COMMONWEALTH OF MASSACHUSETTS
BEFORE THE DEPARTMENT OF LABOR RELATIONS

In the Matter of COMMONWEALTH OF MASSACHUSETTS, SECRETARY OF ADMINISTRATION AND FINANCE and ALLIANCE, AFSCME-SEIU, LOCAL 509	Case No. SUP-20-8334 Date Issued: July 3, 2024

Hearing Officer:

Kendrah L. Davis, Esq.

Appearances:

Carolyn McMenemy, Esq. Michele M. Heffernan, Esq.	-	Representing Commonwealth of Massachusetts, Secretary of Administration and Finance
Ian O. Russel, Esq.	-	Representing ALLIANCE, AFSCME-SEIU/SEIU, LOCAL 509

HEARING OFFICER DECISION

SUMMARY

The issues in this case are whether the Commonwealth of Massachusetts, Secretary of Administration and Finance (Commonwealth), Executive Office of Health and Human Services (EOHHS), Department of Mental Health (DMH) (collectively Employer or Respondent) violated Section 10(a)(5) and, derivatively, Section 10(a)(1) of Massachusetts General Laws, Chapter 150E (the Law) by failing to provide the ALLIANCE, AFSCME-SEIU, Local 509, AFL-CIO (Union or Charging Party) with the following information that is relevant and reasonably necessary for the Union to execute

its duty as the collective bargaining representative: (1) a breakdown of the number of COVID-19 positive cases by agency, clients, patients, and staff at DMH facilities and vendor-operated worksites as of April 29, 2020; (2) the number of COVID-19 positive cases from clients, patients, and staff at DMH community congregate care and non-congregate programs, including all vendor operated sites, broken down by location and/or specific program as of May 8, 2020; (3) all DMH critical incident reports with COVID-19 positive test results grouped by facility and/or community program as of June of 2020; and (4) Survey Monkey information on COVID-19 positive test results in community programs where bargaining unit members worked as of October 29, 2020. The remaining issue is whether the Employer violated Section 10(a)(5) and, derivatively, Section 10(a)(1) of the Law by unreasonably delaying the provision of the following information that is relevant and reasonably necessary for the Union to execute its duty as the collective bargaining representative: COVID-19 positive test results from clients, patients, and staff at DMH community congregate care sites between January and March 15, 2021, broken down by DMH region.

For the reasons explained below, I find that the Employer violated the Law by failing to provide the following information that is relevant and reasonably necessary for the Union to execute its duty as the collective bargaining representative: (1) a breakdown of the number of COVID-19 positive cases by agency, clients, patients, and staff at DMH facilities and vendor-operated worksites as of April 29, 2020; (2) the number of COVID-19 positive cases from clients, patients, and staff at DMH community congregate care and non-congregate programs, including all vendor operated sites, broken down by

location and/or specific program as of May 8, 2020; (3) all DMH critical incident reports with COVID-19 positive test results grouped by facility and/or community program as of June of 2020; and (4) Survey Monkey information on COVID-19 positive test results in community programs where bargaining unit members worked as of October 29, 2020.

I also find that the Employer violated the Law by unreasonably delaying the provision of the following information that is relevant and reasonably necessary for the Union to execute its duty as the collective bargaining representative: COVID-19 positive test results from clients, patients, and staff at DMH community congregate care sites between January and March 15, 2021, broken down by DMH region.

STATEMENT OF THE CASE

On November 24, 2020, the Union filed a Charge of Prohibited Practice (Charge) with the Department of Labor Relations (DLR), alleging that the Employer had violated Section 10(a)(5) and, derivatively, Section 10(a)(1) of Massachusetts General Laws, Chapter 150E (the Law). On March 22, 2021, a DLR investigator investigated the Charge and issued a two-count Complaint on June 1, 2021, alleging that the Employer had violated Section 10(a)(5) and, derivatively, Section 10(a)(1) of the Law by: (1) failing to provide a breakdown of the number of COVID-19 positive cases by agency, clients, patients, and staff members at Employer-operated facilities and vendor-operated worksites as of April 29, 2020; (2) failing to provide the number of COVID-19 positive cases from clients, patients, and staff at DMH community congregate care and non-congregate care programs, including all vendor operated sites, broken down by location and/or specific program as of May 8, 2020; (3) failing to provide all DMH critical incident

reports with COVID-19 positive test results grouped by facility and/or community program as of June of 2020; (4) failing to provide Survey Monkey information on COVID-19 positive test results in community programs and facilities where bargaining unit members worked as of October 29, 2020; and (5) unreasonably delaying the provision of relevant and reasonably necessary information on COVID-19 positive test results from clients, patients, and staff at DMH community congregate care sites between January-March 15, 2021, broken down by DMH region.

The Employer filed its Answer to the Complaint on June 10, 2021. On February 18, 2022, the Union filed a Motion to Amend Complaint (Motion); and, on February 28, 2022, the Employer filed its Opposition to the Motion (Opposition). By Ruling issued on March 9, 2022, I allowed the Motion in part and denied it in part. By Interlocutory Appeal filed on March 18, 2022, the Charging Party appealed part of my Ruling. On March 25, 2022, the Respondent filed an Opposition to the Interlocutory Appeal. On May 13, 2022, the Commonwealth Employment Relations Board (CERB) issued a Ruling that allowed the Interlocutory Appeal in part and denied it in part.[1] Pursuant to the CERB's Ruling, the Employer filed an Amended Answer on September 2, 2022.

[1] The CERB's Ruling amends paragraph 19 of the Complaint as follows:

> On or about March 17, 2021, the Commonwealth provided information relating to positive COVID-19 test results in DMH congregate care sites that was partially responsive to the Union's information request in paragraph 6, subsection C (in that it contained information about positive COVID-19 test results in DMH [c]ongregate [c]are settings for January-March 15, 2021, broken down by DMH region).

STIPULATIONS OF FACT

The parties stipulated to the following facts:

1. The Commonwealth acting through the Secretary of Administration and Finance, is a public employer within the meaning of Section 1 of the Law.

2. The ALLIANCE, AFSCME-SEIU, AFL-CIO is the exclusive bargaining representative for employees in statewide bargaining units 2, 8, and 10.

3. SEIU, Local 509, a member of the ALLIANCE, is an employee organization within the meaning of Section 1 of the Law and represents employees in unit 8 who work for the Department of Mental Health (DMH).

4. DMH is a state agency under the Executive Office of Health and Human Services.

FINDINGS OF FACT

The Organizational Structures

1. EOHHS and DMH

The EOHHS is the largest Secretariat in the Commonwealth which employs over 20,000 employees at various agencies including the DMH and the Department of Public Health (DPH).[2] At all relevant times, Erica Crystal (Crystal) was EOHHS Secretariat Labor Relations Director/ Deputy General Counsel for Labor, Ann Looney (Looney) was EOHHS Director of Labor Relations and Health for DMH and DPH, and Anthony Riccitelli (Riccitelli) was Director of the DMH Office of Inpatient Management (OIM).[3]

[2] The record is unclear about the number of DMH employees that comprise unit 8.

[3] At all relevant times, the DMH OIM oversaw all DMH inpatient facilities and psychiatric units.

The DMH operates multiple hospitals,[4] inpatient facilities, and psychiatric units in the following regional areas: Metro Boston, Northeast, Southeast, Central Mass., and Western Mass. Specifically, the DMH operates at least three hospitals at the Pappas Rehabilitation Hospital for Children (Pappas or PRHC), the Cape Cod and Islands Community Mental Health Center (Cape Cod), and at the Western Massachusetts Hospital. The DMH also operates at least two "acute" facilities at the John C. Corrigan Mental Health Center (Corrigan) and at the Pocasset Mental Health Center (Pocasset), and operates at least three "continuing care" facilities at the Dr. Solomon Carter Fuller Mental Health Center (Fuller), the Worcester Recovery Center and Hospital (WRCH), and at Taunton State Hospital (Taunton). The DMH also operates psychiatric units at Lemuel Shattuck State Hospital (Shattuck) and at Tewksbury State Hospital (Tewksbury). Additionally, the DMH operates separate inpatient facilities for addiction treatment at the Women's Recovery from Addictions Program (WRAP)[5] which is located at Taunton, and at the Andrew House Detoxification Center (Andrew's Detox) which is located at Shattuck.[6]

[4] At certain hospitals where the DMH shares physical space with the DPH, the DPH generally oversees the DMH's operations, which may include adherence to DPH guidance, policies, and procedures. In addition to DPH oversight at these locations, the DMH also follows its own policies and procedures.

[5] WRAP is a residential treatment program that focuses primarily on addiction services rather than mental health, and which operates pursuant to G.L., c. 123, §35.

[6] Andrew's Detox is a vendor-operated addiction program that offers short-term detox services for persons with acute substance abuse issues.

The DMH operates all facilities and units at Fuller, Taunton, and WRAP. The DPH oversees some of the DMH's operations at Shattuck and Tewksbury. Although the DMH operates most parts of the WRCH, the UMass Chan Medical School contracts with the DMH to operate approximately 30 beds at a separate adolescent unit within the WRCH. Similarly, the Northeast Family Institute (NFI) which is a private vendor, also operates another separate 30-bed adolescent unit at the WRCH where the NFI follows its own policies and procedures and leases space from the DMH.

The DMH operates three long-term, transitional homeless shelters in Metro Boston which include the Fernwood Inn, the Lindemann Inn, and the Bayview Inn. The DMH also provides community services to clients who either reside at certain congregate care programs or who utilize certain non-congregate care programs.[7] Congregate care programs comprise group living environments (GLEs) with staff who provide mental health services on a 24/7 basis to clients who reside onsite in group homes, respites,[8] or transitional shelters.[9] Non-congregate care programs comprise clubhouses[10] and day

[7] Neither party provided evidence that identifies the total numbers of DMH community congregate care and non-congregate care programs, nor did they offer a complete list of the names and locations for each program.

[8] Respites are programs that provide short-term residential treatment services on a 24/7 basis, and at a higher level of care than a group home but at a step down from inpatient facilities.

