

The Elder Justice Act: What it Means for Long-term Care

A Care2Learn Enterprise White Paper

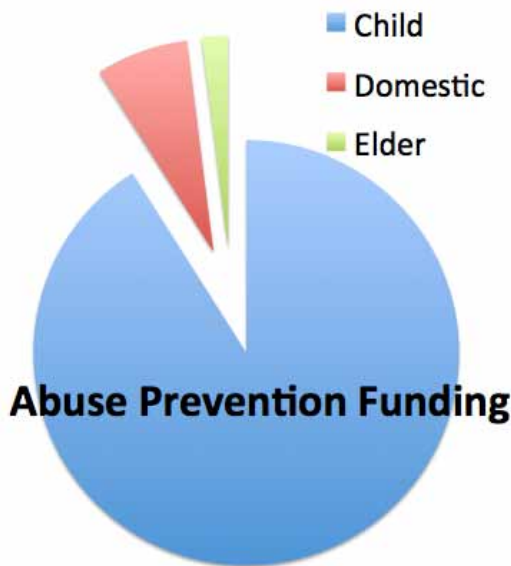
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Overview

The Elder Justice Act has been years in the making. The Elder Justice Coalition and 18 other elder advocacy groups took 100 video testimonies to document the need to pass a law to protect the elderly from abuse. A video was created—An Age for Justice: Confronting Elder Abuse in America—and was sent to legislators during the passage of comprehensive healthcare reform. The Elder Justice Act (EJA or “the Act”) was enacted as part of the Patient Protection and Affordable Care Act (PPACA) and signed into law March 23, 2010.



Prior to passage of the law, less than 2 percent of federal abuse prevention dollars was allocated to elder abuse prevention. Child abuse garnered 91 percent and domestic abuse 7 percent. The 2012 federal budget now includes \$20M in funding for adult protective services and long-term care ombudsman programs. In 2009 the amount was \$11M. This nearly doubles the funding amount. Grants for demonstration projects of \$25M annually are also set in the

Facility Impact

First, the basics: If a long-term care facility receives over \$10,000 annually in federal funds, the EJA applies. The statutory definition of a long-term care facility, pertaining to the Act, includes skilled nursing facilities, nursing homes, hospice programs in long-term care facilities, and

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law. In today’s uncertain political climate, funding may be implemented or it may not be, but the line item is in the projected budget.

The EJA mandates reporting of any suspected crime against an elder in a long-term care facility. Individual employees, owners, managers, and even contractors are all mandatory reporters. Facilities face exclusion from federal funding for retaliation against anyone reporting a suspected crime. Individuals now also face fines for failing to report a suspected crime.

Confusion over current reporting timelines, the requirement to report to two agencies, and fear of personal fines may make the EJA difficult to explain to staff. Liaison with local law enforcement can be a problem due to varying local responses to the new law. This white paper will provide an overview of the impact of the EJA on long-term care facilities, including education suggestions and resources for facilities. The Resources section provides templates for policy and procedure, as well as a poster template. Both are customizable for your facility.

intermediate care facilities for the mentally retarded (ICF/MR). Assisted living is not covered as of late 2011.

The Act applies to every owner, operator, employee, manager, agent, or contractor of the facility. Note that contractors are included.

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- In a Continuing Care Retirement Center (CCRC), the law applies in the nursing home section. Watch for outliers—staff members who work as floaters or normally work in several levels due to their job duties.
- Be sure to notify all facility contractors of the new requirements.

The Act requires any owner, operator, employee, manager, agent, or contractor of the facility (for ease of reference I will use 'staff', even though this group includes contractors, owners and agents) to report a reasonable suspicion of a crime against a resident of the facility or a person who is receiving care at the facility.

- Long-term care facilities with outpatient therapy departments or other services for the elderly should include these components in notification and training for the Act.

A reasonable suspicion does not have to be first-hand knowledge. Attorneys define reasonable suspicion as: **a legal standard of proof that is more than a hunch but less than probable cause.** A reasonable suspicion would include observation, experience, and reports by residents and family members.

Reports must be made no later than two hours after the staff member has formed the suspicion of a crime if there is serious bodily injury involved, and no later than 24 hours if there is not serious bodily injury. The report

must go to both the state survey agency (SSA) and local law enforcement. **As of January 20, 2012 a covered individual may report a reasonable suspicion of a crime to the *facility administrator*, who will then coordinate reporting to the SSA and law enforcement, provided an individual has clear assurance the administrator is reporting it.**

- The reporting timeline is based on clock time, not business hours. State survey agencies not open 24 hours per day are directed to have an answering machine or fax to take reports after hours.



