on this screen using the **+** at the lower right to add.

- To review additional education on Clinical Monitoring, please click here.

Care Plan Editing and Charting

➢ **Care Plan Editing**

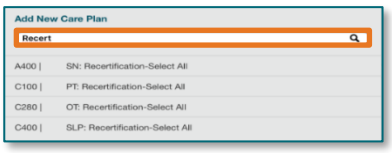
STEP 1: Default screen is **Compact Charting**. Navigate to **Care Plan Editing** tab at end of screen to add or discontinue Care Plans.

STEP 2: In the Search box, enter a word in the title of a Care Plan to open the Care Plan.

STEP 3: Tap the **+** to the far right of **Goals** and of **Interventions** to view list to add.

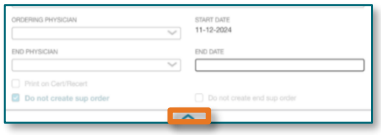
STEP 4: For a Recert, enter **recert** in Search box to choose Care Plan for your discipline.

- The Interventions are a list of reminders for actions needed when documenting a Recertification. Select them to document you have completed the step.

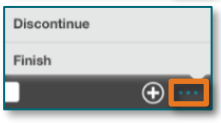


STEP 5: Add other Care Plans for ongoing patient care.

STEP 6: Add an End Date by tapping the **arrow** at the bottom of box for Goals/Interventions no longer part of patient's care.



STEP 7: Discontinue an entire Care Plan - tap **3 dots** at lower right then **Discontinue.**



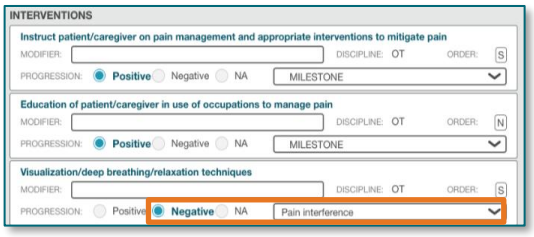
➢ **Care Plan Charting**

STEP 1: Tap **Compact Charting** tab at end of screen to document.

STEP 2: Tap each **Care Plan** in left column to open care plan charting.

STEP 3: Complete the required care plan charting as indicated by the orange outlines.

- Answering P**ositive** or **NR/NA** does not require selecting a Modifier. It is required to select a Modifier when answering **Negative**.



STEP 4: If a modifier needs to be edited

- Add an End Date to the current Goal or Intervention.
- Add a new Goal or Intervention with the new modifier.

STEP 5: Tap the **< back arrow** to return to the charting page.

Clinical Note

Clinical notes previously completed for the patient display on the left. Notes with an end date are only visible under **All** tab at lower left.

STEP 1: Tap **+** to add a new clinical note.

STEP 2: **Use Code** is I.

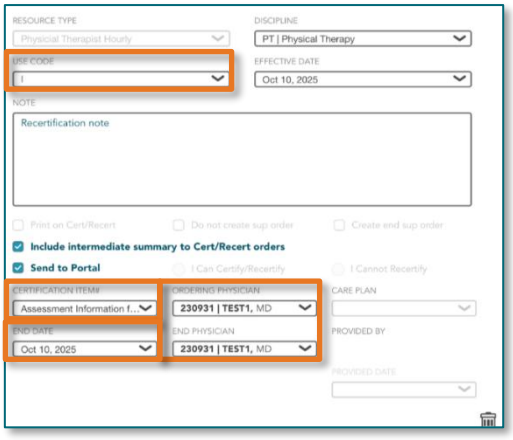
STEP 3: Use the applicable note template and ensure that all required documentation is complete.

STEP 4: Tap Include intermediate summary to Cert/Recert orders and Send to Portal.

STEP 5: **Certification Item#,** select **Assessment Information for Physician Review**.

STEP 6: Add **Ordering Physician** and **End Physician**.

STEP 7: Change the **End Date** to the first day of the new cert period.



STEP 8: Tap the **< back arrow** to save the information and return to the charting page.

Medications

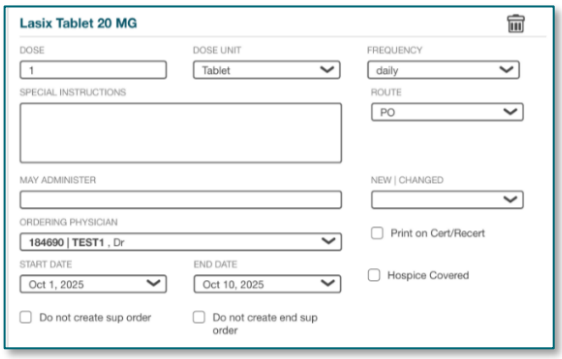
➢ **Adding medications:**

STEP 1: Tap **+ Add** to add new medications.