[9] DMH transitional shelters are located in Metro Boston and provide 24/7 environments for individuals who are homeless and transitioning into other housing options.

[10] A clubhouse is a DMH setting located within a community that is open to adults—including young adults and adults with mental illness—where they may receive social, emotional, and educational support.

programs where staff provide mental health services to clients who do not reside onsite but live elsewhere in the community (e.g., in their own homes or in non-transitional shelters) or who are unhoused. Some community programs may be partially operated by other agencies[11] or may be operated by private vendors who contract with the DMH.[12]

2. The Union

The Union's executive structure comprises various positions, including one President, multiple Vice Presidents, and a Chapter Advisor. At all relevant times, Cassandra Sampas (Sampas) was Union President, Jerry Levinsky (Levinsky) was Union Chapter Advisor, and the following individuals were Union Vice Presidents: Jeremy Weiland (Weiland), Cynthia Davis (Davis), Sheelagh O'Connor (O'Connor), Peter North (North), Laura Justice (Justice), and Phil Mente (Mente), and Kathleen Prince (Prince).[13]

The Union's exclusive representation of unit 8 employees extends to the job titles of clinical social workers and case managers. At all relevant times, clinical social workers

[11] At all relevant times, the following agencies provided community services along with the DMH: DPH, DDS, DYS, Department of Children and Families (DCF), Massachusetts Rehabilitation Commission (MRC), and Massachusetts Commission for the Blind (MCB).

[12] At all relevant times, the following 21 vendors contracted with the DMH to provide community services: Adult Community Clinical Services (ACCS); Advocates, Inc.; Bay Cove; Behavioral Health Network, Inc.; Brien Center; Brockton Area Multi Services, Inc.; Center for Human Development; Community Counseling of Bristol County (CCBC); Community Health Link; DMH State Operated; Edinburgh Center; Eliot Community Human Services; Fellowship Health Resources; North Suffolk Mental Health; NRT; Program for Assertive Community Treatment (PACT); Riverside Community Care; Services Net; South Shore Mental Health Center; The Bridge of Central MA; and Vinfen Corp.

[13] Although the record is clear that Prince was Union President in March of 2020, the record is unclear about when Prince subsequently became Union Vice President.

and case managers assigned to DMH hospitals, facilities, units, shelters, and community programs sometimes interacted and/or overlapped with non-DMH staff, patients, and clients.[14]

[14] Concerning DMH hospitals and units, Weiland testified that the DMH shares space with the DPH at Shattuck and at other facilities. While he later conceded that the DMH does not employ any bargaining unit members at Andrew's Detox which is located at Shattuck, he gave unrebutted testimony that unit members assigned to Shattuck may sometimes interact with non-DMH staff and non-DMH patients at Andrew's Detox. Concerning DMH community programs, O'Connor also gave unrebutted testimony that as a case manager she personally interacted with DMH clients at vendor-operated community sites at least "two to three times a week" between April and June of 2020. During that time, she personally provided "emergency services such as medication drops and food drops," and also provided "[e]motional, medical, and psychiatric support" to clients in community care settings. Although her interactions "increased all the time" between June and October of 2020, and "continued to increase," O'Connor conceded that she did not know how many times she visited a DMH client at a vendor site in September and October of 2020.

Conversely, Crystal testified generally that DMH "employees were not going into the vendors at all" during this time. Looney testified more specifically that, "to [her] knowledge," unit members were not interacting with staff or clients at vendor-operated sites, and "if they were, it was very rare because everything was pretty much closed down ….[i]n terms of visitors. So, people like case managers couldn't go to the facilities…[or] to the clubhouse[s]." Looney also testified that prior to March of 2021, case managers were not going to meetings "very frequently" with patients or residents who were receiving vendor services in the community but were not at the vendor site (e.g., meeting outdoors, at Dunkin Donuts, in their homes, etc.). Rather, case managers met with clients after "they and their supervisors felt that the acuity [made it] necessary [to meet]," which was a "very few" and which were followed by "precautions." However, Looney later conceded that "as far as [she] kn[ew]," DMH unit members were going to vendor-operated sites in March of 2021, and that they were also going to those sites prior to March of 2021, albeit "[n]ot on a regular basis."

Based on the totality of this evidence, I credit the testimonies of Weiland and O'Connor, finding that unit members were interacting with non-DMH staff, non-DMH patients, and/or non-DMH clients at DMH facilities, units and community programs which shared space with other agencies and vendors at those locations between April and March of 2021. This is based on Weiland's general testimony about unit member interaction with non-DMH staff and patients at Shattuck, and is based on O'Connor's specific testimony about

The COVID-19 Data

1. The Excel Spreadsheet and the Dashboard

On March 10, 2020, Governor Charlie Baker declared a "State of Emergency to Respond to COVID-19" (declaration) pursuant to Chapter 639 of the Acts of 1950 and pursuant to G.L., c. 17 §2A. Based on the Governor's declaration, the EOHHS organized incident command groups and designated certain commanders comprising Chief Operating Officers (COOs), Chief Executive Officers (CEOs), and/or Nursing Directors at each hospital, facility, and unit across the five regions.[15] Each designated commander was responsible for reporting daily (or sometimes weekly) to then-DMH Assistant Commissioner for Mental Health Services Beth Lucas (Lucas) with any data about COVID-19 positive test results from patients, clients, and/or staff. On receipt, Lucas would input the reported COVID-19 data into an Excel spreadsheet which she later aggregated into separate weekly reports.

Once completed, the Employer would forward Lucas' weekly reports to the designated incident commanders who later disseminated them to their respective DMH staff. The reports included the number of staff being tested, the number of positive-negative tests, and new updates and guidance from the DPH. Some incident commanders disseminated the reported information in the form of a newsletter or

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her personal interactions with non-DMH clients in the community. My finding is also based on the fact that neither Looney, Crystal, nor any other witness rebutted O'Connor's or Weiland's testimonies on these points.

[15] The command groups also included the following Union representatives: Weiland, Levinsky, O'Connor, Sampas, Mike Foster, and then-President Kathy Prince.

informational flyer via email distribution lists, while other incident commanders communicated the reported information by telephone or in-person, in addition to the newsletters and flyers. At all relevant times, OIM Director Riccitelli was responsible for reviewing and approving DMH newsletters and flyers prior to their weekly dissemination, which did not include the breakdown of any COVID-19 data by agency, facility, unit, or vendor.[16]

At some point around May or June of 2020, the Employer stopped inputting COVID-19 data into the Excel spreadsheet and started inputting that data into a new

[16] In addition to the DMH informational flyers, the DPH also sent separate flyers to Shattuck and Tewksbury where its employees shared certain facilities and units with DMH. During his testimony, Riccitelli admitted that these weekly reports did not breakdown the COVID-19 data by agency, nor did they breakdown this data by facility or unit at those hospitals. Rather, Riccitelli testified that because the disputed COVID-19 data from Shattuck and Tewksbury was "under the [DPH] authority," the DPH decided to disseminate that data in aggregate form "because it was one hospital" and "made no sense" to break it down by agency, which "had no value" to the Employer. Riccitelli later conceded that while he was aware of the Union's specific requests, he never asked Crystal to obtain the requested information from the DPH, and he never directly asked anyone from the DPH for the requested information because it "wasn't [his] data."

Weiland testified that while the initial weekly emails sent by COOs at Shattuck, Tewksbury, and WRCH included "really good" breakdowns of the requested information, "over time those breakdowns continued to diminish" and did not include any data on non-DMH staff and non-DMH patients at Shattuck, Tewksbury, and WRCH. Weiland also gave unrebutted testimony that while the Employer provided the number of deaths from COVID-19 at Shattuck, Tewksbury, and WRCH in those emails, at no point did it ever break down that information by agency, facility, unit, and vendor.

Based on the totality of this evidence, including Riccitelli's admission, I credit Weiland's testimony and find that while the Employer responded to the Union's requests for COVID-19 information by providing weekly updates on the number of deaths at Shattuck, Tewksbury, and WRCH, those updates did not include breakdowns of that information by agency, facility, unit, or vendor.

system called SharePoint or the "dashboard," which allowed incident command groups to report and input COVID-19 data directly into the dashboard; thus, eliminating the need to report directly to Lucas.[17] Once input, Lucas would review the data, aggregate it, and redact any sensitive personally identifiable information[18] prior to dissemination to DMH employees and/or to the public.

At all relevant times between March and June of 2020, vendor-operated community programs usually reported all positive COVID-19 test results to their site's designated incident commander on a voluntary basis. During this time, neither Lucas nor anyone else from EOHHS issued a mandate that required these vendors to report their COVID-19 data. Beginning in or about June of 2020, vendor-operated community sites stopped voluntarily reporting their COVID-19 data,[19] and began documenting this data via critical incident reports. Around this time, the Employer also began regular, mandatory

[17] At all relevant times, the DPH controlled the dashboard and directed its personnel to input data directly into it.

[18] At all relevant times, EOHHS Assistant General Counsel and Records Access Officer for the DMH Olubunmi Olotu (Olotu) oversaw the Employer's responses to all information requests for public records to ensure compliance with the Employer's privacy handbook, data suppression guidelines, and other laws and regulations including the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996, 42 U.S.C. 1320d, *et seq.*; 45 CFR 164, *et seq*. When responding to requests that included groups of individuals, Olotu testified that she would redact certain data involving any group of less than 11 to ensure that those individuals were not easily identifiable. Despite this testimony, Olotu admitted that she never received any requests for data involving vendors and never responded directly to any requests from the Union during the relevant COVID-19 period.

[19] Between March and June of 2020, the Employer received certain COVID-19 data from vendors at Cape Cod because Cape Cod Center Director Naomi Tavares (Tavares) had reached out directly to vendor staff at Vinfen and ACCS. At some point around June of 2020, these vendors stopped providing Tavares with COVID-19 data on a voluntary basis.

testing of vendor staff who entered DMH community care sites and included those test results in its weekly reports.

