

**TESTIMONY OF SID ROCKE
DIRECTOR, MEDICAID FRAUD CONTROL UNIT
ON BEHALF OF CHARLES C. MADDOX, ESQ.
INSPECTOR GENERAL**

**BEFORE THE PUBLIC ROUNDTABLE
ON BILL 14-342, THE “MANDATORY AUTOPSY FOR
DECEASED WARDS OF THE DISTRICT OF COLUMBIA
AND MANDATORY UNUSUAL INCIDENT REPORT ACT OF 2001”**

DECEMBER 13, 2001

GOOD AFTERNOON CHAIRPERSON ALLEN AND MEMBERS OF THE COMMITTEE. I AM SID ROCKE, DIRECTOR OF THE OFFICE OF THE INSPECTOR GENERAL’S MEDICAID FRAUD CONTROL UNIT (MFCU) AND WITH ME TODAY IS ILENE NATHAN, DEPUTY DIRECTOR OF OUR UNIT.

I AM PLEASED TO TESTIFY BEFORE YOU TODAY ON BILL 14-342, THE “MANDATORY AUTOPSY FOR DECEASED WARDS OF THE DISTRICT OF COLUMBIA AND MANDATORY UNUSUAL INCIDENT REPORT ACT OF 2001.” SECTION 4(A) OF THE ACT REQUIRES REPORTING OF ALL UNUSUAL INCIDENTS TO THE DEPARTMENT OF HEALTH (DOH) AND THE INSPECTOR GENERAL (OIG). SECTION 4(B) REQUIRES PROVIDERS TO ALSO NOTIFY THE METROPOLITAN POLICE DEPARTMENT, ALONG WITH DOH AND THE OIG, OF ANY UNUSUAL INCIDENT THAT INVOLVES ABUSE OR DEATH OF A RESIDENT OR OTHER INCIDENTS DEEMED APPROPRIATE FOR POLICE NOTIFICATION. WE ARE HERE TODAY TO DISCUSS THE SIGNIFICANT

IMPACT THIS LEGISLATION HAS ON THE WELL BEING OF NURSING HOME AND GROUP HOME RESIDENTS AND THE EFFECTIVENESS OF OUR UNIT IN FIGHTING ABUSE AND NEGLECT. IN ADDITION, WE WOULD LIKE TO TAKE THIS OPPORTUNITY TO GIVE SUGGESTIONS ON HOW THIS LAW MIGHT BE AMENDED TO INCREASE THE BENEFITS TO RESIDENTS, OUR AGENCY, AND THE DISTRICT OF COLUMBIA IN GENERAL.

ROLE OF THE MEDICAID FRAUD CONTROL UNIT

AS YOU KNOW, THE MEDICAID FRAUD CONTROL UNIT IS THE NEWEST OF THE FOUR DIVISIONS WITHIN THE OFFICE OF THE INSPECTOR GENERAL. IT RECEIVED ITS CERTIFICATION BY THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES ON MARCH 1, 2000. THE MEMBERS OF THE UNIT BRING A VARIETY OF SKILLS AND EXPERIENCES TO THE UNIT. OF PARTICULAR VALUE TO THIS DISCUSSION IS THE PROSECUTION AND THE HEALTH CARE INDUSTRY BACKGROUND THAT MEMBERS POSSESS. THE DIRECTOR AND DEPUTY DIRECTOR HAVE A COMBINED 30 PLUS YEARS EXPERIENCE IN PROSECUTIONS. SEVERAL OF OUR INVESTIGATORS HAVE EXTENSIVE EXPERIENCE IN INVESTIGATING CRIMES AGAINST PERSONS, INCLUDING ASSAULTS. OTHER UNIT MEMBERS HAVE NURSING, HOSPITAL, AND INSURANCE EXPERIENCE.

IN ADDITION TO OUR ANTIFRAUD EFFORTS, WE ARE THE ONLY DISTRICT OF COLUMBIA AGENCY CHARGED WITH THE RESPONSIBILITY OF

INVESTIGATING AND PROSECUTING ABUSE AND NEGLECT IN NURSING HOMES, GROUP HOMES FOR THE MENTALLY RETARDED AND MENTALLY ILL, AND BOARD AND CARE FACILITIES. CASES OF PHYSICAL ABUSE GENERALLY INVOLVE AN INTENTIONAL ASSAULT ON THE PATIENT. IN CONTRAST, NEGLECT CASES TYPICALLY FOCUS ON POOR CARE RENDERED TO THE PATIENT. THIS CAN INCLUDE POOR MEDICAL CARE, POOR NUTRITION OR SANITATION, OR A FAILURE TO PROPERLY SUPERVISE LIVING CONDITIONS.

