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Via Email

The Honorable Michael Rodrigues
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The Honorable Cindy Friedman
Senate Committee on Ways and Means
State House, Room 313
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Re: House 4441 An Act Relative to the Governance, Structure and Care of Veterans at the Commonwealth's Veterans' Homes

Dear Chair Rodrigues and Vice Chair Friedman:

As you consider legislation reforming the Commonwealth's Veterans' Homes (Homes), I urge the Committee to strengthen House 4441 and Senate 2582 to promote effective management of the Homes and enhance the superintendents' direct accountability. The Office of the Inspector General (Office) is an independent state agency charged with preventing and detecting fraud, waste and abuse in the use of public funds and public property. Pursuant to the Office's mandate, I am offering recommendations to support the Legislature's efforts to create a holistic and comprehensive set of reforms.

Following the release of the Special Joint Committee on the Soldiers' Home in Holyoke COVID-19 Outbreak (Special Joint Committee) Report, my Office shared some of these recommendations with the chairs of that committee, provided written feedback to the House members who have been working on these issues and on January 12, 2022, summarized the Office's recommendations for the Joint Committee on Health Care Financing. I respectfully request that we meet to discuss these recommendations.

Structural Overview

The Office has set forth detailed recommendations below. As you will see, the Office finds that the current and proposed structure for the governance and oversight of the Homes are flawed. The Special Joint Committee recognized the need for a clear statutory reporting structure for the superintendents and recommended the establishment of a clear chain of command and communication channels for the Homes. The Office agrees with the Special Joint Committee that the current statute does not provide a clear reporting structure for the Homes. The Office therefore recommended to that Committee, and continues to recommend, the following structure for the supervision and oversight of the Homes:

- Department of Veterans' Services (DVS) Secretary reporting to the Governor.¹
- Superintendents, Executive Director of the Office of Veterans' Homes and Housing (OVHH) and Ombudsperson reporting to the DVS Secretary.
- Independent Office of Veterans Advocate (OVA) reporting to the Governor and Legislature.
- Department of Public Health conducting inspections and providing reports to the DVS Secretary, OVA, OVHH Executive Director and superintendents.
- Council or Boards serving in an advisory capacity.

This would create the necessary structure for the Homes and provide for appropriate stakeholder input. This would also create clarity and direct accountability for the Homes by making one person – the DVS Secretary – responsible for their oversight and management. This structure would set the foundation for the provision of high-quality long-term care, which must always remain the focal point for the Homes. Finally, this structure is similar to other executive branch agencies.

Governance Structure

In light of the need for a clear chain of command and oversight of the Homes, the Office strongly opposes the governance structure set forth in House 4441. In particular, the Office opposes both the creation and mandate of the Veterans' Homes Council (Council), as well as the modifications to the Boards of Trustees (Boards). Adding a Council to the chain of command would reinforce the current lack of accountability, further dilute the current chain of command, and create detrimental layers of management of the Homes. Most importantly, this structure fails to make one person ultimately responsible for the proper functioning of the Homes. As proposed:

- The Governor oversees the EOHHS Secretary.
- The EOHHS Secretary oversees the DVS Secretary.
- The DVS Secretary oversees the OVHH Executive Director.

¹ This change would require amendment to Section 17A of Chapter 6 of the Massachusetts General Laws to place the Secretary in the Governor's cabinet as well as to Section 16 of Chapter 6A of the Massachusetts General Laws to move the Department of Veterans' Services out of the Executive Office of Health and Human Services.

- The OVHH Executive Director coordinates and oversees the implementation and enforcement of laws, regulations and policies relative to the Homes but does not control either the Boards or the Council.
- The OVHH Executive Director oversees the superintendents of the Homes but does not control the day-to-day operations of the Homes.
- The 17-member volunteer Council manages and controls both Homes, administers the Homes' trust funds, appoints and removes the superintendents, and adopts rules and regulations governing the day-to-day operations of the Homes.
- The Boards have no substantive statutory power except for nominating one candidate for superintendent and recommending removal of a superintendent.

The proposed structure in House 4441 does not improve on the current situation. Rather, the proposed structure adds overlapping and misplaced responsibilities by making both the OVHH Executive Director and the 17-member Council responsible for the Homes while removing the DVS Secretary from the superintendents' chain of command. Simply put, these layers of management are not necessary for the Homes.

