1999 Interim Project Report

Committee on Elder Affairs and Long Term Care

EMPLOYMENT CONSEQUENCES OF MALTREATMENT OF ELDERLY AND DISABLED PERSONS

Representative Nancy Argenziano, Chair
Representative Heather Fiorentino, Vice Chair

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Executive Summary

This report is based on the follow-up study to the 1998 House Elder Affairs and Long Term Care Committee Project which examined Florida's adult abuse classification system and its use in employment screening. Committee staff issued a report in December 1998 on the problems with the current system and recommended that the committee explore alternative systems that would be more effective, less costly and less labor intensive. The 1998 committee report documented the cost and effort being invested in the current classification and screening system and the results accomplished. While the report concluded that the current system is in need of major redesign, there was not sufficient time prior to the 1999 Legislative Session for the committee to develop a well thought out new approach.

This interim study focused on a number of issues and concerns identified over the past several years. One major concern is the distracting emphasis on perpetrators created by the 1989 revisions to the adult protective services (APS) statute. While not suggesting that APS staff focus on perpetrator due process issues to the detriment of protecting adult victims of maltreatment, it is clear that these due process requirements must always be considered when evidence suggests an identifiable offender.

A second major concern with the current system is the wasteful effort that results from using the program's clinical electronic database as an inappropriate tool for employment screening of paid caregivers. Hundreds of individuals who never have and never will apply for a job as a paid caregiver, and thus will not ever be screened for employment, are induced to exercise their due process right to appeal the state's adverse action of listing them as confirmed abusers. Of approximately 5,000 persons with confirmed classifications in the database, about 30% are over age 60, and about 20% are over age 65. Nine are at least 100 years old. In addition, because of a recent court ruling, thousands of persons listed on the registry as "closed without classification" are also notified of their right to appeal for amendment or expunction. The court ruled that these individuals, who are not even named as perpetrators, and their employers are harmed by the listing of their names in the electronic record of an abuse investigation.

A third major concern is the disconnection between the state's regulation of health care programs and facilities, generally, and its responsibility to help health care providers maintain a safe and qualified workforce. Specifically, the agency requires corrective action by the licensed facility, but is not authorized to take action against a manifestly dangerous employee. With related responsibilities scattered across several state agencies,

coherence, communication, and common sense are critical to the state's regulatory mission. A major goal of this study is to identify and recommend an optimal structure and process to further strengthen the protections the state can reasonably provide for vulnerable adults.

The major components of the study were (1) analysis of statistical data from the adult abuse registry, (2) review of 84 Recommended Orders in cases appealed to the Division of Administrative Hearings (DOAH), (3) a mail survey to all 50 states regarding their adult protective services systems and caregiver employee background screening requirements, (4) telephone interviews with staff of selected states, (5) review of a number of relevant documents produced by a variety of Florida agencies, and (6) interviews with staff of the Department of Children and Family Services (DCFS), the Agency for Health Care Administration (AHCA), the Department of Health (DOH), the Attorney General's office (AG), Administrative Law Judges (ALJs) in DOAH, and law enforcement representatives.

This study has also taken into account the recent changes in Florida Statutes related to (1) expanded background screening requirements and (2) the creation of a background screening database within the AHCA. These recent statutory enactments, along with the creation by the 1995 Legislature of Chapter 825, F.S., to impose criminal penalties for elder abuse, suggest a continuing commitment by the Florida legislature to protect vulnerable adults from caregivers who would do them harm.

The report reviews (1) the state's regulation of healthcare professionals, (2) the system of both criminal and abuse registry background screening, and (3) the roles of the various state agencies in preventing the victimization of elderly and disabled adults.

The findings of the study were anticipated to help shape a proposal to the Committee on Elder Affairs and Long Term Care for a system that effectively imposes employment consequences on caregivers for non-criminal maltreatment of elderly and disabled adults. Such a system should meet the following criteria:

- be feasible and affordable;
- encourage private and public sector employers to hire more responsibly
- be swift and efficient in the restrictions imposed on such employees and facilities;
- be cost effective in the processes and procedures established to prohibit, discourage, restrict, or constrain the employment of persons who may represent a threat to vulnerable adults; and,
- be fair to persons accused of abuse, neglect or exploitation as well as to the facilities and programs that employ them.

Recommendations

In addition to gathering and analyzing the data presented above, staff of the House Committee on Elder Affairs and Long Term Care conducted interviews with numerous

staff of various state agencies and private organizations, law enforcement representatives, advocates, adult protective service professionals in Florida and legislative and program staff in other states. The ideas, opinions, and information distilled from this intensive review have led staff to propose the following recommendations for affecting the employment of caregivers who may represent a threat to frail elderly and disabled persons. The recommended approach would rely on (A) criminal background screening, (B) mandatory employer reference checks, and (C) the state's ongoing regulation of health care professionals. This approach would substantially reduce the cost to the state compared to the current system and disencumber adult protective services staff from numerous perpetrator oriented activities.

Recommended Approach

A. Disqualify applicants for paid caregiver positions only for criminal offenses set forth in Chapter 435, F.S., under employee background screening requirements and discontinue the statutory requirements for classification of abuse, neglect and exploitation reports and abuse registry screening.

