United States Senate

COMMITTEE ON
HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS

WASHINGTON, DC 20510–6250

February 4, 2015

The Honorable Carolyn M. Clancy
Interim Under Secretary for Health
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, D.C. 20420

Dear Dr. Clancy:

I write to request that the Veterans Health Administration (VHA) and the Office of Medical Inspector examine the treatment of Thomas Patrick Baer, a veteran who sought treatment at the Tomah, Wisconsin, Veterans Affairs Medical Center (VAMC) Urgent Care facility on January 12, 2015. Mr. Baer passed away on January 14, 2015 at the Gundersen Lutheran Medical Center (Gundersen) in La Crosse, Wisconsin from complications of a stroke.[1] The account of Mr. Baer's treatment at the Tomah VAMC Urgent Care center is disturbing.

According to an account of Mr. Baer's treatment provided to my office by Mr. Baer's daughter, Candace Delis, she and her mother called the Tomah VAMC Urgent Care center to inform them that Mr. Baer was not feeling well and that they would be bringing him to the Tomah VAMC. According to Ms. Delis, upon their arrival, she and Mr. Baer waited three hours to be seen. She said that during their wait, Mr. Baer showed a range of symptoms, including labored breathing, confusion, dizziness, and difficulty walking. After he was seated in a wheelchair, Mr. Baer was unresponsive to communications from his family members, and he exhibited signs of paralysis on one side of his body. Ms. Delis said that when she alerted staff to these symptoms, expressing her belief that her father had suffered a stroke, the staff moved her father to an examination room to wait until a staff member was able to evaluate him.

Ms. Delis said that Mr. Baer waited in the examination room for an additional 45 minutes before he underwent an electrocardiogram and a chest x-ray. The staff informed Ms. Delis that they were unable to examine Mr. Baer's brain or conduct any other testing for stroke as the CT scanner at the facility was broken. Without a CT scan, the staff informed Ms. Delis, they could not administer the anticoagulant medication that is commonly used to treat a stroke victim. A short time later, Mr. Baer suffered a second, massive, stroke.

Ms. Delis said that staff at the facility informed her that Mr. Baer would need to be transferred to another hospital because the Tomah VAMC lacked the necessary equipment to properly treat him. They told Ms. Delis, she said, that her father would be transported to

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[1] *Thomas Baer Obituary*, MARSHFIELD NEWS HERALD, Jan. 27, 2015, http://www.legacy.com/obituaries/marshfieldnewsherald/obituary.aspx?pid=173936994.

Gundersen in La Crosse via helicopter. She said that, a short time later and without further explanation, the Tomah staff told her that helicopters were not flying that day, though the weather was clear and the winds calm, and that Mr. Baer would be transported the roughly 45 miles to Gundersen via ambulance.

Upon arrival at Gundersen, doctors there apparently "could not understand" why Mr. Baer was not administered the anticoagulant medication in Tomah or why he was not transported to La Crosse via helicopter. Doctors at Gundersen completed surgery to remove a blot clot in the carotid artery in his neck. However, Mr. Baer never regained consciousness from surgery and passed away on January 14, 2015.

Mr. Baer's alleged treatment at the Tomah VAMC raises serious questions. The VHA must take measures to ensure that it has necessary lifesaving equipment fully maintained and operational to serve patients — not only at the Tomah VAMC but at VAMC facilities nationwide. Accordingly, I request that your office examine the circumstances surrounding Mr. Baer's treatment at the Tomah VAMC on January 12, 2015.

In addition, to inform the Committee's inquiry of these matters, I ask that you please provide the following information and material:

1. What is the average wait time at the Tomah VAMC Urgent Care facility?

2. What is the average wait time at VAMC Urgent Care facilities nationwide?

3. What triage guidelines or procedures are in place to ensure that patients showing signs of catastrophic medical emergencies (for example, strokes, heart attacks, or similar emergencies) are seen in a timely manner?

4. What is the current status (online or offline) of the Tomah VAMC CT scan machine?

    a. How many times since 2012 has the CT scan machine at the Tomah VAMC been offline?

    b. Why was the CT scan machine at the Tomah VAMC offline on January 12, 2015?

    c. How long was the CT scan machine at the Tomah VAMC offline before January 12, 2015?

    d. How many patients came to the Tomah VAMC complaining of stroke symptoms during the time that the CT scan machine at the facility was offline?

    e. How many CT scan machines are at the Tomah VAMC?

5. What guidelines or procedures does the VHA have in place to repair medical equipment when it breaks?

    a. What is the average repair time for VHA electrocardiogram machines nationwide?

    b. What is the average repair time for VHA CT scan machines nationwide?

    c. What is the average repair time for VHA x-ray machines nationwide?

    d. What is the average repair time for VHA MRI machines nationwide?

6. In July 2014, the VA announced plans to restructure the Office of Medical Inspector to "create a strong internal audit function which will ensure issues of care quality and patient safety remain at the forefront."[2]

    a. What is the status of this restructuring? When will the restructuring be complete?

    b. What role will the Office of Medical Inspector play after the restructuring? How will it be different from its role prior to the restructuring?

Please provide this material as soon as possible but no later than 5:00 p.m. on February 18, 2015.

The Committee on Homeland Security and Governmental Affairs is authorized by Rule XXV of the Standing Rules of the Senate to investigate "the efficiency, economy, and effectiveness of all agencies and departments of the Government."[3] Additionally S. Res. 253 (113th Congress) authorizes the Committee to examine "the efficiency and economy of all branches of the Government including the possible existence of fraud, misfeasance, malfeasance, collusion, mismanagement, incompetence, corruption, or unethical practices . . . ."[4] For purposes of this request, please refer to the definitions and instructions in the enclosure.

Thank you for prompt attention to this matter. If you have any questions about this request, please contact Kyle Brosnan of the Committee staff at (202) 224-4751.

Sincerely,

Ron Johnson
Chairman

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[2] Press Release, Department of Veterans Affairs Office of Public and Intergovernmental Affairs, VA to Restructure Office of Medical Inspector (July 8, 2014) http://www.va.gov/opa/pressrel/pressrelease.cfm?id=2579.
[3] S. Rule XXV(k); *see also* S. Res. 445, 108th Cong. (2004).
[4] S. Res. 253 § 12, 113th Cong. (2013).

cc: The Honorable Thomas R. Carper
Ranking Minority Member

Enclosure