Role of Council. Inserting the Council between the Homes and DVS creates a risk of gaps in reporting and knowledge, and increases the likelihood of poor oversight and management. In addition, the significant operational, fiscal and supervisory responsibilities that House 4441 assigns to the Council are far too much management and control for a volunteer body to have over state long-term care facilities. The Office recommends against the creation of the Council.

Role of Boards. House 4441 revises the role of the local Boards, limiting their statutory duties to nominating to the Council a candidate for superintendent and recommending removal of a superintendent. The Council would be responsible for establishing the rules, regulations, by-laws, roles and responsibilities for the Boards. The Office recommends that the Legislature eliminate the Boards as they add yet another layer of supervision of the Homes and, as modified by House 4441, depend entirely on the Council to define their roles.

Adding to the confusion, House 4441 makes the Board members voting members of the Council, filling 10 of the 17 Council positions. It is unclear why local Boards are necessary if the Board members sit on the Council that governs the Boards and the Homes.

Proposed Advisory Role of Council and Boards. As stated above, the Office does not recommend the creation of the Council or retention of the Boards. However, if the Legislature creates a Council or retains the Boards, they should act in an advisory capacity only. To provide meaningful guidance to the superintendents, the members of the Council and Boards should have experience in the following areas: veterans' issues, fiscal management, labor relations, health care and nursing. Further, families and other stakeholders should have representation on the Council and Boards. While the Council and Boards could make recommendations and provide advice, they should not be responsible for the appointment or removal of the superintendents or have any responsibility for the operational decisions involving the Homes.

Superintendents' Reporting Structure. House 4441 attempts to address the current reporting confusion by having the superintendents report to the OVHH Executive Director even though by statute, the Executive Director has no control over the day-to-day operations of the Homes. As set forth below, the bill also assigns additional responsibilities to the Executive Director but does not grant the authority to enforce or implement those duties. Instead of the reporting structure proposed in House 4441, the Office recommends that the Legislature adopt a structure that maximizes the superintendents' direct accountability to the DVS Secretary.

The Office maintains that one person must be accountable for the superintendents – the DVS Secretary. The DVS Secretary should be responsible for managing, conducting regular performance evaluations for and disciplining the superintendents. Unless and until the Legislature streamlines and clarifies the existing statutes to make the reporting structure clear, there will be no direct accountability for the superintendents' performance.

DVS Secretary: Member of Cabinet. Relatedly, the Office endorses the Special Joint Committee's recommendation that the Legislature elevate the DVS Secretary to the Governor's Cabinet. This shift would ensure that the DVS Secretary has access to the Governor to discuss veterans' issues and that the Secretary is directly accountable to the Governor for the performance of the Homes. House 4441 does not include this important change.

Hiring and Removal

With regard to the appointment and removal of the Homes' superintendents, House 4441 provides that the Board for each Home would nominate one superintendent candidate to the Council. The Council would then appoint the superintendents. Similarly, House 4441 allows the Boards or the Governor to recommend to the Council the removal of a superintendent and authorizes the Council to remove a superintendent. The Office does not support this process.

DVS Secretary Should Be Responsible for Superintendents. Although the Homes fall within DVS, House 4441 does not assign the DVS Secretary any role in either the hiring or removal of the superintendents. And as the Office has consistently recommended, one person must be accountable for the superintendents; the person who is responsible for the supervision and evaluation of the superintendents should have the power to decide on an appropriate person to fill the role and, if necessary, whether to remove that person.

If the Homes remain within DVS, the Office recommends that the Legislature make the DVS Secretary responsible for the superintendents' hiring, supervision, evaluation and, if necessary, removal. The Office further recommends that no other person or entity – including the OVHH Executive Director, Council or Boards – play a role in this process. There is no room for confusion or ambiguity about who hires, supervises and evaluates the superintendents. Moreover, the DVS Secretary must be able to determine if and when removal is necessary, and to implement a decision to remove a superintendent in a timely and thoughtful manner so that the leadership of the Homes remains stable and veterans' care is safeguarded.

