S. Hrg. 114–686

TOMAH VAMC: EXAMINING PATIENT CARE AND ABUSE OF AUTHORITY

FIELD HEARING

BEFORE THE

COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS UNITED STATES SENATE

ONE HUNDRED FOURTEENTH CONGRESS

SECOND SESSION

MAY 31, 2016

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Committee on Homeland Security and Governmental Affairs

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TOMAH VAMC: EXAMINING PATIENT CARE AND ABUSE OF AUTHORITY

TUESDAY, MAY 31, 2016

U.S. SENATE,
COMMITTEE ON HOMELAND SECURITY
AND GOVERNMENTAL AFFAIRS,
Tomah, WI.

The Committee met, pursuant to notice, at 10 a.m., at Cranberry County Lodge, 319 Wittig Road, Tomah, Wisconsin, 54660, Hon. Ron Johnson, Chairman of the Committee, presiding.

Present: Senator Johnson, Senator Baldwin, Hon. Tim Walz, and Hon. Ron Kind.

OPENING STATEMENT OF SENATOR RON JOHNSON

Senator JOHNSON. This hearing will come to order.

I think it would be appropriate to start the day, in light of Memorial Day being yesterday, and in light of the tragedies of some of the finest among us, suffering at the hands of people that should be taking care of them, if we can start this hearing with a moment of silence?

If you will please join me?

Thank you.

I would also like to ask anybody who has served in military, and, quite honestly, their family members as well, because this is a service and sacrifice that affects the entire family, if you could please rise and be recognized?

Thank you all for your service and sacrifice. The purpose of this hearing is to make sure that the rest of America honors its promise to you. That's what really is the heart of this hearing. I truly want to thank everybody who as appeared and attended this hearing today.

I want to, in particular, thank the surviving family members of Jason Simcakoski, Thomas Baer, Chris Kirkpatrick, and Kraig Ferrington.

In March of 2015, we held a hearing where the family members stepped forward and whistleblowers stepped forward and provided powerful testimony. And, it was powerful testimony. We heard from Dr. Noelle Johnson, Mr. Ryan Honl, Marv and Heather Simcakoski, and Candace Delis. I have to believe that their testimony had an effect on the officials that were present that day from the U.S. Department of Veterans Affairs (VA).

It is that type of testimony, it is that type of highlighting a problem that is going to be required if we are going to honor the promises of the finest among us.

I do want to thank my staff for doing, I think, an extraordinary job of laying out the findings of a very rigorous, a very comprehensive investigation into how exactly the problems within the Tomah healthcare facility went on for so long without being corrected.[1]

I do encourage everybody, because I think we have a couple of hundred copies, to grab one and read all 359 pages. It lays out exactly what happened with, quite honestly, not all the information.

I do want to say that certainly it has been my experience, because I have traveled around the State of Wisconsin and visited VA healthcare facilities, the vast majority of the doctors, of the nurses, of the administrators are doing an excellent job. They are highly concerned about the finest among us, about our veterans. And, they are doing everything they can to honor those promises.

But the fact of the matter is, they are working within a single-payer, government-run bureaucratic healthcare system and there just are inherent problems. For example, inherent problems of accountability. Inherent problems, unfortunately, within an Office of Inspector General (OIG) that was not living up to its mission. Who, I would say, was captured by the VA itself.

So, the Office of Inspector General under Richard Griffin was loyal to the VA instead of being loyal to the finest among us and to the American public.

This Committee, in particular, the Senate oversight committee, relies on independent and transparent Inspectors General (IGs). Government relies on them. The only hope we have of fixing problems is if you have an Inspector General's office be the independent, transparent watchdog actually doing its job.

And, what is very apparent in our 350 page report and the almost 4 or 5,000 supporting documents is that for years the Office of Inspector General from the VA did not do its job.

And, what is an even greater tragedy is that these tragedies here at Tomah, I believe, could have been prevented, had the Office of Inspector General done its job.

As far back as 2004, Dr. David Houlihan had been referred to as Candy Man. A number of people, as far back as 2008 and 2009, were trying to raise the alarm to a number of Departments, a number of Agencies, a number of Offices. And yet, somehow those alarms did not go public.

I do want to play real quickly, if people are ready, and you can follow along on page 48, there were logs that Heather Simcakoski asked us to basically use the Capitol Police to get into her husband's cell phone to get a record of his call logs.

Now, during the course of our investigations, we contacted the Federal Bureau of Investigation (FBI) about potential contacts as it related to Tomah VA. They claimed there was no contact. And yet, we actually have a voice from a message left by a member of the FBI, which I would like to play right now if we can.

[Audio]. Jason, this is Andy Chapman from the FBI returning your call. My phone number is (608) 782–6030. Thank you. [End of audio].

Now, we asked representatives of the FBI and the Drug Enforcement Agency (DEA) to appear today and they declined. They also

[1] The Majority Staff Report appears in the Appendix on page 63.

continue to convey to this Committee, to our staff, that they have no record of ever having been contacted by Jason Simcakoski. I find that puzzling. I find it troubling.

Again, the failure of the Office of Inspector General to live up to its mission was really at the root cause of why these problems continued to go on for so long.

I do want everybody to refer to page 208 and 209, because I think this is a classic example of how the Office of Inspector General, in their inspection, in their investigation here, narrowed its scope, refused to look beyond its scope, and, as a result, did not do its job.

In 2008, according to our report, during its site visit, this is the first site visit directed by Dr. Alan Mallinger to the Tomah VA following reports that began in 2011. The hotline reports. During its site visit to the Tomah Veterans Affairs Medical Center (VAMC), VA Office of Inspector General officials interviewed both Dr. Houlihan and Deborah Frasher. During the interviews, both Office of Inspector General physicians and Special Agent Porter of the VA OIG's criminal division observed that Dr. Houlihan and Ms. Frasher appeared to be impaired.

Now, unfortunately, during that initial investigation visit, Mr. Mario DeSanctis was not present. So, the Inspector General's team held a phone conference with Mr. DeSanctis, and in 2009 you can read how they informed Mr. DeSanctis about their concern with Dr. Houlihan and Nurse Frasher potentially being impaired, potentially being drug users. There are numerous whistleblower reports that also suspected that Dr. Houlihan and Nurse Frasher were drug users.

I want people to read exactly what they Office of Inspector General did. All they did was inform Mr. DeSanctis and suggest that Mr. DeSanctis perform drug tests on those two individuals. We have no idea whether those drug tests were ever performed. I would think, if they were, back in 2012, these tragedies might have been prevented.

So, again, the bottom line of what this report shows is it was the failure of the Office of Inspector General and the failure of other agencies and offices to actually highlight the problems that they were made aware of that allowed these tragedies to occur.

And, we will get into this further in terms of the testimony and our questions to it.

I do ask that my written prepared statement be entered into the record[1] without objection.

And, with that, to Senator Baldwin.

OPENING STATEMENT OF SENATOR BALDWIN

Senator BALDWIN. Thank you. Thank you, Chairman Johnson. I want to thank you for organizing this hearing today and I also want to add my words of appreciation to your staff, Senator Carper's staff and to my staff in terms of the undertaking that resulted in this work product. It is a very significant investment on their part and we appreciate that.

[1] The prepared statement of Senator Johnson appears in the Appendix on page 33.

I think the fact that we are both here again today sends an important message to this community that we will continue to work across the partisan aisle in order to address the problems at the Tomah VA. In fact, I would describe it as: there is no aisle.

As Americans, we are united. We are united by an eternal bond with the families and friends of our fallen. And, we are also united by the sacred trust that we have with our veterans and their families.

Today, as we hear the story of how that sacred trust with our veterans and their families has been broken, it is important for us to keep in mind what unites us.

One profound thing that I have learned about the tragic problems at the Tomah VA is that veterans, their families, and whistleblowers all want the same thing. They want answers and accountability, but most importantly they want solutions to the problems at the Tomah VA so that these sort of tragedies never ever happen again.

What I am committed to is fixing what has been broken. What I am focused on is restoring the sacred trust that we have with our veterans and their families.

The Committee's reports makes clear much of what we have known for some time. The problems at the Tomah VA have had tragic and preventable consequences.

The report sheds light on the failures surrounding the deaths of Kraig Ferrington, Dr. Christopher Kirkpatrick, Jason Simcakoski and Thomas Baer. What this report can never do is repair the damage that their losses have had on families, many of whom are here with us today.

It is just as clear to me today, as it was a long time ago, that the VA prescribed Jason Simcakoski a deadly mix of drugs that led to his death. And, those responsible at the Tomah VA for this tragic failure should have been held accountable long ago. In fact, they should have been accountable before Jason's death.

The record is clear, for far too long, serious problems have existed at the Tomah VA and they were simply ignored or not taken seriously, as they should have been, by the VA and the VA Inspector General.

My office was just one of many voices who were trying to expose the problems at the VA.

When my Senate office was first contacted in March 2014 with complaints about the Tomah VA, including prescribing practices, they came from an anonymous whistleblower. Someone who still remains anonymous today.

We immediately brought those concerns to the Tomah VA and then to the VA Office of Inspector General, and then to the U.S. Department of Veterans Affairs headquarters in Washington, D.C.

Four months prior to Jason's death, I called for a full review and investigation from the Tomah VA.

Two months prior to Jason's death I called for a full review and investigation from the U.S. Department of Veterans Affairs and the VA Office of Inspector General.

On August 30, 2014, Jason tragically died at the Tomah VA as a result of what was medically deemed, mixed-drug toxicity.

The Simcakoski family lost a son, a husband, a father, and we lost somebody who faithfully served his country.

If there is one thing that I want to come out of this hearing and one thing that comes from this report, I want it to be this. I want everyone to hear the voice of Jason's wife Heather who said, and I quote, "When I look back at the past, I want to know we made a difference. I want to believe we have leaders in our country who care. I want to inspire others to never give up because change is possible."

Jason's family, just like veterans and their families in this community and communities across Wisconsin, are not interested in finger pointing and a blame game and neither am I. That is why over the past year I have focused on solutions to the problems at the VA. I have worked across party lines to advance reforms that will improve transparency, strengthen protections for whistleblowers, and to provide stronger oversight of VA prescribing practices.

I authored a reform that was recently signed into law which requires the VA Inspector General to submit reports to Congress and make them available to the public. That is the standard that must now be met.

Last year, I had the honor of working with Jason's family to develop legislation to provide the VA with the tools that it needs to prevent this type of tragedy from occurring to other veterans and their families.

One year ago, I introduced this bipartisan legislation in Jason's name that earned the support of many veterans service organization. And, I am so proud, Senator Johnson, to have you join in this effort.

I am pleased that the House of Representatives recently passed a version of Jason's bill and I am equally grateful to members of the Senate Veterans' Affairs Committee for their bipartisan support of Jason's bill, the Jason Simcakoski Memorial Opioid Safety Act. It is a critical reform and it continues to move forward. Families like Jason's have a story to tell, and it needs to be heard, and the movement of their legislation is strong evidence that their voice is being heard.

My goal is to put these reforms in place to prevent Jason's tragedy from ever happening to another veteran or any of our veterans' families.

Change is indeed possible. Heather's words inspire me and it is my hope that they will inspire all of us to work together and to prevent these problems and tragedies from ever happening again.

I thank you, Senator Johnson, for providing me with this opportunity to join you today and I look forward to continuing our work together.

Senator JOHNSON. Thank you, Senator Baldwin.

Senator Carper, who is our Ranking Member of the Committee, has a statement[1] and a Minority Views Memo[2] that he would like in the record without objection.

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[1] The prepared statement of Senator Carper appears in the Appendix on page 37.

[2] Minority Views Memo submitted by Senator Carper appears in the Appendix on page 439.

It is the tradition of this Committee to swear in witnesses, so if you will all four rise and raise your right hand?

Do you swear that the testimony that you will give before this Committee will be the truth, the whole truth and nothing but the truth, so help you, God?

Dr. WEST. I do.

Mr. GIBSON. I do.

Mr. MISSAL. I do.

Dr. DAIGH. I do.

Senator JOHNSON. Please be seated.

Our first witness is Sloan Gibson. Mr. Gibson is the Deputy Secretary of the Department of Veterans Affairs. Deputy Secretary Gibson is accompanied by Dr. Gavin West, Senior Medical Advisor of Clinical Operations, Department of Veterans Affairs. Mr. Gibson.

TESTIMONY OF THE HONORABLE SLOAN GIBSON,[1] DEPUTY SECRETARY OF THE U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY DR. GAVIN WEST, SENIOR MEDICAL ADVISOR OF CLINICAL OPERATIONS, U.S. DEPARTMENT OF VETERANS AFFAIRS

Mr. GIBSON. Let me begin by expressing my heartfelt sympathy to the Simcakoski family. I know that no words can ease the pain of your loss, but I would be remiss if I did not recognize the courage and the compassion and the deep devotion that you have displayed in all the work that you have done since Jason's death to make real difference in the lives of many other veterans.

Thank you and God bless you.

I am accompanied today, as you mentioned by Dr. Gavin West. I wanted to point out, prior to his appointment to the responsibilities you have described, Dr. West served as the Chief of Primary Care and Associate Chief of Medicine, accountable for the delivery of evidence-based, high-quality, patient-centered care across VA. He continues to practice medicine at the Salt Lake City VA Healthcare System where he teaches medical students and treats veterans in primary care with a focus on pain management and substance abuse.

He understands the issues and challenges we are facing at Tomah from years of traveling across the country working to optimize clinical care at many site visits to VA Medical Centers, including visits here at Tomah.

Most importantly, perhaps, is that Dr. West served as the co-chair of VA's National Opioid Safety Program.

Jason's death forced us to dive deeply into the Tomah system. What we found was an organization facing numerous challenges in dire need of change and new leadership.

The problems at Tomah have been well documented. Failures related to the prescribing practices of controlled substances, examples of inadequate oversight appear, and failure related to culture.

We own those challenges and problems, those failures. I own those problems, those failures.

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[1] The prepared statement of Mr. Gibson appears in the Appendix on page 44.

Avoidable harms to veterans are not acceptable. When they do occur, our obligation is to act with urgency to investigate and prevent a recurrence.

At Tomah there was a clear and inexcusable lack of leadership that created and exacerbated these serious problems.

The excellent frontline staff here at Tomah—that you have acknowledged in your comments, Mr. Chairman—working under new leadership, is fixing those problems.

On October 5, we appointed Victoria Brahm as Acting Director. In her new role, Vicki did not wait to take action to improve veteran care. On November 27, she began executing Tomah's 100-Day Plan. For those of you that are unfamiliar with this concept, 100-Day Plans are a best practice of new leaders as they transition into their roles. They are not meant to fix everything, but to set a clear and bold direction while delivering near-term tangible results.

The 100-Day Plan period ended in March, but the work continues to transform the way Tomah leaders operate, to change how Tomah treats their veteran patients, and to rebuild trust with veterans, employees, and the community.

Thanks to this ambitious plan and the dedication of caring frontline staff, Tomah, once a symbol of the overuse of opioids, is actually on its way to becoming a model for change and best practices.

Let me highlight some of the great work by Vicki and the staff.

In April, Tomah completed more than 98 percent of their appointments with in 30 days. In fact, nearly 17,000 appointments were completed in April. Of all of those, 217 were over 30 days from the day that the veteran wished to be seen.

Their wait times are consistently among the best in all of the VA.

For primary care, less than 3 days. Specialty care, less than 6 days. And, for mental health, a little more than 2 days.

Vicki and the team are working to restore trust among veterans. She is opening lines of communication with our veterans by opening her door, meeting with countless veterans these past months.

Other continuing efforts include developing an academic detailing team to review the medical center's most complex chronic pain patients and provide additional recommendations for their care.

To support this initiative, more than 30 primary care and mental health providers attended academic detailing educational sessions in the month of March.

She is also creating a veteran pain school to assess and customize alternative pain management strategies for veterans. Importantly, Tomah has reduced the number of veterans receiving opioids by nearly one fourth.

Tomah partners with the Wisconsin State Prescription Drug Monitoring Program, a program designed to ensure veterans are not obtaining opioid medications from multiple providers.

Another step forward is the effective use of VA's audit tool, which allows doctors to improve practice and safety by seeing all the medications veterans are taking on a single dashboard.

Vicki has made overdose education and Naloxone rescue kits available to patients at risk of accidental or intentional overdose. Naloxone has proven effective in reversing an opioid overdose. Simply put, she is finding options, alternatives, and solutions other than just a bag of pills.

Let me tell you about one of Tomah's best practices. Evidence shows that the best outcomes in pain management occur with a comprehensive approach across multiple disciplines with the patient as the central focus. This empowers the veteran to be an active participant in decision making regarding pain care options.

Tomah developed the integrated pain university, which is strongly based on patient education and empowerment. This whole health perspective identifies and addresses biological, psychological, and social aspects of pain management in conjunction with assessment by the Patient Aligned Care Team and any necessary specialty consults.

Additionally, veterans receive information through a variety of elective classes taught by their respective health care professionals, which include pain medications, pain and nutrition, pain and sleep, aroma therapy, mindfulness, the neuroscience of pain, introduction to movement, staying motivated, and spirituality.

The result of these and other efforts. As of the second quarter of fiscal year (FY) 2016, just over 9 percent of veterans at Tomah are prescribed some form of opioid.

Across the entire country, across all of the VA's population, that national rate is nearly 13 percent.

Vicki and the team are also listening. They are listening to veterans, to the community, and to employees. Listening led to the development of the Tomah VAMC Veterans Experience Council and Strategic Partnership Committee. The Veterans Experience Council will help make sure that Tomah leaders have a clear understanding of how veterans perceive VA, while the Strategic Partnership Committee will work to strengthen and promote a unified approach to veteran care throughout the community.

Vicki has hosted more than 15 employee listening sessions covering all work shifts at the Medical Center. These listening sessions are critical in getting a sense of how staff can better serve veterans while using input from these sessions to improve employee engagement, making sure employees are satisfied with their work environment. Monthly staff meetings, quarterly nurse town hall, and roundings with local union officers are all part of the larger efforts of our commitment to employees.

As a result of these and many other actions, we are seeing Tomah's performance improve, as measured both internally and by veterans themselves.

By understanding the challenges and taking ownership in the problems, Vicki and the leadership team are improving the organizational culture and climate, providing more oversight, effective oversight, of care delivery, and addressing problems and prescribing practices.

While there is more work to be done, this strategic direction has led to a real positive change.

Vicki is modeling effective leadership by taking ownership and accepting accountability of past mistakes in order to make tangible progressin caring for our Nation's veterans.

Bob McDonald and I talk a lot about sustainable accountability. Making sure employees understand our mission, values, and strategy. It has accountability that results in positive veteran outcomes, not just in the very near term, but over the long term as well.

And I believe that is what we are seeing here at Tomah.

Across all of the VA, our work to change prescribing practices and develop alternative approaches to pain management is delivering steady progress. We have also developed a predictive model and a clinical decisions support tool to identify patients being treated with opioids, who may be at risk of suicide-related events or overdose.

This tool for opioid risk mitigation estimates the likelihood of an overdose or suicide event in the next year providing patient-tailored recommendations for risk mitigation and nonopioid pain management options.

Lessons learned have caused a greater engagement and improves lives.

We are also getting unwanted drugs out of veterans hands. Removal of veterans unwanted and unneeded medications reduces the risk of diversion, as well as intentional or unintentional overdose or poisonings.

As of May 1, approximately 27,000 pounds of unwanted and unneeded medication have been collected and destroyed in an environmentally responsible manner.

The overuse and misuse of opioids is a national problem, not just a VA problem. What we are doing here at Tomah and across the VA is part of a broader national effort to fight opioid addiction and overprescribing of powerful drugs.

Our hope is that VA's efforts here and elsewhere will become part of the national approach that will benefit not just veterans, but all Americans.

We still have work to do.

With your support and the support of many others, we will succeed. The needs of veterans cannot be secondary to other agendas. It is unacceptable to VA leadership and should be unacceptable to anyone claiming to care about our Nation's veterans.

I need your help to change the dialogue and a perception of this facility in order to get the right people interested in these jobs.

Mr. Chairman, I appreciate your Committee's support in identifying and resolving challenges here in Tomah. And, we look forward to your questions.

Senator JOHNSON. Thank you, Mr. Gibson. Our next witness is Michael Missal. Mr. Missal is the Inspector General for the Department of Veterans Affairs.

I had the privilege of going on the Senate floor and asking unanimous consent to have you confirmed. I know Senator Baldwin and members were calling for a firm Inspector General and we are glad we have one.

Mr. Missal is accompanied by Dr. John Daigh, Assistant Inspector General for the Healthcare Inspections within the VA Office of Inspector General. Inspector General Missal.

TESTIMONY OF THE HONORABLE MICHAEL J. MISSAL,[1] INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY DR. JOHN DAIGH, ASSISTANT INSPECTOR GENERAL FOR HEALTHCARE INSPECTIONS, OFFICE OF THE INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS

Mr. MISSAL. Thank you. Chairman Johnson, Senator Baldwin.

Chairman Johnson, Senator Baldwin, Congressman Kind and Congressman Walz, thank you for the opportunity to appear today regarding the Office of Inspector General's past inspections of the Tomah VA Medical Center and our work in the area of pain management and opioid use.

I am accompanied by Dr. John Daigh, Assistant Inspector General for Healthcare Inspections. He is a retired Army Colonel and has spent over 25 years providing healthcare to soldiers.

First, on a personal note. I want to thank all veterans for their great and selfless service to our Nation.

In addition, I want to express my sympathies to the families of those impacted by events at Tomah. All of us at the OIG need to take these experiences and use them to improve VA's operations.

Finally, as the son of a World War II veteran, I had a strong reminder of our mission's importance when I had the great honor of attending the wreath laying ceremony at Arlington National Cemetery yesterday.

On May 2, 2016, I was sworn in as the Inspector General. Since then, I have immersed myself to understand the people, work and goals of our office. I have been impressed with the OIG staff, many of whom are veterans, and their focus on bringing about positive changes in the integrity, efficiency and effectiveness of VA operations. While my integration has gone very well, I know there is much more to learn.

I strongly advocate three overriding principals for our office. First, we must maintain our independence in all of our work, including avoiding the mere appearance of any undue outside influence. Second, we must be as transparent as possible, while safeguarding the privacy of veterans, whistleblowers, and others. Third, we must produce work of the highest quality, making sure it is accurate, timely, fair, objective and thorough.

During my first month, I have spent significant time reviewing our healthcare inspections of Tomah. I have also met with the Homeland Security staff on two occasions to ensure they have the necessary information about our work as it pertains to Tomah.

My written statement contains a timeline of events related to the Tomah Administrative Closure and I will not repeat it here. The inspection was administratively closed given the totality of the facts identified at that time.

Specifically, that the allegations could not be substantiated, the impact that disclosure of unsubstantiated allegations could have on an individual's reputation and privacy, and knowing our forthcoming 2014 national report would highlight many deficiency in VA providers' compliance with opioid prescribing guidelines.

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[1] The prepared statement of Mr. Missal appears in the Appendix on page 58.

I would like to comment on the White Paper about the Tomah inspection that was issued by my office on June 4, 2015. I do not agree with its tone or the gratuitous attacks on the reputation of individuals mentioned in it. It does not meet the high standards expected of our office.

We have learned important lessons from this experience, including increasing the transparency of our work that should help us better meet our mission going forward.

The changes made should increase the confidence that veterans, Veterans Service Organizations (VSOs), Congress, and the public have in us.

Subsequent to last year's hearing here, we released two additional inspections regarding Tomah. In June we issued a report with local and national recommendations focused on acute stroke treatment. And, in August we issued a report regarding the unexpected death of a patient during treatment at Tomah. This report had four recommendations.

Notably we recommended that the facility ensure clinicians comply with VA policy regarding written informed consent when administering hazardous drugs.

The issues associated with the use of opioids to treat chronic pain and other conditions are a serious concern, not just at Tomah, but throughout our Nation.

We continue to focus on VA's opioid prescription practices, publishing two reports on the topics earlier this year. That work identified many of the same issues reported in our May 2014, national review.

We found VA was not following its own policies and procedures in six key areas, including follow-up evaluations of patients on take-home opioids, prescribing and dispensing of benzodiazepines concurrently with opioids, and routine and random urine drug tests prior to and during take-home opioid therapy.

We note VA has taken actions to implement that report's recommendations, but they must monitor facility compliance with opioid prescription policies.

Later this year we expect to publish a wide-ranging national review of VA's pain management services, substance use treatment programs, use of non-VA treatments, opioid prescribing practices, and access to State prescription drug monitoring programs.

Yesterday our Nation paid tribute to the sacrifices of those who gave their lives in our defense. It is a valuable reminder for us at the OIG to rededicate ourselves to ensuring that our work is independent, accurate, timely, fair, objective and thorough.

Dr. Daigh and I look forward to your questions.

Senator JOHNSON. Thank you, Inspector General Missal.

Mr. Gibson, let me start with you. When did the problems here at Tomah first hit your radar screen? When did you first hear about them? And, you have been in the VA how long?

Mr. GIBSON. I have been in VA for 2 years and 3 months—2 years and 4 months—right around there.

I think I am going to go from broad recollection, because I did not go back to check the record. I am going to say probably sometime around January.

Senator JOHNSON. Ok. When the news story broke, basically?

Mr. GIBSON. Yes, that is correct.

Senator JOHNSON. So, in your experience with the VA, what was—during that time frame, what was the attitude of the VA? The main Department with the Office of Inspector General?

Mr. GIBSON. I would tell you, coming into the organization, I have always viewed, whether it is called an IG or some other entity, an auditor, that having a working relationship, a constructive relationship, albeit recognizing their independence, is vital, because, at the end of the day, we are after the same thing.

I have worked to try to create that kind of relationship. I always find it amusing when folks suggest that the IG has been management's lap dog, because, if you go look, they issue over 300 reports a year, which means we are getting wire-bushed about six times a week, every single week, and you scan the array of IG reports and you will find that there is no pandering to VA interest there. It is a very strong and independent entity.

Senator JOHNSON. This Committee, does a lot of work with different Inspectors General. We see kind of a spectrum, quite honestly.

Mr. GIBSON. I am sure you do.

Senator JOHNSON. As Ranking Member of a Subcommittee of this Committee, we uncovered the corruption within the Office of Inspector General at the Department of Homeland Security and Charles Edwards basically moved on ahead of the posse, so have seen the lack of independence.

Mr. GIBSON. Yes.

Senator JOHNSON. What I thought was quite shocking as we got involved in this situation, is that the Office of Inspector General had 140 reports on investigations and inspections that it buried, that it was covered up, it did not make public. Now, I have mentioned that to other Inspectors General and I asked them, how many reports have you not made public? And, they really look at me like I am from some other planet.

I think I have had one Inspector General say, well, there was one we did not publish, because of concerns about national security.

So, do you think it is appropriate that there are 140—now there is, by the way, another 70 percent reports on different wait time problems that apparently now the Office of Inspector General was starting to produce on a rolling basis, but that is a shocking number of reports on investigations and inspections from an independent transparent office that were not made public.

What is your take on that?

Mr. GIBSON. Well, my take is that, in general, they should be made public. And, I think that is the stance that the IG has taken. There have been instances where this Office of Inspector General has identified things in the course of their investigation that were not related to what they were seeking to look into where they have come to me specifically to say, you need to know about this and where we have taken appropriate actions in the wake of that.

That is the kind, I think, frankly, part of what you see here, and I was not here 4 years ago, so I cannot talk knowledgeably about what was or was not the environment and the practice. But I will tell you, over my two plus years here, that the IG has been willing to bring things to me, and I think it is a much more principled base

view. I think some of this, we get wrapped up in the rules, and we get so wrapped up in the rules, we lose sight of the principles.

And so, here is a case where I think, quite frankly, this is my view from the outside looking in, where we got focused on the rules. And, the rules basically said, this is what we are here to investigate, and we did step back and look more broadly at principles and I think the IG has demonstrated the willingness and the ability to do that in subsequent events. I do not know whether they learned from this particular instance or from other, but I think that is what we owe veterans.

And, I am going to go back and say that, ahead of anything else, this is a leadership failure. There is lots of finger pointing and everything else. At the end of the day, we own this. VA leadership owns this. We had ample opportunity over a period of years to fix this. That was the leadership's responsibility.

And, we failed to get it done.

Senator JOHNSON. I appreciate that. Dr. Daigh, you were part of the inspection team for Tomah, correct?

Dr. DAIGH. That is correct.

Senator JOHNSON. One of the things that come across in our report is the confusion over what is the standard for substantiating a claim? For example, in so many instances, this was not a he said/she said, which, again, I have been in business. I have had these employees situations where it is kind of difficult when it is he said/she said. This is a case with Dr. Houlihan where it was he said/they said. I mean, there was so much corroboration of the allegations.

How did you come to the conclusion that so many of these charges were unsubstantiated? What is the standard?

Dr. DAIGH. Well, maybe what I could do is go through the allegations one by one and we can talk about them.

Senator JOHNSON. Let us talk about, why we do not talk about the allegations of a climate of fear, a culture of fear within the—I mean, there was so many reports and it was so obvious that Dr. Houlihan, according to testimony, was a bully and created that and retaliated, and there were people fired as a result. And, Chris Kirkpatrick committed suicide after he was fired. I mean, there was so much accumulated evidence, how could that not be substantiated?

Dr. DAIGH. So, we did substantiate that there was an issue with the relationship between the Chief of Staff and the pharmacists, primarily. And, we transmitted that information to the Veterans Health Administration (VHA). It was not a surprise. And, the proof that we transmitted that, and that it was not a surprise is at the end our review. We sat down and talked with both the Director of Tomah and the Veterans Integrated Service Network (VISN) Director, and they told us at the time that we were outbriefing them, of the changes they had made so that the Chief of Staff no longer supervised the pharmacists.

They were aware of problems in the pharmacy and were working to try to correct them. So, with respect to the relationship between the Chief of Staff and the pharmacists, our Administrative Closure lays it out clearly that that was an issue.

It was not, in my view, the primary problem that was addressed at Tomah.

The primary problem was the allegation that Tomah providers were providing narcotics outside of the standard of care and that narcotics were being distributed in such a way that the rules of law were being broken.

We looked extensively to find out whether that was true or not.

Medical experts reviewed many charts. We reviewed many emails of 17 providers at VA looking for evidence of a problem. Evidence of criminality.

Our investigators went undercover looking for evidence of criminality.

So, I am left with the problem of, there are allegations, and I just do not have the facts to support many of those allegations.

Senator JOHNSON. I mean, most people reading our report will say there is a lot of substantiated evidence to support that charge.

Just quick before I turn over to Senator Baldwin.

On page 270, we have your signature on the Administrative Closure sheet. Every ounce of evidence that we can find shows that Administrative Closure occurred in August of 2014. I want everybody to take a look at page 270. It completely looks like this has been doctored from 8–12–14 to 3–12–14.

Dr. DAIGH. It has not been doctored.

Senator JOHNSON. So what, what further evidence, other than this, what appears to be a doctored——

VOICE. Liar.

Senator JOHNSON [continued]. Signature, what other evidence would indicate that you closed this out in March versus August?

Dr. DAIGH. So, when information flows, I would sign a document, as I signed this one. And, in the Administrative Closures they come to my desk. I sign them and I write a date on it.

Senator JOHNSON. Is that normally how you write a three? With an eight kind of embodied within the three?

Dr. DAIGH. That is what I wrote.

Senator JOHNSON. Is there any further evidence that this was actually administratively closed in March of 2014, because everything else shows that you administratively closed this in August?

Dr. DAIGH. No, I do not know what you are talking about. The actual date that I signed the report, it then goes into other systems, which are systems of record, and it is entered into what we call a different computer system, and it was closed at that time.

Senator JOHNSON. I find this unbelievably puzzling and I do want to get to the bottom of this. Senator Baldwin.

Senator BALDWIN. Thank you. So, I want to kind of start where Senator Johnson left off with regard to this process on this Administrative Closure.

The report, Committee report outlines a very long inspection, investigation. You used the words somewhat interchangeably.

Now, the work product after the inspection, the visits, the interviews, etc., seems to have gone through a number of iterations prior to there being a decision to make this an Administrative Closure. I know that, and you will see this throughout the Committee report, frustrations expressed about documents that were requested from the Inspector General, but were not granted to the Committee.

But we had an opportunity granted by the IG's office in the last couple of weeks to inspect the draft reports. Could not take notes—and I did not do it, but my staff went in to see them, and so the Committee has reviewed some of the drafts prepared during the Tomah investigation, and I was disturbed to learn, after I was briefed, that things that the IG staff was aware of did not make it into the final Administrative Closure.

For example, one case study referenced in an IG draft report explained that Dr. Houlihan had increased one patient's dosage of oxycodone more than eight fold in one year. And, that there was not always a rationale noted in the chart. During the same time frame, this patient had nine refills of a Schedule II controlled substance dispensed more than a week early.

Probably more disturbing, the case study explained, and I am paraphrasing, because there were not copies available, that Dr. Houlihan miscalculated the number of pills prescribed to the patient and that Dr. Houlihan made up for the shortage by refilling the prescription early.

Can you explain to me why details of these case studies referenced in the draft report did not make it into the final Administrative Closure?

Dr. DAIGH. My instruction to the staff was, because the draft report did not substantiate what I thought were the significant allegations that we were looking at, I asked them then to write an Administrative Closure. So, the same people that wrote the draft report wrote the Administrative Closure. There were no instructions as to what to put in or what to put out.

If you will take a look at the 140 Administrative Closures that we had done previously, and I will say that it was my understanding and our practice that if I took a hotline, I would either publish it to the web or I would note in the Semi-Annual report (SAR) to the Congress that we had an Administrative Closure. So they were, in my view, made public there, although, albeit, not with very much detail. Some years there was a lot of detail, some years there was not, but I asked them to write an Administrative Closure. So they chose, for I do not know what reason, to shorten it up, and it was, 11 pages for the Administrative Closure. Most of the Administrative Closures that we publish are one or two pages, so they were trying to put in the detail they thought was relevant.

Senator BALDWIN. Well, I mean, on that Administrative Closure, you did note that patients requested early refills, but the document does not state that Dr. Houlihan wrote in files that he miscalculated the prescriptions and made up for the shortages by refilling the prescriptions. And, to me, this tells a different story. There is also no mention that he did not always provide a rationale in the charts for substantially increasing already high prescriptions like the example I just mentioned.

So we gathered, in March of 2015, this, the Senate Homeland Security and Governmental Affairs Committee, and you testified. You testified that staff at Tomah were at the outer boundary of acceptable prescribing practices. And, this statement seems to imply to me that there may have been some unusual practices happening at the Tomah facility and within the facility's leadership.

So, is the example I just raised the type of thing that was on the outer boundary of acceptable prescribing practices or is it beyond that boundary.

Dr. DAIGH. I would say that our view was that, in summary, he was at the outer boundary. And, the facts that you described would be, in my view, probably over the outer boundary. But we thought that the totality of the care provided, was at the outer boundary.

Senator BALDWIN. Inspector General Missal, I know you are new to this position, but you have read this Committee report, and I guess I want to know your opinion on putting out a policy that outlines what the standard ought to be in your Agency for substantiating or unsubstantiating allegations, at least for cases like this where you think it might be a close call or right outside those boundaries?

Mr. MISSAL. Yes. I have looked at that. I have had the opportunity to review the report. Standard of care is a complicated issue. For instance, when we are doing an investigation, we look to see if somebody did something wrong. The standard to me is preponderance of the evidence. Is it more likely than not that somebody did it?

With respect to healthcare inspections, you are looking at the quality of care, which is a far more complicated area. And, it really depends on a variety of things of what you are looking at. For example, what the literature says, what experts may say, etc., but I understand the point. I know it was a significant issue and we intend to look very closely at that and to talk about standard of care and the standards that we are going to be using going forward, so we will be doing that.

Senator BALDWIN. Well, with the advantage of hindsight, this does not look all that complicated to me.

Mr. MISSAL. We are going to look at that very closely.

Senator JOHNSON. Thank you, Senator Baldwin.

What is amazing is they had a pretty high standard for, substantiating a claim in their OIG report, but yet in the White Paper, they had no problem rushing out a report that literally threw the whistleblowers and these individuals under the bus. It is really quite remarkable.

I also appreciate the fact that you were talking about the frustration this Committee has had in obtaining the information. I just want to refer everybody to page 324. This is what one of the documents looks like provided by the Office of Inspector General, who has not yet complied with our full subpoena. I mean, think about that. This Committee had to subpoena the Office of Inspector General to get the information. And now, 16 months later, well, it is really about a year later, because we issued the subpoena at the end of April, still has not been complied with, so, Mr. Missal, again, we look forward to working with you on that.

I do want to welcome Representative Kind and Representative Walz from Minnesota, and we will not hold that against you. Congressman Kind.

OPENING STATEMENT OF CONGRESSMAN KIND

Mr. KIND. Thank you, Senator. I want to thank you too for yours and the Committee's invitation for me and Representative Walz to participate in today's hearing.

Yesterday, as many of us were at Memorial Day commemoration events, and during it, it is a sober reminder of not only our obligation to honor our fallen heroes, but the unfinished work of making sure that our veterans, those who served our nation are receiving the care and the treatment that they have earned and that they deserve. And, that has always been my guiding star throughout this whole process, given the tragedy, given the mistakes that were made at Tomah, which, according to your testimony here today, has not been unusual in regards to the VA medical system throughout the nation. If we keep our focus on the veterans and making sure that that is our true guiding star, then hopefully we can bring some good out of a tragedy. And, I know that is exactly what has been motivating the Simcakoski family this whole time.

I have been proud and honored to be able to work with each one of them when it comes to fixing the problems to ensure that no veteran in the future goes through what that family has done. Jason's wife Heather, and his parents, Linda and Marv, have been intimately involved in not only providing feedback on the legislation we have been working on to honor his legacy, the Jason Simcakoski Promise Act, but they have even taken the extra step of making phone calls to appropriate Committee Members, even to Speaker Ryan, about the importance and the urgency of getting this legislation done and implemented as quickly as possible.

In fact, Heather and Linda and Heather's daughter Aniah were out just out in Washington a couple of weeks ago to make some last minute visits, but also to personally witness the passage of the Jason Simcakoski Promise Act unanimously on the House floor, and we look forward to working with this Committee and you Senators in order to ensure that this reaches the President's desk and get this done and implement it as quickly as possible.

Heather asked today if I would be willing to read a short two-paragraph statement for the record and I ask unanimous consent to do so at this time.

Senator JOHNSON. Sure.

Mr. KIND. She writes, and I quote, "It is encouraging to see the Congressional delegation working together in honor of Jason, to ensure no other families go through what we had to endure. We are proud of the progress made so far in passing legislation named after Jason. We look forward to working with the Congressional delegation to make sure the legislation becomes law.

"We are grateful for an opportunity to see everyone come together to turn such tragedy into something that has the potential to save so many lives in the future. As we can continue moving forward, we are committed to remaining focused on the bipartisan support for this legislation."

Clearly the job is not done yet, but I do want to commend Acting Director Vicki Brahm, for the progress that has been made at Tomah. This comes on the heels of the work that then Acting Director John Rohrer when he came in, and inherited the challenge that existed and what they are trying to build on right now—the

community outreach, working with the staff on best practices, but especially listening to the families and to the veterans themselves, making sure that they have input and say in what is taking place there.

I think it is important that we stay focused in that endeavor.

But I also would be remiss if I did not mention the good work that has been done at Tomah. I have been somewhat surprised by the number of veterans who have gone out of their way to personally notify me at how happy they are with the care and treatment they have received at Tomah. Any my guess is this would be fairly consistent around the country too.

So, although there were serious allegations and mistakes made, I do not think we should overlook a lot of the dedication, a lot of the professionalism, a lot of compassion that is taking place at places like Tomah each and every day, and sometimes, given the sensation of these stories and what the media tends to focus on, that gets lost in kind of the fog of everything that we are trying to accomplish.

But, Mr. Missal, while we have you here, and we know you are new to the position, and it has been raised already by the Senators, we did have some communication problems with the IG's office when it comes to conducting the investigation, proper notification.

I know that when I had received an anonymous letter back in September of 2011, I immediately forwarded that onto the OIG's office, asking them to look into it and conduct an investigation. Received notification that they were going to do that and that we be notified at the end of that investigation.

Now, listen, I am a former special prosecutor and I have been involved in a lot of investigations myself. You do not know when you go into an investigation how long it is going to take, how complex it is going to be. You talk to one witness and suddenly 10 more names appear. I get all of that. But what was problematic to me and to the Committees of jurisdiction was the lack of notification when the IG's office administratively closed it with certain reforms and changes that had to be made and we were operating in the dark, because there was no notification again.

And, I also want to commend Representative Walz who serves on the House Committee on Veterans' Affairs for the work that he has done. He has been a good partner through all of this, along with Gus Bilirakis, a real bipartisan effort, but we are only as good as the information that is given to us.

And, Dr. Daigh, when the report did come out, and I later found out that we were not notified, I called you and others that were involved in the investigation into my office immediately to get clarification on what was taking place. To your credit, you guys owned up, that the ball had been dropped, notification was not given when the intent was—I know this was coming at the time of Phoenix and other news stories that were breaking at the time, but in light of all that, I introduced legislation, the Inspector General Transparency Act, which I am glad was included in the year-end budget last year, which now requires that notification.

So, Mr. Missal, on that point specifically, is that going to help in your mind, as far as the lines of communication, keeping policy makers informed of what changes and reforms have to be made, so

we can be working together and in tandem to make sure that this gets done?

Mr. MISSAL. Yes, I think it will help, but hopefully we do not need legislation to become more transparent.

My goal is to communicate better with the public, with Congress and with the Department on issues. There were a number of mistakes made by my office at the time and we agree that one of the mistakes was not keeping Congress better informed on this issue. And, I am going to work very hard to make sure that does not happen again.

Mr. KIND. Mr. Gibson, I appreciate your testimony, written and your oral testimony today, about the need to continue on a more coordinated, integrated veteran-focused healthcare delivery system. I think a lot of ways—the VA system throughout the country has been good in driving that, that goal, that momentum in that direction, but, clearly, more work needs to be done.

Mr. GIBSON. Yes.

Mr. KIND. Is there any other things that Congress needs to be working with the VA on right now to make sure that you are given the policy prescription, but also the tools and resources in order to get this accomplished?

Mr. GIBSON. I appreciate the request, and I appreciate your recognizing the good work that goes on every day. Because, you are right, it does not get reported. It does not diminish the challenges that we have, but it is part of the context. The short answer is yes. And, we have been working, really, with both of our authorizing committees on an array of legislative priorities that we have, many of which get at some of these very issues. I am thinking most immediately of the request to make all of our Medical Center Directors and Network Directors Title 38.

Quite frankly, if I had that authority in my hip pocket right now, the lady sitting behind me would already be the Medical Center Director here. But I am probably going to get in trouble for committing a prohibited personnel practice for having said that, but, she is doing awesome work and she is the kind of person—and having the kind of ability to, to direct hire and a little flexibility around compensation would make that possible, among a large number of other priorities that you have identified. Thank you for asking, sir.

Mr. KIND. Thank you.

Senator JOHNSON. Congressman Walz.

OPENING STATEMENT OF CONGRESSMAN WALZ

Mr. WALZ. Thank you Senator Johnson, for including me in this hearing and the past one.

Thank you, Senator Baldwin and Congressman Kind, for all three of you, the work that you do.

I am Tim Walz. I represent Minnesota's First Congressional District. It is just a little bit west of here across the river and then all the way out to South Dakota. And, that river may separate us on football loyalty, but it does not separate us as Americans.

And, many of my constituents use this facility.

Also, prior to being in Congress I spend 24 years as an artilleryman and retired as a Command Sergeant Major and spent the last 10 years on the House Veterans' Affairs Committee, so I have spent

the last 35 years, not just talking about veterans issues, but being part of that.

And, I can tell you this—that, as a member of Congress, the security of this nation and the care of our warriors is our number one priority. That is also the number one priority of all of you sitting out there and every constituent in my District and Ron's District and across Wisconsin and Minnesota. It is also the number one priority of these folks sitting up here.

And, you just do not get in this and leave. For example, Mr. Gibson, some of you do not know, my capacity of working with him prior to his current position was, he ran the United Service Organizations (USO), a fabulous organization that cares for our warriors, which he did with grace, skill, effectiveness, and I think for all of us trying to find solutions to the best care possible is what we are here for, so I appreciate all of you coming out on a day like this.

And, to the family, you heard it. And, I think that is the thing that always most strikes me. In the midst of heart-wrenching tragedy that I will not even attempt to understand, a family seeking justice, which they deserve, and we should deliver, but also transferring that into solutions to make sure no other family goes through it too, whether they meet them or not. And, that is a very powerful call to action for us. So, I look at it as, our responsibility is to get them the justice, find out what went wrong, find out who is responsible and hold them accountable, but simultaneously making sure that the changes that are being made do not happen.

And, for some of you to think on this is, there really is nothing new under the sun. I think about this, and the folks up here, and Ron and I have talked about this and have worked together on.

The first two things that I was able to do when I got to Congress would actually put into law and effected was first increasing the budget for the VA Inspector General, which at that time was incredibly low and you simply did not have enough people to go out. We would send in a request, and you would say, I do not have people to cover this and we could not find those eyes on it.

And, secondly was passing step pain management on opioid reduction. In 2007 people were already thinking about that. Not just me, but folks up here and folks that understood this were trying to implement that. And, I guess for me, we made a good effort, and I think the VA and Mr. Gibson are right. This is an issue that is systemic to our entire culture. And, it is a huge problem. Now you hear lots of people talking about it. That is great, but there are solutions out there. We need to implement them and move them forward.

And, I know that the bill that I passed went from 2009 to 2014. We were only able to implement 31 percent of it by the time it expired in terms of doing this. And, these are best practices that are out there.

So, I think today in the time that we are going to have here today, I am going to attempt to try to focus on what has changed at Tomah. And, trust me on this. Dr. Houlihan or anyone else involved in this, justice needs to be served and we will find that. Senator Johnson will continue to do that and Senator Baldwin.

As a member of the House Veterans' Affairs Committee, I want to know what you have done to make a difference. What happens

with my veterans from Houston County who come over to Tomah now and what has changed?

And, with my remaining time I am going to start on a line of questioning on this is, and, Mr. Gibson, maybe you can help me with this. How do I know things are better at Tomah? How do I know, if someone asked me, is it better at Tomah or is it the same thing that happened when the reputation that, that started this was there?

Mr. GIBSON. I think some of the activities that I described earlier, Vicki has been engaging in; the open door with veterans, the outreach into the community, and looking for ways where we bring the community together to help support our veterans.

And, one of the things that we started doing recently, because access is such a critical issue for us, is we started, at our kiosks, asking the one very simple question, how satisfied were you that you got today's appointment when you wanted it. At Tomah the answer is 93 percent satisfied or completely satisfied.

They are doing so many things so well. You can look at the sale data.

Many of you may not realize VA leads the country, perhaps the world, in reducing healthcare associated infections. Healthcare associated infections—second leading cause of death in America—more than automobile accidents and breast cancer combined.

And when, and external studies, when looked, who was, who was doing this better than any other organization? It was not the Cleveland Clinic. It was not Kaiser Permanente. It was not Geisinger. It was VA.

Mr. WALZ. Not even Mayo.

Mr. GIBSON. Guess who? Guess who leads VA? Tomah, in minimizing healthcare associated infections.

I will tell you, the number one area where they have work to do is in employee satisfaction and employee engagement. And, that is the culture problem. And, that is why leadership matters so much.

So, veterans are telling us, you are hearing from veterans that are saying—I have heard from veterans here. And, I will tell you, my classmate was a patient here in the Community Living Center (CLC) for 23 years. And, the family in his obituary said the staff here made them feel like they were part of their family.

That is what is happening with so many of the Wisconsinites that are working right here, caring for our veterans, are they doing the right thing, but we did not have the right leadership in place. And, I think, I think we have a good clue——

Mr. WALZ. We need to give them the tools because——

Mr. GIBSON. Yes, we do.

Mr. WALZ. We owe them nothing less. You hear that.

Mr. GIBSON. Yes.

Mr. WALZ. But, and equally important as holding accountable, and if it is firing, or whatever needs to be done to those people, we need to have the ability, as you said, and I am with you on the Title 38. We need to be able to hire the best and possible, because we cannot fire away to a fix, but we can simultaneously get rid of the bad and bring in the good.

Mr. GIBSON. You got it.

Mr. WALZ. And, I yield back.

Mr. GIBSON. You got it.

Senator JOHNSON. Thank you, Congressman Walz.

Let me continue on that vein about accountability.

In 2015 I introduced the Ensuring Veterans Safety Through Accountability Act and I testified with Senator Baldwin when she introduced the Jason Simcakoski—I always forget the full name.

Senator BALDWIN. Opioid Safety Act.

Senator JOHNSON. Opioid Safety Act at the Veterans' Affairs Committee. I was more than disappointed when the representatives from the VA testified against the Accountability Act.

Now, fortunately, a similar provision introduced by Marco Rubio, which I cosponsored, was passed by the VA Committee, but having been in business for 30 some years, I mean, I understand that probably the most corrosive thing to any organization is not being able to hold the bad actors accountable. And, yet here you have the representatives of VA saying, nah, we do not want that authority to hold people accountable.

I mean, that is at the heart. I agree with you. I think all of us here agree. As we tour around and talk to the doctors and nurses, and as I said in my opening statement, they do an extraordinary job. They are really concerned, but unless we really have the ability to hold people accountable, that is what causes these types of tragedies, so is that something that the VA will now embrace? The ability to actually discipline and terminate and hold people accountable through the VA system.

Mr. GIBSON. I would say the answer is an unequivocal yes.

Senator JOHNSON. Good. We will move on.

Mr. GIBSON. Well, that has been part of my own personal obligation as a leader since I first got to VA. I am the guy that takes action on senior leaders in the department. I am the guy that issued the removal on DeSanctis. And, I am the guy that looks at other instances of particular notoriety to ensure that we are taking the appropriate action.

Senator JOHNSON. Good. But we want to give you that authority, because you have to have it.

Another piece of legislation I introduced was the Dr. Chris Kirkpatrick—let me give you the full title of that one as well: The Christopher Kirkpatrick Whistleblower Protection Act. And, this was really prompted by a Committee hearing we had where Sean Kirkpatrick testified before our Committee, and one thing that I have been literally shocked by, again, coming from the private sector, even though we have all these whistleblower protection laws on the books for a hundred years, the level of retaliation against those people that have the courage to come forward, like Dr. Noelle Johnson, like Ryan Honl, like Chris Kirkpatrick, is jaw dropping.

So, again, I hope that the VA will embrace and help support the passage of that piece of legislation to give those whistleblowers the protection they really need.

And, by the way, I would announce again that my Committee has set up the whistleblower hotline. It is just whistleblower@ronjohnson.senate.gov. People are using that. And, I think it is also an important step that is required, so that whistleblowers within the VA—and, by the way, the highest level of retal-

iation, according to the Office of Special Counsel (OSC), is within the Veterans Administration, which is a real problem.

So, again, will you support the Christopher Kirkpatrick Whistleblower Protection Act?

Mr. GIBSON. I do not know what is in the Act and I also do not know what is in the Accountability legislation you referred to earlier.

But what I will tell you is that I personally, as the Acting Secretary, met with Carolyn Lerner, the Special Counsel of the United States. I committed to VA becoming certified, the first large Federal department that became certified as a whistleblower protecting organization. I have publicly recognized and, and presented awards to whistleblowers. I meet with whistleblowers in every location where I go visit. When I came to this location last year, I met with Ryan Honl. I do that. Coming out of the private sector, I understand that your most valuable source of information on how to do things better are your frontline employees.

The last thing you want are people that are afraid to raise their hand, so everything we are doing as an organization has to do with creating that kind of culture.

A little bit along the lines of what Mike said earlier, I do not need a law to tell me to do that. That is back to just good leadership. Not necessarily from me, but from people across the Department.

Senator JOHNSON. I appreciate that.

Dr. Daigh, as I am going through the Committee's report. And, you see that the first hotline notice, really, is about March 2011. And, for whatever reason, it did not rise to the level. And, then in August 2011, partly because of Representative Kind's inquiry, it all of a sudden became a Congressional hotline or Congressional inquiry, gained a little steam and got the notice, but it took until 2014 to complete this inspection, investigation, and then issue some kind of report.

There is an awful lot of activity and I think the first site visit was in 2012, and not a whole lot happened in 2013 into whatever date it actually was closed. What was happening during that point in time?

Dr. DAIGH. Well, let me first set the record straight on the issue of the date at the bottom of the report. That date is accurate. And, if you will look at the e-mails which transmit the pdf of the report I signed, you will find that those dates are consistent with the date I signed.

Senator JOHNSON. OK, good. Great. I appreciate that.

Dr. DAIGH. That is absolutely the truth. And, I believe that data may be in your hands now. I am not absolutely sure how many of the thousands of records we gave you, you have.

The problem with this Tomah allegation was, we got a letter very early on, that laid out a whole series of cases which alleged that there was horrible care provided. And, unfortunately, I received many more allegations than I have the resources to investigate or inspect. So, with that letter, we read it. I did not have the resources at the date that came in, and so I sent it to VHA. I usually send it to one management level above, so it would go the VISN. And, the VISN wrote us back a letter with each of the cases out-

lying how the quality of care has been appropriate. So, we read that letter. And, we said, OK, this makes sense. We will say that, we will close this at this point in time.

As part of the Combined Assessment Program (CAP) process, we have an employee survey where we ask employees what their view of the world is with respect to quality of care at a facility. And, we did a CAP about that time and a number of Tomah employees indicated that there were concerns about medication abuse at Tomah. We had that fact.

We got a letter from Congressman Kind, saying there was an issue, so we said OK. We need to go out to Tomah and figure out what the real story is. And so, that launched our hotline review.

I sent a team out there, as you note, and we made calls before. We got all the data we could ahead of time. We went out there. And, the allegations continued to increase. I think the Administrative Closure lists 32 or 33 different allegations.

So, as the allegations increase, you go down more and more tracks. And, as we would go down a track, unfortunately we got a lot of dead ends. People would say, a certain transaction had occurred at a certain place. We could not find any data for that. We could not find evidence for that.

So, we decided then that what we needed to do was to pull all the emails for employees that worked there for a certain period of time, so you have to stop and say, "OK let us go get the emails." We had an email pull. It was insufficient the first time. Then we had to go actually to their computers and pull the email off their computers, and get that back. You have to read that email. We were in continuous conversation with the DEA, trying to understand where they were or did they have any issues with this?

I then met with our agents and they investigated it, the investigators. They agreed to go on-site. So, they went on site and did work. So, it took a long time, if you have a relatively small number of people and you have allegations that explode, to run down each of these tracks.

Senator JOHNSON. And, I appreciate that, and yes, the VA, when they undertook their own investigation, together with this Committee, in just a couple of months pretty well substantiated the charge and started holding people accountable, so.