NOTE: This option would establish that only persons who have been convicted or plead nolo contendere to certain criminal offenses, including offenses set forth in Chapter 825, F.S.***,** on elder abuse, would be disqualified from working as paid caregivers.* ***This policy would be consistent with the policy enacted by the 1995 Legislature regarding the child abuse system****, and would set the clearest public policy on caregiver employment restrictions. Non-criminal maltreatment administratively determined by state staff outside the criminal justice system would no longer be sufficient to disqualify a person from such caregiver employment. Licensed healthcare professionals and certified nursing assistants would continue to be regulated by the DOH and would continue to be restricted from employment under the disciplinary authority of the regulatory boards and DOH. All of the current effort and expense going into imposing sanctions administratively on alleged perpetrators and in operating the vast due process machinery would be eliminated. Such expense could be redirected to improve protection of victims, support better law enforcement response, and increase state attorney prosecutions. The Attorney General could also be given specific authority, in cooperation with state attorneys, to prosecute crimes against the elderly under specified circumstances.*

B. Require regulated employers of caregivers and all caregiver employers under contract with the state to conduct reference checks to discover any disciplinary action imposed by previous employers on employees for caregiver maltreatment of patients. Require previous employers of applicants to divulge such personnel information relevant to patient protection, and enhance the statutory protections against liability for former employers who report such disciplinary action by protecting from discovery any such factual information received by the requesting employer.

NOTE: Currently, section 435.10, F.S., requires that employers must provide personnel records for employees or former employees to any other employer requesting this

information. The information may include disciplinary matters and any reason for termination. Liability protection is provided to the employer, absent a showing that the employer maliciously falsified such records. Anecdotal information has suggested that many employers of caregivers are reluctant to ask for or provide such information. Mandatory reference checks by employers required to conduct background screening, along with criminal penalties against employees who falsify their employment history in an attempt to deceive an employer about prior disciplinary action taken against them for maltreatment of patients, could enhance the state's interest in protecting patients from unfit caregivers.

C. Require that, in keeping with its statutory duty to protect the health and safety of patients/clients, the DOH through its professional regulatory boards determine the appropriate employment consequences to impose on any caregiver who is licensed or certified by DOH. Further, it is recommended that any disciplinary action imposed by DOH against a professional caregiver for maltreatment of a patient/client be immediately reported to AHCA for inclusion in the background screening database.

NOTE: Disciplinary action reported to the AHCA database would not result in any additional penalties for the professional caregiver, but would serve as notice to a prospective employer of such persons. For example, a registered nurse whose license has been revoked would not be disqualified for working as an unlicensed caregiver in a nursing home or assisted living facilities, but the employer would need to know why the license was revoked if the safety of patients or residents could be put at risk.

Introduction

Purpose of this Committee Interim Study

This report is based on the follow-up study to the 1998 HouseElder Affairs and Long Term Care Committee Project which examined Florida's adult abuse classification system and its use in employment screening. Committee staff issued a report in December 1998 on the problems with the current system and recommended that the committee explore alternative systems that would be more effective, less costly and less labor intensive. The 1998 committee report documented the cost and effort being invested in the current classification and screening system and the results accomplished. While the report concluded that the current system is in need of major redesign, there was not sufficient time prior to the 1999 Legislative Session for the committee to adequately develop a well thought out new approach.

This 1999 committee interim study involved further examination of the current system components and a survey of alternative approaches operating in other states. The findings of the study were anticipated to help shape a proposal to the House Committee on Elder Affairs and Long Term Care for a better system of employment consequences for caregivers involved in maltreatment of elderly and disabled adults. Such a system should meet the following criteria:

- be feasible and affordable;
- encourage private and public sector employers to hire more responsibly;
- be swift and efficient in the restrictions imposed on such employees and facilities;
- be cost effective in the processes and procedures established to prohibit, discourage, restrict, or constrain the employment of persons who may represent a threat to vulnerable adults; and,
- be fair to persons accused of abuse, neglect or exploitation as well as to the facilities and programs that employ them.

Adult Protective Services/Employment Screening Issues

This interim study focused on a number of issues and concerns identified over the past several years. One major concern is the distracting emphasis on perpetrators created by the 1989 revisions to the adult protective services (APS) statute. While not suggesting that APS staff focus on perpetrator due process issues to the detriment of protecting adult victims of maltreatment, it is clear that these due process requirements must always be considered when evidence suggests an identifiable offender. Further, there is no doubt that substantial programmatic, administrative, and legal resources of the Department of Children and Family Services (DCFS) are being applied to the perpetrator due process aspects of the program that could otherwise be used in the complex protective aspects of the program.

