United States Senate

COMMITTEE ON
HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS

WASHINGTON, DC 20510–6250

March 27, 2015

The Honorable Robert A. McDonald
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue NW
Washington, DC 20420

Dear Secretary McDonald:

I write to request that the Department of Veterans Affairs (VA) publicly release the VA Central Office (VACO) Clinical Review Visit Report of the Tomah VA Medical Center. It is crucial that the VA is transparent during its investigation of the Tomah VAMC. A transparent investigation will lead to increased accountability of VA officials and ultimately ensure that Wisconsin's veterans receive the care they deserve.

On March 10, 2015, the VA released a one-page summary of the findings of the preliminary investigation of the Tomah VAMC conducted by Interim Under Secretary for Health, Dr. Carolyn Clancy.[1] While the VA has provided the report to the Committee, the VA has asserted that the document is privileged and confidential in nature and has refused to disclose the report.[2]

Veterans who currently receive treatment at the Tomah VAMC, or may receive treatment in the future, have a direct interest in the findings of the VA investigation. The publicly released one-page summary listed aggregated data from 18 chart reviews to conclude that there are "unsafe clinical practices at the Tomah VAMC in areas such as pain management and psychiatric care."[3] However, these statistics do not fully capture the sentiments expressed in the full interim report. Specifically, the report contains troubling quotes from staff members at the facility regarding potentially dangerous treatment protocols for our veterans. The report also includes charts illustrating how opioid treatment protocols at the Tomah VAMC are in stark contrast to VA system-wide averages. Members of the Tomah community who may receive treatment from the Tomah VAMC have a direct interest in fully understanding the quality of care at the facility.

Moreover, the summary does not comprehensively describe the toxic workplace environment at the Tomah VAMC. Whereas the public summary has identified a "culture of fear

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[1] Office of the Assistant Deputy Under Secretary of Health for Clinical Operations, *VACO Clinical Review Visit Report Tomah VA Medical Center: January 27-29, 2015* (herein after "Dr. Clancy Review").
[2] *See id.*; E-mail from Dep't of Veterans Affairs staff to Committee staff (Mar. 13, 2015).
[3] Memorandum from Dr. Carolyn M. Clancy, Interim Under Secretary for Health, Department of Veterans Affairs, to The Honorable Robert A. McDonald, Secretary, Department of Veterans Affairs, Mar. 10, 2015, http://www.va.gov/opa/docs/MEMO_Summary_of_Phase_One_Clinical_Review_Findings_Tomah_WI.pdf.

at the facility" that has "compromised patient care and impacted staff satisfaction and morale,"[4] the full interim report quotes current Tomah VAMC staff members about their personal experiences at the facility. It is important that the public has the ability to read these first-hand accounts to fully understand the gravity of the problems at the Tomah VAMC.

I understand that the VA has claimed that the report is "confidential and privileged" under 38 U.S.C. § 5705.[5] I believe that the interim report does not qualify as a "medical quality-assurance program" within the meaning of the statute. 38 U.S.C. § 5705(c)(2) defines "medical quality-assurance program" as "a Department *systematic* health-care review activity *designated by the Secretary* to be carried out or for the Department for either such purpose."[6] The applicable regulations also only apply to documents created by the VA while conducting "systematic health care reviews."[7] Dr. Clancy's review of prescription practices and workplace culture was limited to just the Tomah facility. Her isolated review of this single VAMC is hardly indicative of a "systematic health-care review" of the entire VA. Moreover, the VA Under Secretary for Health requested the specific inquiry into Tomah, rather than the Secretary of the VA.

Furthermore, Dr. Clancy's review of the Tomah VAMC fails to meet the definition of "quality-assurance program" within the meaning of 38 U.S.C. § 7311.[8] As part of quality-assurance programs, the statute calls on the Under Secretary for Health to evaluate whether there are "significant deviations in mortality and morbidity rates for surgical procedures" among other events that simply did not take place in Dr. Clancy's review of the Tomah VAMC. Indeed, reviews of opioid prescription trends and evaluations of workplace culture are conspicuously absent from the statute's definition of "quality-assurance program."[9]

Instead, Dr. Clancy conducted her preliminary review of the Tomah VAMC after mounting pressure from members of Congress. I have written letters to both you[10] and Dr. Clancy[11] asking questions, requesting documents, and calling for investigations into the Tomah VAMC regarding issues of opioid over prescription, the substandard care of a veteran at the Tomah VAMC Urgent Care center, and a culture of retaliation at the facility. Dr. Clancy's review is an important first step in Congress's and the VA's collaboration to cure the ills that have plagued the Tomah VAMC.

Publicly releasing the report will allow those in the Tomah community and our nation's veterans to understand more deeply the magnitude of the problems at the Tomah VAMC. Increased transparency will lead to greater accountability at the facility and potentially prevent

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[4] Memo from Dr. Clancy to Secretary McDonald, *supra* note 2.
[5] 38 U.S.C. § 5705.
[6] 38 U.S.C. § 5705(c)(2) (emphasis added)
[7] 38 C.F.R. 17.501(a).
[8] 38 U.S.C. § 7311.
[9] *Id.*
[10] Letter from Senator Ron Johnson, Chairman, Comm. Homeland Security and Gov't Affairs, to Robert A. McDonald, Secretary, U.S. Dep't Veterans Affairs, Feb. 4, 2015.
[11] Letter from Senator Ron Johnson, Chairman, Comm. Homeland Security and Gov't Affairs, to Dr. Carolyn M. Clancy, Interim Under Secretary for Health, U.S. Dep't Veterans Affairs, Feb. 4, 2015.

future deaths. For these reasons, I respectfully urge you to reconsider your assertion of privilege and confidentiality of Dr. Clancy's preliminary review and find a means, through redactions or otherwise, to publicly release the material contained in the interim report of the Tomah VAMC in a manner that safeguards sensitive veterans' health information.

Thank you for your attention to this important matter.

Sincerely,

Ron Johnson
Chairman

cc: The Honorable Thomas R. Carper
Ranking Member

The Honorable Tammy Baldwin
U.S. Senator