Dr. DAIGH. I think, for me, the important question is whether or not VA was aware as we were doing our work of what we were finding and were they aware that there were issues at Tomah? And, I believe that they were at the local level, the VISN level, and at the Veterans Affairs Central Office (VACO), aware that there were issues at Tomah that needed to be addressed and that we were in communication with them. Not every fact was presented to them until we were able to assemble the facts and put them out there, and lay them out for everyone to see clearly.

Senator JOHNSON. I would argue that the responsibility of the Inspector General is to make that information public and also make sure that something is done about it. And, that did not happen.

I am out of time here. Senator Baldwin.

Senator BALDWIN. On the issue of accountability, I have a questions for you, Mr. Gibson.

Dr. Houlihan was fired from the VA. And, at the time that he was fired, I wrote to the VA to ensure that veterans would not ultimately be referred to his practice outside the VA through the Veterans Choice Program.

Subsequently, through public reports, his license was suspended by the State of Wisconsin. And, I received a letter back from the VA indicating that he would not be eligible to serve veterans under the Choice Program because his license was suspended.

You may or may not be aware, again, through public reporting it appears that an Administrative Law Judge (ALJ) has reinstated his license during the pendency of proceedings before this State.

And so, I want to, first of all, get assurances from you that in light of that new development, that Dr. Houlihan would not be getting referrals of veterans through the Veterans Choice Program.

Mr. GIBSON. Absolutely not.

Senator BALDWIN. And——

Senator JOHNSON. Senator Baldwin, if I can briefly interrupt. That is an incredibly important point you are making. That Administrative Law Judge is citing the White Paper, so Inspector General Missal, would you repudiate that so that that can no longer be used by the Administrative Law Judge? That White Paper?

Mr. MISSAL. Yes. My office took the White Paper off its website, so to me that means it no longer is a document of the Inspector General's Office.

Senator JOHNSON. Thank you. Senator Baldwin.

Senator BALDWIN. So, this correspondence between me and the VA has highlighted for me that nothing in the VA Choice legislation explicitly requires that somebody who is fired or suspended from the VA for cause related to their service, to our nation's veterans, there is nothing that explicitly addresses this in the law. And so, I feel like this is a dangerous loophole that we currently have.

I have recently introduced bipartisan legislation that just passed the Senate, although it has not made it all the way through the legislative process. That legislation requires the VA Secretary to block the healthcare provider from participating in community programs if that provider was fired or suspended from the VA, violated his or her medical license, had a Department certification revoked, or otherwise broke the law.

Secretary Gibson, are there steps that the VA can take right now to ensure that this loophole is not being exploited to taken advantage of by other providers other than the case that we are talking about today?

Mr. GIBSON. I have not discussed the matters specifically with the folks that are working here in the community, but I will do so. There is no reason why we cannot implement a policy that accomplishes the same thing without the need for legislation.

Senator BALDWIN. During our Chairman's opening statement, he drew our attention to portions of the Committee report discussing the concern that two of the witnesses during the inspection were impaired, possibly by drugs or alcohol. It was a suspicion. There is a lot of discussion in the Committee report on this.

I think disturbing was that the only two follow-up actions were a doctor emailed the VA OIG's General Counsel wanted to discuss

a concern regarding possibly an impaired interviewee, or interviewees, and subsequently, and off-the-record discussion with the Tomah VA's Director at the time, Mario DeSanctis.

There is no clear record of whether that tip was followed up on or not.

My question is, will the VA Office of Inspector General adopt new policies or procedures so that if this happen in a future case, and, of course, we hope it never does, that the IG suspects that a witness employed by the VA is under the influence of a controlled substance that there is a procedure that will be followed that would provide greater accountability and safety for our Nation's veterans?

I would like to hear both of you on that, but, this was first noticed by the team doing the inspection, and so, I want to hear what the Inspector General has to say about procedures if this should ever happen again. And, then I would like to hear from you, Deputy Secretary Gibson.

Mr. GIBSON. I would love to share my two cents worth, yes, ma'am.

Mr. MISSAL. With respect to my view on that, if I ever see a situation where I think somebody, particularly somebody providing healthcare to veterans, may be in a situation where they are impaired in one way, I would immediately make sure appropriate people within VHA or above that were aware of that and to follow up and to make sure that that situation was resolved to our satisfaction as quickly as possible.

Senator BALDWIN. And, in this particular case, do you have any knowledge that the Committee does not about whether anything was followed up on by Director DeSanctis?

Mr. MISSAL. I do not have any more information.

Mr. GIBSON. I am going to tell you, based upon the first time I ever heard of this was reading it in the report. First time ever. We are right back to leadership. That is what this is about. This is about delivering safe care to veterans. And, the failure of leadership that happened here was the failure on the part of the Medical Center Director to take appropriate action.

And, everything that I mentioned earlier, I issued the removal on the Medical Center Director. I reviewed hundreds and hundreds of pages of evidence. And, I will tell you, not doing something about this would be very consistent with the pattern of behavior that I saw there. It was a failure of leadership. It should not have happened. Period.

The principles here, you said, put the veteran at the center of everything that you are doing, and that is exactly what we are trying to do. And, understanding—making leadership in the organization understand the sense of urgency with which they must act when something has been presented to them that suggests, that the safety of the veteran, the care of the veteran, may be at risk, that is an urgent situation. You have to act and you have to act timely and promptly. That is what these folks have been doing.

There was an instance that happened—these folks, and I am not going to—I will not get into the great details, but here is the timeline. They became aware on November 19, 2015, that there was misconduct. They launched a Fact Finding the next day, November 20, 2015. The Fact Finding was completed on December 7

and the proposed removal was issued on December 8. That is the kind of timely action and follow-up. That is what good leaders do. And, that is what we have to ensure we have in place all across this Department.

Senator JOHNSON. I could not agree more.

Mr. GIBSON. We do not need a watchdog to tell us how to do our job. Important to have a good watchdog, but we do not need one to tell us how to do our job.

Senator JOHNSON. Congressman Kind.

Mr. KIND. Than you, Senator.

Mr. Gibson, let me stay with you, because, clearly, one of the problems we had at Tomah was chain of command. We had a Chief of Staff, in this case Dr. Houlihan, who was also prescribing medication. And, getting back to the team or coordinated approach to proper healthcare delivery, there was a culture of intimidation——

Mr. GIBSON. Yes.

Mr. KIND [continuing]. That was created by Dr. Houlihan that made it almost impossible for someone with a dissenting view or dissenting opinion to come forward in order to change a certain treatment regimen.

Mr. GIBSON. Yes.

Mr. KIND. Has that been fixed now? Not just in Tomah, but throughout the VA Medical System?

Mr. GIBSON. I know it has been fixed here in Tomah. I think the issues that has been raised here prompts a review across our organization to ensure that we have appropriate separation of authority here.

Very early on, in fact, at the very beginning of the Medical Center Director's tenure, the issue of separating the reporting relationship for pharmacy was raised. The Medical Center Director refused to do that, until, I am going to say, roughly a year and a half later, when he finally got a new Associate Director in place. We had problems in construction with VA and, and the Executive Director responsible for that area was encouraged to leave, and he did leave.

I accepted direct responsibility for construction and facilities management until such time as we got the leadership in place. That is precisely the kind of action that should have been taken here.

Mr. KIND. That is the thing that probably made me the angriest, the information coming out, and probably for more most people in this room, was that culture of intimidation.

Mr. GIBSON. Yes.

Mr. KIND. The bullying that was taking place. Good people trying to do the right thing, keeping the focus on the veterans were cut off. And, one instance led to a suicide. Other instances led to firing or people leaving their positions because of this culture that was created. I think it is just essential that we fix that throughout the entire system or we are going to have another hearing somewhere else in this country, I am afraid, talking about the same set of facts.

Mr. GIBSON. The day you and I were here in Tomah, last year, together, was the day that Houlihan was placed on administrative leave.

Mr. KIND. I remember that.

Mr. GIBSON. He had been removed from clinical duties, but it became evident to me that he was still exerting undue influence on other providers in the organization. That was the day he was removed.

Mr. KIND. Back to my original question—what more can Congress be doing working with you? I think in your written testimony, you said we have to adequately fund the OSC to make sure that there are resources to hire additional investigators. Do you still have that opinion?

Mr. GIBSON. I do. We work very closely and very collaboratively with the Office of Special Counsel. I would say to my brethren next to me here that there is probably an opportunity for the Office of Special Counsel and our IG to work more collaboratively together. Sometimes things have gotten in the way of that. But between our investigation resources, their investigative resources, and the Office of Special Counsel's investigative resources, I think there was an opportunity for us to do better by taxpayers and better by veterans both.

Mr. KIND. I would be happy to follow up with you in regards——

Mr. GIBSON. Yes.

Mr. KIND [continuing]. To funding levels and that, but—and I know the VA here in Tomah are also exploring more alternatives and complimentary forms of medical treatment——

Mr. GIBSON. Yes.

Mr. KIND [continuing]. Just not loading the vets up on a cocktail of prescription drugs and expecting that to solve all the problems, but there is also a danger of overreacting. And, I have some feedback from veterans that it is a little more difficult for them to get the prescription meds, the opioids that they need for proper pain management. I know it is a difficult balance, but how well are we doing on that front.

Mr. GIBSON. Dr. West.

Dr. WEST. Thank you for that question, and you bring up a very important point that you cannot overreact, right. I mean, I am a physician that still treats patients every week, in my own clinic, and you know, I kind of see it every week.

Forever, the medical system as a whole, including VA and our academic centers, was moving forward prescribing pills. We found out that was wrong, and that that was actually killing people.

Now we are turning a big aircraft carrier around, and the way we are doing it is through exactly what you mentioned, complimentary and alternative medicines, and there are other medicines to treat pain. There are not just opiates. There are neuromodulating agents, new agents coming out all the time.

So, as a clinician, you have to be very sensitive to the patient and the individual case and really work through the patient's—I mean, this is all a veteran-centric work-through, and it takes a long time. You need things like this. This is a brilliant thing that they have come up with at Tomah to support frontline physicians in decisionmaking for patients, education for patients, and other treatments for patients that they can use for their pain.

Mr. KIND. I would also encourage the VA to continue the efforts to provide an avenue or a line of communication for the family members themselves. I still think they are the best line of defense

in all of this. They are going to know what is working and what is not with the loved one and their family, so making sure we foster that receptive environment for them.

And, finally, Mr. Gibson, we have to get the message to the Directors of all the VA Medical Centers that they have to be as candid and truthful and honest with us, because many of us are visiting these campuses all the time. Check in on the veterans. Find out what is working, what is not working. And, I am at Tomah. I am up in the Cities. I try to get down to Madison too. And, I am always asking, what do I need to be aware of? Are there any problems here that I need to be aware of that we can work with you on?

And, that did not happen, unfortunately, under Director DeSanctis's leadership. And, I was on campus. I was looking him in the eyes. What do I need to know? What is going on? Is there any problems? And, I later found out that just 2 months, 2 months before I had been on campus one time, the IG was there, with the conclusion of the report with recommendations and changes that they were already moving forward on. And, I asked them and they did not breathe of word of it. And, it is just so frustrating, because if you lose that trust, and then something like this blows up, there is a lot of preventable error and a lot that we could accomplish, so we need to communicate with the leadership of our medical centers. They have to be up front and honest with us policymakers for us to make the changes that are necessary.

Mr. GIBSON. One of the things that we have been doing under Leaders Developing Leaders, the Secretary and I have personally met with the 600 top leaders of the entire Department, and one of the messages that we deliver is the message that you just spoke. It is the importance of getting news, whether it be good news or bad news. This is a 180 degree change for this organization. First of all, folks—they were not talking to members of Congress or to the media under any circumstance. What we are trying to do is to get them to talk, both when there is good news or when there is bad news, let us get it out on the table, own the problem, start tackling it, and get it fixed. I mean, that is how you earn trust back.

Mr. KIND. I again commend Acting Director Brahm, because the open policy that she has had, it has been a sea change, and I am sure we are going to see that continue in the future.

Mr. GIBSON. Yes, sir.

Senator JOHNSON. Congressman Walz.

Mr. WALZ. Thank you, Senator. I am going to continue down this kind of same line. And, it is about improvement, about working towards that, and you have heard it, culture of fear, and Senator Johnson rightfully expressed, and I am grateful for him, on protection of whistleblowers, of making sure, folks. And, I think that is an unfortunate name we give people. If you look it up, the synonyms are not positive on this. These are ethical employees trying to improve the care for veterans, and that is how they need to be referred to and that is how they should be treated.

And, Deputy Secretary Gibson and I have both privately and publicly discussed this issue. And, this is frustrating amongst all of you out there and my constituents. Nothing makes me more boil-

ing mad than when you are saying you know someone did something, and then you see they are put on administrative leave with pay, and you are thinking, I would have gotten fired at my job on that. And, all of us up here—in 5 months, all of us are up for that. We get a performance review, and that is good, up or down on how it works. There is that sense of frustration, but it is also balancing, and you have done—we have talked through this.

Due process is important to our system of rule of law. That is due process for the employee and due process for the veteran and their family of trying to strike that balance.

And, I think as you work with—Mr. Kind is right about this. It is the transparency. It is restoring the trust of the veteran and their family so that know they are going to get the best care, but they trust that it is going to work for them. So, when you hear Mr. Gibson talk about this, this is no small matter. When you hear Title 38 and some of these terms or whatever, this part of the authority he is talking about. Laws that both the Senate and the House passed to allow them to work with their special executive service folks. These are the top-ranked administrators. Those are the things we are trying to get at.

And, I am not going—and it is not the appropriate place. I think it is an appropriate debate, but the idea of employee due process, sometimes this idea that you should be able to walk in, point a finger and say, you are gone, for any reason, I do not think any of us want to live under that. And, I do not think any of us want to get rid of the good employees who are there. So, what I worry about is, we go gung ho to say, just clean the dang place out and fire all these. You have a food service worker who has been stripped of their right to have someone represent them, bring an allegation forward against bad management, and they do not have anyone to stand for them, and they are gone. And, the bad management still sits there.

So, Secretary Gibson, your point on this is you do not need a law to do a lot of these things. What you need is an ethical compass and the moral responsibility to care for our veterans, which I believe we are starting to get there, but what we are hearing from up here is, what can we do to ensure that the public believes that? Believes that we are not protecting bad employees? Believe we are not protecting and giving rights that no one else in society would have for bad employees to continue to draw a paycheck? Does the Title 38 and some of these tools—because I can tell you now, if you think it takes a long time to fire somebody, try and hire them at the VA. It takes longer.

You have fresh-faced graduates, psychiatrists, wanting to serve this nation's veterans and they wait 9 months to even hear back if they are going to get a job. These people are like Sasquatch. If you find them, take a picture. Because there is none of them. There is none of them.

And, again, how can we compete if they can go to Mayo Clinic or Cleveland Clinic and make five times more?

Now, I know these people want to serve, but there has to be a fairness, so I am just asking you, Mr. Secretary, how do we strike this balance between appeasing the public's right for justice and getting rid of bad actors, because I deal with this.

I am a school teacher too. And, I know people always say, oh, you cannot get rid of a bad school teacher. You know who wants to get rid of a bad school teacher more than anybody? A good school teacher teaching next door to them.

Do you know who wants to get rid of a bad VA employee? A good VA employee.

So, how would describe what we can do to ensure you have those tools?

Mr. GIBSON. I think first of all, the Title 38 provision around senior executives is precisely the right place to go to give us both the authority that we need on hiring as well as the authority that we need from a disciplinary standpoint.

I freely admit there are instances where I start wading into a particular case, and I ask out loud, who is the advocate for the veteran in all of this, because there are lots of advocates for the employee. Who is the advocate for the veteran? And, I step up and fill that particular void.

We have to ensure that we are restoring balance there and I would tell you, one of the most powerful things that any member can do—we all know that there are a lot of good thing going on at VA. We all know that. And, when there are opportunities to—I am not saying, "do not talk about the bad things," because there are bad things that we have to do, as well, Just tell the whole picture. Yes, we have to fix this. We have to fix this, but did you know they are doing this? They are doing this?

Because the real tragedy comes when veterans who need to come to VA for help or for care do not, because of what they have been reading in the media and they stay away. That is the tragedy. You look at some of the suicide numbers and the statistics, and I think we are close to coming out with some refined statistics there, but, what we have seen consistently when we have looked, is that the preponderant number of suicides that veterans commit, each day are veterans that are not in the VA Healthcare System.

And, you look at—the old number has been 17 of the 22 are veterans that are not receiving care at VA. We want those veterans into the VA Healthcare System if there is any way, shape or form for us to get them.

There were things that we do—Gavin and I have been having this conversation because of some of the transformational work that he is doing. If we sat here and spent 30 minutes and talked about all of the things that VA does around mental healthcare, you would not realize. There is no healthcare organization in America, perhaps even in the world, that does the things, that has the capability that VA has. 550,000 completed mental health outpatient appointments every single month. I mean, all of the ancillary support services that we alluded to earlier.

Mr. WALZ. I would argue with you on that. I think this is a very important point you are bringing up and this is why that simultaneous——

Mr. GIBSON. Thank you very much.

Mr. WALZ [continuing]. Accountability with improvement, if I could, Senator Johnson, just end with this, that we as a Nation need to not talk about those 22. We do not need to set expectations that this is an outcome that is going to happen. We have to talk

about names and individuals, so when we are talking about the mistake here, it is Jason and his family.

Mr. GIBSON. Yes.

Mr. WALZ. What we are going to produce in the future is that individual and I think that attitude——

Mr. GIBSON. Yes.

Mr. WALZ [continuing]. Takes us in a better direction.

Mr. GIBSON. Yes.

VOICE. Thank you, sir.

Senator JOHNSON. Thank you, Congressman Walz.

I want to be respectful of everybody's time here. Another round of questions would definitely eat into that time, so I certainly encourage the Members of the Committee here and the Congressmen to certainly submit their questions for the record. I am sure we all have additional questions.

I want to thank our witnesses, but I particularly want to thank the families that have suffered this tragedy and the whistleblowers for coming forward and having the courage to make this public. I know it is not all that easy, but this is what transparency is all about. It is what really does produce the kind of accountability that, and justice that really is deserved here.

So, with that—I know I have the magic words here somewhere. I have them.

The hearing record will remain open for 15 days until June 15, at 5:00 p.m. for the submission of statements and questions for the record.

This hearing is adjourned.

[Whereupon, at 11:49 a.m., the Committee was adjourned.]

APPENDIX

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.

Statement of Ranking Member Tom Carper:
"Tomah VAMC: Examining Patient Care and Abuse of Authority"

WASHINGTON – *Today, the U.S. Senate Committee on Homeland Security and Governmental Affairs held the hearing, "Tomah VAMC: Examining Patient Care and Abuse of Authority." Ranking Member Tom Carper (D-Del) submitted the following statement for the Record:*

First, I want to thank Chairman Ron Johnson and Senator Tammy Baldwin for working together to address the serious issues at the Tomah VAMC and for holding this important hearing today.

Having served 23 years in the U.S. Navy – five years in a hot war in Southeast Asia, and 18 years in a cold war on reserve duty – I deeply appreciate the sacrifices that veterans have made for our country. I strongly believe that the benefits that the federal government provides to America's veterans are not gifts, but rather entitlements that they've earned as a result of their courage and sacrifice. So I take the reports in recent years of misconduct and poor management at the Veterans Health Administration system seriously.

Fortunately, Congress has taken some action to address the widely-reported problems the VA has been dealing with. I was pleased to support the Veterans Access, Choice, and Accountability and Transparency Act that was signed into law in 2014. This legislation took several steps to hold accountable those responsible for wrongdoing in the Department of Veterans Affairs, and expand and improve healthcare services for veterans. It was a good step forward, but we need to remain vigilant to ensure that the Department of Veterans Affairs is taking appropriate action to fix what went wrong and ensure that our veterans aren't put at risk due to poor care again.

So I was deeply troubled to learn last year about allegations of poor treatment and a management 'culture of fear' at the U.S. Department of Veterans Affairs Medical Center (VAMC) in Tomah, Wisconsin. A January 2015 report from the *Center for Investigative Reporting* described a disturbing and heartbreaking situation that put veterans in harm's way at a place that should be helping them. The report highlighted troubling prescribing practices at the facility and a management environment that failed to adequately address concerns raised by employees about those practices.

Shortly after the release of this report, Chairman Johnson directed his staff to begin an investigation into many of the issues highlighted in the *Center for Investigative Reporting* report. My staff and Senator Baldwin's staff participated in the Committee's investigation, including interviews with 22 individuals with knowledge of the situation at Tomah.

During the Committee's investigation, our staffs learned about an environment at Tomah, especially in the Tomah VAMC's pharmacy and among senior leadership at the facility, that made it difficult for medical providers to freely communicate and collaborate to further patient care. We also learned that some providers' prescribing practices hurt the veterans they were charged with helping.

The death of Marine Jason Simcakoski, who passed away at the facility after seeking treatment for complex mental health issues, comes to mind as one of the most powerful and tragic instances of the kind of poor care provided at the Tomah VA.

Chronic understaffing, a shortage of qualified mental health care professionals, and a lack of adequate oversight over the leadership at the Tomah VAMC may have contributed to some of the issues we identified. In addition, our staff found that the VA OIG's decision to administratively close an investigation it conducted at Tomah without publicly releasing a report made it more difficult for the VA and the public to identify and correct what was going wrong.

The VA conducted its own investigation into the prescribing and management practices at the Tomah VAMC. On March 10, 2015, the agency released a memo detailing its preliminary findings that largely mirrored ours. The report showed that unsafe clinical practices in areas such as pain management and psychiatric care could be at least partially attributable to prescribing practices at the facility. The report also confirmed that the reported 'culture of fear' did compromise patient care and hurt staff morale.

All of that said, I should note that the VA has taken a series of steps to address the issues at Tomah and to try and restore the trust of veterans who rely on the facility. The former Director and Chief of Staff at the facility has been fired and the new leadership there has put into place a number of reforms and new initiatives, including an aggressive recruitment campaign intended to bring qualified physicians on board. Other steps have been taken to improve access to care, improve the culture, encourage open communication between leadership and front line employees, and provide additional tools for providers at the facility. I am encouraged by these initial steps and am optimistic that the quality of care and management practices will improve over time.

I should also note that Chairman Johnson and Senator Baldwin have introduced legislation that would protect whistleblowers at the VA and provide safer and more effective pain management services to our nation's veterans. I commend them both on their efforts, and thank them as well for working with me in the Senate to swiftly confirm our new VA Inspector General, Mr. Michael Missal. My hope is that Mr. Missal can learn from what happened at Tomah and take action as necessary to ensure that the problems that plagued the Tomah VAMC are adequately addressed there and at VA facilities nationwide.

I would like to close with a personal experience that I first had when visiting the VA in Delaware. I visited the Veterans Hospital near Wilmington, Delaware shortly after enrolling in graduate school at the University of Delaware in September 1973 to find out what services were available to me as a veteran of the Vietnam War. The hospital, built just after World War II, was at that time not one that Delaware or its veterans could be proud of. In the years since, I've worked to improve the quality of care offered to veterans in Delaware and make sure that our hospital is one we could be proud of I'm proud to say that we've made some progress. We've expanded access to care in the state with clinics in Dover and Georgetown that serve thousands of veterans. And if you talk to the veterans in Delaware who use the VA, for the most part they tell you that the people who work there are caring, dedicated men and women who are committed to giving veterans the kind of care they deserve. My hope is that the actions taken by

the VA in response to the issues raised at the Tomah VAMC, including some of the reforms put in place by the new leadership there, will go a long way in restoring trust and a high quality of care for our veterans in Wisconsin.

As I've said before, fixing the problems at the VA isn't a partisan issue. It's a shared responsibility among Congress, the Administration, and the VA's leadership. We must continue to work together to improve veterans' access to health care and to restore both veterans' and taxpayers' trust in the VA. It is my hope that we can learn from what happened at Tomah and ensure that reforms are put in place to prevent them from occurring to other veterans and their families.

Opening Statement of Senator Tammy Baldwin
"Tomah VAMC: Examining Patient Care and Abuse of Authority"

Tuesday, May 31, 2016

As submitted for the record:

Thank you, Chairman Johnson. I want to thank you for organizing this hearing today and I also want to add my words of appreciation to your staff, Senator Carper's staff and to my staff in terms of the undertaking that resulted this work product. It is a very significant investment on their part and we appreciate that.

I think the fact that we are both here again today sends an important message to this community that we share a bipartisan commitment to addressing problems at the Tomah VA and that we will continue to work across the partisan aisle in order to address the problems at the Tomah VA. In fact, I would describe it as, there is no aisle.

This weekend, I had the honor of attending a Memorial Day ceremony in Union Grove. Across Wisconsin and in communities across our nation, Americans joined together to pay tribute to everyday heroes who served and sacrificed to protect freedoms that we all cherish.

As Americans, we are united. We are united by an eternal bond with the families and friends of our fallen. We are also united by the sacred trust that we have with our veterans and their families.

I will say this, when you look into the eyes of our American patriots – our veterans, our service members or a family member who lost one to the ultimate sacrifice, you are reminded of the American values that hold us together. You are reminded of the values that define us as one nation united.

Today, as we hear the story of how that sacred trust with our veterans and their families has been broken, it's important for us to keep in mind what unites us.

One profound thing that I have learned about the tragic problems at the Tomah VA is that Veterans, their families and whistleblowers all want the same thing.

They want answers and accountability, but most importantly, they want solutions to the problems at the Tomah VA so that these tragedies never ever happen again.

What I am committed to is fixing what has been broken. What I am focused on is restoring the sacred trust we have with our veterans and their families.

The Committee's report makes clear much of what we have known for some time – the problems at the Tomah VA have had tragic and preventable consequences.

The report sheds light on the failures surrounding the deaths of Kraig Ferrington, Dr. Christopher Kirkpatrick, Jason Simcakoski and Thomas Baer. What this report can never do is repair the damage that their losses have had on their families, many of whom are here with us today.

The Committee's report also confirms the report released by the Department of Veterans Affairs Office of Inspector General last August that found the Tomah VA leadership and physicians entrusted with veterans care failed to keep their promise to a Wisconsin Marine and his family.

It's just as clear to me today, as it was a long time ago, that the VA prescribed Jason Simcakoski a deadly mix of drugs that led to his death. And those responsible at the Tomah VA for this tragic failure should have been held accountable long ago. In fact, they should have been held accountable before Jason's death.

The actions taken by the VA last September to replace Mario DeSanctis, the Director of the Tomah VA, were long overdue.

The actions taken by the VA last November to remove David Houlihan, the Tomah VA Chief of Staff, from federal employment and revoke his clinical privileges came tragically too late.

Both the VA and the VA Inspector General failed to do the job that we all expect them to do.

The result of this failure was a culture of abuse of authority, staff intimidation and retaliation by management of employees. The problem of improper prescribing practices, overmedication and high rates of dangerous drug combinations was simply not properly addressed as it should have been. The result of this failure was tragic.

The record is clear. For far too long, serious problems have existed at the Tomah VA and they were simply ignored or not taken as seriously as they should have been by the VA and the VA Inspector General.

My office was just one of many voices who were trying to expose the problems at the VA.

When my Senate office was first contacted in March 2014 with complaints about the Tomah VA, including prescribing practices, they came from an anonymous whistleblower, someone who still remains anonymous today.

We immediately brought those concerns to the Tomah VA and then to the VA Office of Inspector General, and then to the U.S. Department of Veterans Affairs headquarters in Washington D.C.

Four months prior to Jason's death, I called for a full review and investigation from the Tomah VA.

Two months prior to Jason's death, I called for a full review and investigation from the U.S. Department of Veterans Affairs and the VA Office of Inspector General.

On August 30, 2014, Jason tragically died at the Tomah VA as a result of what was medically deemed, "mixed drug toxicity."

The Simcakoski family lost a son, a husband, a father, and we lost somebody who faithfully served his country.

If there is one thing that I want to come out of this hearing and one thing that comes from this report, I want it to be this.

I want everyone to hear the voice of Jason's wife Heather, who has said, and I quote:

"*When I look back at the past, I want to know we made a difference. I want to believe we have leaders in our country who care. I want to inspire others to never give up because change is possible.*"

Jason's family, just like veterans and their families in this community and communities across Wisconsin, are not interested in finger pointing and a blame game. Neither am I.

That is why over the past year I have focused on solutions to problems at the VA.

I have worked across party lines to advance reforms that will improve transparency at the VA Office of Inspector General, to strengthen protections for whistleblowers and to provide stronger oversight of the VA's prescribing practices.

I authored a reform that was recently signed into law which requires the VA Inspector General to submit reports to Congress and make them available to the public. That is the standard that must now be met.

More must be done to change the status quo at the VA. We must work to build a VA that embraces, rather than retaliates against, whistleblowers who want to improve the system. I have a tremendous amount of respect for the courage of whistleblowers that have come forward about problems at the VA.

Last year, I had the honor of working with Jason's family to develop legislation to provide the VA with the tools it needs to help prevent this type of tragedy from occurring to other veterans and their families.

One year ago, I introduced this bipartisan legislation in Jason's name that earned the support of many veterans service organizations and I'm so proud, Senator Johnson, to have you join in this effort.

I am pleased that House of Representatives recently passed a version of Jason's bill and I am equally grateful to members of the Senate Committee on Veterans' Affairs for their bipartisan support of Jason's bill, the Jason Simcakoski Memorial Opioid Safety Act. It's a critical reform and it continues to move forward. Families like Jason's have a story to tell and it needs to be heard, and the movement of their legislation is strong evidence that their voice is being heard.

My goal is to put these reforms in place to prevent Jason's tragedy from ever happening to another veteran or any of our veterans' families.

Change is indeed possible. Heather's words have inspired me and it is my hope that they will inspire all of us to work together and prevent these problems and tragedies from ever happening again.

I thank you, Senator Johnson, for providing me with this opportunity to join you today. I look forward to continuing our work together.

STATEMENT OF WITNESS
SLOAN D GIBSON
DEPUTY SECRETARY
DEPARTMENT OF VETERANS AFFAIRS (VA)
BEFORE THE
SENATE COMMITTEE ON
HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS

MAY 31, 2016

Good morning, Chairman Johnson, Ranking Member Carper, and Members of the Committee. Thank you for the opportunity to speak about the quality and culture of care at the Department of Veterans Affairs Medical Center (VAMC) in Tomah, Wisconsin. I look forward to sharing with you the progress we have made with patient safety, employee engagement, leadership changes, and improvements in opioid safety and pain management. I am accompanied today by Dr. Gavin West, Senior Medical Advisor, Clinical Operations.

Since our March 30, 2015, hearing, we have worked closely with the Wisconsin Congressional delegation and this Committee to investigate harms experienced by Veterans served by the Tomah VA Medical Center (VAMC) and to hold individuals accountable. In addition, we focused efforts on improvements in mental health, pain management, and culture and working environment. Identifying and addressing challenges is vital to our mission, as is responding to the needs of our dedicated employees.

Tomah VAMC

On January 15, 2015, a physician and nurse practitioner were relieved of their clinical care duties and the ability to prescribe any medications pending the outcome of all investigations. In response to whistleblower allegations of unsafe clinical care and prohibited personnel practices at the Tomah VAMC, on January 23, 2015, Dr. Carolyn Clancy, who was the Interim Under Secretary for Health at the time, charged a clinical review team comprised of leading experts outside the facility and network to assess practice patterns, controlled substance prescribing habits, and administrative

interactions between subordinates and clinical leadership related to opioid prescribing practices.

On March 10, 2015, VA released key findings and recommendations of its initial clinical review into opioid prescription practices at the Tomah VAMC. The team made specific findings relating to overall opioid utilization at the Tomah VAMC and found that an apparent culture of fear at the facility compromised patient care and impacted staff satisfaction and morale. Based on these preliminary findings, the team recommended that VA consider a more in-depth evaluation of the clinical and administrative practices at the Tomah VAMC. Additional cases were brought to the review team's attention, with a second in-depth clinical review being conducted by Lumetra, an external quality improvement organization, beginning on March 11, 2015. Investigators from the independent VA Office of Inspector General (OIG) and the Department of Justice's Drug Enforcement Agency have also been on site.

We are deeply concerned and distressed about the allegations that employees who sought to report deficiencies at the Tomah VAMC were ignored, or worse, intimidated into silence. VA will not tolerate intimidation or suppression of concerns. An administrative review team examined allegations of retaliation against employees and other accountability issues related to Tomah VAMC leadership. The clinical review teams identified patient safety concerns for some patients at Tomah VAMC based on opioid prescribing practices outside generally-accepted standards of care. Two physicians were terminated, and two other personnel resigned.

In order to create a more transparent culture and improve communication with Tomah VAMC employees, leadership has taken a number of actions, including town hall meetings, supervisory forums, and expanded all-employee communications. These were to provide staff support and guidance on how employees can directly and confidentially contact and communicate with the team conducting the investigations. In addition to actions taken to address culture and communication, the Tomah VAMC initiated a number of actions to address opioid/pain management issues. Providers transitioned to using an expanded urine drug screen, and facility clinical leadership is updating their pain management policies. Electronic patient record tools were deployed system wide in March 2015 to make pain management information, including adherence

to recommended practices, individual risks associated with other medications and clinical problems, and impact on pain scores, more easily accessible during patient visits. The facility hosted a regional conference on improved pain management, led by national experts, in June 2015.

We have seen tangible improvements; from January 2015 to December 2015, there has been a 16-percent reduction in the number of patients receiving opioids and benzodiazepines together across VA. During the same time frame, Tomah VAMC has achieved a 27-percent reduction.

Veterans Health Administration (VHA)

As the Nation's largest integrated health care system, VA recognizes that challenges confronting any facility may reflect issues occurring throughout VA as well as in health care across the U.S. Chronic pain has an especially profound impact on the Veteran population. Almost 60 percent of returning Veterans from service and more than 50 percent of older Veterans in the VA health care system live with some form of chronic pain. Moreover, the treatment of Veterans' pain is often very complex. Many of our Veterans have survived severe battlefield injuries, some repeated, resulting in life-long moderate to severe pain related to damage to their musculoskeletal system and permanent nerve damage, which can impact their physical abilities, emotional health, and central nervous system. VA is committed to reducing overreliance on opioid medicines, especially in light of the severe negative consequences many patients on opioids risk.

Current VHA Pain Management Collaboration

To implement effective management of pain, VHA's National Pain Management Program oversees several work groups. A National Pain Management Strategy Coordinating Committee includes representatives from the VHA Offices of Nursing, Pharmacy, Mental Health, Primary Care, Anesthesia, Education, Integrative Health, and Physical Medicine and Rehabilitation. Working with the field, these groups develop, review and communicate strong pain management practices to VHA clinicians and clinical teams.

The Opioid Safety Initiative (OSI) Toolkit Task Force has published and promoted 15 evidenced-based documents and presentations to support provider education in OSI through Academic Detailing. More information on the OSI Toolkit can be found at the following link: (http://vaww.va.gov/PAINMANAGEMENT/index.asp). The Department of Defense (DoD)-VA Health Executive Council's Pain Management Workgroup (PMWG) oversees joint projects with DoD that aim to standardize high-quality pain care across DoD and VHA.

VA's Progress in Pain Management

Chronic pain management is challenging for Veterans and clinicians. VA continues to focus on identifying Veteran-centric approaches that can be tailored to individual needs and remains committed to using non-pharmacologic measures as well as medications safely. Opioids are an effective treatment, but their use requires constant vigilance to minimize risks and adverse effects. VA launched a system-wide OSI in October 2013 and has seen significant safety improvement in the use of opioids, both in terms of the number of Veterans on chronic opioid therapy and the absolute doses. The Specialty Care Access Network-Extension for Community Healthcare Outcomes (SCAN-ECHO) and the OSI have been designed to integrate with our Academic Detailing which is a proven method in changing clinician behavior by providing educational outreach to address a difficult medical problem in a population. Academic Detailing combines longitudinal monitoring of clinical practices, regular feedback to providers on performance, and education and training in safer and more effective pain management.

Rigorous investigations take time, but we did not wait for the completion of the investigation to take action to improve care both at Tomah VAMC and across the system. In March 2015, we launched the new Opioid Therapy Risk Report tool, which provides detailed information on the risk status of Veterans taking opioids to assist VA primary care clinicians with pain management treatment plans. This tool is a core component of our reinvigorated focus on patient safety and effectiveness. VA's own data, as well as the peer-reviewed medical literature, suggest that VA is making progress relative to the rest of the Nation. In December 2014, an independent study by

RTI International health services researcher, Mark Edlund, MD, PhD and colleagues, supported by a grant from the National Institute on Drug Abuse, was published in the journal *PAIN*. This study, using VHA pharmacy and administrative data, reviewed the duration of opioid therapy, the median daily dose of opioids, and the use of opioids in Veterans with substance use disorders and co-morbid chronic non-cancer pain.
Dr. Edlund and his colleagues found the following:

- About 50 percent of Veterans with chronic non-cancer pain in this cohort received an opioid as part of treatment;
- Half of all Veterans receiving opioids for chronic non-cancer pain, are receiving them short-term (i.e., for less than 90 days per year);
- The daily opioid dose in VA is generally modest, with a median of 20 Morphine Equivalent Daily Dose (MEDD);
- The use of high-volume opioids (in terms of total annual dose) is not increased in VA patients with substance use disorders as has been found to be the case in non-VA patients.

By virtue of VA's central national role in medical student education and residency training of primary care physicians and providers, VA will be playing a major role in this nationwide transformation effort. But we have already started with our robust education and training programs for primary care, such as SCAN-ECHO, Mini-residency, Community of Practice calls, two Joint Incentive Fund (JIF) training programs with DoD, and dissemination of the OSI Toolkit.

The Opioid Safety Initiative (OSI)

OSI was implemented nationwide in August 2013. OSI's objective is to make the totality of opioid use visible at all levels in the organization. It includes key clinical indicators such as the number of unique pharmacy patients dispensed an opioid; unique patients on long-term opioids who receive a urine drug screen; the number of patients receiving an opioid and a benzodiazepine (which puts them at a higher risk of adverse events); and the average MEDD of opioids. Results of key clinical metrics for VHA measured by OSI from Quarter 4, Fiscal Year (FY) 2012 (beginning in July 2012) to Quarter 2, FY 2016 (ending in March 2016) are as follows:

- 151,982 fewer patients receiving opioids (679,376 patients to 527,394 patients, a 22-percent reduction).
- 51,916 fewer patients receiving opioids and benzodiazepines together (122,633 patients to 70,717 patients, a 42-percent reduction);
- 94,045 more patients on opioids that have had a urine drug screen to help guide treatment decisions (160,601 patients to 254,646, a 37-percent increase);
- 122,065 fewer patients on long-term opioid therapy (438,329 to 316,264, a 28-percent reduction);

Also, the overall dosage of opioids is decreasing in the VA system as 18,883 fewer patients (59,499 patients to 40,616 patients, a 32-percent reduction) are receiving greater than or equal to 100 MEDD, a figure associated with greater overdose risk[1]. It is important to note that these desired results of the OSI have been achieved during a time in which VA has seen an overall growth of 136,944 patients (3,959,852 patients to 4,096,796 patients, a 3-percent increase) that have utilized VA outpatient pharmacy services.

The OSI dashboard metrics indicate that overall trends are moving steadily in the desired direction. OSI is being implemented in a measured way to give VA time to build the infrastructure and processes necessary to allow VA clinicians to incorporate new pain management strategies into their treatment approaches. A measured process will also give VA patients time to adjust to new treatment options and to mitigate any patient dissatisfaction that may accompany these changes.

VA expects this trend to continue as it renews its efforts to promote safe pain management therapies. VA intends to implement safe opioid prescribing training for all prescribers; 70 percent of prescribers have received training to date.

Psychotropic Drug Safety Initiative

The Psychotropic Drug Safety Initiative (PDSI) is a VA nationwide psychopharmacology quality improvement (QI) program that was launched in December 2013, with the aim of improving the safety and effectiveness of psychopharmacologic treatment across VA. The initial Phase 1 program broadly looked across multiple

[1]Liang Y1, Turner BJ2. Assessing risk for drug overdose in a national cohort: role for both daily and total opioid dose? J Pain. 2015 Apr;16(4):318-25. doi: 10.1016/j.jpain.2014.11.007. Epub 2014 Dec 5. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4385393/

classes of medications and mental health diagnoses. Facilities, on average, identified 3 prescribing measures from among the 20 that served as the focus for their local QI efforts during Phase 1 (priority measures). Facilities were required to prioritize any measure where local performance was a significant outlier compared to the rest of the VA system (defined as local score > 2 standard deviations worse than the national score), but were otherwise given the freedom to identify their own local priorities. Key components of the program implemented during Phase 1 included the following:

- Providing quarterly data on national, Veterans Integrated Service Network (VISN), and facility-level performance on prescribing measures to participants;
- Facilitating clinical review of treatments for Veterans who may benefit from improvement in their psychotropic medication regimen via actionable patient lists updated daily on the PDSI Clinical Management Dashboard;
- Providing feedback and technical assistance to VISNs and facilities for QI action planning;
- Coordinating a national QI learning collaborative; and
- Developing and disseminating training and educational resources.

Since its implementation, the PDSI program has had a robust and positive impact on the care of Veterans. Out of the 20 prescribing metrics tracked in the initial phase of the program, 16 showed improvement in the national score.

There are several areas of prescribing that showed especially strong improvements. Across the system we have decreased use of potentially harmful medications in patients with Posttraumatic Stress Disorder (PTSD), including decreased use of benzodiazepines, antipsychotics, and the use of complex, multiple-drug regimens. We have also decreased the use of benzodiazepines among vulnerable populations, such as Veterans with PTSD or dementia and the elderly, as well as decreased the use of complex, multiple-drug regimens for patients with depression. We have also successfully increased the use of evidence-based medications for treatment of substance use disorders, particularly in Veterans with alcohol and opioid addiction. These improvements have directly and positively impacted the care of thousands of Veterans.

Overdose Education and Naloxone Distribution (OEND)

VA has also undertaken a national initiative to make overdose education and naloxone rescue kits available to patients at risk of accidental or intentional overdose. Naloxone can reverse an opioid overdose, preventing overdose death and morbidity when administered in a timely manner. Distribution of overdose rescue training and naloxone kits is a novel intervention within health care settings, and it is being rapidly adopted by VA. To date, 3,945 VA providers have begun prescribing these kits to at-risk patients, with over 23,330 patients receiving training and kits. Additionally, 172 opioid overdose reversals have been voluntarily reported with the naloxone VA prescribed, demonstrating the potential lifesaving effects of these efforts.

VA has developed a predictive model and clinical decision-support tool to identify patients with opioid prescriptions at risk of suicide-related events and overdose. This Stratification Tool for Opioid Risk Mitigation is available nationally, and it estimates the likelihood of an overdose or suicide event in the next year, providing patient-tailored recommendations for risk mitigation and non-opioid pain management options. VA has continued its efforts to ensure that effective substance use disorder treatments are available for patients with substance use disorders, knowing that they have an elevated risk for suicide and overdose. Greater engagement in VHA substance use disorder programs is associated with lower suicide attempt risk and reduced criminal behavior in Veterans initiating substance use disorder treatment. VHA continues to increase availability of specialty substance use treatment, increasing the number of patients treated per year with specialty treatment services and with opioid antagonist treatment for opioid use disorders.

National Take-Back Initiative

In September 2014, the Drug Enforcement Administration (DEA) published in the Federal Register a final rule, effective October 9, 2014, to implement the Secure and Responsible Drug Disposal Act of 2010. This rule provides three voluntary methods for ultimate users (e.g., Veterans) to dispose of their unwanted/unneeded medications in a secure and responsible manner: 1) Mail Back Packages, 2) On-site Collection Receptacles, and 3) Take Back Events. VA has been a leader in implementing these options for Veterans. We have on-site receptacles in over 70 locations and mail-back

envelopes available at all facilities. Services have been actively marketed to Veterans through the use of facility flyers and with information on MyHealtheVet and on the VA Pharmacy MedSafe website. Both Veterans and staff report a high level of satisfaction with this service, and as of May 1, 2016, approximately 27,000 pounds, almost 14 tons, of unwanted/unneeded medication have been collected and destroyed in an environmentally responsible manner. Removal of this medication from Veterans' homes reduces the risk of diversion as well as intentional and unintentional overdoses and poisonings.

Accountability

In January 2015, the *Milwaukee Journal Sentinel* and other publications ran an article about over-prescription of painkillers by the then-Chief of Staff of the Tomah VAMC, who is a psychiatrist, and cited several former Tomah employees' complaints about retaliatory behavior after they questioned the Chief of Staff's prescribing practices. The article also cited an unpublished March 2014 VA OIG "administrative closure" report finding the Chief of Staff's prescriptions were "at considerable variance compared with most opioid prescribers" and "raised potentially serious concerns." In response to this, we acted quickly to prohibit the Chief of Staff and an affiliated nurse practitioner from providing care to Veterans and initiated a comprehensive evaluation of the quality of the care they provided. The then-interim Under Secretary for Health ordered a series of three clinical reviews to assess practice patterns, prescribing habits, and staff interactions at Tomah. In reports issued between March and August 2015, these review teams found that the Chief of Staff's prescriptive practices were potentially unsafe and that an apparent culture of fear existed at the Tomah facility which compromised patient care and damaged staff satisfaction and morale. Simultaneously, the VA Office of Accountability Review began a series of administrative investigations into alleged mismanagement by Tomah VAMC leadership. Those reviews led to a number of leadership changes at the Tomah facility. The Chief of Staff lost his clinical privileges and was removed from Federal employment; his removal is currently pending appeal. The former Medical Center Director and Associate Director both resigned. Victoria Brahm is the Acting Tomah VAMC Director. Ms. Brahm and her predecessor,

John Rohrer, worked closely with facility leaders, union leaders, employees, and external stakeholders (including Veterans Service Organizations) to ensure that ongoing investigations did not disrupt clinical care and that all voices were heard.

Organizational Excellence

VA acknowledges its failures in the Tomah VAMC and is committed to preventing situations like this in the future. VA has strategically aligned specific program offices to ensure that our Nation's Veterans receive the highest quality health care. These aligned offices were incorporated into the Office of the Deputy Under Secretary for Health for Organizational Excellence. This new office brings together vital portions of VA to focus on assessing and improving quality and safety and to provide the field and leadership with analytics and tools to assess how we are performing as an organization. The office synthesizes information from internal and external oversight activities to promote a strong, ethical, and just culture that builds trust and confidence in Veterans health care. The office aims to achieve continuous improvement in health care system performance by integrating oversight, compliance, and accountability functions. The office conducts internal oversight activities such as investigations, audits, risk assessment, and business compliance in accordance with VA policy and industry standards and proactively identifies system vulnerabilities and manages risk across clinical, administrative, business, and financial domains in order to improve organizational efficiency and effectiveness. Because of this new office's oversight and safeguards, VA is better positioned to mitigate the risk events like those that took place in the Tomah VAMC.

Actions since the 100-Day Plan

Over the course of the last year, the Tomah VAMC has undergone many changes and continues to make improvements. Most recently, the Tomah VAMC has taken a series of actions during a 100-day period (November 27, 2015, through March 6, 2016) to enhance the Veteran experience within the medical center and create an environment of sustainable accountability that rebuilds trust with Veterans and the American people. The Veteran experience is at the forefront of all we do and cannot be

decoupled from the employee experience. Improving the employee experience will positively impact the Veteran experience. We continue to strive to create an organization that both Veterans and employees can be proud to call "MyVA." Tomah VAMC leadership has expanded upon initial efforts and delivered a shared strategic direction for the medical center in January. These objectives are designed to improve and standardize the patient experience, making Tomah VAMC the facility of choice for Veterans:

- The FY 2015 All Employee Workforce Satisfaction and Organizational Climate Survey for Tomah VAMC reported nearly all scores were below the national average. Surveys to date demonstrate improvement in 8 of 10 survey areas, meeting or exceeding the national average in half.
- Employee Town Halls are conducted monthly. MyVA initiatives are delivered by leadership to staff members monthly. More than 15 Employee Listening Sessions were held during the 100-Day Plan; they are now conducted monthly.
- Medical center leadership is committed to instituting an Employee Renewal Center to assist in combatting compassion fatigue. The Center opened to staff on Monday, May 16, 2016. This non-clinical area has been dubbed by employees as "R Place."
- Resources have been provided for managers to create a Personal Development Plan (PDP). More than 85 managers and local American Federation of Government Employees (AFGE) officers have completed a PDP during the "Leaders Developing Leaders" curriculum.
- Patient Centered Care training continues for new hires and staff. The goal is for 75 percent of staff to be trained by the end of the year and to create awareness and unity among staff members by sharing the patient perspective.
- VA's Office of Resolution Management was on site February 23-25, 2016, and held supervisor training sessions and two all-employee training sessions on "Conflict Management" and "Alternative Dispute Resolution."

VA has also taken several steps to focus on the importance of and improvement of leadership-employee interactions. VA recognizes that accountability, visibility, and communication are central for effective relationships between supervisors and employees. VA has emphasized the importance of, and has tracked rounding and monthly staff meetings. In January and February 2016, supervisors met more than 90 percent of rounding opportunities. Re-establishing a culture of trust within the medical center was also a significant priority. During the 100-Day Plan, we provided

Psychological Safety Training on Harassment and Workplace Bullying to supervisors and frontline staff. Additionally, 85 managers, supervisors, and local AFGE officers completed the "Leaders Developing Leaders" curriculum.

An additional part of this effort was to educate supervisors and managers on increasing the quality of staff evaluations through training at the Supervisor's Forum, and this will continue during an upcoming 3-day supervisors' course. Previous results from All Employee Surveys noted a lack of staff recognition and praise. To address this, the "Employee of the Quarter" program was increased to "Employee of the Month" with a panel of frontline employees managing the process and determining who is selected. Other efforts include a "Recognition Toolkit" created for supervisors and non-supervisors. More Patient Experience Cards were displayed and shared, and employees were recognized in the Acting Medical Center Director's weekly message. "Management by Walking About" is practiced by medical center leadership consistently walking through the medical center and being available for impromptu discussions with employees and Veterans. Also, in January 2016, the Acting Associate Director for Patient Care Services began hosting quarterly Nurse Town Hall Meetings.

Whistleblower Protection

VA recognizes the important role that whistleblowing plays in bringing significant issues to light. I was and am personally invested in ensuring that the quality of care at Tomah VAMC is the best available and that any and all circumstances that led to problems at the Tomah VAMC have been diagnosed and fixed. In addition to the many formal feedback mechanisms VHA has built into our system, we need and want all employees and Veterans to feel empowered to provide a first-hand account of their experiences so that we can identify and rectify any problems. The underlying purpose of whistleblower protection rules is to encourage the candid disclosure of information about problems so that deficiencies are corrected, and unsafe or unlawful behavior is quickly rectified.

There are legal disciplinary options for supervisors who retaliate against whistleblowers; they exist to support the primary focus on the flow of information, including information on quality, safety, or process improvement. VA is fully committed

to correcting deficiencies in its processes and programs and to ensuring fair treatment for whistleblowers that bring these deficiencies to light. Secretary McDonald consistently communicates his vision of "sustainable accountability," which he describes as a workplace culture where VA leaders provide the guidance and resources employees need to successfully serve Veterans, and employees are empowered and encouraged to inform VA leaders when challenges hinder their ability to succeed. All VA employees should feel safe sharing what they know, for the benefit of Veterans and as good stewards of the taxpayers' money.

The Department has taken steps to improve how we address operational deficiencies and protect whistleblowers from retaliation. In July 2014, I reorganized and assigned new leadership to the VA Office of the Medical Inspector (OMI). OMI moved quickly to ensure that whistleblower disclosure allegations were investigated objectively, thoroughly, and promptly. Since then, OMI has completed more than 70 initial and supplemental investigation reports in 2015. When an investigation substantiates the whistleblower's disclosure allegations, OMI and Office of Special Counsel (OSC) work closely to track the status of corrective actions to completion.

VA and OSC also created a process that provides for prompt corrective action, referred to as the "expedited process," with relief provided to whistleblowers within who have been retaliated weeks of referral, instead of months. This approach allows OSC and VA to work together to reduce duplicate investigations and to quickly protect whistleblowers from retaliation. As of May 2015, VA had received 28 expedited cases and successfully resolved 19 cases. Resolved cases have taken an average of 30 to 60 days to complete. Once cases are resolved under the expedited process the cases are forwarded to the Office of Accountability Review to determine if discipline is appropriate. VA has also improved its collaboration with OSC by training employees on investigating whistleblower retaliation cases and increasing the number who can work these cases.

VA understands that we can also improve on the timeliness of discipline for individuals found responsible for retaliation. One approach is for Congress to support OSC at a level that enables OSC to hire more investigators to complete this work. This would allow VA's limited investigative assets to focus more in VA's areas of expertise.

Because it is extremely important that VA hold its employees accountable, if they have retaliated against a whistleblower we welcome OSC's additional assistance on this front.

VA senior leaders, including myself, have made it their practice to meet with whistleblowers when traveling, and to engage with them to identify problems and propose solutions. I have personally participated in the public recognition of several whistleblowers, thanking them for their role in improving Veteran outcomes. This is to acknowledge the critical role whistleblowers play in improving the quality, safety, and effectiveness of VA programs, and to model to supervisors VA-wide the engaged, open, and accepting behavior they should exhibit when subordinates express concerns.

VA is still working toward the full culture change we must achieve to ensure that all employees feel safe disclosing problems, and that those who engage in retaliatory behavior are held promptly and meaningfully accountable. VA continues to work with whistleblowers, OSC, and Congress to resolve these issues, and we remain deeply committed to these endeavors.

Mr. Chairman, because of the events that took place at Tomah VAMC, VA has improved how we manage prescriptions nationwide. We will continue to strive for better employee engagement and accountable leadership, all in the name of fulfilling our mission to serve Veterans. I look forward to answering any questions you or the Committee may have.

STATEMENT OF
MICHAEL J. MISSAL
INSPECTOR GENERAL
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
COMMITTEE ON HOMELAND SECURITY
AND GOVERNMENTAL AFFAIRS
UNITED STATES SENATE
FIELD HEARING ON
"THE QUALITY AND CULTURE OF CARE AT
THE DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER
IN TOMAH, WISCONSIN"
MAY 31, 2016

Mr. Chairman and Members of the Congress, thank you for opportunity to appear today and discuss the Office of Inspector General's (OIG) past inspections at the Tomah VA Medical Center (VAMC), in Tomah, Wisconsin and the OIG's work in the area of pain management and opioid use. I am accompanied by John D. Daigh, Jr., MD, CPA, Assistant Inspector General for Healthcare Inspections.

On May 2, 2016, I was sworn in as the Inspector General. In the past four weeks, I have immersed myself in the work of the OIG to understand better the people, policies, workload, strategic goals and priorities of our office. I have been impressed with the commitment and efforts of the staff of the OIG to achieve its mission of bringing about positive change in the integrity, efficiency and effectiveness of VA operations. While my integration into the OIG has gone very well, I know there is much more to learn.

