The Commonwealth of Massachusetts
Office of the Inspector General

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Via Email

The Honorable Michael F. Rush, Chair
State House, Room 208
Boston, MA 02133
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The Honorable Joseph F. Wagner, Chair
State House, Room 234
Boston, MA 02133
Joseph.Wagner@mahouse.gov

Re: An Act Relative to the Governance, Structure and Care of Veterans at the Commonwealth's Veterans' Homes

Dear Chairs Rush and Wagner:

As the Conference Committee considers legislation reforming the Commonwealth's Veterans' Homes (Homes), I write to support many of the proposed changes, which will promote effective management of the Homes, create a clear chain of command 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 have offered 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. I also provided written feedback to the House and Senate members who have been working on these issues and summarized the Office's recommendations for the Joint Committee on Health Care Financing. Consistent with our previous recommendations, I am now providing comments to the Conference Committee for your consideration.

Oversight of the Homes. The Office supports the elimination of the Homes' boards of trustees. (S2761, § 4.) The Office continues to caution against the retention of the boards of trustees or the creation of new councils because they have the potential to create confusion and misunderstandings about the chain of command. (S2761, § 7; H4441, § 2.) If the Legislature includes these councils in its final legislation, the Office strongly recommends that both councils serve only in an advisory capacity.

DVS Secretary. The Office supports the elevation of the Department of Veterans' Services (DVS) Secretary to the Governor's cabinet and the appointment of the DVS Secretary by the Governor. (S2761, §§ 3, 10.) This will provide the DVS Secretary with direct access to the Governor to discuss veterans' issues and will make the Secretary accountable to the Governor for the performance of the Homes. The Office also supports the creation of a stand-alone DVS, which will create a clearer chain of command for the Homes by removing the Executive Office of Health and Human Services from the reporting structure. (S2761, §§ 8, 9, 12.)

Superintendents. The Office supports the DVS Secretary appointing, supervising and removing the superintendents. (S2761, § 82.) This will eliminate any confusion about to whom the superintendents report and allow the DVS Secretary to have a strong role in the management of the Homes. The Office also supports the requirement that the superintendents have relevant training and work experience. (S2761, § 82.) The Office agrees that the DVS Secretary must conduct annual performance reviews of the superintendents. (S2761, § 82.)

Staffing. The Office supports making the DVS Secretary and the superintendents responsible for filling staffing vacancies within a prescribed time. (S2761, § 82.) This will help to ensure that the Homes have the necessary management and direct care staff to properly care for the veterans.

Ombudsperson. The Office supports the creation of an independent ombudsperson. (H4441, § 35; S2761, § 82.) However, the language proposed by the House would create a lack of clarity about the ombudspersons' reporting structure and could jeopardize their independence. The Office prefers the Senate's placement of the ombudsperson as a DVS employee reporting to the DVS Secretary; this will protect the ombudsperson's independence. This reporting relationship will also provide the necessary level of authority over and access to the Homes. Further, it will send the message that the ombudsperson has a significant role and that the Homes' leadership must cooperate with and respect the ombudsperson.

Hotline. The Office supports the creation of a hotline to channel complaints regarding the Homes to the ombudsperson. (S2761, § 82.) The hotline will fill the current reporting gap for complex and time-sensitive complaints about the two Homes.

Ombudsperson and Hotline Confidentiality. Requiring that the ombudsperson and hotline staff maintain strict confidentiality will create trust and encourage reporting of complaints. (H4441, § 35; S2761, § 82.) The Office prefers the Senate's detailed protections of complainants and confidentiality provisions for complainants and veterans' records and files. (S2761, § 82.)

Ombudsperson and Hotline Training, Annual Reports, Referrals, Response Time and Resources. The Office supports the training requirement for the ombudsperson and the hotline staff. (S2761, § 82.) The Office also supports the requirement that the ombudsperson and hotline staff create an annual report that will be available to the public, DVS Secretary and Legislature. (S2761, § 82.) The Office agrees with the requirement that the ombudsperson or hotline staff report any findings relating to a violation of law to the regulatory agency that is responsible for the enforcement of that law. (S2761, § 82.) The Office supports the requirement that the ombudsperson and hotline staff address concerns and complaints in a timely manner, which will enhance confidence in the system. (H4441, § 35; S2761, § 82.) Finally, the Office continues to recommend that the Legislature commit to providing sufficient funding to ensure both resources develop appropriately, function effectively, and serve as a continuous resource and internal control.

