New Hampshire Electronic Visit Verification (EVV)
Provider Survey Summary Report
August 2020

Introduction

The New Hampshire Department of Health and Human Services (DHHS) conducted a survey of Personal Care and Home Health Care (HHC) providers. The purpose of the survey was to seek feedback on proposed EVV design features as well as elicit information from providers who currently operate or are in the process of purchasing and/or implementing an EVV solution. The survey was posted on June 5, 2020 and was available for online completion until July 3, 2020.

General Overview

A total of eighty surveys were initiated. Upon review, it was found that a number of providers submitted more than one survey response. While duplicate surveys from the same provider were removed from the total number of respondents, feedback from duplicate surveys was considered. Likewise, some surveys were incomplete; however, information from partially completed surveys was considered. Forty six provider agency responses are summarized in this report[1].

Summary of Results

Most respondents were either provider agency Executive Directors (46%) or Administrative/Other staff (50%). All counties within the state were represented and all populations subject to EVV were represented. The majority of respondents (73%) indicated they do not currently have an EVV system. Twenty two percent are implementing or currently using a system and 5% are in the process of purchasing a system.

When asked about technology infrastructure, most providers (27%) indicated they have computers with internet access and information technology (IT) support (19%). Fewer (15%) reported using an electronic health record (EHR) and even fewer indicated having tablets with internet access (12%) and mobile internet access (12%). Very few respondents provide cell phones or smart phones and if they do, they

[1] A list of survey respondents can be found in the Appendix.

are generally provided to management level staff, not direct support professionals (DSPs) or HHC workers.

Providers with an EVV system were asked to identify the name of the vendor used by their organization. The following vendors were identified: ClearCare, MITC, ERSP, Home Care Home Base, Brightree, Mobile Care, Riversoft-Elvis, CareWatch, Ankota, and Kantime.

Some providers implemented an EVV system as early as 2013. Most began to electronically verify visits between 2017 and 2019. Implementation timelines ranged from 30 to 270 days (average 103 days); the time from go-live to routine operation ranged from 14 to 180 days (average 77 days). Cost estimates for initial implementation ranged from $1,775 to $300,000 (average $38,707). Ongoing operational costs averaged $24,237.

Most respondents (73%) do not currently have an EVV system. Twenty-two percent are implementing or currently using an EVV system and 4% are purchasing a system. Providers operating an EVV system indicated the minimum visit verification information required under the 21st Century Cures Act is being captured. To address the provision of EVV in rural/urban areas where connectivity of technology infrastructure is limited or non-existent, providers use telephony (30%), manual entry (40%), and other methods (30%) such as mobile applications with an offline mode and tablets that capture real time data and synchronize when back in a coverage area. One provider commented that this has not been an issue. Twenty percent of providers indicated their systems provide accommodations for staff/individuals specific to Limited English Proficiency. None indicated accommodations for individuals with visual, hearing, or physical impairments, but several provided comments indicating they could request modifications to their systems and noted availability of a mobile application for accommodations that has not yet been utilized.

Modes of data collection for providers who currently operate an EVV system include land line telephone-used only with limited connectivity-(19%), fixed in home devices-also used only with limited connectivity-(5%), cell phone (14%), cell phone with GPS (29%), tablet (19%), computer with WiFi (10%), and other unspecified modes (5%).

When asked which modes of data collection are most desirable for inclusion in an EVV system, the top three responses were for tablet-cellular, with WiFi, and/or GPS (52%), cell phone with GPS (43%) and computer WiFi (41%). Several respondents commented that DHHS should consider funding EVV data collection devices.

Respondents commented on data management and security features that are most important to them, including the ability to store encrypted data on a device for uploading later (63%), data encryption when the device is at rest or when data is transmitting (59%), role based security for the various modules with multiple levels of access control (52%), cloud based information storage with data encryption (41%), and provider specific dashboards and other reporting capabilities (36%).

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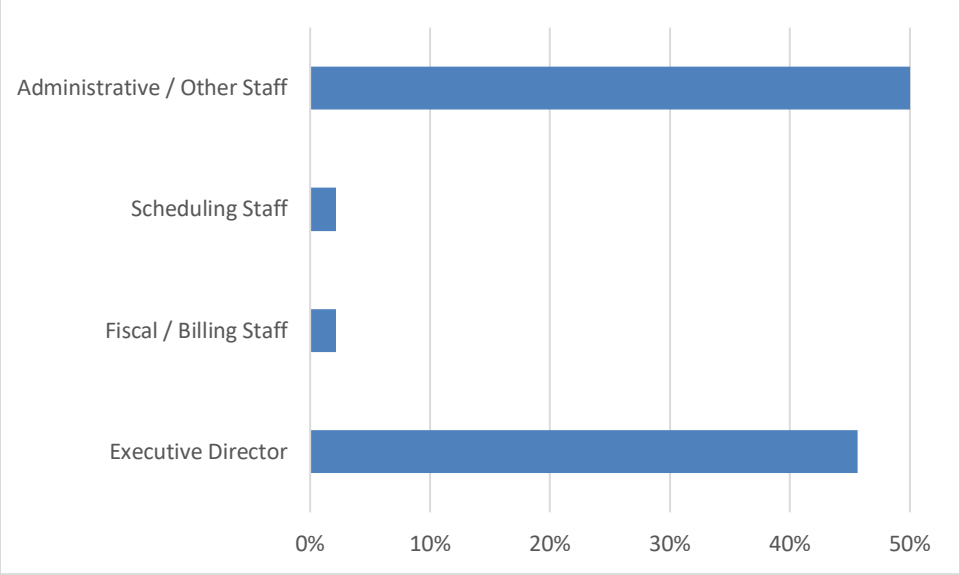
Seventy percent of respondents indicated they support one statewide EVV system for data collection and data aggregation which allows for other systems currently operating to continue to be utilized. Fourteen percent said they do not support this model and 16% indicated “maybe” with regard to their level of support. Eighty four percent expressed support for an “exceptions” process in the system to allow providers to correct errors/mistakes within state prescribed timeframes.

Survey Results

Individual Completing the Survey



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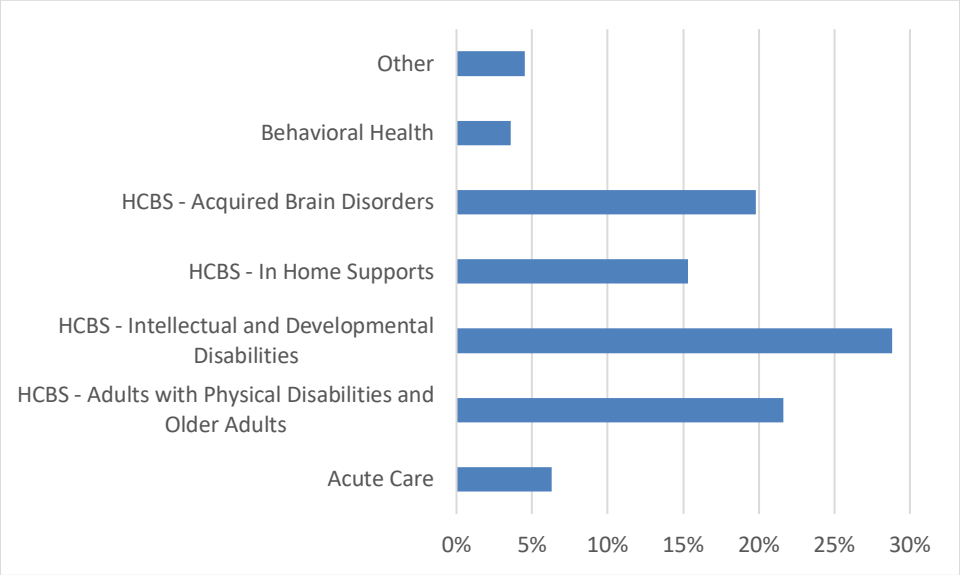
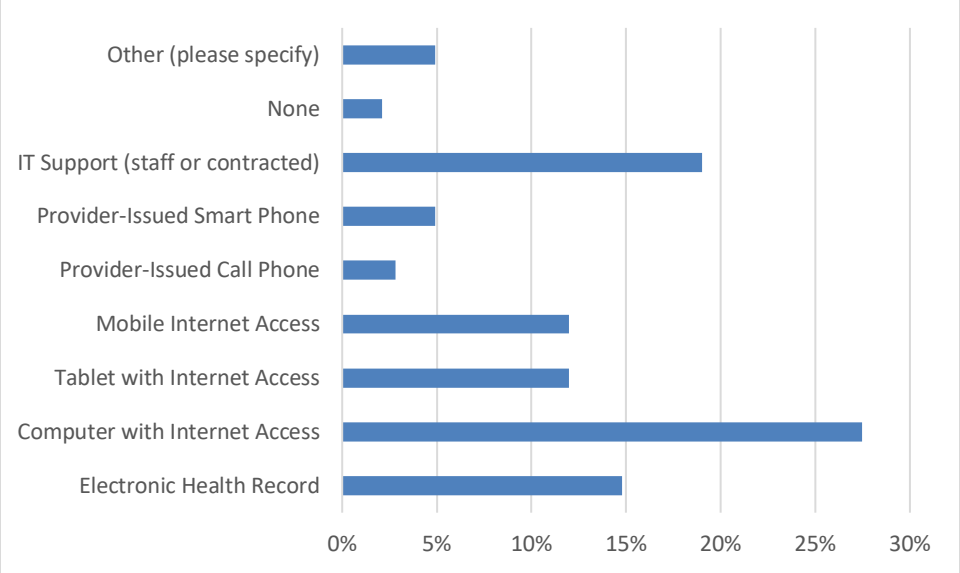
Populations Served by Survey Respondents:



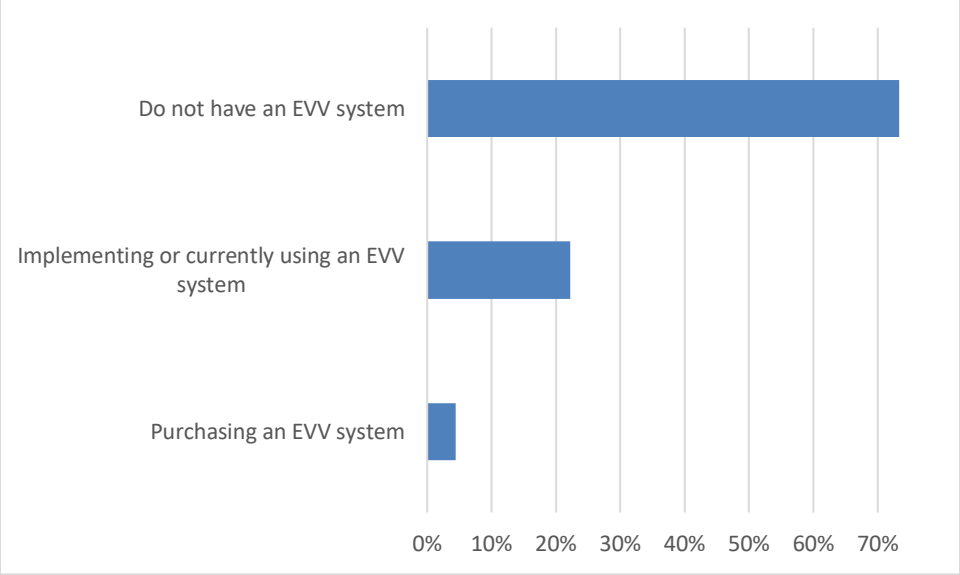
What technology infrastructure does your organization currently use?



Other comments:

Management has a computer and phone. DSPs and HCPs do not.
MITC
Remote Access
VDI environment
use of client phone and app on smart phone
Question is unclear as to whom has this access.
HomeCare software

What is your organization's current status related to use of an EVV system?



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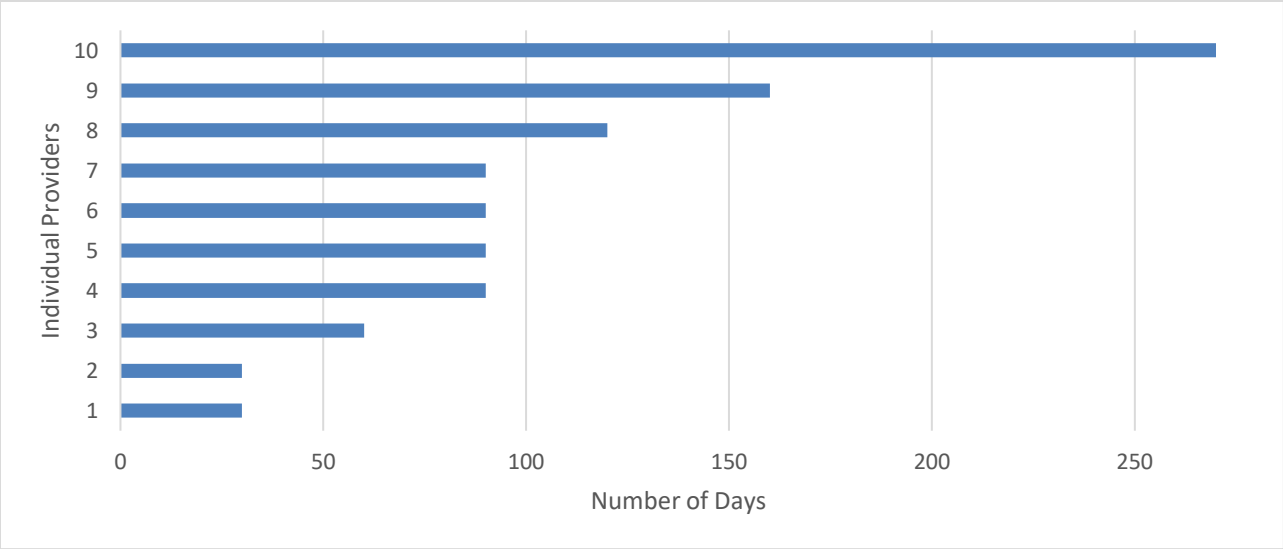
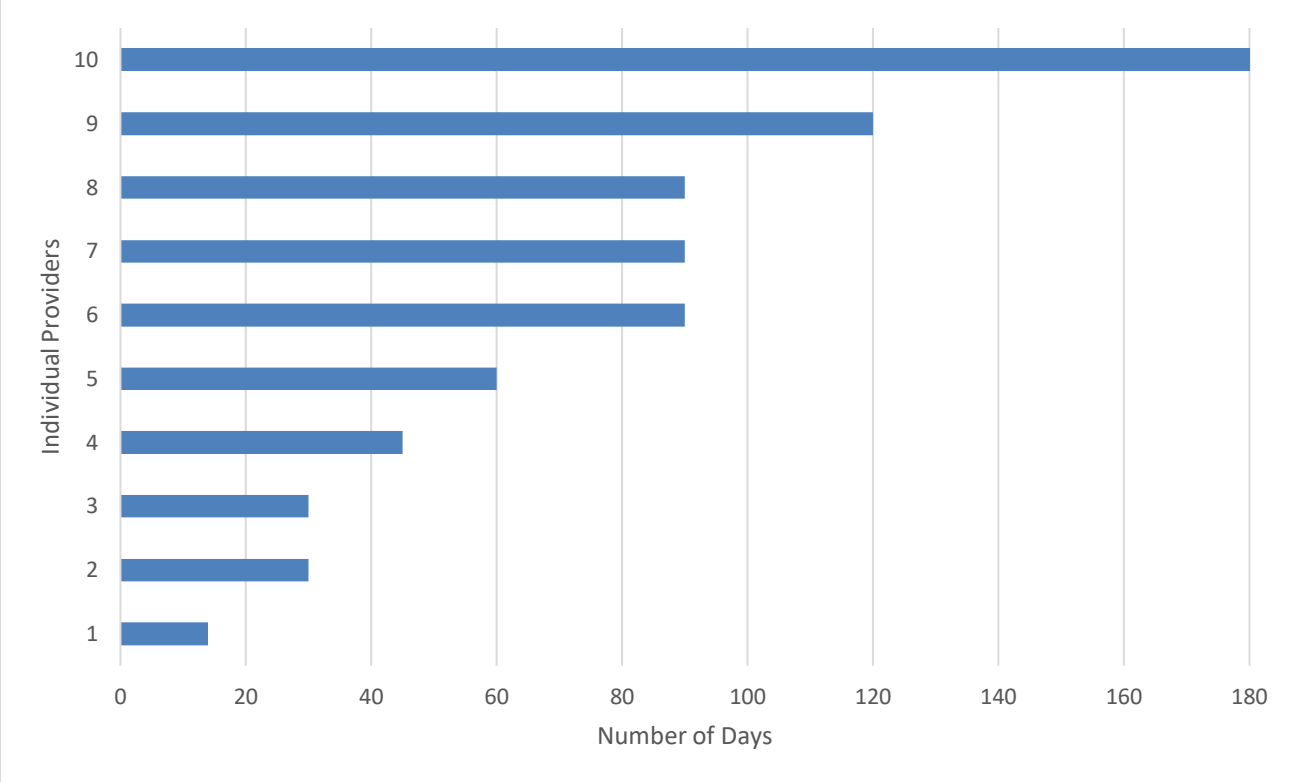
How long did implementation take? List the total number of days spent on testing, initial training, and piloting to the actual "go live" date.



