Criminal Background Checks for Psychiatry? Michigan's Mental Health Exceptionalism

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The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, § 307 (MMA)[1] requires the establishment of a pilot program for background checks of new employees of long-term care (LTC) facilities. Michigan was the only participating state to single out psychiatric facilities and employees under laws designed to comply with the program specified in § 307. The program was a demonstration project from the Centers for Medicare and Medicaid Services (CMS). This three-year pilot (2005–2007) was designed to evaluate the effectiveness of conducting national criminal background checks on prospective employees with direct access to patients in LTC facilities, defined as nursing facilities, long-term care hospitals, intermediate care facilities, home health agencies, certain group homes, and personal care agencies.[2]

We examined the history of the CMS criminal background check program, Michigan's approach, potential implications for public health and public policy, and the possible ramifications of singling out psychiatric facilities.

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History of Background Check Programs

The rationale for the CMS program was that, because many older adults are vulnerable and dependent on supportive care services, it is important to ensure that LTC employees are not criminal offenders who may pose a risk to patients. Congress has enacted measures to protect LTC patients, including a federally required nurse's aide registry and mandatory investigation of fraud, abuse, and misappropriation of nursing home residents' property.[3,4] However, federal law imposes only minimum standards for background checks; states can choose to extend their laws beyond the federal requirements. Michigan state law also requires background checks for nursing home employees.[5]

Michigan was selected as one of seven states (along with Alaska, Idaho, Illinois, Nevada, New Mexico, and Wisconsin) to participate in the CMS demonstration. It is the only state that singles out psychiatric facilities or health care professionals. Other states' fingerprint pilot programs apply broadly to facilities that care for vulnerable populations or only to LTC facilities.

To receive funding from CMS for the background check pilot program, states had to have authority to require LTC facilities to conduct background checks, including fingerprinting, through statute,

regulation, or other mechanism. The MMA does not provide this authority. States participating in the pilot could expand the list of facilities and provider categories to undergo background checks beyond the MMA's minimum requirements. CMS did not recommend any expansion, but specified that states that expanded the scope of existing programs would benefit in the review process.

Each LTC facility providing services in a participating state must conduct a background check of each prospective employee. These background checks examine nurse aide registries, state criminal history records, and national criminal history records. Federal law prohibits LTC facilities from employing anyone convicted of specified crimes, including patient abuse convictions and felony convictions relating to controlled substances or health care fraud.[6] The CMS program does not dispense funds for additional background checks (such as for current LTC employees or new employees of other, non-LTC facilities), but states may use equipment (i.e., fingerprinting machines) for the pilot program for these purposes.[7]

Michigan's Approach to Background Checks

Michigan's participation in the CMS pilot expanded the list of health care facilities and employees who must undergo background checks to include not only LTC employees,[8] but also employees of adult foster care facilities,[9] psychiatric facilities and intermediate care facilities for mental retardation,[10] and to include all applicants for initial licensure or registration in any health profession.[11]

Michigan deliberately exceeded federal requirements so that virtually anyone employed in a psychiatric facility must undergo a background check. The state was approved for the CMS pilot in 2004, but did not pass the bills enabling it to require expanded background and fingerprinting checks until the fall of 2005. The result was that for Michigan to get the $5 million promised to implement the program, the legislature added several populations subject to mandatory background checks.

Michigan could have expanded its background check requirements beyond federal mandates to protect all vulnerable populations, not only those in LTC facilities. The project could support this goal by providing federal funding for state capital investment in equipment such as fingerprinting machines.

Implications for Public Health and Public Policy

Michigan's approach has at least two significant drawbacks. First, CMS funding for background checks is directed specifically to employees with regular, direct access to LTC patients. Once the CMS demonstration project ends, a participating state must fund any statutorily mandated background checks. Michigan's laws do not include sunset provisions for these statutes; the background check requirements will continue, but federal support will not. Moreover, while CMS allocates funds to evaluate the success of Michigan's program, it is unclear what will happen if the evaluation demonstrates that the program failed.

Second, it is unknown whether the expanded background checks will identify criminals who would not have been caught by standard, preexisting background checks. Moreover, the new laws, consistent with MMA requirements, bar any employer discretion. Thus, for example, a Michigan psychiatric facility provider convicted of drug diversion less than 15 years ago is barred from employment at that facility, regardless of the circumstances of the conviction, the provider's rehabilitation history, or contributions to the facility in recent years, even if she or he fully disclosed the conviction to the facility at the time of employment.

Mental Health Exceptionalism in Michigan's Background Check Program

By treating mental illness and psychiatry differently from other diseases and medical practices, Michigan has legislated mental health exceptionalism.[12,13] While exceptionalism purportedly can improve awareness of mental illness-specific needs and access to treatment, it also can lead to separated, uncoordinated and stigmatized, rather than integrated, health care and insurance parity. The net result may be suboptimal treatment and health outcomes.[12,13]

The law is also overly broad. Some subpopulations with mental disorders may need the added protection offered by Michigan's laws, such as patients with severe mental illness who require institutionalization, but most do not. Most employers now conduct checks, as do many licensing bodies (such as medical, psychological, nursing, and pharmacy). Hospitals, for example, must comply with Joint Commission

on Accreditation of Healthcare Organizations (JCAHO) standards for background verification.

