IG LETTERS TO THE LEGISLATURE

The Commonwealth of Massachusetts
Office of the Inspector General

GLENN A. CUNHA
INSPECTOR GENERAL

JOHN W. McCORMACK
STATE OFFICE BUILDING
ONE ASHBURTON PLACE
ROOM 1311
BOSTON, MA 02108
TEL: (617) 727-9140
FAX: (617) 723-2334

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Via Email

The Honorable Cindy F. Friedman, Chair
Joint Committee on Health Care Financing
State House, Room 313
Boston, MA 02133
Cindy.Friedman@masenate.gov

The Honorable John J. Lawn, Chair
Joint Committee on Health Care Financing
State House, Room 236
Boston, MA 02133
John.Lawn@mahouse.gov

Re: House 4298 An Act Relative to the Governance, Structure and Care of Veterans at the Commonwealth's Veterans' Homes

Dear Chair Friedman and Chair Lawn:

As you consider legislation reforming the Commonwealth's Veterans' Homes (Homes), I urge the Committee to strengthen House 4298 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 the committee. I respectfully request the opportunity to meet and discuss these recommendations with you.

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 Office recommends that the supervision and oversight of the Homes include the following:

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

This would create the necessary structure and accountability for the Homes and allow for the provision of high-quality, appropriate long-term care.

Governance Structure

The Office opposes the new governance structure for the Homes. In particular, the Office opposes the creation and mandate of the Veterans' Homes Council (Council) and the modifications to the Boards of Trustees (Boards). If the Legislature does not intend to amend Section 16 of Chapter 6A of the Massachusetts General Laws, this bill adds an additional and unnecessary layer of management and control of the Homes. Currently:

- The Governor oversees the EOHHS Secretary.
- The EOHHS Secretary oversees the DVS Secretary.
- The DVS Secretary oversees the Executive Director of OVHH.
- The Executive Director of OVHH coordinates and oversees the implementation and enforcement of laws, regulations and policies relative to the Homes and meets with the Boards but does not control either the Boards or the day-to-day operations of the Homes.
- Either the DVS Secretary or the Executive Director of OVHH oversees the superintendents of the Homes, but it is unclear from the current statutes who has this responsibility.
- The current statutes provides that the Holyoke Soldiers' Home Board manages and controls that Home and appoints its superintendent; the Chelsea Soldiers' Home Board also manages and controls its Home but the EOHHS Secretary, with the approval of the Governor, appoints that superintendent.[1]

In addition to this structure, House 4298 would add the Council and shift the Boards' responsibility to manage and control the Homes to the Council. The Council would also adopt rules and regulations to govern outpatient treatment and admission to the Homes, develop bylaws about operational issues such as admissions, procurement, per diem rates and staffing levels, create a system for reviewing complaints and consider models and guidelines for the delivery of healthcare to the veterans. The addition of this Council would create confusion about roles and responsibilities. This is also far too much management and control for a volunteer council over a state facility.

[1] M.G.L. c. 6, §§ 40, 71.

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. However, inserting the Council as an additional layer of reporting between the Homes and the DVS Secretary creates a risk of gaps in reporting and knowledge, and increases the likelihood of poor oversight and management.

This bill attempts to address the current reporting confusion by having the superintendents report to the Executive Director of OVHH even though by statute the Executive Director has no control over the day-to-day operations of the Homes. Instead, 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.

House 4298 also revises the role of the local Boards, limiting their statutory duties to only nominating to the Council a candidate for superintendent and participating in trainings. The Council would adopt any 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 4298, depend on the Council to define their roles.

The Office also recommends that if the Legislature creates a Council and retains the Boards, the Council and Boards should act in an advisory capacity only. The Council and Boards should have experience in the following areas: veterans' issues, fiscal management, labor relations, healthcare, 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 in the chain of command for the superintendents or have any responsibility for the operational decisions involving the Homes. Neither the Council nor the Boards should be involved in hiring, supervision, evaluation or removal decisions for the superintendents.

Hiring and Removal

With regard to the appointment and removal of the Homes' superintendents, the structure for both processes in House 4298 is unclear. The bill provides that the Board for each Home would nominate superintendent candidates to the Council. The Council would then "approve" the superintendents. It is unclear who would then appoint the superintendents.