STEP 2: Start typing the medication name in the search box, scroll and select the appropriate medication. If the medication is tapered, tap **Titrate Medication** to add steps.

STEP 3: Continue until all new medications have been entered then select **Next**.

STEP 4: Enter the details for each medication:



- Dose
- Dose Unit
- Frequency
- Route
- Start Date (today's date)
- Ordering Physician
- Optional – Special Instructions – free text box for additional information

STEP 5: Tap **Print on Cert/recert box** and **Hospice Covered** (if applicable),

STEP 6: Tap **Done**.

STEP 7: From the tile page, **sync** the chart.

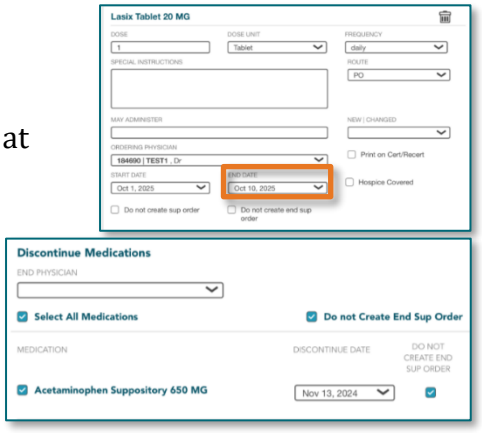
STEP 8: Tap **Medications** tile again.

STEP 9: After adding and synching a medication, tap the 3 dots at lower right then tap **Drug-Drug** to check Interactions.

➢ **Ending Medications**

STEP 1: To end a medication patient is no longer taking, add an End Date.

STEP 2: To end multiple or all medications, tap the three dots menu at the lower right then tap **Discontinue**.



- Tap **Select All Medications.** If a medication should not be discontinued, tap the box next to it to remove the checkmark.
- Add the **End Physician**.
- Tap **Do not Create End Sup Order** box.

Visit Frequency

STEP 1: Tap the current certification period at the top left of the screen.

STEP 2: Tap the **Future certification period** to open.

STEP 3: Tap **+ Add**.

STEP 4: **Verbal Start of Care (VSOC)** is located at top, enter the **date** and tap **sign** button.

STEP 5: Complete the required fields:

- Discipline
- Visits – add High (and low for a range) number
- Physician ID
- Duration
- The **For** field based on the Duration

STEP 6: Tap Cert/Recert and Do not create end sup order boxes.

STEP 7: Tap **PRN** at the lower left to enter PRN Visit Frequencies.

- Enter **Discipline**, **Value**, **Physician ID,** and **Reason(s)** for visits.
- Tap **Cert/Recert** box.

STEP 8: Select the **< back arrow** to save the information then sync the chart.

General Clinical

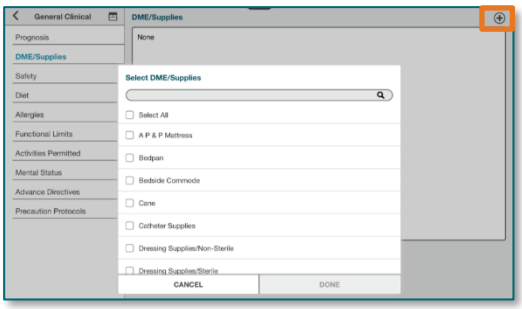
Screen names display on the left. Every screen must contain information.

STEP 1: Tap each screen to review information.

- Update and add information as applicable.

STEP 2: Use the **+** at the top left of screen to add from list. If not on list, free text the information.

STEP 3: Select the **< back arrow** to save the information and return to the charting page.



Care Team

The Care Team types display on the left.

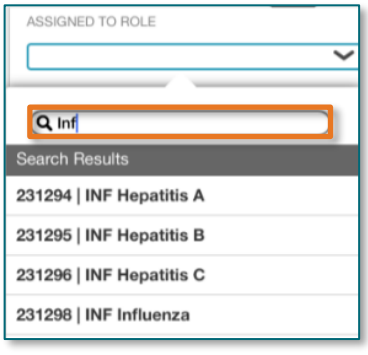
STEP 1: Tap your discipline to add your name if you will continue to see the patient**.**

STEP 2: Tap **+** to add your name.

STEP 3: If another clinician's name is there, add an End date of yesterday on the line with their name. Then add your name with a Start date of today.

