The Commonwealth of Massachusetts
Office of the Inspector General

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Via Email

The Honorable Cindy F. Friedman, Chair
Joint Committee on Health Care Financing
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The Honorable John J. Lawn, Chair
Joint Committee on Health Care Financing
State House, Room 236
Boston, MA 02133
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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
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