Electronic Visit Documentation
Maximizes Service Effectiveness

By
**Kraig Erickson &
Vicki Dalle Molle**

The intersection of technology and care

has brought about numerous approaches, options, vendors, and feature sets as technology has advanced in recent decades. The growth of technology has been much like that of the long-term post-acute care (LTPAC) industry, which is highly fragmented, with over 33,000 providers[1] offering personal health care-related services in the home. Similarly, there are a plethora of technology options that are positioned at various points in the business of delivering services in the home.

One place where technology has come to play a much more significant role is at the point of care. This is an area where technology offers providers a wide range of choices. These include device-based approaches, such as smart phones and laptop or tablet devices, and approaches, such as telephony, that do not require the provider to invest in or manage field devices. All of these approaches collectively make up a category of technology called Electronic Visit Documentation, or EVD.

EVD Needed to Meet Growing Demand for Information

Much attention has been given to point-of-care EVD approaches for nurses and therapists. Paraprofessionals, however, often represent a significant portion of a provider's business. Their numbers are projected to grow significantly over the next decade to meet the increasing demands generated by the approximately 78 million baby boomers. This means that it will become even more critical to manage paraprofessionals and maximize the effectiveness of their encounters with patients.

The "Overview of Home Health Aides" report released May 19, 2011 by the U.S. Department of Health & Human Services, Centers for Disease

Control and Prevention, states that "the number of home health and hospice aides is expected to increase 50% between 2008 and 2018. Direct care jobs are projected to be among the fastest-growing occupations with the greatest increases among home health and hospice aides." In fact, "the bulk of formal long-term care is provided by direct care workers, such as nursing assistants, home health aides, and personal aides, who provide basic care and essential help with daily activities, enabling people with functional and activity limitations to live independently in their homes."

These direct care activities could benefit greatly from EVD technology, as many payers and providers are beginning to realize. All too often, these patient encounters are documented manually, sometimes even with weekly visit logs, which does little to ensure that accurate, comprehensive information is collected at the point of occurrence. The practice of turning in weekly notes diminishes quality and creates a lapse between the time of the patient encounter and when the provider receives information on the visit, making it impractical to effectively manage these services. Even the FedEx guy collects electronic "proof of delivery" for a $4.00 book. Why shouldn't something as valuable as a patient encounter be electronically documented and verified?

While speaking to Senator Amy Klobuchar's (D-MN) legislative aides during the 2011 NAHC March on Washington, I was asked, "What is the industry doing to help reign in fraud and abuse?" I explained that many providers make use of technical and administrative safeguards and that public policy can help maximize the impact of available options. This article is spurred by that conversation. It shows how EVD can help facilitate a proactive approach to combating fraud and abuse instead of a reactive, retrospective approach to finding fraud by data mining, audits, and mandates.

EVD is Comprehensive and Integrated with EMR

While verification of a visit using EVV is important, it doesn't universally address the scope of the data set that is collected or the timely integration with the provider's EMR system. EVD, as stated, includes EVV-related date, time, and location, but also services, tasks, and other discipline specific information that makes up a complete record of the patient encounter. Because EVD solutions integrate tightly with a provider's EMR system, timely management of field staff can occur, enabling providers to effectively respond to scheduling, clinical, or service exceptions. EVD also yields precise productivity reporting, efficient payroll processing, and allows providers to generate accurate, timely claims.
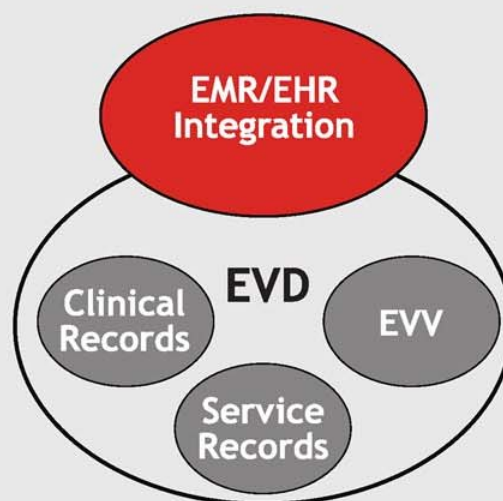
EVD and EVV Standards