I recognize and strongly support three overriding principles for the OIG. First, we need to maintain our independence in all of our work, including avoiding even the mere appearance of any undue outside influence. Second, we need to be as transparent as possible in our work, while safeguarding the privacy of veterans, whistleblowers and others involved in our work. Third, we need to produce work of the highest quality. This includes making sure our work is accurate, timely, fair, objective and thorough.

In my first four weeks, I have also reviewed the previous work of the OIG with respect to our healthcare inspections of the Tomah VA Medical Center. Among other actions, I met with the staff of the Homeland Security and Governmental Affairs Committee to ensure they have the information about our work necessary for the issues to be covered in this hearing. My office has learned important lessons from the Tomah healthcare inspections that should help us better meet our mission going forward. The changes that we have made should increase the confidence that veterans, veterans service organizations, Congress and the American public have in the OIG.

BACKGROUND

In March 2011, the OIG Hotline received a complaint regarding prescription practices at the Tomah VAMC. We referred the allegations to the Director, Veterans Integrated Service Network (VISN) 12, VA Great Lakes Health Care System, who has managerial oversight of the Tomah VAMC. A copy of this referral was also sent to the office of the Veterans Health Administration (VHA) Chief of Staff. The VISN 12 Director provided a detailed response to the allegations on June 22, 2011. This response stated that 16 allegations involving over 30 patients were unsubstantiated. The VISN 12 Director substantiated two allegations involving two patients. As a result of this review, the VISN Director initiated an action plan to:

- Review refill policies at Tomah VAMC.
- Review Tomah VAMC policies regarding lab testing of patients on narcotics.
- Evaluate practice trends and approaches to pain management to ensure the needed variety of pain approaches is available to Tomah VAMC patients.
- Work with the Tomah Chief of Staff to evaluate pain approaches and the effectiveness of such.

Based on the VISN 12 Director's fact-finding efforts and commitment to take corrective action, we closed the complaint.

In August 2011, the OIG Hotline received a new anonymous complaint with similar allegations. Over the course of the next approximately two and a half years, the OIG Office of Healthcare Inspections conducted an extensive inspection of the allegations. This inspection included involvement from the OIG's Office of Investigations, the U.S. Drug Enforcement Administration, and Tomah and Milwaukee municipal police to determine if there was evidence of narcotic abuse at the Tomah VAMC. We reviewed patient medical records, peer reviews of providers' practice and pharmacy records. We conducted an undercover surveillance operation and reviewed email messages and associated files originating from numerous individuals. We interviewed current and former VA employees and conducted a site visit that included touring the outpatient pharmacy to assess security.

We could not substantiate the majority of allegations that the OIG received. Although the allegations dealing with the extensive use of narcotics at the facility may have had some merit, they did not constitute proof of wrongdoing. We did not find any conclusive evidence affirming criminal activity, gross clinical incompetence or negligence, or administrative practices that were illegal or violated personnel policies. We administratively closed the inspection on March 14, 2014 because we believed at the time that given the totality of the facts—paramount of which was that the allegations were not substantiated, the impact disclosure of unfounded allegations could have on an individual's reputation and privacy, and knowing that our forthcoming 2014 national report would highlight the many deficiencies in VA provider's compliance with opioid prescribing guidelines—an administrative closure was appropriate.

We noted several issues of concern and made suggestions to address these concerns to the Tomah VAMC Director and the VISN 12 Director. We conducted a telephone briefing with the Tomah VAMC Director, the VISN 12 Quality Management Officer, and the Organizational Improvement Analyst for the Tomah VAMC on July 3, 2014; and met in person with the VISN 12 Director on July 16, 2014, to discuss the following suggestions:

- The Facility Director should implement a vehicle by which clinicians and staff can openly and constructively communicate concerns and rationale when disagreements arise concerning dispensing of opioid prescriptions.
- The Facility Director should review the reporting structure in the context of safeguarding bi-directional clinical discourse from actual or perceived administrative constraint.
- The Facility Director should ensure development of guidance, parameters, processes, or a specialty clinic-based mechanism to assist clinicians and staff with managing complex patients requesting early opioid refills.
- The Facility Director should consider some variant of the tumor board model as one potential avenue by which to foster collaborative interdisciplinary management when presented with very complex clinical pain cases.
- The VISN should conduct further evaluation and monitoring of relative and case-specific opioid prescribing at Tomah VAMC on both a facility and individual clinician level.

After publication of a news story regarding this work in January 2015, we posted the administrative closure on February 6, 2015. We testified about the 2011 inspection we performed of the Tomah VAMC at a similar field hearing on March 30, 2015. We also provided Chairman Johnson and several other Members of Congress with a "white paper" on June 4, 2015 that was intended to highlight evidence obtained and reviewed during the OIG's 2011 Tomah VAMC inspection.

I do not agree with the tone of the white paper or the gratuitous attacks on the reputation of individuals included in it. Going forward, my office and I will work hard to ensure that all work from the OIG meets the high standards expected of our office.

Since the 2011 inspection, the OIG has conducted two additional inspections regarding allegations at the Tomah VAMC. On June 18, 2015, we issued *Healthcare Inspection – Care of an Urgent Care Clinic Patient, Tomah VA Medical Center, Tomah, Wisconsin.* We made nine recommendations in this report. The recommendations included three directed at the national level to review of policies for acute stroke treatment especially in rural and/or low complexity VA facilities, to improve processes for identifying unauthorized access to VA medical records, and to evaluate rules related to reimbursement for a veteran's emergency care at non-VA facilities.

The remaining six recommendations were directed to the Facility Director. They included providing proper education to veterans and their families about the services an Urgent Care Center is able to provide, providing proper training of staff regarding

treatment of stroke patients and Emergency Department Integration Software training, ensuring routine maintenance on equipment is scheduled during low utilization periods, and ensuring UCC processes are strengthened to improve triage timeliness. As of May 19, 2016, the recommendation that the Facility Director ensure that transfer agreements are established as required remained open.

On August 6, 2015, we issued *Healthcare Inspection – Unexpected Death of a Patient During Treatment with Multiple Medications, Tomah VA Medical Center, Tomah, Wisconsin.* We made four recommendations in this report. Two recommendations are closed. One recommended a further review by VISN leadership of the care provided and a consultation with the appropriate office on any administrative action. The other recommendation for the Acting Facility Director dealt with ensuring that emergency crash carts at the facility are properly stocked with appropriate medications. As of May 9, 2016, two remain open:

- Recommendation 2: The Veterans Health Administration requires written informed consent when administering hazardous drugs including buprenorphine. However, we did not find evidence of written informed consent for buprenorphine treatment. In this case, both psychiatrists involved in the ordering of buprenorphine for the patient acknowledged they did not discuss the risks inherent in off-label use of the drug with the patient. We recommended that the Acting Facility Director ensure compliance with applicable VHA policy that requires informed consent be obtained and documented.

- Recommendation 3: We recommended that the Acting Facility Director review elements needed to respond effectively to medical emergencies including staff training, equipment, and other resources at both the unit and the facility level and take any appropriate actions.

PAIN MANAGEMENT ISSUES

The use of opioids to treat chronic pain and other conditions continues to be a serious concern not just within VA but throughout the Nation. While opioids are considered an important part of pain management, they are also associated with serious adverse effects. Patients prescribed opioids frequently have complex comorbid conditions, making them more likely to be given multiple medications that can interact dangerously with opioid medications and potentially lead to death. Clinicians vary widely in their chronic opioid therapy prescribing practices within VA and the nation and there is little agreement regarding the appropriate use of opioids for treating pain, especially chronic non-cancer pain.

Recently, the OIG published two inspection reports addressing various aspects of VA opioid prescribing practices.[1] Our recent work on this topic identified many of the same

[1] *Healthcare Inspection—Poor Follow-Up Care and Incomplete Assessment of Disability, VA San Diego Healthcare System San Diego, California* (January 5, 2016); *Healthcare Inspection—Quality of Mental Health Care Concerns, VA Long Beach Healthcare System, Long Beach, California* (March 30, 2016).

issues we previously reported in our May 2014 national review, *Healthcare Inspection—VA Patterns of Dispensing Take-Home Opioids and Monitoring Patients on Opioid Therapy*. As the findings in our national report demonstrate, VA was not following its own policies and procedures in six key areas: acetaminophen prescription practices, follow-up evaluations of patients on take-home opioids, concurrent substance use treatment with urine drug tests, prescribing and dispensing of benzodiazepines concurrently with opioids, routine and random urine drug tests prior to and during take-home opioid therapy, and medication reconciliation.

We note that VA has taken actions to implement the recommendations in this report, but VA must be vigilant in monitoring facility compliance with opioid prescription policies. We are currently working on another national review that will review:

- VA's pain management services.
- VA's substance use treatment programs.
- VA's pain management educational efforts.
- Patterns of use of non-VA treatments.
- VA's opioid prescribing practices.
- Access to state prescription drug monitoring programs.
- Oversight of pain management patients.

We expect to publish our findings by the end of the year.

CONCLUSION

Yesterday, our nation paid tribute to the sacrifices of the women and men who gave their lives in our defense. It is a valuable reminder for all of us at the OIG to rededicate ourselves to ensuring that our work is independent, accurate, timely, fair, objective and thorough. We will publish the results of our efforts as permissible under law and will ensure that complainant names, patient records, and confidential sources are protected. We will also continue to review our practices and policies and make whatever additional enhancements are necessary to increase the confidence that veterans, veterans service organizations, Congress and the American public have in the work of the OIG. We thank the Committee for the opportunity to testify about these important issues during this most solemn time.

THE SYSTEMIC FAILURES AND PREVENTABLE TRAGEDIES AT THE TOMAH VA MEDICAL CENTER

Majority Staff Report of the
Committee on Homeland Security and Governmental Affairs
United States Senate
Senator Ron Johnson, Chairman

May 31, 2016

Executive Summary

The tragedies of the Veterans Affairs Medical Center in Tomah, Wisconsin (Tomah VAMC)—the veteran deaths, abuse of authority, and whistleblower retaliation—were preventable. The Department of Veterans Affairs (VA), the federal entity entrusted with protecting and supporting the finest among us, failed the veterans in and around Tomah, Wisconsin. That is the fundament truth to these tragedies. But the fault is not the VA's alone. The tragedies of Tomah were the result of systemic failures across the executive branch.

Precisely how a moderately sized VA facility in a western Wisconsin city came to become known as "Candy Land"—for its easy access to prescription medications—is unclear. Although the "Candy Land" moniker had been around for over a decade, and despite multiple investigations, the root causes were never addressed. Allegations of drug diversion, opioid over-prescription, retaliation, and mismanagement festered. As a result, veterans died.

In January 2015, an article published by the *Center for Investigative Reporting* exposed the realities of the Tomah VAMC. The article told the story of Jason Simcakoski, a 35-year-old Marine Corps veteran who passed away at the Tomah VAMC in August 2014 from a lethal cocktail of medication. It recounted allegations against the facility's chief of staff, Dr. David Houlihan—who veterans dubbed the "Candy Man"—relating to over-prescription, retaliation, and drug diversion. The article also exposed the existence of a then-secret report, written by the VA Office of Inspector General (VA OIG) and dated March 12, 2014, concerning the Tomah VAMC.

Days after the publication of the article, Senator Ron Johnson, Chairman of the Senate Committee on Homeland Security and Governmental Affairs, initiated a bipartisan investigation into the allegations surrounding the Tomah VAMC. The investigation has been comprehensive. Chairman Johnson requested documents from the VA, the VA OIG, and other federal agencies. Chairman Johnson's staff, along with staff of Ranking Member Tom Carper and Senator Tammy Baldwin, conducted in-depth transcribed interviews with current and former employees of the VA and the VA OIG. Chairman Johnson convened two hearings, including a field hearing in Tomah to hear directly from veterans and family members of those affected. Chairman Johnson even issued a subpoena to the VA OIG for documents relating to its work at the Tomah VAMC.

Chairman Johnson's investigation reveals new information about the Tomah VAMC. Although much is still unknown—the VA OIG continues to withhold material—one overarching conclusion is apparent. Federal executive branch entities missed several opportunities to prevent the tragedies at Tomah.

In 2002, the VA hired Dr. David Houlihan, and it promoted him in 2004 to be chief of staff of the Tomah VAMC. 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. Subsequently, during Dr. Houlihan's re-credentialing in 2009, suddenly "there was a lot of Houlihan attention" within the VA's regional office. The VA regional leadership finally ordered an examination of the Iowa allegations and determined that the issue was "resolved." It could have probed deeper into these allegations when Dr. Houlihan was hired or when he was promoted. It did not.

In the early morning hours of November 11, 2007, just a day after being discharged from the Tomah VAMC, veteran Kraig Ferrington passed away from "poly medication overdose." Consultants retained and peer reviews performed after his death showed deficiencies in the Tomah VAMC's medication management, with one consultant writing "there is a general concern regarding the number of medications [Mr. Ferrington] was on, and the potential interactions among them." Kraig Ferrington's death could have been an opportunity for the Tomah VAMC to revisit its prescription practices. It did not.

In January 2009, the local union for Tomah VAMC employees alerted the VA OIG about allegations of over-prescription at the facility. The union informed the VA OIG that there was "several staff whom, in their professional judgment, believe that Dr. Houlihan overmedicates patients." The VA OIG could have launched an investigation in to over-prescription at the Tomah VAMC at that time. It did not.

In June 2009, a Drug Enforcement Administration investigator interviewed Noelle Johnson, a pharmacist at the Tomah VAMC. Dr. Johnson showed the investigator ten examples of patients who, in her opinion, had prescriptions either too high in dosage or too long in length. The DEA examined other allegations of opioid over-prescription at the Tomah VAMC in 2011 and allegations of drug diversion in 2012. With multiple inquiries spanning several years, the DEA could have stopped the abuse of opioids at the facility. It did not.

On July 14, 2009, the Tomah VAMC 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 attempted to raise concerns within the facility about the over-prescription of medications. The VA could have investigated the circumstances of Dr. Kirkpatrick's death and learned of the serious issues he was raising. It did not.

In September 2009, Roberto Obong became the chief of VA police at the Tomah VAMC. In starting his new job, Chief Obong researched the facility's reputation. He learned that the Tomah VAMC was known in "the law enforcement community as a big pillbox" and that Dr. Houlihan was known as the "Candy Man." Over Chief Obong's four-year tenure at the facility, he could have investigated these allegations. He did not.

In March 2011, the VA OIG received a phone call alerting it to serious issues at the Tomah VAMC. The OIG referred the allegations to the VA's regional office and closed the case. When it received additional allegations five months later, in August 2011, the VA OIG re-examined the matter and began a two-and-a-half-year inquiry into the Tomah VAMC. The VA OIG collected hundreds of thousands of emails, interviewed facility staff, coordinated with local

and federal law enforcement, surveilled Dr. Houlihan, and issued at least one subpoena. The result of this work was an eleven-page report that was initially kept secret. The VA OIG could have fixed the problem. It did not.

In August 2013, the VA headquarters conducted a site visit to the Tomah VAMC. The report of the visit noted that the facility dispensed benzodiazepines for older veterans and for 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. The VA could have done more to recognize the concerns at the Tomah VAMC, understand the root causes, and proactively fix the problems at the facility. It did not.

In November 2013, less than a year before his death, veteran Jason Simcakoski sought help from federal and local law enforcement about the Tomah VAMC. Call logs and voicemails from his cell phones show numerous contacts with Tomah police, the VA police, and even the FBI. An FBI agent left a voicemail on Mr. Simcakoski's phone, but the FBI denies any record of these communications. Law enforcement could have investigated Mr. Simcakoski's allegations and stopped the abuses. It did not.

These systemic failures were not harmless. In January 2015, Candace Delis took her 74-year-old father, Thomas Baer, to the Tomah VAMC. 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 VAMC if she had known about the facility's problems.

The greatest share of responsibility lies with the VA OIG, the entity charged with overseeing and investigating the VA's programs and operations. The VA OIG conducted a multi-year inspection of the facility that failed to substantiate allegations it received. In early 2015, however, in the course of just three months, the VA substantiated similar allegations at the Tomah VAMC.

Chairman Johnson's investigation highlights deficiencies in how the VA OIG conducted its work at the Tomah VAMC. The office had no clear standard for substantiating allegations, with the burden of proof differing from inspector to inspector. Evidence also suggests that the line-level VA OIG inspectors intended to draft a public work product that would explain the results their inspection of the Tomah VAMC. Instead, VA OIG leadership chose for unknown reasons to issue a short, non-public administrative closure.

The VA OIG selectively narrowed the focus of its work in Tomah. It limited its inquiry to just opioid prescription practices, ignoring the potential consequences of interactions between opioids and other drugs, such as benzodiazepines. The VA OIG did not do enough to address allegations—and firsthand observations from its own inspectors—that Dr. Houlihan was possibly under the influence of a controlled substance. The VA OIG discounted allegations levied by

Tomah VAMC pharmacists about retaliation and abuse, despite interviewing some of the pharmacists who suffered the abuse and receiving other firsthand evidence supporting their claims.

Chairman Johnson's investigation has been hampered by the VA OIG's obstruction. In April 2015, because of the OIG's noncooperation, Chairman Johnson reluctantly issued a subpoena to then-Deputy Inspector General Richard Griffin for material relating to the VA OIG's work at the Tomah VAMC. Even after Mr. Griffin retired under pressure from Chairman Johnson, the VA OIG still has not fully complied with the subpoena. The VA OIG continues to withhold valuable information and has heavily redacted some material produced to the Chairman.

In addition, although VA OIG employees were interviewed by Chairman Johnson's staff, OIG lawyers often directed them not to answer certain questions and the answers given were not always forthcoming. In response to one question from Chairman Johnson's staff, a VA OIG witness initially answered, "I don't know." After an OIG lawyer told him that he *could* answer the question, the witness provided a substantive response.

Chairman Johnson's investigation also details the culture of fear at the Tomah VAMC—the retaliation against employees who sought to speak up about over-prescription. People like Dr. Noelle Johnson and Dr. Christopher Kirkpatrick lost their jobs after asking questions about prescriptions. The VA OIG—an entity that is supposed to protect VA whistleblowers—piled on, issuing an unsolicited white paper that attempted to discredit these whistleblowers. The VA OIG went so far as to imply that Dr. Kirkpatrick was a drug dealer and that Dr. Johnson had poor interpersonal skills. These facts have no bearing whatsoever on the merits of these whistleblowers' allegations.

What transpired at the Tomah VAMC was indisputably a tragedy. Since January 2015, Chairman Johnson's investigation and increased public attention on the facility have led to changes. The facility's director, Mario DeSanctis, and its chief of staff, Dr. David Houlihan, have been fired. The Deputy VA Inspector General, Richard Griffin, retired under intense scrutiny of his work. President Obama heeded the calls of Chairman Johnson and other senators to appoint a new VA Inspector General, Michael Missal, who Chairman Johnson shepherded through his Committee to confirmation by the Senate.

Pressure from Chairman Johnson and others has forced the VA OIG to become more transparent, releasing reports that would have otherwise never have been public. A new federal law requires greater IG transparency. The VA and the Tomah VAMC have changed their opioid prescription practices. VA whistleblowers from across the country are empowered to speak out, and Chairman Johnson has provided them with a venue to tell their stories.

While progress has been made, there is more that can be done to address the problems illustrated by the Tomah VAMC. This report presents recommendations from the Committee's majority staff that the VA and VA OIG can implement to improve accountability and

transparency. The VA OIG should clarify its standards for substantiating allegations and its processes for handling and referring hotline complaints. The VA should limit the patient loads of facility management, alter the medical center reporting structure, and establish a procedure for pharmacists to communicate prescription concerns. Overall, the VA ought to improve the Choice program to give more veterans flexibility in access to health care providers.

* * *

For years, veterans, employees, and others were shouting for help at the Tomah VAMC. They were pleading with whoever would listen. The VA OIG inspected, the DEA investigated, the FBI engaged, the VA inquired. Nothing was fixed. Instead, whistleblowers faced retaliation and a "culture of fear" descended upon the facility.

To fix a problem, it is first necessary to understand it. Since January 2015, Chairman Johnson has engaged in a thorough effort to investigate the allegations of opioid over-prescription, abuse of authority, whistleblower retaliation, and related issues at the Tomah VAMC. While it was not intended at the outset, this inquiry included a critical examination of the work of the VA OIG relating to the Tomah VAMC.

The information presented in this majority staff report is the product of a robust effort by Chairman Johnson to gather material from federal agencies, witness interviews, and whistleblower accounts. This report painstakingly presents the information received to date about the Tomah VAMC. It describes the systemic failures across agencies to identify and fix the problems over the course of a decade. It recounts in detail the course of the VA OIG's health care inspection of the Tomah VAMC and explains how the VA OIG failed to fix the problems. The report highlights the retaliation faced by whistleblowers who sought to speak out about what they saw. Although the majority staff does not have access to all the relevant information, this report paints the first comprehensive picture of the allegations surrounding the Tomah VAMC.

The United States owes a tremendous debt to the men and women who served the nation in uniform. The agencies' failures at the Tomah VAMC do no justice to these men and women. To prevent similar tragedies in the future, it is necessary to fully understand what happened in the past. Chairman Ron Johnson has undertaken this work for that reason. Although some information remains unknown, this majority staff report endeavors to tell the story of the Tomah VAMC to help ensure that tragedies like these never happen again.

Findings

- From at least 2007 to 2015, serious problems of over-prescription and abuse of authority existed at the Tomah VAMC, resulting in at least two veterans' deaths and the suicide of a staff psychologist.

- The allegations of over-prescription at the Tomah VAMC were known to law enforcement and executive branch agencies since at least 2009, as were the monikers "Candy Land"—referring to the facility—and the "Candy Man"—referring to the facility's chief of staff, Dr. David Houlihan.

- Employees at the Tomah VAMC referred to Dr. Houlihan as the "Candy Man" since at least 2004.

- Despite receiving various complaints over the course of several years, federal law-enforcement agencies and other executive branch entities failed to identify or address the root causes. For example:

    - VA consultants and peer reviews in connection with the 2007 death of a Tomah VAMC patient showed concerns about prescription practices at the facility.

    - The VA headquarters identified higher-than-average prescription rates at the Tomah VAMC in 2013.

    - The VA OIG received information about deficient patient care and abuse of authority in 2009 from the Tomah VAMC employees union and apparently ignored the complaints.

    - The VA OIG received anonymous complaints about over-prescription in March 2011, referred the matter to the VA's regional office, and closed the case.

    - The VA OIG received a similar complaint about over-prescription in August 2011, initiated a health care inspection, and ultimately closed the case in 2014 with a non-public report.

    - The VA OIG received a complaint in March 2012 during its inspection—"HOUSTON, WE NEED SOME HELP DOWN HERE."

    - The VA OIG surveilled Dr. Houlihan and subpoenaed a car dealership in 2012 in connection to Tomah VAMC allegations.

- The Drug Enforcement Administration inquired about potential drug diversion relating to the Tomah VAMC in 2009, 2012, and 2015, but the DEA will not discuss the results of its investigations.

- Less than a year before he died, Jason Simcakoski reached out to multiple local and federal law-enforcement agencies, including the Federal Bureau of Investigation, about drug diversion at the Tomah VAMC. In contemporaneous Facebook and text messages, Mr. Simcakoski claimed he was in contact with the FBI. The FBI denies having a record of its contacts with Mr. Simcakoski.

- A culture of fear and whistleblower retaliation at the Tomah VAMC allowed over-prescription and other abuses to continue unaddressed. The belief among Tomah VAMC staff that they could not report wrongdoing compromised patient care.

- The VA OIG's Office of Healthcare Inspections lacks clear standards for substantiating allegations it receives. The lack of clear standards leads to the potentially arbitrary and subjective treatment of health care inspections.

- The VA OIG inspection team originally intended to publish the findings of its multi-year inspection in a public report before OIG leadership decided to administratively close the inspection without a public report. The failure to publish the results of the Tomah VAMC inspection compromised veteran care at the facility.

- The VA OIG narrowly focused its inspection of the Tomah VAMC on just the allegations it received and did not fully probe other related issues it observed during the inspection, including the interaction of opioids with other medication, and the potential impairment of Dr. Houlihan during an interview with OIG staff.

- The VA OIG ignored findings of independent pharmacy consultants retained to evaluate prescription practices at the Tomah VAMC, including findings that the facility could be in danger of losing its controlled substance license.

- The VA OIG, under acting leadership of Deputy Inspector General Richard Griffin, lacked independence and transparency. The VA OIG dismissed concerns about whistleblower retaliation at the Tomah VAMC and its non-public administrative closure prevented the Tomah community from fully knowing the concerns about the facility.

- There is uncertainty about the date on which the VA OIG completed its Tomah VAMC health care inspection. The administrative closure notes a handwritten date that appears to be March 2014, but internal OIG case tracking documents show an August 2014 date.

- The reporting structure of the Tomah VAMC pharmacy department to the facility's chief of staff led to conflicts of interests that discouraged pharmacists from reporting concerns about Dr. Houlihan's prescription practices.

- In addition to managing a large patient case load, Dr. Houlihan served for a time as the facility's acting director or chief of staff, creating a potential conflict between his administrative duties and his care of veterans at the Tomah VAMC.

- Dr. Houlihan was the facility's acting director or chief of staff while still seeing patients, creating a conflict of interest with respect to the Tomah VA police's inquiries into potential drug diversion at the facility.

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I. Introduction

In January 2015, Wisconsinites learned of the detailed reports of "doped up" and "zombified" veterans at the Department of Veterans Affairs Medical Center in Tomah, Wisconsin (Tomah VAMC).[1] According to the *Center for Investigative Reporting*, veterans and employees at the facility referred to the Tomah VAMC as "Candy Land" and nicknamed the facility's chief of staff, Dr. David Houlihan, the "Candy Man" because of his alleged reputation for dispensing narcotics like candy.[2] The article brought to light the overdose death of Jason Simcakoski, a 35-year old Marine Corps veteran, who died at the Tomah VAMC on August 30, 2014. Autopsy results showed that when he died, Jason Simcakoski had over a dozen different drugs in his system and his cause of death was identified as "mixed drug toxicity."[3] Days after the initial news accounts, another veteran, Thomas Baer, died at the Tomah VAMC urgent care center after waiting hours to be seen for an apparent stroke.

The *Center for Investigative Reporting* article also uncovered the existence of a then-secret report that was not made public by the Department of Veterans Affairs Office of Inspector General (VA OIG).[4] The VA OIG's eleven-page administrative closure summarized the findings of its three-year-long health care inspection of the Tomah VAMC.[5] Since at least March 2011, the VA OIG had received complaints from Tomah VAMC employees and veterans that highlighted allegations of questionable prescription practices, administrative abuses including whistleblower retaliation, veteran deaths, and drug diversion.[6] The VA OIG found that some prescribing practices at the Tomah VAMC were "at considerable variance compared with most opioid prescribers" in the region and that these prescriptions "raised potentially serious concerns."[7] Despite these findings, the VA OIG did not substantiate the allegations and administratively closed its Tomah VAMC inspection on March 12, 2014. The VA OIG did not make the report public; it only later released the report in February 2015 amid public scrutiny.[8]

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[1] Aaron Glantz, *Opiates Handed out Like Candy to 'Doped-up' Veterans at Wisconsin VA*, REVEAL NEWS (Jan. 8, 2015), https://www revealnews.org/article-legacy/opiates-handed-out-like-candy-to-doped-up-veterans-at-wisconsin-va/ [hereinafter Glantz, *Opiates Handed out Like Candy*, REVEAL NEWS (Jan. 8, 2015)].
[2] *Id.*
[3] *Id.*
[4] VA OFFICE OF INSPECTOR GENERAL, TOMAH VAMC ADMINISTRATIVE CLOSURE, MCI# 2011-04212-HI-0267 (Mar. 12, 2014) [hereinafter VA OIG TOMAH VAMC ADMINISTRATIVE CLOSURE].
[5] *Id.*
[6] *Id.*
[7] *Id.* at 9.
[8] *Report Summary: Healthcare Inspection – Alleged Inappropriate Prescribing of Controlled Substances and Alleged Abuse of Authority, Tomah VA Medical Center, Tomah, Wisconsin*, DEP'T OF VETERANS AFFAIRS, OFFICE OF INSPECTOR GENERAL (Feb. 6, 2015), http://www.va.gov/oig/publications/report-summary.asp?id=3283.

Immediately after he was made aware of the allegations concerning the Tomah VAMC, Senator Ron Johnson, in his capacity as Chairman of the Committee on Homeland Security and Governmental Affairs, launched a bipartisan investigation. In January 2015, Chairman Johnson directed his staff to examine the allegations relating to the Tomah VAMC—including allegations of drug diversion, abuse of authority, patient deaths, retaliation against whistleblowers, and a culture of fear at the facility—and the VA OIG's work relating to the Tomah VAMC. Since then, Chairman Johnson's staff has been engaged in a comprehensive and detailed investigation of the Tomah VAMC.

This report explains the majority staff's findings over the past fifteen months. The report builds off of the preliminary findings presented in the interim report issued by Chairman Johnson's staff in June 2015, as well as the Committee's field hearing in Tomah, Wisconsin, in March 2015, and other public hearings in Washington, D.C. This report presents new information obtained from documents received from the VA, the VA OIG, and other entities, as well as information obtained from transcribed interviews with twenty-two current and former VA and VA OIG employees. Some questions remain unanswered—the VA OIG still has yet to fully comply with Chairman Johnson's April 2015 subpoena for relevant documents—but the majority staff presents this report now to encourage greater transparency and accountability at the Tomah VAMC, the VA OIG, and the VA.

A. The scope of Chairman Johnson's investigation

The Committee on Homeland Security and Governmental Affairs of the United States Senate serves as the Senate's chief oversight and investigatory committee. The Standing Rules of the Senate authorize the Committee to investigate "the efficiency and economy of operations of all branches of the Government."[9] In addition, the Senate has specifically authorized 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 . . . ."[10]

Although this staff report is comprehensive, it is admittedly with limitations. It does not purport to independently assess the appropriateness of medical judgments by professionals at the Tomah VAMC. Committee investigators are not doctors, and they do not have the expertise or training to determine whether care in a given situation met acceptable medical standards. Any critiques of the medial practices at the Tomah VAMC are presented through the findings and conclusions of other medical professionals.

The Committee did not request, receive, or review any medical records of the veterans who received care at the Tomah VAMC. Chairman Johnson chose to exclude that material from his review out of respect for the patients and veterans affected. Similarly, the Committee has

[9] S. Rule XXV(k); *see also* S. Res. 445, 108th Cong. (2004).
[10] S. Res. 73, 114th Cong. (2015).

largely not received peer review material from the VA and the VA OIG. Where the Committee received such information, it concerns outside assessment of clinical care and does not contain any identifying information about the patients or underlying medical issues.

B. The entities contacted during Chairman Johnson's investigation

Over the course of the investigation, Chairman Johnson requested information from a number of sources, including federal, state, local, and non-governmental entities. In addition, Chairman Johnson's staff had informal communications with federal and local entities. The entities contacted during the investigation include:

- The Department of Veterans Affairs;
- The VA Office of Inspector General;
- The Drug Enforcement Administration (DEA);
- The Federal Bureau of Investigation (FBI);
- The United States Attorney's Office for the Western District of Wisconsin;
- The Merit Systems Protection Board (MSPB);
- The Government Accountability Office (GAO);
- The Office of Special Counsel (OSC);
- The Tomah VAMC police department;
- The American Federation of Government Employees (AFGE) Local 007;
- Wisconsin state, county and local law-enforcement entities;
- The Wisconsin Department of Safety and Professional Services;
- The Joint Commission; and
- Dozens of whistleblowers who currently work, previously worked, or were treated at the Tomah VAMC.

In total, Chairman Johnson sent twenty-eight letters in connection with his investigation of the Tomah VAMC. A number of these entities voluntarily provided information and documents responsive to Chairman Johnson's requests. A few agencies declined to provide information or documents due to ongoing law-enforcement matters. Out of respect to the law-enforcement equities at stake in this matter, the majority staff chose to defer to the law-enforcement interests.

The VA OIG, however, took a different tack altogether. Even after Chairman Johnson agreed to forgo sensitive patient health information that could be included in the requested documents, the VA OIG refused to provide documents on the basis of general and vague assertions of "deliberative process" and "attorney client privilege." After multiple requests for voluntary compliance, on April 29, 2015, Chairman Johnson was forced to issue a subpoena to VA Deputy Inspector General Richard Griffin for material about the Tomah VAMC. Even after the subpoena, the VA OIG continues to withhold documents that are relevant to the Committee's

investigation, including drafts of its Tomah VAMC health care inspection and internal communications about the inspection.

C. The transcribed interviews conducted during Chairman Johnson's investigation

At Chairman Johnson's direction, and with the concurrence of Ranking Member Carper, staff conducted twenty-two transcribed interviews of current and former VA and VA OIG staff. These transcribed interviews included staff members of Chairman Johnson, Ranking Member Carper, and Senator Baldwin, and often lasted several hours. The witnesses were represented by counsel and afforded the opportunity to review the transcript of their interviews for accuracy. Staff interviewed the following individuals from the VA and the VA OIG:

- Rene Oshinski, *Deputy Network Director, Veterans Integrated Service Network (VISN) 12, VA*;
- Dr. Michael Bonner, *Former VISN 12 Chief Medical Officer, VA*;
- Donna Leslie, *VISN 12 Pharmacy Executive, VA*;
- Victoria Brahm, *Former VISN 12 Quality Management Officer and current Acting Tomah VAMC Facility Director, VA*;
- John Rohrer, *Former Acting Tomah VAMC Facility Director, VA*;[11]
- Katherine Pica, *Acting Tomah VAMC Chief of Staff, VA*;
- Jeff Evanson, *Acting Tomah VAMC Associate Director, VA*;
- Julie Nutting, *Organization Improvement Analyst, Tomah VAMC, VA*;
- Roberto Obong, *Former Tomah VAMC Chief of Police, VA*;
- Dr. Nick Beckey, *Director of Pharmacy, West Palm Brach VAMC, VA*;
- Dr. Mitchell Nazario, *Clinical Pharmacy Specialist, Pain Management, West Palm Beach VAMC, VA*;
- Linda Ellinghuysen, *Registered Nurse, Tomah VAMC; President, American Federation of Government Employees Local 0007, VA*;
- Dr. Laureen Savage, *Clinical Pharmacist, Tomah VAMC, VA*;
- Diane Streeter, *Licensed Practical Nurse, Tomah VAMC; Union Steward, American Federation of Government Employees Local 0007, VA*;
- Dr. John D. Daigh, Jr., *Assistant Inspector General, Office of Healthcare Inspections, VA OIG*;
- Dr. George Wesley, *Physician, Office of Healthcare Inspections, VA OIG*;
- Dr. Alan Mallinger, *Senior Physician, Office of Healthcare Inspections, VA OIG*;
- Dr. Michael Shepherd, *Physician, Office of Healthcare Inspections, VA OIG*;
- Dr. Robert Yang, *Physician, Office of Healthcare Inspections, VA OIG*;

[11] John Rohrer is the current director of the William S. Middleton Memorial Veterans Hospital in Madison, Wisconsin.

- Greg Porter, *Special Agent, Office of Investigations, VA OIG*; and
- Wachita Haywood, *Associate Director, Chicago Office of Healthcare Inspections, VA OIG*.

Staff did not conduct transcribed interviews with Dr. David Houlihan, Deborah Frasher, Mario DeSanctis, Ronda Davis, or Margaret Hyde out of respect for possible administrative action by the VA.[12] Staff sought not to jeopardize the integrity of these proceedings by conducting transcribed interviews with these individuals.

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Chairman Johnson's investigation is focused on identifying the root causes of the tragedies of the Tomah VAMC. Administrative misconduct, whistleblower retaliation, and a lack of VA oversight all directly compromised veteran care at the Tomah VAMC. Under acting leadership, the VA OIG lacked the independence and transparency that are the tenants of successful inspectors general. Chairman Johnson launched his investigation to identify the problems at the Tomah VAMC as an essential first step to enacting reforms to ensure that veterans at the Tomah VAMC and across the United States receive the care they deserve.

As explained in this report, the majority staff does not possess all relevant information about the Tomah VAMC. The VA has not fully produced all of its documents relating to the Tomah VAMC, and federal law-enforcement agencies have declined to provide information to further Chairman Johnson's inquiry. The VA OIG continues to withhold documents and information responsive to Chairman Johnson's April 2015 subpoena.

Despite these instances, Chairman Johnson has received a substantial amount of material concerning the Tomah VAMC. The majority staff relies on the information received to present the findings and recommendations contained in this staff report.

[12] On June 17, 2015, Dr. Houlihan voluntarily contacted Chairman Johnson's staff to signal his willingness to speak with investigators; he again voluntarily contacted staff on June 29, 2015, noting a change of heart. Staff also conducted an informal telephone conversation with Mr. DeSanctis and his attorney early in the investigation.

II. Missed opportunities to prevent the tragedies at Tomah

The story of the Tomah VAMC represents a trail of missed opportunities by the executive branch—unrealized chances to prevent or to fix a multitude of problems at the facility. For years, Tomah VAMC employees, patients, and others pled for help. These cries were ignored, warning signs were overlooked, and individuals in key positions failed to heed concerns of the Tomah community. The problems at Tomah were preventable. Failures on multiple levels by multiple entities within the executive branch to listen to the problems at the Tomah VAMC directly compromised veteran care and bred a culture of fear and retaliation at the facility.

A. The Death of Kraig Ferrington in 2007 was a warning sign of over-prescription at the Tomah VAMC

More than seven years before Jason Simcakoski died at the Tomah VAMC in August 2014, another veteran died of a drug overdose after receiving care at the Tomah VAMC. The death of Kraig Ferrington, a U.S. Army veteran, should have served as a warning to the VA, VISN, and the Tomah VAMC about the possible dangers of simultaneously prescribing veterans many different drugs. Instead, nothing changed in the wake of Mr. Ferrington's death. There was no internal investigation and no VA OIG investigation.

In early 2015, Kraig Ferrington's sister, Kari Hemb, contacted Chairman Johnson's staff with information about Mr. Ferrington's treatment at the Tomah VAMC. She provided the Chairman with documents about Mr. Ferrington's care at the Tomah VAMC. Chairman Johnson subsequently wrote to VA Secretary Robert McDonald requesting information about the Equal Employment Opportunity Commission (EEOC) and tort claims filed against the Tomah VAMC in connection with Mr. Ferrington's death.[13] Chairman Johnson received documents pursuant to this request, which help to explain Mr. Ferrington's treatment at the Tomah VAMC.

1. Kraig Ferrington's care at the Tomah VAMC

Kraig Ferrington served in the Army from 1982 to 1986. Mr. Ferrington battled with substance abuse problems in civilian life, spending time in and out of jail. In October 2007, Mr. Ferrington's sister, Kari Hemb, enrolled him at the Tomah VAMC for medication management.

[13] Letter from Hon. Ron Johnson, Chairman, S. Comm. on Homeland Sec. & Governmental Affairs, to Hon. Robert McDonald, Secretary, Dep't of Veterans Affairs, at 1 (Mar. 24, 2015) [hereinafter 3/24/2015 Letter from Chairman Johnson, HSGAC, to Secretary McDonald, VA].

Documents show that Mr. Ferrington was admitted to the Tomah VAMC in the afternoon of October 10, 2007, to seek help with medication management and PTSD treatment.[14] The mental health progress note addendum documenting Mr. Ferrington's admission to the Tomah VAMC stated that his sister, Keri Hemb, was managing Mr. Ferrington's medication because she was "afraid he will take too many."[15] When he was admitted, Ms. Hemb observed that Mr. Ferrington was "talking funny" and "calling her by names from his childhood."[16] The Tomah VAMC employee who admitted Mr. Ferrington noted that Mr. Ferrington knew what month and year it was, but thought the date was October 12 and he "did not know what day of the week it was."[17] Mr. Ferrington was placed in an observation bed and was assessed by a physician's assistant in the substance abuse program the following morning.[18] When he was admitted, Mr. Ferrington indicated that he "would very much like to go through the [substance abuse] program."[19]

Mr. Ferrington was evaluated the following day by a physician assistant, with Dr. Houlihan serving as the "EXP COSIGNER" of the evaluation.[20] Dr. Houlihan served as the attending psychiatrist on the Tomah VAMC mental health wing during Mr. Ferrington's care; however, records indicate he did not prescribe any medication to Mr. Ferrington. The documents show that the Tomah VAMC continued administering the six non-VA medications Mr. Ferrington was prescribed, and placed Mr. Ferrington on a seventh medication.[21] The Tomah VAMC diagnosed Mr. Ferrington with a number of substance use disorders and admitted him to the substance abuse program. The examination notes show that Mr. Ferrington was given "Patient Education" on his diagnosed conditions and the medications he was prescribed.[22] The note also indicated that Mr. Ferrington was "to be allowed to self medicate while on the ward."[23]

Subsequent annotations to Mr. Ferrington's medical records highlight alarming red flags with his care at the Tomah VAMC. A Mental Health Progress Note dated October 13, 2007, showed that Mr. Ferrington was "restless and incoherent with his speech and makes little or no sense."[24] The note indicated that Mr. Ferrington's "condition and behaviour [*sic*] may warrent

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[14] Claim for Damage, Injury, or Death for Kraig Ferrington, Ex. 5, at 1 [hereinafter Ferrington Exhibits] (on file with Comm.).
[15] *Id.*
[16] *Id.*
[17] *Id.*
[18] *Id.*
[19] *Id.*
[20] *Id.* Ex. 6, at 1. In instances where medical students, residents, or some other medical profession enter a course of action into a chart, the attending, or senior physician on duty at the time is needed to cosign the entry to show they were aware of the entry. *See* Thomas Payne et al., *The Transition to Electronic Documentation on a Teaching Hospital Medical Service*, AMIA ANNUAL SYMPOSIUM PROCEEDINGS (2006), http://www ncbi.nlm.nih.gov/pmc/articles/PMC1839294/.
[21] Ferrington Exhibits, Ex. 6, at 3.
[22] *Id.* Ex. 6, at 7.
[23] *Id.*
[24] *Id.* Ex. 7, at 17.

[*sic*] move to another unit for observation for [patient's] safety and well being [*sic*]."[25] A note logged on October 14, 2007 recounted that Mr. Ferrington was "unable to stay awake" and when he was woken up and escorted to his room, Mr. Ferrington "was very lethargic and confused and disoriented."[26] Earlier that night, Mr. Ferrington had "needed assistance with finding his room and to get sleep/rest."[27] Later in the morning on October 14, 2007, Mr. Ferrington was transferred to the Tomah VAMC Urgent Care unit where staff "voiced concern about him being forgetful and confused."[28]

On October 15, the Tomah VAMC changed Mr. Ferrington's medication regimen. Tomah VAMC personnel increased Mr. Ferrington's prescriptions to ten separate medications.[29] At this time, Mr. Ferrington was taking both an opioid and a benzodiazepine simultaneously.[30]

Around midnight, Tomah VAMC staff observed that Mr. Ferrington was "confused and need constant redirection."[31] The note taker wrote "[q]uestion if [patient] is able to take his own meds. Continue to observe."[32] On the morning of October 16, a different Tomah VAMC staff member noted that Mr. Ferrington "appears much more alert and oriented in the morning wake up hours."[33] Nevertheless, the Tomah VAMC employee noted that Mr. Ferrington "[n]eeds to be seen by appropriate staff in regards to his confusion and other related issues."[34] Mr. Ferrington underwent a psychological evaluation later that morning and interviewed with a social worker the next day.[35]

Medical notes indicate that Mr. Ferrington had slept soundly the night of October 18, 2007.[36] On October 19, Tomah VAMC staff spoke with Ms. Hemb about Mr. Ferrington's care and about some of her ground rules for when Mr. Ferrington was to be released to her care.[37]

From October 19 to October 23, Tomah VAMC staff reduced Mr. Ferrington's prescription for certain medications that made him feel drowsy.[38] A note dated October 23, 2007, stated that Mr. Ferrington required "very frequent reinforcement and reminders regarding his medications – what to take and when."[39] A social work note on October 23, 2007, stated that Mr. Ferrington was "having problems managing his medications, is a fall risk, has extreme

[25] *Id.* Ex. 7, at 17.
[26] *Id.*
[27] *Id.*
[28] *Id.* Ex. 8, at 18.
[29] *Id.* Ex. 9, at 19–20.
[30] *Id.*
[31] *Id.* Ex. 9, at 20.
[32] *Id.*
[33] *Id.* Ex. 10, at 21.
[34] *Id.*
[35] *Id.* Ex. 10, at 21–26, Ex. 11, at 27.
[36] *Id.* Ex. 11, at 27.
[37] *Id.* Ex. 11, at 27, Ex. 12, at 28.
[38] *Id.* Ex. 12, at 28.
[39] *Id.* Ex. 13, at 31.

difficulty with memory and require[s] more supervision than routinely provided in [the substance abuse] program."[40] On October 24, Mr. Ferrington "attempted to attend group this afternoon, but after having fallen asleep (and snoring loudly) two times, with rigorous attempts to wake him, he was advised to return to his unit."[41]

On November 9, Mr. Ferrington was found "to be very drowsy with slurred speech and being barely able to keep his eyes open."[42] Nevertheless, he was discharged from the Tomah VAMC having completed the Tomah VAMC substance abuse program.[43] Mr. Ferrington's discharge documents indicate that when he left the Tomah VAMC, he was on 11 different medications.[44] The discharge documents indicated that Tomah VAMC staff explained to Mr. Ferrington how to take his medications. Ms. Hemb could not pick up Mr. Ferrington on November 9, 2007 because of car trouble, but picked him up from the Tomah VAMC on November 10, 2007. Mr. Ferrington died in the early morning hours of November 11, 2007 at Ms. Hemb's home. The Brown County Medical Examiner determined that the cause of death was "poly medication overdose."[45]

Mr. Ferrington's autopsy revealed that when he died, he had seven different drugs in his system. Autopsy results found the presence of hydrocodone,[46] the benzodiazepines diazepam[47] and nordiazepam,[48] fluoxetine,[49] amitriptyline,[50] nortriptyline,[51] and methadone[52] in Mr. Ferrington's system when he died. The VA prescribed all of the drugs found in his system, with the exception of the methadone, to Mr. Ferrington when he was discharged from the Tomah VAMC. There is no evidence that the VA prescribed Mr. Ferrington methadone and it is unclear how the methadone made its way into Mr. Ferrington's system.

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[40] *Id.* Ex. 19; *see also* 4.24.09 Medical Record Synopsis at p. 5 in the pdf
[41] Ferrington Exhibits, Ex. 13, at 31.
[42] VA Consultant 1 at 2.
[43] Ferrington Exhibits, Ex. 14, at 1.
[44] *Id.*
[45] *Id.* Ex. 1.
[46] Hydrocodone is an "opioid pain medication." *Hydrocodone*, DRUGS.COM, http://www.drugs.com/hydrocodone.html.
[47] Diazepam is a "benzodiazepine," or tranquilizer, that is commonly used to treat "anxiety disorders, alcohol withdrawal symptoms, or muscle spasms." *Diazepam*, DRUGS.COM, http://www.drugs.com/diazepam.html.
[48] Nordiazepam is a benzodiazepine derivative and is commonly used to treat anxiety. *See* Joshua Gunn, *Understanding the Toxicology of Diazepam*, PRACTICAL PAIN MANAGEMENT (Apr. 15, 2015), http://www.practicalpainmanagement.com/treatments/pharmacological/understanding-toxicology-diazepam.
[49] Fluoxetine is an antidepressant. *Fluoxetine*, DRUGS.COM, http://www.drugs.com/fluoxetine html.
[50] Amitriptyline is an antidepressant. *Amitriptyline*, DRUGS.COM, http://www.drugs.com/amitriptyline html.
[51] Nortriptyline is an antidepressant. *Nortriptyline*, DRUGS.COM, http://www.drugs.com/nortriptyline.html.
[52] Methadone is an opioid medication that is used as a pain reliever and as part of drug addiction detoxification. *Methadone*, DRUGS.COM, http://www.drugs.com/methadone.html.

2. Medical consultants identified significant concerns with Mr. Ferrington's treatment at the Tomah VAMC

Shortly after Mr. Ferrington passed away, Ms. Hemb filed a wrongful death claim against the VA.[53] Documents obtained related to this claim reveal troubling aspects of Mr. Ferrington's care at the Tomah VAMC—revelations that should have been a warning of broader issues with the facility.

As part of the legal proceedings between Ms. Hemb and the VA, both sides sought expert opinions of physicians outside the Tomah VAMC to determine whether the medical professionals at the Tomah VAMC treated Mr. Ferrington within the standard of care.[54] The VA solicited the opinions of two VA psychiatrists at hospitals other than the Tomah VAMC.[55] Both consultants identified significant concerns with Mr. Ferrington's treatment at the Tomah VAMC.[56] To preserve the privacy interests of the consultants, and to allow medical consultants inside and outside the VA to continue to provide candid analysis of quality-of-care issues, this majority staff report does not identify the consultants by name. Instead, it marks the consultants as "VA Consultant 1" and "VA Consultant 2," and refers to both with male pronouns.[57]

i. Findings of VA Consultant 1

VA Consultant 1 began his consultation by summarizing the notes in Mr. Ferrington's charts. He found that when Mr. Ferrington died, toxicology results showed "toxic levels of Methadone (not prescribed), high levels of fluoxetine and it's [*sic*] metabolite norfluoxetine, high levels of the metabolite of diazepam, and evidence of the presence of hydrocodone and amitryptelene and it's [*sic*] metabolite."[58] VA Consultant 1 answered a number of questions with respect to whether Mr. Ferrington's care at the Tomah VAMC met the required standard of care. His findings are summarized below.

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[53] *See* Ferrington July 2 production SF-95 and supporting documents received

[54] VA Consultant 1 Medical Opinion Re.: Administrative Tort Claim: Ferrington, Craig, TCIS 09-713 [hereinafter VA Consultant 1 Medical Opinion] (on file with Comm.); VA Consultant 2 Medical Opinion Re.: Administrative Tort Claim: Ferrington, Craig, TCIS 09-713 [hereinafter VA Consultant 2 Medical Opinion] (on file with Comm.).

[55] VA Consultant 1 Medical Opinion; VA Consultant 2 Medical Opinion.

[56] VA Consultant 1 Medical Opinion; VA Consultant 2 Medical Opinion.

[57] Ms. Hemb also hired her own expert, a medical doctor board certified in forensic pathology who rendered an opinion on the care Mr. Ferrington received at the Tomah VAMC. Ms. Hemb's consultant did not draw conclusions on whether the Tomah VAMC's treatment of Mr. Ferrington fell inside the standard of care. Ms. Hemb's consultant ultimately concluded that "Ferrington died from a lethal mixture of medications given to him at the Tomah VA. But for this treatment, Kraig Ferrington would likely still be alive." Ferrington Exhibits, Ex. 15, at 1.

[58] VA Consultant 1 Medical Opinion, at 3.

a. Standard of care with respect to medication management

VA Consultant 1 identified significant concerns with the Tomah VAMC's management of Mr. Ferrington's medication regimen. With respect to the medications that Mr. Ferrington was on, VA Consultant 1 wrote:

> [T]here is a general concern regarding the number of medications [Mr. Ferrington] was on, and the potential interactions among them. The greatest concern in this regard has to do with being on several medications which have a warning regarding the potential to cause confusion, unsteadiness, memory impairment, unsteadiness, and which generally warn against use with other "CNS [central nervous system] depressants" due to a cumulative adverse effect burden in such combination. He was being prescribed concomitantly the following CNS depressant agents: valium, toradol, valium, amytriptylene and later ultram and vicodin. The only medication that was discontinued due to the presence of all the above noted adverse effects was amytriptylene (elavil) despite ongoing report of sedation, unsteadiness, "extreme difficulty with memory" and slurred speech. **All of these medications and their combination should have suspect with regard to these adverse effects, and consideration of this possibility is not evident in my perusal of the record.** Also, many of the medications he was on had known abuse potential.[59]

VA Consultant 1 added that it was "apparent" that the Tomah VAMC did not "adequately control [Mr. Ferrington's] intake of medications or other substances from outside the VA."[60] The Consultant raised concerns with Mr. Ferrington's continued allowance to self-medicate while in the Tomah VAMC's substance abuse program, explaining that "[t]he record clearly noted his problems with addiction, with his inappropriate and excessive use of medications, and his obvious confusion – all of which are relative contraindications for self-medication due to the safety issues of medication misuse."[61] With respect to the methadone found in Mr. Ferrington's system, the consultant noted that the presence of methadone suggested that Mr. Ferrington was able to obtain and use non-prescribed medications while in the program.[62]

VA Consultant 1 concluded that "[t]he VA failed to address the risk" of medication misuse or abuse when it allowed him to "control his intake of these medications."[63]

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[59] *Id.* (emphasis added).
[60] *Id.* at 4.
[61] *Id.*
[62] *Id.*
[63] *Id.*

b. Standard of care with respect to monitoring Mr. Ferrington's behavior at the Tomah VAMC

VA Consultant 1 noted that the Tomah VAMC staff "was clearly aware" that Mr. Ferrington's apparent continued lethargy was "a problem."[64] When the Tomah VAMC Medical Service evaluated Mr. Ferrington to try and address this issue, VA Consultant 1 found that Mr. Ferrington "appeared to have been given short-shrift."[65] On this issue, VA Consultant 1 concluded:

> The decision not to return him to the Medical Service when the problems that lead [*sic*] him to admission were not evidentially resolved is also a failure on the part of his treatment team, as there continued to be evidence of this problem on a daily basis noted in the record with inadequate response to the serious safety issues raised.[66]

c. Standard of care with respect to medical care

VA Consultant 1 identified that Mr. Ferrington suffered from diabetes and pain.[67] With respect to the pain, Mr. Ferrington's pain was addressed using medications.[68] VA Consultant 1 noted that Mr. Ferrington's rehab consultation "suggested [Mr. Ferrington's medication regimen] was contraindicated in his case, and they suggested physical therapy."[69] VA Consultant 1 concluded that Mr. Ferrington's pain was "not properly addressed."[70]

d. Standard of care with respect to psychiatric care

On this issue, VA Consultant 1 found that the Tomah VAMC failed to conduct proper follow-up on how it treated Mr. Ferrington's depression and anxiety, writing: "I was not able to identify evidence that his depression or anxiety treatment was being actively reassessed for adequacy of treatment benefit during his stay in the [substance abuse] program."[71]

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[64] *Id.* at 5.
[65] *Id.*
[66] *Id.*
[67] *Id.*
[68] *Id.*
[69] *Id.*
[70] *Id.*
[71] *Id.*

e. Standard of care with respect to counseling

VA Consultant 1 concluded that "[t]here is evidence that [counseling] was not adequately addressed."[72] He noted that because Mr. Ferrington was oftentimes confused and lethargic, he was not able to benefit from group counseling sessions. VA Consultant 1 explained:

> A patient who is this often and severely confused is unable to benefit from psychotherapy groups and activities. His sister reported that all of his therapy homework was never completed, which begs the question of whether staff was adequately reviewing and monitoring his participation in the program.[73]

f. Standard of care with respect to Mr. Ferrington's discharge

On the issue of Mr. Ferrington's discharge from the Tomah VAMC, VA Consultant 1 concluded that Mr. Ferrington was "clearly not capable of being safely released to home at the time of discharge."[74] VA Consultant 1 noted observations from the day prior to discharge that Mr. Ferrington appeared "very drowsy with slurred speech and being barely able to keep his eyes open."[75] In addition, he appeared "sedated" and "very unsteady on his feet"[76] On the day of discharge, VA Consultant 1 noted Ms. Hemb's observations: "I was upset when I went to pick him up because he was so buzzed I stated I wanted to put him in Complete Detox right then."[77] Ms. Hemb noted that Mr. Ferrington died "not even 8 hours after we got home."[78]

VA Consultant 1 identified six ways in which the Tomah VAMC failed to meet the standard of care with respect to its treatment of Mr. Ferrington:

1. Inadequate monitoring of medication and allowing Mr. Ferrington to self-medicate;
2. A failure to reduce or stop medications that are noted to be addictive, sedating, and which cause confusion and unsteadiness—symptoms that Mr. Ferrington exhibited;
3. A failure to adequately respond to frequent presentations of these symptoms, too rapid of a return to the unsupervised substance abuse program where Mr. Ferrington was sent for evaluation, and a failure to return him for medical admission when these same problems were clearly unresolved on his return from the substance abuse program;
4. Allowing Mr. Ferrington to "graduate" from a therapy program through which he was frequently slept and for which he failed to complete homework assignments;

[72] *Id.*
[73] *Id.* at 6.
[74] *Id.*
[75] *Id.*
[76] *Id.*
[77] *Id.*
[78] *Id.*

5. A failure to address psychological issues raised in the program, which may have lead him to seek substances to abuse; and
6. Allowing Mr. Ferrington to be released home despite appearing physically and mentally compromised.[79]

VA Consultant 1 ultimately concluded:

> I believe there is a clear path from the above failures of adequate care and monitoring to Mr. Ferrington's death. If these issues were more appropriately addressed Mr. Ferrington would not have been allowed to have been on the combination of medications he was taken [*sic*] at the time of discharge nor would he have been allowed to return home in the clearly compromised state he was in. If toxicology screens were performed the staff may have been able to detect illicit substance use and address it. Given his proclivity for substance misuse and overuse, it is certainly possible that at some point Mr. Ferrington might have overdosed and died of the same cause. However, when he was in the care of a health care system, it is their responsibility to identify potential causes of risk of harm and to try to mitigate them. **Having failed to do so, their actions lead directly to the death of Mr. Ferrington in my medical opinion.**[80]

ii. Findings of VA Consultant 2

VA Consultant 2 presented a slightly different opinion than VA Consultant 1 on the degree of the Tomah VAMC's responsibility for Mr. Ferrington's death. He ultimately found that the Tomah VAMC's care was "benign" and "[n]othing that [the Tomah VAMC] did directly contributed to his death."[81] VA Consultant 2's analysis heavily emphasized the presence of methadone in Mr. Ferrington's system at the time of his death and found that the "overdose that killed him was with methadone and Valium (these are the two medications that most probably suppressed this patient's respiratory drive)."[82] Although VA Consultant 2's opinion on the cause of Mr. Ferrington's death differed from VA Consultant 1, VA Consultant 2 still identified issues of concern with Mr. Ferrington's care at the Tomah VAMC.

a. Standard of care with respect to medication management

VA Consultant 2 noted concerns with the Tomah VAMC's management of Mr. Ferrington's medication regimen. With respect to the medications Mr. Ferrington was on, VA Consultant 2 wrote:

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[79] *Id.*
[80] *Id.* at 6-7 (emphasis added).
[81] VA Consultant 2 Medical Opinion, at 2.
[82] *Id.* at 1.

