

From the Office of Clinical Informatics

Netsmart Home Care and Hospice Secondary Evaluation

May 8, 2023

A Secondary Evaluation is the first visit by each discipline other than the admitting clinician that performed the admission.

Secondary Evaluation

On a Secondary Evaluation, not everything listed may be required. Listed are various windows you might need to touch on a Secondary Evaluation.

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.

Visit Documentation

STEP 1: Tap **Assessment**.

- The assessments completed for the patient display on the left.
- Tap + Add.
 - Select the **Template**, **Visit Type** as needed.
- Complete the required fields in the assessment as indicated by the orange outlines.

STEP 2: Tap **Care Plan/Charting**.

- The care plans for the patient display on the left.
 - Navigate between care plan editing and compact charting, along with the active and discontinued care plans, as necessary. End date any unnecessary care plans
- Tap the applicable **Care Plan** to complete care plan charting.
- Complete the required care plan charting as indicated by the orange outlines
 - If a modifier needs to be edited, end the current goal or intervention with the current date, and add a new goal or intervention with the new modifier.
- Tap the back arrow to return to the charting page.





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STEP 3: 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 notes and notes without an end date are under Active.
- Tap Add to add a new clinical note.
- Complete the required documentation.
 - Enter the Use Code of O and C.
 - Tap Send to Portal.
- Tap the **< back arrow** to save the information return to the charting page.

STEP 4: 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.
 - Tap 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 5: 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.
 - o 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.

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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 End Visit.

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 completed, select the required documentation from **Open Charts** and complete the documentation.