STEP 4: If field is blank, enter **Code Status**. If new information discovered, enter (INFections, ALERTs, PREcautions, and other known information).

STEP 5: If the name of the Care Team type starts with capital letters, enter those then tap Enter to view all options.



STEP 6: Select the **< back arrow** to save the information and return to the charting page.

Basic/Demographics

➢ **Basic**

STEP 1: Review information on screen for accuracy and completeness.

STEP 2: Add Preferred Name and/or Preferred Pronoun if provided.

STEP 3: Review the Notes text box for further insurance information.

STEP 4: Tap Addresses on the left.

- Confirm place of service is correct then verify Active, Service Location and Default boxes are checked off.

STEP 5: Add or edit pertinent information in Staff Information box which will display on the Today screen for all clinicians to review.

➢ **Demographics**

STEP 1: Tap Demographics

STEP 2: Add information to any fields that are blank.

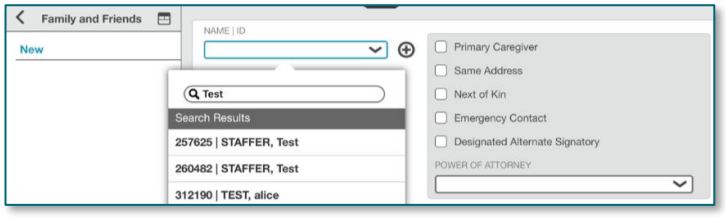
STEP 3: Edit any fields with incorrect information.

STEP 4: Select the < back arrow to save the information and return to the charting page.

Family/Friends

Review current information.

➢ **Add a Family/Friend from database**



STEP 1: Tap **+** at lower right.

STEP 2: Tap the dropdown in **Name/ID** box to search for person in the existing database.

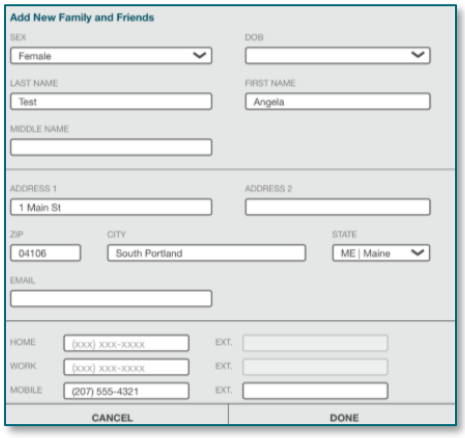
STEP 3: Add **Relationship to patient**.

STEP 4: Use boxes on right to designate roles. If someone besides patient may sign at the end of the visit, choose **Designated Alternate Signatory**.

➢ **Adding a new Family/Friend – after searching in database.**

STEP 1: If new person is not found in database, add a new resource by tapping **+** next to Name/ID box.

STEP 2: Add required information. If information unavailable, enter **unknown**.



- Sex
- Last Name
- First Name
- Address
- Zip – add 00000 if unknown
- City
- State
- Phone number – must enter area code.

STEP 3: Add Relationship to patient.

STEP 4: Use boxes on right to designate roles. If someone besides patient may sign at the end of the visit, choose **Designated Alternate Signatory**.

➢ **Updating or Deleting Family/Friend**

- To delete or update a family/friend, contact someone in the office as this cannot be done on the iPad.
- To update information for a family/friend, contact someone in the office as this cannot be done on the iPad.

Calendar

➢ **Add one visit**

STEP 1: Tap **+** at lower right. If adding on your Calendar, tap **Visit**.

STEP 2: Resource – tap dropdown to change if necessary.

STEP 3: Resource **Type** – if not auto populated, tap dropdown to search. If more than one listed, always choose the last one.

STEP 4: Visit **Type** – add using dropdown.

STEP 5: **Notes** – free text information to be added to each visit.

STEP 6: Tap Done.

➢ **Add multiple visits**

STEP 1: Tap **+** at lower right. If adding on your Calendar, tap **Visit**.

STEP 2: Tap **Recurring** button.

STEP 3: Resource – change to appropriate clinician if necessary.

STEP 4: Edit **Start date**, if necessary, as default it today.

STEP 5: Recurrence – add number and Day or Week.

STEP 6: Service **Day** – choose which days to add the visits to the Calendar. Add a 1 hr **Duration**.

STEP 7: **Every –** how often (i.e., 1 x a week would be every week).

STEP 8: **For –** how long (i.e., 4 weeks).

STEP 9: Add **Resource Type** if not auto populated.

STEP 10: Add appropriate Visit Type.

STEP 11: Add a Schedule **Note** (optional) – scroll down to end of box.

STEP 12: Tap **Done**.