From the Office of Health Informatics

Netsmart Home Care and Hospice
Resumption of Care

April 27, 2026

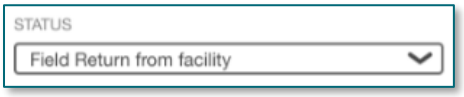
A Resumption of Care (ROC) is required when a patient is admitted to a hospital or facility for more than 24 hours then returns home during the current certification period.

Visit Documentation

➢ **Admission / Status**

STEP 1: Update the **Patient Status** to Field Return from facility.

STEP 2: **Status Date** will default to today so change if ROC was not today.



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

STEP 4: **Sync** the chart to update the new status.

➢ **Assessment**

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

STEP 1: Tap **+ Add**.

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

- **Resource Type** – Discipline
- **Template** – Discipline (OASIS)
- **Visit Type** – 3 Resumption of Care (after inpatient stay) or **Routine Visit**.

STEP 3: Complete the required fields 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** in the top left to save 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 **+** in the lower right to add.

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

Care Plan Editing and Charting

➢ Care Plan Editing

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

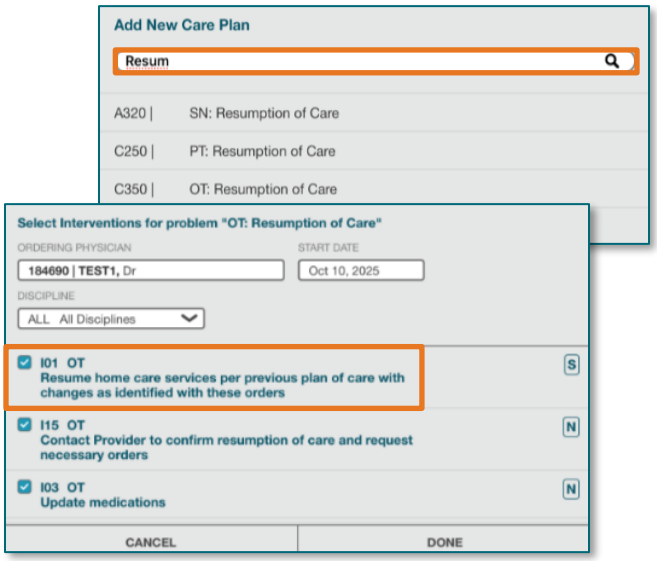
STEP 1: In the Search box, enter a word in the title of a Care Plan to open the Care Plan.

STEP 2: Tap the **+** to the far right of **Goals** and of **Interventions** to view list to add.

STEP 3: For a ROC, enter **resum** in Search box to choose Care Plan for your discipline.

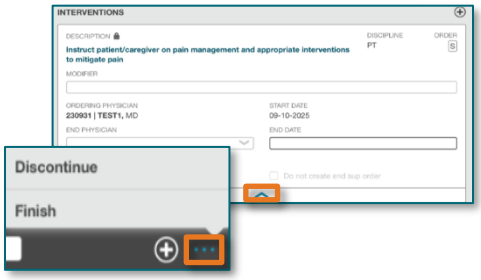
STEP 4: Select the Intervention starting with, **Resume home care services** to send the order to the Provider for signature.

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



STEP 5: Discontinue Goals/Interventions no longer part of patient's care.

- Add an End Date (tap the **arrow** at the bottom of the box).
- Add End dates to an entire Care Plan by tapping **three dots** at lower right then tapping **Discontinue.**



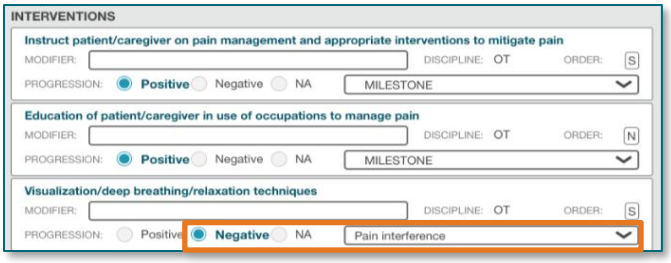
➢ Care Plan Charting

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

STEP 2: Tap each **Care Plan** 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**.