How long did it take to transition from "go-live" to routine operation?



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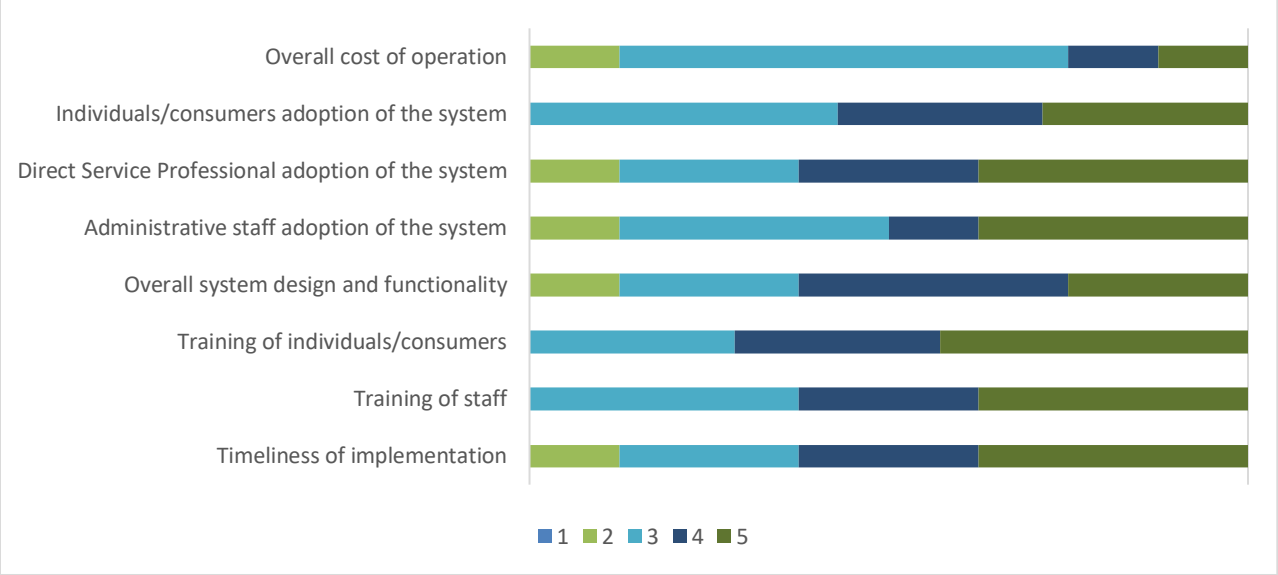
Rank your experience on a scale of 1 (poor) to 5 (excellent) related to the elements shown in the graphic below.

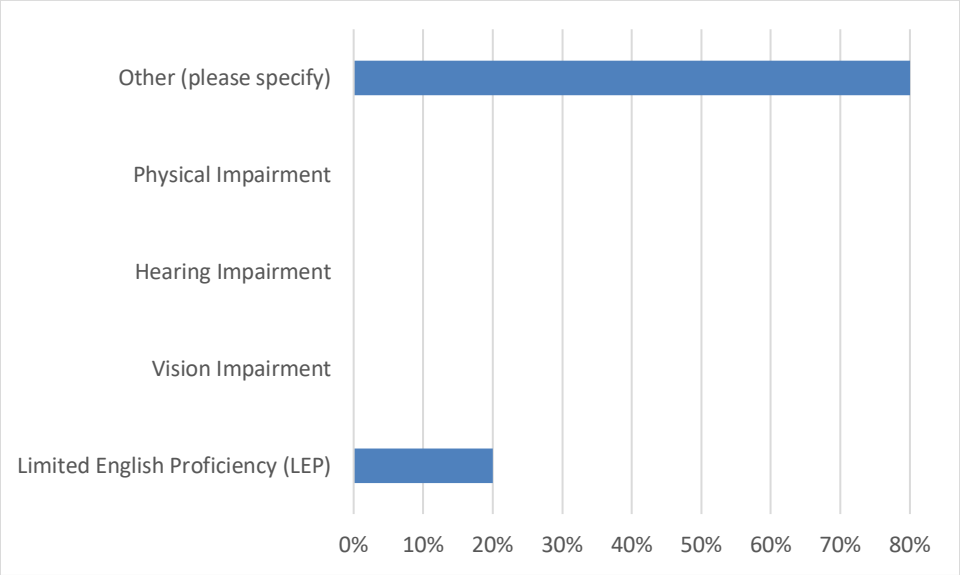


Comment/Feedback: What other aspects of the EVV system experiences have been important to your organization?

We have not implemented that portion of the system yet due to initial problems encountered when it was first available.
We have electronic time sheets that date and time stamp when employee is working. We have not implemented the EVV system which has geo tracking, and other services.
The Elvis system is on our current software: must have a smart phone. The CareWatch we use for those employees who don't have smart phones.
1. GEO location indicator 2. Ability to upload care plan for tasks (system as about specific tasks) 3 Ability to have 2 different programs (PCSP/PCA state plan) 4. Ability to add missed clock ins/outs
It was difficult finding a system that could work with both CFI clients and private clients for billing, authorizations, communication, etc. This system was able to meet most of our expectations. The training and lack of documentation was the hardest part of the transition. Also, trying to adapt our ways of work and what we needed the system to do for us, that other agencies may not need, so it

wasn't something they were willing to add just for us. Overall, we are pretty satisfied and are leaps ahead of the old homegrown system we used to have.

Does the EVV system have features that address individual specific needs or accommodations for staff and/or individuals providing/receiving services?



Other comments:

Environmental codes
We would request modifications
There is a mobile app that may work for some of these limitations, but we have not implemented it with staff yet. Our clients do not have access to the system.