A second major concern with the current system is the wasteful effort that results from using the program's clinical electronic database as an inappropriate tool for employment

screening of paid caregivers. Hundreds of individuals who never have and never will apply for a job as a paid caregiver, and, thus, will not ever be screened for employment, are induced to exercise their due process right to appeal the state's adverse action of listing them as confirmed abusers. Of approximately 5,000 persons with confirmed classifications in the database, about 30% are over age 60 and about 20% are over age 65. **Nine are at least 100 years old.** Further, the department's data suggest that the vast majority of "confirmed", and thus employment disqualified, individuals are not paid caregivers at all. To require, for example, an elderly person suffering years of caregiver fatigue, and unjustly accused of neglect of a frail parent or spouse, to deplete her meager resources in order to clear the stain on her reputation for no practical protective purpose could be considered by some as unconscionable. Data will be presented in this report showing that the appeals process sometimes takes years and substantial resources, both public and private, to complete. Even when the department invests months or years of effort and expense to "win" a case under appeal, the result is sometimes moot, because the Agency for Health Care Administration (unlicensed caregivers) or the Department of Health (licensed caregivers) exempts the person from employment disqualification.

A third major concern is the disconnection between the state's regulation of health care programs and facilities, generally, and its responsibility to help health care providers maintain a safe and qualified workforce. Specifically, the agency requires corrective action by the licensed facility, but is not authorized to take action against a manifestly dangerous employee. With related responsibilities scattered across several state agencies, coherence, communication, and common sense are critical to the state's regulatory mission. Clearly, the current system arrangements are inefficient and deficient in achieving these health and safety goals. Without the oversight of a regulatory board, the question arises as to whether unlicensed employees should be subject to the state's review in some fashion. A thorough employment history check by a potential employer is clearly critical in the hiring of an unlicensed caregiver. Background screening is the other most practical method customarily used to alert employers about unlicensed caregivers who may be unsuitable or unfit. A major goal of this study is to identify and recommend an optimal structure and process to further strengthen the protections the state can reasonably provide for vulnerable adults.

Recent Statutory Changes

This study has also taken into account the recent changes in Florida Statutes related to (1) expanded background screening requirements, and (2) the creation of a background screening database within the Agency for Health Care Administration (AHCA). The 1998 Legislature enacted Senate Bill 714 (CH. 98-80, L.O.F.),, which imposed strict background screening requirements on owners and operators of entities regulated by AHCA, including hospitals, nursing homes, assisted living facilities (ALFs), adult day care centers (ADCs), adult family care homes (AFCHs), hospices, home health agencies (HHAs), nurse registries, and transitional living facilities.

The 1998 Legislature also enacted Committee Substitute for House Bills 3089 & 171 (CH. 98-248, L.O.F.), related to background screening of nursing home employees. In that bill, AHCA was directed to establish a background screening database which could be easily accessed by nursing homes, specifically, but also by other entities that conduct

employee background screening. The main purpose of this database is to make applicant/employee screening results readily available to employers of caregivers and, thus, reduce the unnecessary, costly and time consuming duplication of screening.

The costs for background screening can be burdensome for individuals and employers, as well as for Florida taxpayers, since screening costs of most nursing home employees are reimbursable under Medicaid. A level 2 screening provided in Chapter 435, F.S., involves the use of fingerprints to search the FBI national files, a search of the Florida Department of Law Enforcement (FDLE) files and a search of the Florida Adult Abuse Registry. The cost for level 2 screening is $45, including $24 for the FBI check, $15 for the FDLE check and $6 for the abuse registry check. A level 1 screening does not include the FBI file search, so the cost is typically $21. (Screenings requested by some state agencies cost less, since the FDLE discounts its fee to only $8. Attempts by sponsors of CS/HB 3089&171 to obtain a similar discount for screenings requested by AHCA to establish its database were strongly opposed by FDLE, although the enrolled bill required that FDLE provide such screenings at approximate costs.)

Currently, there are more than 160,000 records in the AHCA background screening database. Nursing home employee applicants who have been screened and cleared and who have not been unemployed for more than 180 days can be checked against the AHCA database by Internet inquiry. In these cases, no unnecessary duplicative screening is conducted, and no screening fees are charged. (Internet access user fees will be charged when AHCA has sufficient data to establish the amount of the fee.) Likewise, employers can easily and with little cost determine that an applicant has been screened and is disqualified from employment, thus saving time, effort, and expense. Applicants for employment in other entities regulated under Chapter 400, F.S., by AHCA, such as ALFs, ADCs, and AFCHs, benefit from this same screening resource, except that the provisions of SB 714 (CH. 98-248, L.O.F.), render invalid certain background screenings over 2 years old.

These recent statutory enactments, along with the creation by the 1995 Legislature of Chapter 825, F.S., to impose criminal penalties for elder abuse, suggest a continuing commitment by the Florida legislature to protect vulnerable adults from caregivers who would do them harm. Currently, Florida has over two and a half million residents age 65 and older, representing about 25 percent of the total population. This is the highest percentage of elderly in any state. The fastest growing segment of Florida's population is the age 85 and older cohort. With advancing age comes the likelihood of a number of physical and mental infirmities. The incidence of Alzheimer's disease and other dementias is rapidly increasing. The need for safe, reliable, trained, competent health care personnel to assist and care for frail elderly and other adults with disabilities is growing.