2. Survey Monkey

In addition to the dashboard, the Employer also began using another database in or around June of 2020 called Survey Monkey as a repository for COVID-19 data from community programs. Specifically, by email on June 24, 2020, DMH Northeast Area Director Susan C. Wing (Wing) notified all DMH staff about certain COVID-19 reporting changes that required all staff and clients at "DMH Community-Based Outreach Services" (i.e., non-congregate care programs) and certain staff and clients at "DMH Congregate Care Community Locations" (i.e., congregate care programs) who tested positive for COVID-19 to report all confirmed cases into Survey Monkey.

The Union's Information Requests

1. March of 2020

Shortly after the Governor's declaration, the parties began meeting weekly, sometimes twice weekly, to bargain over unit members' safety and other terms and conditions of employment. The Employer's bargaining team included Crystal, Looney, Riccitelli, DMH Commissioner Joan Mikula (Mikula),[20] DMH Deputy Commissioner

[20] Mikula was Commissioner at all relevant times between April of 2020 until July of 2020.

Brooke Doyle (Doyle),[21] and Crystal Collier (Collier).[22] The Union's bargaining team included Sampas, Weiland, Davis, O'Connor, Levinsky, and Joceyln Shubow (Shubow).[23]

During the first few months of meetings, the Union would request certain information that the Employer would either provide orally at the meetings or would later provide in writing, usually through the weekly informational flyers. At these meetings, the Union would also take notes and later send them to the Employer. Beginning around August of 2020, the Employer asked the Union to stop sending the meeting notes.[24]

In addition to the Employer's oral responses, Looney also provided the Union with written responses on March 11, 18, 24, 25, and 31, 2020, which included information

[21] Beginning in July of 2020, Doyle became DMH Acting Commissioner. Around the early winter of 2020, the Employer promoted Doyle to DMH Commissioner.

[22] The record is unclear about Collier's official job title.

[23] The record is unclear if Shubow held an official Union position during the parties' bargaining period.

[24] By emails on August 17 and 30, 2020, Crystal asked the Union to stop sending the bargaining notes because they were cumbersome and did not create an agreement between the parties. By reply email on September 1, 2020, Union Chapter Advisor Levinsky informed Crystal that "[t]he Union team has decided, and I agree with them, that the notes are helpful as a way of staying organized and facilitating clarity about our discussions." Although the Union acknowledged Crystal's requests to stop sending the notes, neither Levinsky nor anyone else from the Union agreed to stop sending the notes, nor did the Union ever agree to refrain from using the notes in any proceedings. Moreover, Levinsky and O'Connor both testified on rebuttal that there was no agreement. Thus, based on the corroborating testimonies of Levinsky and O'Connor, and based on the parties' emails on August 17 and 30, 2020, and on September 1, 2020, I do not credit Crystal's testimony that there was an agreement between the parties not to send the meeting notes or use them in any proceedings. Rather, I credit testimonies of Levinsky and O'Connor and find that parties did not reach any agreement over whether to stop sending these notes and whether to use them in certain proceedings.

about the current numbers of total deaths and the total patients and staff who had tested positive for COVID-19 at Tewksbury and WRCH.

2. April and May of 2020

The parties continued to meet on bi-weekly or weekly bases in April of 2020, where the Employer continued to respond orally to the Union's oral requests for information, with general updates about COVID-19 deaths and positive test results affecting all patients and staff Statewide. After one of their weekly meetings, Weiland sent the Union's first written request for information by email on April 29, 2020, seeking the "number of COVID 19 positive cases [of] both staff and persons served in our work sites….as well as updates at least weekly, due to the ever-changing nature of this illness." In that email, Weiland also stated that while the Union "would like this [information] for each site, our primary focus is in inpatient facilities and DMH shelters." Further, Weiland requested "totals for each facility as well as break downs of information by specific programs in those facilities (i.e.[,] WRAP, Andrew's Detox, [s]helters, respite, IRTP, etc.) and agency (i.e.[,] DPH)."

By follow-up email on May 8, 2020, Weiland amended his initial request and sought the following additional information: "Positive cases associated with DMH in the community…[which] includes all vender[25] sites/agencies[,] both patients and staff, and at each location." Weiland also sought information about "clients living outside of vendor agencies in the community that are still served by DMH (i.e.[,] in subsidized housing, with

[25] The parties use the terms "vender" and "vendor" interchangeably.

friends/family, homeless etc.)," and requested "the numbers of staff cases in each of our site offices, as well as client demographic information."

By email on May 25, 2020, Weiland reiterated his prior requests for the following information:

> Inpatient
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> > We would like both the percentage of staff tested at each facility, as well as updated numbers as we understand more testing has occurred.
> >
> > We would also like the information broken down by program/agency. As previously stated "…as well as break downs of information by specific programs in those facilities (i.e.[,] WRAP, Andrews Detox, Shelters, respite, IRTP, etc.), and agency (i.e.[,] DPH)." [Emphases omitted.]
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> Community
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> > As previously stated, we would like all positive cases associated with DMH in the community. We would like this information to include and be itemized by all vender sites/agencies (both clients and staff), and at each work site/location. As well as information about clients living outside of vender agencies in the community that are still served by DMH (i.e.[,] in subsidized housing, with friends/family, homeless[,] etc.).

By email on May 28, 2020, Crystal sent the Employer's first written response to Weiland's email requests, which stated that beginning on May 27, 2020, "and going forward on a weekly basis, EOHHS will provide the following information [via the dashboard] at this link: https://www.mass.gov/doc/eohhs-state-operated-facility-and-congregate-care-site-data/download" (May 2020 dashboard). By that same email, Crystal

also provided the Union with the following "Data Summary," explaining that "[t]his is the information we have to provide:"

- Total residents/patients and staff as well as COVID-19 positive patients/residents and staff at EOHHS state-operated facilities.
- Total residents and staff as well as COVID-19 positive residents and staff at congregate care sites under the [DDS, DCF, DMH, DPH, DYS, and MRC].
- EOHHS mobile testing program data
- EOHHS mobile testing program data [sic]
- Department of Corrections [DOC] onsite testing data

Concerning facilities, the May 2020 dashboard link provided by Crystal included the total number of COVID-19 positive test results and deaths for staff and patients "as of May 26, 2020." Specifically, at the Corrigan and Pocasset facilities, the Employer did not include the exact number of total staff cases but only listed "< 5."[26] Similarly, at the Pappas, Taunton, and Western Mass. facilities, the Employer did not include the exact number of total patient cases but listed only "< 5." Further, at Shattuck, Tewksbury, and

[26] Looney testified that the DMH uses the "less-than-11" rule where any response to a request for information requires the suppression of "small cell" and "aggregate cell" data or specifically where "any total cell that contains less than 11" persons and "represents a total from one to ten." Looney also testified that "if giving that number would make the information identifiable, then it cannot be reported that way" or, in other words, "it can't be reported that five people in Central Mass. got or had COVID." Similarly, both Lucas and Olotu testified that the DMH's data suppression guidelines prohibit disclosure of certain data involving "non-zero numbers that are less than 11" to prevent an individual from being identified. Despite this testimony, Looney admitted that she did not know why the DPH reported < 5 numbers for the Corrigan and Pocasset facilities in the May 2020 dashboard, and did not know whether DPH used a different suppression number rule from the DMH's less-than-11 rule. Nonetheless, Looney testified that because DPH personnel input its own data directly into the dashboard, the DPH "could have" reported the < 5 numbers where its facilities "probably ha[d] fewer people in it." Similarly, neither Olotu, Lucas, nor any other witness offered testimony to explain or reconcile why the DPH had reported < 5 numbers at the Corrigan and Pocasset facilities in May of 2020.

Wrentham DDS Development Center, the Employer did not include the exact number of total patient deaths but listed only "< 10," "< 18," and "< 5," respectively. Despite this information, the May 2020 dashboard link did not break down the data by agency, program, or vendor, and did not include any transitional shelter information.

Concerning community congregate care programs, the May 2020 dashboard link also included the total number of COVID-19 positive test results and deaths for staff and residents "as of May 26, 2020." Although this data referenced the names of other agencies and vendors, the Employer did not break down the data by agency, program, worksite, or vendor. Moreover, the May 2020 dashboard did not include any COVID-19 data for community non-congregate care programs.

In addition to Crystal's email response on May 28, 2020, Looney also provided the Union with certain COVID-19 information by emails on April 19, 23, 27, 30, 2020, and on May 6, 8, 11, 14, 21, and 26, 2020. Looney's emails included data on the total number of deaths, total patients, and total staff who tested positive for COVID-19 at Tewksbury, Shattuck, Pappas, and Western Mass. However, her emails did not breakdown this data by agency, program, or vendor**,** and did not include any other COVID-19 data for other DMH facilities, shelters, community programs, or any vendors.

3. June and July of 2020

At a meeting on or about June 2, 2020, the Union made additional requests for information to which the Employer responded that it had provided everything in its possession. By email later that day, Weiland informed the Employer that the Union had yet to receive information that "breaks down the impact on specific

worksites/facilities/communities." By that same email, Weiland also renewed his earlier requests for information on April 29, May 8 and 25, 2020, and sought the following "outstanding" information:[27]

> Inpatient
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> We would like both the percentage of staff tested at each facility, as well as updated numbers as we understand more testing has occurred.
>
> We would also like the information broken down by program/agency. As previously stated "…as well as break downs of information by specific programs in those facilities (i.e.[,] WRAP, Andrews Detox, Shelters, respite, IRTP, etc.), and agency (i.e.[,] DPH)."
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> Community
>
> As previously stated, we would like all positive cases associated with DMH in the community. We would like this information to include and be itemized by all vender sites/agencies (both clients and staff), and at each work site/location. As well as information about clients living outside of vender agencies in the community that are still served by DMH (i.e.[,] in subsidized housing, with friends/family, homeless[,] etc.).

Weiland's email also enumerated the Union's reasons for seeking the requested information:

> 1. The DMH SEIU Local 509 Executive Chapter Board represents all DMH members working across the state[.]
> 2. We have the right to know the risk in our work sites[.]
> 3. So the Union can support/encourage members to follow [Centers for Disease Control and Prevention] CDC, DPH, and DMH policies, procedures and best practices for infection control[.]
> 4. Be active representation of members on the statewide health and safety committee[.]
> 5. Ensure that DMH management is following CDC/DPH guidelines and providing appropriate PPE[.]