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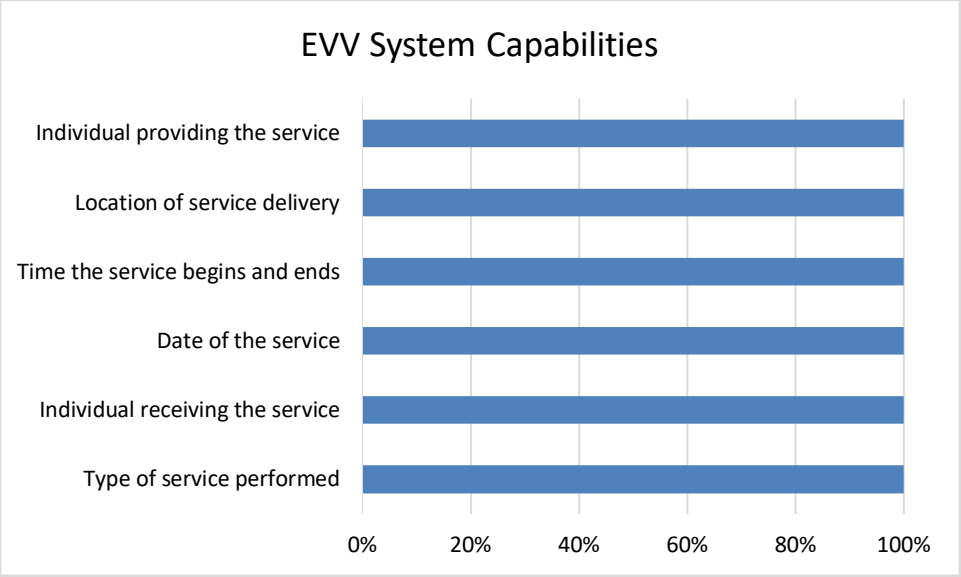
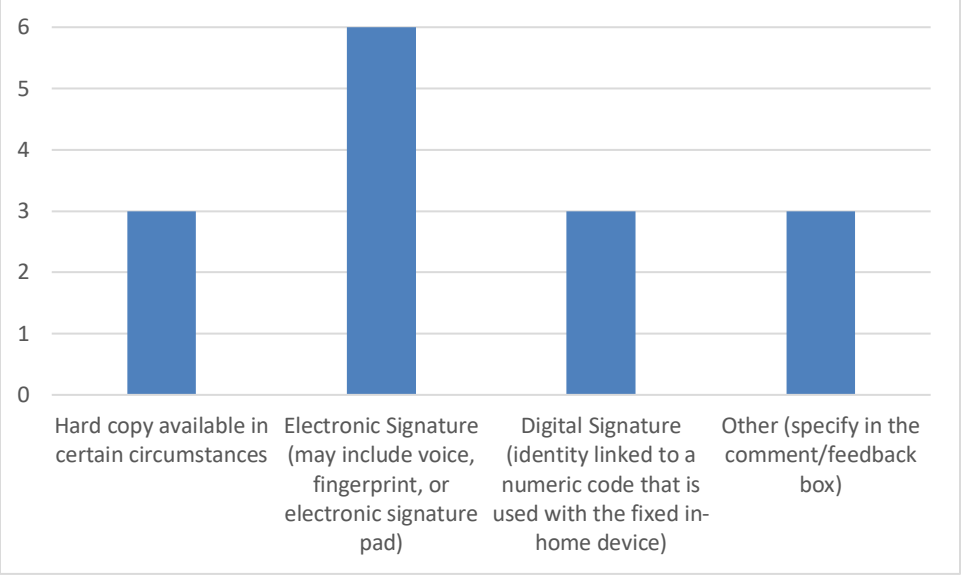
Does your EVV system collect all of the information required under the 21st Century Cures Act?



Select the manner by which the services are verified within the EVV system. "Other" responses indicated the system has the capability of capturing signatures, but this functionality hasn't been implemented yet and system verification based on use of the client's phone.



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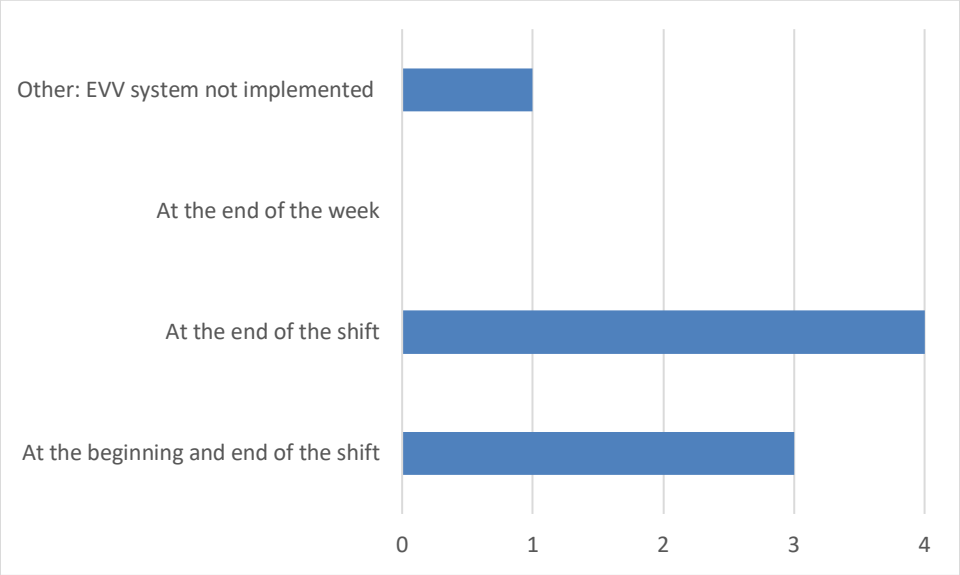
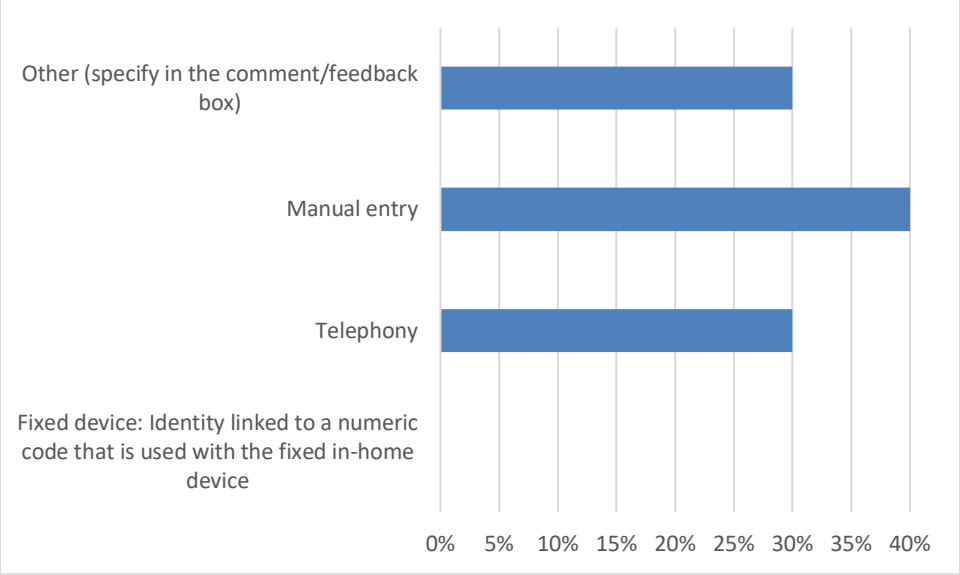
When are services being verified by the individual or individual receiving services?



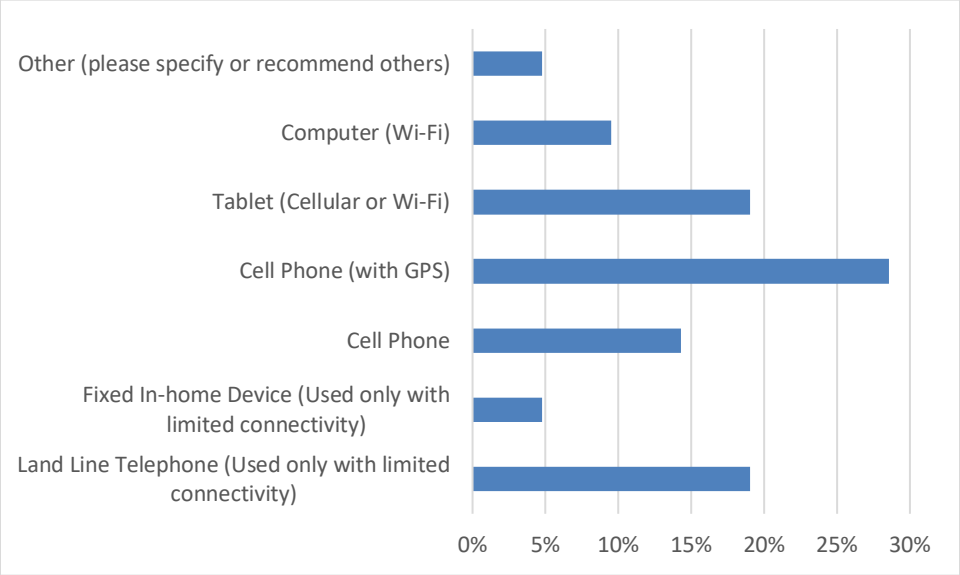
Indicate the features of the organization's system that address the provision of EVV in rural/urban areas where connectivity or technology infrastructure (e.g., internet access, cellular service, or other impediments) is limited or non-existent. "Other" responses included use of an App with offline mode, use of a tablet that captures the verification in real time and will sync/upload when back in a coverage area, and another indicated this has not been a problem.