Regulation of Health Care Professionals

The state, under its obligation to protect the health, safety and welfare of its residents, licenses some caregivers, such as nurses, doctors, and therapists of various skills. Some caregivers, such as certified nursing assistants (CNAs), are certified by the state as having met a basic level of competency. The regulation of these professionals is the responsibility of the Department of Health (DOH). Some paid caregivers provide hands-on personal

services and care without any ongoing prior approval or recognition by the state. Many thousands of these employees work under supervision in acute care and long term care facilities as well as in the private residences of vulnerable adults. Many work for entities such as nursing homes, ALFs, home health agencies, and adult day care centers licensed and regulated by the AHCA. Many others work in institutions and programs operated by, regulated by, or funded by the DCFS, for programs operated or funded by the DOH, or for any of a variety of community care programs funded and administered by the Department of Elder Affairs (DOEA). Numerous such persons work for local private agencies, including those funded by local governments and charitable organizations. How many of these health care employees undergo background screening is unknown.

Overview of criminal and adult abuse registry employment screening system

The use of criminal history information for conducting background screening of individuals working in sensitive positions or positions of "special trust" began in the late 1970s. The 1974 legislature created the Department of Criminal Law Enforcement (now FDLE) and included a Division of Criminal Justice Information Systems. Since its creation, the division has conducted hundreds of thousands of screenings, providing a variety of entities with information needed in making personnel and other decisions. Many of these have involved caregivers of elderly and disabled persons.

In 1995 the legislature created Chapter 435, F.S., which sets forth the requirements for screenings according to level 1 and level 2. In creating Chapter 435 the legislature consolidated screening requirements and disqualifying offenses which were distributed throughout numerous other chapters. One intent was to provide a more uniform set of standards and procedures related to employment disqualification.

When the legislature established the current abuse registry and the classification and screening system 11 years ago, it was intended to prevent the employment of persons who have harmed an elderly or disabled person through abuse, neglect or exploitation and, thus, have demonstrated that they are not fit to be employed to care for vulnerable adults. As of February 1999, the adult abuse registry contained the names of 4,998 individuals classified as **confirmed perpetrators**. As confirmed perpetrators, all of these individuals are disqualified from employment in a variety of caregiver environments.

The abuse, neglect, and exploitation (ANE) classification and employment screening system is operated primarily by the DCFS, but also involves the AHCA, the DOH, and the Division of Administrative Hearings (DOAH). Infrequently, the District Court of Appeals hears a case in which a person continues to challenge the classification entered in the adult abuse registry by the DCFS.

Roles of the Department of Children and Family Services

Currently, adult protective services (APS) investigators are responsible for investigating reports of adult abuse, neglect, or exploitation without regard to where such alleged maltreatment takes place, i.e., a private home, a nursing home, hospital, mental health institution, or other location.

In addition to investigations, APS staff are involved in a number of important service and protective functions. In 1998-99, for example, APS was involved in placing hundreds of victims in alternate environments, including nursing homes (1,687), ALFs (834), foster care (26), and other temporary placements (974). They were also involved in 779 judicial dispositions for victims, including court ordered guardianship (336), court ordered involuntary placement (70), and court ordered protective supervision (210). Additionally, 19 court ordered protective supervision referrals were made to DOEA and four to the Community Care for Disabled Adults program. The legal resources of the department are involved in many of these responsibilities.

The department is also deeply involved in due process requirements. An extensive and costly network operates throughout this department to provide due process to alleged perpetrators whose employment rights are threatened by the department's abuse/neglect classification decisions. In the 15 DCFS districts, hundreds of staff must focus some portion of their time on perpetrator rights. Typically, these staff include adult protective services investigators and supervisors who must classify cases and defend those classifications, attorneys and other legal office staff who must advise other staff and the district administrator as well as represent the department in appeal challenges, numerous program administration staff and clerical staff, district screening coordinators and teams, and, finally, district administrators, their deputies and a variety of other management and administration staff.

At department headquarters, adult protective services staff work on policy and procedural issues related to due process requirements and provide training to district staff. General counsel's office coordinates due process appeals to the Division of Administrative Hearings and to District Courts of Appeal and maintains records on those cases. The Abuse Hotline does almost 100,000 employment screenings annually. Until last year when responsibility for screening certified nursing assistants (CNAs) was reassigned to AHCA, the Hotline screened an additional 50,000. Finally, the Secretary of the department has to issue Final Orders in appealed cases. The department estimated that approximately 400 employees play some role in this due process system at a cost of almost $1.5 million. Given the variability in the staff effort and costs reported by the 15 districts, it is likely that these estimates considerably understate the full effort and costs.

Roles of the Agency for Health Care Administration

Under the current system, AHCA investigates complaints in regulated facilities and by law must issue its report within 60 days. While these complaints may involve allegations of abuse, neglect or exploitation, the agency does not take action against any specific employee involved. Only adult protective services and law enforcement are authorized to take such action. However, AHCA may require the facility to develop a corrective action plan to resolve the particulars of the complaint. It should be noted that the Long Term Care Ombudsman and the Human Rights Advocacy Committee may also be investigating the same complaint, with the purpose of advocating with the facility on behalf of one or more residents. In addition, the Attorney General's staff in the Medicaid Fraud Unit investigate reports of abuse, neglect, and exploitation in Medicaid certified facilities.

The agency also operates an office which acts on requests by **non-licensed** applicants and

employees for exemption from criminal or abuse registry disqualification for employment. The provisions governing the exemption processes are set forth in section 435.07, F.S. The office processes about 400 criminal exemption requests and 200 abuse registry exemption requests per year. This process mirrors the exemption process in DOH, which acts on exemption requests from state licensed and certified health care professionals.