[27] All emphases omitted.

6. Members can adequately support DMH clientele and their loved ones in managing physical and mental health issues in the wake of this pandemic, including psychoeducation related infection rates, proper use and level of PPE and risk factors[.]
7. Informing recommendations on "new normal" and timelines for implementation[.]
8. Ease members[']' anxieties of changes at worksites in moving toward the new normal[.]

At some point around June of 2020, Weiland became aware that DMH vendors had stopped reporting its COVID-19 data into the dashboard and had started using critical incident reports to document this data.[28] Based on this awareness, Weiland sent an email to the Employer on June 11, 2020, requesting "All [c]ritical incident reports from every region including all vender agencies connected with DMH within the last six months." By reply email on July 2, 2020,[29] Crystal responded to Weiland, stating, in pertinent part:

[28] Weiland gave unrebutted testimony that in or around June of 2020, certain unit members assigned to community care sites informed the Union that DMH vendors had stopped reporting its COVID-19 data into the dashboard and had started using critical incident reports to document this data. On cross examination, Looney conceded that she did not know how DMH was gathering vendor information about COVID test results or why the Employer did not include any vendor information in the dashboard. Similarly, Riccitelli admitted that he did not know when vendors had stopped reporting their COVID-19 data into the dashboard or when they had begun reporting test results directly to the DMH. At Cape Cod, Riccitelli testified specifically that he knew that the DMH "was receiving some vendor data" at those locations because Naomi Tavares had reached out to Vinfen staff and ACCS staff who provided that data voluntarily. However, he conceded that at some point after May or June of 2020, Vinfen stopped cooperating with the DMH and declined to report further COVID-19 data into the dashboard. Based on the totality of this evidence, I credit Weiland's testimony that DMH vendors at community care sites had stopped voluntarily reporting COVID-19 data into the dashboard beginning in or around June of 2020.

[29] By separate email on July 2, 2020, Crystal provided Weiland with a COVID-19 Preparedness Assessment Draft Summary Report dated June 4, 2020, concerning DMH inpatient facilities for a two-week period between May 1 and 15, 2020. However, this

> Thank you for your patience as we sort through the various information requests from Local 509 and other unions.
>
> I appreciate that we were able to find a way to share COVID-19 positive test numbers on a routine basis and our continued dialogue. Regarding this particular request for all critical incident reports, after reviewing more closely, I have a couple of questions that I hope will help expedite your request, since as I am sure you are aware, given the patient nature of the reports any reports provided would have to be reviewed by legal and redacted. It seems that the request for "all critical incident reports," is overly broad. I have attached the relevant regulation to evidence my concern. I do not know why the Union would be seeking all such reports? Can you explain why and/or narrow your request?
>
> I also do not understand why the Union is seeking information about the vendors, since there are no bargaining unit employees working for vendors. Please explain.
>
> ….

By reply email on July 3, 2020, Weiland amended his earlier request for vendor-related critical incident reports, stating, in pertinent part:

> Thank you for your response to our inquiry. It seemed that after numerous requests for data specific to COVID 19 at our DMH worksites, the management team was only able to provide us a broad overview which did not provide specific information about the infection rates/safety that our members would be exposed to in their job duties. When we asked in meetings we were told that either the data did not exist or that it would not be provided. We therefor[e] became more general in the information request as we are prepared to sort through all the information and design our own matrix of exposure risks and safety at our worksites for members. If you would prefer to narrow the pervious requests to all COVID 19 related critical incident reports from all areas and venders from March 2020 till [sic] present, we would be okay with that.
>
> As for the venders, while they are not in the SEIU Local 509 DMH chapter[,] their worksites and staffing are directly tied to our members

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report did not include any information about COVID-19 infection rates, test results for either patients or staff at those facilities, and did not include any of the previously requested critical incident reports.

> especially in the case management. Many clients in vender services may also be enrolled with DMH Case management or in some form of transition which would cause overlap. Especially as we have been discussing reopening, this easily could mean that Case Managers/inpatient SW would be again going to Group Living Environments, as well as potentially having vender/DMH meetings at various locations. To ensure our members can return to Face to Face visits in the community safely as well as we prepare to have venders return to visiting the facilities this information is imperative. Also some vender agencies share work sites with our members such as in Boston. Lastly knowing the situation at [v]ender agencies allows us a better ability to understand how it impacts individuals that we as DMH employees serve, so we can plan and provide the best care possible.

By reply email later that day, Crystal informed to Weiland that she would "review and circle back as soon as possible." By follow-up email on July 30, 2020, Crystal contacted Weiland to ask if he wanted to "have a quick call?"[30] Around that time, the

[30] Crystal testified that her correspondence was responsive to the Union's requests for the critical incident reports from the vendors and that the dashboard was "the best, most accurate information" available. She explained to the Union that the Employer was not "tracking data" in the manner requested because these "reports had deaths only, which is what [the Employer had] provided to [the Union]." Crystal also testified that while "there were many, many, many—hundreds, I guess—of critical incident reports" which were sometimes "voluminous" and included "a lot" of privacy information that required additional time to make all necessary redactions, and while the Employer had provided the Union with all of "the data we had," she continued to question the relevancy of these requests.

Conversely, O'Connor testified that the requested critical incident reports were relevant "to keep [unit] members as safe as possible" because they were "working with individuals living in the community." O'Connor also testified the Union "knew the vendors were reporting that information through DMH," and needed the information so that "case managers would be aware of infection rates, possible contamination rates, [and] cross contamination." Further the requested information "was the only way of monitoring [vendor test results] in those early stages." Similarly, Weiland testified that his reasons for requesting the critical incident reports were based on certain members who reported to the Union that their supervisors had informed them that the Employer was tracking

Employer also provided the Union with a spreadsheet containing COVID-19 data related to deaths at certain vendor sites across the State.

In addition to Crystal's responses, Looney also provided the Union with COVID-19 data by emails on June 2 and 11, 2020, which included information on the numbers of total deaths, total patients, and total staff who tested positive for COVID-19 at Tewksbury, Shattuck, Pappas, and Western Mass. Looney's emails did not include further breakdowns by agency, program, or vendor at Tewksbury, Shattuck, Pappas, and Western Mass. Her emails also did not include COVID-19 data at other DMH facilities, community care settings, or vendors.

4. August of 2020

By telephone and later by email on August 31, 2020, Crystal provided Weiland with information related to total number of deaths from COVID-19 for the period of April – June of 2020, broken down by region, facility, and vendor:

	Central Mass.	Metro Boston	Northeast	Southeast	Western Mass.	Total
Advocates, Inc. | A	2	0	0	0	0	2

COVID-19 data through these reports. Weiland also testified that the Union sought the reports "to review them for patterns of COVID cases that would connect to our specific worksites."

Based on the totality of this evidence, I credit the testimonies of O'Connor and Weiland, and find that the Union's requests for critical incident reports concerning COVID-19 data from vendor-operated community sites are relevant because they pertain to unit members who either shared space and/or interacted with vendor staff and clients at those sites, and that certain supervisors had informed unit members that the Employer was tracking COVID-19 data through these reports.

Bay Cove Human Services	0	1	0	0	0	1
CCBC | A	0	0	0	2	0	2
Center for Human Development | A	0	0	0	0	1	1
Clinical & Support Options, Inc. | A	0	0	0	0	1	1
Community Healthlink, Inc. | A	1	0	0	0	0	1
DMH State Operated | A	0	2	1	1	0	4
Lemuel Shattuck Hospital	0	3	0	0	0	3
Riverside Community Care, Inc. | A	3	0	0	0	0	3
Tewksbury Hospital	0	0	3	0	0	3
Vinfen Corporation	0	2	3	1	0	6
Site Office	3	0	0	0	0	3
Total	9	8	7	4	2	30

Crystal's email on August 31, 2020, did not breakdown the COVID-19 data by agency or program.

5. September of 2020

By email to the Employer on September 2, 2020, Weiland stated, in pertinent part:

> ….Thank you for the new data on [v]ender agency [d]eaths across the state. Is it possible to get an updated version of this as it only seems to go to June so [it's] at least 2 months old?

> While we appreciate this information[,] it does not really get to what we are requesting. We are really looking for not just deaths but all the infection cases of staff, vendors and DMH clients served across the state preferably broken down by site/facility. When we asked for this we were told that it did not exist despite site/area directors seeming to have direct knowledge of the infection rates in facilities, work sites, communities, vendor agencies, and clients served both in and out of the hospitals. Because management was unable to provide this streamlined data to us, we made it broad requesting all critical incident reports across the state for the period from when COVID 19 started to the present, that we would go through ourselves to evaluate COVID 19 rates. It is concerning that after starting our request for information in March, and continuously narrowing it down most recently in June and then July[,] we still don't have the data, or DMH it's self [sic] does not have the data about the impact of COVID 19 on their person's [sic] served and staff. We would like infection rates in facilities, work sites, communities, vendor agencies, for clients served and staff both in and out of the hospitals, across the [S]tate broken down by sites or in lieu of that all [c]ritical [i]ncident [r]eports related to COVID 19 infections.

6. October of 2020

By email on October 1, 2020, Weiland reiterated his prior request for information from September 2, 2020, stating in full:

> As you can see from the emails below this has been a long standing request which has yet to be addressed to the [U]nion's satisfaction. At today's meeting our understanding was that the information that we are requesting is not coded for COVID 19 incidents but only coded for COVID 19 deaths, which you did provide to us. As you may notice from past requests we did indicate that if what we were requesting could not be provided in the way we were requesting it that we would like all critical incident reports for the period of COVID 19. Based on what we believed to be the current way the data is coded we would like to again formally request that all critical incident reports for the past 7 months for DMH areas, sites, facilities, vendors and clients. Please provide this information within 7 days, as we are dedicated to continued collaboration and we would prefer to resolve this matter now, without the need for any additional proceedings.