The facility may not retaliate against any staff member that reports a crime; must educate staff at orientation and annually; and is required to post information about the EJA's requirements.

Penalties

The Act fines **individuals** who do not report, rather than facilities. The fines can be as large as \$300,000. Individuals can also be excluded from participation in any federal healthcare program.

Facility penalties may be applied for employing an excluded individual and for retaliation toward any staff for reporting under the Act. Employing an excluded individual makes the facility ineligible to receive federal funds during the time the individual was employed by the facility.

- The Secretary may make an exception by considering the financial burden on a provider with underserved populations. This includes rural facilities, those with racial and ethnic minority populations, and those with residents who have special needs such as language barriers, alien status, age, or disabilities.



The penalties for a facility that retaliates against a staff member for reporting a crime include fines up to \$200,000 and exclusion from federal funding.

- Retaliation includes any harassment, threats, suspension, termination, or reports to licensing agencies (such as a nursing board) as a result of reporting a suspected crime against a resident.

Risk Factors

The primary risk factors associated with the implementation of the EJA in a facility are: confusion, coordination, and culture.

Confusion is due to the duplicative nature of the reporting requirements. There are already reporting requirements for abuse—a 24-hour and then a 5-day report. The timeline for elder justice reporting is different and requires a distinction of serious vs. non-serious injury. CMS, in its direction to surveyors, repeats the requirement for a report to both the state survey agency and local law enforcement.

- Facilities may want to teach staff the “highest common denominator” method for reporting: Report using the most restrictive time limits.

There is also confusion in the reporting and notification processes. The law specifically mandates that **individuals** report, not facilities. Federal regulations already require SNFs and NFs to ensure all alleged violations involving mistreatment, neglect, or abuse are reported immediately to the administrator of the facility.

- Be sure the policy and procedure for abuse and criminal reporting stresses the non-retaliatory nature of reporting. Facility policies should reflect a culture of safety and constant improvement.

Confusion about the criteria for “serious bodily injury” may make it difficult for staff to know when to report in the two-hour window. The Act defines a serious bodily injury as an injury with extreme physical pain; with the possibility of loss or impairment of a bodily member, mental faculty, or organ; a risk of death; or that may require surgery, hospitalization, or rehabilitation.

- When in doubt with regard to whether an injury qualifies as ‘serious bodily injury’, report using the earlier timeline.

Coordination with law enforcement is another risk area. The Act requires a report of “any reasonable suspicion of a crime” as defined by local law. Facilities must coordinate with their local law enforcement entities to determine what actions are considered crimes. In a discussion among peers of the American College of Health Care Administrators (ACHCA), the answers to “What is a crime?” were variable across the country. The amount of cooperation from local law enforcement also varied from supportive to nonresponsive.



- Meet with local police or sheriff to talk about the law, what constitutes a crime, and how law enforcement will respond to reports. Use your local nursing home association to assist if needed. Education of law enforcement about the Act as well as an overview of how long-term care facilities operate in the regulatory arena may be helpful.

Coordination with contractors is an important part of compliance with the Act. This is especially true of hospice contractors. CMS recommends in its letter to surveyors that the facility has a written agreement that includes a provision stating that the hospice must report all alleged violations involving mistreatment; neglect; or verbal, mental, sexual, or physical abuse—including injuries of unknown source and misappropriation of patient property by anyone unrelated to the hospice, to the SNF/NF, or to the ICF/MR administrator within 24 hours of the hospice becoming aware of the alleged violation.

- Therapy and other contractors: Physician assistants, mobile x-ray technicians, podiatrists, and others will require written agreements.

Culture is the third risk factor. The National Center on Elder Abuse has published the “Nursing Home Abuse Risk Prevention Profile and Checklist” to help facilities assess and address the risk factors for abuse. According to the NCEA, risk factors include the following: abuse prevention policy, staff training, staff screening, staff burnout, staff ratio and turnover, history of deficiencies or complaints, culture, management, and physical environment.

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Culture in particular can affect the risk of abuse. The least risky culture looks like this:

- Leadership and staff acknowledge that abuse could happen in the facility.
- Staff members feel they can report problems without fear of reprisal (or fear of being ignored or trivialized).
- Problem solving is proactive, not reactive.
- The resident's version of events is given as much credence as the staff member's.
- Staff members feel free to "let go" and change direction when alternate care strategies are needed to care for the resident.