As previously noted, the agency was directed by the 1998 Legislature in CS/HB 3089 & 171 to establish a screening database which could be easily accessed by nursing homes and other programs to determine if an applicant had been screened. The background screening office processes about 500 inquiries daily, of which about 167 have records already in the database. The funds saved in avoiding unnecessary duplicative screening are substantial.

Roles of the Department of Health

The only directly related function of the DOH in the current system is its processing of exemption from disqualification requests submitted by licensed or certified health care workers. The department reported last year that between July 1996 and June 1998 it received 263 exemption from employment disqualification requests. Of these, 244 involved a criminal disqualification, with 196 being granted and 46 being denied. The remaining 19 exemption requests were because of a confirmed abuse report. Of these, DOH granted 13 and denied 6. Most of the exemption requests were from certified nursing assistants (CNAs).

Federal rules require states to maintain a registry of all certified nursing assistants working in long term care facilities. The department has been maintaining this registry for several years within the Division of Health Quality Assurance. This division is responsible for the regulation of licensed health care professionals in Florida. Although the federal regulations govern only CNA's working in nursing homes, Florida's registry includes CNA's working in other health care environments, such as hospitals, home health agencies, and nurse registries. At present there are just over 50,000 CNA's employed by Florida's nursing homes. Estimates of the total number of individuals certified as nursing assistants in Florida range from 200,000-300,000. The department is currently trying to identify all active CNAs and their employers. The federal rules disqualify from employment in a long term care facility individuals who have been "(A) Found guilty of abusing, neglecting or mistreating residents by a court of law; or... (B) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; " While there seems to be no provision for exemptions in the federal rules, AHCA staff report that federal regulators have approved Florida's state plan which provides for exemptions.

Division of Administrative Hearings

Florida, like other states, provides to the citizens of the state an avenue to protest or appeal adverse actions imposed by any state entity against them. Chapter 120, F.S., sets forth the rights and procedures for securing those rights. Over the past 11 years since the current screening system has been operating, DOAH administrative law judges (ALJs) have heard hundreds of appeals of citizens challenging their classification by APS as

confirmed perpetrators. Data supplied by the DCFS show that during FY 1996/97 and FY 1997/98 there were 231 appeals under the provisions of Chapter 120, F.S. Of these, 94 actually went to a hearing before an ALJ. In 49 of these hearings the recommended order by the ALJ was in favor of the alleged perpetrator, and in 45 the recommended order upheld the department's classification. Individuals who have requested an exemption from employment disqualification because of a criminal conviction or confirmed abuse finding and have been denied exemption by either DOH or AHCA may also request an administrative hearing.

Role of the Department of Elder Affairs

The Department of Elderly Affairs was created by the Florida legislature in 1991. Among the purposes provided in s. 430.03, F.S., the department has the responsibility to "Assist elderly persons to secure needed services ..." and "Promote the prevention of neglect, abuse, or exploitation of elderly persons unable to protect their own interests." The department, through its area agencies on aging, administers both federal and state programs for the elderly.

The DOEA does not have any direct participation in the system of adult abuse investigation, classification and employment screening. In 1998, however, substantial statutory changes were enacted related to APS investigations of reports of neglect in situations in which no second party perpetrator was involved. These cases represent about a third of all reports to the Hotline of adult abuse, neglect and exploitation. The 1998 legislation removed references to "self-neglect" from provisions relating to APS cases and reports. It set up a system whereby individuals, who under the prior law would be charged with "self-neglect", may be determined by adult protective services to be either a disabled adult in need of services or an elderly person in need of services. Such persons are no longer classified in the central abuse registry and tracking system, so there is no longer the requirement to send letters notifying the person, their guardian, attorney or others of the person's appeal rights. The legislation strengthened and clarified DOEA requirements for providing assessment and services on an expedited basis to such persons referred from APS. The Office of Program Policy Analysis and Government Accountability (OPPAGA) was directed to study the referral process between the DCFS and DOEA and the process used by DOEA to set service priorities, and report to the legislative presiding officers by December 31, 2000.

Study Approach

Information presented in this report was gleaned from numerous sources. Statistical data related to the operation of the adult protective services program and the classification/screening system were reviewed. The database of all individuals classified by DCFS as confirmed perpetrators was provided to the Legislative Office of Economic and Demographic Research for analysis and cross tabulations of a number of relevant variables. All 50 states were surveyed by mail about their adult protective services systems and caregiver employee background screening requirements. Telephone interviews were conducted with staff of selected states. Relevant reports and statutory

provisions were procured from a number of states, as well. In addition to gathering data from other states, committee staff reviewed a number of relevant documents produced by a variety of Florida agencies, conducted interviews with staff of theDCFS, AHCA, the DOH, the Attorney General's office, Administrative Law Judges in DOAH, and law enforcement representatives. Further, staff reviewed about 84 Recommended Orders issued by ALJs and distilled a range of relevant data from those Orders. Most of these Orders were issued during the six month period of July through December, 1998.