At a meeting on or about October 29, 2020, the Union inquired about its prior requests for critical incident reports, and how the Employer was collecting, collating and sharing that data via Survey Monkey. The Employer responded that all critical incident report information was on the dashboard, but it did not explain how it was inputting that data into Survey Monkey. Later that same day, Crystal sent a reply email which stated, in pertinent part:[31]

> Regarding your request for information: "…that management was requesting the CEOs of each facility put together a *list* of "lessons learned" to be compiled into a document that would help guide DMH in how to continue to provide care…" and that "we would like to formally request that this information be turned over to the Union, *in whatever format it is in.*" (Email communication from DMH SEIU dated 10/1/20). Below please find DMH's response to this request.
>
> "Lessons learned" does not exist as a document or list as referenced above. The initial thought may have been to have "one" seminal document compiled into a list, however, that is not what has occurred and no such document exists. DMH has been in constant contact with its CEOs/COOs/DONs and CNOs[32] and what has transpired is that communications that have occurred have been incorporated and distributed as best practices/policy in various documents concerning emergent issues during the pandemic. These documents have been shared with the [U]nion in numerous forms including but not limited to: PPE guidance; weekly and/or daily hospital reports; cleaning protocols; in-person template; etc. Accordingly, DMH has made reasonable efforts to provide the [U]nion with as much of the requested information as possible. *Boston School Committee*, 37 MLC 140 (2011). Therefore, DMH has complied with its obligations under M. G.L. c 150E *et seq.*
>
> A public employer only has an obligation to provide information that is within its possession or control. To be clear, there is no document or list entitled "lessons learned." DMH as a public employer has

[31] All emphases in original.

[32] Neither party identified this term.

> satisfied its statutory obligation to bargain in good faith with the Union as DMH has provided a wealth of requested information to the Union directly (and also to its' [sic] members) for the Union to perform its duties as the exclusive bargaining representative. See *Higher Educ. Coordinating Council*, 19 MLC 1035 (1992); *Commonwealth of Mass.*[,] 11 MLC 1440 (1985); *Boston Sc.* [sic] *Comm.*, 10 MLC 1501 (1984); *Bd. [o]f Trs., Univ. of Mass.*, 8 MLC 1139 (1981); *Bd. of Higher Educ.*, 26 MLC91 (2000). The information DMH has provided, and continues to provide to the Union regarding management of its' facilities during the pandemic, is sufficient for the Union to decide whether a grievance should be filed. See *Boston Public School Committee and Boston Public School Buildings Custodians' Association*, 24 MLC 9 (1997).
>
> We would be pleased to discuss this request further in order to provide responsive documents.

Crystal did not include any of the requested critical incident reports in her email response on October 29, 2020.[33] Nonetheless, by separate emails on October 7, 8, 19, 22, 23, 27, 28, and 30, 2020, Looney provided the Union with other COVID-19 data related to the number of total deaths, total patients, and total staff who tested positive for COVID-19 at Tewksbury, Shattuck, Pappas, Taunton, WRCH, Pocasset, Western Mass., and Cape Cod. Looney's emails did not include further breakdowns by agency, program, or vendor at these facilities**,** and they did not include any COVID-19 data for the remaining DMH facilities, shelters, or community care settings.

1. November and December of 2020

[33] Between July 3 and October 29, 2020, Weiland conceded that the Employer replied orally to his requests for critical incident reports by informing the Union that the Employer was unable to "specifically extrapolate" which reports were COVID-related and that the reports "were not coded" in the way that the Union wanted. Despite informing the Employer that the provided data "was not sufficient," Weiland gave unrebutted testimony the Employer never provided the Union with any of the requested critical incident reports.

At a meeting on or about November 3, 2020, Weiland renewed his request for certain COVID-19 information that the Employer had input into Survey Monkey, and Crystal responded that she would get back to the Union. By email on December 3, 2020, Crystal provided the Union with the following information:

> ….
>
> - Fuller had four positive staff but the testing has not increased in frequency, why not? They are testing staff this week per monthly schedule and will begin weekly next week.
> - Tewksbury numbers are going up and staff believes there is a gap in the protocols. If staff turn out to be positive, [Local] 509 wonders why the unit on which the staff person worked doesn't become quarantined – a [COIVD] unit. This would be more impactful, [Local] 509 explains, since patients can refuse testing. Quarantining at TH is determined by ID and medicine. It is not automatic to quarantine based on one positive staff. The contact tracing would determine next steps.

By separate emails on November 8, 16, and 25, 2020, and on December 12, 20, 21, and 26, 2020, Fuller COO James Cooney (Cooney) provided additional updates to all Fuller "Inpatient Staff," which included information on the number of total deaths, and total patients and total staff who tested positive for COVID-19 at Fuller. However, Cooney's updates did not break down this data by agency, program, or vendor at Fuller.

Similarly, Taunton COO James A. Gedra (Gedra) provided separate updates to all staff at Taunton by emails on November 2 and 6, 2020, and on December 3, 4 and 17, 2020, which included information on the number of total deaths, and total patients and total staff who tested positive for COVID-19 at Taunton. Gedra's email on December 3, 2020, also included COVID-19 data about the number of patients and employees who

had tested positive, were "newly recovered" and/or who had "returned to work." Despite these updates, Gedra's emails did not breakdown any data by agency, program, or vendor at Taunton.

During this time, WRCH CEO Jacqueline Ducharme (Ducharme) also provided separate updates to all WRCH staff by emails on November 6 and 19, 2020, and on December 7, 12, and 18, 2020, which included information on the number of total deaths, and total patients and total staff who tested positive for COVID-19 at WRCH. Ducharme's emails did not include any data breakdowns by agency, program, or vendor at WRCH. By email on December 6, 2020, Kathleen Wenzel (Wenzel)[34] sent an "Informational Update" to all WRCH staff which included "COVID-related" data about total testing numbers and total "active cases hospital wide" for staff and patients, but did not include other specific breakdowns.

At Corrigan, Interim Center Director Paulo J. Santos (Santos), provided an update to all staff by email on December 10, 2020, which included COVID-19 test results for employees who were "home self-isolating." Despite this update, Santos' email did not include any COVID-19 data for patients or did not include any breakdowns by agency, program, or vendor at Corrigan.

2. January and February of 2021

By letter dated January 15, 2021, the Employer provided an informational update to all "Tewksbury Hospital Colleagues," which included the numbers of COVID-19 positive

[34] The record is unclear about Wenzel's job title.

test results, recoveries, and deaths broken down by patients, employees, and vendors. This letter also listed specific units that the Employer had placed "on quarantine status with restricted access," units that were "currently vacant and closed," and units that were on "isolation." Further, the letter included information about the number of staff persons who had tested positive and were either at home "self-isolating" or who had "returned to work."

By email on February 3, 2021, Union President Sampas informed Crystal that the Union was seeking additional COVID-19 information from Survey Monkey. Specifically, Sampas' email stated, in part:

> ….
>
> Inpatient
>
> While inpatient communication has improved beyond what is listed on the website we still are not getting it broken down the way that would better inform us of the risk in our direct worksite. We would like the cases on inpatient facilities to be broken down by vender/Agency (i.e.[,] DPH vs. DMH for joint facilities). We used to get better information at some of our facilities (mostly just Worcester), but that has changed we would like it reinstated and done at all facilities. We would also like the information about patient positive cases broken down the same way (Agency, vendor[,] etc.), as well as [by] [u]nit if possible. See example of a better disclosure and the current which is less specific below.
> Earlier Version (closer to what we want)
>
> Total number of staff that have tested positive since March = 30
> - 24 WRCH adult staff tested positive
> - 5 IRTP staff and 1 U[M]ass adolescent staff that tested positive.
>
> • Total number of staff that have returned to work post positive status = 12 (3 IRTP and 9 WRCH)
> • Current number of staff that tested positive and have not yet been cleared to return to work = 18

- In addition, 4 of the 11 patients that tested positive have been medically cleared.

….

Patients:

13 [p]atients have tested positive
6 have been discharged
5 have been medically cleared
2 are + [sic]

Here is the current version (father [sic] from what we want):
Patients

Positive: 1 (in hospital)
Total Positives: 45 Newly recovered: 0
Employees
Positive: 16
Total Positives 188 (including WRCH, NFI, U[M]ass) Newly recovered: 2

Community
The much bigger issue is for the community numbers. Currently we are being only told to look at the [S]tate data base that is update [sic]. This does not provide the specifics that we have requested. Below is the link to the information from the [C]ommonwealth's website. As you can see (pg [sic] 2) DMH is broken down by [S]tate and vender, but not geographically (area or site) and only for congregate care not those living or working with clients in the community (that do not reside in a group living environment). It also does not include [v]ender staff which often cross over with our inpatient and community members. On page 6 surveillance testing for congregate sites is reported. Again this is for DDS. DYS and DMH giving [sic] even less information specific to our members about testing results in their work site.

For DMH staff that work in the community we would like infection rates by area (5 [DMH] areas) and sites (each area comprised of several work sites that are primary work locations for our members). For DMH clients we would like the information broken down by [a]rea and site (like listed above) as well as in the community vs. a congregate care site. We would also like [v]endor infection/testing rates for each one of the [v]endors listed below, for both [s]taff, and

client services, broken down into congregate and community (as Adult Community Clinical Services runs [g]roup [h]omes and support services).
….

ACCS Contracted agencies:
Advocates, Inc.
Bay Cove
Behavioral Health Network, Inc.
Brien Center
Brockton Area Multi Services, Inc.
Center for Human Development
Community Counseling of Bristol County
Community Health Link
DMH State Operated
Edinburgh Center
Eliot Community Human Services
Fellowship Health Resources
North Suffolk Mental Health
Riverside Community Care
Services Net
South Shore Mental Health Center
The Bridge of Central MA
Vinfen

(and any that we might have missed)

Management has stated that the information that we are requesting, [sic] yet our members tell us that sporadically at the site or facility level they are occasionally getting specific information like we are requesting. Some of this seems to come from Survey Monkey, which we have requested copies of as well. Management has stated they will not provide us [with] copies of the Survey Monkey results as it is the same information that is listed on the website. If it is the same information why is it being recorded and provided to management differently? Other than the information from weekly inpatient updates and listed on the website, Management has not provided us any additional break down needed for the [U]nion to ensure that we are safe to do our jobs, which is why we requested the [c]ritical incidents [sic] reports, especially for the community. If [M]anagement is using a different way (i.e.[,] Survey Monkey, or infection charts submitted by vender, etc[.]) to track the COVID-19 cases connected to their clients, their venders, and their worksites please let us know and

> provide us [with] that information. Or provide us with any other way that [M]anagement breaks down in a similar way to what we are requesting.
> ….

