Testimony from James Ulinski at Public Hearing of Pennsylvania's Veterans Home Care and COVID-19 Mitigation Protocols on Thursday, May 6th, 2020.

1. E.A.P. (Emergency Action Plan) Should contain procedures for all types of emergencies. Fires, floods, nuclear disaster threats, bomb threats, water pollution, where to go in event of need to shut down building, virus/infection control protocols, isolation, PPE, Safety Committee, Veteran Rights Committee, etc. Be proactive instead of reactive!

2. Better oversight by all involved parties. SEVC largely ignored DMVA's planning directives (Executive Summary P2). What is now in place to ensure breakdowns/neglecting protocols ever happens again. This still falls in some part on DMVA (poor administrative follow-up)

3. Infection Control procedures when working with veterans/residents must always be followed---even in non-COVID times.

4. Having a rigid chain of command from top to bottom can hurt as it did in the situation at S.E. Veterans Center. We can respect a chain of command, but transparency and allowing staff at the ground level to have a voice should be expected. Many times, great ideas come from line staff. Sadly, the military is not noted for this ability—generally speaking.

5. Poor communication from the top down and from the bottom-up needs to be much better (this is not the military) Communication needs to improve at all levels, including with families or you see poor morale.

6. Veterans living at facilities should have a group established where they can discuss what they feel is important/needs improved----food selection, ambiance, other issues. Families should be afforded the same courtesy. I had parents' meetings every month---9 months of the year where we addressed common issues relevant to them and their loved ones. We did the same with our residents. They were not bitch sessions but how we could make everything better. Never should families be threatened or left in the dark. DMVA and their employees work for those veterans and their families living there---it's the reason they get a paycheck!

7. Training needs to be on going. Some simple training can be just paper with a knowledgeable person presenting, others require hands on training and always---properly documented and repeated when needed.

8. People making medical decisions must have an extensive medical background which is carefully vetted. The same should apply for the major positions of Commandant, D.O.N., etc. Whoever interviewed these people surely did not do their background checks. The Commandant would never have made it through my interview and screening. All staff should need previous employers checked and my personal opinion is at least two staff in the department hiring should do interviews together and then take a trip through the facility.

9. The Commandant and other major officers should have nursing home experience as well as administrative experience.

10. I talked with my line staff as well as each of my numerous departments frequently. I also had an open door for all my staff and family members.

11. Where there is smoke, there is often a fire. The Commandant (Blackwood) and the D.O.N. (Mullane) had numerous issues with their rigid authoritative style of managing. Great leaders modify their style as times require (they are flexible). As I've said already---this is not the military—nor should it be run like the military. P15 Executive Summary—no action taken with regards to numerous complaints against the SEVC and the Commandant specifically.

12. Constant "pushback" from the Commandant and the D.O.N. when attempting to communicate (Dr. Jackson)

13. Poor leadership from the top down allowed many of the problems to persist and surely did not help when the COVID outbreak started.

14. Having worked with Life Safety, D.O.H., Federal Look Behinds, Independent Family Advocacy Groups, Area on Aging, etc. I also know that not always are "surprise visits" a surprise at all. Where were these groups in finding problems until too late? Clean reviews until problems surfaced!!

15. How can you have National Guard come to help and then be denied access to SEVC's leadership (P34 Executive Summary)?

16. Can have an independent group consisting of various department staff do periodic "walk throughs" with the purpose of looking for problems. Can also have an independent consultant do periodic reviews like I did for years.

17. The improper use of Hydroxychloroquine was obviously a terrible blunder. Issues such as lack of informed consent also were lacking.

18. "DMVA purportedly worn down by SEVC's consistent pushback failed to exercise necessary oversight over SEVC and insist on compliance with directives" (P51 Executive Summary) What the heck was going on. Leaders need to lead!

19. Giving N95 masks to management before even nurses and direct care staff—ridiculous (P81 Executive Summary)!

20. Typical of military decisions, (then Adjutant) General Carrelli said National Guard can get any info from the chain of command (PP90-91 Executive Summary)!

21. DMVA (P11 Executive Summary) "DMVA leadership also disclaimed any accountability for the problems at SEVC. HUH???? Sorry, but top leadership (leadership used lightly here) botched everything!

22. As I mentioned in several of our Joint State Government Commission's Task Force and Advisory Committee Report which was just released in March of 2021, there is often a disconnect between military organizations and veterans, and the same thing applied at SE Veterans Center as well as many Veteran Facilities across the country. We also have too many "good old boys"---can be good old gals too, doing things that long ago passed them by and stuck in yesteryear!

23. All staff should have criminal background checks---if not already done.

24. The veterans who live at these facilities should have ample opportunities to be directly involved with their treatment goals. If not capable their guardian should be involved. Families should also be able to be involved. My wife and I are and have been involved with a lady we have been guardians for many, many years.

25. Can not repeat this often enough---much better oversight of all facilities that care for veterans. This should include the Area on Aging and accredited medical organizational reviews. I welcomed them.

26. Case management clinical reviews should be done weekly to ensure proper clinical documentation, including talks with family and reviews of clinical assessments, reviews and treatment, objectives/goals are moving forward. Chart reviews headed by a case manager with certification and medical documentation reviewed by a licensed doctor, psychiatrist, etc.

27. All deaths be reviewed for cause of death by an outside county coroner to ensure they are in agreement with reports made solely by the PA SE Veterans Morgue (obviously all info we mention should be applied everywhere veterans are cared for.

28.Treatment and goals must be thought out to include the open communication/transparency often mentioned by us. A veteran's family is an extension of their PTSD or other problems. Many physical and mental health issues not only affect the veteran, but also those who love them. Families must have a say in treatment plans as guardians or having power of attorney. All drug potential side effects should be discussed involving all informed legal parties. We had a member of social services, nursing, residential services, dietary, the family, the resident themselves, and a doctor if the discussion was such that his/her information would be important at that time. Informed consent is a must!

29. Lee pointed out that he has seen in his experiences, veterans are often nominated by the PA Veterans War Council who lack any health care or medical credentials, education, or experience. Some are picked for political purposes (our belief) To provide the best care---we need properly vetted, trained (training should never stop), and the necessary credentials to do the job properly.

30. There should be a Training Dept. with people who provide the required/needed training on a continuous schedule. I had staff at our major facilities who helped me provide all departments training---often obviously involved the proper certified people---e.g., nursing, dietary.

31. Lee also added and I agree, if possible, veterans who could stay at home with their families should do so. The cost is far less than Nursing Home Care, Personal Care Homes, or Attendant Care. This would allow relief care up to 8 hours a day at $60 per day. This could be done with Adult Day Care vouchers. Reduces stress of having an elderly veteran move into a facility/home and is cheaper.

32. We both in our experiences found residents/veterans who remain in their homes often fare much better than those placed/moved to congregate settings. They have more opportunities for a home life, community involvement, loving families, etc. FYI---often older patients/veterans who are moved from their home setting do not fare well health wise.

33. Veterans needing to leave the facility for a hospital should be able to not wait and possibly aggravate the injury or illness---or even die. There should never be hesitancy for any reason. When in doubt send out!

34. Documentation must be accurate and done as quickly after an incident as possible. Most people have short attention spans. No one should suffer because of hesitancy!

Lee and I have had very long and diverse careers involving health care and for me, education as well. We both are 100% disabled veterans and want to see our brothers and sisters cared for in the best manner possible. We hope moving forward, this will happen!

We thank you for the opportunity to present today.