Other comments:

App has offline mode
Tablet captures real time and will sync when back in coverage area
This hasn't been an issue

What modes of data collection are being used? Note: No "other" comments were recorded.



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What system capabilities are you using with your current EVV system?

Scheduling module for Direct Service Professionals:
7 providers

Service plan module that captures tasks completed:
8 providers

Track prior authorization, service approval, and utilization reporting for managing and monitoring:
3 providers

Ability to include service delivery note:
7 providers

Provider notification of missed or late visit with real-time alerts:
5 providers

Automated claims submission and staff payroll administration:
4 providers

Interactive provider dashboards:
3 providers

Access provider rules, policies, and procedures:
3 providers

Staff credentialing module:
2 providers

Quality assurance and quality improvement activities (i.e., health and welfare monitoring, including the ability to capture t individuals' experience of care):
2 providers

Ability to allow individual access to the system:
4 providers

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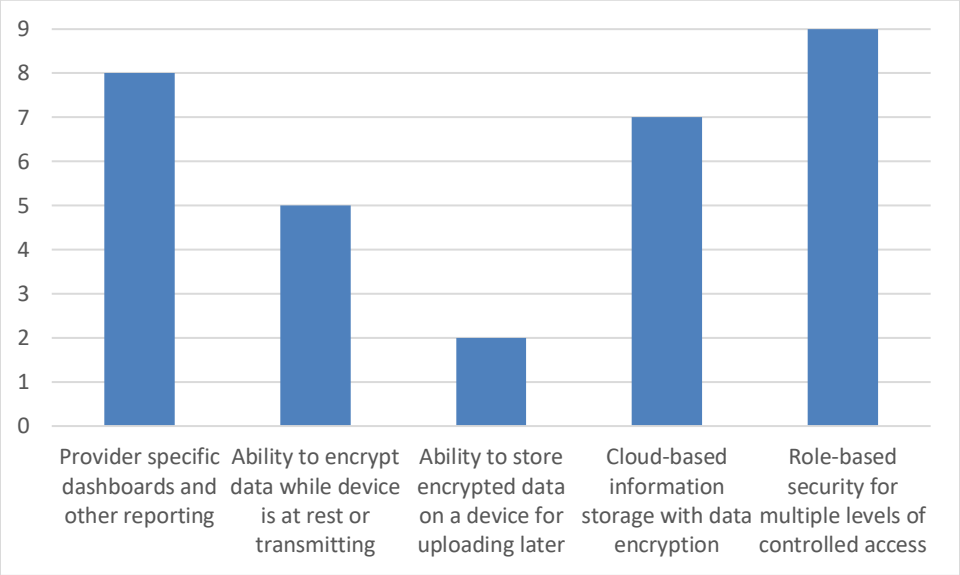
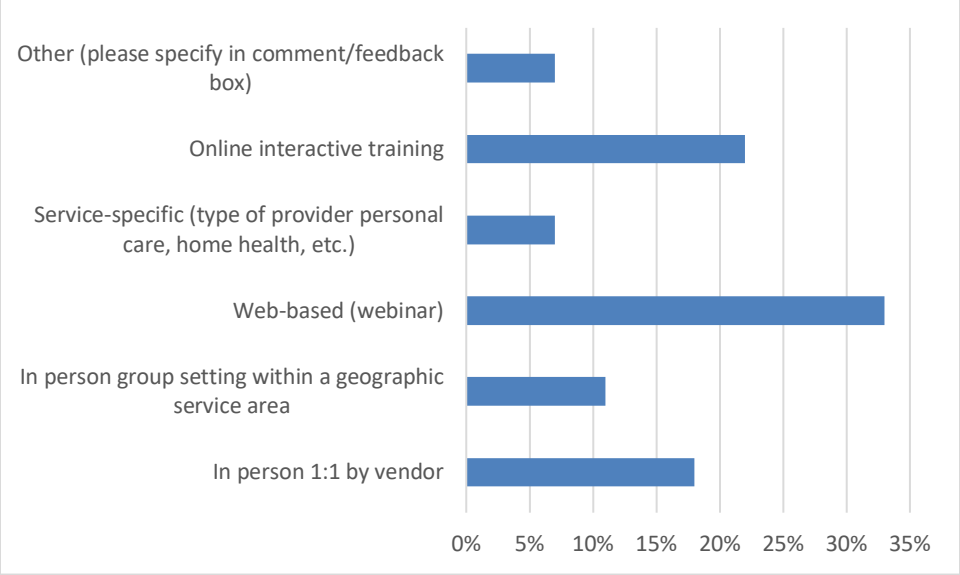
What data management and security features are current capabilities within your EVV system?



Indicate all training mechanisms available to ADMINISTRATIVE STAFF in the past and currently.



Other comments:

In person by education staff
YouTube videos

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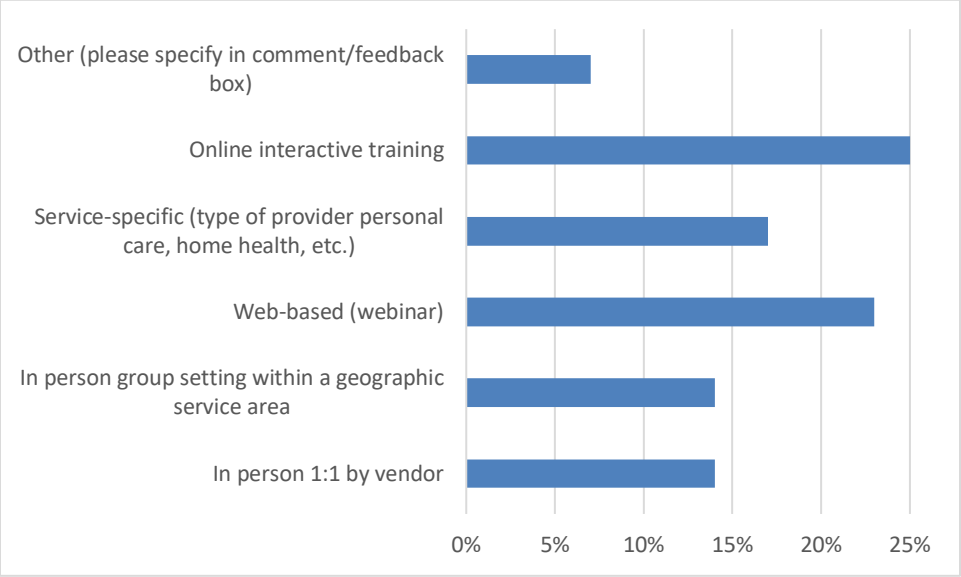
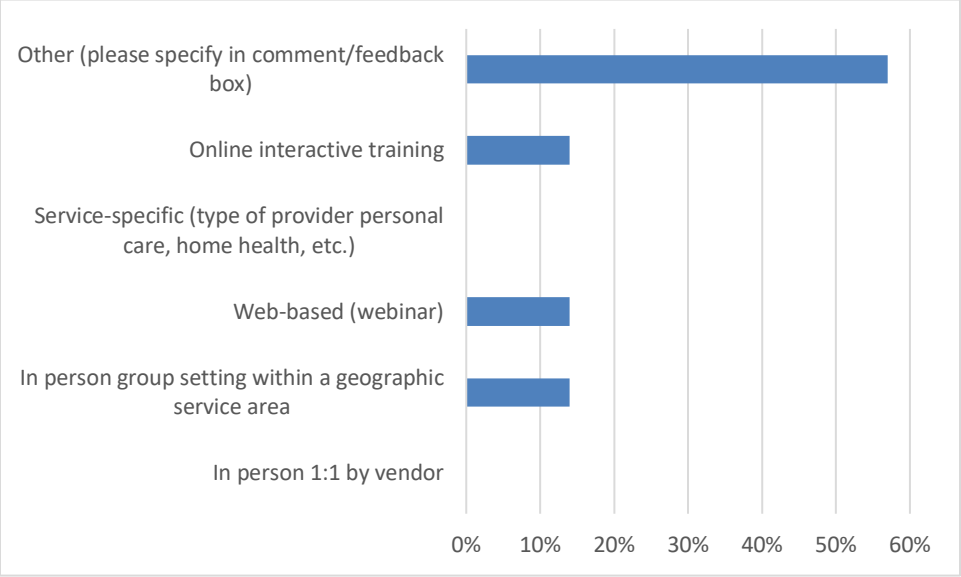
Indicate all training mechanisms available to DIRECT SERVICE PROVIDERS in the past and currently.