ABUSE CASES ARE AMONG THE MOST DISTURBING MATTERS HANDLED BY THE UNIT. THESE CASES ARE GENERALLY ASSIGNED TO THE UNIT PERSONNEL WITH A SPECIALIZED BACKGROUND WHO CAN HANDLE THEM IN A DILIGENT AND EXPEDITIOUS, YET SENSITIVE MANNER. THEY REQUIRE INVESTIGATORS AND PROSECUTORS TO SORT THROUGH VOLUMINOUS MEDICAL RECORDS AND DOCUMENTS, WHILE OFTEN WORKING WITH EMOTIONAL AND DISTRESSED PATIENTS, THEIR FAMILIES, AND MEDICAL STAFF.

INCIDENT REPORTING

THE ACT REQUIRES THAT ANY UNUSUAL INCIDENT BE REPORTED IMMEDIATELY AFTER IT OCCURS, BUT CERTAINLY NO LATER THAN 24 HOURS AFTER ITS OCCURRENCE. AN UNUSUAL INCIDENT MUST BE

REPORTED TO THE HEALTH CARE FACILITY DIVISION OF DOH'S HEALTH REGULATION ADMINISTRATION. A REPORT CAN BE MADE BY CALLING THE HEALTH CARE FACILITY DIVISION 24-HOUR HOTLINE OR BY TRANSMITTING BY FAX, OR BY REGULAR MAIL. UNUSUAL INCIDENTS MAY BE REPORTED TO THE OIG BY PHONE, FAX OR MAIL. ADDITIONALLY AN OIG AGENT, SPECIALLY TRAINED IN THE INVESTIGATION OF ABUSE AND NEGLECT, IS AVAILABLE BY PAGER 24 HOURS A DAY TO RECEIVE REPORTS. IN ALL CASES, TELEPHONE REPORTS MUST BE FOLLOWED BY WRITTEN REPORTS WITHIN 24 HOURS.

REPERCUSSIONS OF THE ACT

HOW AND IF UNUSUAL INCIDENTS ARE REPORTED BY PROVIDERS IS LARGELY DETERMINED BY THEIR INTERPRETATION OF THE LANGUAGE OF THE ACT. SECTION 2 (A) (2) STATES, "*UNUSUAL INCIDENT* SHALL MEAN ANY INCIDENT THAT RESULTS IN PHYSICAL INJURY TO A WARD OR RESIDENT OF A NURSING HOME, COMMUNITY RESIDENCE FACILITY, OR GROUP HOME FOR PERSONS WITH MENTAL RETARDATION AS THOSE TERMS ARE DEFINED IN THE HEALTH CARE AND COMMUNITY RESIDENCE FACILITY HOME CARE LICENSURE ACT OF 1983...." IN FY 2001, OUR UNIT RECEIVED OVER 2800 UNUSUAL INCIDENTS REPORTS. THEY RANGED FROM REPORTS OF CHANGES IN MEDICAL CONDITIONS OF NURSING HOME

PATIENTS (SOMETIMES ONLY A FEVER OR VOMITING) TO REPORTS OF ALLEGED ASSAULTS OF RESIDENTS BY EMPLOYEES OF THE FACILITIES. THIS ACT HAS PROMPTED DISCUSSION WITH THE DEPARTMENT OF HEALTH AND PROVIDER GROUPS ON WAYS TO INITIATE BETTER REPORTING. POSSIBLY BECAUSE OF THE NEWNESS OF THE LAW AND THE POSSIBLE AMBIGUITY OF THE DEFINITIONS, WE HAVE EXPERIENCED A FEW CHALLENGES. AS WE STATED EARLIER, IN FY 2001, WE RECEIVED THOUSANDS OF INCIDENT REPORTS, OF WHICH MANY RELATED TO INCIDENTS, SUCH AS FEVERS AND VOMITING, THAT WE BELIEVE THE LAW WAS NOT INTENDED TO COVER. AFTER NUMEROUS DISCUSSIONS AND CORRESPONDENCE WITH DOH AND PROVIDER GROUPS, WE HAVE SEEN A NOTABLE DECREASE IN THE REPORTING OF THESE TYPE INCIDENTS.