By email on February 3, 2021, at 2:40 p.m., Crystal provided Sampas with the following response:

> …. I just read through what you wrote quickly and I am not sure we are going to be able to work this out easily. We simply can't give what we do not have. I will discuss with Ann [Looney] and after we discuss, I will let you know if we think there is anything else we have that is relevant and that we are able to provide.

By follow-up email on February 3, 2021, at 3:24 p.m., Crystal provided Sampas with the following update:

> Ann and I had a brief conversation and unfortunately it appears that now the Union is expanding its request.
>
> As we have said many times, we have provided to you (and we continue to provide) the information that is relevant to bargaining unit employees and the information broken down as we have it.
>
> Please explain the relevance for the individual vendors from whom you are seeking information. Each one. If, for example, bargaining unit employees have rare or no contact with the vendor, there is simply no rationale for the information. At least none that I am aware of at this point. Furthermore, we do not have the information broken down in the way you seek. You seem to suggest that there are bargaining unit employees who continue to see information in the way you want us to provide it, so maybe the best thing to do is to show us what this information is so we can react.
>
> Are you asking for information about each house a case worker might visit?

By separate emails on February 17 and 26, 2021, Cape Cod Center Director Naomi Tavares (Tavares) provided separate updates to all Cape Cod staff which included

information on the numbers of total patients and total staff who tested positive or negative for COVID-19, newly positive results, "PUIs,"[35] total active infections, and newly recovered results. Tavares' updates also included breakdowns by programs, units, and vendors (i.e., at ACCS, Hyannis, Vinfen, Pocasset, CM, and Respite) for all staff and clients with COVID-19 "positive/negative" cases in the Cape Cod region.

Similarly, Fuller COO Cooney provided separate updates to all Fuller staff by emails on February 7, 13, 21, and 27, 2021, which included information since at least "1/1/21" concerning the number of total patients and total staff who tested positive or negative for COVID-19 and who were either newly recovered, had returned to work, or were PUI. Cooney's updates did not breakdown this data by agency, program, or vendor at Fuller.

WRCH CEO Ducharme also provided separate updates to all WRCH staff by emails on February 16 and 22, 2021, which included information on the number of total patients and total staff who tested positive or negative for COVID-19 and/or who were either newly recovered, medically cleared, currently positive, or had returned to work. Despite these updates, Ducharme did not include any specific breakdowns by agency, program, or vendor at WRCH.

3. March of 2021

[35] Neither party defined this term.

From March of 2020 throughout March of 2021, the parties continued to meet weekly. On March 17, 2021, Looney sent the following email to Weiland, which stated in full:

> We thought our last meeting was productive. As agreed, below is a chart that has aggregate numbers of DMH community congregate care positive test rates for January 2021, February 2021 and March to date. There are Personally Identifiable Information (PII) policy guidelines which limit releasing any information that may potentially be identifiable by applying what is known as small cell suppression to aggregate cell data. Any total (cell) that contains <11 represents a total from 1 – 10 to protect PII of all individuals. As you can see, there are a significant number of less than 11 cells. The blank cells are zeroes.

# of Individuals in DMH Community Congregate Care Settings Testing Positive for COVID by Month (January-March*, 2021)						
	Jan		Feb		Mar	
Area	Client	Staff	Client	Staff	Client	Staff
Central Mass	<11	<11	<11	<11	<11	<11
Metro Boston	16	29	<11	12	<11	
North East	<11	15	<11	<11	<11	<11
South East	18	15	<11	<11		<11
Western Mass	<11	11		<11		

> Includes DMH state-operated and provider community congregate care locations
>
> *Reporting as of 3/15/21
> You were going to get back to us with locations where [Loca] 509 members have difficulty getting a non-client on the telephone when they call ahead for COVID information. Additionally, you agreed to specify which facilities [L]ocal 509 members engage with at this

> time, i.e., how many members go to the facility and what percentage of their time do they spend there? Could you forward that information as well as dates for a follow-up meeting?

Looney's email response on March 17, 2021, did not include any COVID-19 data from non-congregate care settings.

By separate email on March 4, 2021, Tavares sent an update to all Cape Cod staff which included information on the numbers of total patients and total staff at facilities (i.e., Pocasset) who tested positive or negative for COVID-19, including positive results, PUIs, total active infections, and newly recovered results. This update also included the number of COVID-19 "positive/negative" cases for all staff and clients at congregate care sites broken down by vendor (i.e., at ACCS, Hyannis, Vinfen, CM, and Respite).

Similarly, Cooney provided updates to all Fuller staff by separate emails on March 4, 8, 15, and 21, 2021, which included information "since 3/1/21" on the numbers of total patients and total staff at Cape Cod who tested positive for COVID-19 and were newly recovered. His updates also included the numbers of total employees who tested positive or negative for COVID-19, were newly recovered or had returned to work, total PUIs, and percentages of employees who had received vaccinations. Although Cooney's emails did not break down COVID-19 data by agency or vendor at Fuller, they did break down the data by specific programs where patients who tested positive for COVID-19 were also isolated or quarantined.

At WRCH, CEO Ducharme also provided updates to all WRCH staff by separate emails on March 1, 5, 12, and 19, 2021, which included information on the number of total patients who tested positive for COVID-19 and/or were either newly recovered or totally

recovered. Her emails also included the number of total employees who tested either positive or negative for COVID-19, who were currently positive, were medically cleared, and/or had returned to work, along with the number of total employees who were "TNPs/Invalids/Inconclusives."[36] Despite these updates, Ducharme did not include any data breakdowns by unit, program, or vendor at WRCH.

DECISION

Section 6 of the Law requires public employers and exclusive bargaining representatives to negotiate collectively in good faith with respect to wages, hours, standards of productivity and performance, and any other terms and conditions of employment. Commonwealth of Massachusetts v. Labor Relations Commission, 404 Mass. 124, 127 (1989); School Committee of Newton v. Labor Relations Commission, 388 Mass. 557 (1983). The Commonwealth Employment Relations Board (CERB) has long-held that an employee organization's right to receive relevant and reasonably necessary information is derived from the statutory requirement of parties to engage in good faith collective bargaining. Boston School Committee, 13 MLC 1290, 1294, MUP-5905 (Nov. 21, 1986). The CERB also holds that information about the terms and conditions of employment of bargaining unit members is presumptively relevant and reasonably necessary for an employee organization to perform its statutory duties. City of Lynn, 27 MLC 60, MUP-2236 and MUP-2237 (Dec. 1, 2000). Thus, if a public employer possesses information that is relevant and reasonably necessary to an employee

[36] The record is unclear about these terms.

organization in the performance of its duties as the exclusive collective bargaining representative, the employer is generally obligated to provide the information upon request of the employee organization. City of Boston, 32 MLC 1, MUP-1687 (June 23, 2005) (citing Higher Education Coordinating Council (HECC), 23 MLC 266, 268, SUP-4142 (June 6, 1997)); Worcester County Jail and House of Correction, 28 MLC 189, 190, MUP-1885 (Dec. 28, 2001) (citing Board of Trustees, University of Massachusetts Amherst, 8 MLC 1148, 1149, SUP-2427 (June 24, 1981)); see also Board of Trustees, University of Massachusetts Amherst, 8 MLC 1139, 1141-42, SUP-2306 (June 24, 1981). Information about terms and conditions of employment of bargaining unit members is presumptively relevant and necessary to an employee organization to perform its statutory duties. City of Lynn, 27 MLC at 61.

1. Relevant and Reasonably Necessary Information

The Union argues that while it made numerous written requests to the Employer for COVID-19 data from DMH facilities, shelters, and community settings, broken down by agency, program, and vendor between April of 2020 through February of 2021, the Employer failed to provide this information. The Union also argues that the requested information is relevant and reasonably necessary to perform its duties as the employees' exclusive representative because the information relates directly to the terms and conditions of employment for its members, including workplace safety. Further, the Union contends that it was reasonably necessary to breakdown the requested data by agency, program, and vendor because unit members were interacting "face-to-face" with non-DMH patients, non-DMH clients, and non-DMH staff at facilities which created a risk of

infection based on these interactions. Conversely, the Employer asserts that it provided the Union with all relevant information that was in its possession. It also asserts that the Union's requests for the remaining information, such as the critical incident reports and Survey Monkey data, were neither reasonable nor relevant because those documents did not contain any COVID-19 information and unit members were not working at any of the vendor-operated sites.

I am unpersuaded by the Employer's assertions for the following reasons. First**,** the requests for information broken down by agency, program, and vendor were relevant because between March of 2020 and March of 2021, unit members were sharing space with other agencies and vendors and were interacting with non-DMH staff, patients, and clients at certain DMH facilities and community settings (e.g., at Shattuck, WRCH, and Cape Cod). Next, the requests for critical incident reports were relevant because both Weiland and O'Connor gave unrebutted testimony that supervisors had informed their unit members about certain vendors that were reporting COVID-19 data via critical incident reports in June of 2020. Weiland also explained that the Union requested the reports "to review them for patterns of COVID cases that would connect to our specific worksites." Similarly, there is no dispute that the Employer began inputting into Survey Monkey COVID-19 data from community congregate care and non-congregate care programs in June of 2020, and that the Union made repeated requests for this data beginning in October of 2020 and continuing through February of 2021 based on its members who were interacting with vendor staff and/or clients at these programs.