Other comments:

In person by education staff
YouTube videos

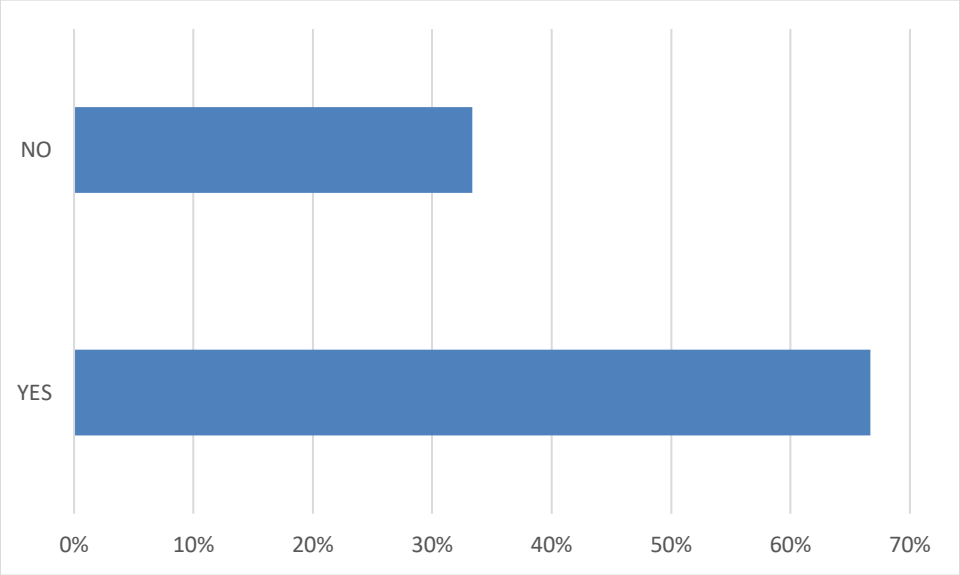
Indicate all training mechanisms available to INDIVIDUALS AND FAMILIES in the past and currently.



Other comments:

None that I am aware of
Not used by client's/families
Would not allow more than one. Answers same as DSP above

Would you recommend this system/vendor for the State's EVV solution?



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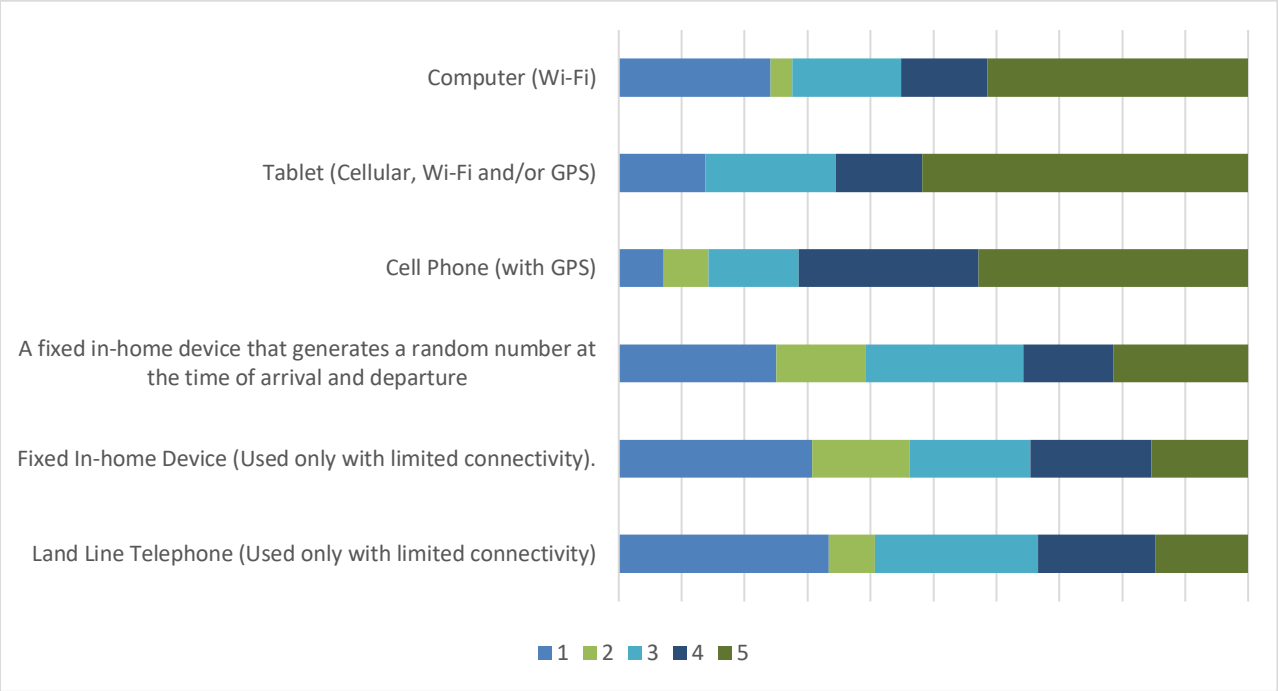
Which modes of data collection would you recommend be included in an EVV system?

On a Likert scale where 1 = Least Desirable and 5 = Most Desirable:



Are there other modes of data collection that you would recommend?

Funding from DHHS for hardware should be considered
No, I only recommend cell phone if the purchase of cell phones in order to create this system will be funded by the State
MIFI

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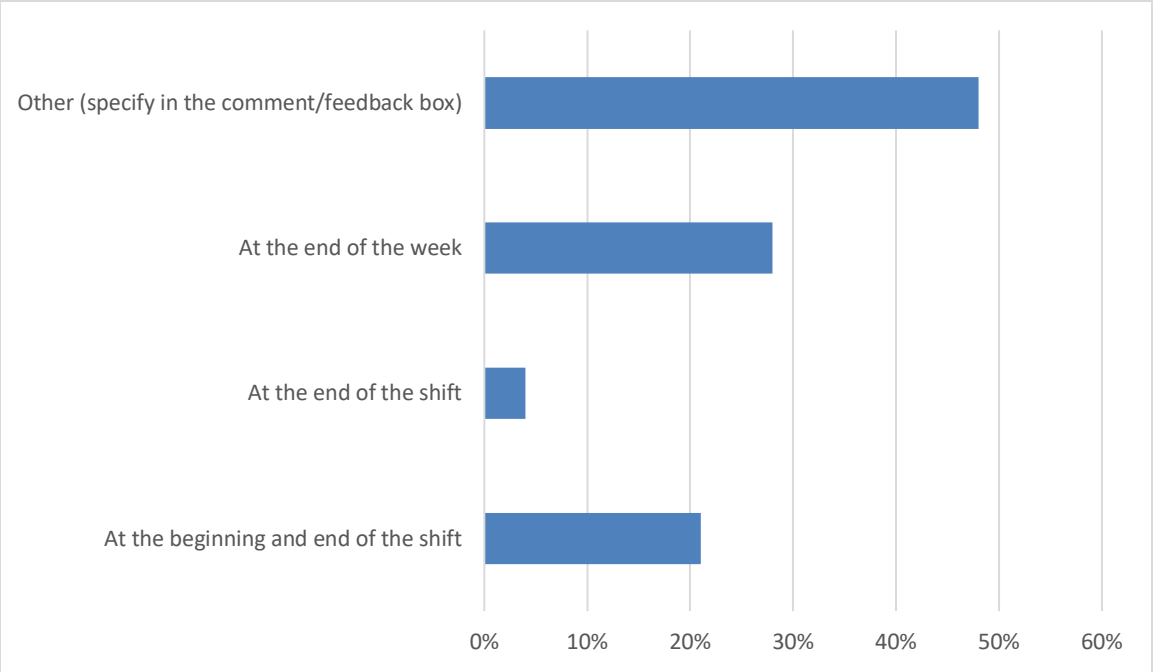
DHHS is interested in how your organization is verifying visits. When does your organization verify visits by the individual or individual receiving services?