Summary of Findings

Florida Adult Abuse Registry Statistics

As noted above, in February 1999 the adult abuse registry contained the names of 4,998 individuals classified as confirmed perpetrators. As confirmed perpetrators, all of these individuals are disqualified from employment in a variety of caregiver environments. Of interest, however, is the fact that 40% of these 4,998 individuals were classified in the first two and a half years of operation (between July 1, 1989 and December 31, 1991), according to the department's statistical reports. During that period an average of about 66 individuals were confirmed each month, statewide. In the following six year period, FY 1992-93 through FY 1997-98, an average of 19 persons were confirmed monthly, statewide. Such a disparity is impossible to reconcile and explain, but it suggests that the department's standards and practices changed dramatically.

Of the cases involving the 4,998 confirmed perpetrators, 40% were related to the victim. Of the remaining 60%, it is unknown how many or what percentage were paid caregivers versus volunteer neighbors or friends. Over the 11 year period about 35% of the total confirmed incidents occurred in institutional settings. This figure is somewhat skewed due to the fact that in the first year, 750 (54%) of the 1,384 confirmed cases were in institutional environments, including 299 in mental health institutions (MHI). **The next year MHI confirmed cases dropped dramatically from 299 to only nine,** and since then have ranged from three to nine per year, statewide. Whether reductions in the actual incidence of maltreatment of patients in mental health institutions occurred or whether the nature of investigations changed is unknown.

Over the past eight years, about 25% of abuse reports involved persons in institutional settings. These reports are classified according to 34 separate "institutional" settings, including such diverse listings as residential detox, foster homes, home health care, general hospital, nursing home, mental health day treatment, public school non-residential, and developmental services group home. The great majority of these alleged incidents occurred in nursing homes and ALFs. Interestingly, about 75% of these reports were determined by APS to be unfounded, compared to about 50% of the reports not involving institutions. According to the APS 1997-98 Annual Statistical Report,

> " Facility reports are among those that are the most difficult to investigate. There are often multiple victims, many of whom are physically or mentally unable to communicate. It is also extremely difficult to identify the perpetrator in facility neglect cases since many staff have contact and/or responsibility for the victim."

Further analysis of the database of 4,998 disqualified persons by the Joint Legislative Office of Economic and Demographic Research showed that about 20% of these confirmed perpetrators are age 65 or over. As noted earlier, **nine are 100 years old or older** and certainly not likely to apply for a caregiver job. The utility and appropriateness of this database for employment screening purposes is highly suspect.

DOAH Recommended Orders

Committee staff visited the Division of Administrative Hearings to review a sample of cases appealed to DOAH. Most of these records were closed by DOAH during the period July 1, 1998 through December 31, 1998. The remainder were closed between September 1995 and October 1999. It must be emphasized that the sample drawn was not random and, thus, cannot be considered representative of all cases closed by DOAH. Of the 84 Recommended Orders reviewed by staff, 68% of the victims were female and 32% were male. The average age of the victims was 79. Perpetrators were predominantly female (84% vs 16% male). The site where the alleged incident took place was nursing homes (30%), private homes (25%), ALFs (25%), and other (20%). Of the 73 orders that included data on date of denial of classification expunction/amendment request and date of the ALJ's order, the average length of time the case was open was 285 days. The average number of days from the date of the initial abuse/neglect/exploitation report to the completion of this process was 517 days. In order to get a sense of private costs involved in an appeal, the number of persons represented by an attorney was 36 out of 76. Clearly, substantial time, effort, and money are being spent both by the state and by accused persons to reach a decision which might disqualify an individual from some work environments as a paid caregiver.

Survey of other states

In July 1999, a survey was sent to the adult protective services programs in all fifty states in order to gain an understanding of the variety of approaches taken to prevent employee victimization of vulnerable adults. One objective of the survey was to discover innovative ideas that could be appropriately adapted to improve Florida's system. Twenty-one states responded to the survey including: AL, AZ, AR, CA, CO, CT, HI, ID, IL, IA, LA, ME, MI, NM, NC, OH, PA, TX, UT, VT, WV.

Variation of Responses

The variation in these survey responses reflects the wide range of strategies that are used by states to screen employees. Indeed, of the states responding, no two states have identical systems. Some examples of other states' systems as reported are as follows:

- 67% of the states maintain some form of a state-wide adult abuse registry. About 30% of these states, however, do not use these registries for employment screening purposes.
- 67% of the states require that criminal background checks be performed on employees.
- 48% of the states require BOTH criminal background and some type of abuse registry checks.
- 67% of the states maintain Certified Nursing Assistant (CNA) Registries that are used for employment screening purposes.
- 24% of the states rely solely on the CNA registry to screen employees. In these states, neither criminal background nor abuse registry checks are performed.

Where abuse registry and criminal background checks are required, the actual screening processes can vary in many different ways.

- **Who requests the background screening?** (e.g., training school, licensing board, health care employer.)
- **What is the timing and frequency of background checks?** (e.g., during training process, upon certification, upon hiring, once a year, once a career.)
- **What are the employment consequences of a criminal or abuse history?** (Some states mandate consequences, while others do not. For those states which mandate consequences, each has its own list of which offenses require action.)
- **What constitutes a criminal background screening?** (Some states require FBI fingerprint checks against the national database, and some only screening against state police records. The FBI check may depend on how long the individual has lived in the state.)
- **What types of facilities require background screening?** (Within a state there may be considerable variation in facility screening requirements. For example, nursing homes may have different employee screening requirements than adult day care centers, home health agencies, or hospitals.)