Protection for Current Superintendents. For the same reasons discussed in the prior section, the Office recommends against House 4441's provision allowing the current superintendents to continue to serve in their roles "in accordance with the terms of any existing employment contracts" and subject to the proposed removal provisions set forth above.²

Moreover, this provision could delay the removal of a superintendent if a serious issue were to arise before the EOHHS Secretary's appointment of 10 qualified people to the two Boards and the appointment of the Governor's two Council members, the EOHHS Secretary's one Council member, the Speaker of the House's one Council member and the Senate President's one Council member.³ The appointment process alone could take up to a year because House 4441 does not require the Governor, EOHHS Secretary, Speaker of the House or Senate President to make their respective appointments to the Council until February 1, 2023.

Even after the appointment of the 10 Board members and five Council members, the Board or Governor would have to decide whether to recommend removal and then the Council would have to consider and vote on removal. As discussed above, delaying the removal of a superintendent could destabilize leadership, compromise the veterans' care or threaten the working conditions for the staff at one of the Homes, any one of which is unacceptable. For the reasons set forth above, the Office recommends that the DVS Secretary have the power to remove the superintendents.

Qualifications for the Superintendent

The Office supports the requirements that a superintendent must (1) be licensed as a nursing home administrator pursuant to Section 109 of Chapter 112 of the Massachusetts General Laws; and (2) be a veteran or have experience managing the health care of veterans in a nursing home setting.

Additional Required Qualifications. The Special Joint Committee correctly identified that a superintendent must possess a unique blend of experience and skills to be effective in this role. The Office agrees that experience in nursing home management is an essential qualification to provide appropriate leadership in a long-term care setting. Moreover, a superintendent must also have experience with fiscal management practices, executive management, and how unions operate and how to navigate labor relations issues. The Office recommends that any bill include experience in these four areas as additional required qualifications for the role of superintendent.

Channels for Communication and Problem-solving

Protecting the Ombudspersons' Independence. The Office supports the creation of an independent ombudsperson at each of the Homes to focus on concerns regarding veterans' health,

² The Office understands that neither superintendent has an employment contract.

³ The OVHH Executive Director and adjutant general of the Massachusetts National Guard serve as *ex officio* members of the Council.

safety, welfare and rights. House 4441 protects the ombudsperson's independence by making them a DVS employee rather than an employee of the Home.

However, the Office recommends that the ombudsperson report to the DVS Secretary and not the OVHH Executive Director. Having the ombudsperson report to the DVS Secretary would provide the necessary level of authority over and access to the Homes. It would send the message that the ombudsperson has a significant role and that the Homes' leadership must treat the ombudsperson with respect and cooperation.

Ombudspersons' Qualifications. In responding to numerous complaints about the Homes, the Office has found that they may involve a mixture of complex management and clinical concerns. As a result, it is essential that the ombudsperson be qualified in that role. To that end, the Office recommends that the Legislature include a requirement for the ombudspersons to have both clinical and management expertise to enable them to address the issues that are present in both Homes.

Creation of Hotline. The Office urges the Legislature to create a hotline, which is an important internal control and is often an impetus for problem-solving. The Office supported the creation of the hotline in House 4195 and recommends that the Legislature include this important reporting mechanism. The complaints that the Office has received reveal a reporting gap: there is no appropriate resource available under EOHHS or elsewhere within the executive branch to receive and address complex and time-sensitive complaints about the two Homes.

The hotline should receive complaints and concerns from residents, staff, families and others, and have a process for qualified investigators to evaluate these reports of problems at the Homes. The Legislature should clearly delineate the types of complaints the hotline would handle in a way that complements those of the ombudsperson. The Office recommends that the hotline handle complaints relating to day-to-day management, personnel, staffing and operational issues.

Further, the hotline staff must have the appropriate authority to conduct investigations and make recommendations. The hotline staff also needs independence from the management structure; to ensure this independence, the Office suggests that the Department of Veterans' Services manage this hotline.

Ombudsperson and Hotline Confidentiality. The bill's provision that the ombudsperson shall "make best efforts to ensure the confidentiality of complainants" does not provide enough clarity or assurance that the ombudsperson will keep a complainant's identity confidential upon request. To encourage complainants to share concerns, the ombudsperson and hotline staff must be able to offer strong statutory protections. Accordingly, the Office recommends requiring that the ombudsperson and hotline staff maintain strict confidence unless disclosure is necessary to make a referral to another agency or law enforcement. In addition, because each entity may receive complaints that fall within the other's purview, the ombudsperson and hotline staff should each be able to refer a matter to the other when necessary. The ombudsperson and hotline staff should share information only to the extent necessary to complete the referral.