Copies of both the NCEA profile and checklist are located in the Resources section.

The difficult part of this discussion is that, consciously or not, some supervisors do not want to hear about suspected abuse. A nursing assistant who reports abuse to her supervisor may be tagged as negative, pushy, or uncooperative. The administrator may view a nurse who reports suspected abuse as a troublemaker. It is almost a reverse-halo effect. Instead of remembering the many instances of good resident care, the abuse report tinges the perception of job performance. The person who

reports may be fired for a contrived reason or the reporting individual may be scheduled for the least desirable shifts.

A recent study showed that 44 percent of nurses who did not report a patient care condition that could have caused harm chose to remain quiet because they feared workplace retaliation. Administrators, supervisors and other staff members pass on the subtle culture of overlooking issues. It is necessary to take a hard look at everyone's attitudes and actions regarding abuse reporting. Only then can negative influences be exposed and eradicated.



"Alas, culture is not what we say, what we think, what we mean, or even what we intend; it's what we do." Jon Burroughs, MD

Education

The Act requires that all staff be notified annually of their obligation to report elder abuse. CMS suggests using a completed orientation or training attendance sheet that specifies education in this area, or a copy of a letter sent "to covered individuals". Additionally, information about the Act must be posted in the facility. A sample poster is located in the Resources section.

For direct care staff, annual training can be paired with the now-mandatory annual dementia management education. Many cases of resident abuse are related to dementia. Ongoing education about how to deal with behaviors associated with dementia will be helpful in reducing staff stress and potential problems in dealing with these residents.

Education and supervision of direct care staff are vital in order to point out inappropriate behavior in resident care. Some staff members may come from home settings where derogatory remarks are considered normal behavior. Some may have boundary issues and do not know how to draw the line between personal and professional relationships. This is best taught as it happens, using the real-life examples of current behavior. Nonpunitive feedback with

teaching of correct behavior works best. You might try saying, "Put your shirt on now, please" instead of "Get your shirt on". The resident will hear it as a request, not an order.



The Good News

A 2011 survey of 16,000 nursing assistants conducted by the Agency for Healthcare Research and Quality (AHRQ) reported that 84 percent of nursing assistants had positive feedback about reporting incidents at their facility. Also, the perception of resident safety had the highest average positive response, at 86 percent. Communication and feedback are a strength at most facilities, with resident safety a primary focus of care.

For most facilities, the EJA is another layer of reporting that will be incorporated into daily facility operations. After the initial education and implementation, staff will grow used to this requirement just as they have others. The reality is that more regulations will be coming in this and other areas. Stay in touch with your professional associations for updates. As always, keep learning. A mindset of ongoing learning is the best quality for any professional.

Resources

CMS S&C letter 8/12/11 with specific instructions for implementing the Elder Justice Act provisions. Click here:

< ElderJusticeCMS2011.pdf >

Policy and procedure template, customizable for your facility, to meet Elder Justice Act requirements. Click here:

< ElderJusticePP.docx >

Elder Justice poster template, customizable for your facility, to meet Elder Justice Act requirements. Click here:

< ElderJusticePosterC2L.docx >

Nursing Home Abuse Risk Prevention Profile and Checklist, by the National Council on Elder Abuse. Click here:

< NursingHomeRisk.pdf >

Elder Justice Act video and other information: <http://elderjusticenow.org/>

About the Author



Barbara Acello is an independent nurse consultant and educator in Denton, Texas. She is a member of the Texas Nurses Association, NANDA International, and the American College of Healthcare Administrators (ACHCA). She is the recipient of the 2006 ACHCA Education Award and the 2008 ACHCA journalism award. She has assisted with writing and developing mandatory state curricula for nurse aides and EMTs and has written and contributed to

numerous textbooks, instructor guides, quick reference guides, and supplemental instructional material for healthcare personnel. Geriatrics is her preferred area of clinical practice, and she is committed to improving working conditions, education, and professionalism for personnel in the long-term care industry. Resident safety, pain assessment and management, restraints, pressure

ulcers, and infection control are sub-specialty areas of her practice.

Barbara has over 25 books, workbooks, examination preparation guides, and desktop references published, including:

- The Long-Term Care Director of Nursing Field Guide
- The Long-Term Care Legal Desk Reference
- Ending Hospital Readmissions: A Blueprint for SNFs
- Clinical Pain Management for Long-Term Care Nurses
- Nursing Assistant: A Nursing Process Approach (basic and advanced)

Google "Barbara Acello" to find Barbara's books online.

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Graphics

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