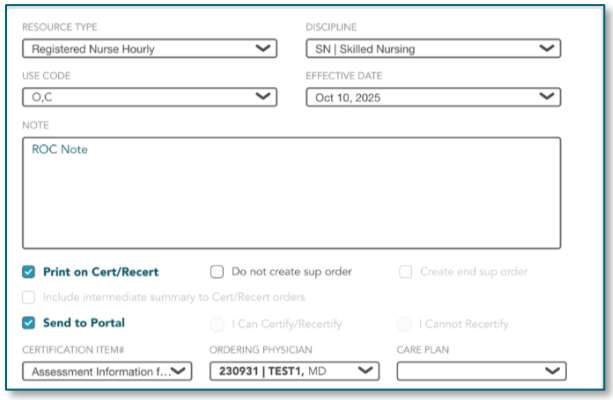


- If a modifier needs to be edited, add an End Date to the current Goal or Intervention then add a new Goal or Intervention with the new modifier.

STEP 4: Tap the **< back arrow** to return to the charting page.

Clinical Note

The clinical notes previously completed for the patient display on the left. Navigate between **Active** and **All** (includes notes with an End date) as necessary.



STEP 1: Tap **+** to add a new Clinical Note.

STEP 2: Enter the Use Code of **O & C**.

STEP 3: Edit date if visit was not today.

STEP 4: Add Note using template.

STEP 5: Tap **Send to Portal**.

STEP 6: Certification Item - Assessment Information for Physician Review (at the end of the list).

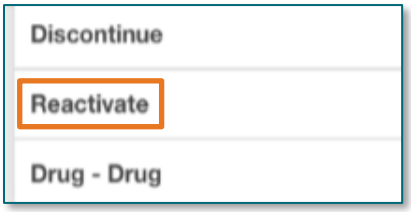
STEP 7: Add **Ordering Physician**.

STEP 8: Change **End date** to date of visit.

STEP 9: Tap the **< back arrow** to save the information return to the charting page.

Medications

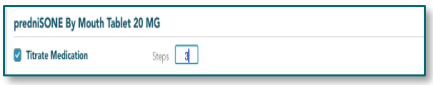
- **Adding medications**



STEP 1: For a ROC, tap the three dots in the lower right then tap **Reactivate** if it is in black font.

- This allows adding the medications discontinued when the patient was transferred back into the chart.

STEP 2: Tap **+ Add** to add new medications.



STEP 3: Enter a word in 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 4: Continue until all new medications have been entered then select **Next**.

STEP 5: 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

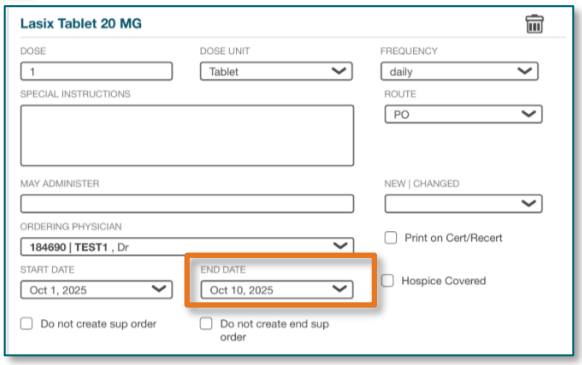
STEP 6: Tap **Done**.

STEP 7: Tap the arrow in the top left next to **Medications**.

STEP 8: From the tile page, **sync** the chart.

STEP 9: Tap **Medications** tile again.

STEP 10: Tap the three dots in lower right then tap **Drug-Drug** to check Interactions. This is required any time a new medication is added.