Ombudsperson and Hotline Annual Reports, Training, Referrals, Response Time and Resources. To create transparency and accountability, the Office recommends that both the ombudsperson and the hotline staff submit an annual report to the Legislature with summaries of their caseloads and activities. To fulfill their important responsibilities, the ombudsperson and the hotline staff should receive extensive training and guidance. In addition, the Legislature should be clear about whether the ombudsperson and hotline staff must refer certain complaints to agencies or entities already charged with investigating specific types of issues.⁴ The Legislature should also mandate that both the ombudsperson and hotline staff address concerns and complaints in a timely, meaningful way, which will enhance confidence in both entities. Perhaps most importantly, the Legislature must commit sufficient funding to ensure both programs develop appropriately, function effectively and serve as a continuous resource and internal control.

Whistleblower Protection. The Office endorses House 4441's strong whistleblower protections for any person who files a complaint with a Home's ombudsperson. However, the Office encourages the Legislature to include similar protections for any individual who reports an issue to a hotline or another entity or person responsible for management or oversight of the Homes.

Office of the Veteran Advocate

House 4441 creates the Office of the Veteran Advocate (OVA), an independent agency charged with ensuring that veterans receive timely, safe and effective services. The Office endorses the creation of this oversight agency. The OVA could operate a complaint line, much like the Office of the Child Advocate operates its own complaint line, to receive concerns about children receiving state services.

The Office recommends that in addition to the list of abilities and professional qualifications included in House 4441, the Legislature should also require that the Veteran Advocate have health care experience because many of the issues that the advocate addresses will involve veterans' health issues.

⁴ For example, if the hotline receives a complaint alleging abuse or neglect of a disabled person under 60 years old, the legislation should state whether the hotline staff must refer that complaint to the Disabled Persons Protection Commission. Similarly, the legislation should articulate whether the hotline should refer a complaint to the Commonwealth's Human Resources Division Center of Expertise if the complaint alleges a violation of a Commonwealth-wide policy involving sexual harassment, discrimination, workplace violence, domestic violence/sexual assault/stalking or retaliation related to those policies.

Inspections by the Department of Public Health

Given the Homes' critical role in providing health care to veterans, the Office supports House 4441's proposal that the Department of Public Health (DPH) inspect the Homes. The Office recognizes the role that DPH currently plays in supporting the quality of care in different health care settings and the vital role that it could play in providing clinical support and independent oversight to the Homes. Accordingly, the Office recommends additional provisions to clarify and strengthen DPH's role.

Authorizing DPH to Address Noncompliance. To leverage DPH's expertise in overseeing long-term care facilities, the Office respectfully suggests that the Legislature provide more specific delineation of DPH's role with respect to the Homes. In addition to the inspections that House 4441 and other versions of the legislation have proposed, the Legislature should specify that DPH must monitor the implementation of the Homes' corrective action plans. The Legislature should also empower DPH to act on noncompliance with federal or state long-term care standards. DPH must have the authority and a clear mandate to take enforcement actions if the Homes fail to implement necessary changes. To this end, the Office recommends that the Legislature provide DPH with the statutory authorization to take such actions. As there is no other state agency charged with addressing noncompliance with 105 CMR 150 or subpart B of 42 C.F.R. § 483, DPH is the correct agency to take on this responsibility.

Creating Consequences for Noncompliance. In addition to charging DPH with the responsibility for addressing noncompliance with these regulatory provisions, the Office recommends that the Legislature create remedies if one of the Homes does not comply with federal or state long-term care standards, does not follow through on a plan of correction, or does not implement other DPH recommendations.

Leveraging DPH's Expertise. The Office also respectfully suggests that the Legislature further develop DPH's clinical oversight role and leverage DPH's expertise in long-term care. The Office recommends that the Legislature direct DPH to identify and help address vulnerabilities and to assist the Homes in implementing the best clinical practices to serve veterans. For example, in response to hotline complaints from whistleblowers and other stakeholders, DVS or the OVA should be able to request that DPH review clinical practices and have DPH's assistance with implementing any resulting recommendations. Finally, DPH should continue to set clinical standards for and conduct oversight of infection control at the Homes.