> While there was and [*sic*] an attempt to understand why this patient appeared over sedated (including the notion that the patient might have sleep apnea with a plan for a sleep study after the patient was discharged from residential treatment—however this writer could find no evidence that the sleep study was ever scheduled) his medications were never completely held to see if his mental status cleared. He also appeared to be getting medications from an outside pharmacy; in an over separated patient one of the first issues that should have been addressed is to determine the relationship between his medication intake and his oversedation. It is this writers [*sic*] belief that the patient should have been detoxed off of the benzodiazepine Valium.[83]

b. Standard of care with respect to monitoring Mr. Ferrington's behavior at the Tomah VAMC

On the issue of monitoring Mr. Ferrington's' behavior to respond appropriately to his sleepiness, VA Consultant 2 did not determine whether the Tomah VAMC met the standard of care. The consultant wrote:

> [T]he patient's medications should have been held to see if his mental status/oversedation cleared. It should be noted that some clinicians might have had ethical concerns about this; as the patient was suffering from severe pain per his report. Some of his medications ameliorated his discomfort.[84]

c. Standard of care with respect to medical care

VA Consultant 2 did not determine whether Mr. Ferrington's medical care at the Tomah VAMC met the standard of care. However, he identified areas of concern with how the Tomah VAMC treated Mr. Ferrington's diabetes and pain. With respect to the Tomah VAMC's treatment of Mr. Ferrington's pain, VA Consultant 2 wrote that the Tomah VAMC staff should have completed a "more rigorous workup" to determine the role that Mr. Ferrington's drug addiction played in his complaints of pain.[85]

On the questions of whether Mr. Ferrington received proper psychiatric care or was offered appropriate counseling, VA Consultant 2 made no determinations of whether the facility offered the proper standard of care.[86] The consultant summarized the care that Mr. Ferrington received and noted some other treatments that were not rendered according to Mr. Ferrington's

[83] *Id.* at 4.
[84] *Id.*
[85] *Id.* at 5.
[86] *Id.*

medical files.[87] He did not draw a conclusion of whether the omission of those evaluations or treatments fell outside of the standard of care.[88]

d. Standard of care with respect to Mr. Ferrington's discharge

On the issue of Mr. Ferrington's discharge from the Tomah VAMC, VA Consultant 2 wrote:

> Patient continued to have periods of oversedation up until the time of his discharge: this writer does not think the patient was ready for discharge until there was a better understanding of why the patient was so oversedated so much of the time. In the context of substance use disorder; it strongly suggests uncontrolled drug use.[89]

When asked to clarify if and how the Tomah VAMC failed to meet the standard of care, VA Consultant 2 wrote:

> There should have been a better attempt to understand why this patient was oversedated to the extent he was. This might have included serum blood samples to obtain blood levels of the medications he was on such as his amitriptyline and Valium; if there were excessive blood levels of these medications; the patient might have been a slow metabolizer; or taking more than the prescribed doses of these medications. If the latter were the case; he certainly was not getting the benefit of the substance abuse treatment he was involved in. In an oversedated state; the patient would not have been able to fully benefit from the learning and psychosocial interventions being provided in the residential program.[90]

VA Consultant 2 found that that the Tomah VAMC did not "adequately control [Mr. Ferrington's] intake of medications or other substances from outside the VA."[91] Ultimately, however, VA Consultant 2 concluded that the Tomah VAMC was not responsible for Mr. Ferrington's death:

> It is not the belief of this writer that the patient died due to oversedation/ polypharmacy/overmedication by the Tomah VA. Proof that this patient did not die from VA medications is the fact that the VA did not prescribe the patient the medication that most likely killed him; namely methadone.[92]

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[87] *Id.*
[88] *Id.*
[89] *Id.*
[90] *Id.* at 6.
[91] *Id.*
[92] *Id.*

3. Peer reviews of the Tomah VAMC in connection with Kraig Ferrington's death suggest other practitioners would have provided different treatment

The VA has an internal mechanism, known as a peer review, to review the care that its medical professionals provide to individual patients. Peer reviews are conducted by VA staff members and are graded on an increasing scale of Levels 1 through 3. When a medical professional is reviewed and receives a Level 1, the highest level, it means that "most experienced, competent practitioners *would* have handled the case *similarly* in all of the respects listed."[93] Level 2 peer reviews indicate that "most experienced, competent practitioners *might* have handled the case *differently* in one or more of the respects listed."[94] Level 3 peer reviews indicate that "most experienced, competent practitioners *would* have handled the case *differently* in one or more of the respects listed."[95]

The VA performed peer reviews for three providers in connection with their care of Kraig Ferrington. One provider, a physician's assistant in the Tomah VAMC mental health wing, received a level 3 for his care of Mr. Ferrington—meaning that most experienced practitioners would have treated Mr. Ferrington differently than this physician's assistant had.[96] Another medical professional, a clinical substance abuse counselor at the Tomah VAMC, received a level 2 peer review—meaning that most practitioners might have treated Mr. Ferrington differently than the substance abuse counselor had.[97] A third provider, a nurse, received no level rating in their peer review.

The peer reviews identified similar issues with the care as the VA's own consultants found. For example, the level 3 peer review noted "CONSTANT!! Documentation regarding patient falling asleep—slurred speech—unable to walk" and other issues that were "all documented" but noted that there was "nothing done" to address this issue.[98] That same peer review found that "when discharging, noted patient sleeping—had report of [patient] being 'snowed' that am [morning]—still discharged patient."[99] It is unclear, however whether the VA disciplined any health care providers in connection to their care for Kraig Ferrington.

* * *

[93] Letter from Office of Regional Counsel, VA Regional Office, Dep't of Veterans Affairs, to Director, VA Medical Center, Tomah, WI, at 14 (Dec.17, 2008) (VA Peer Review) (on file with Comm.).
[94] *Id.*
[95] *Id.*
[96] *Id.*
[97] *Id.*
[98] *Id.* at 10.
[99] *Id.*

The VA ultimately settled the administrative proceeding about its care of Kraig Ferrington.[100] The treatment of Kraig Ferrington and Jason Simcakoski's at the Tomah VAMC, although seven years apart, are similar. Both patients had a complex mixture of PTSD and medication management issues. Both sought care at the Tomah VAMC to regain control of their lives. Both were prescribed large amounts of dangerous drugs, and both ultimately died from a mixture of drugs.

Kraig Ferrington's death should have been an opportunity for the Tomah VAMC and the VA at large to revisit its prescription practices. His care represents one in a long list of missed opportunities to identify problems in prescription practices at the facility and take steps to implement solutions.

B. The VA apparently did not fully examine past allegations against Dr. David Houlihan during his hiring and promotion at the Tomah VAMC

Long before Dr. David Houlihan became the chief of staff at the Tomah VAMC—before he was even hired as a psychiatrist there—he was subject to disciplinary charges by the Iowa Board of Medical Examiners. These disciplinary proceedings, which cast doubt on Dr. Houlihan's judgment as a practitioner, were apparently known to the Tomah VAMC at the time of his hiring. From information available to the majority staff, the VA regional leadership apparently overlooked these issues in hiring Dr. Houlihan in 2002 and in promoting him to chief of staff in 2004. The Tomah VAMC—at the direction of regional leadership—only closely examined these issues in 2009. The VA regional leadership's failure to promptly and closely examine the Iowa Board of Medical Examiners' actions concerning Dr. Houlihan until well after he became chief of staff at the Tomah VAMC represents another missed opportunity to prevent the tragic outcomes.

1. Dr. Houlihan's apparent prior misconduct in Iowa

On June 5, 2002, the Iowa Board of Medical Examiners charged Dr. Houlihan with "engaging in unethical conduct or practice harmful or detrimental to the public when he violated appropriate professional physician/patient boundaries."[101] Specifically, Dr. Houlihan was accused of hiring two patients to perform work for him, engaging in an inappropriate social relationship with a patient, and inappropriately possessing patient medications at his home.[102] The Iowa Board of Medical Examiners referred these allegations to a "peer review committee

[100] Letter from Office of Regional Counsel, VA Regional Office, Dep't of Veterans Affairs, to Director, VA Medical Center, Tomah, WI (Jan. 25, 2011) (on file with Comm.).
[101] In re Confidential Investigation Concerning David Houlihan, No. 02-01-1429, Settlement Agreement & Final Order, OIG 5741, at OIG 5745 [hereinafter Houlihan Settlement Agreement & Final Order].
[102] Iowa Board of Medical Examiners Press Release, at OIG 18.

consisting of two Iowa licensed psychiatrists."[103] The panel concluded that Dr. Houlihan "failed to maintain proper boundaries with respect to his relationship with a former patient."[104] The Board filed charges on June 5, 2002.[105]

On April 3, 2003, Dr. Houlihan settled his case with the Board.[106] The settlement agreement noted that Dr. Houlihan had completed a "comprehensive professional boundary evaluation" in April 2002.[107] The agreement required Dr. Houlihan to "successfully complete an education program on physician-patient boundaries" within 90 days of the order.[108] The Iowa Board of Medical Examiners issued a press release on the settlement on April 9, 2003.[109]

Dr. Houlihan joined the staff of the Tomah VAMC in 2002 and became chief of staff at the facility in 2004.[110] During transcribed interviews with VA and VA OIG personnel, Chairman Johnson's staff inquired about the severity of the alleged boundary violations and whether the Iowa Board of Medical Examiners' complaint was considered when the VA hired Dr. Houlihan.[111] Renee Oshinski, who became deputy VISN 12 director in 2004, stated that she believed that the leadership of VISN 12—the regional entity responsible for the Tomah VAMC—saw these allegations during the VA's "hiring process" of Dr. Houlihan.[112] When asked about the severity of these allegations, Ms. Oshinski opined that "things don't get reported to State Boards if they are not of consequence."[113]

The charges from the Iowa Board of Medical Examiners resurfaced when Dr. Houlihan was under consideration to become the chief of staff of the Tomah VAMC. According to Ms. Oshinski, there were "discussion[s] about issues with his previous employment" among VISN 12 leadership and Tomah VAMC officials during that time.[114] When asked why VISN 12 and Tomah VAMC leadership overlooked these concerns and decided to promote him to chief of

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[103] Houlihan Settlement Agreement & Final Order, at OIG 5745.
[104] *Id.*
[105] *Id.*
[106] *Id.* at OIG 5741.
[107] *Id.* at OIG 5742.
[108] *Id.*
[109] Iowa Board of Medical Examiners Press Release, at OIG 16.
[110] David Houlihan eOPF File and Performance Appraisal (on file with Comm.).
[111] *See generally*, Transcribed Interview with Renee Oshinski, in Washington, D.C. (Dec. 14, 2015) [hereinafter Oshinski Transcribed Interview]; Transcribed Interview with Alan Mallinger, in Washington, D.C. (Mar. 8, 2016) [hereinafter Mallinger 3/8/2016 Transcribed Interview]; Transcribed Interview with Alan Mallinger, in Washington, D.C. (Apr. 6, 2016) [hereinafter Mallinger 4/6/2016 Transcribed Interview]; Transcribed Interview with Alan Mallinger, in Washington, D.C. (Apr. 21, 2016) [hereinafter Mallinger 4/21/2016 Transcribed Interview]; Transcribed Interview with Katherine Pica, in Tomah, Wis. (Dec. 17, 2015) [hereinafter Pica Transcribed Interview]; Transcribed Interview with Michael Bonner, in Tomah, Wis. (Dec. 16, 2015) [hereinafter Bonner Transcribed Interview].
[112] Oshinski Transcribed Interview, at 22.
[113] *Id.* at 23.
[114] *Id.*

staff, Ms. Oshinski highlighted three factors she believed contributed to Dr. Houlihan's promotion:

1. Dr. Houlihan had strong support from then-Tomah VAMC Director, Stan Johnson;
2. Dr. Houlihan had worked at the Tomah VAMC for "awhile" and was a "strong" provider; and
3. Difficulties in recruiting psychiatrists to the Tomah VAMC, combined with Dr. Houlihan's strength as a provider, led leadership to believe Dr. Houlihan "did what he needed to do to clear his record based on what they said in Iowa."[115]

2. The VA did not address the apparent Iowa misconduct until 2009

Every two years, the VA reviews and recertifies the credentials of its medical professionals.[116] This re-credentialing process reviews the medical professional's medical license and Drug Enforcement Administration license status, and queries the National Practitioner's Data Bank and the appropriate state databases.[117] The re-certification process may also measure additional metrics depending on the medical professional's specialty.[118] Once the appropriate data are collected and reviewed, the Medical Executive Committee at the professional's facility ensures that all the proper documentation is in order and approves, or denies, the professional's reappointment for VA privileges.[119] At the facility level, the chief of staff is the "key player" in this re-credentialing process.[120]

Dr. Houlihan underwent this typical re-credentialing procedure in 2003, 2005, and 2007.[121] None of these biannual re-credential reviews examined the allegations that the Iowa Board of Medical Professionals levied against Dr. Houlihan in 2002.[122] Victoria Brahm, who served at the time as VISN 12 Quality Management Officer and Acting Chief Medical Officer, noted that in 2009 "there was a lot of Houlihan attention" at VISN 12 about his clinical practices and other issues.[123] Ms. Brahm explained that the increased attention and communications at the VISN level was unusual as the Tomah VAMC was "one hospital that previously hasn't required a lot of attention."[124] In light of these concerns, Ms. Brahm stated that she "started to pay a lot of

[115] *Id.* at 25.
[116] *See generally* Memorandum from Katherine Pica, Assoc. Chief of Staff, Tomah VAMC, to Victoria Brahm, Acting Chief Med. Officer, VISN 12 (Nov. 9, 2009), OIG 10458 [hereinafter 11/9/2009 Memo from Katherine Pica to Victoria Brahm].
[117], Bonner Transcribed Interview, at 50–51.
[118] *Id.* at 50.
[119] *Id.* at 51–52.
[120] *Id.* at 52.
[121] 11/9/2009 Memo from Katherine Pica to Victoria Brahm, at OIG 10458–59.
[122] *Id.*
[123] Transcribed Interview with Victoria Brahm, in Tomah, Wis., at 53 (Dec. 16, 2015) [hereinafter Brahm Transcribed Interview].
[124] *Id.*

attention to Tomah" and began taking a closer look at documentation she had not reviewed prior to the influx of concerns about Dr. Houlihan.[125]

As part of her increased emphasis on the Tomah VAMC, Ms. Brahm inquired into whether the VA had ever reviewed the 2002 allegations against Dr. Houlihan.[126] She believed that the VA reviewed these allegations when Dr. Houlihan was hired, but found no documentation in his VA employee file to verify that fact.[127] In a transcribed interview, Ms. Brahm told Chairman Johnson's staff that through informal discussions with VA personnel, leadership agreed that as of 2009, the 2002 issue was in the past and that Dr. Houlihan possessed an "unrestricted license."[128] Nonetheless, she felt "angst" over the lack of a documented VA review and asked Dr. Katherine Pica, the then-Tomah VAMC Associate Chief of Staff, to complete an evaluation of the 2002 Iowa allegations.[129]

The results of Ms. Brahm's request were summarized in a November 9, 2009, memorandum from Dr. Pica to Ms. Brahm.[130] The memorandum summarized the charges that the Iowa Board of Medical Examiners had levied against Dr. Houlihan in 2002. The review included verification from a representative of the Iowa Board of Medical Examiners that Dr. Houlihan had completed the patient boundary education program within the required 90 days and that upon completion of that program, Dr. Houlihan had a "clear, unrestricted license in the State of Iowa."[131] The memorandum noted that as of February 1, 2004, Dr. Houlihan allowed his Iowa license to lapse and that he held a current Wisconsin license.[132]

Dr. Pica's memorandum included an explanation of why the VA failed to document the Iowa Medical Board's allegations until 2009. She wrote:

> No issues have been identified during the biennial reappointment processes. Since the license issue had been resolved, it has not been addressed as part of the 2003, 2005, and 2007 reappointments. This oversight will be acknowledged on the Service Chief Approval screen at time of future reappointments. A review by the Chief Medical Officer will also be obtained on subsequent reappointments.[133]

Chairman Johnson's staff conducted a transcribed interview of Dr. Pica on December 17, 2015. When staff showed the memorandum to her, Dr. Pica had no recollection of reviewing the 2002 Iowa Board of Medical Examiners allegations against Dr. Houlihan.[134] She said that she

[125] *Id.*
[126] *Id.* at 52–53.
[127] *Id.* at 49.
[128] *Id.* at 52.
[129] *Id.* at 49.
[130] 11/9/2009 Memo from Katherine Pica to Victoria Brahm, at OIG 10458–59.
[131] *Id.*
[132] *Id.*
[133] *Id.*
[134] Pica Transcribed Interview, at 84–92.

did not recall creating the memorandum, stating "no. I did not type up this memo."[135] When asked who did create the memorandum, Dr. Pica replied, "[t]he credentialer maybe."[136] Although Dr. Pica did not recall reviewing the 2002 Iowa allegations or creating the 2009 memorandum, she did acknowledge that it was her signature on the document.[137] Despite her failure to remember the memorandum, Dr. Pica informed Chairman Johnson's staff that the 2009 review of Dr. Houlihan's 2002 Iowa allegations was the only time she has signed a re-credentialing document for the VA.[138]

Although aware of the charges when he was hired, the VA regional leadership only ordered a full examination of the Iowa charges against Dr. Houlihan in 2009—years after he became chief of staff at the Tomah VAMC. By that time, leadership determined that the issues were "cleared up" and Dr. Houlihan was fit to continue practice.[139] In not acting sooner, the VA missed an opportunity to carefully examine Dr. Houlihan and potentially prevent the issues at the Tomah VAMC before they arose.

C. The Tomah employees union complained to the VA OIG about over-prescription at the Tomah VAMC in 2009, but it is unclear whether the OIG took action

Local 0007 of the American Federation of Government Employees (AFGE) represents non-physician employees of the Tomah VAMC. Local 0007 officials told the Committee that they raised concerns to the VA OIG about over-prescription practices at the Tomah VAMC in 2009.[140] However, VA OIG personnel on site at the Tomah VAMC cancelled their scheduled meeting with AFGE officials less than one hour before the meeting was scheduled to occur.[141] According to the AFGE officials, they supplied a package of documents outlining concerns about over-prescription of drugs to veterans and issues with management, among other concerns.[142] When asked by Chairman Johnson's staff about this information, VA OIG officials said that they did not recall receiving the information from AFGE officials in 2009.[143] It is unclear whether the VA OIG conducted any investigation as a result of the AFGE's reports.

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[135] *Id.* at 89.
[136] *Id.* at 89.
[137] *Id.* at 93.
[138] *Id.* at 93–94.
[139] Brahm Transcribed Interview, at 49.
[140] *See* Transcribed Interview with Linda Ellinghuysen, in Tomah, Wis., at 85–88 (Dec. 14, 2015) [hereinafter Ellinghuysen Transcribed Interview].
[141] *See* Memorandum from American Federation of Government Employees (AFGE) Local 1882 AFL-CIO to IG Representatives (Jan. 8, 2009), *in* AFGE Local 0007 June 4, 2015 Document Production, at 2 [hereinafter 1/8/2009 Memo from AFGE Local 1882 AFL-CIO to IG Representatives].
[142] Ellinghuysen Transcribed Interview, at 141–42.
[143] Transcribed Interview with Wachita Haywood, in Washington, D.C., at 70–72 (Feb. 11, 2016) [hereinafter Haywood Transcribed Interview].

In early 2009, the VA OIG visited the Tomah VAMC to examine an unrelated allegation of patient abuse.[144] While they were on the facility grounds, Linda Ellinghuysen, an official with AFGE Local 0007, scheduled an appointment with the OIG investigators, which was initially cancelled.[145] During a transcribed interview, she explained how she presented information to the VA OIG. She stated:

> But I had a packet of information and I knew that they were in the library conference room, so I went over there and knocked on the door and asked to speak with them. And I did not—I got a very cold reception, like they did not want to speak with a union rep.
>
> They asked me if I called the hotline and I said no. Well, you need to call the hotline. And my recall is I said, well, no. You're right here.
>
> I mean it took enough courage just to go over there. I'm not going to call the hotline. I needed to speak with these people. But they didn't want to talk to me, so I had a packet of information in a manila envelope and I slid it on the table. And I said, there's confidential information in there about narcotics and patient suicides and bad behavior by the Chief of Staff. If you're not going to read it, please shred it, because it's confidential, but I left it there.
>
> And then within 20 minutes they called the union office and asked us to come over.[146]

Ms. Ellinghuysen's memorandum, dated January 8, 2009, was addressed to unnamed "IG Representatives."[147] The memorandum read in part: "AFGE Officers were looking forward to meeting with you this date at 1:00pm; however, at approximately 12:15pm today we received a telephone call from the P.I. Director, Judith Broad, and she informed the Chief Steward that you had cancelled your meeting with us."[148] The memorandum explained that the union had "glean[ed] valuable information related to Patient Abuse and related to Fraud."[149] She provided a package of documents that accompanied the memorandum and requested a copy of the IG's subsequent findings.[150]

Ms. Ellinghuysen said that the package of documents also included a document titled "Questions For Leadership."[151] The document highlighted complaints and allegations from two separate dates: August 7, 2008, and January 2009.

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[144] Ellinghuysen Transcribed Interview, at 69–70.
[145] *Id.* at 70.
[146] *Id.* at 70–71.
[147] 1/8/2009 Memo from AFGE Local 1882 AFL-CIO to IG Representatives.
[148] *Id.*
[149] *Id.*
[150] *Id.*
[151] Ellinghuysen Transcribed Interview, at 140.

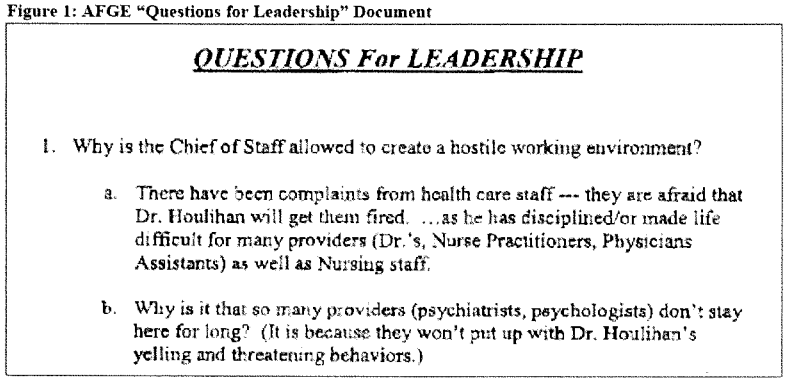
The complaint dated August 7, 2008, included a broad question—"why is the Chief of Staff allowed to create a hostile working environment?"[152] The document noted the difficulties that the Tomah VAMC had in retaining providers, issues with the quality of veteran care at the facility, and a fear among the staff that Dr. Houlihan would fire them.[153] The complaint also posed questions about the potential misuse of funds.[154]

The "Questions for Leadership" document also contained allegations date stamped January 2009.[155] One of the allegations read:

> There have been several staff reports that Dr. Houlihan is known as the "candy man" by several patients here. There are several staff whom, in their professional judgement [*sic*], believe that Dr. Houlihan overmedicates patients. There have been several patients who have had to be given Narcan [an opiate antidote] due to adverse side affects [*sic*] from too many narcotics and other medications.[156]

According to a whistleblower who contacted Chairman Johnson's staff in May 2015, the "Candy Man" moniker dates back to at least 2004.[157] The whistleblower stated that Dr. Houlihan was "furious" when he learned of the nickname.[158]

Figure 1: AFGE "Questions for Leadership" Document



QUESTIONS For LEADERSHIP

1. Why is the Chief of Staff allowed to create a hostile working environment?

    a. There have been complaints from health care staff --- they are afraid that Dr. Houlihan will get them fired. ...as he has disciplined/or made life difficult for many providers (Dr.'s, Nurse Practitioners, Physicians Assistants) as well as Nursing staff.

    b. Why is it that so many providers (psychiatrists, psychologists) don't stay here for long? (It is because they won't put up with Dr. Houlihan's yelling and threatening behaviors.)

[152] Questions for Leadership, *in* AFGE Local 0007 June 4, 2015 Document Production, at 3.
[153] *Id.* at 3–4.
[154] *Id.*
[155] *Id.* at 4.
[156] *Id.*
[157] *See* S. COMM. ON HOMELAND SEC. & GOVERNMENTAL AFFAIRS, MAJORITY STAFF REPORT: TRAGEDY AT TOMAH: INITIAL FINDINGS 14 (2015).
[158] *Id.*

Figure 2: AFGE "Questions for Leadership" Document

1. There have been several staff reports that Dr. Houlihan is known as the "candy man" by several patients here. There are several staff whom, in their professional judgement, believe that Dr. Houlihan overmedicates patients. There have been several patients who have had to be given Narcan due to adverse side affects from too many narcotics and other medications. (or similar medications)

2. Dr. Houlihan, early December 2008, screamed at a Registered Pharmacist, who used to be the Coordinator of a Pain Clinic at another health care agency, because she recommended to him a different regimen of pain medications. The Pharmacist refused to fill the prescription because the patient would have overdosed on narcotics.

January 2009

When Chairman Johnson's staff interviewed Ms. Ellinghuysen, she stated that when she provided these documents to VA OIG personnel at the Tomah facility in January 2009, they were initially dismissive of her concerns.[159] However, Ms. Ellinghuysen said that when she attempted to meet with the VA OIG representatives for a second time that day, she was able to speak with the OIG staff for about 45 minutes.[160] When Chairman Johnson's staff inquired about the identities of the VA OIG staff, she explained that she could not recall the names. She said:

> A: I do not recall the names. There were two females. One black American and one Caucasian. The black American female appeared very angry at me when I walked in. But she softened after I went back the second time and we stated talking.
>
> Q: And how long was that that second time? How long did you meet and speak with them?
>
> A: I would guess 45 minutes.
>
> Q: Do you recall where they were out of? Were they out of Chicago? Where were these OIG agents from? Where was their home office?
>
> A: My recollection is Chicago. I cannot be certain of that. I don't have cards from them. But I thought it was out of Chicago.[161]

[159] Ellinghuysen Transcribed Interview, at 86–87.
[160] *Id.*
[161] *Id.*

Chairman Johnson's staff inquired about the documentation that Ms. Ellinghuysen provided to the VA OIG when the OIG employees were at the Tomah VAMC in January 2009. She stated:

Q: This is a January, 2009, memo from you to the IG. I believe, is this the document we were referring to earlier when discussing your interactions with the IG back in January?

A: Yes.

Q: In the corresponding two pages there is a list of questions for leadership. Was that also provided to the IG?

A: I think it was.

Q: So if we go through it. In January, there's an addendum at the end of page 2 of 2. It says, in January 2009, point one, I'll read from it. "There have been several staff reports that Dr. Houlihan is known as the, quote, Candy Man by several patients here. Several staff whom, in their professional judgment, believe that Dr. Houlihan overmedicates patients. There have been several patients who have been given Narcan due to adverse side affects from too many narcotics and other medications."

So if your recollection is correct, and you included this in your Memorandum to the Inspector General's office, did the Inspector General's office know about Candy Man as early as 2009 then?

A: Yes.

Q: And so when you're in the meeting with the Inspector General's office, did they go over any of these documents with you or did you just kind of drop it off and leave? I know you said they didn't take any notes.

A: Right.

Q: Was there any presentation of documents?

A: I don't recall if I took my own notes, because I only gave them copies, or if I had their notes.

Q: Gave them copies of what?

A: Copies of what I put in the manila envelope for them.

Q: Um-hum.

A: And, you know, lots of enclosures. I don't recall sitting down, going over paperwork. But what I recall is, the two other officers and I, we talked about these issues. And we talked about Candy Land. We talked about Candy Man. We talked about narcotics and, you know, by this time we had had a couple of suicides in our parking lot and that concerned us, because, there again, we can't get in the charts and the staff are afraid to freely give information, we're piecing things together.

And we're saying, you know, we think these may be Dr. Houlihan's patients, and we're hearing that they have a lot of opioids and benzos and all these medications, but we can only, you know, I mean, we tell them what we hear, and we expect them to investigate. And that, and that did not occur.[162]

Chairman Johnson's staff questioned VA OIG officials about whether they recalled receiving these allegations in 2009. In a transcribed interview, staff presented Wachita Haywood, the Associate Director of the VA OIG's Chicago Office of Healthcare Inspections, with the January 8, 2009 memorandum from Ms. Ellinghuysen, as well as the "Questions for Leadership" document.[163] Chairman Johnson's staff also presented Ms. Haywood with sections of Ms. Ellinghuysen's statements where she claims that she spoke to VA OIG officials.[164] Ms. Haywood said that she was not present at the 2009 meeting between the VA OIG and the Tomah VAMC union officials.[165]

On April 21, 2016, Maureen Regan, Counselor to the VA Inspector General, wrote to Chairman Johnson and Ranking Member Caper to offer an account of the VA OIG's involvement at the Tomah VAMC in the January 2009 timeframe. The VA OIG's account of the interaction differed slightly from Ms. Ellinghuysen's account; however, the VA OIG admitted to receiving a copy of Ms. Ellinghuysen's memorandum.

The VA OIG's account differs from Ms. Ellinghuysen's with respect to the additional documentation she provided to the VA OIG in January 2009. Ms. Regan wrote that the VA OIG "reviewed OIG records and determined that there was an on-going healthcare inspection at the

[162] *Id.* at 140–42.
[163] Haywood Transcribed Interview, at 70–74.
[164] *Id.* at 75–81.
[165] *Id.* at 81.

time that included a site visit."[166] Following the interview with Ms. Haywood, the VA OIG was able to identify the two inspectors who were on-site in January 2009.[167] According to Ms. Regan:

> The inspectors confirmed that they did receive a copy of the January 8, 2009 memorandum; however they did not recall receiving any additional documents and denied having met with Ms. Ellinghuysen. We showed the inspectors a picture of Ms. Ellinghuysen and neither inspector recognized her. We also pulled the file for the inspection and did not find any documents relating to the issues Ms. Ellinghuysen claims to have raised during that inspection.[168]

Given the different recollections between Ms. Ellinghuysen and the VA OIG, it is unclear what information the VA OIG received and whether the VA OIG did any investigation into these allegations. Ms. Ellinghuysen explained that she did not follow up with the VA OIG. When asked why, she listed three reasons. First, she explained that the cold and dismissive reception she received from the VA OIG dissuaded her from following up.[169] Second, she felt that the fact that the VA OIG personnel did not take notes at the meeting made it look like "they weren't going to do anything" about her allegations.[170] Third, the culture of fear and reprisal at the Tomah VAMC, combined with the apparent low likelihood that the VA OIG was going to do anything about her allegations, posed a risk that she could face retaliation for her reporting of wrongdoing.[171]

As part of its subsequent Tomah VAMC health care inspection, the VA OIG reviewed the VA "OIG Master Case Index records of 19 cases at Tomah VAMC since 2009."[172] In an attempt to ascertain whether the VA OIG received and reviewed Ms. Ellinghuysen's 2009 allegations, Chairman Johnson's staff asked the VA OIG for a list of the 19 cases referred to in the VA OIG's administrative closure.[173] The VA OIG refused to provide that information.[174] Given the VA OIG's continued obstruction of the investigation, the majority staff is unable to

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[166] Letter from Maureen Regan, Counselor to the Inspector General, Dep't of Veterans Affairs, to Hon. Ron Johnson, Chairman, S. Comm. on Homeland Sec. & Governmental Affairs, and Hon. Thomas R. Carper, Ranking Member, S. Comm. on Homeland Sec. & Governmental Affairs, at 1 (Apr. 21, 2016) [hereinafter 4/21/2016 Letter from Maureen Regan, VA OIG, to Chairman Johnson and Ranking Member Carper, HSGAC].

[167] *Id.* Ms. Regan's letter also suggests a discrepancy in the identity of the VA OIG inspectors. Ms. Regan wrote that "both inspectors are female and both are African-American; no Caucasian inspectors were on-site for this inspection." *Id.* This account differs from Ms. Ellinghuysen's recollection that she met with "one black American and one Caucasian." Ellinghuysen Transcribed Interview, at 86–87.

[168] 4/21/2016 Letter from Maureen Regan, VA OIG, to Chairman Johnson and Ranking Member Carper, HSGAC, at 1.

[169] Ellinghuysen Transcribed Interview, at 87–88.

[170] *Id.* at 88.

[171] *Id.*

[172] VA OIG TOMAH VAMC ADMINISTRATIVE CLOSURE, at 2.

[173] E-mail from Majority Staff, HSGAC, to Staff, VA OIG (Mar. 2, 2016, 2:27 PM) (on file with Comm.).

[174] E-mail from Staff, VA OIG, to Staff, HSGAC (Mar. 16, 2016, 2:20 PM) (on file with Comm.).

independently ascertain whether the VA OIG took any action in response to Ms. Ellinghuysen's allegations.

D. The Drug Enforcement Administration has been investigating potential drug diversion at the Tomah VAMC since 2009, with no public results

The DEA is the federal law-enforcement entity charged with enforcing federal drug laws. According to information received by Chairman Johnson's staff, the DEA has been examining potential drug diversion in and around the Tomah VAMC since at least 2009. In addition to investigative actions in 2011 and 2012, the DEA is said to be currently investigating the Tomah VAMC.

On June 19, 2009, a DEA investigator interviewed Dr. Noelle Johnson, a pharmacist at the Tomah VAMC.[175] During the interview, Dr. Johnson provided the investigator with about ten examples of patients under Dr. Houlihan's care for whom Dr. Johnson believed the narcotic prescription was either too high in dosage or too long in length.[176] Dr. Johnson also apparently informed the investigator about three "unexplained" deaths of Dr. Houlihan's patients during her time at the facility.[177] The DEA's interview of Dr. Johnson lasted approximately two hours.[178] During her testimony before Chairman Johnson's field hearing in Tomah in March 2015, Dr. Johnson stated that she was interviewed by the DEA on two other occasions.[179]

According to other documents obtained by Chairman Johnson, the DEA investigated potential drug diversion at the Tomah VAMC in concert with the VA OIG's inquiry in 2011 and 2012. VA OIG personnel joined DEA diversion investigators in 2012 in examining potential drug abuse at the Tomah facility. On March 28, 2012, VA OIG Special Agent Greg Porter joined the DEA and a detective from the Tomah Police Department in interviewing a Tomah VAMC police officer.[180] The VA police officer alleged that Dr. Houlihan abused his authority

[175] Noelle Johnson v. Dep't of Veterans Affairs, MSPB Docket No. CH-1221-10-0036-W-1, Tab 1 at 6 (on file with Comm.). Dr. Johnson also confirmed that she was interviewed by the DEA in 2009 in her written testimony for the Committee's Field Hearing in Tomah on March 30, 2015. *Tomah VAMC: Examining Quality, Access, and Culture of Overreliance on High-Risk Medications, Joint Field Hearing Before S. Comm. on Homeland Sec. & Governmental Affairs & H. Comm. on Veterans Affairs*, 114th Cong. (2015) (statement of Dr. Noelle Johnson); VA OIG Interview with Noelle Johnson (May 10, 2012), OIG 5935, at OIG 5955, at 78.

[176] Noelle A. Johnson v. Dep't of Veterans Affairs, MSPB Docket No. CH-1221-10-0036-W-1, Tab 1 at 6 (on file with Comm.).

[177] *Id.*

[178] *Id.*

[179] *Tomah VAMC: Examining Quality, Access, and Culture of Overreliance on High-Risk Medications, Joint Field Hearing Before S. Comm. on Homeland Sec. & Governmental Affairs & H. Comm. on Veterans Affairs*, 114th Cong. (2015) (statement of Dr. Noelle Johnson).

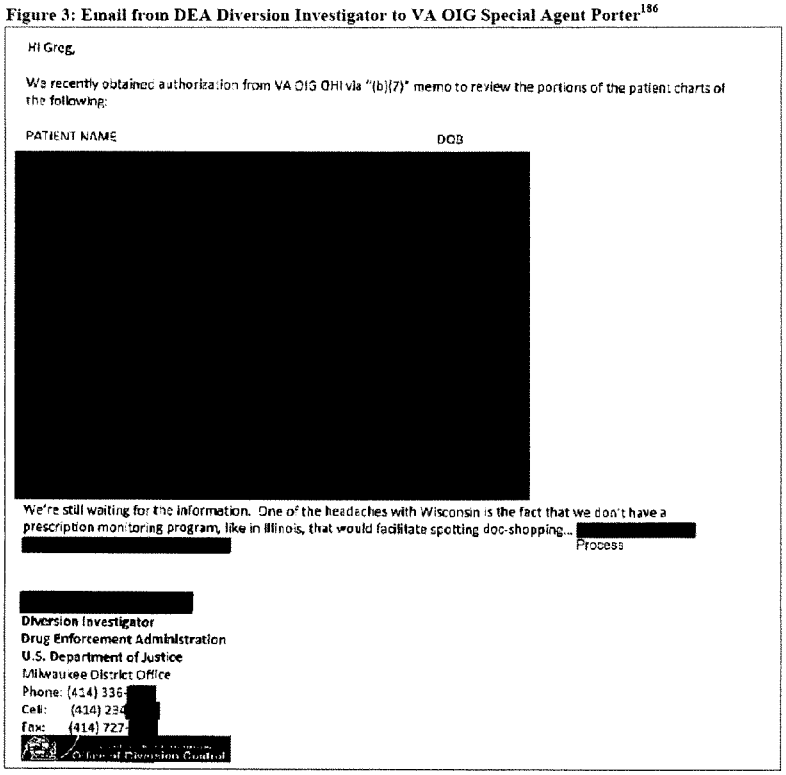
[180] VA OIG Criminal Investigations Div., Greg Porter, Memorandum of Interview of Tomah VAMC Employee (Mar. 28, 2012), OIG 10592, at OIG 10592–93. Dr. Mallinger also spoke with this DEA diversion investigator and documented additional details of the March 28, 2012 meeting. VA OIG Office of Healthcare Inspections, Alan Mallinger, Report of Contact with Diversion Investigator, DEA (Apr. 2, 2012), at OIG 5895.

by interfering in VA police activities on the grounds of the Tomah VAMC—specifically, that Dr. Houlihan would not allow VA police "to interact with patients, even if they are suspected of criminal activity."[181] The VA police officer described Dr. Houlihan as having a "short fuse" and a "bad temper" when dealing with VA police.[182]

Later, in May 2012, the DEA received from the VA OIG sensitive patient information, including patient charts.[183] The DEA diversion investigator wrote in an email to VA OIG Special Agent Porter: "We recently obtained authorization from VA OIG [Office of Healthcare Inspections] via '(b)(7)' memo to review the portions of the patient charts . . . ."[184] In September 2012, the DEA apparently made a Privacy Act request for information from the Tomah VAMC, including patient records relating to Dr. Houlihan.[185]

[181] VA OIG Office of Healthcare Inspections, Alan Mallinger, Report of Contact with Diversion Investigator, DEA (Apr. 2, 2012), OIG 5895.
[182] *Id.*
[183] E-mails between Greg Porter, VA OIG, and Diversion Investigator, DEA (May 2012), OIG 10607, at OIG 10608–09.
[184] *Id.* at OIG 10608.
[185] E-mail from John Brooks, VA OIG, to George Wesley and Alan Mallinger, VA OIG (Sept. 19, 2012, 12:38 PM), at OIG 11507.

Figure 3: Email from DEA Diversion Investigator to VA OIG Special Agent Porter[186]



Hi Greg,

We recently obtained authorization from VA OIG OHI via "(b)(7)" memo to review the portions of the patient charts of the following:

PATIENT NAME DOB

[redacted]

We're still waiting for the information. One of the headaches with Wisconsin is the fact that we don't have a prescription monitoring program, like in Illinois, that would facilitate spotting doc-shopping... [redacted] Process

[redacted]

Diversion Investigator
Drug Enforcement Administration
U.S. Department of Justice
Milwaukee District Office
Phone: (414) 336-[redacted]
Cell: (414) 234-[redacted]
Fax: (414) 727-[redacted]

[redacted]

During a transcribed interview, Chairman Johnson's staff asked Special Agent Porter about the purpose of a "(b)(7)" memo. He explained it was "an official request to an agency for information that they would not normally release."[187] Special Agent Porter also confirmed that the DEA had an ongoing investigation at the facility in 2012. He said:

> Q: So, Agent Porter, speaking about the DEA, from your viewpoint, and—and sharing information back and forth with the DEA, was it

[186] E-mail from Diversion Investigator, DEA, to Greg Porter, VA OIG (May 21, 2012, 1:49 PM), at OIG 10608.
[187] Transcribed Interview with Greg Porter, in Washington, D.C., at 38 (Jan. 28, 2016) [hereinafter Porter Transcribed Interview].

your view, in 2012, that the DEA had an investigation ongoing that included the Tomah VA?

A: Yes.[188]

Although the DEA and OIG shared information about the Tomah VAMC, there is not a clear delineation of which agency was charged with investigating the potential diversion of controlled substances prescribed at the VA. Special Agent Porter described how the OIG's mission differed from the DEA's duties in regards to investigating drug diversion.[189] He explained further:

A: As the [VA OIG] Office of Criminal Investigations, there are limited circumstances where we can obviously take part in investigations, you know, assist DEA with, you know, parts of their investigations as requested, things like that. You know, unless it—I don't really know all of the limited situations, but basically we don't have statutory authority as a primary agency to investigate drug diversion, is the simplest way to put it.

Q: Even if the drugs are alleged to be coming from a VA facility?

A: Yeah, just because it comes from a VA facility doesn't give us primary authority, as I understand it, to solely investigate that. We would, you know, typically have to be working with DEA, who has the statutory authority to investigate those crimes.

Q: What if the suspect is an employee—does that change anything?—of the VA?

A: Well, I think if it's happening on VA property and things like that, I think that gives us a bigger stake in the game, so to speak. But without having to go research it, I couldn't tell you for certain, you know, what the limited situations are and things like that.[190]

Special Agent Porter also said that he was unaware of whether any formal delineation of responsibility—such as in a memorandum of understanding—existed between the VA OIG and DEA.[191]

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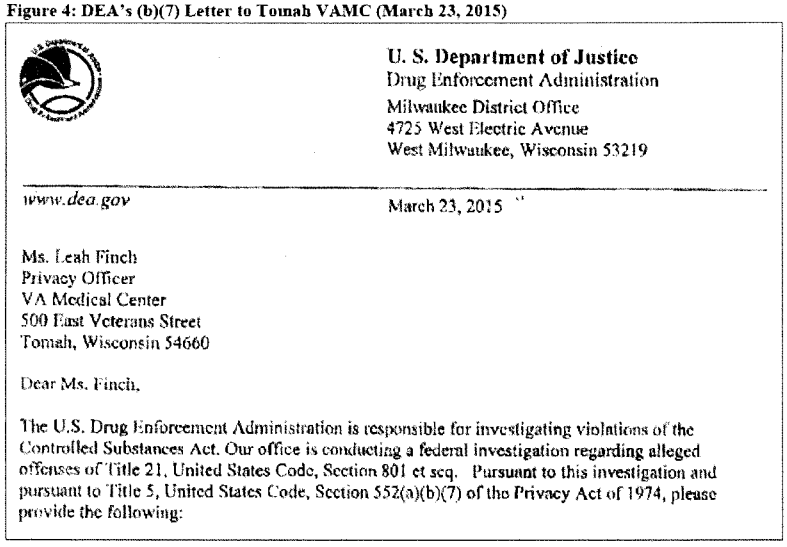
[188] *Id.* at 151.
[189] *Id.* at 43–44.
[190] *Id.* at 44.
[191] *Id.* at 44–45.

On January 28, 2015, Chairman Johnson wrote to then-DEA Administrator Michele Leonhart requesting information and material about the DEA's investigations into the Tomah VAMC.[192] DEA staff informed Chairman Johnson's staff that the DEA would not provide any information about its work.[193] On March 3, 2015, Chairman Johnson again wrote to Ms. Leonhart to reiterate his request for information about the DEA's investigation of the Tomah VAMC.[194] On March 17, 2015, the DEA responded, again declining to provide any details about its work at the facility.[195]

Interestingly, on March 23, 2015—shortly after the DEA informed Chairman Johnson of its refusal to provide information about its work at the Tomah VAMC—the Milwaukee office of the DEA sent a lengthy "(b)(7)" document request to the Tomah VAMC.[196] The letter requested 30 separate categories of material, including specific information about Dr. Houlihan and Deborah Frasher.[197] When Chairman Johnson's staff attempted to ask Special Agent Porter about this (b)(7) letter, a VA OIG attorney interrupted and prevented him from answering.[198]

[192] Letter from Hon. Ron Johnson, Chairman, S. Comm. on Homeland Sec. & Governmental Affairs, to Hon. Michelle M. Leonhart, Administrator, Drug Enforcement Administration, at 2 (Jan. 28, 2015) [hereinafter 1/28/2015 Letter from Chairman Johnson, HSGAC, to Administrator Leonhart, DEA].
[193] E-mails between Matt Strait, DEA, and Majority Staff, HSGAC (Feb. 5–9, 2015) (on file with Comm.).
[194] Letter from Hon. Ron Johnson, Chairman, S. Comm. on Homeland Sec. & Governmental Affairs, to Hon. Michelle M. Leonhart, Administrator, Drug Enforcement Administration, at 1 (Mar. 3, 2015) [hereinafter 3/3/2015 Letter from Chairman Johnson, HSGAC, to Administrator Leonhart, DEA].
[195] Letter from Eric J. Akers, Deputy Chief, Office of Congressional & Public Affairs, DEA, to Hon. Ron Johnson, Chairman, S. Comm. on Homeland Sec. & Governmental Affairs, at 1 (Mar. 17, 2015) [hereinafter 3/17/2015 Letter from Deputy Chief Akers, DEA, to Chairman Johnson, HSGAC].
[196] Letter from Christopher J. Hackbarth, Acting Asst. Special Agent in Charge, Milwaukee District Office, DEA, to Leah Finch, Privacy Office, Tomah VAMC (Mar. 23, 2015).
[197] *Id.*
[198] Porter Transcribed Interview, at 151.

Figure 4: DEA's (b)(7) Letter to Tomah VAMC (March 23, 2015)



U. S. Department of Justice
Drug Enforcement Administration
Milwaukee District Office
4725 West Electric Avenue
West Milwaukee, Wisconsin 53219

www.dea.gov

March 23, 2015

Ms. Leah Finch
Privacy Officer
VA Medical Center
500 East Veterans Street
Tomah, Wisconsin 54660

Dear Ms. Finch,

The U.S. Drug Enforcement Administration is responsible for investigating violations of the Controlled Substances Act. Our office is conducting a federal investigation regarding alleged offenses of Title 21, United States Code, Section 801 et seq. Pursuant to this investigation and pursuant to Title 5, United States Code, Section 552(a)(b)(7) of the Privacy Act of 1974, please provide the following:

Despite examining potential drug diversion in and around the Tomah VAMC for over six years, the DEA refuses to discuss what it has done. The DEA has interviewed at least one concerned pharmacist from the facility, has collected patient charts, and has now apparently requested substantially more information. Even after collecting all this material, the DEA did not prevent the abuse of opioids at the Tomah VAMC.

E. The VA did not investigate the 2009 death of Dr. Christopher Kirkpatrick, who attempted to blow the whistle on over-medication

Dr. Christopher Kirkpatrick was a clinical psychologist at the Tomah VAMC from September 2008 to July 2009. Dr. Kirkpatrick raised concerns within the facility about prescription practices. He faced discipline for blowing the whistle and was eventually fired from his position. On the evening of his termination of employment with the Tomah VAMC, Dr. Kirkpatrick committed suicide. The VA never investigated his death.

In April 2009, Dr. Kirkpatrick alerted representatives from the local Tomah VAMC employee's union about trouble he was having with his immediate supervisor. He wrote of an

accusation levied against him that he inappropriately discussed medications with a colleague with whom he shared patients.[199] He wrote:

> I have had words with [the colleague] inquiring about medications and possible side effect/adverse reactions they were experiencing but these conversations happened months ago. These situations put me into an ethical dilemma. . . . Based on what others have told me, I have every reason to be very afraid of Dr. Houlihan. I have sacrificed a lot to move up here and do the kind of work I excel at and help people in. I need help.[200]

Days later, Dr. Kirkpatrick received a written counseling from his immediate supervisor, advising him that he "should not be 'educating' patients about what medications they are on."[201] Dr. Kirkpatrick's supervisor, Dr. Gary Loethen testified to a VA Administrative Investigation Board (AIB) in 2015 that he felt coerced into issuing Dr. Kirkpatrick the written counseling. He testified:

> Q: I was going to ask you whether you felt Dr. Kirkpatrick's actions warranted a reprimand or whether you felt you were simply carrying out instructions?
>
> A: I felt I was carrying out instructions. I testified previously that I was quite—I don't know what the right word is—concerned, afraid—of Dr. Houlihan and what he would do if I did not comply with whatever he wanted me to do regarding the job. So I didn't feel I had any choice other than to follow those, those orders.[202]

In May 2009, Dr. Kirkpatrick wrote to his immediate supervisor that he and other colleagues had "notic[ed] changes in demeanor in our patients. I do not presume to prescribe medications but think it is important there be a dialogue between providers so as to best serve our patients."[203]

On July 14, 2009, Dr. Kirkpatrick was called into the human resources office at the Tomah VAMC, along with his union representative. The union official, Linda Ellinghuysen, described the meeting as "gruesome," writing that "management would not listen to any rationale

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[199] E-mail from Chris Kirkpatrick, Tomah VAMC, to Dianne Streeter and Linda Ellinghuysen (Apr. 23, 2009), *in* JUNEAU COUNTY SHERIFF'S DEPARTMENT, CHRIS KIRKPATRICK DEATH INVESTIGATION REPORT 40, 43 (2009).
[200] *Id.*
[201] Memorandum from Gary Loethen, M.D., U.S. Dep't of Veterans Affairs, to Chris Kirkpatrick, M.D., U.S. Dep't of Veterans Affairs (Apr. 30, 2009), *in* JUNEAU COUNTY SHERIFF'S DEPARTMENT, CHRIS KIRKPATRICK DEATH INVESTIGATION REPORT, at 24 (2009).
[202] Admin. Board of Investigation Transcribed Interview with Gary Loethen (Apr. 15, 2015), at 20–21 [hereinafter AIB Transcribed Interview with Gary Loethen].
[203] Letter from Chris Kirkpatrick, Tomah VAMC, to Gary Loethen, U.S. Dep't of Veterans Affairs (May 13, 2009), *in* JUNEAU COUNTY SHERIFF'S DEPARTMENT, CHRIS KIRKPATRICK DEATH INVESTIGATION REPORT, at 23 (2009).

[*sic*] argument."[204] Dr. Kirkpatrick, who was employed on a temporary status, was fired for vague "performance issues" the same day.[205] That evening, Dr. Kirkpatrick was found dead from a self-inflicted gunshot wound.

Dr. Kirkpatrick's supervisor, Dr. Loethen, was present at the meeting during which Dr. Kirkpatrick was terminated from the Tomah VAMC. He testified to the VA's AIB in 2015 that he did not agree with the decision to fire Dr. Kirkpatrick:

Q: Did you agree with the decision to remove Dr. Kirkpatrick?

A: I did not.

Q: Did you ever express your belief that he should not be removed?

A: Yes I did.

Q: Who did you speak with about that?

A: [The Director of the Residential Post Traumatic Stress Disorder Treatment Program]

Q: What did you tell him, to the best of your recollection?

