Mitigate Risk Through Background Screening Best Practices

By Madhavi Koli and Chuck Hammel, HireRight

Employment screening is ubiquitous among health care organizations prompted by both regulatory requirements and good business practice. But effective employment screening is based on a series of best practices which can help health care organizations to find the best employees, protect patients, and ensure a safer workplace. At the same time, these best practices help to overcome common screening gaps, which will go a long way toward protecting organizations from hiring someone unqualified, unlicensed, or unsafe, as well as mitigating the risk of lawsuits, fines, and brand damage. Following are some industry best practices, and organizations can use these guidelines as the basis for a discussion with their legal counsel to determine what is best for their individual companies.

Gap 1: Drug and Alcohol Testing for All

Drug and alcohol testing of health care employees isn't required by law, and though 79 percent of respondents to the *HireRight Health Care Spotlight* conduct drug/alcohol testing, 16 percent do not, and have no plans to implement one.[1]

The risks are obvious: An impaired health care employee can expose the organization to malpractice and workers' compensation claims, as well as potentially be dangerous to patients. Yet, the survey discovered that only 56 percent of current employees are tested (as opposed to 92 percent of job applicants).

It's best practice for health care organizations to conduct drug testing for all new hires and at random intervals on all employees (where allowable), as well as contract and contingent workers and volunteers.

Gap 2: The One-Size-Fits-All Screening

Health care organizations can sometimes err by using the same process to screen all employees regardless of role – doctors, nurses, receptionists, janitors, physical therapists, transcriptionists, X-ray technicians, security guards, cafeteria workers, IT specialists, and more. Obviously, a physician is going to come into the hiring process with a different job history and credentials than a building custodian. Screening both jobs the same way, often in an effort to save time and money, can result in the hiring of someone (in this case, likely a doctor) who would have never passed muster with a more thorough background check.

It's important that the screening program be designed so that every position is screened appropriately based on the requirements of each individual role, rather than trying to force a one-size-fits-all solution.

Gap 3: Incomplete Criminal History Searches

A criminal history search is a requirement for all organizations, but there are a myriad of databases and registries to check that often overwhelm HR departments.

For example, medical professionals often work in different states; since there's a lack of integration among state registries and databases, hiring professionals may miss a conviction in a criminal history search if they aren't checking every state where an individual lived or worked.

[1] *HireRight 2013 Health Care Spotlight*, page 14

Incomplete criminal record searches increase the risk that someone who has no business working for a health care organization can slip through the cracks and get hired.

It's best practice for health care organizations to check for criminal histories at the county courthouses for every county in which an individual has lived, worked or attended school. In addition, it's best to perform a national criminal history database search to uncover any convictions in other areas. However, since the national criminal history databases are not guaranteed to be completely updated and accurate, it's critical that if any records are found in the database the employer must verify them directly with the applicable courthouse or agency to ensure the record data is accurate and current.

Gap 4: Failure to Rescreen for Criminal Activity

Individuals with access to patients may potentially be convicted of a crime that might disqualify them from working in a health care environment or with a vulnerable population such as children or the elderly. Without recurring criminal history checks, an at-risk act may occur without the organization's knowledge, and ineligible employees may continue being employed. Doctors often have privileges at other hospitals where an at-risk incident may occur. It's important to rescreen current employees for criminal activity that may open health care organizations to risk of fines and malpractice.

Gap 5: Medical Sanction Monitoring

Health care organizations use state and federal databases to check that applicants and employees are licensed and free of medical sanctions. However, many organizations make only the bare minimum effort when performing these checks. In a recent HireRight survey, 42 percent of respondents use only the Office of the Inspector General's List of Excluded Individuals/Entities (OIG LEIE). Furthermore, just 19 percent of the organizations are using FACIS® – the Fraud and Abuse Control and Information System, which is considered a more thorough solution to confirm an applicant's history. And only 16 percent of respondents perform checks more than required – an overwhelming number do so only when necessary.[2]

Because the OIG LEIE and other federal exclusion lists are far from complete, and updated intermittently (possibly meaning a sanctioned individual might not appear on the lists for months), it's critical that organizations perform rescreening on a regular basis to ensure that all staff and contractor licenses remain active and in good standing. It's also industry best practice to exceed minimum requirements by employing FACIS as well.

Gap 6: Insufficient Extended Workforce Screening

Thoroughly vetting prospective and current employees is only one challenge. Contracted and temporary workers represent another significant gap, plus hospitals use volunteers perhaps more than any industry. In the same survey, 98 percent of the respondents screened job candidates, but only 60 percent screened contractors, 46 percent screened volunteers, and 13 percent screened vendors.[3] Contracted employees, and especially volunteers, typically interact with patients.

Adding to this dilemma of screening extended workforce is high turnover: a contracted employee may finish a job and then return for another job three years later, at which time another background check should be performed, but often isn't.

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[2] *HireRight 2013 Health Care Spotlight,* page 13
[3] *HireRight 2013 Health Care Spotlight,* page 11

It's crucial for health care organizations to follow industry best practice guidelines and screen the extended workforce to the same standards as the permanent workforce.

Gap 7: Checking Aliases and AKAs

People's names aren't permanent. Most name changes are innocent enough, such as for married names or nicknames, but some individuals use a name change to evade the system. For example, "John M. Doe" might have lost his medical license in one state, then apply for a job in another under the name "Michael Doe" and get hired, with his new employer never fully investigating his past.

It's important to screen by social security number or name variations to ensure a complete and accurate check.

Gap 8: Inconsistent Credentialing

Medical credentialing is a key process to verify the experience and qualifications of the health care staff and physicians by examining their licensure, training, experience, and criminal or disciplinary actions. It's important, and in some cases a legal requirement, that organizations credential an individual prior to employment and on an ongoing basis to ensure that the individual is qualified to provide specific care.

The credentialing process can take a significant amount of time and effort, and it's important that the person performing the credentialing uses primary source records and consistent search methodologies. Often hospitals and health care organizations perform their credentialing using in-house staff – and that process can vary by the individual performing the task and can lead to inconsistencies and safety and liability risks.

Some of these gaps will likely look familiar to almost any health care organization. One large senior care organization found out they had gaps the hard way when it was audited by the U.S. Department of Health & Human Services Office of Inspector General. With over 200 facilities nationwide and 20,000 workers serving 25,000 patients, officials began the audit confident they were compliant. They checked every job candidate against the OIG List of Excluded Individuals and Entities (LEIE) and even ran criminal history checks on all applicants.

However, during the routine audit, the authorities uncovered one current employee with outstanding sanctions. As a result, the government ultimately fined the provider $500,000 and issued a formal warning that if the organization didn't improve its employment screening system, the fines would increase. To address this issue, the organization reviewed its entire screening system and established new processes based on best practices. With the new system in place, compliance officers re-screened every employee and found about a dozen indications of potential violations and sanctions that required further investigation. Once fully scrutinized, the organization found that five individuals were sanctioned and had to be released. While five out of 20,000 employees doesn't sound like a high risk, when the penalty is $500,000 per person, the liability is tremendous.

Establishing a screening policy with a hard eye on closing these gaps is a worthwhile step for any health care organization.

About the Author

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