Drawing similarities again to the LTPAC provider market and its many options, the emergence of numerous EVD and EVV technology options and approaches can be overwhelming if commonalities and standards are not defined and understood. Just like a provider must meet CoPs in order to provide
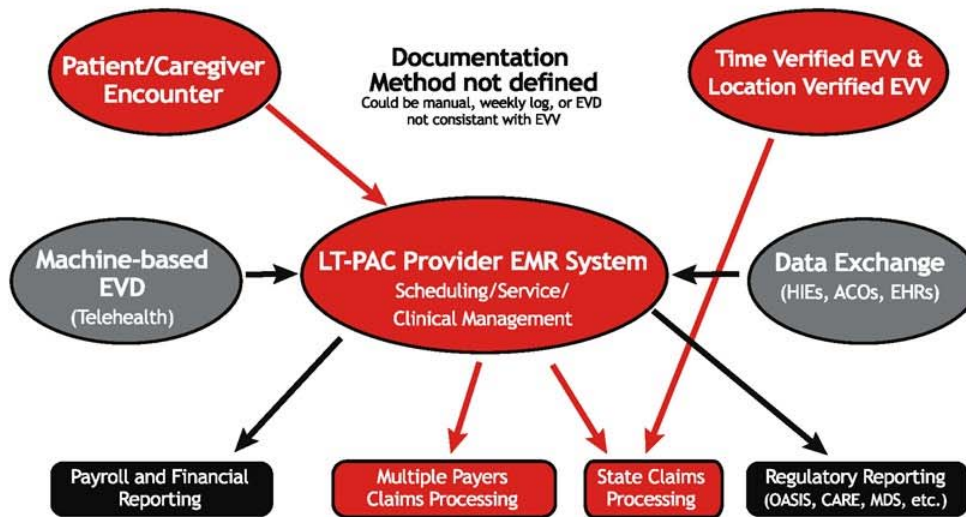
EVD and EVV Definitions

EVD, Electronic Visit Documentation, is a comprehensive, complete account of a patient encounter which is integrated tightly with a provider's EMR system. EVD should include everything on the patient encounter that is needed to support charting, billing, and payroll. EVD could represent human-based patient encounters and also machine-based patient encounters in the case of telehealth. This article will focus primarily on EVD for human-based patient encounters.

EVV, Electronic Visit Verification, is just one feature of a more comprehensive EVD solution that provides proof of visit. One of the most common methods of EVV, telephony, uses recognition of a recipient's phone number to capture the date, time, and location of service. Other types of EVV technology include cell phone GPS, tablet-based digital signature with time and date stamping, biometric recognition, and electronic random number generation matching devices.

For the purposes of this article, the term **patient** collectively represents consumers, clients, and recipients, and the term **clinician** includes field staff, caregivers, workers, aides, PCAs, and attendants. Providers represent businesses who manage both medical and non-medical services in the home.

Fragmented, Payer-mandated EVV Data Flow

Patient/Caregiver Encounter

Documentation Method not defined
Could be manual, weekly log, or EVD not consistant with EVV

Time Verified EVV & Location Verified EVV

Machine-based EVD (Telehealth)

LT-PAC Provider EMR System
Scheduling/Service/ Clinical Management

Data Exchange (HIEs, ACOs, EHRs)

Payroll and Financial Reporting

Multiple Payers Claims Processing

State Claims Processing

Regulatory Reporting (OASIS, CARE, MDS, etc.)

certain services, wouldn't it also be helpful if standards could be established to ensure an EVD or EVV technology meets certain requirements?

There are emerging standards movements for EHRs (Electronic Health Records) that now include LTPAC providers, but they focus on aggregate standardized record sets and interoperability. Aside from OASIS, they provide minimal definition of "how" and "what" data gets collected during the patient encounter. The progression towards standardized EHRs further strengthens the need to collect patient encounter data electronically during the visit, at the point of care, via comprehensive EVD approaches that encompass all disciplines. As interconnected health care continues to evolve, this EVD data will pass through a provider's EMR system and on to other parts of the health care spectrum through their trusted HIE and ACO networks as well as being sent to payers for billing purposes.

While no federal standards now define EVD or EVV, one group of industry vendors is working to provide a definition so providers and payers can be confident that features meet a minimum set of specifications. The EVV Workgroup for Home Care and Hospice (www.EVVworkgroup.org) has recently established draft standards for EVV. The language of the draft standards is designed to enable states and payers to ensure that a provider's chosen EVD or EVV solution meets basic criteria for proof of visit. The current verification standard published by the EVV Workgroup reads as follows:

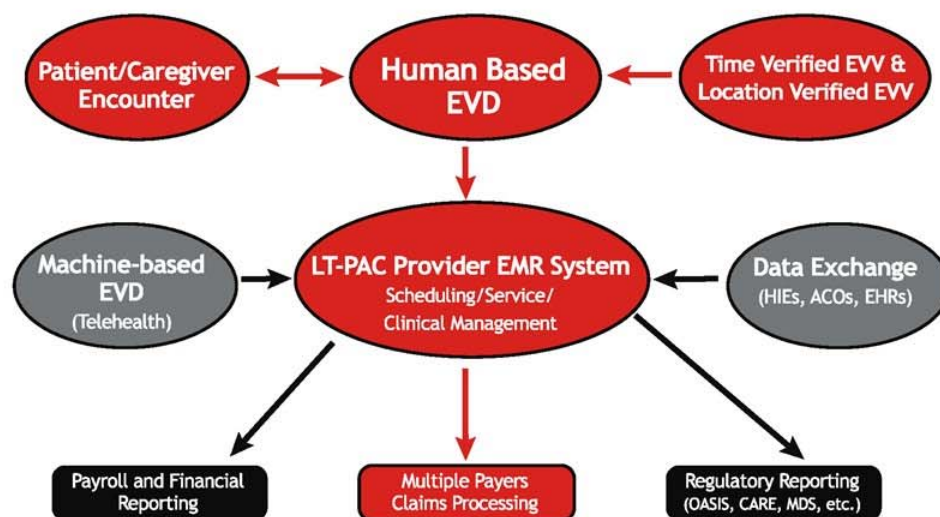### At a minimum, an Electronic Visit Verification (EVV) system shall:

a. Record the exact date services are delivered;

b. Record the exact time the services begin and exact time the services end;

c. Verify the telephone number or location from which the services are registered;

d. Include a mechanism to verify whether their employees are present (e.g., at the beginning and end of a visit) at the location and time where services are to be provided for recipient;

e. Require a personal identification number unique to each caregiver and, if appropriate, a unique password established by said caregiver;

f. If required by a State or other jurisdiction, the system must have a proven biometric identification system for purposes of identifying the caregiver beyond the entry of a personal identification number and / or unique password;

g. Be capable of producing reports of services delivered, tasks performed, recipient identity, beginning and ending times of service and date of service in summary fashion that constitute adequate documentation of service;

h. The system must be HIPAA compliant;

i. The system must insure at least daily back-up of all data collected;

j. Due to the mission critical nature of such a documentation system, it must demonstrate a viable disaster recovery mechanism allowing for its use within 12 hours of any disruption to services, subject to exceptional circumstances such as war and other disasters of national scope.

EVV Movements and Payer Strategies

If you are providing services in Florida or Texas, you've likely heard of EVV. Pilot projects are currently underway in these states to examine payer-related benefits of EVV in an effort to curtail fraud and abuse and establish more control over some of their Medicaid programs. There appear to be two very different

Optimal, Provider-centric Data Flow Supports EVD

Patient/Caregiver Encounter ⟷ **Human Based EVD** ⟵ **Time Verified EVV & Location Verified EVV**

Machine-based EVD (Telehealth) → **LT-PAC Provider EMR System** Scheduling/Service/Clinical Management ← **Data Exchange** (HIEs, ACOs, EHRs)

Payroll and Financial Reporting   **Multiple Payers Claims Processing**   **Regulatory Reporting** (OASIS, CARE, MDS, etc.)

strategies when it comes to how states are introducing EVV to provide proof of visit.

Taxpayer Funded, Single Vendor Strategy

Some states have gone down the path of purchasing and running their own EVV system and mandating its use, even though many providers already have EVV-capable systems in place.

The value proposition of providers is defined by the quality and scope of services they provide. To provide optimal value, it is important for providers to be in the direct path of data as it comes in from the patient encounter. With a state-run, state-mandated approach to EVV, providers are often left on the sideline and out of the data path if the EVV portion of the data set travels directly to the payer without first going through the provider's EMR system for QA, analysis, and processing. This is an obvious problem for providers serving multiple jurisdictions who already have a comprehensive EVD solution in place.

The red lines in Figure 1 below highlight how the data flow of state-run EVV sidesteps the provider. The patient encounter data travels into the provider's EMR system, either manually or electronically, while the EVV data travels directly to the payer.

While there is clearly some benefit for states to mandate use of EVV, the benefits are diluted when providers are forced to use state-run EVV systems in addition to their own more comprehensive EVD solution.

This approach introduces inefficiencies caused by redundant double entry, and creates "data silos," putting more administrative burdens on providers and decreasing their ability to effectively manage service delivery in a timely manner. It does not facilitate timely provider QA management, scheduling and services adherence, or billing and payroll compliance via a pro-

vider's EMR system, which likely manages services for multiple payers. This approach can only be effective for providers who service a single program or do not have an EMR system, limitations that do not support EVD and are not in line with national goals for EHRs.

Mandating use of a single, state-run system also limits the ability of the payer to take advantage of innovation and competitive drivers in the fast-paced world of mobile health care technology.

Standards Based, Free Market Strategy

An optimal, provider-centric EVD data flow is represented below in Figure 2. The red arrows follow the data path from the patient encounter > through the provider > to payer. The provider gets timely information to manage service quality and the payer gets the accountability they are seeking.