A: I told him that I didn't think that, you know, what was going on wasn't anything that couldn't be resolved. And if there was this ongoing conflict between Dr. Kirkpatrick and [the colleague Dr. Kirkpatrick had "words" with in April 2009] and [the colleague] had the backing of the Chief of Staff, which was a very powerful backing, that probably the, the easiest thing to do, if we were going to try and resolve the situation, would be to transfer Dr. Kirkpatrick to the Mental Health Clinic downstairs and have him work as an outpatient therapist in there where he could still treat PTSD patients, but he would not have any ongoing direct contact with [the colleague].[206]

Dr. Kirkpatrick's brother, Sean Kirkpatrick, testified during a Committee hearing in September 2015 about his brother. Mr. Kirkpatrick testified:

> While at the Tomah VA Medical Center, Chris told us that he was concerned about the overmedication of many of his veteran patients and raised questions –

[204] Memorandum by Linda Ellinghuysen, Executive V.P., AFGE Local 1882, at 1 (2009), *in* JUNEAU COUNTY SHERIFF'S DEPARTMENT, CHRIS KIRKPATRICK DEATH INVESTIGATION REPORT 34 (2009).
[205] Memo from VA to Kirkpatrick July 14, 2009.
[206] AIB Transcribed Interview with Gary Loethen, at 22–23.

> therapy sessions that he was facilitating were not effective, because veterans were not alert, lethargic/too impaired and drugged due to the overmedication side effects so he could not help them.[207]

Mr. Kirkpatrick continued: "The Tomah VA Medical Center did not disclose the circumstances of Chris' termination . . . . We were told that he had 'missed too many days.'"[208]

On April 20, 2015, Chairman Johnson wrote to VA Secretary McDonald asking about the circumstances of Dr. Kirkpatrick's termination and death.[209] On May 29, 2015, VA Deputy Secretary Sloan Gibson responded to Chairman Johnson's letter.[210] Deputy Secretary Gibson wrote that the "VA did not conduct an investigation into Dr. Kirkpatrick's termination and suicide" because "during the July 14, 2009, meeting where Dr. Kirkpatrick was notified that his temporary appointment would be terminated effective July 28, 2009, he indicated his intention to resign prior to the termination effective date."[211]

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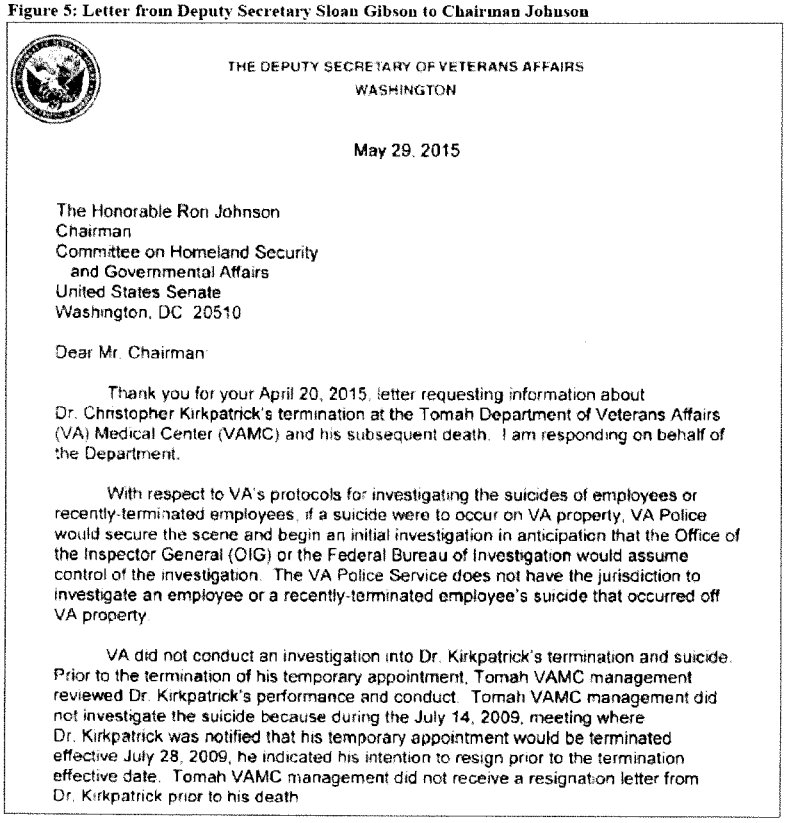
[207] *Improving VA Accountability: Examining First-Hand Accounts of Department of Veterans Affairs Whistleblowers, Hearing before the S. Comm. on Homeland Security and Governmental Affairs*, 114th Cong. (2015) (written testimony of Sean Kirkpatrick).
[208] *Id.*
[209] Letter from Hon. Ron Johnson, Chairman, S. Comm. on Homeland Sec. & Governmental Affairs, to Hon. Robert McDonald, Secretary, Dep't of Veterans Affairs (Apr. 20, 2015) [hereinafter 4/20/2015 Letter from Chairman Johnson, HSGAC, to Secretary McDonald, VA].
[210] Letter from Hon. Sloan Gibson, Deputy Secretary, Dep't of Veterans Affairs, to Hon. Ron Johnson, Chairman, S. Comm. on Homeland Sec. & Governmental Affairs, at 1 (May 29, 2015) [hereinafter 5/29/2015 Letter from Deputy Secretary Gibson, VA, to Chairman Johnson, HSGAC].
[211] *Id.*

Figure 5: Letter from Deputy Secretary Sloan Gibson to Chairman Johnson



THE DEPUTY SECRETARY OF VETERANS AFFAIRS
WASHINGTON

May 29, 2015

The Honorable Ron Johnson
Chairman
Committee on Homeland Security
and Governmental Affairs
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

Thank you for your April 20, 2015, letter requesting information about Dr. Christopher Kirkpatrick's termination at the Tomah Department of Veterans Affairs (VA) Medical Center (VAMC) and his subsequent death. I am responding on behalf of the Department.

With respect to VA's protocols for investigating the suicides of employees or recently-terminated employees, if a suicide were to occur on VA property, VA Police would secure the scene and begin an initial investigation in anticipation that the Office of the Inspector General (OIG) or the Federal Bureau of Investigation would assume control of the investigation. The VA Police Service does not have the jurisdiction to investigate an employee or a recently-terminated employee's suicide that occurred off VA property.

VA did not conduct an investigation into Dr. Kirkpatrick's termination and suicide. Prior to the termination of his temporary appointment, Tomah VAMC management reviewed Dr. Kirkpatrick's performance and conduct. Tomah VAMC management did not investigate the suicide because during the July 14, 2009, meeting where Dr. Kirkpatrick was notified that his temporary appointment would be terminated effective July 28, 2009, he indicated his intention to resign prior to the termination effective date. Tomah VAMC management did not receive a resignation letter from Dr. Kirkpatrick prior to his death.

If the VA had investigated the underlying causes of Dr. Kirkpatrick's termination and death, it is possible that VA leadership could have learned additional details about the allegations of overmedication in 2009. The VA's inaction, even in the face of whistleblower complaints of opioid abuse, allowed the culture and conduct of the facility to continue unaddressed.

F. The former Tomah VAMC Police Chief knew the facility was a "big pill box" when he took the job in 2009, but never investigated the allegations

Roberto Obong served as Tomah VAMC police chief from September 2009 to September 2013.[212] He is a combat veteran of the Marine Corps and served in the Los Angeles Police Department and in various law enforcement positions throughout the VA.[213] When he took the job as the Tomah VAMC police chief, he said he knew that the law-enforcement community in western Wisconsin referred to the Tomah VAMC as a "big pill box."[214] Ultimately, despite knowing the facility's reputation, Chief Obong did little to address the issues or change the facility's culture.

Chairman Johnson's staff interviewed Chief Obong on December 1, 2015. During the interview, staff inquired about Chief Obong's familiarity with the Tomah VAMC when he applied for the police chief position. Chief Obong replied that he researched the facility and spoke to members of the community to learn about the facility's reputation in the community and to identify areas for improvement. Chief Obong said: "I spoke to the Sheriff. I spoke to the Chief of Police. I spoke to the firefighters, you name it. I researched it. **Their reputation is really not quite well.**"[215] He continued:

> Q: Can you explain what you found out, what was the reputation?
>
> A: Well what I found out, sir, is that not only they are not providing the type of service that they're supposed to provide, meaning poor customer service—or customer servant, they're supposed to be veteran centric or customer centric and it wasn't. That was a lot of the main complaints. Also, **the facility itself is well known in the law enforcement community as a big pillbox.**[216]

Chief Obong described how he came to this conclusion. He explained that he "Googled everything" about the Tomah VAMC and examined news articles about the facility's propensity to prescribe large quantities of narcotics.[217]

Chief Obong also explained that he was aware before his hiring that the Tomah VAMC had the nickname "Candy Land" and that a prescriber was described as the "Candy Man."[218]

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[212] Transcribed Interview with Roberto Miguel Vida Obong, in West Palm Beach, Fla., at 7 (Dec. 1, 2015) [hereinafter Obong Transcribed Interview].
[213] *Id.* at 7.
[214] *Id.* at 13.
[215] *Id.* at 12 (emphasis added).
[216] *Id.* at 13 (emphasis added).
[217] *Id.*
[218] *Id.* at 74.

When asked about his opinion of those monikers, Chief Obong replied: "It's not for me to think anything. What I think as a Chief of Police from a law-enforcement perspective is, if it's true, I'm pretty sure somebody is already investigating it or had investigated it."[219] In particular, Chief Obong referred to the VA OIG health care inspection.[220]

Chief Obong also recalled the discussions he had with local law-enforcement personnel before he was hired at the Tomah VAMC.[221] He said that local law-enforcement personnel informed him that "the VA is one of the main issues they have because a lot of our veterans are gaining so much pills."[222] Chief Obong described accounts of local law-enforcement personnel finding large quantities of medications in the Tomah community, in veteran homes, and in the belongings of homeless veterans.[223] He added that the prevalence of prescription drugs in the Tomah area was "out there in the community, and it's out of control" and that law enforcement "see it every day."[224] Chief Obong elaborated:

> The local law-enforcement agencies are out there complaining. The Coulee Regional Law Enforcement Executive Group [asked], "Chief, what can you do about this? They are giving these patients tons and tons of prescriptions, and they're just sitting in their cabinets not being used. They need to get rid of that at some point." It is over prescription. Either that or they just pile it in the cabinets they they're not using it.[225]

Chairman Johnson's staff inquired whether and how Chief Obong worked with local law-enforcement entities to address the Tomah VAMC's reputation after he became the Tomah VAMC Chief of Police. He explained that he reached out to the Monroe County Drug Task Force and the Coulee Regional Law Enforcement Executive Group to determine how the VA was affecting the community, to start joint investigations with police departments, and to implement community policing.[226] Through his work and coordination with local law-enforcement, Chief Obong orchestrated the first buy-bust of narcotics on the Tomah VAMC campus in the history of the Tomah VAMC Police Department.[227] Because the Tomah VAMC's Police Department's jurisdiction is limited to only the Tomah VAMC campus, Chief Obong explained that it was a "miracle" that he was able to get the VA's approval to conduct a successful buy-bust operation.[228] Chief Obong recalled conducting two or three joint investigations in total during his tenure as the Tomah VAMC Chief of Police.[229]

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[219] *Id.* at 75.
[220] *Id.*
[221] *Id.* at 12–13.
[222] *Id.* at 14.
[223] *Id.* at 15.
[224] *Id.* at 76.
[225] *Id.*
[226] *Id.* at 16–17.
[227] *Id.* at 18–19.
[228] *Id.*
[229] *Id.* at 43.

During his transcribed interview, Chief Obong explained that Tomah VAMC leadership informed him during his selection process that the Tomah VAMC Police Department lacked "persistent leadership" and needed a chief to "integrate the police service to other services" at the facility.[230] Chief Obong stated that although he was aware of the Tomah VAMC's perception in the Tomah community that it contributed to the drug trade, he did not raise those concerns to the facility's interview panel.[231]

Chairman Johnson's staff asked whether Chief Obong or anyone within the Tomah VAMC Police Department investigated Dr. Houlihan in light of Chief Obong's knowledge of the monikers "Candy Man" and "Candy Land" and the facility's reputation in the community as the "big pill box."[232] Chief Obong stated that, despite the well-known use of these monikers, he was not aware of any VA investigation into Dr. Houlihan for potential criminal activity in connection to his prescription practices.[233] Chief Obong explained that the inquiry into the Candy Man and Candy Land was instead properly "an OIG case."[234] He added that "if they [the VA OIG] ask me to dig, then I'll dig, but they didn't. That's not up to me to say."[235] When Chairman Johnson's staff pointed out that the VA Police and VA OIG are separate entities with separate mission statements, Chief Obong replied:

> A: The way it works is simply this; as the Chief of Police, as the top cop, if there's any indication that a crime is happening and there is tangible evidence, not hearsay but an actual witness, primary witness that says that this is happening, we will dig into it, and then we will refer it to OIG. That's how we do it.
>
> Q: So during your tenure as Chief of Police, you or the VA, Tomah VA Police did not investigate Dr. Houlihan at all?
>
> A: Not me personally, sir, not on a criminal conviction.
>
> Q: Did any of your officers?
>
> A: I'm not quite sure on that one, sir. I have to refer back to old police reports on file, if there is such an investigation.[236]

Chairman Johnson' staff inquired further into any potential Tomah VAMC Police Department investigations into Dr. Houlihan under Chief Obong's leadership. Chief Obong

[230] *Id.* at 21.
[231] *Id.* at 20.
[232] *Id.* at 94.
[233] *Id.* at 95.
[234] *Id.*
[235] *Id.*
[236] *Id.*

again pointed out that the VA OIG had investigated Dr. Houlihan "in multiple locations" and that he "defer[ed] that information to them because they have the upper hand on that."[237] He added that "in my case as far as my tenure as Chief of Police there, you know, we did not receive any complaint pertaining to [Dr. Houlihan] overprescribing or committing any type of crime that would merit some type of Uniform Offense Report or a[n] investigative report."[238]

Despite not investigating Dr. Houlihan in light of the facility's reputation, Chief Obong defended his time as Police Chief, stating: "During my tenure at the VA out there, we were very proactive, not only, not only from a law-enforcement prospective, but criminal investigation. We did follow through in all of those cases. We see to it that all cases are closed."[239]

It is difficult to agree completely with Chief Obong's assertion that the Tomah VAMC Police Department was "proactive" under his leadership. On one hand Chief Obong organized and executed a buy-bust on the Tomah VAMC grounds and effectively coordinated with local law enforcement on multiple joint investigations. On the other hand, under his leadership, the top Tomah VAMC officials did little internally to address or investigate whether providers contributed to the Tomah VAMC's reputation as a "big pill box" or to determine whether there was any truth to the monikers "Candy Man" and "Candy Land." Chief Obong's belief that the VA OIG was investigating the possibility that providers were overprescribing opioids at the Tomah VAMC did not abdicate his responsibilities as the chief law-enforcement officer at the facility to investigate whether Tomah VAMC employees were engaging in criminal activity.

Chief Obong's statements revealed an inherent conflict of interest with the chain of command of the Tomah VAMC Police Department and how issues were reported to the VA OIG. During his tenure as Chief of Police, Chief Obong reported to the Tomah VAMC Associate Director.[240] Chief Obong said that he had to notify Tomah VAMC leadership whenever he reported an incident to the VA OIG. Chief Obong explained: "[B]eing a good leader, you have to be a good follower. You have to know your chain of command. My chain of command is the associate director. If she does not know what I'm doing, I will be accountable. That is her expectation."[241] This reporting structure created the possibility of a conflict of interest for investigations concerning senior Tomah VAMC leaders.

The Tomah VAMC is led by a "Quadrad" of four senior leaders: the facility Director, Associate Director, Chief of Staff, and Chief Nurse.[242] Chief Obong interviewed with the "Quadrad" when he was hired at the Tomah VAMC.[243] Because Dr. Houlihan served on the Quadrad as the chief of staff, Dr. Houlihan played a role in hiring Chief Obong as the Tomah

[237] *Id.* at 97.
[238] *Id.*
[239] *Id.* at 99.
[240] *Id.* at 109.
[241] *Id.* at 112–13.
[242] Pica Transcribed Interview, at 20.
[243] Obong Transcribed Interview, at 8–9.

VAMC Chief of Police. This hiring structure, combined with the practice of notifying senior facility leadership of VA OIG referral, potentially inhibited robust internal investigations into misconduct by Tomah VAMC senior leadership. Although Chief Obong said that he was never dissuaded from reporting incidents to the VA OIG, there remains an inherent conflict of interest and significant deterrence factor.

Chief Obong chose not to investigate potential opioid abuse at the Tomah VAMC despite knowing the facility's reputation as a "big pill box" and "Candy Land." He reported, via the Quadrad, to the individual called "Candy Man." Chief Obong explained that allegations concerning the facility—including potential criminal charges—were "an OIG case." He left the Tomah VAMC in September 2013, during the VA OIG's inspection of the Tomah VAMC and Dr. Houlihan.[244] Whatever his reasons, Chief Obong's reluctance to examine the serious allegations surrounding the Tomah VAMC represents another missed opportunity to address the opioid overprescription.

G. VA headquarters noticed higher-than-average prescription rates at the Tomah VAMC in 2013, and only "encouraged" the facility to "review" its practices

The VA Central Office (VACO) is the Department's headquarters in Washington, D.C. According to information received by Chairman Johnson, VACO identified prescription irregularities and excessive wait times for mental health patients at the Tomah VAMC in 2013. Chairman Johnson's staff received documents from a whistleblower that included a report of a VACO site visit at the Tomah VAMC from August 2013.[245] The stated purpose of the site visit was to "review continued compliance to VHA [Veterans Health Administration] standards for mental health services at all facilities, identifying both areas for growth and areas of exemplary service."[246] However, it does not appear that the VA took substantive action to address these irregularities at the time as questionable prescription practices at the Tomah VAMC continued after this site visit.

The report of VACO's site visit noted that "[t]he provision of benzodiazepines for older Veterans and for Veterans diagnosed with [post-traumatic stress disorder (PTSD)] is much higher when compared to the national average."[247] According to the VACO report, 27.4 percent of Tomah VAMC veterans with dementia were prescribed benzodiazepine, as compared to the national average of 16.7 percent.[248] In addition, VACO found that the percentage of older veterans receiving an antipsychotic medication was higher than the national average—31.8

[244] *Id.* at 7.
[245] VACO Consultative Site Visit Report, Tomah VAMC, August 12–13, 2013, at 1.
[246] VACO Consultative Site Visit Report, Tomah VAMC, August 12-13 at 1.
[247] VACO Consultative Site Visit Report, Tomah VAMC, August 12-13 at 2.
[248] VACO Consultative Site Visit Report, Tomah VAMC, August 12-13 at 3.

percent at the Tomah VAMC compared to the national average of 27.6 percent.[249] The report also noted that Tomah VAMC staff "reported challenges with community placements of older Veterans" who have both a serious mental illness and a dementia diagnoses.[250] On the issue of wait times, VACO found that "only 53.19% of new Veteran patients are seen for a mental health appointment within 14 days compared to the national average of 67.90%."[251]

VACO's site review also identified issues with how the Tomah VAMC treated PTSD. Tomah VAMC staff reported to the VACO consultants that veterans waited up to eight weeks to access the PTSD residential program.[252] The VACO review found that the Tomah VAMC's "score on the proportion of patients with PTSD receiving a benzodiazepine is much higher than the national average (facility score 45.3%; compared to the national average of 27.7%)."[253] VACO's review found that 17.6 percent of Tomah VAMC veterans with PTSD received anti-psychotic medications, higher than the 15.8 percent of veterans with PTSD nationally who receive anti-psychotic medications.[254]

The VACO site consultation also solicited concerns from veterans who received care at the Tomah VAMC. Veterans told the VACO interviewers that the facility did not always consider patient views on their PTSD medications. According to the report:

> Veterans enrolled in the PTSD [Residential Rehabilitation Treatment Program (RRTP)] program voiced concerns that the medications they were on prior to entering the program were not reviewed and revised, although many felt their medications were not helping them or were inappropriate for their care. While leadership reported that medication reconciliation takes place, that process does not appear to address the patient's subjective experiences about feeling information about the medications were not communicated with them directly. We recommend a process for enhancing communication with Veterans about psychiatric medications as they enter the RRTP to ensure Veterans are satisfied with and benefiting from the medications they are taking upon intake and that there is adherence to the provision of evidence-based psychopharmacology. The facility also is encouraged to review their current safe medication management policies, procedures, and current practices in the [mental health] RRTPs to ensure that they are consistent with policy requirements.[255]

The site visit report made a number of recommendations to improve care at the Tomah VAMC. Notably, VACO site consultants recommended that the Tomah VAMC "develop an

[249] VACO Consultative Site Visit Report, Tomah VAMC, August 12-13 at 3.
[250] VACO Consultative Site Visit Report, Tomah VAMC, August 12-13 at 3.
[251] VACO Consultative Site Visit Report, Tomah VAMC, August 12-13 at 3.
[252] VACO Consultative Site Visit Report, Tomah VAMC, August 12-13 at 9.
[253] VACO Consultative Site Visit Report, Tomah VAMC, August 12-13 at 10.
[254] VACO Consultative Site Visit Report, Tomah VAMC, August 12-13 at 10.
[255] VACO Consultative Site Visit Report, Tomah VAMC, August 12-13 at 10.

action plan" to address staffing shortages in an effort to reduce wait times for access to mental health professionals.[256] VACO also "encouraged" the Tomah VAMC to "review their safe [medication] management policies, procedures, and practices to ensure that medication needs of Veterans are being addressed in a manner consistent with national policy."[257] It is unclear what, if any, remedial measures the Tomah VAMC put in place to address these issues.

The VA Central Office noted higher than average prescription rates at the Tomah VAMC in 2013 and merely "encouraged" the facility to "review" whether its medication practices were in accord with national policy. The VA could have, and should have, done more to recognize the problems at the Tomah VAMC in 2013 and understand the root causes. VACO did not, and this failure represents one more missed opportunity to prevent the tragedies of the Tomah VAMC.

H. Jason Simcakoski sought help from local and federal law enforcement multiple times in November 2013, with no results

Jason Simcakoski was a Marine Corps veteran who sought care at the Tomah VAMC for PTSD and other mental health ailments. On August 30, 2014, Mr. Simcakoski died in the Tomah VAMC's mental health ward. The Wisconsin Medical Examiner determined that Mr. Simcakoski died of "mixed drug toxicity."[258] Autopsy results showed that when he died, Mr. Simcakoski had over a dozen different drugs in his system.[259] Before his death, while the VA OIG and DEA were apparently conducting investigations relating to the Tomah VAMC, Mr. Simcakoski attempted to contact both local and federal law enforcement to report drug diversion at the Tomah VAMC.

At the Committee's March 2015 field hearing in Tomah, Wisconsin, Heather Simcakoski, Mr. Simcakoski's widow, testified that he reached out to multiple law-enforcement entities about drug diversion at the Tomah VAMC in 2013.[260] Mrs. Simcakoski testified:

> There are reports that were made to Dr. Houlihan, the Tomah VA, the Tomah City Police Department as well as the FBI – regarding patients selling their prescriptions back in 2013 – making so much money that they had saved enough to put a down payment on a house. Thankfully I have voicemails and text messages between Jason and the officers – otherwise I am not convinced anyone would be listening to this point today. I would like to understand who is

[256] VACO Consultative Site Visit Report, Tomah VAMC, August 12-13 at 12;.
[257] VACO Consultative Site Visit Report, Tomah VAMC, August 12-13 at 12-13.
[258] Glantz, *Opiates Handed out Like Candy*, REVEAL NEWS (Jan. 8, 2015).
[259] *Id.*
[260] *Tomah VAMC: Examining Quality, Access, and Culture of Overreliance on High-Risk Medications, Joint Field Hearing Before S. Comm. on Homeland Sec. & Governmental Affairs & H. Comm. on Veterans Affairs*, 114th Cong. (2015) (statement of Heather Simcakoski).

responsible for these reports, where they are, and why no one did anything with the reports?[261]

After the field hearing, Chairman Johnson's staff obtained Mr. Simcakoski's cell phones and with the consent of Mrs. Simcakoski, the United States Capitol Police successfully retrieved the data off of the phone.[262] The majority staff's review of the cell phone records showed that in November 2013—less than a year before his death—Jason Simcakoski contacted multiple law-enforcement entities in western Wisconsin. In particular, Jason Simcakoski contacted representatives from the Federal Bureau of Investigation (FBI),[263] the city of Tomah Police Department (Tomah PD), the Tomah VAMC Police Department (Tomah VAMC PD), and the Portage County Sheriff's Office.[264] The following chart illustrates Jason Simcakoski's contact with law enforcement in the fall of 2013.

Figure 6: Jason Simcakoski's contacts with law enforcement[265]

Date of Contact	Law Enforcement Entity	Incoming or Outgoing	Time of Contact (UTC)[266]	Duration of Phone Call
October 30, 2013	Tomah VAMC Police Chief, Perry Huffman	Incoming (Missed)	8:08 PM	0:00
October 30, 2013	Tomah VAMC Police Chief, Perry Huffman	Outgoing	8:13 PM	6:29
October 31, 2013	Tomah VAMC Police Chief, Perry Huffman	Outgoing	10:31 PM	0:24
October 31, 2013	Tomah VAMC Police Chief, Perry Huffman	Outgoing	10:32 PM	1:07

[261] *Id.*

[262] *See* Letter from Hon. Ron Johnson, Chairman, S. Comm. on Homeland Sec. & Governmental Affairs, to Kim Dine, Chief of Police, U.S. Capitol Police (July 13, 2015). At the request of the Simcakoski family, the majority staff provided the information obtained from the cell phones to the Simcakoski family, the minority staff, and the staff of Senator Baldwin.

[263] All telephone correspondence between Mr. Simcakoski and the FBI was conducted through the FBI satellite office in La Crosse, Wisconsin.

[264] *See infra* Figure 6.

[265] The data contained in this chart was obtained from forensic imaging of Jason Simcakoski's cell phones.

[266] All times referenced are Coordinated Universal Time (UTC). Wisconsin is located in the Central Time Zone and is either five or six hours behind UTC, depending on the time of the year. In 2013, daylight savings time ended on Sunday, November 3. Prior to November 3, Wisconsin was five hours behind UTC; after November 3, Wisconsin was six hours behind UTC. *See Time Changes in Chicago Over the Years*, TIMEANDDATE.COM, http://www.timeanddate.com/time/zone/usa/chicago.

Date of Contact	Law Enforcement Entity	Incoming or Outgoing	Time of Contact (UTC)[266]	Duration of Phone Call
October 31, 2013	Tomah PD	Outgoing	10:41 PM	4:48
November 1, 2013	Tomah VAMC Police	Incoming	12:13 AM	7:34
November 1, 2013	Tomah PD	Outgoing	9:16 PM	3:50
November 2, 2013	Tomah VAMC Police Chief, Perry Huffman	Incoming (Missed)	3:18 PM	0:00
November 2, 2013	Tomah VAMC Police Chief, Perry Huffman	Outgoing	3:29 PM	20:09
November 2, 2013	Portage County Sheriff's Department	Outgoing	3:59 PM	1:43
November 2, 2013	Portage County Sheriff's Department	Outgoing	4:27 PM	0:00
November 2, 2013	Tomah VAMC Police Chief, Perry Huffman	Outgoing	4:28 PM	0:38
November 2, 2013	Tomah PD	Outgoing	4:29 PM	20:14
November 2, 2013	Tomah VAMC Police Chief, Perry Huffman	Incoming	5:53 PM	5:29
November 3, 2013	Tomah PD	Outgoing	4:10 PM	2:17
November 3, 2013	FBI	Outgoing	10:36 PM	1:11
November 4, 2013	FBI	Outgoing	8:29 PM	12:25
November 4, 2013	FBI	Outgoing	9:25 PM	2:05
November 6, 2013	FBI	Outgoing	2:45 PM	6:48
November 6, 2013	Tomah PD	Outgoing	3:07 PM	1:41
November 6, 2013	Tomah VAMC Police	Outgoing	3:10 PM	3:41

Date of Contact	Law Enforcement Entity	Incoming or Outgoing	Time of Contact (UTC)[266]	Duration of Phone Call
November 6, 2013	Tomah VAMC Police	Outgoing	3:14 PM	0:03
November 6, 2013	Tomah VAMC Police	Outgoing	4:23 PM	0:20
November 7, 2013	Tomah VAMC Police	Outgoing	3:04 PM	11:30
November 8, 2013	Tomah VAMC Police	Outgoing	6:12 PM	1:13
November 8, 2013	FBI	Outgoing	6:43 PM	8:24
November 8, 2013	Tomah VAMC Police	Outgoing	9:21 PM	2:13
November 8, 2013	Tomah VAMC Police Chief, Perry Huffman	Incoming	11:13 PM	12:30
November 8, 2013	Tomah VAMC Police Chief, Perry Huffman	Outgoing	11:34 PM	0:52
November 8, 2013	Tomah VAMC Police Chief, Perry Huffman	Outgoing	11:35 PM	1:23
November 11, 2013	Tomah VAMC Police	Outgoing	2:18 PM	0:32
November 11, 2013	Tomah VAMC Police Chief, Perry Huffman	Outgoing	2:18 PM	1:34

1. Despite evidence showing multiple contacts and a voicemail, the FBI denied communicating with Jason Simcakoski in 2013

Mr. Simcakoski's cell phones contained a voicemail from a federal law-enforcement officer. On November 4, 2013, at approximately 4:37 PM UTC, Jason Simcakoski received a voicemail from an individual claiming to be an FBI agent who said he was returning Mr. Simcakoski's call to the FBI. The voicemail stated:

> Jason, this is Andy Chapman[267] from the FBI returning your call. My phone number is (608) 782-6030. Thank you.[268]

The phone number that the caller left is the main phone number for the FBI satellite office in La Crosse, Wisconsin—the office closest to Tomah with jurisdiction over Monroe County. The phone number also matches the number that Mr. Simcakoski dialed on five occasions in early November 2013.[269] According to the call logs from Mr. Simcakoski's phones, he called the FBI satellite office in La Crosse less than four hours after he received this voicemail.[270] This phone call lasted more than twelve minutes.[271] Less than an hour later, Mr. Simcakoski again called the phone number of the FBI's La Crosse satellite office and had a conversation that lasted more than two minutes.[272] His subsequent calls to the phone number of the FBI's La Crosse satellite office were on November 6 and November 8, and lasted more than six and eight minutes, respectively.[273]

Other records obtained from Mr. Simcakoski's cell phone suggest he communicated with the FBI. On November 4, 2013, at 9:55 PM UTC, just a half hour after his final call that night with the FBI, Mr. Simcakoski sent a text to his wife: "I talked to the FBI today."[274] Subsequently, in a series of Facebook messages with another individual on November 6, 2013, Mr. Simcakoski wrote: "I'm not working with tomah pd or va pd I'm a lot higher than them . . . . FBI . . . ."[275]

Figure 7: Text message from Jason Simcakoski

225	Sent	[redacted]	11/4/2013	**Network:**	Sent I talked to the FBI today
		Heather St. Point*	9:55:20	11/4/2013	
			PM(UTC+0)	9:55:20	
				PM(UTC+0)	

[267] Due to the quality of the audio, the majority staff is unable to verify with absolute certainty the name the FBI official on the voice mail.
[268] Voicemail from FBI to Jason Simcakoski (Nov.4, 2013, 4:37 PM UTC) (on file with Comm.).
[269] *See supra* Figure 6.
[270] *See supra* Figure 6.
[271] *See supra* Figure 6.
[272] *See supra* Figure 6.
[273] *See supra* Figure 6.,
[274] SMS Text Message from Jason Simcakoski to Heather Simcakoski (Nov. 4, 2013, 9:55:20 PM UTC).
[275] Facebook Messages from Jason Simcakoski (Nov. 6, 2013, 3:57:46 AM UTC; 3:58:46 AM UTC).

Figure 8: Facebook messages sent by Jason Simcakoski

[redacted] Jason Simcakoski	**Timestamp:** 11/6/2013 3:57:46 AM(UTC+0)	**Body:** I saved every text and message we ever made. [illegible] higher than them because I know I couldnt trust them. your doctor is going down to. See you soon
[redacted]	**Timestamp:** 11/6/2013 3:58:39 AM(UTC+0)	**Body:** K BYE
[redacted] Jason Simcakoski	**Timestamp:** 11/6/2013 3:59:46 AM(UTC+0)	**Body:** FBI bitch
[redacted]	**Timestamp:** 11/6/2013 [illegible] AM(UTC+0)	**Body:** K BYE
[redacted] Jason Simcakoski	**Timestamp:** 11/6/2013 3:59:45 AM(UTC+0)	**Body:** That's what I'm capable of. You cant do [redacted]
[redacted]	**Timestamp:** 11/6/2013 [illegible] AM(UTC+0)	**Body:** U to stupid to deal with the fbi my dr can't get it trouble he prescribes what you need. The Fed's [illegible]

The majority staff does not know the substance of these phone calls placed to the phone number of the FBI's satellite office in La Crosse. In an effort to gain better insight, on September 14, 2015, Chairman Johnson sent a letter to FBI Director James Comey inquiring about the contents of Jason Simcakoski's communications with the FBI and requesting records of all communications between Jason Simcakoski and the FBI.[276] On October 2, 2015, Chairman Johnson received a response from Patrick Fallon, Jr., the Acting Deputy Assistant Director for the FBI's Criminal Investigative Division, stating that the FBI had no record of Jason Simcakoski contacting the FBI.[277] The letter read, in part:

> Our records have not shown that Mr. Simcakoski was in contact with any FBI field office. Additionally, when the FBI's Milwaukee Field Office met with

[276] Letter from Hon. Ron Johnson, Chairman, S. Comm. on Homeland Sec. & Governmental Affairs, to Hon. James B. Comey, Jr., Director, FBI, at 1 (Sept. 14, 2015).

[277] Letter from Patrick F. Fallon, Jr., Acting Deputy Assistant Director, FBI, to Hon. Ron Johnson, Chairman, S. Comm. on Homeland Sec. & Governmental Affairs (Oct. 2, 2015).

Senator Baldwin in February 2015 regarding possible allegations of public corruption at the Tomah VA Medical Center, a follow-up interview with Mr. Simcakoski's father yielded that Mr. Simcakoski had been in contact with the Tomah Police Department and the Tomah VA Police Department.[278]

Chairman Johnson's staff met with FBI officials on October 9, 2015, to address the discrepancy between what the data on Mr. Simcakoski's phones showed and the FBI's response to Chairman Johnson's letter.[279] During this meeting, in an effort to assist the FBI in resolving the discrepancy, Chairman Johnson's staff played the recording of the November 4, 2013 voicemail. FBI officials informed staff that there are no employees at the FBI satellite office in La Crosse with similar names to the name on the voicemail.[280] The FBI official reiterated that the FBI possessed no records of any communications with Jason Simcakoski and that FBI personnel in La Crosse did not recall speaking to Mr. Simeakoski.[281] The FBI official declined Chairman Johnson's staff's request to speak with the FBI field personnel directly to confirm this information.[282]

[278] *Id.* at 1.
[279] Meeting between Staff, FBI, and Staff, HSGAC (Oct. 9, 2015).
[280] *Id.*
[281] *Id.*
[282] *Id.*

Figure 9: Letter from FBI to Chairman Johnson regarding Jason Simcakoski's contact with FBI

U.S. Department of Justice

Federal Bureau of Investigation

Washington, DC 20535-0001

OCT 02 2015

The Honorable Ron Johnson
Chairman
Committee on Homeland Security and Governmental Affairs
United States Senate
Washington, DC 20510

Dear Chairman Johnson:

I am writing in response to your September 14, 2015, letter to Director Comey regarding the Department of Veterans Affairs (VA) Medical Center in Tomah, Wisconsin, and the FBI's interactions with Mr. Jason Simcakoski.

Our records have not shown that Mr. Simcakoski was in contact with any FBI field office. Additionally, when the FBI's Milwaukee Field Office met with Senator Baldwin in February 2015 regarding possible allegations of public corruption at the Tomah VA Medical Center, a follow-up interview with Mr. Simcakoski's father yielded that Mr. Simcakoski had been in contact with the Tomah Police Department and the Tomah VA Police Department.

I appreciate your bringing this matter to our attention, and I hope this information will be helpful to you.

Sincerely,

Patrick F. Fallon, Jr.
Acting Deputy Assistant Director
Criminal Investigative Division

Based on the information available, the majority staff cannot know exactly what Jason Simcakoski communicated to law-enforcement entities in 2013. While the FBI maintains that they have no records of communications with Jason Simcakoski, his phone records clearly show that he reached out to them and other law enforcement entities on multiple occasions in the fall of 2013. Tragically, less than a year after making contact with law enforcement entities, Jason Simcakoski died at the Tomah VAMC.

2. Jason Simcakoski's contact with Dr. Houlihan is the subject of a current VA OIG criminal investigation

The VA OIG currently has an open criminal investigation based, in part, on a 2013 communication between Jason Simcakoski and the former Tomah VAMC chief of staff, Dr. David Houlihan. The Committee obtained a Report of Contact (ROC) dated November 6, 2013—during the same period that Mr. Simcakoski's phone records show that he contacted law enforcement—completed by Dr. Houlihan detailing a conversation that he had with Mr. Simcakoski.[283] The conversation between Dr. Houlihan and Mr. Simcakoski detailed specific accounts of drug diversion by another veteran at the Tomah VAMC.[284] The ROC indicated that the veteran that was the subject of the ROC sold 10 pills for $200.00 on one occasion and "continued to contact [Mr. Simcakoski] to inquire if he wanted to buy more."[285] Mr. Simcakoski also informed Dr. Houlihan that the veteran had offered him "oxycodone and methylphenidate" [also known as Ritalin] as well.[286]

The document also suggests that Mr. Simcakoski may have confronted Dr. Houlihan about Dr. Houlihan possibly informing the veteran that Mr. Simcakoski had been in contact with law enforcement. The ROC noted that the veteran called Jason a "rat" for speaking to the police about drug diversion at the Tomah VAMC.[287] Dr. Houlihan wrote: "Jason called the Tomah PD who stated that they felt someone such as this MD tipped off the [veteran]. I assured [Jason] that I did not nor did I think our VA police tipped the [veteran] off."[288] Dr. Houlihan wrote that he informed the Tomah VAMC Police of the incident and told the veteran that they would "no longer get prescriptions for controlled medications" from the Tomah VAMC "based on credible evidence that [the veteran] was diverting [their] medications." Dr. Houlihan concluded the ROC by noting that the veteran was welcome to seek admission for detoxification and noted concerns that the veteran would "retaliate" against Mr. Simcakoski or against the facility due to Dr. Houlihan's orders to restrict medications.

Chairman Johnson's staff has learned that this ROC is the subject of a current investigation of the VA OIG criminal investigation unit. As a part of Chairman Johnson's investigation, his staff interviewed VA OIG Special Agent Greg Porter. Special Agent Porter was the lead investigator for the VA OIG's criminal investigation unit's involvement with the Tomah health care inspection. When staff presented the ROC to Special Agent Porter, he refused to answer specific questions about the documents because it was the subject of an open investigation. Through further questioning, Chairman Johnson's staff was able to ascertain when the VA OIG opened its investigation. After staff entered the ROC into the record and described the document, Agent Porter explained:

[283] VA production Tomah Emails & Documents (15-18) 000091.
[284] VA production Tomah Emails & Documents (15-18) 000091.
[285] VA production Tomah Emails & Documents (15-18) 000091.
[286] VA production Tomah Emails & Documents (15-18) 000091.
[287] VA production Tomah Emails & Documents (15-18) 000091.
[288] VA production Tomah Emails & Documents (15-18) 000091.

A: This, again, I have an open investigation and I—this—I—I can't really get into this.

Q: So the contents of this report of contact are directly connected to your open investigation.

VA OIG Attorney: He—he—I think he just said he can't answer that question. Can you answer that question?

A: I cannot answer that.

Q: So you have an open investigation in 2016 with something that may have occurred in 2013.

A: Yes, sir. It—my investigation incorporates things that happened in 2013, yes.

VA OIG Attorney: Can we maybe clarify--when did your investigation open up?

A: In approximately February of 2015.[289]

This ROC highlighted specific instances of drug diversion and was recorded during the VA OIG's health care inspection of the Tomah VAMC. Parallel to the health care inspection, VA OIG criminal investigators conducted their own investigation of the facility in 2012. Records indicate that the VA OIG criminal investigation unit closed its investigation of Dr. Houlihan on August 28, 2012.[290] According to the former Tomah VAMC Police Chief, Roberto Obong, protocols require accusations of drug diversion to be forwarded to the VA OIG for review.[291] Maureen Regan, Counselor to the VA Inspector General confirmed that pursuant to VA regulations, allegations of felonies on VA campuses are referred to the VA OIG for investigation.[292]

It is unclear when VA OIG criminal investigators became aware of Jason Simcakoski's reports to Dr. Houlihan of drug diversion at the Tomah VAMC. Special Agent Porter said that "prior to the current investigation that I opened in February of 2015, I hadn't had this

[289] Porter Transcribed Interview, at 142.
[290] VA OIG MCI Search Results, MCI # 2011-04212-DC-0252 (May 1, 2015, 11:23 AM), OIG 1392, at OIG 1392–93.
[291] Obong Transcribed Interview, at 27–28.
[292] Porter Transcribed Interview, at 143.

information or I hadn't seen this document [the ROC], to my recollection."[293] He stated that Jason Simcakoski's November 2013 report of drug diversion to Dr. Houlihan is "familiar" to him in the context of his current and ongoing investigation.[294] Nevertheless, it appears that the VA OIG was either unaware of, or failed to act upon, Jason Simcakoski's November 2013 allegations of drug diversion until it opened its investigation in February 2015. It is unclear what further actions, if any, local law enforcement or the Tomah VAMC took in response to this information.

What is clear, however, is that Jason Simcakoski attempted multiple times to engage local and federal law enforcement in examining drug diversion at the Tomah VAMC. For whatever reason, these law-enforcement officials apparently did not pursue the matter. The failure to do so represents yet another—and a very serious—missed opportunity to prevent the tragedies of the Tomah VAMC.

* * *

The overprescription, retaliation, veterans' deaths, and abuse of authority at the Tomah VAMC did not occur in a vacuum. Veterans, employees, and whistleblowers tried for years to get someone to address the problems. Along the way, since at least 2004, there were several opportunities when federal agencies could have inquired further or taken direct action. At each step, however, these opportunities were missed. The tragedies that occurred at the Tomah VAMC were preventable and were the result of systemic executive branch failures.

[293] *Id.* at 142.
[294] *Id.*

III. The VA OIG's health care inspection of the Tomah VAMC

Perhaps the greatest failure to identify and prevent the tragedies at the Tomah VAMC was the VA Office of Inspector General's two-year health care inspection of the facility. The VA OIG dedicated considerable resources to examining allegations of opioid overprescription, abuse of authority, and other misconduct at the facility. The watchdog collected over 200,000 employee emails, conducted interviews with Tomah VAMC employees, reviewed patient information, issued at least one subpoena, and even surveilled Dr. Houlihan. Yet, the product of this intensive effort was just an eleven-page administrative closure, which did not substantiate a majority of the allegations and was not publicly issued.

Months after the VA OIG closed its inspection, in August 2014, Jason Simcakoski died at the Tomah VAMC of "mixed drug toxicity." In January 2015, Thomas Baer, a 74-year-old veteran, died after receiving treatment at the facility's urgent care center. His daughter, Candace Delis, said that she would not have taken her father to the Tomah VAMC if she had known about the VA OIG's inspection. After public scrutiny surrounding the Tomah VAMC arose in January 2015, the VA Central Office in Washington, DC, examined the allegations. In just three months, the VA investigated and substantiated a majority of the allegations that the VA OIG could not substantiate after several years.

Chairman Johnson's investigation provides some explanation for the VA OIG's failed inspection. The VA OIG narrowly focused its investigation on overly literal readings of the allegations. The office did not have a clear standard for substantiating allegations, as evident by the different explanations provided by several different employees. The VA OIG discounted allegations from Tomah VAMC pharmacists, despite firsthand evidence to support their claims. Chairman Johnson's investigation also shows that the VA OIG team initially intended to draft a public work product on the Tomah VAMC, only to see the allegations closed administratively.

A. The VA OIG's hotline process: A primer

The VA OIG exists to be an independent watchdog of the VA. One of the primary ways that the OIG receives allegations about waste, fraud, abuse, or misconduct is through its OIG hotline process. The VA OIG's health care inspection of the Tomah VAMC began as a result of complaints received through the OIG Hotline.

The VA OIG commonly receives hotlines by e-mail, phone call, fax, and by mail.[295] In general, a group of the OIG employees reviews the incoming hotlines, determines the veracity of the allegations, and whether the allegations should be sent to a division within OIG for further

[295] *VA OIG Hotline Homepage*, DEP'T OF VETERANS AFF., OFFICE OF INSPECTOR GEN., http://www.va.gov/oig/hotline/.

review.[296] Dr. Robert Yang, a VA OIG inspector who assisted on the Tomah VAMC inspection, also served on the OIG hotline group from 2010 to 2014.[297] He described the hotline process during a transcribed interview with Chairman Johnson's staff. He said:

> Q: But it is a group. It's not really a committee.
>
> A: Right. It's more of a group. It's not a—it's not as formal as a committee.
>
> * * *
>
> Q: And how large is this group? I know it varies, but can you give us a—
>
> A: It could be as small—well, over time, sort of the membership in this group has changed. But at least at this time [in 2011], it could have been anything from three to, say, eight members.[298]

Dr. John Daigh, the Assistant Inspector General for Healthcare Inspections, regularly receives allegations from the VA OIG's hotline group. In a transcribed interview with Chairman Johnson's staff, he explained how his office receives hotline allegations:

> We run a hotline, that being the management of the IG runs a hotline, and a portion of those hotline issues come to my office, so I call that our hotline. And we have the ability to publish about one a week, so we publish somewhere between 50 and 60, 65 hotlines a year.[299]

The OIG's Office of Healthcare Inspections (OHI) may publish a report for approximately 50 to 65 hotlines during a given year, but Dr. Daigh explained that his office receives about 20 hotline complaints a week. He stated:

> Q: On hotlines, you said you publish between 50 to 65 a year. How many, roughly, reports or inquiries are put into the hotline? How many complaints does the hotline receive, OHI hotline receive in a given year?

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[296] The VA Office of Inspector General has four divisions. Investigations, Audits and Evaluations, Management and Administration, and Healthcare Inspections. *OIG Organizational Chart*, DEP'T OF VETERANS AFF., OFFICE OF INSPECTOR GEN., http://www.va.gov/oig/about/org-chart.asp; *see also* Transcribed Interview with George Blake Wesley, in Washington, D.C., at 20–25 (Apr. 20, 2016) [hereinafter Wesley Transcribed Interview].

[297] Transcribed Interview with Robert K. Yang, in Washington, D.C., at 13–14 (Feb. 17, 2016) [hereinafter Yang Transcribed Interview].

[298] *Id.* at 38–39.

[299] Transcribed Interview with John D. Daigh, Jr., in Washington, D.C., at 9 (Mar. 23, 2016) [hereinafter Daigh Transcribed Interview].

A: So the number varies by year, but I would say that a rough way to think about it is if we got 1,000 complaints in a year, then we get—that would be roughly, what, 20 complaints in a week. And so I have the opportunity to publish one a week. That means I can publish 5 percent of the hotline complaints I get.

I get on the order of 3,000 to 4,000, somewhere between 2,000 and 4,000 complaints in a year, so I have the opportunity to publish at some rate much less than 5 percent, and it has varied over the last, oh, 6 or 7 years. It's ramped up steadily, with a big bump after Phoenix.[300]

Overall, according to Dr. Daigh, the VA Office of Healthcare Inspections will only publish a report for less than 5 percent of the all incoming hotline complaints.[301] Dr. Daigh explained that after the Phoenix VAMC wait-list scandal,[302] the number of incoming hotlines for the Office of Healthcare Inspections grew "massively."[303] Dr. Yang also talked about the growing number of hotlines:

Q: As your time on the hotline group from 2010 to 2014, can you give the Committee a sense of the magnitude of how many allegations and hotlines were coming in during your time on that team? Was it kind of a pretty steady flow of allegations coming in? Or was there an uptick at some point? Can you give us kind of a brief summary of your time there?

A: I can't recall the precise numbers.

Q: That's okay.

A: My recollection is that that number has actually been—it had actually been steadily increasing over time from when I started, and then it actually essentially exploded. I'm trying to think of exactly when it sort of skyrocketed, essentially. I'm not sure what a precise date would be for that, but basically, in general, it has been increasing over time fairly steadily and much more so at some point in the relatively recent past.[304]

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[300] *Id.* at 9–10.
[301] *Id.* at 10.
[302] The Phoenix VAMC Wait-list scandal became public in April 2014. Scott Bronstein & Drew Griffin, *A Fatal Wait: Veterans Languish and Die on a VA Hospital's Secret List*, CNN (Apr. 23, 2014), http://www.cnn.com/2014/04/23/health/veterans-dying-health-care-delays/.
[303] Daigh Transcribed Interview, at 11.
[304] Yang Transcribed Interview, at 13–14.

Although the volume of incoming hotline complaints has grown dramatically, the manner in which the Office of Healthcare Inspections processes these hotlines seems to have not changed over time. Dr. Daigh explained:

Q: And can you kind of walk us through the termination [*sic*] process that OHI uses to determine whether or not to take on a hotline and open up an OHI inquiry versus sending it back to VA, VHA, what have you?

VA OIG Attorney: At this time or back in 2011?

Q: Well, has it changed?

A: It hasn't substantially changed. The numbers of complaints change a little bit year to year, but the basic way we think about it hasn't changed. So the first cut would be, does the allegation allege what we would consider to be serious issues with patient care? Is there an allegation that something happened that resulted in death or harm to a patient? That would be those complaints that we would take most seriously and try, if possible, to work.

We also consider in the decision-making process a number of other factors. Is the request from a Member of Congress? Is the request understandable? In other words, is it written in such a way that, although we understand there is an allegation, does it look like there might be data that we could actually use to determine the answer to the question?

Was it written by someone who we think would likely have insight into and make it more likely that the allegations are truthful or correct? So if it is written from a doc or written from a nurse or written from a patient or written from a patient's family, we take all those issues into consideration in trying to figure out which, you know, 2, 3 percent of the complaints that come in that I—that we should accept and work.

We've always had a committee that meets to look at these complaints. We get complaints on a regular basis. I think years ago—and I am talking in 2003, '04, '05—we would get few enough complaints that you could sit down and—twice a week sit down and look at the complaints and decide what to do. When we get, you know, 10 a day or we get, you know, 30 or 40 a week, then we have a process whereby the hotlines are administratively registered in our office from [the hotline group] 53, which would be the large hotline group in the IG. We would then send those hotlines out to the team so they can look at

> it to the extent possible. We have a VA medical record on our desktop, so they would do a little background work to try to figure out whether the complaint made sense or not. And then the group which is composed of health care inspectors, which are largely nurses and social workers, and a doc from my office who rotates in on that meeting, they would sit down and have a meeting and decide which ones we're going to take.
>
> So it's been done in that way for a long time.[305]

There appears to be no formalized complaint process with the Office of Healthcare Inspections, other than employees reading an internal "handbook."[306] The hotline process discussed by Dr. Daigh was in place in 2011, when the VA OIG received the hotline allegations about the Tomah VAMC.[307]

Dr. Alan Mallinger, who was one of the lead VA OIG inspectors on the Tomah VAMC inspection, also participated in the hotline group for a period of time.[308] He explained how "various factors" determine the hotline group's decision on how to refer complaints.[309] He cited "the complexity of the case" and "the seriousness of the case" as two factors that "can weigh into" deciding how to dispose of hotline complaints.[310] Dr. Mallinger described the hotline process as a "case-by-case" decision.[311]

Dr. Yang explained his view on how the VA OIG evaluates hotline complaints.[312] Like Dr. Mallinger, he said that the disposition of a hotline complaint depends on the discretion of the hotline group. He explained:

> Q: Just quickly, what would be the reasons why the hotline group would decline looking at an allegation further? Is there certain written policies or written standards, or is it sort of like the group sort of has a group consensus on accepting a hotline or not?
>
> A: Are you sort of wondering what is the criteria for—
>
> Q: Yeah, is there kind of a hard criteria of, you know, these boxes need to be checked for the IG to accept a hotline case? Or is it more up to the discretion of the hotline group?

[305] Daigh Transcribed Interview, at 11–13.
[306] *Id.* at 13-14.
[307] *Id.* at 14.
[308] Mallinger 3/8/2016 Transcribed Interview, at 27.
[309] *Id.* at 28.
[310] *Id.*
[311] *Id.*
[312] Yang Transcribed Interview, at 10–11.