Each state's policy appears to have been crafted at a point in time to address the specific needs and political environment of the state. The states' characteristics (population, percentage of elderly/disabled citizens, geographic location, etc.) cannot be used to predict their screening strategies. The following summaries of selected states' systems shows some of the variability across the country.

<u>California</u>

California relies on criminal background checks to screen elder caregivers. Upon enrollment in a training program, certified nursing assistants (CNAs) and home health aides (HHAs) are required to submit their fingerprints to the California Department of Health Services for a criminal background check. Most programs which serve vulnerable adults are also required to perform a criminal background check on CNA and HHA applicants prior to employment.

Each of California's 58 counties maintains its own database of adult abuse investigations. This information is used by Adult Protective Services (APS) for investigative purposes only.

<u>Connecticut</u>

Connecticut relies on the applicant/employee to self-disclose any disqualifying history. The state does not require criminal background checks and its adult abuse registry is not available to employers for screening purposes. To prevent employee victimization of vulnerable adults, the employer is simply required to ask applicants if they have ever been

convicted of a felony. If they have, they are disqualified from employment.

Illinois

Illinois requires frequent background checks throughout a CNA's career. All CNA schools must run a criminal background check before admitting a student. After completing training, the individual must have another criminal background check before they can be added to the CNA registry. Every time the individual is hired, the employer must request a criminal background check unless the one on file with the CNA registry is less than one year old.

North Carolina

The North Carolina Department of Health and Human Services maintains two databases which are used to screen employees who work with vulnerable adults. (Criminal background checks are also required.) The specific entity which operates these databases is the Health Care Personnel Registry (HCPR) section of the Department's Division of Facility Services (DFS). The information in both of these databases can be accessed by any employer or member of the general public, 24 hours a day, via a telephone voice response system. The only information needed to access a record is the caregiver's social security number.

One database is the Nurse Aide I Registry. This is a listing of all the health care professionals (RN's, LPN's, Nurse Aides II, and Nurse Aide I) who have been trained and certified by the state and includes any abuse findings relating to these individuals. Before any such employee is hired by a nursing home, the employer must check their status in this registry. Every 24 months, employees must update their records with the registry. Employers can check the status of all of their employees' certifications at once by sending a written request to DFS.

The second database which is maintained by DFS is the Health Care Personnel Registry. This registry includes the names of all licensed and unlicensed health care personnel against whom abuse findings have been substantiated. Nursing homes are prohibited by law from hiring these individuals. Only abuse which occurred in institutional settings is found in this registry. The **county** Departments of Social Service maintain the records relating to cases of adult abuse in the community.

The responsibility for investigating institutional elder abuse allegations is shared by the facility and HCPR. Facilities are required to conduct the preliminary investigations. If evidence arises that would lead a reasonable person to suspect abuse had occurred, all facilities must forward these results to HCPR for further investigation. Nursing homes must forward both substantiated and unsubstantiated findings to HCPR. If a finding is substantiated by HCPR, the accused individual is sent notice of this finding and has 30 days to challenge the conclusion.

Texas

Texas has a decentralized system in which investigations of abuse are performed by the licensing agency. Each agency conducts its own investigations and maintains its own database.

Department	Jurisdiction
Texas Department of Health	Hospitals including psychiatric hospitals
Texas Commission on Alcohol and Drug Abuse	Alcohol and drug treatment facilities
Department of Health Services (DHS)	Nursing homes, assisted living facilities (ALF), adult foster care, Medicaid waiver programs, intermediate care facilities for the mentally retarded and developmentally disabled (ICFMR)
Texas Department of Protective and Regulatory Services (PRS)	Community settings (private homes), mental health and mental retardation settings

Due to the nature of their jurisdictions, the majority of the investigations are performed by DHS and PRS. These two agencies handle their investigations and records in different ways.

> Upon completion of an adult abuse investigation, PRS classifies the case as valid, invalid, valid/no-fault or unable to determine. This information remains in the PRS database for five years for investigative purposes and is not generally available to employers. However, an employer can request a letter from PRS indicating if an employee/applicant has a "valid" record in the abuse database. If a "valid" record is found, PRS must offer the employee/applicant due process before releasing this information to the employer.
>
> DHS monitors the status of the nursing aides' certificates which can be either valid, expired, or revoked. This information is kept in the DHS database permanently and can only be removed if a nursing aide successfully challenges a finding. Texas law requires employers to screen all nurses aides against this DHS database. This information is available to employers over the phone. (If more specific information about findings is required, details of a finding can also be obtained by writing to DHS.) On September 1, 1999, DHS' monitoring responsibilities were expanded to include unlicensed direct care providers.

The following chart highlights the differences between the PRS and DHS adult abuse registry systems.