For the superintendents' removal, House 4298 allows the Boards or the Governor to recommend to the Council for "review" the removal of a superintendent but does not specifically authorize the removal of a superintendent or indicate who has the power of removal.

The Office recommends that the legislation clearly state who is responsible for hiring, appointing, supervising, evaluating and removing the superintendent. As discussed above, 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 DVS Secretary be responsible for the superintendents' hiring, removal, supervision and evaluation. The Office recommends that no other person or entity – including the Executive Director of OVHH , the Council or Boards – play a role in this process. There is no room for confusion or ambiguity about who hires, supervises, evaluates and, if necessary, removes the superintendent.

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.

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.

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 clinical 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 an amendment to this bill to include experience in these areas as additional required qualifications for the role of Superintendent.

Channels for Communication and Problem-solving

The Office supports the creation of an independent ombudsperson at each of the Veterans' Homes to focus on concerns regarding veterans' health, safety, welfare and rights. However, an ombudsperson must have independence from the management structure; to ensure this independence the ombudsperson should report to the DVS Secretary and not the Executive Director of Veterans' Homes and Housing. Another way of protecting the ombudsperson's independence is to make them a DVS employee rather than an employee of a Home.

Moreover, the Legislature should 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 current bill include this important reporting mechanism. 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 hotline staff should report to the DVS Secretary as the supervisor of the Homes. In the alternative, the Office of the Veteran Advocate proposed in House 4298 could run the hotline.

To fulfill their important responsibilities, the ombudsperson and the hotline staff should receive extensive training and guidance. The bill's provision that the ombudsperson "make every effort to ensure the confidentiality of those who submit complaints" 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. To this end, the Office recommends requiring that the ombudsperson and hotline staff maintain all information in strict confidence unless disclosure is necessary to make a referral to another agency or law enforcement. In addition, because the entities have distinct but potentially overlapping roles, the ombudsperson and hotline staff should each have the ability 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.

Both the ombudsperson and the hotline staff should submit an annual report to the Legislature with summaries of their caseloads and activities to create transparency and accountability. 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.[2] 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 the process. 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.

[2] For example, if the hotline receives a complaint alleging abuse or neglect of a disabled person, 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.

Moreover, the Office endorses House 4298'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 4298 creates the Office of the Veteran Advocate (OVA), an independent agency charged with ensuring veterans receive timely, safe and effective services. The Office endorses the creation of this oversight agency; however, the Legislature must clearly define the roles of the OVA, the ombudsperson and the Executive Director of OVHH to avoid duplication of efforts or confusion about roles that involve oversight and accountability for the Homes. As noted above, the OVA could run the hotline, much like the Office of the Child Advocate operates its own complaint line to receive concerns about children receiving state services.

Inspections by the Department of Public Health

Given the Homes' critical role in providing health care to veterans, the Office supports the 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 healthcare settings and the vital role that it could play in providing clinical support and independent oversight to the Homes.

The Office respectfully suggests that House 4298 provide more structure and specific guidance about the role of DPH and the inspections. For example, the legislation should clarify the purpose and scope of the inspections and delineate how they will differ from other reviews, surveys and inspections by oversight entities. The Office recommends that DPH focus on promoting continuous improvement and evaluating the quality of care at each Home.

The Office also respectfully suggests that the scope of the inspections address concerns related to each home as reflected in issues and findings by other oversight entities, as well as in complaints raised by veterans, families, employees and other complainants. The Legislature should specify that the Homes must provide DPH with a corrective action plan in response to the findings from the inspections and DPH must monitor the Homes' implementation of corrective action. Finally, DPH must have the authority and a clear mandate to take enforcement actions that may be necessary if the Homes fail to implement necessary changes.

To provide inspections and clinical oversight to the Homes, DPH needs adequate resources. The Office recommends that the Legislature create and support a dedicated unit within DPH to support clinical oversight at the Homes.