If providers are not in the path of the data flow, they lose control, as they would in the case of telehealth (identified in both figures as Machine-based EVD"). The result is to diminish manageability of field staff across all programs and their value proposition to the health care system.

Supporters of the EVV Workgroup believe that payers could realize maximum benefit by letting providers adopt whichever standards-based EVV type meets their needs. By promoting, encouraging, or even mandating use of a qualifying EVV system of the provider's choosing, public payers would not only save taxpayers the cost of paying for and maintaining their own EVV system, but also reap more benefit for themselves and other stakeholders by eliminating redundancies.

One state that has taken a supportive approach to standards-based EVV is Pennsylvania. The Pennsylvania Department of

Aging issued a bulletin on November 23, 2010 that "strongly encourages telephony." Acknowledging that providers also need administrative safeguards in place to complement this EVV type, the bulletin goes on to clarify that:

> "Agencies must have a protocol in place for making edits to electronic time sheets that includes making contact with the participant and the worker.
> Telephony time & attendance electronic records are accepted by the Commonwealth as documentation of services rendered in support of claims for Medicaid reimbursement under OLTL Waivers. Substantiation or backup of telephony time & attendance records with paper timesheets is not required."

Ohio is another state that has adopted a standards-based strategy to help provide time, location, and service delivery assurance through visit verification. The following is an excerpt from The Ohio Division of Medical Assistance Administrative Code, Chapter 510:3:

> (2) A home care service provider, who provides home care services to a home care dependent adult, must have a system which effectively monitors the delivery of services by its employee(s). The system must include:
>
> (a) A mechanism to verify whether their employees are present (e.g., at the beginning and end of a visit) at the location and time where services are to be provided for home care dependent adults who have a mental impairment or life-threatening condition;
>
> (b) Verification of whether the provider's employees have provided the services at the proper location and time at the end of each working day for all other home care dependent adults.

The State of Missouri had standards-based EVV language in place which was recently challenged. The state legislature was specifically asked to determine whether a single-vendor, state-mandated system should be piloted or if it should stay the course with a standards-based, free market approach. After becoming educated on the relative merits of each approach, the legislature opted for the standards-based, free market strategy, enabling innovation, competitiveness, and support for a provider's value.

Be sure to reference your payer's current policies since language is subject to change.

In today's budget crisis, it is important that public payers pursue strategies that maximize taxpayer dollars and choose the approach that yields the most benefit for all stakeholders, including the recipient, the provider, and the payer. Even though the value to providers of using EVV typically pays for the cost of these systems, payers could consider reimbursing more for

EVV visits than non-EVV visits, similar to how credit card companies charge merchants different rates based on the level of confidence in the transaction. Another approach would be to use an allotment of funds given back to providers who meet certain EVV-use percentages across their patient encounters for a particular program.

EVD in the Payer Provider Relationship

In summary, strategies and policies that encourage accountable, accurate service delivery information could be clarified by asking this question: Who needs the point-of-service data in real time, the provider or the payer?

Unless the payer is going to respond in real time to service alerts, vital sign exceptions, or scheduling variances, policy and strategy should support all patient encounter data traveling directly to the provider first, then to the payer. By establishing visit verification standards and enabling providers to choose EVV types and vendors that meet standards, both payers and providers can maximize the benefits of incorporating EVD into their practices and support national goals of EHRs. It is an important time for our industry's creative thought leaders to chime in to help guide and inform policy makers.

References

[1]This number is a combination of Medicare-certified home health agencies, Medicare-certified hospices, and an estimate of non-Medicare agencies providing care in the home. From a report prepared by The National Association for Home Care & Hospice, "Basic Statistics About Home Care – Updated 2010."

About the Author: *Kraig Erickson is a Vice President at Sansio and founding member of the EVV Workgroup for Home Care & Hospice. Established in 1997, Sansio helps Home Care & Hospice, Assisted Living, and Fire/EMS providers deliver and manage over 7 million patient encounters annually through its EVD and cloud-based decision support solutions. www.Sansio.com. EVV Workgroup for Home-Care & Hospice provides education, raises awareness, and assists with standards development on the use of EVV and full-featured EVD solutions so that payers and providers can maximize their effectiveness through free market, standards-based solution approaches. Connect with Kraig at: www.linkedin.com/in/kraigjerickson.*

Vicki Dalle Molle, MPA, is the Executive Director of Choice Home Care, a Medicare-certified home health agency, and the Southeastern Minnesota Center for Independent Living in Rochester, Minnesota. The agencies serve an 11-county area in southeastern Minnesota. Ms. Molle has led both organizations since 2002 and has worked in health care and human services for the past 20 years. She can be reached at vickidm@semcil.org.