A: I think it's more up to the discretion of the hotline group. I think there were concerns that if we tried to limit it to very specific hard and fast rules, that might either limit us from taking a case that people thought either should be taken or, vice versa, that we take one where it seems unlikely that, you know, something is occurring, where we sort of say, "Well, our criteria is sort of"—so having—it was difficult to come up with necessarily sort of a hard and fast sort of rule that if this happens, then this absolutely results in a—you know, basically a case sort of being accepted as a hotline.[313]

Dr. Yang provided his insight into how the VA OIG's hotline group processed hotline complaints. He explained that sometimes the VA OIG hotline group would refer an allegation to the facility's leadership or the VA's regional office, rather than having the VA OIG examine the allegations itself. He stated:

> Typically, the group would come to consensus. We have people, physicians with backgrounds and specializations in several areas, and so, not surprisingly, we all might bring a slightly different perspective to—and so in the course of discussion, there might be a variety of reasons for choosing exactly what sort of route to take with a hotline. So if there were cases of serious sort of patient harm, then there was typically sort of a bias, especially if we could confirm that in the medical record, there would be a bias toward examining that directly. Sometimes, though, it actually would be faster for us to actually send it back to the medical center because then we could make other people aware of what was going on with the complaint. So we would—in that case, it might make more sense to send it back because then it would allow people at either the medical center or VISN potentially to take action as well. And those kinds of complaints might be something where something's occurring somewhere in the facility, and there isn't necessarily reasonable expectation the medical center director maybe is aware that's what's going on, say the complaint is directed against, say, the chief of a service, or we might send it to the VISN so that way it could be reviewed, again, by people who weren't involved in the allegation itself.[314]

In addition to complaints from veterans and practitioners, the VA OIG routinely receives complaints from Members of Congress on behalf of their constituents. When the VA OIG hotline group receives this type of complaint, they mark the complaint with a unique "congressional" label and handle it separately from other hotline complaints. Dr. Daigh said that "there is a subtly different process" on how the VA OIG handles congressional requests.[315] He explained that these requests usually go to the VA OIG's congressional liaison officer and the

[313] *Id.* at 12–13.
[314] *Id.* at 17–18.
[315] Daigh Transcribed Interview, at 15.

incoming letter is logged into the VA OIG system.[316] The complaint is then provided to the hotline group for review. Dr. Daigh admitted that his office may accept some congressional complaints that it may otherwise not have accepted based on the merit of the complaint.[317] He told the committee that congressional requests "do get a preference in terms of taking their allegations over the other ones that we have sometimes."[318] Likewise, Dr. Mallinger said that congressional cases do take precedent over other cases and that they are important.[319]

B. The VA OIG's work relating to the Tomah VAMC: A timeline

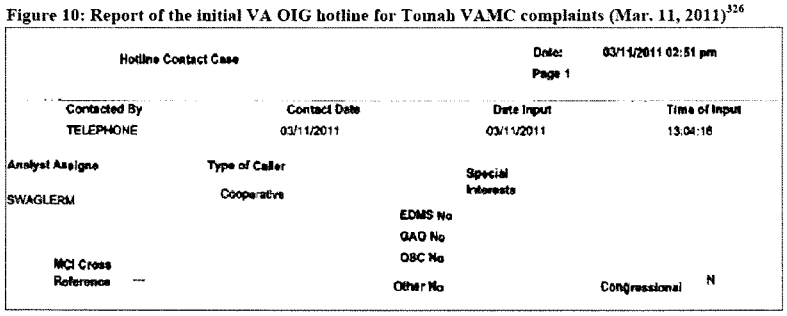
1. March 11, 2011: The VA OIG received a phone call alleging problems at the Tomah VAMC

From information available to the Committee, the first time that the VA OIG received a complaint concerning the Tomah VAMC that led the Tomah VAMC healthcare inspection was on March 11, 2011.[320] This complaint came in to the VA OIG's hotline process via a telephone call from an individual who originally wanted to serve as a "confidential source."[321]

The OIG analyst who received the call described the caller as "cooperative."[322] The caller disclosed a litany of problems concerning the Tomah VAMC, many of them relating to veteran care and the prescription practices at the facility.[323] Among the allegations recorded by the OIG analyst were "reports that veterans fall, Benzo-diazaptine, ritalin, etc are traded/sold. The COS [chief of staff] does not like non-prescribing people to question doctor's prescriptions. The COS is a believer in giving vets drugs from the VA rather than have them buying them on the strect and/or drinking to take away the pain."[324] The OIG logged the phone call, but the contact was not assigned a case number.[325]

[316] *Id.*
[317] *Id.*
[318] *Id.*
[319] Mallinger 3/8/2016 Transcribed Interview, at 23–24.
[320] VA OIG Hotline Contact Case, Contact # 12003 (Mar. 11, 2011, 2:51 PM), OIG 5663, at OIG 5663–65.
[321] *Id.*
[322] *Id.*
[323] *Id.*
[324] *Id.* at OIG 5663.
[325] *Id.*.

Figure 10: Report of the initial VA OIG hotline for Tomah VAMC complaints (Mar. 11, 2011)[326]



Hotline Contact Case

Date: 03/11/2011 02:51 pm
Page 1

Contacted By	Contact Date	Date Input	Time of Input
TELEPHONE	03/11/2011	03/11/2011	13:04:16

Analyst Assigne	Type of Caller	Special Interests
SWAGLERM	Cooperative	

EDMS No
GAO No
OSC No
Other No

MCI Cross Reference —

Congressional N

2. March 13, 2011: The VA OIG receives additional allegations via facsimile about the Tomah VAMC from a social worker

A few days later, on March 13, 2011, the VA OIG received a 30-page facsimile addressed to "Rep 99" of the OIG's hotline group.[327] The subject of the fax read "Tomah WI" and the cover page referenced a case number: 2011-02008-HL-0497.[328] The fax also included a three-page summary of the problems at the Tomah VAMC, along with a number of press articles about the facility.[329] The author, who described himself as a social worker, addressed the summary to "Agent 99" and described the situation at the Tomah VAMC as "[e]thically and morally" compelling.[330] The social worker concluded the fax:

> At this time it would be best to remain anonymous due to the hostile nature of the Tomah VA. Please do not let the staff at Tomah read this report. I will send more information in the future that addresses individual veterans and their files.[331]

[326] *Id.*
[327] Fax to Representative 99, VA OIG Hotline (Mar. 13, 2011), OIG 5666, at OIG 5666–95.
[328] *Id.* at OIG 5666.
[329] *Id.* at OIG 5677–95.
[330] *Id.* at OIG 5667.
[331] *Id.* at OIG 5669.

Figure 11: Summary of facsimile received by the VA OIG hotline (Mar. 13, 2011)[332]

> This is for Agent 99.
>
> The veterans at the Tomah VA are sadly not receiving the services they need. I'm contacting you because I feel compelled to share the many issues I encountered as a social worker. Ethically and morally I can no longer turn away from the issues at the Tomah, Wisconsin Veterans Affairs.
>
> There are many areas that the VA in Tomah is failing its veterans.

The social worker categorized the allegations into four general areas: (1) veterans' access to the mental health clinic, (2) medications, (3) medical and mental health staff, and (4) management.[333] The social worker informed the VA OIG that "veterans call Tomah 'Candy Land' and the Chief of staff 'Candy man' because of the medications they receive."[334] The social worker also presented other allegations, including waiting list issues for veterans receiving mental health treatment, veterans who were overmedicated, veterans who were arrested for selling their VA prescription medications, concerns about fear and intimidation in the work environment, and an assertion that doctors do not wish to prescribe controlled substances.[335]

The social worker summarized the issues at the Tomah VAMC in March 2011 as "veterans are receiving a good to poor quality of care."[336] He requested assistance from the OIG to look into "the prescriptions prescribes [*sic*] by the chief of staff and look at the mental health and health care programs."[337] The social worker requested anonymity "due to the hostile nature of the Tomah VA" and also asked the VA OIG not to allow the Tomah VAMC leadership to become aware of the complaint.[338]

One of the press articles that the social worker included in his fax was a June 2010 article from the *Virginian-Pilot* titled, "Doctor: Veterans get hooked, not healed, at VA hospital."[339] The article recounted the experiences of a VA facility in Hampton Roads, Virginia, where two doctors said powerful narcotics were being overprescribed to veterans, leaving them addicted while their underlying medical conditions go untreated.[340] The doctors warned that the high volume of narcotics may be feeding a pipeline of drugs that were resold in the community.[341] According to the article, one of the doctors was fired after airing concerns.[342]

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[332] *Id.* at OIG 5667.
[333] *Id.* at OIG 5667–69.
[334] *Id.* at OIG 5669.
[335] *Id.* at OIG 5667–69.
[336] *Id.* at OIG 5669.
[337] *Id.*
[338] *Id.*
[339] *Id.* at OIG 5690–94.
[340] *Id.*
[341] *Id.*
[342] *Id.*

The social worker asked the OIG to review the article because it "is a prime example of what the Tomah VA is experiencing."[343] The social worker believed there were "similarities" between the VA facility in Hampton Roads and the Tomah VAMC "that need attention."[344] In addition to the *Virginian-Pilot* article, the social worker included other articles concerning arrests of individuals in the Tomah region around 2009 and 2010.[345] The social worker wrote in the fax message that "the local Tomah Police Department has made several drug arrests in the Tomah area regarding veterans and their prescription medications. Many veterans sell their medications after they pick them up from the VA."[346]

3. March 14, 2011: The VA OIG receives allegations via email about the Tomah VAMC

One day after the 30-page fax was sent to "Rep 99," the VA OIG hotline group received an email that also raised concerns about the Tomah VAMC.[347] This email was addressed to "Representative 99."[348] The author described himself as an employee of the Tomah VAMC who also received care at the facility.[349] He explained that he felt compelled to contact the OIG because he was "unable to continue working in this environment and watch veterans [*sic*] health be jeprodised [*sic*] or posably [*sic*] worse."[350]

Figure 12: Email received by VA OIG hotline (Mar. 14, 2011)[351]

VA OIG Hotline

From: [redacted]
Sent: Monday, March 14, 2011 11:51 PM
To: VA OIG Hotline
Subject: REP 99

Representive 99

I've been working at the VA in Tomah since [redacted] I've been reciving my care at the Tomah VA since I came home from the [redacted] in [redacted] As a [redacted] im compeled to do the right thing for my felow veterans. I'm unable to continue working in this environment and watch veterans health be jeprodised or posably worse

[343] *Id.* at OIG 5669.
[344] *Id.*
[345] *See generally id.* at OIG 5677–95.
[346] *Id.* at OIG 5667.
[347] E-mail to Representative 99, VA OIG Hotline (Mar. 14, 2011, 11:51 PM), at OIG 5696.
[348] *Id.*
[349] *Id.*
[350] *Id.*
[351] *Id.* The redactions were applied by the VA OIG prior to production of the document to the Committee.

This email offered more details about the working environment with the Tomah VAMC. The author described Dr. Houlihan as the one who controls the environment and explained that the three other senior leader do not have as much "influence in the daily operations of programming or decision making."[352] The author alleged that Dr. Houlihan maintained "favorite people" at the facility and that if an employee ran afoul of one of Dr. Houlihan's favorites, he or she would be reported to Dr. Houlihan. The complainant described this situation as "children telling on each other to a parent in order to look better and to get in the good graces of that parent."[353]

The author acknowledged that colleagues at the facility had discouraged him from going to the OIG, writing "I'm not sure that putting my head on the chopping block will do anything but cause me to have trouble at work or even lose my job,"[354] The author also noted that the employee's union at the Tomah VAMC, which received complaints about the work environment, was "overwhelmed with complaints."[355]

Figure 13: Email received by VA OIG hotline (Mar. 14, 2011)[356]

> I've asked several colleagues why Dr. Houlihan is still practicing at Tomah if all of these medication problems, employee work related issues and power and control issues are around. They said, "He survived an ethics board in [redacted] and he's survived other investigations here. He's untouchable, and if you go after him you will lose your job or be shoved in the worst job ever and hounded until you quit". I was informed that others have investigated and nothing ever happens. This is a large part of why I've been hesitant to approach the OIG. I'm not sure that putting my head on the chopping block will do anything but cause me to have trouble at work or even lose my job.

The March 14, 2011, email received by the VA OIG hotline group had other serious allegations. The author levied allegations that Dr. Houlihan was using Tomah VAMC veterans to conduct "his research into benzodiazepine, Ritalin and opiates for healing PTSD."[357] The email described the "cocktail of medications veterans received" and the health problems that veterans experienced after receiving the cocktail of medications.[358]

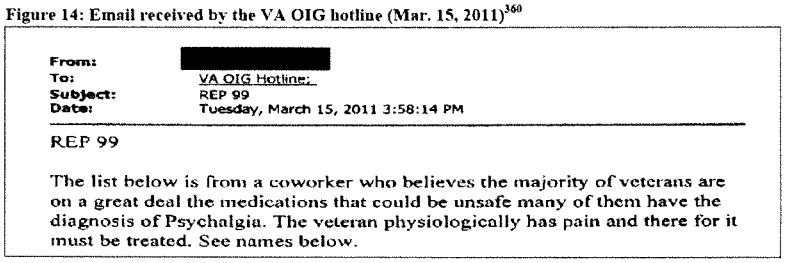
4. March 15 and 22, 2011: The VA OIG received two more complaints about the Tomah VAMC

The OIG hotline group received another email addressed to "REP 99" on March 15, 2011. This short message read: "The list below is from a coworker who believes the majority of veterans are on a great deal the medications that could be unsafe many of them have the

[352] *Id.*
[353] *Id.*
[354] *Id.*
[355] *Id.*
[356] *Id.*
[357] *Id.* at OIG 5697.
[358] *Id.*

diagnosis of Psyhalgia. The veteran physiologically has pain and there for [*sic*] it must be treated. See names below."[359]

Figure 14: Email received by the VA OIG hotline (Mar. 15, 2011)[360]



From: [redacted]
To: VA OIG Hotline;
Subject: REP 99
Date: Tuesday, March 15, 2011 3:58:14 PM

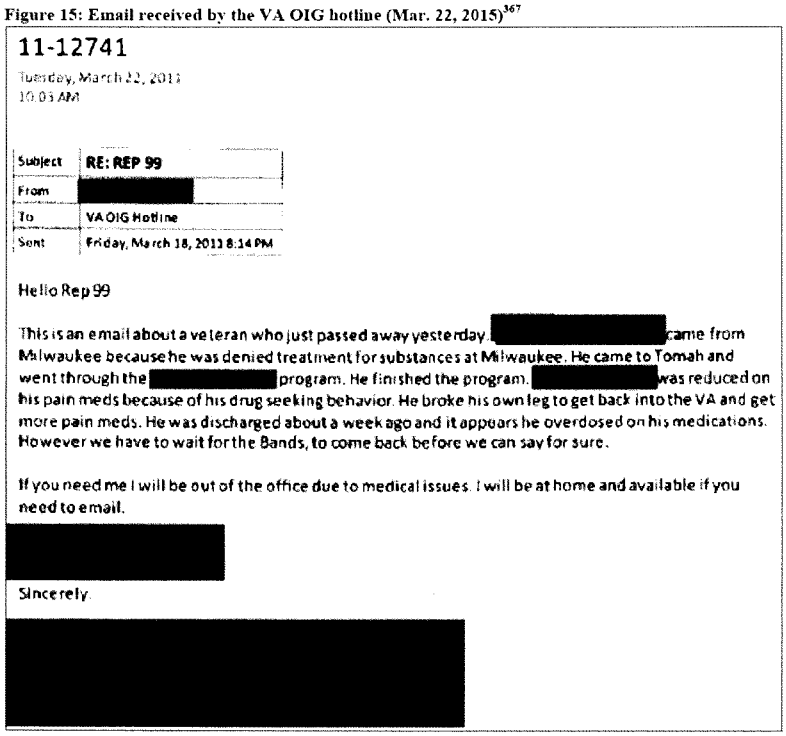
REP 99

The list below is from a coworker who believes the majority of veterans are on a great deal the medications that could be unsafe many of them have the diagnosis of Psychalgia. The veteran physiologically has pain and there for it must be treated. See names below.

Just a week later, on March 22, 2011, the VA OIG hotline received another communication.[361] This email, like the others, was addressed to "Rep 99" and concerned a veteran who "just passed away."[362] According to the email, the deceased veteran came to the Tomah VAMC from the Milwaukee VAMC "because he was denied treatment for substances at Milwaukee."[363] The veteran allegedly had "drug seeking behavior" and was placed into a Tomah VAMC program, which the veteran completed.[364] After completing the program, the veteran apparently attempted to get back into the VA to receive more pain medication.[365] After an unknown amount of time back at the VA, the veteran was discharged and later died on March 21, 2011.[366]

[359] E-mail to Representative 99, VA OIG Hotline (Mar. 15, 2011, 3:58 PM), at OIG 5701.
[360] The Tomah VAMC is not named in this hotline but documents were produced pursuant to Chairman Johnson's subpoena for the VA OIG's Tomah VAMC inspection.
[361] The VA OIG hotline contact referral is 2011-12741.
[362] E-mail to Representative 99, VA OIG Hotline (Mar. 18, 2011, 8:14 PM), at OIG 5702.
[363] *Id.*
[364] *Id.*
[365] *Id.*
[366] E-mail from Steven Wise, VA OIG Hotline Referrals, to Victoria Coates & Misti Kincaid, VA OIG (Mar. 24, 2011, 2:59 PM), OIG 10316, at OIG 10316–10317.

Figure 15: Email received by the VA OIG hotline (Mar. 22, 2015)[367]



11-12741

Tuesday, March 22, 2011
10:03 AM

Subject	RE: REP 99
From	[redacted]
To	VA OIG Hotline
Sent	Friday, March 18, 2011 8:14 PM

Hello Rep 99

This is an email about a veteran who just passed away yesterday. [redacted] came from Milwaukee because he was denied treatment for substances at Milwaukee. He came to Tomah and went through the [redacted] program. He finished the program. [redacted] was reduced on his pain meds because of his drug seeking behavior. He broke his own leg to get back into the VA and get more pain meds. He was discharged about a week ago and it appears he overdosed on his medications. However we have to wait for the Bands, to come back before we can say for sure.

If you need me I will be out of the office due to medical issues. I will be at home and available if you need to email.

[redacted]

Sincerely,

[redacted]

5. March 2011: The VA OIG Office of Healthcare Inspections hotline group assessed the Tomah VAMC allegations

The VA OIG's Office of Healthcare Inspection (OHI) hotline group examined the complaints it received in March 2011 via email, telephone, and facsimile about the Tomah VAMC. The complaints appear to have been made by the same individual because the email references both the facsimile with the news articles and phone call from earlier in March 2011.[368] The hotline group bundled the contacts together under the same OIG case number: 2011-02008-

[367] E-mail to Representative 99, VA OIG Hotline (Mar. 18, 2011, 8:14 PM), at OIG 5702.
[368] E-mail to Representative 99, VA OIG Hotline (Mar. 14, 2011, 11:51 PM), at OIG 5696.

HL-0497 VAMC, Tomah, WI RP99. The allegation involving the death of a veteran after his discharge, hotline number 2011-12741, was also bundled under the -0497 case number.[369]

Dr. Yang, who was part of the VA OIG's hotline group in March 2011, recalled the contents of the March 2011 Tomah VAMC allegations and what the group thought about the allegations.[370] He remembered that the complainants were concerned "about the level of opioid prescribing that was occurring" at the Tomah VAMC.[371] Dr. Yang explained that he "was actually one of the people who reviewed material," and he specifically recalled "looking at news articles that came in."[372] He said that he may have also reviewed specific patient charts.[373]

Dr. Yang discussed a specific allegation that patients with additive diagnoses were being treated with medications that can cause addiction. He believed this type of treatment "is not an uncommon practice, from [my] understanding, of the treatment of addiction, that people may be on opioids for—and treated with opioids for their addiction problem."[374] Dr. Yang explained how "there was concern" with the hotline group about the general allegations, but he was searching for the "context of are we dealing with a provider who is simply dispensing out of control, or are we dealing with a provider who is trying to deal with a very difficult group of patients that they're trying to manage?"[375]

According to Dr. Yang, there were other factors that contributed to the VA OIG hotline group's assessment of the Tomah allegations. He explained that some of the allegations had more detail and the group decided to "read through some of the materials that were turned in."[376] The hotline group also sought to better understand the allegations about the prescription of opioids.[377] Regarding that allegation, Dr. Yang said that "it's oftentimes—prescribing of opioids a bit of a gray area in that there is oftentimes no absolute sort of level above or below."[378] He attributed that "gray area" of prescribing opioids to being "dependent on the patient."[379]

According to an internal OIG document, a source separately notified the OIG of allegations that the high prescription rates at the Tomah VAMC related to research on PTSD.[380] The allegations were also levied in the hotline complaint emailed to the VA OIG on the March

[369] Yang Transcribed Interview, at 33; E-mails between Steven Wise, Victoria Coates, & Michelle Swagler (Mar. 24–25, 2011), OIG 1368, at OIG 1368–69.
[370] Yang Transcribed Interview, at 22.
[371] *Id.*
[372] *Id.* at 24.
[373] *Id.*
[374] *Id.* at 23.
[375] *Id.*
[376] *Id.*
[377] *Id.* at 23–24.
[378] *Id.*
[379] *Id.*
[380] 3/17/2011 E-mail from VA OIG Hotline Referrals, at OIG 1387.

15, 2011.[381] When asked whether he examined the clinical study allegation in or around March 2011, Dr. Yang said that he did not have a recollection one way or another.[382]

Figure 16: VA OIG document concerning the Tomah VAMC[383]

> The source also reported concerns about the practices of an alleged clinical study involving the use of Ritalin for treatment of TBI and PTSD patients and has sent in additional documentation.

Chairman Johnson's staff questioned Dr. Yang on whether he or another member of the VA OIG's hotline group communicated directly with complainant.[384] He said that he did not recall if a contact occurred in this instance, but provided an overview of how the VA OIG hotline group typically contacted complainants:

> So in this case, typically we'll reach out to the complainant if either there are questions about we need clarification of what is occurring or we—in some cases, complainants give us essentially allegations that are, at least to the best we can determine, uninvestigable without additional detail. And so sometimes we will call and say, you know, "In order for us to really pursue this further, we need additional information from you." And in those settings, we try and reach out to the complainant. The worst cases are the ones where, unfortunately, the complainant is anonymous, we do not even known who reached out to—and this—and I'm just thinking, again, I can't remember if this was my thought thinking of this case specifically, but in general, if we are going to send for a response or take something, we don't always sort of reach out to the complainant if we feel that the nature of the allegations has been sufficiently prepared.[385]

Dr. Mallinger, a physician with the OIG Healthcare Inspections unit, who later would become one of the leading OIG employees conducting the Tomah VAMC inspection, described his thoughts upon reviewing the March 2011 allegations about the Tomah VAMC.[386] He called the allegations "alarming," stating:

> Q: So during your inspection, did you like—were you able to review what actually came in? That's what I'm trying to get at, some of these March 2011 allegations.
>
> A: I did review the entire set, including the news articles.

[381] *Id.* Allegations received March 15, 2011. *Id.*
[382] Yang Transcribed Interview, at 32.
[383] 3/17/2011 E-mail from VA OIG Hotline Referrals, at OIG 1387.
[384] Yang Transcribed Interview, at 28.
[385] *Id.* at 28–29.
[386] Dr. Mallinger and Dr. Shepherd explained that they did not review the March 2011 Hotlines until they became involved in the Tomah VAMC inspection.

Q: Do you recall what your reaction was with these series of submissions by a complainant regarding Tomah? Did you think they were serious? Did you think that—what was your reaction?

A: These allegations were to me at the time alarming. You know, they have a very—they allege some very serious problems.[387]

Another employee, Dr. Michael Shepherd, who would also subsequently work on the Tomah VAMC inspection, described the March 2011 complaints as "serious allegations."[388]

6. March 15, 2011: The VA OIG hotline group referred an allegation of prescription hording to the OIG's criminal division, which declined to investigate

The VA OIG's hotline group referred an allegation of "a patient amassing 300 oxycodone tablets" to the OIG's Criminal Division for review on March 15, 2011.[389] Ten days later, on March 25, 2011, the Criminal Division declined to open a formal investigation because the allegation had "little criminal information" to potentially investigate."[390]

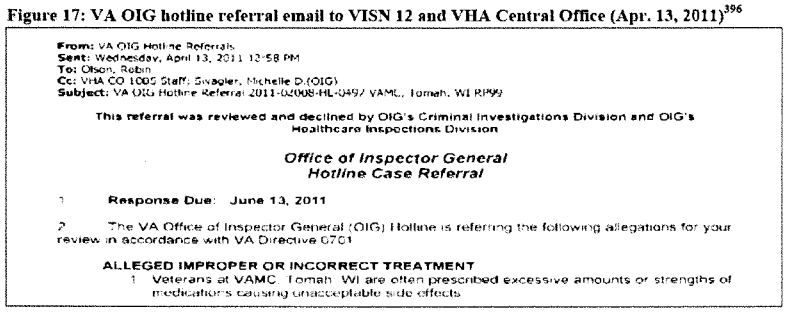
7. April 13, 2011: The VA OIG referred the Tomah VAMC allegations to VISN 12 and Veterans Health Administration Central Office

Nearly a month after receiving the allegations about the Tomah VAMC, the VA OIG referred the allegations to the VA. According to OIG documents, on April 13, 2011, the OIG referred the allegations contained in the hotline complaints[391] to the VA's regional office, VISN 12, in Chicago, Illinois.[392] The VA OIG explained that the allegations were "declined by OIG's Criminal Investigations Division and OIG's Healthcare Inspections Division."[393] VISN 12 received an email from the VA OIG Hotline Referrals that contained numerous allegations and provided a response deadline of June 13, 2011.[394] In the same transmittal email, the OIG hotline group sent an "information copy" of the Tomah VAMC allegations to "staff in the office of the

[387] Mallinger 3/8/2016 Transcribed Interview, at 43–44.
[388] Transcribed Interview with Michael Shepherd, in Washington, D.C., at 32, 37 (Jan. 27, 2016) [hereinafter Shepherd 1/27/2016 Transcribed Interview].
[389] VA OIG Hotline Input Transaction, MCI # 2011-02008-HL-0497 (May 1, 2015, 11:50 AM), OIG 1390, at OIG 1391. "51" is the Criminal Division at the VA OIG.
[390] *Id.*
[391] The Tomah Hotlines sent to VISN 12 were assigned the OIG case number 2011-02008-HL-0497.
[392] *Id.* The document reads "54 [VA OIG Office of Health Care Inspections] tasks to VISN, but will review response." The VISN referred to is VISN 12 in Chicago because the Tomah VAMC is located in VISN 12.
[393] *Id.* at OIG 1390; *see also* Yang Transcribed Interview, at 36.
[394] E-mail from Steven Wise, VA OIG Hotline Referrals, to Robin Olson (Apr. 13, 2011, 12:58 PM), OIG 1435, at OIG 1435–37.

VHA Chief of Staff at VHA Central Office."[395] It is unclear what actions, if any, the VHA central office took after becoming aware of these allegations.

Figure 17: VA OIG hotline referral email to VISN 12 and VHA Central Office (Apr. 13, 2011)[396]



From: VA OIG Hotline Referrals
Sent: Wednesday, April 13, 2011 12:58 PM
To: Olson, Robin
Cc: VHA CO 10QS Staff; Swagler, Michelle D.(OIG)
Subject: VA OIG Hotline Referral 2011-02008-HL-0497 VAMC, Tomah, WI RP99

This referral was reviewed and declined by OIG's Criminal Investigations Division and OIG's Healthcare Inspections Division

Office of Inspector General
Hotline Case Referral

1 **Response Due: June 13, 2011**

2 The VA Office of Inspector General (OIG) Hotline is referring the following allegations for your review in accordance with VA Directive 0701

ALLEGED IMPROPER OR INCORRECT TREATMENT
1 Veterans at VAMC Tomah WI are often prescribed excessive amounts or strengths of medications causing unacceptable side effects

Dr. Yang, who was part of the VA OIG's hotline group in 2011, described his recollection of the decision to refer the allegations to VISN 12. In a transcribed interview, he told Chairman Johnson's staff that the hotline group "felt that there were enough serious findings that we requested an official response from—and I believe we directed it at the VISN so they would be—it was not just directed to the prescriber."[397]

Chairman Johnson's staff questioned Dr. Yang on the reasons for sending serious allegations to the VA for review rather than the VA OIG immediately opening an independent examination. Dr. Yang explained that the VA OIG would send allegations to the VA so that the agency leadership could be aware of the issues and take remedial actions. He said:

> So whether it gets sent to the VISN or not sometimes isn't so much a function of the seriousness of the case. Sometimes it's a function of ensuring that people are aware of what was going on so that people who, you know, basically have responsible [*sic*] for overseeing the care can take action more rapidly. So sometimes actually the more serious cases may be referred specifically because we want VA officials to, A, basically have it on the record that they are aware of what is occurring, and then B is hopefully to get them to respond in a way that's appropriate.[398]

[395] Letter from Hon. Richard Griffin, Deputy Inspector General, VA OIG, to Hon. Tammy Baldwin, U.S. Senate (Mar. 24, 2015), OIG 10198, at OIG 10198–99.
[396] E-mail from Steven Wise, VA OIG Hotline Referrals, to Robin Olson (Apr. 13, 2011, 12:58 PM), OIG 1435, at OIG 1435–37.
[397] Yang Transcribed Interview, at 24.
[398] *Id.* at 25.

According to Dr. Yang's explanation, it appears that the decision to send the allegations about the Tomah VAMC to VISN 12 comport with the OIG's desire to make VA officials "aware of what was going on."[399] The VA OIG Hotline Division notified the complainant on April 18, 2011, that OIG had "opened a case based on a review of the information you sent to our office."[400] The notice did not inform the complainant that the OIG had merely forwarded the allegations to the VA.

8. June 21, 2011: VISN 12 responded to the Tomah VAMC complaints, unsubstantiating a majority of the allegations

In April 2011, the VA OIG referred the allegations concerning the Tomah VAMC to VISN 12 in Chicago, Illinois. Chairman Johnson's staff conducted transcribed interviews with four VISN 12 employees to gain a better understanding of VISN 12's review. VISN 12, in general, was accustomed to receiving hotlines. One employee explained that "I don't think a day goes by when I don't get a hotline, so that is a very routine event."[401] The same employee noted "we get a lot of IG complaints and those many times come to the VISN to respond to."[402]

Figure 18: VISN 12's response memorandum to the Tomah VAMC allegations (June 21, 2011)[403]

DEPARTMENT OF VETERANS AFFAIRS

Memorandum

Date: June 21, 2011

From: Network Director, VISN 12 (10N12)

Subj: Hotline Case Number 2011-02008-HL-0497

To: VA OIG Hotline Division

The VA OIG allowed VISN 12 a two-month period to complete its examination of the Tomah VAMC allegations. After requesting a brief extension,[404] on June 21, 2011, VISN 12's Network Director provided the VA OIG Hotline Division with a six-page memorandum that

[399] *Id.*
[400] E-mails with Representative 99, VA OIG Hotline (May 21, 2012), OIG 1381, at OIG 1381–82.
[401] Oshinski Transcribed Interview, at 76.
[402] *Id.*
[403] Memorandum from Network Director, VISN 12, to VA OIG Hotline Div. (June 21, 2011), OIG 1435, at OIG 1438.
[404] VA OIG Hotline Input Transaction, MCI # 2011-02008-HL-0497 (May 1, 2015, 11:50 AM), OIG 1390, at OIG 1391.

outlined VISN 12's process and findings for each allegation.[405] VISN 12 found seventeen of the nineteen total allegations to be "unsubstantiated," including the allegations about diversion of controlled pharmaceuticals, patient dosages increased to unsafe levels, and patients being too close to Dr. Houlihan.[406]

VISN did substantiate an allegation that a patient discharged in June 2011 received oxycodone despite a history of violating his narcotic contract.[407] Based on this finding, VISN issued four recommendations, including a review of the prescription refill policies at the Tomah VAMC.[408] The only other substantiated allegation concerned a veteran who was diagnosed with Psychalgia and prescribed unsafe levels of pain medications.[409] The VISN created an action plan to examine this incident, led by the VISN's Chief Medical Officer (CMO), Dr. Michael Bonner.[410]

Victoria Brahm, a VA employee for over 34 years and who in April 2011 held the position of Chief of Quality Management (QMO) and Chief of Nursing, was among the VISN employees who reviewed the Tomah allegations.[411] According to Ms. Brahm, the VISN action plan examined three main areas at the Tomah VAMC.[412] First, it addressed the Tomah VAMC's failure to follow early refill guidance, which Ms. Brahm found concerning because "there was lots of documentation indicating that early refills were still continuing" with patients who regularly received early prescription refills in the past.[413] The action plan also sought to institute a strong policy rooted in annual urine screens, and associated negative action if the screens returned negative.[414] Finally, the action plan sought to address the failure of Tomah VAMC's lab panels to properly document and justify such exotic prescription practices.

In a transcribed interview, Ms. Brahm explained the VISN's concern that the Tomah VAMC did not have documentation that other pain management methods were ineffective. She stated:

> So when you looked for 24 drugs, I don't think marijuana or Oxycodone was in those. So to use a different panel to enhance their panel when they were screening. So they wouldn't have seen marijuana usage on those [panels], which would have been a big factor in these patients. And then the other thing was to assess—the CMO was going to assess whether or not these patients really were

[405] Memorandum from Network Director, VISN 12, to VA OIG Hotline Div. (June 21, 2011), OIG 1435, at OIG 1438–43.
[406] *Id.*
[407] *Id.* at OIG 1441.
[408] *Id.*
[409] *Id.* at OIG 1441–42.
[410] *Id.* at OIG 1442; *see also* Brahm Transcribed Interview, at 11.
[411] Brahm Transcribed Interview, at 9, 96.
[412] *Id.* at 74.
[413] *Id.* at 74–77.
[414] *Id.* at 74.

> getting all of this other modality that we kept hearing. You know, they flunked all this, so we have to use the benzos and opioids because they've done all these alternate therapies. Really, because we didn't assess—how can we make more of those therapies available? Like aroma therapy. Like acupuncture. Like healing touch. Like chiropractors. That kind of thing. **Because the documentation was not strong, other than verbally saying, these, they had failed. We weren't seeing it.**[415]

Subsequent transcribed interviews conducted by Chairman Johnson's staff cast some doubt on the thoroughness of the VISN 12's review. Chairman Johnson's staff interviewed Renee Oshinski, who served as the VISN 12 Deputy Network Director since 2004.[416] During Ms. Oshinski's interview, Chairman Johnson's staff presented to her the hotline complaints received by the VA OIG.[417] She said that she had "never seen" these VA OIG hotlines, reiterating later "this is not anything I have even seen."[418] When asked to elaborate, Ms. Oshinski also offered "an educated guess" that VISN did not receive everything surrounding the hotlines.[419] Indeed, the VA OIG's referral email only provided VISN 12 with a list of the allegations and not all the associated material that the OIG had on record.[420]

Ms. Brahm explained that she became aware of the Tomah VAMC hotline complaints when they were sent to the VISN and the VISN 12 Network Director Dr. Jeffrey Murawsky assigned her as the lead.[421] Dr. Murawsky instructed Ms. Brahm to ask Jolena Renda, a nurse practitioner, to examine the cases.[422] Ms. Renda, according to Ms. Brahm, had worked for the VISN and performed many of the chart reviews and was familiar with all the Tomah VAMC records.[423] Ms. Renda performed the preliminary chart reviews before they were sent "off site" for review by a psychiatrist.[424] Ms. Renda performed a total of five peer reviews, the findings of which were two findings of level 1, two findings of level 2, and one finding of level 3.[425] Ms. Brahm said that she then sent the peer reviews to Dr. Murawsky for his review before the eventual response to the VA OIG Hotline Division.[426]

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[415] *Id.* at 74–75 (emphasis added).
[416] Oshinski Transcribed Interview, at 9–10; *VISN 12 – Great Lakes Health Care System: Leadership Team*, DEP'T OF VETERANS AFF., http://www.visn12.va.gov/about/leadership.asp.
[417] Oshinski Transcribed Interview, at 77–80.
[418] *Id.* at 79.
[419] *Id.* at 80.
[420] The VA OIG Hotline Division April 13, 2011 email transmission to VISN 12. OIG 1435-37.
[421] Brahm Transcribed Interview, at 96.
[422] *Id.*
[423] *Id.* at 99.
[424] *Id.*
[425] *Id.* at 104.
[426] *Id.* at 104–05.

Ms. Brahm stated that after VISN 12 sent its response to the VA OIG, she sent an email to Dr. Murawsky requesting that the VA initiate an Administrative Investigation Board (AIB).[427] She said that Dr. Murawsky denied her AIB request.[428]

Ms. Oshinski explained to Chairman Johnson's staff that she had no involvement or input into the VISN 12's review of the Tomah VAMC allegations.[429] Despite her not being involved, however, the document sent back to the VA OIG on June 21, 2011, displays Ms. Oshinski's electronic signature on the last page.[430] Ms. Oshinski said that she did recall reviewing the document before it was sent to the VA OIG, but she confirmed it was her electronic signature.[431] During her transcribed interview with Chairman Johnson's staff, she explained why her electronic signature was attached rather than the signature of Dr. Murawsky. She stated:

> Q: So you signed this document on behalf of Dr. Murawsky who was the VISN Director?
>
> A: I happen to know lot about this today. Is that Dr. Murawsky was on travel and had been working with the individuals who responded to this and so they sent him everything and he okayed sending it out, and our office manager, because he was not in the office, attached my electronic signature instead of Dr. Murawsky's.[432]

In support of her belief that her signature was a mistake, Ms. Oshinski cited an email that Dr. Murawsky sent that gave the office approval to send the document to the VA OIG.[433] Not only did she believe the signature was mistakenly affixed to the response memorandum, but Ms. Oshinski said that she did not agree with VISN 12's conclusions. She explained:

> Q: Correct me if I'm wrong. I sense that you're not too pleased that your signature was placed on this?
>
> A: I'm not very pleased, no, I'm not. I at the time made a comment that I was astounded that they were all unsubstantiated.[434]

When asked to elaborate, she responded:

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[427] *Id.* at 105.
[428] *Id.*
[429] Oshinski Transcribed Interview, at 81.
[430] Memorandum from Network Director, VISN 12, to VA OIG Hotline Div. (June 21, 2011), OIG 1435, at OIG 1443.
[431] Oshinski Transcribed Interview, at 80.
[432] *Id.*
[433] *Id.* at 81.
[434] *Id.* at 82–83.

> I just thought with the number that were there—honestly, when we respond to an IG report, we could either say substantiated, partially substantiated, unsubstantiated. With the number of things here, I would have thought there would have been some partially or whatever. I mean, just based on the number, that it's not a normal response that we would have, but, again, I know that people looked at the charts. I don't know who they talked to.[435]

Ms. Oshinski explained that, for her, what differentiated VISN 12's response to the Tomah VAMC allegations from other similar OIG referral was the lack of any "partially substantiated" findings in the Tomah VAMC review.[436] When asked how the VISN handled substantiating allegations, she described a lack of "a hard-and-fast criteria" and that it is a "judgement call of the individuals who . . . put[ ] . . . together" the review.[437] She further stated that she felt the Tomah hotline was an outlier compared to other referrals due to the number of allegations that were in the Tomah complaints.[438] Ms. Oshinski recalled being "surprised" that the OIG sent this to the VISN and wasn't conducting a separate investigation.[439]

9. June 28, 2011: The VA OIG closed the March 2011 Tomah VAMC hotline complaints

Shortly after it received the VISN 12 response that did not substantiate a majority of the allegations, the VA OIG authorized the closure of the case on June 28, 2011.[440] The VA OIG notified the complainant via an email dated July 5, 2011 that the case was closed.[441]

Figure 19: VA OIG Hotline notification to complainant of closed case (July 5, 2011)[442]

VA OIG Hotline

From: VA OIG Hotline
Sent: Tuesday, July 05, 2011 9:32 AM
To: [redacted]
Subject: VA OIG Hotline Case Closed (53E/99)

Dear [redacted]:

This will notify you that the VA Office of Inspector General (OIG) has closed Case Number **2011–02008–HL–0497**. As we advised you when we opened this case, our decision to close a Hotline case is final, and there are no appeal rights. Inquiries for release of the results are considered on a case-by-case basis in response to written and signed requests made pursuant to the Freedom of Information Act.

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[435] *Id.* at 83.
[436] *Id.*
[437] *Id.* at 92–93.
[438] *Id.* at 85–86.
[439] *Id.* at 85.
[440] VA OIG Hotline Input Transaction, MCI # 2011-02008-HL-0497 (May 1, 2015, 11:50 AM), OIG 1390, at OIG 1390–91.
[441] E-mail from Representative 99, VA OIG Hotline (July 5, 2011, 9:32 AM), at OIG 1380.
[442] *Id.*

10. Fall 2011: VISN 12's Chief Medical Officer visited the Tomah VAMC, noting "room for improvement"

Although the VA OIG closed the Tomah VAMC allegations in July 2011, VISN 12 continued to address the issues disclosed in the OIG complaints. VISN 12's Chief Medical Officer, Dr. Bonner,[443] served as the lead official on VISN 12's action plan and visited the Tomah VAMC in the fall 2011.[444] Dr. Bonner said in a transcribed interview with Chairman Johnson's staff that he did not recall seeing the June 2011 referral from the VA OIG, but that he did understand that the action plan would be sent to the OIG.[445] During his site visit at the Tomah VAMC, he had discussions with Dr. Houlihan about the use of urine drug screens, among other topics.[446] He also reviewed Dr. Houlihan's patient charts.[447]

What Dr. Bonner learned was not encouraging. Dr. Bonner determined the Tomah VAMC was not doing urine drug screens "routinely."[448] He said that he recalled having thought "there was room for improvement" at the facility.[449] During his site visit, Dr. Bonner learned from staff that the Tomah VAMC did not have an early prescription refill policy. He spoke directly with Dr. Houlihan about the facility's early refill policy, random urine drug screens, opiate agreements among other "process issues."[450] Dr. Houlihan apparently responded to the conversation well and agreed to institute changes in those specific areas.[451]

During his transcribed interview with Chairman Johnson's staff, Dr. Bonner described his impressions of this conversation with Dr. Houlihan. He stated:

> Q: I think you said at the time, you left in September, 2011, pretty much feeling that Dr. Houlihan had agreed to fix–
>
> A: Yeah.
>
> Q: –these issues? Would that be correct?
>
> A: Correct. He seemed open to it. I mean, he wasn't, he wasn't resistant to it. I mean, this issue of his prescribing habits had, you know, from what I had been told had already been—come up and been looked at. That's a, that's a clinical provider issue that's separate than process

[443] Dr. Bonner became the Chief Medical Officer at VISN 12 in December 2010 and left the position in July 2012. Bonner Transcribed Interview, at 10.
[444] *Id.* at 21.
[445] *Id.* at 19–21.
[446] *Id.* at 20–21.
[447] *Id.* at 21.
[448] *Id.*
[449] *Id.* at 23.
[450] *Id.* at 24.
[451] *Id.*

> issues related to overall prescribing. And, you know, I mean, I tried to, you know, emphasize to him the need to have a very strong, you know, process related to this, especially if he was practicing, you know, the way he was practicing.[452]

On September 15, 2011, Dr. Bonner drafted and sent a two-page memorandum to the VISN 12 Network Director, Dr. Murawsky, summarizing the actions completed by the VISN 12 in connection with the VA OIG hotline complaints on the Tomah VAMC.[453] He told Chairman Johnson's staff that he drafted this document after his Tomah VAMC site visit based on a "referral for action" he received from Dr. Murawsky.[454]

The memorandum tracks closely with Dr. Bonner's recollection of his conversation with Dr. Houlihan that the Tomah VAMC would institute new policies. Dr. Bonner's examination of the Tomah VAMC included "a review of the Tomah early fill policy" and it found that "no written policy was identified."[455] His memorandum noted that based on his site visit "[a]n early fill policy was developed cooperatively with involvement of primary care, mental health and pharmacy and was implemented."[456] In total, three out of the four areas that Dr. Bonner examined in his site visit required "action items" to meet applicable guidelines.[457] Only one area was deemed sufficient, as Dr. Bonner determined that the "Tomah VAMC's pain treatment options [met] applicable guidelines."[458] Accordingly, VISN 12 took no action in this area.[459]

11. August 25, 2011: The VA OIG hotline group received additional allegations about Dr. Houlihan and prescribing practices at the Tomah VAMC

In late August 2011, less than two months after the VA OIG closed its hotline complaints about the Tomah VAMC, it received new allegations via an anonymous phone call about Dr. Houlihan and Deborah Frasher, a nurse practitioner at the facility. These allegations would eventually become the basis for the VA OIG's health care inspection of the Tomah VAMC that it closed in 2014.

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[452] *Id.* at 26–27.
[453] 9/15/2011 Memo from Michael Bonner to VISN 12 Network Director, at OIG 19–20.
[454] Bonner Transcribed Interview, at 39–40.
[455] 9/15/2011 Memo from Michael Bonner to VISN 12 Network Director, at OIG 19.
[456] *Id.*
[457] *Id.* at OIG 19–20
[458] *Id.* at OIG 20.
[459] *Id.* at OIG 20.

Figure 20: Report of VA OIG hotline complaint (Aug. 25, 2011)[460]

Hotline Input Transaction — Page: 1

MCI Number 2011-04212-HL-1068 Fiscal Year 2011 Analyst WILLIAMS

Date of Complaint 08/25/2011 Complaint Received 08/25/2011

VA Station 676-TOMAH Functional Area Code A19-MEDICAL CENTER

Corrective Action
Disposition Date Priority Congressional Interest No

According to an internal OIG document, on August 25, 2011, the OIG hotline group received a phone call from an anonymous complainant who provided a number of serious allegations that involved Dr. Houlihan and Ms. Frasher.[461] The caller alleged Dr. Houlihan and Ms. Frasher were abusing their authority and were prescribing "massive doses of opiates to veterans with posttraumatic stress disorder (PTSD)."[462] The caller further told the VA OIG that Dr. Houlihan "writes prescriptions continuously for early re-fills and when questioned, he instructs the pharmacy to fill it anyway."[463] At the time of the contact, the OIG document noted that the issue had not been previously reported and described the case as having no congressional interest.[464] The hotline complaint received the case number 2011-04212-HL-1068.[465]

12. September 1, 2011: The VA logged an anonymous letter presenting additional allegations about the Tomah VAMC

Separately, the VA OIG received an anonymous two-page letter alleging problems at the Tomah VAMC.[466] The letter was postmarked from La Crosse, Wisconsin, and addressed to the VA OIG Hotline office in Washington, D.C.[467] This letter alleged the same issues concerning Dr. Houlihan that the OIG hotline group received via a phone call on August 25, 2011.[468] The date stamp on the envelope was August 18, 2011,[469] but the complaint was not logged into the VA OIG's case management system until September 1, 2011.[470]

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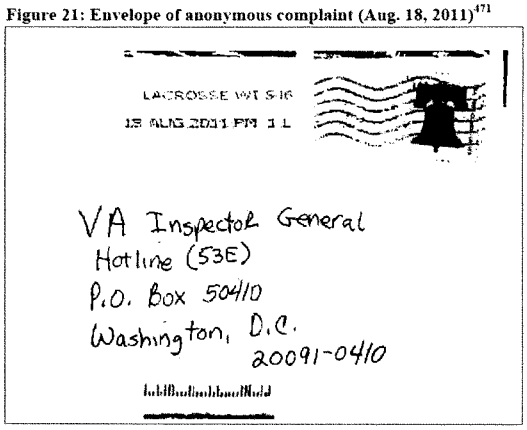
[460] VA OIG Hotline Input Transaction, MCI # 2011-04212-HL-1068 (Oct. 3, 2011, 7:36 AM, at OIG 12352.
[461] *Id.*; Porter Transcribed Interview, at 19 (VA OIG Special Agent Porter identified Ms. Frasher as the name under the redactions).
[462] *Id.*
[463] *Id.*
[464] *Id.*
[465] *Id.*
[466] Anonymous Letter and Envelope, OIG 12354-57.
[467] Envelope, OIG 12357.
[468] VA OIG Hotline Input Transaction, MCI # 2011-04212-HL-1068 (Oct. 3, 2011, 7:36 AM), at OIG 12352.
[469] Envelope, OIG 12357.
[470] VA OIG MCI Search Results, MCI # 2011-04212-HI-0267 (Oct. 3, 2011, 7:25 AM), at OIG 12358.

Figure 21: Envelope of anonymous complaint (Aug. 18, 2011)[471]



13. September 2, 2011: The VA OIG's Chicago office developed a work plan and assembled a team to examine the Tomah VAMC allegations

On August 29, 2011, the VA OIG hotline group presented the complaints about the Tomah VAMC to the Office of Healthcare Inspections field office in Chicago, Illinois.[472] The field office accepted the complaints the following day.[473] The Associate Director of the Chicago field office, Wachita Haywood, assigned the hotline complaints to Roberta Thompson,[474] but the lead OIG point of contact remained Verena Briley-Hudson, the Regional Director of the Chicago office.[475] Along with other employees from the OIG's Chicago field office,[476] a team of three physicians—Dr. Michael Shepherd, Dr. Thomas Jamieson, and Dr. Alan Mallinger—were assigned to the case as well.[477]

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[471] Envelope, OIG 12357.
[472] E-mails between Steven Wise, Yohannes Debesai, Wachita Haywood, & Verena Briley-Hudson, VA OIG (Aug. 29–31, 2011), OIG 11204, at OIG 11205.
[473] E-mails between Steven Wise, Yohannes Debesai, Wachita Haywood, & Verena Briley-Hudson, VA OIG (Aug. 29–31, 2011), OIG 11204, at OIG 11204–06.
[474] E-mail from Wachita Haywood, VA OIG, to Roberta Thompson, VA OIG (Aug. 31, 2011, 9:53 AM), OIG 12874, at OIG 12874–75.
[475] VA OIG MCI Search Results, MCI # 2011-04212-HI-0267 (Oct. 3, 2011, 7:25 AM), at OIG 12358; Haywood Transcribed Interview, at 21.
[476] E-mail from Yohannes Debesai, VA OIG, to Verena Briley-Hudson, VA OIG (Aug. 31, 2011, 3:03 PM), at OIG 11204. Verena Briley-Hudson and Roberta Thompson from the Chicago Field Office were also assigned to the Tomah case. *Id.*
[477] *Id.*

This complaint was assigned the case number 2011-04212-HI-0267,[478] which is the case number associated with the final administrative closure issued in 2014.[479] Internal OIG notes indicate that by September 2, 2011, the VA OIG team was "developing [a] workplan."[480]

14. Fall 2011: The VA OIG's Chicago field office slowly assembled information about the Tomah VAMC allegations

According to Ms. Haywood, after receiving the allegations about the Tomah VAMC, she called leaders from VISN 12 and the Tomah VAMC to alert them that the OIG had received allegations, explain "a little bit about the case," and identify a liaison for the OIG inspectors.[481] Ms. Haywood said that she spoke by phone, at an unknown date, with either Dr. Murawsky or Ms. Oshinski of VISN 12 about the Tomah VAMC allegations and hotline.[482] On the morning of September 29, 2011, Ms. Haywood spoke with Carla Loging, the secretary to the Tomah VAMC Director, about the hotline.[483] After the conversation, Ms. Haywood emailed Ms. Loging to formally request an "[a]ssigned [l]iaison from Tomah VA."[484] Ms. Haywood copied on the email Dr. Houlihan and OIG staff assigned to the case.[485] Dr. Houlihan responded, apprising the OIG that Julie Nutting would be the point of contact.[486] Ms. Haywood described her actions as a "courtesy call" and stated that she handled this hotline in "the way I do it all the time."[487]

Documents obtained by Chairman Johnson indicate that the VA OIG's progress in examining the allegations was slow. The original due date for a report was December 31, 2011,[488] but it became clear that the Chicago field office would not meet that timeframe. At the end of August 2011, when the hotline complaint was assigned to the Chicago OIG field office, the VA OIG headquarters office provided Dr. Shepherd and Dr. Mallinger with the "old Tomah case"—meaning the allegations received in March 2011 and closed in July 2011—along with the response from VISN 12.[489]

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[478] The MCI Number was assigned by Yohannes Debesai on September 7, 2011. OIG Bates number 11203.
[479] E-mail from Yohannes Debesai, VA OIG, to Verena Briley-Hudson, Wachita Haywood, & Judy Brown, VA OIG (Sept. 7, 2011, 9:46 AM), at OIG 11203; VA OIG TOMAH VAMC ADMINISTRATIVE CLOSURE.
[480] VA OIG MCI Search Results, MCI # 2011-04212-HI-0267 (Oct. 3, 2011, 7:25 AM), OIG 12358, at OIG 12359.
[481] Haywood Transcribed Interview, at 26–27.
[482] *Id.* at 27.
[483] E-mail from Wachita Haywood, VA OIG, to Carla Loging, Tomah VAMC (Sept. 29, 2011, 12:44 PM), at OIG 8987.
[484] E-mail from Wachita Haywood, VA OIG, to Carla Loging, Tomah VAMC (Sept. 29, 2011, 12:44 PM), at OIG 8987.
[485] *Id.*
[486] *Id.*
[487] Haywood Transcribed Interview, at 27.
[488] E-mail from Yohannes Debesai, VA OIG, to Verena Briley-Hudson, VA OIG (Aug. 31, 2011, 3:03 PM), at OIG 11204.
[489] E-mail from Yohannes Debesai, VA OIG, to George Wesley et al., VA OIG (Aug. 30, 2011, 11:02 AM), at OIG 11207.

VA OIG documents suggest that only a small amount of inspection activity occurred in the months between September 2011 and January 2012. Instead, it appears that much of this time was spent understanding the closed Tomah VAMC allegations and coordinating between the VA OIG's Chicago field office and Washington headquarters office. In mid-September 2011, Ms. Haywood emailed a number of documents to Dr. Shepherd, Dr. Jamieson, and Dr. Mallinger, and other OIG employees from the Chicago field office who were assigned to the inspection.[490] The documents were obtained from VISN 12 and appear to concern Dr. Houlihan. Ms. Haywood's email referenced a letter sent by an unknown individual—the VA OIG redacted the individual's identity before producing the email to the Committee—to VISN 12 and to the Peer Review Oversight Committee.[491] She also noted that another document attached to the email was a summary review of Dr. Houlihan's patients conducted by the same unknown individual.[492] Ms. Haywood opined the documents were "[i]nteresting reading indeed."[493]

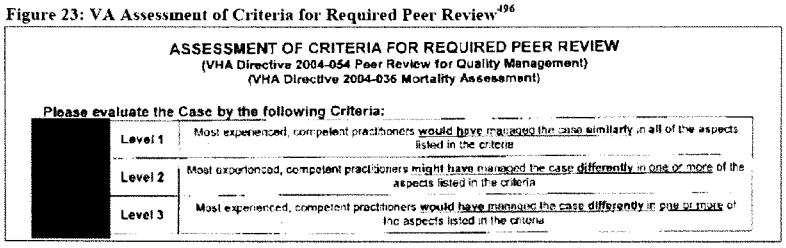
Figure 22: Email from Wachita Haywood to VA OIG employees (September 20 2011)[494]

> Included in these documents is a letter from [redacted] to the VISN and to the Peer Review Oversight Committee. [redacted] also did a summary review of his patients and provided his opinion back to the committee. There were several Level 3, and others were Level 2. Interesting reading indeed.

As explained, VA physicians are evaluated by their peers on a three-tier scoring system, with level 1 indicating the highest score and level 3 the lowest score. According to Ms. Haywood's email, the unknown individual's review of Dr. Houlihan's cases came to "several" level 3 conclusions—in which "most experienced, competent practitioners would have managed the case differently in one or more aspects listed in the criteria."[495]

[490] E-mail from Wachita Haywood, VA OIG, to Michael Shepherd, Thomas Jamieson, & Alan Mallinger, VA OIG (Sept. 20, 2011, 11:30 PM), at OIG 11201.
[491] *Id.*; OIG Bates number OIG 4757-4763. Peer Review Committee minutes. VA Memorandum.
[492] E-mail from Wachita Haywood, VA OIG, to Michael Shepherd, Thomas Jamieson, & Alan Mallinger, VA OIG (Sept. 20, 2011, 11:30 PM), at OIG 11201.
[493] *Id.*
[494] *Id.*
[495] Veterans Health Affairs, Assessment of Criteria for Required Peer Review, OIG 4768, at OIG 4769; E-mail from Wachita Haywood, VA OIG, to Michael Shepherd, Thomas Jamieson, & Alan Mallinger, VA OIG (Sept. 20, 2011, 11:30 PM), at OIG 11201.