Reporting Requirements

The bill also includes several reporting requirements, including an annual report from the Executive Director of OVHH 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 and the Executive Director of OVHH on the Homes' health record system, and at least twice each year DPH inspection reports and corrections of violation reports. The Office also recommends that the Legislature require the Ombudsperson and the hotline to submit annual reports documenting their activities. These proposed reports would provide important information about the status of, and recommendations to improve, the Homes. Without coordination, there is a risk that there may not be efficient or effective implementation of these recommendations. The Legislature should designate the DVS Secretary as responsible for integrating, coordinating and implementing these recommendations.

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 annual review by the superintendents and the Executive Director of OVHH on the Homes' health record system proposed in the bill 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
- Executive Director of OVHH
- Department of Public Health
- Ombudsperson

- Superintendents
- Council
- Boards

Although these roles involve overlapping responsibilities, the current bill does not designate a person (or people) at DVS who would be responsible for integrating resources, tracking recommendations and coordinating and implementing improvements to the Homes.

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.

I am happy 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,

Glenn A. Cunha
Inspector General

cc: Honorable Michael F. Rush, Special Joint Oversight Committee on the Soldiers' Home in Holyoke COVID-19 Outbreak
Mike.Rush@masenate.gov
Honorable Linda Dean Campbell, Special Joint Oversight Committee on the Soldiers' Home in Holyoke COVID-19 Outbreak
Linda.Campbell@mahouse.gov
Honorable John C. Velis, Joint Committee on Veterans and Federal Affairs
John.Velis@masenate.gov
Honorable Paul McMurtry, Joint Committee on Veterans and Federal Affairs
Paul.McMurtry@mahouse.gov

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GLENN A. CUNHA
INSPECTOR GENERAL

JOHN W. McCORMACK
STATE OFFICE BUILDING
ONE ASHBURTON PLACE
ROOM 1311
BOSTON, MA 02108
TEL: (617) 727-9140
FAX: (617) 723-2334

February 17, 2022

Via Email

The Honorable Michael Rodrigues
Senate Committee on Ways and Means
State House, Room 212
Boston, MA 02133
Michael.Rodrigues@masenate.gov

The Honorable Cindy Friedman
Senate Committee on Ways and Means
State House, Room 313
Boston, MA 02133
Cindy.Friedman@masenate.gov

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.

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,

Glenn A. Cunha
Inspector General

cc: Honorable Karen Spilka, Senate President
Karen.Spilka@masenate.gov
Honorable Michael F. Rush, Special Joint Oversight Committee on the Soldiers' Home in Holyoke COVID-19 Outbreak
Mike.Rush@masenate.gov
Honorable Linda Dean Campbell, Special Joint Oversight Committee on the Soldiers' Home in Holyoke COVID-19 Outbreak
Linda.Campbell@mahouse.gov
Honorable John C. Velis, Joint Committee on Veterans and Federal Affairs
John.Velis@masenate.gov
Honorable Paul McMurtry, Joint Committee on Veterans and Federal Affairs
Paul.McMurtry@mahouse.gov

The Commonwealth of Massachusetts
Office of the Inspector General

GLENN A. CUNHA
INSPECTOR GENERAL

JOHN W. McCORMACK
STATE OFFICE BUILDING
ONE ASHBURTON PLACE
ROOM 1311
BOSTON, MA 02108
TEL: (617) 727-9140
FAX: (617) 723-2334

March 25, 2022

Via Email

The Honorable Michael F. Rush, Chair
State House, Room 208
Boston, MA 02133
Mike.Rush@masenate.gov

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

cc: Honorable John C. Velis
John.Velis@masenate.gov
Honorable Bruce E. Tarr
Bruce.Tarr@masenate.gov
Honorable Paul McMurtry
Paul.McMurtry@mahouse.gov
Honorable David F. DeCoste
David.DeCoste@mahouse.gov
Honorable Karen E. Spilka, Senate President
Karen.Spilka@masenate.gov
Honorable Ronald Mariano, Speaker of the House
Ronald.Mariano@mahouse.gov
Honorable Linda Dean Campbell, Special Joint Oversight Committee on the Soldiers' Home in Holyoke COVID-19 Outbreak
Linda.Campbell@mahouse.gov