Based on the totality of this evidence, I find that the Union's requests for COVID-19 information from facilities, shelters, and programs beginning in April of 2020 and continuing through February of 2021, which sought a breakdown by agency, program, and vendor are relevant and reasonably necessary for the Union to execute its duties as .the exclusive bargaining representative because the requests relate directly to the terms and conditions of unit members' health and safety while they shared space and/or interacted with non-DMH staff and patients at DMH facilities and shelters during this time. City of Lynn, 27 MLC at 61; see, generally, Town of Marshfield, 30 MLC 164, 173, MUP-02-3327 (June 2, 2004) (the impact of an employer's level of services decision on unit members' safety is a mandatory subject of bargaining). I also find that the Union's requests for critical incident reports beginning in June of 2020, and for Survey Monkey data beginning in October of 2020, are relevant and reasonably necessary because these requests relate directly to unit members' health and safety while they were actively sharing space and/or interacting with non-DMH staff and clients at DMH community care programs during the pandemic which created a heightened risk of infection from the COVID-19 virus. Id.

For all these reasons, I find that the Union has satisfied its burden of proving that the requested information is relevant and reasonably necessary to perform its duties as the exclusive bargaining representative.

2. The Respondent's Shifting Burden

Once a union shows that the requested information is relevant and reasonably necessary to its duties as bargaining agent, the employer has the burden of

demonstrating that its concerns about disclosure of the information are legitimate and substantial. City of Somerville, 29 MLC 199, 202, MUP-2691 (April 24, 2003) (citing Board of Trustees, 8 MLC at 1144); see also Board of Higher Education, 26 MLC 91, 93, SUP-4509 (Jan. 11, 2000), citing Boston School Committee, 13 MLC 1290, 1294-95, MUP-5905 (Nov. 21, 1986); Adrian Advertising a/k/a Advanced Advertising, 13 MLC 1233, 1262-63, UP-2497 (Nov. 6, 1986), aff'd sub nom., Despres v. Labor Relations Commission, 25 Mass. App. Ct. 430 (1988)).

Here, the Union argues that the Employer cannot demonstrate that its concerns about disclosing the requested information are legitimate or substantial. Specifically, it asserts that the Employer never initiated discussions about alternatives to providing the requested information, including the critical incident reports and Survey Monkey data. The Union also asserts that while the Employer explained its confidentiality concerns about the critical incident reports, it never communicated those same concerns about the requested Survey Monkey data. Moreover, it maintains that the Employer never provided any of these requested documents in redacted form and never provided the Union with alternatives to accessing this information.

Conversely, the Employer contends that its concerns about producing the disputed information are legitimate and substantial for several reasons. First, it maintains that it neither possessed nor controlled the disputed information because it did not exist in the manner requested by the Union (i.e., broken down by agency, program, and vendor). Next, the Employer maintains that it was unduly burdensome to produce the disputed information due to the voluminosity of the requests. Last, the Employer argues that it

could not disclose the critical incident reports due to privacy and confidentiality concerns. Despite these concerns, the Employer maintains that it notified the Union "early and often" about the reasons why it could not provide the dispute information.[37]

a. Possession and Control

The CERB holds that an employer is not required to provide information that is not within its possession or control. Bristol County Sheriff's Department, 32 MLC 76, MUP-01-3068 (Aug. 3, 2005). However, even where the employer does not possess or control the requested information, it is obligated to timely notify the union of that status. Id.

This record shows that between April of 2020 and February of 2021, the Employer was collecting certain COVID-19 data, including deaths and test results, via the excel spreadsheet, the dashboard, Survey Monkey, and critical incident reports. Initially, Lucas received this data from incident commanders (e.g., CEOs, COOs, and Nursing Directors) and input it into Excel. Later, the Employer stopped using Excel and began utilizing the dashboard into which incident commanders and vendors could directly input their data and bypass Lucas. Beginning in June of 2020, the Employer also began using Survey Monkey, in addition to the dashboard, to collect specific COVID-19 data from community congregate care and non-congregate care programs. Moreover, when community vendors stopped voluntarily reporting their COVID-19 data into the dashboard and/or

[37] As an alternative argument, the Employer maintains that it was "incumbent" on the Union to "attempt to reach some type of compromise…as to form, extent or timing of [the] disclosure" of the requested information. However, because the Employer failed to cite to any relevant case law or other authority to support this position, I decline to address this argument.

Survey Monkey, the Employer continued to collect any relevant COVID-19 from them via critical incident reports. Based on this evidence, I find that the Employer was in possession of the disputed information.

Similarly, the record shows that Riccitelli reviewed this data weekly prior to disseminating it to the Unions via informational flyers and newsletters. Looney and Crystal also reviewed the data on the dashboard and Survey Monkey prior to responding to the Union's requests in compliance with the relevant privacy laws and guidelines. Moreover, Crystal informed Weiland by email on July 2, 2020, that the requested critical incident reports would have to "be reviewed by legal and redacted," and that the Union would have to both "narrow" its "overly broad" request and also explain its relevance. For all these reasons, I find that the Employer was in control of the disputed information.

Despite the Employer's contention that it neither possessed nor controlled the disputed information, the record shows that EOHHS has managerial authority over both the DMH and the DPH, including over facilities where DPH and DMH staff and patients may share physical space. The record also shows that the Employer received and maintained COVID-19 data related to deaths and test results from all staff and patients at these facilities and that both agencies reported this data into the dashboard. The record shows further that EOHHS has managerial authority over all DMH community congregate care and non-congregate programs, including programs operated by both the DMH and vendors; and that it received and maintained all COVID-19 information pertaining to deaths and test results via Survey Monkey. Moreover, between March and June of 2020, the Employer received and maintained COVID-19 data related to deaths and test results

which vendors reported voluntarily. Even when certain vendors stopped volunteering this information around June of 2020, they continued to provide critical incident reports which the Employer also received and maintained at all relevant times.

Based on the totality of this evidence, I find that the Employer was in control and possession of the disputed information. Bristol County Sheriff's Department, 32 MLC 76 at 81 (employer violated the Law by failing to provide the union with copies of requested reports that was in the employer's possession and control); compare Commonwealth of Massachusetts, 34 MLC 148, 152, SUP-03-4965 (June 6, 2008) (employer did not act unlawfully when it promptly informed the union that it could not say that the requested information existed—which later turned out not to exist—and the union did not inquire about the information at subsequent negotiations and failed to ask affirmatively whether the information existed).

b. Confidentiality

Where an employer claims that the release of disputed information is exempt from disclosure pursuant to an asserted privilege or statute, the CERB balances the union's need for that information against the employer's legitimate and substantial interests in non-disclosure. Bristol County Sheriff's Department, 28 MLC 113, 121, MUP-1820 (Oct. 10, 2001), aff'd sub nom. Bristol County Sheriff's Department v. Labor Relations Commission, 62 Mass. App. Ct. 665 (2004); City of Boston, 22 MLC 1698, 1706, MUP-9605 (April 26, 1996) (citing Board of Trustees, 8 MLC at1143-44). Once the union demonstrates that the requested information is relevant and reasonably necessary, the employer must establish that it made reasonable efforts to accommodate the union's

request consistent with its expressed concerns. Id. at 1707. Specifically, when the employer has a good faith concern involving confidentiality, it is obligated to initiate a discussion with the union to explore acceptable alternative ways to permit access to the necessary information. Id. at 1709 (citing Worcester School Committee, 14 MLC 1682, 1684-85, MUP-6169 (April 20, 1988).

Here, the critical incident reports are exempt from disclosure because they contain confidential medical information covered under G.L., c.4, §7(26)(c) and the Health Insurance Portability and Accountability Act (HIPPA), 42 U.S.C. s. 201, *et. seq*. City of Newton, 36 MLC 71, 74, MUP-05-4489 (Oct. 28, 2009) (citing Sheriff's Office of Middlesex County, 30 MLC 91, 98, MUP-2754 (Dec. 31, 2003); Wakefield Teachers Association v. School Committee of Wakefield, 431 Mass. 792, 796 (2000). Moreover, the record shows that Crystal communicated her confidentiality concerns to Weiland by email and by telephone on or about July 30, 2020. Based on this evidence, I find that the Employer is able to demonstrate a legitimate and substantial concern about disclosure of the critical incident reports. City of Boston, 22 MLC at 1706.

However, because the Union has demonstrated that its need for the critical incident reports is relevant and reasonably necessary to perform its exclusive bargaining duties, the Employer must establish that it made reasonable efforts to accommodate the Union's requests for these documents consistent with its expressed concerns. City of Boston, 22 MLC at 1707. Specifically, when an employer has a good faith concern involving confidentiality, that employer must initiate a discussion with the union to explore acceptable alternative ways to permit access to the disputed information, which may

include one or more of the following judicially-approved safeguards: (1) limits on the number of individuals who receive access to the information and their use of the information; (2) redaction or other mechanisms to hide the identity of certain individuals named in the information; (3) confidentiality certifications by persons with access to the information; and (4) procedures to track access to the information. City of Newton, 36 MLC at 74-75 (citing Sheriff's Office of Middlesex County, 30 MLC at 99).

Although the Employer asked the Union to narrow the scope of its request for the critical incident reports, and asked the Union to further explain its need for the information, the Employer never initiated any meaningful discussions with the Union to find acceptable alternatives to disclosure of those documents, nor did the Employer make any reasonable efforts to disclose as much information as possible consistent with its concerns about confidentiality or with any judicially-approved safeguards. See, City of Newton, 36 MLC at 74; (although CERB found certain documents were exempt from disclosure, employer failed to provide the requested information pursuant to recognized safeguards).

c. Undue Burden

The CERB holds that where an employer asserts that providing disputed information amounts to an undue burden, it remains obligated to attempt to provide as much information consistent with the employer's expressed concerns or to discuss acceptable alternative ways to provide the information. Bristol County Sheriff's Department, 32 MLC 76, 80, MUP-01-3086 (Aug. 3, 2005).

The record shows that the Employer consistently responded to the Union's ongoing requests for information with almost 70 emails between March 11, 2020 and

March 15, 2021, from Crystal, Looney, Cooney, Gedra, Ducharme, Wenzel, Santos, and Tavares. In addition to updating the dashboard and Survey Monkey on a weekly basis, the Employer also continued to respond orally to Union's oral requests at the parties' weekly and bi-weekly meetings. While all of the Employer's responses contained COVID-19 data mostly broken down by total number of deaths and total number positive test results for patients and staff at DMH facilities Statewide, they did not contain any COVID-19 information broken down by agency, program, or vendor, and did not contain any critical incident reports or Survey Monkey data.

