Chairman Johnson Opening Statement:
"Tomah VAMC: Examining Patient Care and Abuse of Authority"

Tuesday, May 31, 2016

As submitted for the record:

Senate Homeland Security and Governmental Affairs Committee held a hearing Tuesday, May 31 titled: "Tomah VAMC: Examining Patient Care and Abuse of Authority" to examine alleged overprescription at the Tomah Veterans Affairs Medical Center (VAMC), as well as patient deaths and an alleged culture of fear among hospital employees. Below is Chairman Johnson's opening statement as submitted for the record:

Good morning. I have called this hearing to continue the committee's 16-month investigation into the disturbing accounts of veteran deaths, whistleblower retaliation, and government misconduct surrounding the Department of Veterans Affairs Medical Center here in Tomah, Wisconsin.

This hearing has two goals. First, we are here today to examine the troubled history of the Tomah VA. Dating back nearly 10 years, the Tomah VA has been plagued by allegations of dangerous prescription practices and administrative abuses. For years, actions that should have served as warning signs were ignored and problems at the Tomah VA festered.

The second goal of this hearing is to look forward. Wrongdoers at the facility level and in Washington have been held accountable. Now it is vital that we enact necessary reforms to prevent tragedies like what occurred at the Tomah VA from ever happening again.

Like most Wisconsinites, I first became aware of problems at the Tomah VA following a news article in January 2015. We were all shocked to read that drugs were prescribed in such large quantities at the Tomah VA that the facility was known by the moniker "Candy Land" and the former Tomah VA chief of staff was nicknamed "Candy Man." The article also unveiled the existence of a then-secret report of a multi-year health care inspection by the VA Office of Inspector General.

Immediately after I became aware of the problems at Tomah, I directed committee staff to launch an investigation. Since then, the Tomah VA investigation has been a top priority for me and my committee. Over the past 16 months, the committee has conducted a comprehensive, bipartisan investigation on how the problems festering at the Tomah VA went unaddressed for so long. During that time, the committee has:

- Held two hearings on the Tomah VA, including a field hearing in Tomah last March;
- Issued a subpoena of the VA OIG for documents;
- Wrote 28 letters to multiple federal agencies;

- Along with staff of Ranking Member Carper and Senator Baldwin, my staff conducted bipartisan transcribed interviews of 22 VA and VA OIG employees, totaling nearly 82 hours of interviews; and
- Reviewed tens of thousands of pages of documents.

In conjunction with today's hearing, I am releasing a 359-page majority staff report detailing our findings and recommendations. Our investigation found that these tragedies were preventable and the failures were systemic across the executive branch. Here is what we found:

In 2002, the VA hired Dr. David Houlihan, and it promoted him in 2004 to be chief of staff of the Tomah VA. Both times, VA regional leadership was aware of charges against Dr. Houlihan from the Iowa State Board of Medical Examiners that he had inappropriate professional boundaries with a patient. The VA did not formally address the Iowa allegations against Dr. Houlihan until 2009. By that time, VA regional leadership determined that the issue was "resolved."

On Nov. 11, 2007, less than 24 hours after he was discharged from the Tomah VA, veteran Kraig Ferrington passed away from "poly medication overdose." Consultants retained and peer reviews performed after his death showed deficiencies in the Tomah VA's medication management. One VA consultant wrote "there is a general concern regarding the number of medications [Mr. Ferrington] was on, and the potential interactions among them."

In January 2009, the local union for Tomah VA employees alerted the VA OIG about allegations of over-prescription at the facility. The VA OIG does not have a record of receiving this information.

In June 2009, a Drug Enforcement Administration investigator interviewed Noelle Johnson, a pharmacist at the Tomah VA who was fired after she questioned prescriptions. Dr. Johnson showed the DEA 10 examples of patients who had prescriptions that were either too high in dosage or too long in length. The DEA examined other allegations in both 2011 and 2012 and has informed my staff that they have a current open investigation into the Tomah VA. I invited the DEA to testify here today to talk about its work and potential drug diversion relating to the Tomah VA, but it declined the invitation.

On July 14, 2009, the Tomah VA fired Dr. Christopher Kirkpatrick, a clinical psychologist at the facility. That evening, he was found dead from a self-inflicted gunshot wound. Prior to his death, Dr. Kirkpatrick had tried to raise concerns within the facility about the over-prescription of medications. At least one of Dr. Kirkpatrick's supervisors testified to the VA accountability board that he felt coerced into disciplining Dr. Kirkpatrick. This same supervisor also testified that he disagreed with the decision to fire Dr. Kirkpatrick.

In September 2009, Roberto Obong became the chief of VA police at the Tomah VA. In starting his new job, Chief Obong researched the facility's reputation and found that the Tomah VA was known in the community as the "big pillbox." Over Chief Obong's four-year tenure at the facility, he did not investigate these allegations.

In August 2013, VA headquarters conducted a site visit to the Tomah VA. The report of the visit noted that the facility dispensed benzodiazepines to older veterans and to veterans diagnosed with post-traumatic stress disorder (PTSD) at a rate much higher than the national average. The VA merely "encouraged" the facility to "review" whether its medication practices were in accordance with national policy.

In November 2013, less than a year before his death, veteran Jason Simcakoski sought help from federal and local law enforcement about the Tomah VA. Call logs and voicemails from his cell phones show numerous contacts with Tomah police, the VA police, and even the FBI. Our investigation found that in early November 2013, Jason placed five separate phone calls to the FBI and had conversations totaling more than 30 minutes in length.

The FBI denies that it has any record of these communications from Mr. Simcakoski. My staff even played this voicemail for FBI officials last year to help them get to the bottom of this, and still the FBI denies having any communications with Mr. Simcakoski. I invited the FBI to testify today to help us understand the discrepancy between what Mr. Simcakoski's phone records show and their recollections of the November 2013 timeframe. The FBI declined the invitation.

These systemic failures from the VA, the OIG, and other agencies were not harmless. In January 2015, Candace Delis took her 74-year-old father, Thomas Baer, to the Tomah VA. According to Ms. Delis, Mr. Baer waited two hours to be seen. During this time, he suffered an apparent stroke, but the facility's CT scan machine was down for maintenance that day. Mr. Baer later died, and his daughter said that she would never have taken him to the Tomah VA if she had known about the facility's problems.

The public attention brought by news media reports and our investigation is bringing real accountability to the Tomah VA and the VA Office of Inspector General. The former Tomah VA director and multiple medical professionals who provided substandard care to veterans and perpetuated a culture fear among the Tomah VA staff are no longer employed at the facility. Richard Griffin—the former deputy VA inspector general who failed to publish hundreds of reports of health care inspections, including the Tomah report—retired from federal service last July. Finally, in October of last year, President Obama heeded a more-than-year-long call to appoint a permanent VA inspector general. I was honored to champion and confirm Michael Missal on the floor of the United States Senate to serve as the first permanent inspector general of the Department of Veterans Affairs in nearly two years.

Today we are joined by two witnesses, Mr. Missal and the VA Deputy Secretary Sloan Gibson. These two officials will play a key role in helping to fix the problems at the Tomah VA and other VA health care facilities to ensure that these tragedies are never repeated. I thank the witnesses for attending today's field hearing.

We owe a tremendous debt to the men and women who served the nation in uniform. All of us bear the important responsibility of ensuring that the finest among us receive the high-quality care they deserve. Today's hearing is an important step in providing closure for the families of those who died because of mismanagement at the Tomah VA. While we will not be able to fix

past mistakes, it is necessary that we learn from the tragedies here so that no family has to endure such pain in the future.