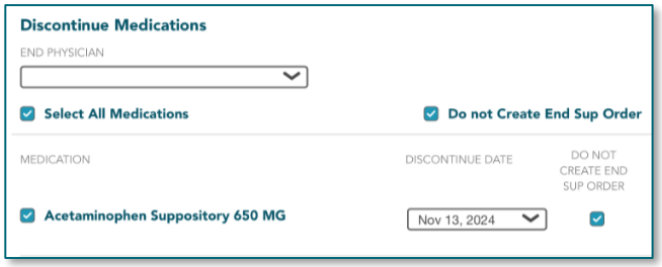


➢ **Ending Medications**

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

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

STEP 3: Tap **Select All Medications.** If a medication should not be discontinued, tap the box next to it to remove the checkmark.



STEP 4: Add the **End Physician**.

STEP 5: Tap **Do not Create End Sup Order** box.

Visit Frequency

Active visit frequencies display on the left with the current certification period at the top.

STEP 1: Edit the end date of the current Visit Frequency to date of visit if applicable. Enter **ROC** in **Change Reason** box.

STEP 2: Tap **+** to add new visit frequency.

STEP 3: 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 4: Tap **Do not create end sup order** box.

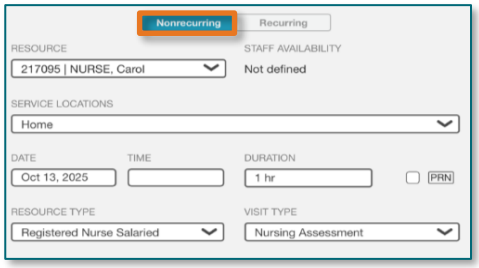
STEP 5: Tap **PRN** in the lower left to enter PRN Visit Frequencies.

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

STEP 6: Tap the **< back arrow** to save the information, enter your password to accept the changes and return to the charting page.

Calendar

STEP 1: Select **+Add**. If adding to Calendar, then tap **Visit**.



STEP 2: Adding a **non-recurring visit**:

- Edit **Resource** if assigning to another clinician.
- Date will default to today, tap on date to use calendar to choose date.
- Tap **PRN** box if applicable.
- Add **Resource Type** if box is blank. If multiple Resource Types are listed, always choose the last one on list.
- Add **Visit Type**.
- Swipe up to add information to the Schedule **Notes** box. This information is viewed on the Today screen by tapping **Notes** under Staff Information.

STEP 3: Adding **recurring visits**:

- Tap **Recurring** at top of box. Edit **Resource** to assign to another clinician.
- Date will default to today, tap date to use calendar to choose start date.
- **Recurrence** – add number of visits per Week or Day by editng number.
- Use dropdown to edit frequency in **time(s) a** box.
- Select **Service Day(s)** and add 1 hr **Duration** for each Service Day.
- **Every** – leave as **1** unless frequency is, for example, every other day or week.
- Leave default value of **week(s)** unless frequency is **(days)**.
- Change **for** the number of **week(s)** or **day(s)** the long frequency will last.
- Select **Done** to add visit(s) to the schedule.

Care Team

The Care Team types display on the left.

STEP 1: Tap **+** to the right of your discipline then enter your last name in the Search box if you will continue to see the patient.

- To replace the current clinician with your name, add an End date of yesterday on the line with their name. Then add your name with a Start date of today.

STEP 2: If blank, enter **Code Status**. In the Search filed , enter **CODE** then tap **Enter** to see the options.

STEP 3: If any new information is discovered, enter in the appropriate **Care Team Type**.

- If the name of the Care Team type starts with capital letters, enter those (**INF**ections, **ALERT**s, **PRE**cautions)**,** then tap **Enter** to view all options.

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

For questions regarding process and/or policies, please contact your unit's Clinical Educator. For questions regarding workflow, please place a ticket to Health Informatics. For any other questions please contact the Customer Support Center at: 207-973-7728 or 1-888-827-7728.