Despite the Employer's numerous and ongoing attempts to provide the Union with as much of the requested COVID-19, it failed to show why the Union's requests were unduly burdensome as they pertained to the relevant critical incident reports and Survey Monkey data, and a break-down of the COVID-19 information by agency, program, and vendor. Specifically, the Employer failed to meet its burden of demonstrating that the disputed information was extensive or difficult to gather. This is because the record is void of evidence demonstrating the specific number of hours, personnel, or other resources necessary for the Employer to respond to the requests. Nor does the record demonstrate that the Employer was unable to reformat the information in a manner sought by the Union. Moreover, the record is clear that the Employer is the largest Secretariat in the Commonwealth with over 20,000 employees, there is no evidence showing how many of these employees comprise unit 8, how many comprise non-unit employees or vendor staff who interact with unit members, or how many patients and clients are served by these employees.

Consequently, based on this evidence, I am unable to find that the requested information was unduly burdensome. Bristol County Sheriff's Department, 32 MLC at 80; see generally, Colgate-Palmolive Co., 261 NLRB 90, 92 (1982) (employer failed to substantiate its defense of undue burden).

3. Unreasonable Delay

A public employer may not unreasonably delay furnishing the requested information. In determining whether a delay in the production of information is unreasonable, the CERB considers a variety of factors including: (1) whether the delay diminishes the employee organization's ability to fulfill its role as the exclusive representative, City of Somerville, 29 MLC at 202; (2) the difficulty of gathering the information, Id.; (3) the period of time between the request and the receipt of the information, HECC, 23 MLC at 269; (4) the extensive nature of the request, Trustees of the University of Massachusetts Medical Center (UMass Medical Center), 26 MLC 149, 158, SUP-4392 and SUP-4400 (March 10, 2000); and (5) whether the employee organization was forced to file a prohibited practice charge to retrieve the information. Board of Higher Education, 26 MLC 91, 93, SUP-4509 (Jan. 11, 2000).

The Union contends that the Employer's provision of Survey Monkey data pertaining to community congregate care programs was unreasonably delayed because it requested the information in October of 2020 but did not receive it until March of 2021. Conversely, the Employer argues that because COVID-19 was "an unprecedented public health crisis," it was only able to obtain more data as the crisis unfolded and provide it to the Union as it became available. The Employer also argues that all of the requested

information was available on the dashboard site, in addition to the weekly reports which included regular testing and screening of vendor employees at DMH facilities. Additionally, the Employer argues that its delay in providing the Survey Monkey data for congregate care sites in March of 2021 was not unreasonable because it maintained "constant communication" with the Union regarding its ongoing requests for information at the weekly meetings, via telephone, and by email.

I am unpersuaded by the Employer's arguments for the following reasons. First, the delay diminished the Union's ability to fulfill its role as the exclusive representative because it needed the information to effectively represent the health and safety concerns of its members during the pandemic. City of Somerville, 29 MLC at 202. Second, the record is void of evidence showing that the Employer had difficulty gathering the information provided in its response in March of 2021. Id. Third, I find that the period of time between the Union's first request for the information in October of 2020 and its receipt of the information in March of 2021 was unreasonable because the Employer had this information in its possession since at least October of 2020, and possibly prior to that time in June of 2020 when DMH Northeast Director Wing notified DMH staff about reporting changes for community programs via Survey Monkey. HECC, 23 MLC at 269. Moreover, I find that the nature of the Union's requests was not extensive because had the Employer responded to the Union's first request in October of 2020, and had it subsequently responded on a monthly basis thereafter, it would not have had to compile multiple months-worth of data into its response on March 17, 2021. Moreover, while the Employer's response on that date comprised less than two pages of data for the period

between January and March of 2021, the Employer failed to show that its delay in providing the aggregate data of clients and staff who tested positive for COVID-19 in all five regions was difficult to aggregate or that it needed to hire additional personnel to gather and review that data. Contrast UMass Medical Center, 26 MLC at 158 (CERB found one-year delay in providing accrued creditable service of members was not unlawful due to extensive nature of request, difficulty calculating the information, and hiring temporary personnel to gather and review data). Finally, the record shows that the Employer's failure to respond to the Union's requests, which began in October of 2020, forced the Union to file the instant Charge to retrieve the disputed information. Board of Higher Education, 26 MLC at 93.

For all these reasons, I find that the Employer's delay in providing the Union with the requested information on March 17, 2021, was unreasonable.

CONCLUSION

I conclude that the Employer violated Section 10(a)(5) and, derivatively, Section 10(a)(1) of the Law by failing to provide the Union with following information that is relevant and reasonably necessary for the Union to execute its duty as the collective bargaining representative: (1) a breakdown of the number of COVID-19 positive cases by agency, clients, patients, and staff at DMH facilities and vendor-operated worksites as of April 29, 2020; (2) the number of COVID-19 positive cases from clients, patients, and staff at DMH community congregate care and non-congregate programs, including all vendor operated sites, broken down by location and/or specific program as of May 8, 2020; (3) all DMH critical incident reports with COVID-19 positive test results grouped by facility

and/or community program as of June of 2020; and (4) Survey Monkey information on COVID-19 positive test results in community programs where bargaining unit members worked as of October 29, 2020. I also find that the Employer violated the Law by unreasonably delaying the provision of the following information that is relevant and reasonably necessary for the Union to execute its duty as the collective bargaining representative: COVID-19 positive test results from clients, patients, and staff at DMH community congregate care sites between January and March 15, 2021, broken down by DMH region.

ORDER

WHEREFORE, based on the foregoing, IT IS HEREBY ORDERED that the Commonwealth of Massachusetts, Secretary of Administration and Finance via the Executive Office of Health and Human Services and the Department of Mental Health (collectively Employer) shall:

1. Cease and desist from:

    a. Failing to bargain in good faith with the Union by refusing to timely provide requested information that is relevant and reasonably necessary for the Union to execute its role as the exclusive bargaining representative;

    b. Failing to bargain in good faith with the Union by refusing to provide all other requested information that is relevant and reasonably necessary for the Union to execute its role as the exclusive bargaining representative;

    c. Interfering with, restraining, or coercing employees in the exercise of their rights guaranteed under the Law.

2. Take the following affirmative action:

a. Provide the Union with requested information that is relevant and reasonably necessary for the Union to execute its role as the exclusive bargaining representative, subject to the following safeguards:

   i. Place a limit[38] on the number of Union representatives who may receive access to any confidential information and their use of the information;
   ii. Make all appropriate redactions or utilize other mechanisms to hide the identity and other sensitive personally identifiable health information of the individuals named in the confidential information, including all necessary redactions required by state and federal privacy laws;
   iii. Obtain written certifications from all persons authorized to access the confidential information pursuant to the limit established above in paragraph i, stating that they will not disclose the confidential information to any unauthorized persons; and
   iv. Utilize appropriate procedures to track access to the confidential information

b. Post immediately, signed copies of the attached Notice to Employees in all conspicuous places where members of the Union's bargaining unit usually congregate or where notices are usually posted, including electronically if the Employer customarily communicates with these unit members via intranet or email, and display for a period of thirty (30) days thereafter; and

c. Notify the DLR in writing of the steps taken to comply with this Order within ten (10) days of its receipt.

SO ORDERED.

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF LABOR RELATIONS

KENDRAH DAVIS, ESQ.
HEARING OFFICER

[38] By mutual agreement, the parties may modify this limit.

APPEAL RIGHTS

The parties are advised of their right, pursuant to M.G.L. Chapter 150E, Section 11 and 456 CMR 13.19, to request a review of this decision by the Commonwealth Employment Relations Board by filing a Request for Review with the Department of Labor Relations within ten days after receiving notice of this decision. If a Request for Review is not filed within ten days, this decision shall become final and binding on the parties.

THE COMMONWEALTH OF MASSACHUSETTS

NOTICE TO EMPLOYEES

POSTED BY ORDER OF A HEARING OFFICER OF THE MASSACHUSETTS DEPARTMENT OF LABOR RELATIONS AN AGENCY OF THE COMMONWEALTH OF MASSACHUSETTS

A Hearing Officer of the Massachusetts Department of Labor Relations (DLR) has held that the Commonwealth of Massachusetts, Secretary of Administration and Finance, Executive Office of Health and Human Services, Department of Mental Health (collectively, Employer) has violated Section 10(a)(5) and, derivatively, Section 10(a)(1) of Massachusetts General Laws, Chapter 150E (the Law) by failing to fully, completely, and timely provide the ALLIANCE, AFSCME-SEIU, Local 509, AFL-CIO (Union) with information that is relevant and reasonably necessary for the Union to execute its duties as collective bargaining representative.

The Law gives public employees the right to form, join or assist a union; to participate in proceedings at the DLR; to act together with other employees for the purpose of collective bargaining or other mutual aid or protection; and, to choose not to engage in any of these protected activities.

The Employer assures its employees that:

- WE WILL NOT fail to bargain in good faith with the Union by refusing to timely provide requested information that is relevant and reasonably necessary for the Union to execute its role as the exclusive bargaining representative;
- WE WILL NOT fail to bargain in good faith with the Union by refusing to provide all other requested information that is relevant and reasonably necessary for the Union to execute its role as the exclusive bargaining representative;
- WE WILL NOT interfere with, restrain or coerce employees in any right guaranteed under the Law;
- WE WILL provide the Union with requested information that is relevant and reasonably necessary for the Union to execute its role as the exclusive bargaining representative subject to judicially-approved safeguards outlined in the Hearing Officer's Decision and Order in Case No. SUP-20-8334.

_____ _____

Commonwealth of Massachusetts Date

THIS IS AN OFFICIAL NOTICE AND MUST NOT BE DEFACED OR REMOVED

This notice must remain posted for 30 consecutive days from the date of posting and must not be altered, defaced, or covered by any other material. Any questions concerning this notice or compliance with its provisions may be directed to the Department Labor Relations, Charles F. Hurley Building, 1st Floor, 19 Staniford Street, Boston, MA 02114 (Telephone: (617) 626-7132).