Figure 23: VA Assessment of Criteria for Required Peer Review[496]



ASSESSMENT OF CRITERIA FOR REQUIRED PEER REVIEW
(VHA Directive 2004-054 Peer Review for Quality Management)
(VHA Directive 2004-036 Mortality Assessment)

Please evaluate the Case by the following Criteria:

Level 1	Most experienced, competent practitioners would have managed the case similarly in all of the aspects listed in the criteria
Level 2	Most experienced, competent practitioners might have managed the case differently in one or more of the aspects listed in the criteria
Level 3	Most experienced, competent practitioners would have managed the case differently in one or more of the aspects listed in the criteria

Ms. Haywood also alerted the team that VISN 12 planned to review Deborah Frasher's patients as well.[497] A little over a week later, on September 29, 2011, VISN 12 provided peer reviews for two of Ms. Frasher's patients, along with a "Scope of Practice" document that outlined what Ms. Frasher was authorized to do as a nurse practitioner.[498]

On November 10, 2011, Ms. Nutting, the Tomah VAMC's point of contact with the OIG, emailed Roberta Thompson with a hyperlink to a restricted SharePoint site.[499] This site allowed the Tomah VAMC to upload documents for OIG's review. She advised the OIG that documents would be uploaded soon and responded to a question of whether the police staff at Tomah were contractors or VA employees.[500] Five days later, on November 15, 2011, Ms. Thompson shared the SharePoint site with the rest of the OIG team.[501]

The VA OIG removed one physician, Dr. Jamieson, from the Tomah VAMC case on November 15, 2011, after he was assigned to work another congressional request.[502] In late 2011, VA OIG employees in Chicago and Washington continued to share information via phone calls and emails. In preparation for a scheduled conference call on the Tomah VAMC hotline allegations, Dr. Mallinger emailed Dr. Shepherd and Dr. Jamieson the March 2011 complaints, the VISN 12 response, and articles written on Dr. Houlihan.[503] In the end, Ms. Thompson cancelled the conference call on November 17, 2011; there is no indication that the call was rescheduled.[504]

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[496] Veterans Health Affairs, Assessment of Criteria for Required Peer Review, OIG 4768, at OIG 4769.
[497] E-mail from Wachita Haywood, VA OIG, to Michael Shepherd, Thomas Jamieson, & Alan Mallinger, VA OIG (Sept. 20, 2011, 11:30 PM), at OIG 11201.
[498] E-mail from Wachita Haywood, VA OIG, to Roberta Thompson, VA OIG, et al. (Sept. 29, 2011, 11:48 AM), at OIG 11200.
[499] E-mail from Thomas Jamieson, VA OIG, to Roberta Thompson, VA OIG (Nov. 15, 2011, 1:37 PM), at OIG 11190.
[500] *Id.* The Tomah VAMC Police Department staff members are VA employees, not contractors.
[501] *Id.*
[502] *Id.*
[503] E-mail from Alan Mallinger, VA OIG, to Michael Shepherd & Thomas Jamieson, VA OIG (Nov. 8, 2011, 2:42 PM), at OIG 11197.
[504] E-mail from Roberta Thompson, VA OIG, to Alan Mallinger, VA OIG (Nov. 17, 2011, 9:34 AM), at OIG 11187.

15. September 29, 2011: The Tomah VAMC Hotline became a "congressional" request

About one month later, on September 29, 2011, Congressman Ron Kind's office sent a fax to the VA OIG asking the office to review a complaint that the office had received concerning "Dr. David Houlihan at the VA Tomah."[505] This anonymous two-page letter was identical to the letter the VA OIG received on September 1, 2011.[506] The letter raised concerns about the prescribing practices of Dr. Houlihan and nurse practitioner Deborah Frasher. The complaint described Dr. Houlihan and Ms. Frasher's prescription practices as "escalating at such a high rate it is scary."[507]

The letter provided a summary of an "incident" in which one of Dr. Houlihan's patients allegedly received an early refill on his narcotic medication.[508] Shortly after receiving the early refill of narcotics, the patient checked himself into the Tomah VAMC in a poor physical condition.[509] While at the facility, doctors performed a drug screen, which showed that there were no opiates in the patient's system.[510] This result led the complainant to conclude that the patient had sold his medication.[511] This patient was admitted to the Tomah VAMC for a month longer and, after his discharge, Dr. Houlihan prescribed the patient oxycodone for pain.[512] Allegedly, the patient ended up back in the hospital shortly after due to a "cocaine binge."[513] The complainant concluded: "This is just one of many patients of [Dr. Houlihan's] that are out and out drug abusers, but he continues to give them what they want, no questions asked."[514]

After receiving the letter from Congressman Kind, the VA OIG's legislative affairs officer alerted the congressional staffer via email that the VA OIG had received matching allegations separately.[515] In the same email, the VA OIG legislative affairs officer inquired whether Congressman Kind sought a response and the staffer asked the OIG to prepare a written response.[516] On October 11, 2011, the VA OIG sent a response letter to Congressman Kind, confirming that the VA OIG had initiated a review of the allegations and planned to provide the

[505] Fax from Hon. Ron Kind, Member, U.S. H. of Reps., to VA Inspector General (Sept. 29, 2011), OIG 1484, at OIG 1484–86 [hereinafter 9/29/2011 Fax from Rep. Ron Kind to VA IG].
[506] VA OIG MCI Search Results, MCI # 2011-04212-H1-0267 (Oct. 3, 2011, 7:25 PM), at OIG 12358; Anonymous Letter to VA Inspector General, OIG 12354, at OIG 12354–57; 9/29/2011 Fax from Rep. Ron Kind to VA IG, OIG 1484, at OIG 1484–86.
[507] 9/29/2011 Fax from Rep. Ron Kind to VA IG, at OIG 1486.
[508] *Id.* at OIG 1485.
[509] *Id.*
[510] *Id.*
[511] *Id.*
[512] *Id.* at 1486
[513] *Id.*
[514] *Id.*
[515] B50, E-mail from Staff of Hon. Ron Kind, U.S. H. of Reps., to Catherine Gromek, VA OIG (Oct. 4, 2011, 4:29 PM), at OIG 9962 [hereinafter 10/4/2011 E-mail from Staff of Rep. Ron Kind to Catherine Gromek, VA OIG]; VA Hotline Input Transaction, MCI # 2011-04212-hl-1068 (Oct. 3, 2011, 7:36 AM), OIG 12352, at OIG 12352–53.
[516] 10/4/2011 E-mail from Staff of Rep. Ron Kind to Catherine Gromek, VA OIG, at OIG 9962.

results when completed.[517] This response was signed by Richard Griffin, the Deputy Inspector General, in lieu of VA Inspector General George Opfer.[518]

On October 3, 2011, over a month after receiving the same allegations, the VA OIG categorized this complaint as a "congressional" complaint and the correspondence was assigned a case number of 2011-04212-CR-0001.[519] On October 6, the VA OIG's legislative affairs officer informed Office of Healthcare Inspections and the OIG Hotline Division that the Tomah VAMC allegations were now a "congressional."[520] According to VA OIG documents, this congressional request was assigned the same case number as the OIG hotline contact from August 25, 2011.[521]

Figure 24: VA OIG email regarding congressional interest in the Tomah VAMC (Oct. 6, 2011)[522]

From:	Gromek, Catherine A. (OIG)
Sent:	Thursday, October 06, 2011 2:30 PM
To:	Wise, Steven (OIG); Phillips, Cliff (OIG); OIG 54 Hotline Management Team
Cc:	Richardson, Dwight (OIG)
Subject:	Tomah VAMC

The case 2011-4212-HL-1068 and 2011-4214-HI-0267 is now a congressional – please note that in your records. Also note that the 120 days runs from Sept. 1, 2011 – so this is due around the New Year!

Happy New Year!

Subsequently, in mid-December 2011, Ms. Haywood sought to understand how the Tomah VAMC allegation had become a congressional request and she requested a copy of the congressional letter from VA OIG headquarters office.[523] A response from the OIG central office, with Congressman Kind's letter, was sent to her on December 14, 2011.[524]

[517] Letter from George Opfer, VA OIG, to Hon. Ron Kind, Member, U.S. H. of Reps. (Oct. 11, 2011), OIG 12342, at OIG 12342.
[518] *Id.*; VA OIG Concurrence and Summary Sheet (Oct. 6, 2011), at OIG 12348.
[519] VA OIG Hotline Input Transaction, MCI # 2011-04212-CR-001 (May 5, 2015, 11:37 AM), at OIG 1481.
[520] E-mail from Catherine Gromek, VA OIG, to Hotline Mgmt. Team, VA OIG (Oct. 6, 2011, 2:30 PM), at OIG 11199.
[521] Hotline Contact Case, Case # 2011-04212-HL-1058 / HI-0267 (May 5, 2015, 4:18 PM), at OIG 1487.
[522] E-mail from Catherine Gromek, VA OIG, to Hotline Mgmt. Team, VA OIG (Oct. 6, 2011, 2:30 PM), at OIG 11199.
[523] E-mail from Wachita Haywood, VA OIG, to Yohannes Debesai, VA OIG (Dec. 13, 2011, 1:22 PM), at OIG 11181
[524] E-mail from Yohannes Debesai, VA OIG, to Alan Mallinger et al., VA OIG (Dec. 14, 2011, 1:49 PM), at OIG 11181

16. December 2011: VISN surmises to VA OIG that "disgruntled employees" could be responsible for Tomah VAMC allegations

In December 2011, Dr. Mallinger sought out VISN 12 Chief Medical Officer, Dr. Bonner, to seek his "insights into the situation" because the August 2011 allegations were not "very substantive."[525] The insight yielded more of the same from the VA, as Dr. Bonner advised the OIG that the Tomah VAMC "had made some changes" and VISN 12 was "hopeful things would be better."[526] At the time of the phone call, Dr. Mallinger recalled having a skeptical view of what Dr. Bonner was telling him.[527]

According to Dr. Mallinger, he had another conversation with Dr. Bonner around the same time about the Tomah VAMC allegations. Dr. Mallinger described the conversation during his transcribed interview with Chairman Johnson's staff. He stated:

> I remember having a conversation with him around that time, and I asked him why he thought someone would make these kinds of complaints, you know, particularly the March complaint where it wasn't anonymous, and put their reputation on the line, you know, if—if there wasn't some kind of a serious problem going on there. And his reply to me at the time was that he thought these were disgruntled employees making these allegations.[528]

Dr. Mallinger recalls noting these conversations with Dr. Bonner, but he continued his work on the inspection to determine the veracity of the allegations himself.[529]

17. December 2011: The VA OIG team in Chicago requested an extension on their work

On December 13, 2011, a few weeks before the original due date for the OIG's work, Ms. Thompson emailed Dr. George Wesley, the Director of the Medical Consultation and Review Division within the VA OIG's Office of Healthcare Inspections, requesting an extension of the due date for the Tomah VAMC hotline.[530] Ms. Thompson communicated to Dr. Wesley that the extension is necessary "due to the complexity and scope of the hotline, as well as the workload and leave schedules of the staff assigned to the hotline."[531] Dr. Shepherd and Dr. Mallinger, along with the other employees on the Tomah VAMC inspection, informed Dr. Wesley that a

[525] Mallinger 3/8/2016 Transcribed Interview, at 78; VA OIG Healthcare Transaction Report, MCI # 2011-04212-HI-0267 (May 1, 2015, 11:46 AM), at OIG 1394.
[526] Mallinger 3/8/2016 Transcribed Interview, at 78.
[527] *Id.* at 79.
[528] *Id.* at 80.
[529] *Id.* at 81.
[530] E-mail from Roberta Thompson, VA OIG, to George Wesley, VA OIG (Dec. 13, 2011, 5:15 PM), at OIG 11183
[531] *Id.*

"realistic" draft report due date was March 31, 2012.[532] Dr. Wesley granted the extension request.[533]

Dr. Mallinger explained that he thought there were several things that contributed to the Chicago office requesting an extension. He first believed the Chicago office was "very overworked" and had a lot of commitments to other responsibilities.[534] The other reason for the delay, according to Dr. Mallinger, was that the case "was a very complex hotline in many ways."[535] Dr. Mallinger complained that the "allegations were all over the place. You know, they ran from law enforcement to clinical practice to personnel practices. They ran into a lot of things that we really even can only touch on in selected ways as they related to patient care."[536]

He also explained that the VA OIG would typically seek to interview the complainant and hopefully gain valuable information to further the inspection.[537] However, because the August 2011 allegations were made anonymously, Dr. Mallinger explained that was not an avenue for the OIG.[538] He said the complaint "was kind of like being dropped into the middle of the desert, you know, and not really even necessarily knowing what direction to go in."[539]

Dr. Mallinger said to Chairman Johnson's staff that the VA OIG inspectors tried to use the March 2011 complaint for some leads. The OIG did not interview the March 2011 complainant, however, because, according to Dr. Mallinger, "[t]hey were different allegations" and "the case wasn't reopened."[540] When further questioned about the decision whether to interview the March 2011 complainant, Dr. Mallinger stated that the VA OIG did not have any questions for him after reviewing the documents. He said:

> Q: Did you have any thoughts of potentially reaching out to that March 2011 complainant since an interview of that person wasn't done? Because, you know, you're in the desert here, as you're saying, and you're looking for leads. Potentially talking to that person from the March 2011 complaint might have—could help, maybe.
>
> A: Well, I can't say that I have any recollection of whether we thought about it and didn't do it or didn't think about it. We had a lot of material that he had submitted, and in a sense that was a logical

[532] *Id.*
[533] VA OIG Hotline Inspection Work Plan, MCI # 2011-04212-HI-0267, # 2011-04212-CR-0001 (Apr. 30, 2012), OIG 12222, at OIG 12223 [hereinafter VA OIG Hotline Inspection Work Plan]..
[534] Mallinger 3/8/2016 Transcribed Interview, at 83.
[535] *Id.*
[536] *Id.*
[537] *Id.*
[538] *Id.*
[539] *Id.* at 83–84.
[540] *Id.* at 84–85.

> starting place. And I think that by the time we got through that material, I don't think we had questions for him.[541]

It is not known if the VA OIG spoke with the March 2011 complainant with the complaint in the spring of 2011. If the VA OIG did interview the complainant then, it appears the information was not shared with Dr. Mallinger.

18. December 2011: Deputy Inspector General Richard Griffin requested the referrals relating to the Tomah VAMC allegations

Separately, in mid-December 2011, Deputy Inspector General Richard Griffin requested from a VA OIG legislative affairs officer the "referrals" concerning the Tomah VAMC and another case.[542] It is unclear what prompted Mr. Griffin to request the referral relating to the Tomah VAMC.

Figure 25: Email from Catherine Gromek to Dr. John Daigh et al.[543]

Daigh, John (OIG)

From: Gromek, Catherine A. (OIG)
Sent: Thursday, December 15, 2011 11:50 AM
To: Daigh, John (SES) (OIG); Christ, Patricia (SES) (OIG); Wesley, George (SES) (OIG)
Subject: Referrals

Griff would like the see the referrals for [redacted] and Tomah.

During his transcribed interview with Chairman Johnson's staff, Dr. Daigh said that he did not recall the request but that he "always tr[ies] to answer my boss' request, so I'm going to—without any specific memory or notes, I'm going to say I'm sure we talked about this."[544] Dr. Wesley also did not recall this request but he provided a more in-depth explanation to Mr. Griffin's request to see referrals.[545] He explained:

> Let me explain as best I can because I agree the word "referrals" is complicated, so please bear with me. But in that it was now a congressional, it meant Cathy Gromek now had an interest in it. She wouldn't have prior or would have been less interested prior. Now, the way our building is, it's the 10th floor where the operational offices are; the 11th floor is where Mr. Griffin and counsel and Cathy Gromek are. So now, because of—

[541] *Id.* at 85.
[542] E-mail from Catherine Gromek, VA OIG, to John Daigh, Patricia Christ, George Wesley, VA OIG (Dec. 15, 2011, 11:50 AM), at OIG 10298
[543] *Id.*
[544] Daigh Transcribed Interview, at 32.
[545] Wesley Transcribed Interview, at 119–20.

> Cathy is now interested in the case—that's what I take from this—because it's a congressional. The 11th floor, Mr. Griffin would worry about congressionals. So he would weigh in more than he would have if it was a non congressional.
>
> The thing that bothers me about this email is it says "referrals." Does this mean he actually wants to see the raw allegation that came in at the end of—in August? Or does he want a briefing on just where we are with the case? I take "referrals" to mean they're asking actually—I think he actually wanted to see the raw material, whatever that exhibit was.[546]

19. Late 2011: VA OIG headquarters in Washington became increasingly involved the Tomah VAMC inspection

The VA OIG health care inspection of the Tomah VAMC was originally assigned and worked from the OIG's office in Chicago, Illinois; however, after a period of time, the OIG team in Washington took an increasing role. The VA OIG assigned three physicians to examine the Tomah VAMC hotline allegations. Dr. Alan Mallinger and Dr. Michael Shepherd—both of the OIG's Washington, D.C. office—actively reviewed the allegations in the fall of 2011, but as the year ended, it appears that a decision was made to transfer the inspection to the Washington office full time. Dr. Mallinger's work on the inspection grew accordingly.

During his transcribed interview with Chairman Johnson's staff, Dr. Mallinger said that his involvement in the inspection increased in late 2011. He recalled reviewing all of the allegations made in March 2011—referred to VISN 12 for action—and the VISN 12 response in June 2011.[547] He was unclear precisely when he reviewed these documents, but he recalled the allegations and described them as "alarming" and involving "some very serious problems."[548] Dr. Mallinger was a member of the VA OIG's hotline team when the OIG received the VISN 12 response in the summer of 2011. He took note of the response but was not involved in the review at that time.[549] His involvement changed after the VA OIG received the new anonymous allegations in August 2011.

He told Chairman Johnson's staff that the March 2011 allegations were "serious" and the "August allegations were equally as serious" and that some of the allegations in both cases were similar.[550] Dr. Mallinger offered two reasons why, at the time, he believed the allegations deserved a second look. First, the August 2011 allegations, he said, contained "alarming

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[546] *Id.* at 120–21.
[547] Mallinger 3/8/2016 Transcribed Interview, at 44–45.
[548] *Id.* at 44.
[549] *Id.* at 46.
[550] *Id.* at 46–47.

material" that evinced a "pattern."[551] Second, he explained that the August 2011 allegations convinced him to review the March 2011 allegations. He stated:

> [T]he August allegation that came in was—although it was very well written and it was—like I say, it was, you know, equally alarming, it was very, very lacking in details. You know, aside from talking about the doctor and the other clinician involved, there really weren't any names, there weren't any dates, there weren't any places. There was very little for us to hang our hat on in terms of proving or disproving those allegations. So I felt that digging into this earlier set of allegations, which, you know, had quite a lot of detail in it and had—you know, additional documents had come back to us as a result of it, might shed light on the August allegations. And so that was why I did the review that I did.[552]

During his transcribed interview, Dr. Mallinger recalled the August 2011 letter that was mailed to the VA OIG in Washington, DC, and postmarked from La Crosse, Wisconsin.[553] He did not recall how he was assigned to work the Tomah VAMC allegations other than "it was sort of the natural flow of things. You know I had followed Dr. Shepherd around on the previous hotline."[554] Dr. Mallinger described his role in this inspection as "more of the first chair position" while Dr. Shepherd took "the second chair position."[555] He explained why he wanted to work the case, stating that the allegations "make[] you mad, and you want to do something. And I think people wanted to be involved in this . . . ."[556]

During the fall of 2011, Dr. Mallinger and Dr. Shepherd consulted on the Tomah VAMC hotline work being performed by the Chicago office, a role Dr. Mallinger described as providing medical expertise to support the inspection.[557] He recalled that Roberta Thompson, out of the Chicago OIG office, was the lead inspector on the inspection at the time.[558] At that time, the Chicago team was the lead and according to Dr. Mallinger, "[t]hey started collecting documents" but he had difficulty describing what other actions the Chicago team accomplished.[559]

As 2011 ended, the VA OIG had very little to show for its work on the Tomah VAMC health care inspection. Other than some document collection by the Chicago OIG office and preliminary conversations with VISN 12, the VA OIG felt that the inspection was not moving forward. Dr. Wesley noted this lack progress, telling Chairman Johnson's staff that the Chicago office "had trouble moving it forward" with the Tomah VAMC inspection.[560]

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[551] *Id.* at 47.
[552] *Id.* at 47–48.
[553] *Id.* at 71–72.
[554] *Id.* at 72–73.
[555] *Id.* at 73.
[556] *Id.*
[557] *Id.* at 75.
[558] *Id.*
[559] *Id.* at 76.
[560] Wesley Transcribed Interview, at 106.

Around January 2012, Dr. Mallinger had conversations with Roberta Thompson of the Chicago OIG Office and told her that he was "concerned that we weren't really moving ahead very well" on the inspection.[561] According to Dr. Mallinger, Ms. Thompson blamed the Chicago office's heavy workload, other obligations the office had, and told him the office would eventually get to the inspection.[562]

After this conversation, Dr. Mallinger discussed with Dr. Shepherd and Dr. Wesley his concerns about the pace of the inspection. These discussions appear to have resulted in a decision that the OIG would "try something new."[563] During his transcribed interview with Chairman Johnson's staff, Dr. Mallinger explained that a physician from the VA OIG's headquarters would be assigned the inspection. He stated:

> I discussed it with Dr. Wesley. And, again, my—again, remember that I was new in the organization at this time, and I—so I don't necessarily have institutional memory for the way things are usually done. But the way I understood it, they were going to try something new. Now, whether it was really new or it was just new to me, I'm not sure I'm remembering exactly, but the something new would have been to bring it into the central office, put a physician at the charge of it, and . . . .[564]

Dr. Mallinger further explained the OIG's decision to try something "new" may have been based on the complexity of the allegations.[565] He recalled the office seeking to do the Tomah VAMC health care inspection in a different way and, by extension, provide more resources and raise the priority of this inspection.[566]

20. February 2012: Dr. Mallinger contacted the Tomah, Wisconsin, Police Department, and learned of a confidential informant with allegations of drug diversion

Shortly after speaking with Dr. Wesley about the pace of the inspection and the decision to try something "new," Dr. Mallinger took the initiative to contact the Tomah Police Department. He memorialized his conversation with two individuals from the Tomah Police Department in a report of contact dated February 13, 2012.[567] The VA OIG redacted the names of the Tomah Police Department representatives with whom Dr. Mallinger spoke.[568] The Tomah

[561] Mallinger 3/8/2016 Transcribed Interview, at 88.
[562] *Id.*
[563] *Id.*
[564] *Id.* at 88–89.
[565] *Id.* at 89.
[566] *Id.*
[567] *Id.* at 109; VA OIG 5905
[568] VA OIG Office of Healthcare Inspections, Alan Mallinger, Report of Contact with Tomah Police Dep't, (Feb. 13, 2012) OIG 5905, at 5905.

Police Department advised Dr. Mallinger about the history of drug problems at the Tomah VAMC, mentioning that between 2006 and 2008 the department conducted "a large cocaine conspiracy investigation and arrested several VA employees."[569] At the time of this conversation, the Tomah Police Department had no active drug investigations at the Tomah VAMC.[570]

Despite not having any active drug investigations, the officers told Dr. Mallinger that they believed that "excessive amounts of narcotic drugs are sometimes prescribed by Tomah VAMC to individuals who are involved in illegal drug activities."[571] Dr. Mallinger also learned from this communication that several veterans who had passed away were found with "several thousand pills in their possession."[572] In addition, Dr. Mallinger learned that the Tomah VAMC had received information from a confidential informant about a veteran selling drugs obtained by prescription from the VA.[573]

Figure 26: Report of Contact with Tomah Police Department[574]

possession. In addition, a confidential informant provided information to them that a VA patient by the name of [redacted] was regularly selling the drugs he obtained by prescription. [redacted] stated that he has access to information on several other individuals involved in selling drugs obtained by prescription from the VA, and that he would provide me with these names when he has a chance to assemble them.

During his transcribed interview with Chairman Johnson's staff, Dr. Mallinger stated that he did not learn the identity of the confidential informant at the time of the phone call.[575] However, he said that the VA OIG confirmed the patient named by the Tomah Police Department was in treatment at the Tomah VAMC and was receiving a prescription for narcotic medication.[576] Curiously, Dr. Mallinger and the OIG did not dig further. He stated:

> Q: And did you confirm whether they were regularly selling the drugs he obtained by prescription?
>
> A: No. Again, you know, I'm not a law enforcement officer. You know, I was looking into the clinical side of it, where were the drugs obtained.
>
> Q: So did you farm that out to the criminal side of OIG to follow up on, or no one looked into that?

[569] *Id.*
[570] *Id.*
[571] *Id.*
[572] *Id.*
[573] *Id.*
[574] *Id.*
[575] Mallinger 3/8/2016 Transcribed Interview, at 114–15.
[576] *Id.* at 115.

VA OIG
Attorney: I believe they tell the police how—

A: They tell the police where—

Q: So nothing from your inspection? You didn't follow the selling of the drugs he obtained. You just looked—

A: I did not look into that.

Q: You just looked into it and confirmed that he was a Tomah patient in for treatment and had a narcotic medication prescribed?

A: That's correct.[577]

During his communication with the Tomah Police Department, Dr. Mallinger recounted one particular allegation that the OIG had received and asked whether the officers had any further information.[578] The allegation was that Dr. Houlihan interfered with a police officer who sought to arrest a patient trying to sell his narcotic prescription on VA grounds.[579] The allegation also claimed that Dr. Houlihan threatened the officer's job.[580] Dr. Mallinger said that the officers were unable to confirm the allegation, but an officer told Dr. Mallinger that the alleged run-in between an officer and Dr. Houlihan "was unlikely, since Tomah officers do not routinely patrol or access the VA grounds except for occasional traffic stops, and would not in any case be deterred from making an arrest if this was needed."[581]

Dr. Mallinger explained that he did not further examine the past cocaine conspiracy event or research arrests of VA employees.[582] He described his overall purpose for contacting the police as following-up solely on the allegation involving Dr. Houlihan.[583] Although the officers could not confirm the allegation, they did provide Dr. Mallinger with information about VA patients.[584] Specifically, they gave him names of VA patients who were suspected of drug crimes and, according to Dr. Mallinger, those patient names became "a major part of our structured chart review of the information."[585]

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[577] *Id.* at 115–16.
[578] VA OIG Office of Healthcare Inspections, Alan Mallinger, Report of Contact with Tomah Police Dep't (Feb. 13, 2012) OIG 5905, at OIG 5905–06.
[579] *Id.*
[580] *Id.*
[581] *Id.*
[582] Mallinger 3/8/2016 Transcribed Interview, at 111.
[583] *Id.* at 111–12.
[584] *Id.* at 114.
[585] *Id.*

Later that same week in February 2012, Dr. Mallinger emailed an investigator with the Tomah Police Department to follow up on his earlier conversation. Dr. Mallinger wrote that he had examined VA records and found some "prescribing irregularities that will provide a basis for further investigation of a particular healthcare provider."[586] During his transcribed interview, Dr. Mallinger confirmed the healthcare provider in question was Tomah nurse practitioner Deborah Frasher.[587] In his email, Dr. Mallinger asked the police investigator to "collect the names of additional individuals [they] discussed" as he believed "this could be very valuable" for the VA OIG's inspection.[588]

The Tomah police did not respond initially to Dr. Mallinger's request for more information. After not receiving a response, Dr. Mallinger sent a follow-up email nearly a month later, on March 16, 2012.[589] In this email Dr. Mallinger reiterated why the information would be valuable to the VA OIG's inspection and thanked the Tomah Police Department for their prior assistance on the Tomah VAMC.[590]

An employee of the Tomah Police Department responded on March 20, 2012, copying the Chief of Police on the email.[591] In that response, the employee advised Dr. Mallinger that the Tomah Police Department had recently met with a DEA diversion agent from Milwaukee about the prescription issues at the Tomah VAMC.[592] According to the email, the Tomah Police learned from the DEA agent that VA OIG had already been in contact with the same DEA agent and that the OIG had actually provided the DEA with contact information for the Tomah Police Department.[593] The Tomah Police Department told Dr. Mallinger that to maintain the integrity of the inquiry, the VA OIG should contact the DEA agent with any additional questions.[594] The email added that the Tomah Police Department wanted "to make sure everyone involved in this matter has the same information necessary to conduct a thorough and appropriate investigation."[595]

After his initial conversation with the Tomah Police Department, and at the suggestion of the Tomah officers, Dr. Mallinger contacted the Milwaukee Police Department on February 17, 2012.[596] The phone conversation concerned the hotline allegations that referenced the

[586] E-mail from Alan Mallinger, VA OIG, to Investigator, Tomah Police Dep't (Feb. 17, 2012, 9:59 AM), OIG 11125, at OIG 11125–26.
[587] Mallinger 3/8/2016 Transcribed Interview, at 139.
[588] E-mail from Alan Malinger, VA OIG, to Investigator, Tomah Police Dep't (Feb. 17, 2012, 9:59 AM), OIG 11125, at OIG 11126.
[589] E-mail from Alan Malinger, VA OIG, to Investigators, Tomah Police Dep't (Mar. 16, 2012, 8:54 AM), at OIG 11125.
[590] *Id.*
[591] E-mail from Tomah Police Dep't to Alan Mallinger, VA OIG (Mar. 20, 2012, 11:15 AM), at OIG 11125.
[592] *Id.*
[593] *Id.*
[594] *Id.*
[595] *Id.*
[596] VA OIG Office of Healthcare Inspections, Alan Mallinger, Report of Contact with Milwaukee Police Dep't, (Feb. 17, 2012), at OIG 5728.

Milwaukee Police and the Tomah VAMC.[597] Dr. Mallinger spoke with a detective who was on the High Intensity Drug Trafficking Area REACT Interdiction Task Force.[598] The phone call did not yield much information. The Milwaukee detective told Dr. Mallinger that "to his knowledge the Milwaukee police have no current involvement of concerns about Tomah VA."[599] Dr. Mallinger was advised to contact a DEA investigator who handled drug diversion cases in Wisconsin.[600]

21. February 17, 2012: The VA OIG developed a Tomah VAMC "work plan"

While Dr. Mallinger contacted local law enforcement in Wisconsin, the VA OIG's Chicago office decided upon its investigative plan for the Tomah VAMC inspection. According to documents, the Chicago OIG authored a "work plan" that was approved days before the inspection was transferred to Washington, D.C. The document was submitted and signed on February 17, 2012, by Roberta Thompson and Laura Spottiswood, both inspectors in the Chicago office of the VA OIG.[601] According to her statements during a transcribed interview, Wachita Haywood of the Chicago VA OIG Field Office also reviewed and signed off on the work plan.[602] The document described the purpose of the inspection as reviewing allegations submitted to the VA OIG on August 26, 2011 which later became a "congressional."[603] The three-page work plan[604] document listed five objectives of the inspection with a final report due date of April 30, 2012.[605]

[597] *Id.*
[598] E-mails from Alan Mallinger, VA OIG, to Detective, Milwaukee Police Dep't (Feb. 27–28, 2012), at OIG 11144; *see also* EXEC. OFFICE OF THE PRESIDENT, OFFICE OF NAT'L DRUG CONTROL POLICY, HIGH INTENSITY DRUG TRAFFICKING AREAS PROGRAM REPORT TO CONG. 88 (2011), *available at* https://www.whitehouse.gov/sites/default/files/ondcp/policy-and-research/hidta_2011.pdf.
[599] VA OIG Office of Healthcare Inspections, Alan Mallinger, Report of Contact with Milwaukee Police Dep't, (Feb. 17, 2012), at OIG 5728.
[600] E-mail from Alan Mallinger, VA OIG, to Detective, Milwaukee Police Dep't (Feb. 27, 2012, 4:30 PM), at OIG 1114.
[601] VA OIG Hotline Inspection Work Plan, at OIG 12224.
[602] Haywood Transcribed Interview, at 47.
[603] VA OIG Hotline Inspection Work Plan, at OIG 12222–24.
[604] Ms. Haywood advised the committee that the "Work Plan" was a template that was used in the office for all work plans. Haywood Transcribed Interview, at 43.
[605] VA OIG Hotline Inspection Work Plan, at OIG 12222–24.

Figure 27: VA OIG work plan for Tomah VAMC health care inspection[606]

WORK PLAN

HOTLINE INSPECTION
Quality of Care and Prescribing Practices in Mental Health
Tomah VA Medical Center, Tomah, Wisconsin
Project No. 2011-04212-HI-0267 and 2011-04212-CR-0001

Ms. Haywood, identified as the Project Manager in the work plan,[607] provided the document via email on February 17, 2012, to Dr. Mallinger and Dr. Shepherd.[608] She asked the physicians to review the document and provide comments or additions to Ms. Thompson. Ms. Haywood ended the email by thanking the physicians for their assistance on "this complex [hotline]. We all are looking forward to moving along and closing it out."[609]

Figure 28: VA OIG work plan for Tomah VAMC health care inspection[610]

4. Resources:

A. Staff Assignments:

Project Manager:	Wachita Haywood, RN
Team Leaders:	Roberta J. Thompson, LCSW
	Laura Spottiswood, RN
Team Members:	Michael L. Shepherd, MD
	Alan Mallinger, MD
Consultant Costs:	None

B. Staff Days/TDY Resources to Complete Project: 3-4 days on site
C. References: TBD

During his transcribed interview with Chairman Johnson's staff, Dr. Mallinger stated that he did not recall the "Tomah Work Plan" or developing a similar work plan after the inspection was transferred to Washington, D.C.[611] Dr. Mallinger's views on the work plan document were not complimentary. He stated: "I'd say that this work plan is written in such a way that it's not

[606] VA OIG Hotline Inspection Work Plan, at OIG 12222.
[607] Ms. Haywood was the acting director in the Chicago OIG office for a short period time. Haywood Transcribed Interview, at 51.
[608] E-mail from Wachita Haywood, VA OIG, to Alan Mallinger & Michael Shepherd, VA OIG (Feb. 17, 2012, 4:45 PM), at OIG 11148.
[609] *Id.*
[610] VA OIG Hotline Inspection Work Plan, at 12223.
[611] Mallinger 3/8/2016 Transcribed Interview, at 94.

really clear."[612] He continued: "You know, Objective 1 here, to determine if the identified providers prescribed massive doses of narcotics for patients who experienced pain and who were diagnosed with post-traumatic stress disorder. Well, it's not even clear to me what that means, and I don't think it follows the allegations very closely."[613]

Dr. Wesley explained that he would typically review work plans because he liked to know what was going on but it was not a formal part of his job duties.[614] He described the document as a "team's first step to turn the complaint into a work plan."[615] Dr. Wesley agreed that it was unusual that the work plan for the VA OIG's health care inspection of the Tomah VAMC took over five months to be developed.[616] It appears that the physicians leading the Tomah VAMC health care inspection out of the Washington D.C. office neither implemented nor followed the "work plan" developed and approved by the VA OIG office in Chicago.[617] Dr. Mallinger stated:

> Q: Did you follow this work plan?
>
> A: Well, as I said, I followed the allegations. To the extent that this work plan reflects the allegations, I would have followed that area. But I think as far as spelling out detailed objectives, that I would have sliced and diced the allegations differently.[618]

22. February 27, 2012: The Tomah VAMC inspection was transferred to Washington, D.C. and Dr. Mallinger was assigned team leader

According to VA OIG documents, the "transfer" of the Tomah VAMC inspection from the Chicago office to Washington, D.C. headquarters appears to have occurred on February 27, 2012.[619] On this day, the Tomah VAMC hotline was referred to Pat Christ, the Deputy Assistant Inspector General.[620] Dr. Mallinger described Ms. Christ as the head of all OIG regional offices.[621] At this time, Dr. Mallinger understood that the Tomah VAMC hotline was the responsibility of the OIG central office in Washington, D.C.[622]

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[612] *Id.* at 95
[613] *Id.*
[614] Wesley Transcribed Interview, at 139.
[615] *Id.* at 104.
[616] *Id.*
[617] Dr. Mallinger held a briefing with OIG central office where he explained where the Tomah Hotline was at and where the case was going. Mallinger 3/8/2016 Transcribed Interview, at 96.
[618] *Id.* at 96 .
[619] VA OIG Healthcare Transaction Report, MCI # 2011-04212-HI-0267 (May 1, 2015, 11:46 AM), OIG 1394.
[620] *Id.*
[621] Mallinger 3/8/2016 Transcribed Interview, at 90.
[622] *Id.*

Originally assigned as a physician consultant on the case, Dr. Mallinger's role changed to a "team leader role"—a transition that he said occurred without any formal process.[623] Dr. Mallinger told Chairman Johnson's staff that the Tomah VAMC inspection was "still in a way a learning case for me."[624] He emphasized that although he had assumed the "team leader role," Dr. Shepherd and Dr. Wesley took a "very hands-on approach." He explained:

> And, you know, I think there was always—it was never the case that I was alone there. You know, there was always the, you know, sort of Dr. Shepherd, you know, there doing whatever you want to call it, mentoring or, you know, sort of—because this was, you know, still in a way a learning case for me. And I'd say that Dr. Wesley also took a very hands-on approach. And, you know, maybe part of the central office issue was to bring it a little closer to him, because he did take a very active role. He was—I mean, he was on—when we called key people, very often he was on the call. You know, when we got a second complainant later that year, you know, he was very key in doing that interview. So he actually stepped up and, you know, became very hands-on with it as well.[625]

Dr. Mallinger stated that the Tomah VAMC inspection was the first case in his career on which he was the lead inspector.[626] He explained the case "wasn't being tried in a 'throw it up in the air and see what comes down' kind of way. It was being tried with a tremendous amount of support from the leadership."[627] Dr. Mallinger explained that after the referral, the Chicago OHI office's role in the Tomah VAMC hotline was over. He said:

> Q: What was the Chicago regional office personnel's role following, you know, the referral, so to speak, to Ms. Christ?
>
> A: Well, then they were gone.[628]

On March 8, 2012, about a week after the inspection was transferred to Washington, D.C., in an email to Dr. Shepherd, Dr. Wesley recounted a meeting he had with Dr. Mallinger to discuss the Tomah VAMC inspection. This meeting lasted approximately two hours.[629] Dr. Wesley emailed Dr. Shepherd about the meeting and the decision to "focus our efforts as we did for the Palo Alto VAMC case."[630] The Palo Alto VAMC case to which Dr. Wesley referred was a complex psychiatric health care inspection in which Dr. Shepherd served as the lead inspector and Dr. Mallinger served as "second chair."[631] The restructuring within the Tomah VAMC health care inspection would mirror the procedures of the Palo Alto VAMC case—meaning that

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[623] *Id.*
[624] *Id.*
[625] *Id.* at 90–91.
[626] *Id.* at 91.
[627] *Id.* at 92.
[628] *Id.* at 93.
[629] E-mail from George Wesley, VA OIG, to Michael Shepherd, VA OIG (Mar. 8, 2012, 8:13 PM), at OIG 11140.
[630] *Id.*
[631] Mallinger 3/8/2016 Transcribed Interview, at 12.

a psychiatrist within the Office of Health Care Inspections would lead the inspection and another psychologist would serve as a the "second chair."[632] Except in the Tomah VAMC inspection, Dr. Mallinger would lead and Dr. Shepherd would serve as the "second chair" for the inspection.[633] According to the email, Dr. Wesley requested a separate meeting with Dr. Shepherd to go over the proposals and take a break from his "waiting time project."[634] When Chairman Johnson's staff asked Dr. Mallinger about this meeting, he could not recall the conversation.[635]

During his transcribed interview, Dr. Wesley said that he recalled sending the email to Dr. Mallinger on March 8, 2012.[636] He also explained what transpired during the two-hour meeting. He recalled:

> In other words, taking your first question, do I recall sitting at my word processor and writing the email? No. Do I recall the substance of the email? Yes. Despite, I think, the very important concerns you've raised about the work plan and the time that's traversed, Alan in particular and, to a lesser extent, Dr. Shepherd and Dr. Yang were working the case quite extensively, particularly Dr. Mallinger because it was his first case, and it may well have been his only case. I only give people one or two cases when they start out. So they were gathering lots of data, and the data was flowing in, particularly into Alan's office. I'd hear parts of discussions. I'd hear talk about Dr. Houlihan and his patients and his prescriptions. I'd hear so many of the concerns that make up the case. And I was a little—that's why I say I remember the content. I was as little worried that the case and its substance was running away from me. So I said to Alan, "We've got to meet, and you've got to take me through this whole thing from beginning to end," just the way you folks are. "I've got to understand every aspect of it and where you're going"—with or without knowing about a work plan. And so I got Alan out of the office. We went to a private place, and we sat down for 2 hours, and he took me through everything he had done on it, what he was thinking about it, how he analyzed it, and so on and so forth. So that's the reference to, "Mike, I had a productive almost 2-hour meeting with Alan." Again, do I remember this? No. But I think—I hope it's a legitimate inference. After meeting with Al for 2 hours—and you guys have met with him; he can stimulate a lot of thinking—I must have wanted to share my enthusiasm with Mike and say, "We've got to talk some more." So that's what that's about.[637]

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[632] *Id.* at 12–16.
[633] *Id.*
[634] E-mail from George Wesley, VA OIG, to Michael Shepherd, VA OIG (March 8, 2012, 8:13 PM), at OIG 11140.
[635] Mallinger 3/8/2016 Transcribed Interview, at 100–01.
[636] Wesley Transcribed Interview, at 141–42.
[637] *Id.* at 142–43.

Dr. Wesley also talked about the Chicago office's removal from the Tomah VAMC inspection. He described the Tomah VAMC inspection as "so incredibly physician-intense, there was very little any of our regional offices could contribute to."[638] Dr. Wesley did not recall making a decision to remove the Chicago office from the inspection, but he described the transfer of the inspection duties as occurring "by osmosis."[639] He described the Washington office's ownership of the Tomah VAMC inspection, saying it had become "Alan [Mallinger] and Michael [Shepherd] and Dr. Yang's baby, if you will."[640] Dr. Wesley confirmed the Tomah VAMC inspection "definitely left Chicago, and clearly, from 2012 on, in any practical sense, it was run by Dr. Mallinger."[641]

23. February 28, 2012: Dr. Mallinger began to communicate with the Drug Enforcement Administration about the Tomah VAMC, eventually receiving a list of suspected drug diverters

During February 2012, Dr. Mallinger made a number of contacts with law enforcement, both local and federal, to discuss the Tomah VAMC. As explained above, Dr. Mallinger spoke with the Tomah Police Department a few weeks before he made contact with the DEA.[642] According to a report of contact dated February 28, 2012, Dr. Mallinger had a conversation with an unidentified DEA employee about the Tomah VAMC, in which he shared the allegations about the Tomah VAMC and asked if the DEA possessed any "contributory information."[643]

Figure 29: Report of Contact of Dr. Mallinger's communication with DEA[644]

Report of Contact

Date: 2-28-12

Contacted: [redacted]
DEA
[redacted]

Subject: Hotline re: 2011-04212-HL-1068: VAMC Tomah, WI (676); RP71

[638] *Id.* at 125.
[639] *Id.*
[640] *Id.*
[641] *Id.*
[642] As of January 2015, the DEA had a total of 50 employees in the State of Wisconsin. The DEA has a total of 8 Diversion Investigators. The DEA has three offices in the State of Wisconsin: Milwaukee (District Office), Madison, and Green Bay. Maj. staff email from the DEA April 30, 2015.
[643] VA OIG Office of Healthcare Inspections, Alan Mallinger, Report of Contact with DEA (Feb. 28, 2012), at OIG 5726.
[644] *Id.*

According to the report of contact, the DEA had also "recently received a confidential complaint regarding the excessive prescribing practices of opiates at the Tomah VA Medical Center."[645] The DEA employee confirmed to Dr. Mallinger that "he is investigating possible drug diversion related to this."[646] Dr. Mallinger's report of contact also explained that the DEA's "complainant works in the pharmacy and alleges excessive prescribing of opiates by Dr. Houlihan to patient [redacted]."[647] According to the document, the DEA employee informed Dr. Mallinger about his investigative actions up to then—"he had interviewed two employees from the VA pharmacy and has reviewed pharmacy records."[648] The DEA employee concluded the conversation by saying it was too early in the investigation to have reached any conclusions, but he promised to keep Dr. Mallinger informed on any developments.[649] Dr. Mallinger agreed to do the same.[650]

On March 22, 2012, Dr. Mallinger spoke by phone with a DEA diversion investigator.[651] During the call, the DEA investigator told Dr. Mallinger that the DEA had obtained a list of over 30 individuals associated with the Tomah VAMC from an investigator at the Tomah Police Department.[652] The individuals listed were described as "suspected of possible drug diversion."[653] The DEA investigator planned to share the list with the VA OIG via fax and further advised Dr. Mallinger that the DEA was planning to "visit the Tomah area (but probably not the VAMC) next week along with Special Agent Porter of the OIG Chicago Office in furtherance of the investigation."[654]

During a transcribed interview with Chairman Johnson's staff, Special Agent Porter said that he received the list of 30 individuals from Detective Walensky of the Tomah Police Department.[655] Special Agent Porter apparently took no action on the list, as he explained that his role was limited. He stated:

> Q: When you were made aware of this list of individuals associated with the Tomah VA, what reaction or what action did you or could you take after receiving that information from Detective Walensky?
>
> A: The—well, action that I did take was basic, just to make myself mentally aware that there are these people named. I don't recall taking

[645] *Id.*
[646] *Id.*
[647] *Id.*
[648] *Id.*
[649] *Id.*
[650] *Id.*
[651] VA OIG Office of Healthcare Inspections, Alan Mallinger, Report of Contact with Diversion Investigator, DEA (Mar. 22, 2012), at OIG 5894.
[652] *Id.*
[653] *Id.*
[654] *Id.*
[655] Porter Transcribed Interview, at 33–34.

> any direct action on that at all, other than to let DEA Diversion and the Office of Healthcare Inspections look into their conditions, et cetera, et cetera, and their levels of prescriptions and things like that. And the Tomah Police can take action where they can, you know, research their police reports and the rest of the records to see if any of these names were people that had been arrested before, and if so, get the details of those incidents, et cetera, et cetera. I did not take any direct[] action on them. That was the police.[656]

Dr. Mallinger said that he received the list of 30 suspected individuals and that the OIG conducted a review.[657] He understood the list to have come from the Tomah Police Department and that the 30 individuals were suspected of drug crimes.[658] Dr. Mallinger explained that not all the individuals on the list were patients at the Tomah VAMC, but the OIG reviewed the prescriptions of controlled substances for the individual who were patients.[659] Dr. Mallinger could not recall whether the OIG structured chart reviews showed any prescription irregularities for the 30 individuals on the Tomah Police Department's list.[660]

In April 2012, Dr. Mallinger filed additional reports of contacts with a DEA diversion investigator. On April 2, 2012, Dr. Mallinger received an update on the DEA's "field investigation" that occurred on March 28, 2012.[661] According to Dr. Mallinger, VA OIG Special Agent Porter joined the DEA in these actions, jointly interviewing a Tomah VAMC police officer and another individual.[662] The VA police officer alleged that Dr. Houlihan abused his authority hy interfering in VA police activities on the grounds of the Tomah VAMC—specifically that Dr. Houlihan would not allow VA police to interact with patients even if there is suspicion of "criminal activity."[663] The VA police officer described Dr. Houlihan as having a "short fuse" and a "bad temper" when dealing with VA police.[664]

Dr. Mallinger told Chairman Johnson's staff that he understood the allegation referenced in the report of contact of April 2, 2012 as "[Dr. Houlihan] was trying to exert inappropriate authority over the Tomah municipal police."[665] The VA OIG health care inspectors did not speak with the police officer in question because the identity of the officer was "never revealed"

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[656] *Id.* at 34–35.
[657] Mallinger 3/8/2016 Transcribed Interview, at 152–53.
[658] *Id.* at 153.
[659] *Id.* at 152–53.
[660] *Id.* at 153.
[661] VA OIG Office of Healthcare Inspections, Alan Mallinger, Report of Contact with Diversion Investigator, DEA, (Apr. 2, 2012) OIG 5895, at 5895.
[662] *Id.* The other individual's name was redacted by the VA OIG.
[663] *Id.*
[664] *Id.*
[665] Mallinger 4/6/2016 Transcribed Interview, at 217.

to Dr. Mallinger.[666] Dr. Mallinger did not recall finding any evidence of improper influence over the Tomah VA police by Tomah VAMC senior management.[667]

Figure 30: Report of Contact of Dr. Mallinger's communication with DEA Diversion Investigator[668]

VA OIG Office of Healthcare Inspections
Hotline Inspection – Tomah VA Medical Center

Report of Contact

Completed by: Alan G. Mallinger, M.D.

Date: 4-4-12

Contacted: [redacted]
Diversion Investigator
DEA
[redacted]

Subject: Hotline re: 2011-04212-HL-1068; VAMC Tomah, WI (676); RP71

Two days later, on April 4, 2012, Dr. Mallinger again spoke with the DEA diversion investigator about the Tomah VAMC.[669] During this conversation, the DEA provided the VA OIG with the names of three individuals who were potential sources of information.[670] The three individuals all had worked at the Tomah VAMC, but had since left the facility for a variety of reasons.[671] The sources of information were described as a physician; a pharmacist; and the former Chief of Pharmacy, who quit working at the facility after being "forced to fire another pharmacist."[672]

Dr. Mallinger interviewed two of the individuals whose names were provided by the DEA. Dr. Mallinger told Chairman Johnson's staff that he interviewed the former Chief of Pharmacy Tom Jaeger and a pharmacist who left Tomah because he was pressured to fill prescriptions against his judgement.[673] During his transcribed interview, Dr. Mallinger recalled what the pharmacist told VA OIG inspectors about his time at the Tomah VAMC. Dr. Mallinger said:

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[666] *Id.* at 217.
[667] *Id.* at 218.
[668] VA OIG Office of Healthcare Inspections, Alan Mallinger, Report of Contact with Diversion Investigator, DEA, (Apr. 4, 2012), OIG 5896, at 5896.
[669] *Id.*
[670] *Id.*
[671] *Id.*
[672] *Id.*
[673] *Id.*

A: Their story was that they—this was a fairly young, kind of a beginner pharmacist who came to Tomah who felt there was kind of a core group of patients who were regularly requesting early refills of their medications. And that pharmacist felt uncomfortable doing the early refills, but was told to fill them.

Q: By who?

A: My recollection is by Dr. Houlihan, but, again, you probably have all the interviews, so I would leave it to you to verify that. But that's my recollection. And he was uncomfortable and felt like, you know, that he wasn't fulfilling his requirements as a pharmacist, and so he went to work somewhere else.

Q: So he resigned from the Tomah VA? Is that your understanding? It says he left.

A: He left, yeah.

Q: Okay.

A: He wasn't asked to leave, to my recollection. He voluntarily left.[674]

24. March 12, 2012: The VA OIG received another Tomah VAMC complaint—"HOUSTON, WE NEED SOME HELP DOWN HERE"

On March 12, 2012, the VA OIG hotline group received a two-page complaint concerning the Tomah VAMC.[675] According to Dr. Mallinger, this new complaint was important and provided "a lot of specific information about people's names that didn't come through in the first complaint," aiding the VA OIG's health care inspection.[676] The allegations involved a specific case in which a high ranking physician at the Tomah VAMC altered patient notes, describing the facility as "an institution that is compromised by an atmosphere of fear and intimidation that is incapacitating."[677] The complainant, a staff physician at the Wausau Community-Based Outpatient Clinic (CBOC), had "practiced medicine for thirty years" and said "I have never seen such mayhem. The privilege of caring for our vets is the only reason I have

[674] Mallinger 4/6/2016 Transcribed Interview, at 221.
[675] This complaint was initially assigned the case number 2012-09567 before it was bundled into the Tomah inspection. VA OIG Office of Healthcare Inspections, Alan Mallinger, Report of Contact with Diversion Investigator, DEA (Mar. 29, 2012), at OIG 5897; VA OIG Hotline Complaint (Mar. 12, 2012), OIG 11800.
[676] Mallinger Transcribed at 210.
[677] VA OIG Hotline Complaint (Mar. 12, 2012), OIG 11800, at OIG 11800–01.

not resigned. These men and women do not deserve this travesty."[678] The complaint ended with a plea: "HOUSTON WE NEED SOME HELP DOWN HERE."[679] Due to the nature of the allegations, the VA OIG bundled this hotline into the previously opened Tomah VAMC inspection.[680]

Figure 31: Hotline complaint regarding the Tomah VAMC (March 12, 2012) [681]

> More than two months have passed since I originally contacted the regional lawyer Mike Newman and Chicago OIG. If anyone is minding the store, I want to know. I have practiced medicine for thirty years. I have never seen such mayhem. The privilege of caring for our vets is the only reason I have not resigned. These men and women do not deserve this travesty
> HOUSTON WE NEED SOME HELP DOWN HERE.