Reciprocal Obligations

Section 46 of House 4441 creates reciprocal obligations for the two Homes so that each Home is responsible for any obligation of the other Home. The Office objects to the inclusion of Section 46; its vague language and unstated purpose raise concerns about its practical effect on the Homes. The Office is unaware of any similar statutory provision making one state agency responsible for the obligations of another agency. Further, Section 46 is not specific as to what obligations this language encompasses or what funds one Home could use to satisfy the other

Home's obligations. For example, it is unclear whether this language could obligate Chelsea to satisfy any judgments that result from pending civil litigation against Holyoke. Moreover, each Home holds millions of dollars in donated funds and it is unclear whether one Home could use – or could be required to use – its donated funds to pay for the other Home's obligations.

The Office also has questions about the fiscal infrastructure of the Homes, including whether they have proper oversight and controls in place. In light of these concerns, Section 46 could make an already complex situation more challenging and could reduce the transparency of how the Homes are using their appropriated and donated funds.

Reporting Requirements

The bill also includes several reporting requirements, including:

- An annual report from the OVHH, in coordination with the Council, on the status of the Homes.
- An annual report from the Veterans' Advocate on the activities of that office.
- An annual review by the superintendents, in coordination with the OVHH Executive Director, on the Homes' health record system.
- At least biannual DPH inspection reports and corrections of violation reports.

The Office also recommends that the Legislature require the ombudsperson and the hotline staff to submit annual reports documenting their activities. These proposed reports would provide important information about the status of, and recommendations to improve, the Homes.

Coordination of Recommendations and Action Plans. House 4441 provides that the OVHH Executive Director would work with the superintendents and Council on two of these reports. The purpose of these reports is not only to provide transparency, but also to create a platform for coordinated recommendations and action plans to move the Homes forward. However, the work lies in the implementation and prioritization of projects to improve the Homes for veterans. To this end, the Office recommends that the Legislature designate the DVS Secretary as responsible for integrating, coordinating and implementing any recommendations and action plans that result from the Homes' reports.

Frequent Status Updates on the Electronic Medical Record System. To promote accountability and transparency, the Legislature should require the DVS Secretary to provide monthly updates on the status of the implementation of the electronic medical record system (EMR). Both Homes still operate with paper medical records because there is no EMR at either Home. This is unacceptable and compromises veterans' care. As a result, the Office does not support the proposed annual review by the superintendents and the OVHH Executive Director on the Homes' health record system because annual reporting for this critical system is simply not enough. DVS and the Homes have discussed procuring such a system since at least 2016, but there has been a lack of commitment to and funding for the project. Attorney Mark Pearlstein identified

this as a long-standing, significant problem in his report to the Governor, *The COVID-19 Outbreak at the Soldiers' Home in Holyoke, An Independent Investigation Conducted for the Governor of Massachusetts*, as well as in his subsequent testimony to the Legislature. DVS and the Homes have had years to put this important system in place, and 18 months have passed since Attorney Pearlstein recommended that the administration make EMR a priority for both Homes. The Legislature must now make EMR a high priority.

Oversight and Clinical Expertise

Finally, the Office strongly recommends that the Legislature consider how the various people and entities charged with leadership responsibilities and oversight of the Homes will coordinate and integrate their efforts. As the bill currently stands, leadership and oversight responsibilities fall under the following roles:

- Governor
- EOHHS Secretary
- DVS Secretary
- Office of the Veteran Advocate
- OVHH Executive Director
- Department of Public Health
- Ombudsperson
- Superintendents
- Council
- Boards

Because these roles involve overlapping responsibilities, the Office recommends that the Legislature designate a person (or people) at DVS who would be responsible for tracking recommendations, setting priorities for implementing these recommendations, and coordinating and integrating resources to support and improve the Homes. House 4441 assigns some of these responsibilities to the OVHH Executive Director, but the legislation does not provide the person in that role with any authority to hold the Homes or superintendents accountable for their actions or inactions.

It is critical that the Homes have stable and sustainable clinical leadership and oversight. When creating a new governance structure for the Homes, serving the health care needs of the veterans should remain the highest priority. Leaders with expertise in health care and in particular, long-term care, should be at the center – not on the periphery – of governing the Homes.

Chair Rodrigues and Vice Chair Friedman
Senate Committee on Ways and Means
February 17, 2022
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I would like to meet with you to discuss these recommendations, the questions that we have proposed for your consideration, or any other questions you may have. Thank you for your attention to this matter.

Sincerely,



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Inspector General

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