BUT, EVEN WITH CONSIDERABLE OUTREACH TO PROVIDERS, WE ARE UNFORTUNATELY STILL SEEING INCONSISTENT REPORTING: OF THE 21 NURSING HOMES AND NUMEROUS GROUP HOMES, SOME REPORT ON A REGULAR BASIS, BUT OTHERS HAVE NOT REPORTED AT ALL. ALTHOUGH WE WOULD LIKE TO BELIEVE THAT NOTHING IS OCCURRING IN THOSE NON-REPORTING FACILITIES, STATISTICALLY, THERE HAS TO HAVE BEEN SOME UNEXPECTED ILLNESSES, DEATH, OR INJURIES. FOR EXAMPLE, OF THE OVER 100 GROUP HOMES, ONLY 11 REPORTED IN OCTOBER AND ONLY 15 REPORTED IN NOVEMBER. OF THE 21 NURSING HOMES, ONLY 9 REPORTED IN OCTOBER AND ONLY 10 REPORTED IN NOVEMBER. OUR

INTENTIONS ARE TO CONTINUE TO HAVE DISCUSSIONS WITH DOH, MPD, MRDDA AND PROVIDER GROUPS ABOUT THIS LAW IN ORDER TO INCREASE AWARENESS OF THE LAW AND ITS MANDATE.

ON A VERY POSITIVE NOTE, I WOULD LIKE TO ADVISE YOU THAT AS A RESULT OF THE ALMOST 3000 INCIDENT REPORTS, WE HAVE INITIATED SEVERAL INVESTIGATIONS, AND ARREST WARRANTS HAVE BEEN ISSUED IN A NUMBER OF CASES. WARRANTS HAVE BEEN ISSUED FOR CAREGIVERS, WHO ARE PRIMARILY CERTIFIED NURSING ASSISTANTS (CNAS) WHO HAVE ALLEGEDLY COMMITTED VARIOUS ACTS OF ABUSE AGAINST NURSING HOME AND GROUP HOME RESIDENTS. ONE CAREGIVER PUNCHED WITH A CLOSED FIST AN ALZHEIMER'S PATIENT AND ANOTHER CAREGIVER SLAMMED TO THE FLOOR A MENTALLY RETARDED GROUP HOME RESIDENT. WE SUCCESSFULLY PROSECUTED WITH THE U.S. ATTORNEY'S OFFICE ONE CAREGIVER WHO BEAT A MENTALLY RETARDED, BLIND PATIENT WITH A VENETIAN BLIND. THAT CAREGIVER WAS IMMEDIATELY INCARCERATED AFTER TRIAL AND IS BEING SENTENCED TOMORROW.

RECOMMENDATIONS

FINALLY I WOULD LIKE TO RECOMMEND ACTION THAT COULD ADDRESS THE PROBLEMS OF BOTH INCONSISTENT REPORTING AND UNNECESSARY

REPORTING OF ROUTINE MATTERS. WE BELIEVE THAT THE DEFINITION OF UNUSUAL INCIDENT SHOULD BE NARROWED AND CLARIFIED TO COVER INSTANCES THAT ARE VALUABLE INDICATORS OF ABUSE AND/OR NEGLECT. THIS WOULD HAVE THE EFFECT OF REDUCING THE BURDEN ON PROVIDERS AND ALLOWING US TO CONCENTRATE OUR RESOURCES MOST EFFECTIVELY.

IN CONCLUSION, THIS BILL HAS HAD A VERY POSITIVE EFFECT ON THE ABILITY OF OUR UNIT TO RECEIVE NOTIFICATION ON ABUSE AND NEGLECT OF THE ADULT VULNERABLE POPULATION IN THE DISTRICT. SINCE THE COUNCIL ENACTED THIS LEGISLATION, WE HAVE EXPERIENCED A FEW CHALLENGES IN GETTING THE WORD OUT THAT THE LAW EXISTS AND WHAT INCIDENTS SHOULD BE REPORTED. HOWEVER, I AM PLEASED TO SAY THAT, OVERALL, THIS MANDATE MAKES PROVIDERS AND US MORE ACCOUNTABLE TO THESE VULNERABLE ADULTS AND TO OUR COMMUNITY IN GENERAL.

THANK YOU FOR INVITING ME TO TESTIFY. I AM HAPPY TO ANSWER ANY QUESTIONS YOU MAY HAVE.