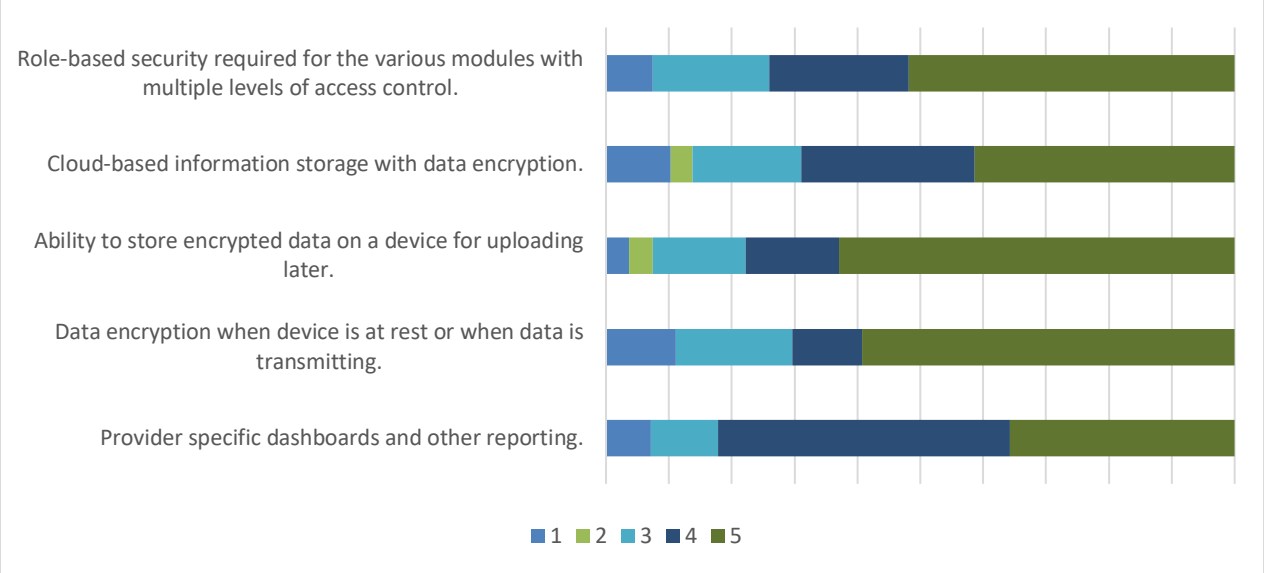
Other comments:

Staff time sheets, client daily calendar, daily notes
Our individuals live here-not sure how to complete
Not currently verifying
N/A: 24/7 residential facility
Daily Notes
Notes, attendance
We do not verify visits as we do day program and enhanced family care only
Random calls to patients
ON provides Day Program Services only. Attendance is tracked and verified daily when individuals either attend or do not attend day program. We do not have residential programs so we do not do home visits.
Check in and documentation
We do not currently have a system for verifying visits

Bi-Weekly at timesheet submission
We are a site based program so it is well documented as to who is providing the supports and when
In real time by departing staff

DHHS would like feedback on data management and security features of the EVV system that might be important to providers. What features of the EVV system do you think might be important to providers with and without EVV systems?

On a Likert scale where 1 = Least Important and 5 = Most Important, please rank the following features:



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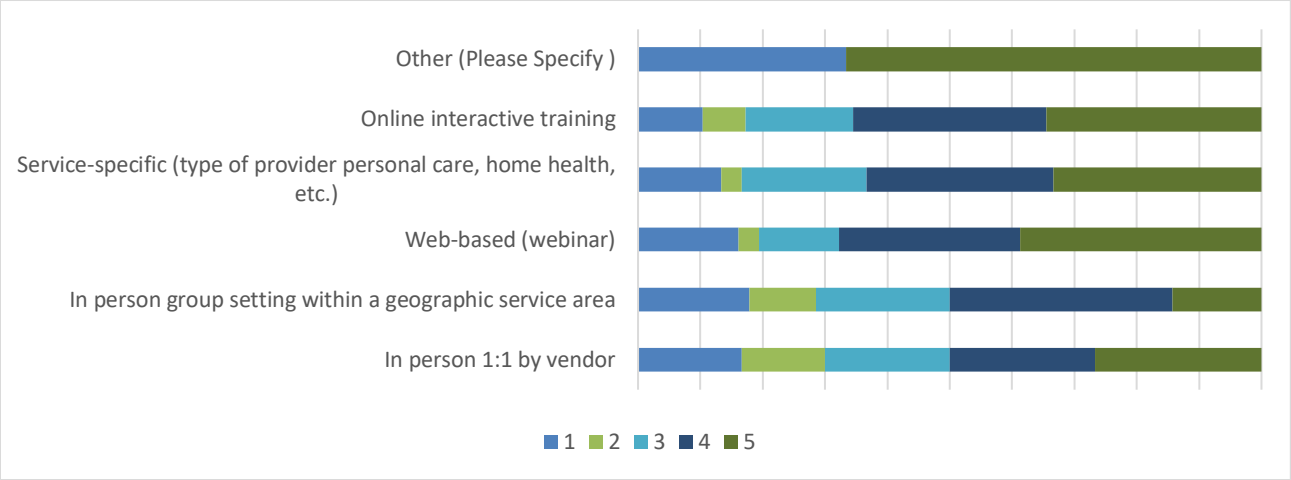
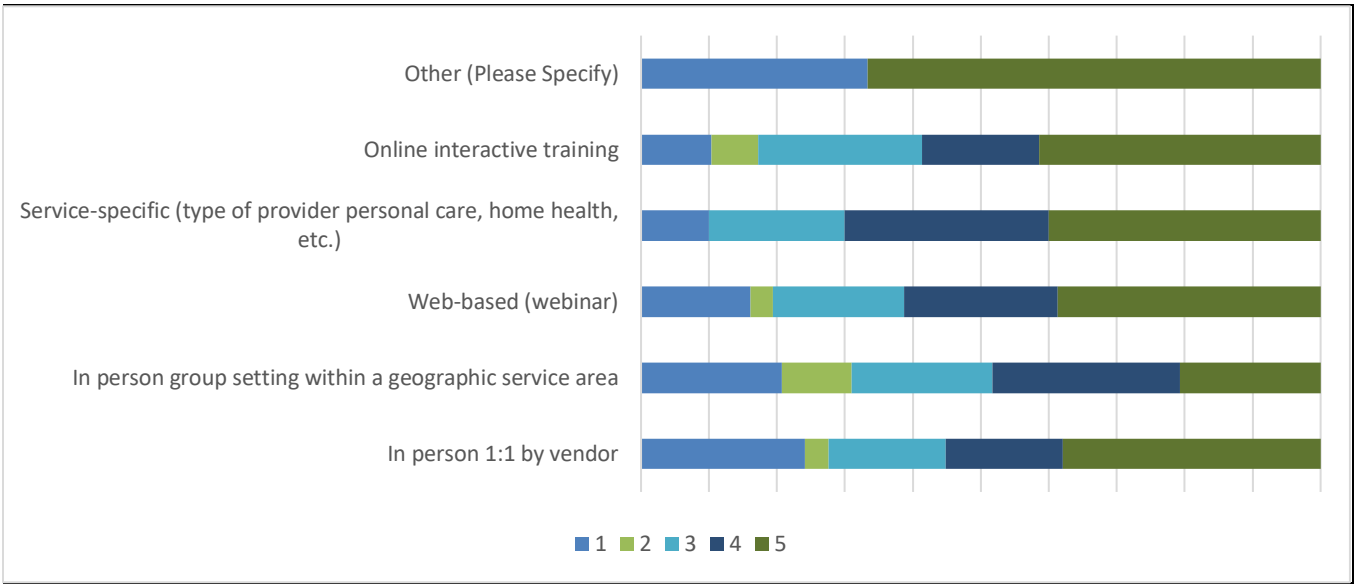
<u>Provider administrative staff</u> will require training on the EVV system. What are the preferred modes for administrative staff training on EVV system requirements and use?