Whistleblower Protection. The Office endorses the strong whistleblower protections for any person who files a complaint with the ombudsperson or hotline staff. (S2761, § 82; H4441, § 35.) The Office supports the Senate language that offers robust protections for those who report issues at either of the Homes. (S2761, § 82.)

Office of the Veteran Advocate. The Office supports the creation of the Office of the Veteran Advocate (OVA), an independent agency charged with ensuring that veterans receive timely, safe and effective services. (H4441, § 36.) The Office endorses the creation of this oversight agency to add a layer of accountability for the caregivers of veterans who reside both in and out of the Homes. However, the Office recommends that the DVS Secretary serve as chair and coordinator for the Veteran Advocate's nominating committee. In addition, the Office recommends that the enabling legislation require the OVA to refer appropriate cases to a law enforcement agency. Finally, the Office recommends that the OVA receive confidentiality protections that are similar to those found in the Senate bill for the ombudsperson and hotline. (S2761, § 82.)

Inspections by the Department of Public Health. The Office supports the requirement that the Department of Public Health (DPH) conduct biannual inspections of the Homes. (S2761, § 27; H4441, § 13.) The Office also supports the requirement that DPH report violations of the applicable rules and regulations to the superintendents and DVS Secretary, and the requirement that the superintendent remedy any violations within 30 days. (S2761, § 27.) The Office agrees that the superintendent must report weekly to DPH on efforts to remediate violations and that DPH must conduct follow-up inspections to verify that the Home has taken the necessary corrective actions. (S2761, § 27.)

The Office continues to strongly recommend that the Legislature authorize DPH to follow up on inspections of the Homes in the same way that it follows up on inspections of private skilled nursing facilities. If one of the Homes fails to implement DPH recommendations or does not follow through on a plan of correction, DPH should have the authority to take remedial steps and enforcement actions as necessary. Without such authority, DPH would conduct inspections without any consequences or impetus for change.

Further, the Office recommends that the Legislature direct DPH to identify and help address clinical or staffing vulnerabilities and to assist the Homes implement the best clinical practices to serve the veterans. Because DPH has the appropriate clinical expertise, DPH should play a vital role in providing independent oversight of and supporting the quality of care at the Homes.

Reporting requirements. The Office supports the reporting requirements for the Office of Veterans' Homes and Housing (S2761, §§ 82; H4441, §§ 34, 35), Ombudsperson and Hotline staff (S2761, § 82), superintendents (S2761, §§ 27, 82; H4441, § 35), Massachusetts Veterans' Homes Advisory Council and Regional Councils (S2761, § 7), DPH (S2761, §§ 27; H4441, § 13) and the Veteran Advocate (H4441, § 36). These reports will create transparency around the organizational plan for emergency response operations, findings of regulatory deficiencies, violations of state or federal law, complaints, caseloads, recommendations for changes to policy or procedures, staffing, monetary donations, and the Homes' census and demographics, among other issues.

Electronic medical records. The Office supports requiring the superintendents to report on the Homes' health record systems, but strongly objects to these reviews occurring only annually. (H4441, § 35.) 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). The administration identified the need for an EMR more than five years ago, yet both Homes still operate with paper medical records. 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.

Continuing to use paper medical records is unacceptable and compromises veterans' care. Annual reporting for this critical system is simply not enough. 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 more than 18 months have passed since Attorney Pearlstein recommended that the administration make EMR a priority for both Homes. The Office therefore recommends that the Legislature make EMR a high priority and require monthly reporting on the Homes' progress with the procurement and implementation of an EMR.

Thank you for your attention to this matter. If you have any questions, please feel free to contact me.

Sincerely,

Glenn A. Cunha
Inspector General

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