In high-risk situations, Michigan's program could cover people with equivalent access as health professionals to patients, such as students, volunteers, contractors, individuals with occasional, but not regular, direct access to patients or patient information. There is no evidence that these people are less likely than mental health professionals to have criminal histories or to abuse vulnerable patients. Thus, Michigan's law cannot achieve its objective of protecting patients and has significant drawbacks. The state should expand its background checks to cover all health care providers, or limit them to direct care providers who work with the most vulnerable patients.

It is difficult to recruit and retain medical students in psychiatry,[14–17] and this law may intensify these problems. The background check requirements could dissuade mental health professionals from practicing in Michigan. In addition, psychiatry as a discipline historically has been stigmatized,[18] and these laws intensify this stigma, because other providers do not face similar requirements.

It is not surprising that Michigan's decision to require background checks for mental health facilities, but not for other health care facilities, has innate shortcomings. No physician groups (including psychiatrists) were involved in drafting the legislation, whereas the legislature received input and support from interest groups and policymakers such as the Department of Community Health, the Health Care Association of Michigan, the Michigan Association of Homes and Services for the Aging, the Michigan Assisted Living Association, the Michigan County Medical Care Facilities Council, and the Michigan Home Health Association.[19] When the Michigan Psychiatric Society learned of the legislation just days before its introduction, they felt it was too late and politically inadvisable to go on record opposing its passage, given its widespread support and lack of opposition by the Michigan State Medical Society.[20]

Despite these limitations, Michigan assumed an aggressive stance by conducting checks on anyone employed in a psychiatric facility rather than focusing on vulnerable patients and their providers. This approach increases risks, costs, and stigma with little benefit to at-risk populations.

Recommendations and Conclusions

It may not be too late to correct Michigan's flawed approach to protecting mental health patients. Instead of targeting only psychiatric facilities, Michigan could require employees of all facilities licensed under Article XVII of the Public Health Code to undergo background checks. This approach would avoid the problem of mental health exceptionalism and result in more efficient screening. Alternatively, and perhaps preferably, Michigan could more clearly define the patients who truly are at high risk of abuse.

When drafting future legislation, all states should also include stakeholders, including consumer panels, psychiatric societies, hospital associations, and university medical centers, among others, in deciding how necessary safeguards can be implemented without stigmatizing patients or their caregivers. The shortcomings of Michigan's policy affect not only its citizens, but also citizens of other states who may adopt its approach without awareness or examination of the flaws in Michigan's law, its implementation, and its outcome. Finally, when seeking to achieve the goal of improving mental health patients' safety and clinical outcomes in response to time-limited, narrowly focused federal demonstration projects, states must consider the potential unintended consequences of stigma and exceptionalism.

References

1. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. Law No. 108-173, § 307, 117 Stat. 2066, 2257 (2003)
2. Department of Health and Human Services (DHHS): Program for background checks for employees with direct access to individuals who require long term care. Initial Announcement, OPDIV Number CMS-04-004, CFDA No. 93.785 6 (2004)
3. 42 C.F.R. § 483.156 (1987)
4. 42 C.F.R. § 488.355 (1984)
5. 2002 Mich. Pub. Acts 303 (2002)
6. 42 U.S.C. § 1320a-7(a) (2006)
7. Department of Health and Human Services (DHHS): Questions and answers on the invitation to apply for the program for background checks for employees with direct access to individuals who require long term care. Initial Announcement, OPDIV Number CMS-04-004, CFDA No. 93.785 20 (2004)
8. 2006 Mich. Pub. Acts 28 (codified as Mich. Comp. Laws Ann. § 333.20173a and § 333.20173b (2006))
9. 2006 Mich. Pub. Acts 26 (codified as amended at Mich. Comp. Laws Ann. § 333.16146, § 333.16174, and § 333.16245 (2006))
10. 2006 Mich. Pub. Acts 27 (codified as amended at Mich. Comp. Laws Ann. § 330.1147 and adds § 333.1134(a) (2006))
11. 2006 Mich. Pub. Acts 29 (codified at Mich. Comp. Laws Ann. § 400.734b (2006))
12. Rochefort DA: From Poorhouses to Homelessness: Policy Analysis and Mental Health Care. Westport, CT: Auburn House, 1997

13. Bambauer KZ: State mental health policy: Proposition 63—should other states follow California's lead? Psychiatr Serv 56: 642–4, 2005
14. Colenda CC, Wilk JE, West JC: The geriatric psychiatry workforce in 2002: analysis from the 2002 National Survey of Psychiatric Practice. Am J Geriatr Psychiatry 13:756–65, 2005
15. Zarrinpar A: Psychiatry and stigmatization. JAMA 287:1856, 2002
16. Tamaskar P, McGinnis RA: Declining student interest in psychiatry. JAMA 287:1859, 2002
17. Yager J, Greden J, Abrams M, *et al*: The Institute of Medicine's Report on Research Training in Psychiatry Residency: strategies for reform—background, results, and follow up. Acad Psychiatry 28:267–74, 2004
18. Shorter E: A History of Psychiatry: From the Era of the Asylum to the Age of Prozac. New York: John Wiley & Sons, Inc., 1997
19. Best E: Legislative Analysis: Health Facilities, Agencies, and Occupations—Expanded Criminal Background Checks, First Analysis December 6, 2005. Available at http://www.legislature.mi.gov/documents/2005-2006/billanalysis/House/htm/2005-HLA-5166–3.htm/ or http://www.michiganlegislature.org. Accessed October 31, 2006
20. Aaron H, Schwartz WB: Rationing health care: the choice before us. Science 247:418–22, 1990