	PRS (Community)	**DHS (Institution)**
Classification System	Valid, Invalid, Valid/No Fault, Unable to Determine	Valid, Expired, Revoked
Longevity of records	5 years	Permanent
Used for investigations?	Yes	Yes
Used by employers?	Not generally	Yes, required by Texas law
Due process?	Prior to release to employer	At the time findings are made

Other innovative approaches to adult protection and caregiver review

The state of Delaware passed legislation in the last two legislative sessions which substantially changed the system of employment consequences for paid caregivers. Although Delaware personnel did not respond to the survey, committee staff has maintained contact with agency and legislative staff over the past year. In 1998 the Delaware legislature created a Division of Long Term Care Consumer Protection in the Department of Health and Social Services. This Division has numerous duties including licensing facilities, investigating abuse, neglect, mistreatment, and exploitation, maintaining an adult abuse registry, and operating a consumer Hotline. The Division must refer complaints requiring an immediate investigation to the appropriate law enforcement agency (local law enforcement, the Attorney General's office, or the Delaware State Police). The Department is authorized to appoint special investigators with experience as police officers who may make arrests under particular circumstances.

Delaware has also created an Adult Abuse Statewide Committee (six appointees) which reviews investigative reports and recommends whether, and for how long, a confirmed perpetrator is listed in the abuse registry. Such individuals may receive a fair hearing to contest the decision. The Hearing Officer can set the time, if any, such person's name remains on the registry. Unlike Florida's abuse registry, being on the registry does not disqualify the caregiver from employment, but serves as notice to a potential employer.

Delaware has also implemented a requirement involving a "Service Letter". By law, an employer must request from the previous employer information about the caregiver applicant's work history. The prior employer must, by law, respond and supply the information.

Recommendations

In addition to gathering and analyzing the data presented above, staff of the House Committee on Elder Affairs and Long Term Care conducted interviews with numerous staff of various state agencies and private organizations, law enforcement representatives, advocates, adult protective service professionals in Florida and legislative and program staff in other states. The ideas, opinions, and information distilled from this intensive review have led staff to propose the following recommendations for affecting the employment of caregivers who may represent a threat to frail elderly and disabled persons. The recommended approach would rely on (A) criminal background screening, (B) mandatory employer reference checks, and (C) the state's ongoing regulation of health care professionals. This approach would substantially reduce the cost to the state compared to the current system and disencumber adult protective services staff from numerous perpetrator oriented activities.

Recommended Approach

B. Disqualify applicants for paid caregiver positions only for criminal offenses set forth in Chapter 435, F.S., under employee background screening requirements and discontinue the statutory requirements for classification of abuse, neglect and exploitation reports and abuse registry screening.

NOTE: This option would establish that only persons who have been convicted or plead nolo contendere to certain criminal offenses, including offenses set forth in Chapter 825, F.S., on elder abuse, would be disqualified from working as paid caregivers. ***This policy would be consistent with the policy enacted by the 1995 Legislature regarding the child abuse system****, and would set the clearest public policy on caregiver employment restrictions. Non-criminal maltreatment administratively determined by state staff outside the criminal justice system would no longer be sufficient to disqualify a person from such caregiver employment. Licensed health care professionals and certified nursing assistants would continue to be regulated by the Department of Health and would continue to be restricted from employment under the disciplinary authority of the regulatory boards and DOH. All of the current effort and expense going into imposing sanctions administratively on alleged perpetrators and in operating the vast due process machinery would be eliminated. Such expense could be redirected to improve protection of victims, support better law enforcement response, and increase state attorney prosecutions. The Attorney General could also be given specific authority, in cooperation with state attorneys, to prosecute crimes against the elderly under specified circumstances.*

B. Require regulated employers of caregivers and all caregiver employers under contract with the state to conduct reference checks to discover any disciplinary action imposed by previous employers on employees for caregiver maltreatment of patients. Require previous employers of applicants to divulge such personnel information relevant to patient protection, and enhance the statutory protections against liability for former employers who report such disciplinary action by protecting from discovery any such factual information received by the requesting employer.

NOTE: Currently, section 435.10, F.S., requires that employers must provide personnel records for employees or former employees to any other employer requesting this information. The information may include disciplinary matters and any reason for termination. Liability protection is provided to the employer, absent a showing that the employer maliciously falsified such records. Anecdotal information has suggested that many employers of caregivers are reluctant to ask for or provide such information. Mandatory reference checks by employers required to conduct background screening, along with criminal penalties against employees who falsify their employment history in an attempt to deceive an employer about prior disciplinary action taken against them for maltreatment of patients, could enhance the state's interest in protecting patients from unfit caregivers.

C. Require that, in keeping with its statutory duty to protect the health and safety of patients/clients, the Department of Health through its professional regulatory boards determine the appropriate employment consequences to impose on any caregiver who is licensed or certified by DOH. Further, it is recommended that any disciplinary action imposed by DOH against a professional caregiver for maltreatment of a patient/client be immediately reported to AHCA for inclusion in the background screening database.

NOTE: Disciplinary action reported to the AHCA database would not result in any additional penalties for the professional caregiver, but would serve as notice to a prospective employer of such persons. For example, a registered nurse whose license has been revoked would not be disqualified for working as an unlicensed caregiver in a nursing home or ALF, but the employer would need to know why the license was revoked if the safety of patients or residents could be put at risk.

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