Opening Statement of Chairman Ron Johnson

"Tomah VAMC: Examining Quality, Access, and a Culture of Overreliance on High-Risk Medications"

March 30, 2015

As prepared for delivery:

Good afternoon. I would like to begin by thanking Chairman Miller of the House Veterans Affairs Committee for his collaboration and leadership in holding today's hearing. I would also like to thank all of our colleagues for their participation.

Today's hearing has been called to examine the disturbing allegations surrounding the Veterans Affairs Medical Center here in Tomah.

The primary goal of this hearing -- and of all our future actions -- is to help prevent tragedies like the ones we will hear about today from happening to other veterans and their families.

I first became aware of problems at the Tomah VA following news reports in January of this year. I immediately assigned committee staff to launch an investigation into what had occurred -- and was occurring -- at Tomah, and the VA's reaction to it. Here is what we have found so far

> In April 2003, Dr. David Houlihan was disciplined by the Iowa Board of Medicine for having an inappropriate relationship with a psychiatric patient. According to the executive director of the Board of Medicine, the sanction should have been a serious concern for future employers.
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> In 2004, Dr. Houlihan was hired as a psychiatrist at the Tomah VA Medical Center.
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> In August 2005, Dr. Houlihan became chief of staff at the Tomah medical center.
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> In November 2007, Kraig Ferrington, a veteran who sought treatment at the Tomah facility for medication management died from a lethal mixture of drugs. Autopsy results showed Mr. Ferrington had seven drugs in his system.
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> In April 2009, it was known and documented by employees at the Tomah VA that many of Dr. Houlihan's patients called him "the Candy Man" and they were concerned that veterans were "prescribed large quantities of narcotics."
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> In June 2009, Dr. Noelle Johnson was fired from Tomah for refusing to fill prescriptions that she believed to be unsafe. Dr. Johnson had raised concerns to her superiors, had sought guidance from the Iowa medical licensing board, and later spoke with the Drug Enforcement Administration about Dr. Houlihan.

In July 2009, Dr. Chris Kirkpatrick was fired from Tomah. Dr. Kirkpatrick had raised concerns to his union about over-medication at Tomah. Tragically, later in the day of his termination, Dr. Kirkpatrick committed suicide.

In August 2011, the VA Office of Inspector General (OIG) received an anonymous complaint about overprescription and retaliation by Dr. Houlihan at Tomah.

In March 2012, a second anonymous complaint was filed with the IG against Dr. Houlihan. The OIG examined 32 separate allegations during its two and a half year long inspection.

In March 2014, the OIG finished its inspection of Tomah and administratively closed the case without making it public.

On Aug. 30, 2014, Jason Simcakoski died in the Tomah mental health wing as a result of "mixed drug toxicity." Simcakoski was a patient of Dr. Houlihan. His autopsy revealed he had over a dozen different medications in his system.

In September 2014, Ryan Honl began lodging whistleblower complaints about patient safety and quality of care at Tomah.

On Jan. 8, 2015, the Center for Investigative Reporting published an article detailing over prescription and retaliation at Tomah. The article revealed that veterans and employees referred to the Tomah VA Medical Center as "Candy Land."

On Jan. 12, 2015, Candace Delis brought her father, Thomas Baer, to the Tomah VA Urgent Care Center with stroke-like symptoms. Mr. Baer waited over two hours for attention. That day, the facility's only CT scanner was down for "routine preventative maintenance." Mr. Baer passed away two days later.

On Feb. 6, 2015, the OIG finally posted its Tomah health care inspection report on its website.

We continue to gather the facts about what occurred at Tomah. Our investigation is far from over. Revelations of the problems at Tomah have prompted additional whistleblowers to contact our committee with information that indicates systemic problems within the VA health care system.

It is important to acknowledge and thank the members of the media who have uncovered, reported and highlighted the problems within the VA health care system. Without a free press, few if any of these problems would have ever seen the light of day.

Legislatively, this hearing is just the first step. In order to solve a problem, we must fully understand it and be willing to admit we have one. To that end, today we will hear from surviving

family members, former employees, and representatives from the VA, and the VA Office of Inspector General.

Tragically, we will hear the stories of two families, the Simcakoski and the Baer families, who lost loved ones during their treatment at the Tomah facility. They have many questions, and they have a right to have those questions answered.

I want to convey our sincere condolences to the family members and friends of Jason Simcakoski and Thomas Baer. We thank them for being here today so that Wisconsin and the American people can hear their stories first-hand.

The lack of public knowledge and scrutiny of the problems -- not only at Tomah, but at other VA health care facilities -- indicates that transparency and accountability both within the VA and the VA Office of Inspector General must be improved.

As the last two months have shown, the crucial first step in improving service and the quality of care in the VA health care system is a process for transparent disclosure.

In spite of the revelations regarding the Tomah facility, I still believe that the vast majority of men and women working in Wisconsin's VA facilities are dedicated to providing quality care to the finest among us.

Nevertheless, the VA and the VA OIG must take necessary steps to ensure that substandard clinical practices and the retaliatory tactics used at Tomah never occur or go unreported again.

We owe our veterans the best possible treatment and care. I hope that, with proper oversight, increased transparency and swift accountability within the VA, that goal will be achieved.