TESTIMONY OF

PAUL BARABANI
HOLYOKE SOLDIERS' HOME COALITION MEMBER
(SUPERINTENDENT OF THE SOLDIERS' HOME IN HOLYOKE FROM 2011-2016)

BEFORE THE

HOUSE VETERANS' AFFAIRS SUBCOMMITTEE ON HEALTH

HEARING ON

"Who's in Charge? Examining Oversight of State Veterans Homes During the COVID-19 Pandemic"

JULY 29, 2020

Chairwoman Brownley, Ranking Member Dr. Dunn and Members of the Health Subcommittee:

Thank you for this opportunity to represent the Holyoke Soldiers' Home Coalition in providing testimony on the oversight of State Veterans Homes during the COVID-19 pandemic.

The Coalition is comprised of former executive staff from the Home, family members of Veteran residents at the Home who died of COVID-19, family members of Veterans at the Home, other Veterans in the community and concerned citizens. Our mission is to advocate for the staff and Veteran residents of the Soldiers' Home in Holyoke by demanding improved staffing, the construction of a new Home to include an Adult Day Healthcare Program and better governance and oversight. We greatly appreciate the commitment of Congressman Richard Neal in his support for the construction of a new Home, to include an Adult Day Healthcare program.

The lack of state support to the Soldiers' Home in Holyoke has long been a topic of much consternation among Veterans in western Massachusetts.

In 2010 the Annual Survey by the U.S. Department of Veteran Affairs conducted at the Soldiers' Home in Holyoke noted deficiencies in life safety and resident room size. Of the 278 existing beds at the time, less that 5% met VA Standards and the majority of rooms did not have direct access from the bedroom to the toilet.

Subsequently, under my leadership, a design was created to house 270 residents, in 12- and 15-bed units with integral living space typical of the VA's Community Living Center model. This plan was approved by the VA Construction Grant Program in 2013. In 2014, the VA approved the design of an Adult Day Healthcare program at Holyoke. Unfortunately, both remain on the 2020 list of projects ***lacking state matching funds***.

It is our Coalition's belief that the lack of sufficient staff and space were ***potential root causes*** of the rapid spread of the virus which resulted in the deaths of 76 Veterans. Other contributing factors may include:

a. the vulnerability of Veterans most of whom have multi-morbidities and compromised immune systems
b. the number of staff and residents who may have been asymptomatic carriers
c. the lack of sufficient Personal Protective Equipment and an infection control policy
d. the lack of COVID-19 testing capabilities
e. the congregate living areas to include community bathrooms
f. the lack of an Electronic Medical Record system
g. the wandering tendencies of the Veterans with dementia as well as their inability to comprehend the need to wear a mask
h. the failure to isolate the Veterans with symptoms
i. the lack of negative pressure isolation rooms

Regarding the VA's responsibility for oversight, the Annual VA Survey is a thorough review of clinical and life safety standards to ensure quality resident care and compliance with VA standards. It is particularly noteworthy that the 2020 survey of the Soldiers' Home in Holyoke,

completed on January 31, 2020 stated, “Review of the facility’s program management records confirmed the facility did not have an established infection control program.”

Despite the thoroughness of the VA Annual Survey during my tenure as superintendent, I also saw many opportunities for improving the survey process. Currently, the Annual VA Survey has VA Central Office reviewing State Veteran Homes through a contractor, essentially delegating a nationally directed program to the local VA medical center via a third party.

My personal thoughts on improving the VA oversight of State Veteran Homes would be a much greater collaboration, partnership and relationship between the VA and State Veteran Homes. Here are my recommendations:

a. The VA survey should include an analysis of staffing levels in relation to resident complexity, as the critical first step of the annual survey.
b. VA should require the Facility of Jurisdiction to assist the State Veteran Home with developing corrective action plans; utilizing their expertise, network of data and their vast knowledge of successful clinical practice guidelines.
c. The survey process should require the VISN Director to approve the Corrective Action Plan.
d. I would incorporate the results of the State Veteran Homes survey into the performance metrics for the Director of the Facility of Jurisdiction.
e. Establishment of a formal “Partnership” between the Facility of Jurisdiction and the State Veteran Home, which should include:
    a. Attendance of State Veteran Home staff at VA training classes
    b. Access for State Veteran Home employees to VA On-Line training, Evidence Based Practices, and other VA resources
    c. Joint participation in Disaster Preparedness Exercises
    d. Assistance with placement of “challenging” residents
    e. Facility of Jurisdiction providing Assistance Visits or collaboration in areas such as:
        i. Facilities Management
        ii. Quality Management
        iii. Falls/Risk Management
        iv. Dietary Services
        v. Pharmacy Program
        vi. Systems Redesign/Lean Training
        vii. Root Cause Analysis
f. Establishing a methodology to formally address “recurring deficiencies”; especially those that require corrective action above the facility level.

The Department of Veteran Affairs and the State Veteran Homes have a moral obligation to provide quality care for all Veterans, whether in a VA Community Living Center or a State Veteran Home. Through a professional partnership and collaboration, we have a unique opportunity to vastly improve the quality of Veteran care for future generations of Veterans.