On a Likert scale where 1 = Least Desirable and 5 = Most Desirable form of training. Note: no "other" comments were provided.



<u>Provider direct service staff</u> will require training on the EVV system. What are the preferred modes for direct service staff training on EVV system requirements and use?

On a Likert scale where 1 = Least Desirable and 5 = Most Desirable form of training. Note: no "other" comments were provided.



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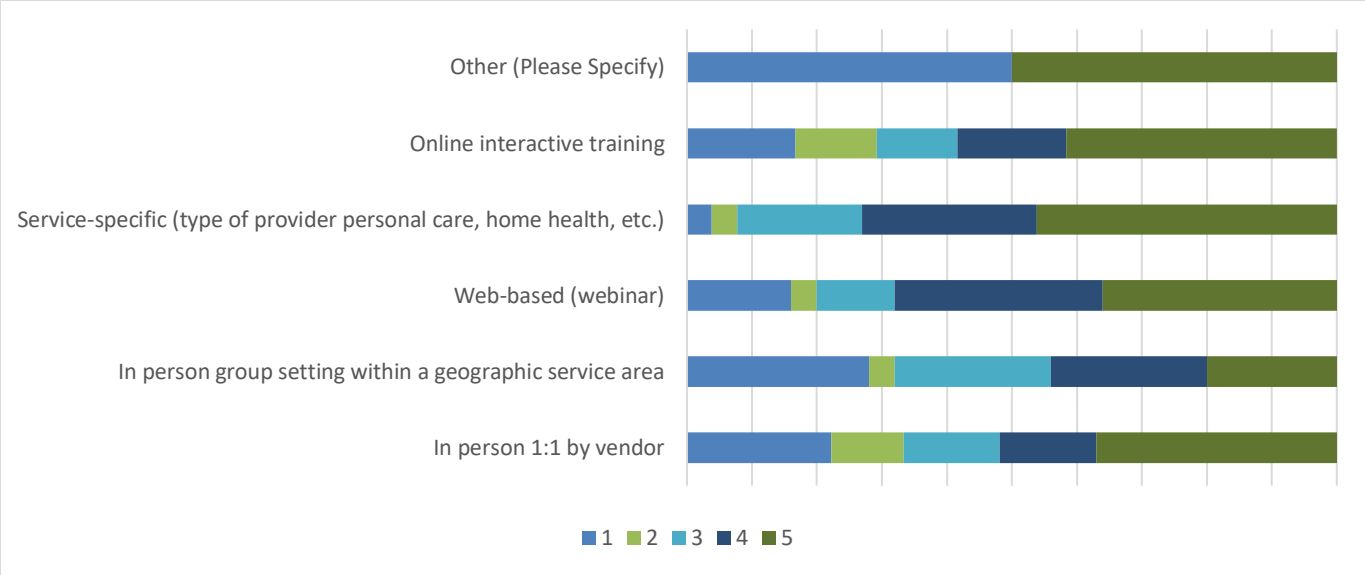
<u>Individuals and families</u> will require training on the EVV system. What are the preferred modes for individual and family training on EVV system requirements and use?

On a Likert scale where 1 = Least Desirable and 5 = Most Desirable form of training. Note: no "other" comments were provided.



For each initial design element of the EVV system, please select the answer that reflects your organization's support for that design element:

	Support	Do not Support	Maybe
One state-wide EVV system for data collection and data aggregation. This would allow other systems currently operating to continue to be used.	70%	13%	16%
Direct Service Professional will verify services at the end of every shift/visit.	82%	13%	5%
System will include a list of tasks from which the Direct Service Professional can select during each shift.	71%	10%	18%
System will include an "exceptions" process that permits providers to correct errors/mistakes within state prescribed timeframes.	84%	3%	13%
The system will include functionality that allows for an individual/family portal for verification of services, comments and general review of EVV data and information.	72%	6%	22%

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	Support	Do not Support	Maybe
The system will include reporting and dashboard functionality at various user levels (State, MCO, and provider).	81%	3%	16%
Some quality of service information may be captured.	71%	8%	21%
System may generate unique Direct Service Professional identifier allowing DSPs to be tracked across providers.	45%	13%	41%

Please provide any additional detail regarding any design decisions where "Do not support" or "Maybe" was the selected answer above.

It will be very difficult to monitor community based services in this manner without risk of exploitation of personal client and DSP data. Also near impossible to separate duties of enhanced family care providers for verification. EVV seems more appropriate for a medical model of monitoring rather than a normalized community based system that tries to avoid the appearance and feel of the medical model. We do not feel EVV is appropriate for these types of community based services.
We need to better understand what sort of 'partial' verification there could be. Also, regarding DSP tracking, we would want to offer our DSP's specific details about how they may be tracked.
Family portal--need to understand more on who is hosting and interaction with an electronic medical record? DSP-I need to understand more information on this.
We would need a system designed for the 24 hour services we provide across multiple shifts and the ability to record care provided after every resident interaction.
Having a list of choices means that folks will make errors on that choice. Since it's not clear to me what services we are talking about for home providers doing adult foster care, I don't know what this list would have on it. Why do we want to track our DSPs? Seems intrusive.
We are a small agency already burdened with financial obligations to comply with licensure/regulatory requirements. Poor reimbursement rates limit our ability to purchase additional equipment/software or hire employees to implement/monitor/participate with new requirements of data aggregation. Our staff are resistant to having patients/families "touch" their phones, particularly during the pandemic. We also do not want our staff to use patient phones at this time due to the risk

of transmission of illness. Our employees would be very open to a safe manner of patient verification that does not include touching their devices or close facial contact.
Integration with any vendor system through application program interfaces (API) or scheduled file delivery.
Prefer to use existing EMR vendor than state system. EMR vendor needs to provide EVV functionality
One State wide system would like to know more on how the system was designed and implemented. How will it interface with external systems such as payroll? The work commitment involved. Unique ID for DSP, how would that work for several different providers? How does the id assignment take place? What responsibility of the individual providers of that employee have related to other employment with other providers?
With the current EMRs that most agencies are already using, it would appear that a Data Collection system would more easily be able to incorporate what users are already working with. For example, HomeCare HomeBase may be too expensive for smaller agencies or for Private Duty, but does capture everything we need, and a process could be developed to upload. **As long as the state and not the agency covers the cost of any integrations
Adding an additional system for EVV for those agencies that already use an EMR and have EVV capabilities will be burdensome. That would mandate employees to document in 2 electronic systems for Medicaid clients. Most field employees don't know which client has what insurance so this would be very confusing and problematic.
1. One system: as we have and will continue to have a huge expense for what we have already purchased. 2. Providers can't legally change a time sheet of an employee. 3. Would need to understand the reason for the ask. Our "DSPs" are often hired directly with the consumer and they do not want to lose their DSP to another agency or consumer, leaving them without. Now, if it was to track employees that are on an OIG or excluded list, I might think differently.

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Appendix: List of Provider Agency Respondents

Androscoggin Valley Home Care
Arc of NH, Inc
Ascentria In-Home Care
Becket Family of Services
Becket Family of Services - Shared Living
BrightStar Care
BROCK CHILDREN'S HOME LLC
Comfort Keepers
Community Bridges
Community Crossroads Inc.
Community Integrated Services
Concord Regional VNA
Cornerstone VNA
Crotched Mountain Community Care
Easterseals NH
Farmsteads of New England
Gateways Community Services
Granite State Independent Living
Healthy at Home, Inc.
Home Health & Hospice Care
Lake Sunapee VNA & Hospice
Lakes Region Community Services
Life Transition Services
Life Visions
Living Innovations
Monadnock Worksource
Neurorestorative
North Country Independent Living
Northern Human Services
One Sky Community Services, Inc.
Opportunity Networks
Pemi Baker Community Health
Psalm 33, Inc.
Regency Home Health
Residential Resources, Inc
Robin Hill Farm
Rose Meadow Group
SB Nursing Care Management Services
Senior Class Corp.

Siddharth Services, Inc.
The Inn at Deerfield, Inc
The Institute of Professional Practice, Inc
The Lukas Community
The Moore Center
The PLUS Company
Waypoint NH