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MICHIGAN HOUSE OF REPRESENTATIVES

EDWARD MCBROOM

STATE REPRESENTATIVE

March 17, 2016

Speaker of the House
Representative Kevin Cotter
State Capitol

House Appropriations Committee
Representative Al Pscholka, Chair
State Capitol

House Military and Veterans Affairs Committee
Representative Tom Barrett, Chair
Anderson House Office Building

Dear Mr. Speaker, Chairmen Pscholka and Barrett,

Pursuant to House Rule 36 the House Oversight and Ethics Committee has reviewed the *Performance Audit of the Grand Rapids Home for Veterans*.

During the first of the two committee hearings, on March 3, 2016, testimony was given by the Auditor General and the Department of Military and Veterans Affairs. The Auditor gave an overview of the audit and the recommendations contained therein. The audit concluded the following: surveillance checks were not being conducted properly and staff signed off on falsified checks; the contractor did not meet staffing needs consistently; improper administration of nonnarcotic pharmaceuticals; failure to monitor comprehensive care plans; lack of controls over nonnarcotic pharmaceuticals; failure to properly bill insurance for members' eligible prescriptions; failure to track and properly investigate complaints and allegations of abuse and neglect; failure to properly dispense discharged or deceased member funds; and failure to timely resolve past due member assessments.

Representatives from the Department of Military and Veterans Affairs agreed with the findings of the Auditor General. In addition, the Department focused much of its testimony on specific changes in policy and personnel meant to address the Audit findings.

Following a hearing dedicated to the facts of the audit, the House Oversight and Ethics Committee met jointly with the House Military and Veterans Affairs Committee on March 10, 2016 and March 17, 2016. These hearings were an opportunity for committee members to hear further testimony from advocates and residents of the home. After these hearings, the committee has adopted the attached report and its recommendations.

If you have questions or desire to hear from the chairman or members of the Oversight and Ethics committee for any future discussions please do not hesitate to ask.

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Respectfully,

Ed McBroom
Chair

Martin Howrylak
Majority Vice Chair

Rose Mary C. Robinson
Minority Vice Chair

Joseph Graves
51st District

Lana Theis
42nd District

Kristy Pagan
21st District

Auditor General Report Recommendation
by the
House Oversight and Ethics Committee

The Committee agrees with the findings in the Auditor General's report on the Grand Rapids Home for Veterans. There are areas noted in this report that indicate a need for improvement and further review. Further review should include, but not be limited to, the following:

1. The establishment of an independent ombudsman's office. This individual or individuals should be available on a full time basis to respond to complaints or other grievances. In addition, they should not report to an individual in a position of power or control at the Grand Rapids Home for Veterans.
2. The establishment of a rigorous protocol to address complaints and appeals of complaints. The Appropriations Committee should consider inclusion of a reporting requirement detailing the complaint protocol, its implementation, and successes or failures.
3. The alteration of state law to require continuing inspections of the Grand Rapids Home for Veterans. Though the Department disclosed pursuance of Centers for Medicare & Medicaid Services (CMS) licensing, there is not currently any minimum requirement that the Home be held to the same standard as other nursing homes in the state. This is of particular concern if CMS licensing is either not attained or were to be subsequently dropped. Licensing and inspection of the Home would ensure the statewide standards are being upheld. These standards and inspections could be similar to those required by CMS but ought to be housed in another department such as LARA. The regular standards for state nursing homes may not be entirely applicable to the Home as it is not simply a nursing home.
4. The review of the structure, role and makeup of the Board of Managers. Further discussion on the proper role of the Board of Managers could assist in resolving governance related issues. Concerns have been voiced regarding their proper role in the oversight of the Home.
5. The review of the budgeting process. To ensure that funds are appropriated and utilized in the manner intended by the legislature, a return to the line item formatting should be implemented. The auditing process has repeatedly shown a failure to follow through with state budget plans for appropriated funding. Specifically, the two most recent audits

included evidence of funding allocated and not used to purchase Pyxis pharmaceutical machines during those specific budget cycles.

6. The program currently utilized for security cameras should be reviewed to allow for the flexibility of the Home to save available footage into a portable electronic storage device. Evidence has been presented that suggests the footage is unavailable for offsite review or verification, resulting in a failure for the legislature or any other legally appropriate entity to review the data anywhere but at the Home. Further, this inability to offload data could ultimately inhibit the Home's ability to save its own footage and protect itself from liability. The Appropriations Committee could consider assisting in the exploration of new security camera technology and a reporting requirement ensuring implementation of proper technology.
7. The review of contracting and employment overall. Several consecutive audits have indicated both the apparent inability to enforce a contract as well as obvious difficulties in dealing with discipline or removal of employees, both state civil service and contracted, who were either deceptive, negligent, or indifferent. Further, a discussion should be had regarding competitive, marketplace wages to promote and attract the most qualified full cohort of employees.
8. The review of protocols surrounding the final handling of the bodies of deceased members. Testimony indicated some inconsistencies about when autopsies are performed. While autopsies are certainly not always necessary, there ought to be a transparent process applied. The Appropriations Committee could consider a reporting requirement to ensure implementation of a transparent, family oriented, respectful practice.
9. A full review of the Veterans Home model in this state. It may be wise for the policy committee, with the Department of Military and Veterans Affairs, to create a special work group to explore a complete overhaul of the system to make sure it has not become archaic. This review might include finding ways to provide a more comprehensive model for providing housing and medical care for veterans to more diverse levels of need.
10. The Appropriations Committee could consider the placement of a funded compliance officer within the Veterans Home modeled after other large scale health care providers. The compliance officer should be required to send monthly reports to the Director of the Department of Military and Veterans Affairs, with copies sent to the Auditor

General's Office, the Speaker of the House, and the Senate Majority Leader. To the extent the Veteran's Home may come under the regulation of the Bureau of Community and Health Systems within the Department of Licensing and Regulatory Affairs, the compliance officer should also send monthly reports to the Director of Licensing and Regulatory Affairs regarding the facility regulations, with copies sent to the Auditor General's Office, the Speaker of the House, and the Senate Majority Leader. Monthly reporting should continue until the next report by the Auditor General expected in 2018.

Following diligent assessment by the House Military and Veterans Affairs Committee and the House Appropriations Committee, the House Oversight and Ethics will request a formal follow up audit of the Grand Rapids Home for Veterans. Committee members agree that the role of the Auditor General is integral to identifying areas of concern and to effectuate accountability measures. The Committee recommends a six month and twelve month follow up review, as well as a formal audit to be completed by August 2018.

The Oversight and Ethics Committee will provide copies of this report to the Attorney General's office. Testimony indicated a number of very troubling allegations, including the misuse of certain powerful drugs, abuse and neglect of home members, and other potentially serious malfeasance. It is the opinion of the Oversight and Ethics Committee that the Attorney General is the proper individual to further review those allegations.

The Oversight and Ethics Committee has diligently performed its duty under House Rule 36 and submits this report to the House Appropriations Committee and the House Military and Veterans Affairs Committee.