The complainant described Dr. Katherine J. Pica, a physician at the Tomah VAMC, as the "wrongdoer," and alleged that a VA patient died due to "failure to diagnose bladder cancer until disease had metastasized."[682] Further, it alleged that the CPRS—the VA's computerized patient records system—notes "were altered to make it appear that the patient declined recommended evaluation that would have been life-saving."[683] The complainant believed the CPRS notes were altered because the complainant had filed a complaint.[684] During his transcribed interview with Chairman Johnson's staff, Dr. Mallinger stated that the VA OIG examined the alleged altering of medical records but he could not recall what happened with this allegation.[685]

Other information in the complaint concerned the overall culture at the facility and the allegation of "overuse of narcotics."[686] The complainant provided the VA OIG with names of Tomah VAMC employees to contact, including pharmacists who left the facility due to the problems. According to the complainant, the VA OIG's Chicago office received these or similar allegations on January 13, 2012.[687] The complainant wrote:

> I reported [the issues in this complaint] to the VISN 12 regional lawyer who told me he had forward [*sic*] it to the IG for VISN 12 in Chicago and it was subsequently forwarded to Washington. This occurred in early January 2012. I

[678] VA OIG Hotline Complaint (Mar. 12, 2012), OIG 11800, at OIG 11801; *see also* Memorandum of Conversation from VA OIG Telephone Interview (Mar. 29, 2012), OIG 13704.
[679] VA OIG Hotline Complaint (Mar. 12, 2012), OIG 11800, at OIG 11801.
[680] Mallinger 3/8/2016 Transcribed Interview, at 127. On March 20, 2012, Dr. Mallinger emailed Dr. Shepherd with the subject line "Another Tomah complaint." The body of the email reads: "For discussion today. Note last section." E-mail from Alan Mallinger, VA OIG, to Michael Shepherd, VA OIG (Mar. 20, 2012), at OIG 11127.
[681] VA OIG Hotline Complaint (Mar. 12, 2012), OIG 11800, at OIG 11801.
[682] *Id.* at OIG 11800.
[683] *Id.*
[684] *Id.* at OIG 11800–01.
[685] Mallinger 3/8/2016 Transcribed Interview, at 128.
[686] VA OIG Hotline Complaint (Mar. 12, 2012), OIG 11800, at OIG 11801.
[687] *Id.*

> don't know if any attention has been given to this problem. I had to call to find out if my complaint had been received and have become skeptical.[688]

Dr. Mallinger talked about the significance of this particular complaint because the complainant was able to elaborate on the concerns and "had a lot of information."[689] The OIG conducted a phone interview with the complainant on March 29, 2012, a few weeks after it received the allegations.[690] The complainant identified herself as a staff physician who began at the Tomah VAMC in 2009.[691] The complainant listed specific patients, including a female veteran with a 'bad shoulder' who was "treated with a huge amount of narcotic medications for her sore shoulder."[692]

Dr. Mallinger asked Dr. Wesley to participate in the phone interview with the Tomah VAMC staff physician who made the March 12 complaint.[693] According to Dr. Wesley, it was unusual for him to participate in "the guts of the inspection," but he explained his reasons for doing so during a transcribed interview with Chairman Johnson's staff.[694] Dr. Wesley stated:

> So it was important to me because Alan wanted me to sit in on the meeting, which is the exception rather than the rule. It was secondly important to me because I thought the complainant was significant. It was thirdly important to me because if you remember I talked about the structure of VA, Tomah has four CBOCs feeding into it: Wisconsin Rapids, Wausau, La Crosse, and Clark County. So, suddenly—let me make sure this is here. Yeah, it says CBOC. My thinking was now here's someone complaining from a CBOC, not from the parent facility but from one of its satellites, and that bothered me. So for those three reasons, it was an important conversation.[695]

During the interview, the VA OIG learned of an allegation that a veteran "was at kind of immediate risk of having their leg inappropriately amputated on the advice and support of Dr. Houlihan."[696] According to VA OIG documents, Dr. Wesley emailed Dr. Bonner, the VISN 12 Chief Medical Officer, to request a phone call regarding the allegation.[697] At some point, Dr. Bonner apparently apprised Dr. Houlihan of the allegation and Dr. Houlihan provided a lengthy

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[688] *Id.*
[689] Mallinger 3/8/2016 Transcribed Interview, at 127, 129.
[690] *Id.* at 126–27. Drs. Mallinger, Wesley, and Shepherd attended this conference call. VA OIG Office of Healthcare Inspections, Alan Mallinger, Report of Contact with Diversion Investigator, DEA (Mar. 29, 2012), at OIG 5897.
[691] *Id.*
[692] *Id.*
[693] Wesley Transcribed Interview, at 159–61; see also 13704-05
[694] *Id.* at 160.
[695] *Id.* at 161–62.
[696] Mallinger 3/8/2016 Transcribed Interview, at 127.
[697] E-mail from Robert Yang, VA OIG, to Alan Mallinger, VA OIG (Apr. 3, 2012, 9:03 AM), OIG 11081, at OIG 11081–82.

email response on March 30, 2012, describing the circumstances and health of the veteran.[698] Dr. Bonner forwarded the explanation from Dr. Houlihan to the OIG and described the case as "very challenging."[699] He advised the OIG that he would follow the case and opined that the complainant "did not have all the information."[700]

Other issues arose from the VA OIG's telephone interview with the physician. The OIG team learned that the DEA was allegedly subpoenaing records from Dr. Houlihan.[701] The complainant also informed the OIG inspectors that pharmacists had concerns about Dr. Houlihan's prescribing practices and that a number of them left the facility.[702] The complainant also provided the VA OIG team with information for other individuals to contact and the names of veterans allegedly diverting prescription medications.[703] The complainant also spoke about the use of narcotics and specifically issues surrounding Dr. Houlihan. The individual described the firing of the Tomah VA pharmacist Noelle Johnson, who refused to fill Dr. Houlihan's prescriptions and another psychiatrist, John Edwards, who allegedly "would not allow himself to be supervised by Dr. Houlihan."[704]

Figure 32: Summary of VA OIG's interview with Tomah VAMC staff physician[705]

> We then discussed her concerns about the overuse of narcotics at Tomah. She stated the COS is Dr. David Houlihan. He is known for his foul temper. He trashes people's careers when he fires them. He fired a psychologist 18 months ago, who then went home and committed suicide.

The complainant also raised the Tomah VAMC's reliance on Foreign Medical Graduates (FMGs) to fill medical positions. The complainant alleged that the FMGs were beholden to management at the Tomah VAMC and that many would not speak out due to fear of losing their immigration status, as it depends on the successful completion of their contractual obligation with the VA.[706] During his transcribed interview with Chairman Johnson's staff, Dr. Mallinger could not recall if this issue was discussed with the complainant but also admitted that he was not very sure what the issue was.[707] He explained that the complainant was not really alleging that there has been any retaliation against any FMG.[708]

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[698] *Id.* at OIG 11081–82.
[699] *Id.* at OIG 11081.
[700] *Id.*
[701] Memorandum of Conversation from VA OIG Telephone Interview (Mar. 29, 2012), OIG 13704, at OIG 13705.
[702] *Id.* at OIG 13704–05.
[703] *Id.*
[704] VA OIG Office of Healthcare Inspections, Alan Mallinger, Report of Contact with Diversion Investigator, DEA (Mar. 29, 2012), OIG 5897, at OIG 5897–98.
[705] *Id.* at OIG 5897. The psychologist that committed suicide after being fired appears to be referring to Dr. Christopher Kirkpatrick.
[706] Mallinger 3/8/2016 Transcribed Interview, at 129–30.
[707] *Id.* at 130–31.
[708] *Id.*

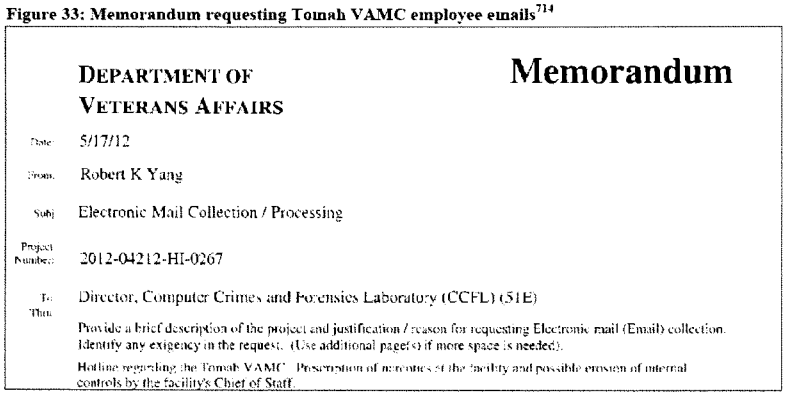
25. May 2012: The VA OIG requested Tomah VAMC employee emails

Beginning in May 2012, the VA OIG's inspection of the Tomah VAMC continued to progress at a slow pace. Now over a year since the initial allegations, and nine months since the allegations became a congressional hotline, the OIG team began the process of collecting emails of selected Tomah VAMC employees. This facet of the inspection was new to Dr. Mallinger and according to documents, Dr. Robert Yang completed the OIG memorandum that officially requested the email collection.[709]

On May 17, 2012, Dr. Yang sent three memoranda to the VA OIG's Director of Computer Crimes and Forensics Laboratory.[710] The memoranda explained that the emails were requested in connection to the OIG's hotline of the Tomah VAMC and specifically the "prescription of narcotics at the facility and possible erosion of internal controls by the facility's Chief of Staff."[711] Dr. Yang requested the emails from a total of 17 employees at the Tomah VAMC, including Dr. Houlihan, Deborah Frasher, and Margaret Hyde.[712] The VA OIG also collected emails of Dr. Christopher Kirkpatrick, Linda Ellinghuysen, and the former Director of the Tomah VAMC, Jerry Molnar.[713]

[709] According to OIG documents, Dr. Yang began assisting on the Tomah inspection in April 2012. E-mail from Robert Yang, VA OIG, to Alan Mallinger, VA OIG (Apr. 3, 2012, 9:03 AM), OIG 11081, at OIG 11081–82; *see* Mallinger 4/21/2016 Transcribed Interview, at 334.
[710] The OIG's Computer Crimes and Forensics Laboratory (CCFL) is coded 51E. Memorandum from Robert Yang, VA, to Director, Computer Crimes and Forensics Laboratory (May 17, 2012), at OIG 13676.
[711] *Id.*
[712] VA OIG MCI Search Results, MCI # 2011-04212-1E-0087 (May 5, 2015, 11:53 AM), at OIG 12368.
[713] VA OIG documents indicate the following emails were not obtained and processed: Thomas Jaegar, Christopher Kirkpatrick, Craig Otting, Jerald Molnar, and Cindy Gile. *Id.* at OIG 12368–69.

Figure 33: Memorandum requesting Tomah VAMC employee emails[714]



DEPARTMENT OF VETERANS AFFAIRS

Memorandum

Date: 5/17/12

From: Robert K Yang

Subj: Electronic Mail Collection / Processing

Project Number: 2012-04212-HI-0267

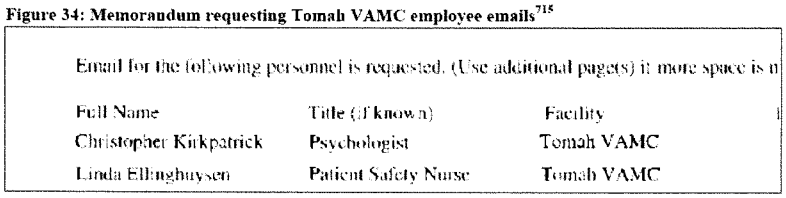
To: Director, Computer Crimes and Forensics Laboratory (CCFL) (51E)

Thru:

Provide a brief description of the project and justification / reason for requesting Electronic mail (Email) collection. Identify any exigency in the request. (Use additional page(s) if more space is needed).

Hotline regarding the Tomah VAMC. Prescription of narcotics at the facility and possible erosion of internal controls by the facility's Chief of Staff.

Figure 34: Memorandum requesting Tomah VAMC employee emails[715]



Email for the following personnel is requested. (Use additional page(s) if more space is n

Full Name	Title (if known)	Facility
Christopher Kirkpatrick	Psychologist	Tomah VAMC
Linda Ellinghuysen	Patient Safety Nurse	Tomah VAMC

Dr. Mallinger explained the OIG collected around a total of 220,000 emails, including 800 to 900 attachments.[716] Dr. Mallinger said that because he was not experienced in pulling emails, Dr. Yang "stepped into this particular part" of the inspection as he "had done it before."[717]

During a transcribed interview, Chairman Johnson's staff asked Dr. Mallinger how the VA OIG decided which Tomah employees' emails to collect. He responded that the VA OIG "pulled different employees for different reasons."[718] It appears, according to his statements, that the decision to pull certain individuals' emails was based on the allegations in the hotlines, documents, and other inspection sources.[719] For example, Dr. Mallinger explained that the OIG

[714] Memorandum from Robert Yang, VA, to Director, Computer Crimes and Forensics Laboratory (May 17, 2012), at OIG 13676.
[715] Memorandum from Robert Yang, VA, to Director, Computer Crimes and Forensics Laboratory (May 17, 2012), at OIG 13677.
[716] Mallinger 4/6/2016 Transcribed Interview, at 251.
[717] *Id.* at 251.
[718] *Id.* at 251–52.
[719] *Id.*

chose to collect Margaret Hyde's email because it would shed light on the "polarization" of the facility, which was a "very dysfunctional kind of place" where "two groups had formed."[720] He said:

> Margaret Hyde is actually a—she may be a clinical pharmacist, and I'll try and remember why we looked at her email. She was someone who I recall was—you know, you asked me before about the environment at Tomah and the culture, and while a culture of fear is sort of an element of that in terms of the perception of, you know, fearful circumstances, the culture at Tomah was really one of polarization. It was a very dysfunctional kind of a place in which two groups had formed: a very small group that was centered around Dr. Houlihan, and a larger group that was a little bit more diverse but was primarily pharmacists with a smattering of other disciplines in there. And so Dr. Houlihan had some close associates who were part of this—you know, the two warring factions, if you will—that were part of his faction. And I believe that I'm remembering this right—I'm not totally positive, but I believe Margaret Hyde was a clinical pharmacist who was in Dr. Houlihan's faction, if you will, and who was kind of like the only one who was regarded as a good pharmacist by him, if you will. So I hope I'm remembering her—I'm hoping I'm putting the name together with who that was. But, obviously, we wanted to look at people who were associates to see what kind of messages he was giving to them.[721]

Dr. Yang explained that the decision on the email collection was a collaborative effort between Dr. Yang and Dr. Mallinger and that they decided to "go with as broad a brush as we could and just see what we sort of would find."[722] He further explained the list of employees was decided based off of "who we thought might be in communication with Dr. Houlihan."[723]

The VA OIG's Office of Investigation Forensic Laboratory closed the email request on June 6, 2012.[724] The office succeeded at securing a total of 12 VA employee email accounts.[725]

[720] *Id.* at 252–53.
[721] *Id.*
[722] Yang Transcribed Interview, at 121.
[723] *Id.* at 118–19.
[724] VA OIG, Office of Investigation, Forensic Laboratory Report (June 6, 2012), OIG 12370, at OIG 12370–71.
[725] *Id.*

Figure 35: VA OIG Forensic Laboratory Report of Tomah VAMC email collections[726]

FORENSIC LABORATORY REPORT

06/06/2012

HOULIHAN, David

APPR: ASAC Brian K. Tullis

Lab # 2011-04212-IE-0087
File # 2011-04212-HI-0276

IT Specialist Sharon A. Forbes

Status: Closed

Dist: 51CH, 51E, 54

SYNOPSIS:

Department of Veterans Affairs Office of Inspector General (VA OIG) has received allegations regarding the Tomah Veteran Affairs Medical Center facility, specifically the prescription of narcotics at the facility and possible erosion of internal controls by the facility's Chief of Staff. A request for the email accounts for seventeen current and former Department of Veterans Affairs employees was made.

VA OIG Computer Crime and Forensics Laboratory (CCFL) obtained and processed VA email account files for twelve of the seventeen employees. The results were provided to the requestors for their review.

REQUEST:

On May 17, 2012, the CCFL was requested to obtain and process the VA e-mail accounts for the following employees.

- David Houlihan
- Deborah Frasher
- Margaret Hyde
- Mary Forslund
- Zakia Amling (Siddiqi)
- Linda Ellinghuysen
- Gary Loethen
- Angela Cournoyer
- Donna Leslie
- Ron Pelham
- John H. Edwards
- Dean Whiteway

26. May 2012: The VA OIG conducted a site visit to the Tomah VAMC, with employee survey results showing disturbing complaints

The VA OIG conducts a number of routine program reviews of VA facilities, including the Employee Assessment Review (EAR) and a Combined Assessment Program (CAP) report.

[726] *Id.* at 12370.

According to the VA OIG, the purpose of the EAR survey is to "get a better understanding of the facility and concerns that they [the staff] may have."[727] The EAR survey typically occurs before the VA OIG conducts a CAP site visit of a VA facility.[728] The EAR survey is completed by VA employees and responses are anonymous.[729] Ms. Haywood described the EAR process as an "electronic" survey "that the IG sends out to the facility, to the employees, prior to us coming onboard so that they can give their comments of different issues, patient safety issues, environment and care type things like that."[730] The EAR survey generally closes a few weeks before the CAP site visit and responses to the survey are collected. The responses may assist the CAP team's understanding of potential issues before visiting the facility. According to Ms. Haywood, responses to an EAR survey can serve as the basis to opening an OIG investigation.[731]

Ms. Haywood told Chairman Johnson's staff that she was involved in the Tomah VAMC CAP site visit during the week of May 7, 2012.[732] She confirmed that the VA OIG conducted an EAR survey of Tomah VAMC personnel prior to its CAP review of the facility.[733] The EAR survey yielded seven specific responses that were flagged by a VA OIG employee and sent to the OIG hotline group on May 4, 2012.[734] The VA OIG hotline group compartmentalized the EAR survey comments into a list of complaints and emailed the list to Dr. Wesley and others serving on the OIG's OHI hotline group for their review on May 7, 2012.[735]

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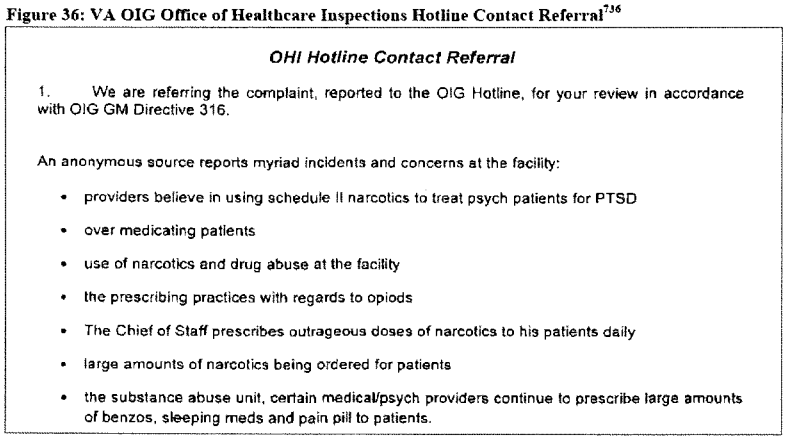
[727] Letter from Hon. Richard Griffin, Deputy Inspector Gen., to Hon. Ron Johnson, Chairman, S. Comm. on Homeland Sec. & Governmental Affairs (Apr. 24, 2015), OIG 10124, at OIG 10129.
[728] *Office of Inspector General Reports and Publications*, DEP'T OF VETERANS AFFAIRS, OFFICE OF INSPECTOR GEN., http://www.va.gov/oig/publications/. CAP reviews are part of OIG's efforts to ensure that quality health care services are provided to Veterans. CAP reviews provide cyclical oversight of VHA health care facilities; their purpose is to review selected clinical and administrative operations and to conduct fraud and integrity awareness briefing.
[729] Letter from Hon. Richard Griffin, Deputy Inspector Gen., to Hon. Ron Johnson, Chairman, S. Comm. on Homeland Sec. & Governmental Affairs (Apr. 24, 2015), OIG 10124, at OIG 10129.
[730] Haywood Transcribed Interview, at 59.
[731] *Id.* at 63.
[732] *Id.* at 58. The CAP Review of the Tomah VAMC was issued September 5, 2012. VA OIG, OFFICE OF HEALTHCARE INSPECTIONS, COMBINED ASSESSMENT PROGRAM REVIEW OF THE TOMAH VA MEDICAL CENTER, REPORT NO. 12-01337-267 (2012), OIG 13918, at OIG 13918–49.
[733] OHI CAP Employee Survey (EAR) Results, Tomah VAMC (May 7, 2012), OIG 12057; *see also* Haywood Transcribed Interview, at 60.
[734] Haywood Transcribed Interview, at 63; *see also* E-mail from Shirley Carlite, VA OIG, to VA OIG Hotline (May 4, 2012, 8:14 AM), at OIG 13656.
[735] E-mail from Yohannes Debesai, VA OIG, to Alan Mallinger, VA OIG (May 10, 2012, 5:00 PM), OIG10943, at OIG 10943–44.

Figure 36: VA OIG Office of Healthcare Inspections Hotline Contact Referral[736]



OHI Hotline Contact Referral

1. We are referring the complaint, reported to the OIG Hotline, for your review in accordance with OIG GM Directive 316.

An anonymous source reports myriad incidents and concerns at the facility:

- providers believe in using schedule II narcotics to treat psych patients for PTSD
- over medicating patients
- use of narcotics and drug abuse at the facility
- the prescribing practices with regards to opiods
- The Chief of Staff prescribes outrageous doses of narcotics to his patients daily
- large amounts of narcotics being ordered for patients
- the substance abuse unit, certain medical/psych providers continue to prescribe large amounts of benzos, sleeping meds and pain pill to patients.

Originally, these seven complaints from Tomah VAMC employees were assigned the case number 2012-12541 but after OIG personnel discussed the complaints, the hotline group decided to bundle the complaints with the ongoing Tomah VAMC inspection on May 10, 2012.[737] According to OIG documents, the complaints from the 2012 Tomah VAMC EAR survey included a number of serious concerns, many of which focused on Dr. Houlihan.[738] The allegations included potential drug diversion, over-medicated patients, certain providers using schedule II narcotics with no boundaries, and Dr. Houlihan prescribing large doses of narcotics to his patients.[739]

Tomah VAMC employees described the facility's work environment as one in which "no one can question the prescribing . . . due to fear of retaliation by the COS [chief of staff]."[740] Another complaint echoed the fear at the facility, explaining that "[t]he people here are afraid of having their careers ruined if they speak up. It's happened to others."[741]

[736] *Id.*
[737] VA OIG Bates number OIG 13825; *see also* E-mail from Yohannes Debesai, VA OIG, to Alan Mallinger, VA OIG (May 10, 2012, 5:00 PM), OIG 10943, at OIG 10943–44.
[738] Complaints Received from the EAR Survey, Tomah VAMC, OIG 5730, at OIG 5730–31.
[739] *Id.*
[740] *Id.* at 5730.
[741] *Id.*

Figure 37: Tomah VAMC employee survey results[742]

4. The prescribing practices with regards to opioids at the Tomah Facility are questionable if not downright unethical. No one can question the prescribing however due to fear of retaliation by the COS.
   Again, in the area of prescribing chronic opioids in our Veteran population - I strongly suspect that there is lots of drug diversion. Urine drug screens that are negative are not acted on - controlled substances are still being prescribed. COS does not encourage getting UDS, narcotic contracts or holding patients accountable for "lost" medications - providers encouraged to let "minor infractions" go.
5. The Chief of Staff prescribes outrageous doses of narcotics to his patients (i.e. oxycodone 1000 mg daily, morphine 1200 mg daily!). He also likes to prescribe benzos and stimulants to patients. It seems he thinks mental health patients should be treated with pain meds and stimulants, like that will help their mental health condition. He uses

27. May 10, 2012: The VA OIG interviewed Dr. Noelle Johnson

Dr. Noelle Johnson worked as a pharmacist at the Tomah VAMC for just under a year before she was fired after raising concerns about the prescribing practices at the facility. According to information provided to Chairman Johnson, the VA OIG reached out to Dr. Johnson—identified as a "former Tomah pharmacist (says she was fired for refusing to fil Rx, won a 'case' about it)."[743]

Figure 38: Email from Dr. Alan Mallinger to Yohannes Debesai[744]

From: Mallinger, Alan (OIG)
Sent: Thursday, May 03, 2012 6:25 PM
To: Debesai, Yohannes (OIG)
Cc: Shepherd, Michael L, MD (OIG); Wesley, George (SES) (OIG)
Subject: FW: pharmacist who left Tomah

Hi Yohannes,

I set up a phone interview with a former Tomah pharmacist for next Wed at 11 am.
Please schedule a VANTS line ASAP.

George and Mike, I spoke with a second former Tomah pharmacist (says she was fired for refusing to fil Rx, won a "case" about it). She is available to interview any time next week, as she is home recovering from surgery. Could you give me some available times and I will schedule her as well?

Many thanks,
Alan

[742] *Id.*
[743] E-mail from Alan Mallinger, VA OIG, to Yohannes Debesai, VA OIG (May 3, 2012, 6:25 PM), at OIG 10968.
[744] *Id.*

The VA OIG phone interview with Dr. Johnson, which occurred on May 10, 2012, lasted nearly two and half hours.[745] Dr. Johnson discussed a number of issues with the VA OIG, including concerns related to prescription practices, early refills, and an overall view of the unease in the Tomah VAMC pharmacy during the 2008 and 2009 period.[746] Dr. Wesley, Dr. Mallinger, Dr. Shepherd, and Dr. Yang conducted the interview on behalf of the VA OIG.[747]

Dr. Johnson told OIG inspectors that she was fired because she refused to fill three prescriptions written by Dr. Houlihan. According to Dr. Johnson, one of the prescriptions was for 1,080 immediate-release morphine tablets (15 milligrams) for a 30-day supply. Dr. Johnson told the OIG that she was alarmed because she had "never seen doses like the doses [she has] seen come from here, and [she] didn't feel comfortable filling the prescription." She continued: "I felt it was unsafe for the veteran."[748] When asked about similar experiences during her time as a VA pharmacist, Dr. Johnson told the OIG she "never" had a similar situation of feeling uncomfortable and refusing to fill a script.[749]

[745] The entire Noelle Johnson transcript is found at VA OIG Bates number OIG 5935–5992.
[746] VA OIG Interview with Noelle Johnson (May 10, 2012), OIG 5935.
[747] *Id.*
[748] *Id.* at OIG 5942.
[749] *Id.* at OIG 5944.

Figure 39: Excerpt of VA OIG's interview of Dr. Noelle Johnson[750]

00:19:47

report and put in for destruction. It goes to your -- how many levels of supervisory people, and the police also do an investigation and report.

DR. YANG: Right. So basically it's -- there was a circumvention of the internal controls of the pharmacy.

DR. JOHNSON: Yes, absolutely. By being the vault pharmacist, that's where I encountered the trouble. The reason I was fired, I believe, was because I chose to refuse to fill three prescriptions. They were all written by Dr. Houlihan, and the first one was for an immediate-release morphine, and it was 1,080 immediate-release morphine tablets for a 30-day supply.

DR. YANG: I'm sorry. Could you say that again, 1,000?

DR. JOHNSON: 1,080.

DR. YANG: 1,080.

DR. MALLINGER: So I'm sorry, 1,080?

DR. JOHNSON: Immediate-release

[750] *Id.* at OIG 5941.

Figure 40: Excerpt of VA OIG's interview of Dr. Noelle Johnson[751]

DR. YANG: Just to get a sense, um, while you were in Columbus, did you ever have a similar situation where you felt uncomfortable and refused to fill a script?
DR. JOHNSON: Never. The doses -- and let me tell you, I mean, this is just the start of it. I have examples of quite a few more, but --
DR. YANG: Right.

DR. JOHNSON: -- are nothing compared to what I was seeing. I work in -- I work in our pain clinic here in Des Moines as well. I've never seen anything like this.
DR. YANG: Sure. And in terms of sort of this kind of disagreement with sort of another sort of a clinical provider, had you ever had a similar sort of people getting upset and screaming sort of at this level?
DR. JOHNSON: No.
DR. YANG: So this is really sort of a first in multiple ways.
DR. JOHNSON: Yes.

During her interview with VA OIG inspectors, Dr. Johnson recalled a meeting—which Dr. Johnson did not attend—at the Tomah VAMC in which Dr. Houlihan allegedly told a number of employees that Dr. Johnson had turned him in to the inspector general.[752] She became aware of this incident from two colleagues. According to Dr. Johnson, she "turned him in to the union, which [*sic*] a grievance with the union was to be turned in to the inspector general."[753] Dr. Mallinger responded, "I don't think anybody called us that far back. This is back in 2009,

[751] *Id.* at OIG 5944.
[752] *Id.* at OIG 5946.
[753] *Id.* at OIG 5946, at 44–45.

right?"[754] Dr. Mallinger did not inquire further, reasoning that "it probably wouldn't have that much meaning if you didn't hear it directly . . . ."[755]

Figure 41: Excerpt of VA OIG interview of Dr. Noelle Johnson[756]

DR. MALLINGER: Okay. Do you know if he said -- well, you weren't there. Never mind.
DR. JOHNSON: I'm sorry.
DR. MALLINGER: No, it's okay. You know, it's just that it probably wouldn't -- if -- it probably wouldn't have that much meaning

if you didn't hear it directly anyway, so I might as well focus on the things you experienced directly.

Dr. Johnson also described to the VA OIG how Tomah VAMC patients would call Dr. Houlihan the "Candy Man." She elaborated on the moniker, explaining: "I would hear them say things like, well, 'I went to my primary care doctor and she took me off my pain medications, but I went to Dr. Houlihan and he put me back on, so he's the guy you need to go to.'"[757] The VA OIG inspectors did not pose any follow-up questions.

Dr. Johnson verified allegations in the hotline complaints received by the VA OIG that a number of pharmacists left the Tomah VAMC. She said during her short time at the facility, "probably nine or so pharmacists" left.[758] She explained:

> They either just—they're like they can't take it anymore and they're not willing to fill those prescriptions or put their license on the line, so they leave, or they can't handle him, or they just eventually—most of them leave or—they made an example of me, and I think people are afraid to come forward and afraid to tell the truth about what's going on. But the DEA is currently investigating.[759]

[754] *Id.* at OIG 5946.
[755] *Id.* at OIG 5947, at 46–47.
[756] *Id.* at OIG 5947.
[757] *Id.* at OIG 5955.
[758] *Id.* at OIG 5965.
[759] *Id.*

Figure 42: Excerpt of VA OIG's interview of Dr. Noelle Johnson[760]

DR. JOHNSON: They either just -- they're like they can't take it anymore and they're not willing to fill those prescriptions or put their license on the line, so they leave, or can't handle him, or they just eventually -- most of them leave or -- they made an example of me, and I think people are afraid to come forward and afraid to tell the truth about what's going on. But the DEA is currently investigating.

Again, I actually -- I was called by a new investigator a couple weeks ago --

By May 2012, Dr. Mallinger was aware from his contacts with the DEA that it was investigating the Tomah VAMC. During her VA OIG interview, Dr. Johnson spoke about her interactions with the DEA and the fact she was "called by a new investigator" a few weeks before her interview with the OIG.[761] She described this contact with the DEA as a two-hour phone call that covered much of the same material as the OIG interview.[762]

Dr. Yang asked Dr. Johnson why she thought Dr. Houlihan was prescribing such high prescription dosages. Dr. Johnson gave two answers:

> One is that he's using himself and he gets, you know, whatever—my boss said to me once that he acted like he was on a cocaine high, which he does. But what I truthfully feel like is that his patients are diverting the medicine and he's getting a kickback.[763]

[760] *Id.*
[761] *Id.*
[762] *Id.* at OIG 5973.
[763] *Id.* at OIG 5970.

Figure 43: Excerpt of VA OIG's interview of Dr. Noelle Johnson[764]

DR. YANG: Oh, geez. And I know this calls for a bit of speculation, so if you don't want to say anything along these lines, that's fine. Do you have any idea as to why he was sort of doing what -- sort of this sort of practice the way that he was --

DR. JOHNSON: You know, people ask me these many questions, and there's two reasons that I can think. One is that he's using himself and he gets, you know, whatever -- my boss said to me once that he acted like he was on a cocaine high, which he does. But what I truthfully feel like is that his patients are diverting the medicine and he's getting a kickback.

DR. YANG: Uh-huh.

DR. HALLINGER: What makes you think that?

DR. JOHNSON: That's what I -- I truthfully feel that, because so many -- one, the

01:55:31

Monroe County Sheriff's Department has been a little involved. Milwaukee County -- or Milwaukee Sheriff's Department has been involved, and they've been getting -- the VA is known as the place to go to get narcotics. I mean, there is a huge diversion problem there. And it's not a secret.

[764] *Id.*

At the conclusion of the interview, Dr. Mallinger expressed his interest in obtaining a statement from Dr. Johnson's Merit Systems Protection Board (MSPB) case file about Dr. Houlihan's conversation with two other Tomah VAMC employees.[765] Dr. Johnson had the statement as it was part of her MSPB case but told the OIG that the Tomah union representatives would also be a good place to obtain a copy, as they have "documentation of all that."[766] Dr. Mallinger responded that he did not know if the OIG had authority over the union. Directly following this exchange, Johnson posed a question for the inspectors about what the OIG had done to investigate the Tomah VAMC allegations in 2009. Dr. Mallinger responded: "It wasn't us."

Figure 44: Excerpt of VA OIG interview of Dr. Noelle Johnson[767]

DR. MALLINGER: Yeah. I'm not sure if we have authority over the union.

DR. WESLEY: I don't know. But that's not -- we'll figure that out.

DR. JOHNSON: And that's what I was told. Like I told my grievance was going -- I was told the inspector general was doing an investigation when the stuff happened and that the information was given to them. But as I recall, nothing came of it. So, Dr. Mallinger, I'd ask you about what happened? Where were you guys in 2009 when we contacted you?

DR. MALLINGER: Yeah. It wasn't us.

The VA OIG's reaction to this information is unclear. During his transcribed interview with Chairman Johnson's staff, Dr. Wesley could not recall interviewing Dr. Johnson.[768] When interviewed by Chairman Johnson's staff, Dr. Yang did not recall any conversations with Dr. Mallinger, Dr. Wesley, or Dr. Shepherd about Dr. Johnson's allegations that Dr. Houlihan was on a "cocaine high" or diverting drugs.[769] Dr. Yang also said that he was not aware of any review of files or prior contacts by individuals at the Tomah VAMC.[770] However, an email sent by Dr. Shepherd contemporaneous with the interview showed that Dr. Shepherd saw the conversation as "interesting."

[765] *Id.* at OIG 5974, at 154.
[766] *Id.* at OIG 5974.
[767] *Id.*
[768] Wesley Transcribed Interview, at 189.
[769] Yang Transcribed Interview, at 88.
[770] *Id.* at 91.

Figure 45: Email from Dr. Michael Shepherd to Dr. George Wesley and Dr. Alan Mallinger[771]

From:	Shepherd, Michael L., MD (OIG)
Sent:	Thursday, May 10, 2012 5:46 PM
To:	Wesley, George (SES) (OIG); Mallinger, Alan (OIG)

Interesting interview. Do we have a master list of who we are planning on interviewing via phone and on-site?

Thanks,

Mike

Months later, on July 26, 2012, Dr. Johnson emailed Dr. Mallinger to send him documents relating to her experiences at the Tomah VAMC.[772] Although Dr. Johnson told Dr. Mallinger that her settlement with the VA cleared her record and name, she seemed disappointed that changes at the "facility level" did not occur. She explained: "I want nothing more than the safety of those veterans to be a priority."[773]

Figure 46: Email from Dr. Noelle Johnson to Dr. Alan Mallinger[774]

From:	Johnson, Noelle A.
Sent:	Tuesday, July 31, 2012 3:12 PM
To:	Mallinger, Alan (OIG)
Subject:	RE: Noelle Johnson Documents

No, there was no acknowledgment of wrong doing, although the VA was eager to enter into a settlement. I was able to get my name and record cleared which was important to me, however first and foremost I wanted changes to be implemented at the facility level for the safety of the veterans. Unfortunately, this did not happen with the mediation.

I hope the documents were useful. I want nothing more than the safety of those veterans to be a priority. Let me know if there is anything else you need

Respectfully,
Noelle Johnson

From: Mallinger, Alan (OIG)
Sent: Tuesday, July 31, 2012 10:09 AM
To: Johnson, Noelle A.
Subject: RE: Noelle Johnson Documents

I'd forgotten it was a settlement agreement - should have consulted my notes before asking you. Since it was a settlement, unless they acknowledged some wrongdoing it would probably not add to what we have. Thanks very much for the other documents, though. They were very useful.

Regards,
Alan Mallinger

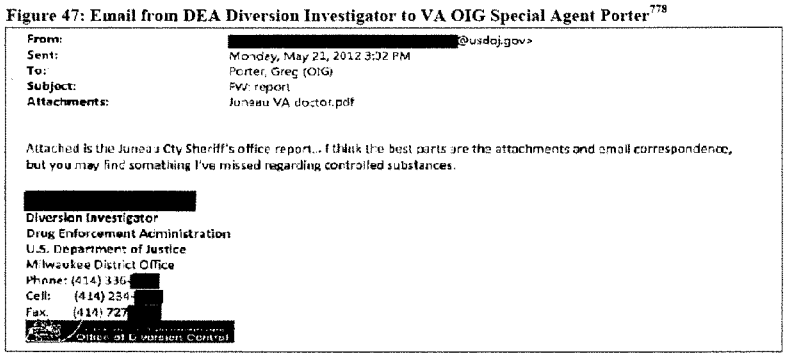
[771] E-mail from Michael Shepherd, VA OIG, to George Wesley, VA OIG (May 10, 2012, 5:46 PM), at OIG 10942.
[772] E-mail from Noelle Johnson, Tomah VAMC, to Alan Mallinger, VA OIG (July 26, 2012, 3:09 PM), OIG 10693, at OIG 10694.
[773] *Id.* at 10693.
[774] *Id.*

28. May 16, 2012: DEA provided the VA OIG with a copy of the Juneau County Sherriff report about the suicide of Dr. Christopher Kirkpatrick

By May 2012, Dr. Mallinger had established a working relationship with a DEA diversion investigator in Milwaukee, Wisconsin. They both were examining allegations that related to Dr. Houlihan and the Tomah VAMC and they agreed to keep each other informed on the progress of their respective work.[775] On May 16, 2012, Dr. Mallinger emailed the DEA investigator requesting "a copy of the report we discussed previously, in regard to our case 2011-04212-HI-0267, VAMC Tomah, WI."[776] On the same day the DEA investigator responded by email, attaching the Juneau County Sherriff's report of Dr. Christopher Kirkpatrick's suicide.[777] It is unclear how or when the DEA investigator obtained the report.

About a week after providing the report to Dr. Mallinger, the DEA agent sent it to VA OIG Special Agent Greg Porter. In the transmittal email, the DEA agent emphasized, "I think the best parts are the attachments and email correspondence, but you may find something I've missed regarding controlled substances."

Figure 47: Email from DEA Diversion Investigator to VA OIG Special Agent Porter[778]



From: [redacted]@usdoj.gov>
Sent: Monday, May 21, 2012 3:02 PM
To: Porter, Greg (OIG)
Subject: FW: report
Attachments: Juneau VA doctor.pdf

Attached is the Juneau City Sheriff's office report... I think the best parts are the attachments and email correspondence, but you may find something I've missed regarding controlled substances.

[redacted]
Diversion Investigator
Drug Enforcement Administration
U.S. Department of Justice
Milwaukee District Office
Phone: (414) 336-[redacted]
Cell: (414) 234-[redacted]
Fax. (414) 727-[redacted]
Office of Diversion Control

During a transcribed interview with Chairman Johnson's staff, Special Agent Porter recalled seeing the report and told staff that he believed this was the first time he became aware of it.[779] He was unsure whether he reviewed the report, but he thought that he "skimmed through

[775] E-mails between Alan Mallinger, VA OIG, to Diversion Investigator, DEA (May 16, 2012), OIG 10598, at OIG 10598–99.
[776] *Id.*
[777] E-mail from Diversion Investigator, DEA, to Greg Porter, VA OIG (May 21, 2012, 3:02 PM), at OIG 10598.
[778] *Id.*
[779] Porter Transcribed Interview, at 80.

it" after it was set to him.[780] Special Agent Porter could not recall if he spoke with the DEA about the contents of the report or his reaction. He stated:

> Q: So you received the Juneau County Sheriff's Department report in May of 2012, and the diversion investigator on Exhibit 11 said in his email, "I think the best parts are the attachments and email correspondence, but you may find something I've missed regarding controlled substances." After this report was sent to you, did you ever discuss with this diversion investigator of the DEA the contents of this Juneau County report?
>
> A: Not that I recall.
>
> Q: Do you recall reviewing this and can you recall your reaction to reviewing these 58 pages [of the Sheriff's report]?
>
> A: No, I cannot. I would look at—as I sit here looking at it, the first thing I would look at is when this happened, and this happened three years prior to my investigation at the Tomah, and it was a suicide by gunshot. So I wouldn't have given much credence to this as being relevant to my investigation.[781]

The Juneau County Sherriff report is a publically available document that details the death of former Tomah VAMC psychologist, Dr. Christopher Kirkpatrick.[782] Dr. Kirkpatrick committed suicide on July 14, 2009—the same day he was terminated from the Tomah VAMC.[783] During his transcribed interview, Dr. Mallinger recalled reviewing the Juneau County Sherriff's report, and he spoke about the report in reference to the OIG's request to collect Dr. Kirkpatrick's emails.[784] He stated:

> A: So Dr. Kirkpatrick was a psychologist at the Tomah VA who committed suicide, and some information about him came to our attention, specifically an investigation into his death by the Juneau County Sheriff's Department and we reviewed a lot of—and you probably have a copy of that, but there was a lot of VA material considered in that investigation that had been supplied by a union representative who had represented Mr. Kirkpatrick.

---

[780] *Id.*
[781] *Id.* at 82–83.
[782] JUNEAU COUNTY SHERIFF'S DEPARTMENT, CHRIS KIRKPATRICK DEATH INVESTIGATION REPORT (2009). Additionally, the VA OIG produced the Juneau Country report pursuant to the Committee's subpoena.
[783] Chairman Ron Johnson sent a letter to VA Secretary McDonald regarding Dr. Kirkpatrick's death on April 20, 2015. 4/20/2015 Letter from Chairman Johnson, HSGAC, to Secretary McDonald, VA.
[784] Mallinger 4/6/2016 Transcribed Interview, at 259.

Q: Were you able to pull Dr. Kirkpatrick's emails since he did pass away in 2009 and this email pull is in 2012? I just want confirmation you were able to pull some of his emails?

A: I really don't recall.[785]

Chairman Johnson's staff also inquired about why the VA OIG collected emails from Linda Ellinghuysen, the Tomah VAMC union official who represented Dr. Kirkpatrick before Tomah VAMC management. In responding, Dr. Mallinger explained how Dr. Kirkpatrick's death and the Sherriff's report became part of the VA OIG's inspection. He stated:

Q: So Linda Ellinghuysen, why was her emails pulled?

A: So in the Juneau County sheriff's investigation, there were several individuals who were named. And, again, we wanted to look more carefully at this because there were allegations that somehow he had been critical of Dr. Houlihan's prescribing practices and had been fired because of that. And so these people listed below his name—Linda Ellinghuysen, as I said, had represented him, Gary Loethen was his supervisor, and Cindy Gile was a physician's assistant who supposedly he made these comments to about Dr. Houlihan's practice. And so we wanted to see whether, you know, we could get any further information about any potential administrative abuse that might have taken place by looking through these records to basically see if, you know, they were sent emails or, you know, that they sent emails that would shed further light on that.[786]

29. Spring 2012: The VA OIG Criminal Investigation heated up

While Dr. Mallinger and other members of the health care inspection team in Washington, D.C., continued their work on the Tomah VAMC allegations, the VA OIG Criminal Investigations unit in Chicago took an increasingly active role beginning in March 2012.[787]

On March 28, 2012, VA OIG Special Agent Porter, along with a detective with the Tomah Police Department, and two DEA investigators from Milwaukee interviewed an

[785] *Id.* at 255–56.
[786] *Id.* at 256–57.
[787] VA OIG Criminal Investigations Div., Greg Porter, Memorandum of Interview of Tomah VAMC Employee (Mar. 28, 2012), OIG 10592, at OIG 10592–93.

"anonymous Tomah VAMC employee."[788] The DEA set up this voluntary interview, which took place at the Tomah Police Department and lasted for a little over one hour.[789] According to Special Agent Porter's subsequent memorandum documenting the interview,[790] the anonymous source was a "full-time employee at the Tomah VAMC" and was in "regular and familiar contact" with Dr. Houlihan.[791] The source provided information similar to the allegations in some of the Tomah VAMC hotline complaints. For example, the source told law enforcement that "[i]t is widely believed, through word of mouth at the Tomah VAMC, that veterans who need certain prescribed opiates and/or other pain killers go directly to Houlihan or Frasher."[792] The source also alleged that Tomah VAMC pharmacists had "raised issues about Houlihan and Frasher over-prescribing painkillers for veterans, often noting that the same veterans would receive several prescriptions in a short amount of time."[793]

During the interview, the source told of the work culture at the facility. The source relayed allegations that Ms. Frasher "is often 'stoned' while at work,"[794] and that "[m]any of the employees who have complained have been 'forced-out' or intimidated by Houlihan to the point that they resigned or transferred from the Tomah VAMC."[795] With Special Agent Porter in attendance, the source talked about Dr. Houlihan and his alleged braggadocio about being untouchable to the OIG and other law enforcement.[796] Finally, the anonymous source stated that Dr. Houlihan and Ms. Frasher were allegedly "at the root of the drug diversion/pill-selling by veterans at the Tomah VAMC."[797]

Figure 48: Report of VA OIG interview with anonymous Tomah VAMC employee[798]

- [redacted] is often "stoned" while at work, meaning [redacted] is incoherent, and many believe [redacted] may have dependency issues involving alcohol and/or pain killers.

[788] *Id.* at OIG 10592–93. Special Agent Porter did not draft the Memorandum of Interview until April 25, 2012. *Id.* at 10592.
[789] *Id.*
[790] The interview occured on March 28, 2012, but the memorandum authored by Special Agent Porter did not occur until April 25, 2012. *Id.*; E-mails between Alan Mallinger, George Wesley, & Greg Porter (Apr. 17, 2012), at OIG 10320.
[791] VA OIG Criminal Investigations Div., Greg Porter, Memorandum of Interview of Tomah VAMC Employee (Mar. 28, 2012), at OIG 10592.
[792] *Id.*
[793] *Id.* at OIG 10592–93.
[794] During his transcribed interview, Agent Porter confirmed that Deborah Frasher is the name of the individual redacted in the documents. Porter Transcribed Interview, at 19.
[795] VA OIG Criminal Investigations Div., Greg Porter, Memorandum of Interview of Tomah VAMC Employee (Mar. 28, 2012), OIG 10592, at OIG 10593.
[796] *Id.*
[797] *Id.*
[798] *Id.* at OIG 10592.

Figure 49: Report of VA OIG interview with anonymous Tomah VAMC employee[799]

- Houlihan has been known to openly "brag" about the fact that OIG "Can't touch him" and that the VA Police cannot contact OIG without his permission.

Figure 50: Report of VA OIG interview with anonymous Tomah VAMC employee[800]

A.S. concluded the interview by stating Houlihan and [redacted] are at the root of drug diversion / pill-selling by veterans at the Tomah VAMC and they have created a culture of fear within the Tomah VAMC, to which employees are afraid to step forward and/or speak their minds.

During a transcribed interview, Chairman Johnson's staff asked Special Agent Porter about this March 2012 interview with an anonymous Tomah VAMC employee. Special Agent Porter recalled his impression of the interview. He stated:

> Well, doing this as long as I've been doing this, I document what the person says. I don't operate from the vantage point of assuming that they're telling the truth or assuming that they're correct, because that wouldn't be fair to the person that they're making an allegation against.
>
> So, I came away from this interview, you know, acknowledging, okay, there's these—pretty much what it says in the memorandum, that these are things either my Office of Criminal Investigations or the Office of Healthcare Inspections or DEA Diversion or the local police, these are things that different entities can start to look at.[801]

Two days after the interview at the Tomah Police Department, Dr. Houlihan sent an email marked "confidential" to VISN 12 executive Victoria Brahm.[802] In this email, sent on March 30, 2012, Dr. Houlihan wrote to Ms. Brahm: "I am probably going to step down from the COS position following the IG survey."[803] Although it is not clear from the email, the "IG survey" mentioned by Dr. Houlihan may have been the EAR Survey, which was conducted between March 5 and March 23, 2012.[804]

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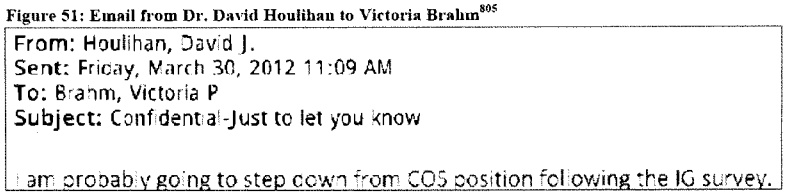
[799] *Id.* at OIG 10593.
[800] *Id.*
[801] Porter Transcribed Interview, at 20–21.
[802] It is not known if Dr. Houlihan was made aware of the March 28, 2012, meeting with the anonymous Tomah VAMC employee. *See* E-mail from David Houlihan, Tomah VAMC, to Victoria Brahm, Tomah VAMC (Mar. 30, 2012, 12:15 PM), at OIG 9048.
[803] *Id.*
[804] The VA OIG EAR Survey occurred between March 5, 2012 and March 23, 2012. E-mail from Marnette Dhooghe, VA OIG, to Linda Lutes (May 11, 2012, 10:30 AM), at OIG 10294.

Figure 51: Email from Dr. David Houlihan to Victoria Brahm[805]

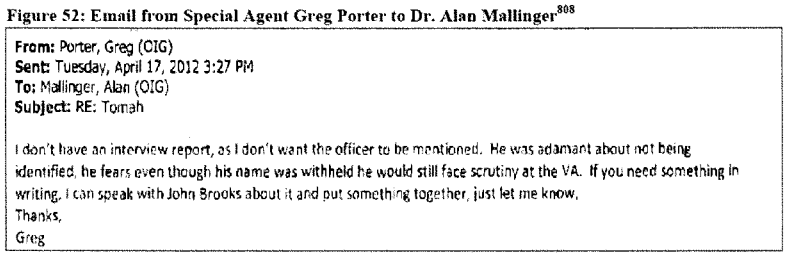


From: Houlihan, David J.
Sent: Friday, March 30, 2012 11:09 AM
To: Brahm, Victoria P
Subject: Confidential-Just to let you know

I am probably going to step down from COS position following the IG survey.

A few weeks after the interview with the anonymous Tomah VAMC employee, on April 17, 2012, Special Agent Porter had a conversation with Dr. Mallinger about the situation at the facility. In an email referring to their conversation, Dr. Mallinger asked Special Agent Porter to "send a copy of" the interview "with the VA police officer."[806] Special Agent Porter responded that he did not have an interview report and that the officer was "adamant about not being identified."[807]

Figure 52: Email from Special Agent Greg Porter to Dr. Alan Mallinger[808]



From: Porter, Greg (CIG)
Sent: Tuesday, April 17, 2012 3:27 PM
To: Mallinger, Alan (OIG)
Subject: RE: Tomah

I don't have an interview report, as I don't want the officer to be mentioned. He was adamant about not being identified, he fears even though his name was withheld he would still face scrutiny at the VA. If you need something in writing, I can speak with John Brooks about it and put something together, just let me know.
Thanks,
Greg

Dr. Mallinger forwarded Special Agent Porter's response to his health care inspection colleagues, seeking advice on how he should respond.[809] After this email exchange, and for unknown reasons, Special Agent Porter decided to author a memorandum of interview and provided it to Dr. Mallinger via email on May 2, 2012.[810]

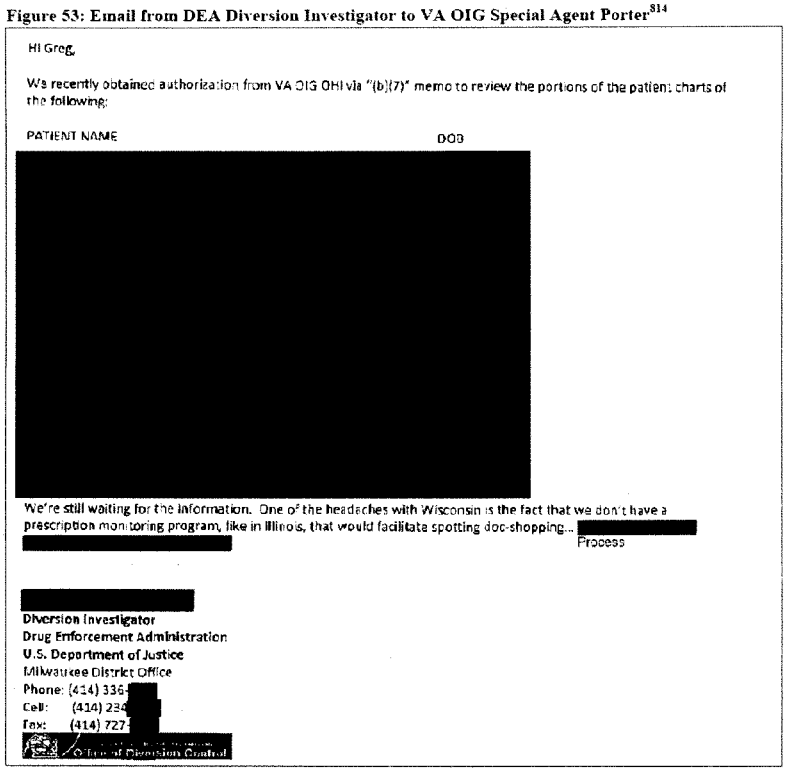
[805] E-mail from David Houlihan, Tomah VAMC, to Victoria Brahm, Tomah VAMC (Mar. 30, 2012, 12:15 PM), at OIG 9048.
[806] E-mail from Alan Mallinger, VA OIG, to Greg Porter, VA OIG (Apr. 17, 2012, 2:16 PM), OIG 10320, at 10320.
[807] *Id.*
[808] *Id.*
[809] *Id.*
[810] E-mail from Greg Porter, VA OIG, to Alan Mallinger, VA OIG (May 2, 2012, 11:00 AM), at OIG 10308.

30. May 21, 2012: The VA OIG provided the DEA with (b)(7) memo to allow the DEA to review portions of patient charts

The DEA continued to work closely with the VA OIG during the spring of 2012. On May 21, 2012, VA OIG Special Agent Porter emailed a DEA diversion investigator about "Pharmacy databases" but the substance of the email is largely unknown due to redactions applied by the VA OIG.[811] The same day, the DEA diversion investigator informed Special Agent Porter that the DEA had obtained a "(b)(7)" memo from the VA OIG's Office of Healthcare Inspections.[812] The diversion investigator wrote: "We recently obtained authorization from VA OIG OHI via '(b)(7)' memo to review the portions of the patient charts of the following." The VA OIG redacted the identities of the patients.[813]

[811] E-mail from Greg Porter, VA OIG, to Diversion Investigator, DEA (May 21, 2012, 1:10 PM), OIG 10607, at OIG 10608–09.
[812] E-mail from Diversion Investigator, DEA, to Greg Porter, VA OIG (May 21, 2012, 1:49 PM), OIG 10607, at OIG 10607–08.
[813] *Id.*

Figure 53: Email from DEA Diversion Investigator to VA OIG Special Agent Porter[814]



Hi Greg,

We recently obtained authorization from VA OIG OHI via "(b)(7)" memo to review the portions of the patient charts of the following:

PATIENT NAME DOB

[redacted]

We're still waiting for the information. One of the headaches with Wisconsin is the fact that we don't have a prescription monitoring program, like in Illinois, that would facilitate spotting doc-shopping... [redacted] Process

[redacted]
Diversion Investigator
Drug Enforcement Administration
U.S. Department of Justice
Milwaukee District Office
Phone: (414) 336-[redacted]
Cell: (414) 234-[redacted]
Fax: (414) 727-[redacted]
Office of Diversion Control

During a transcribed interview, Chairman Johnson's staff asked Special Agent Porter about the purpose of a (b)(7) memo. He explained it was "an official request to an agency for information that they would not normally release." Special Agent Porter stated:

> A: The (b)(7) memo is basically—I can only give you a very general interpretation of what that is. It's basically an official request to an agency for information that they would not normally release.
>
> Q: So, the diversion investigator for the Drug Enforcement Administration was seeking patient names and patient charts of VA

[814] *Id.*

employees, and I guess this must be at Tomah, at Tomah VA, because we just don't know with the document in front of us, but would that be your understanding?

A: Yes.[815]

Special Agent Porter forwarded the DEA diversion investigator's email to John Brooks, the Special Agent in Charge of the Chicago office of the VA OIG's Criminal Investigations unit, and another employee, alerting them that the list of names in the email "are the vets and they all are patients of Houlihan, Frasher or both."[816] A colleague of Special Agent Porter responded, noting that it was "interesting" that one of the patients "is driving a new [redacted] Chevy [redacted]."[817] According to Special Agent Porter, the patient identified as driving a new Chevy was the same patient who was alleged to have an inappropriate relationship with Dr. Houlihan.[818]

Figure 54: Email from Suzanne Humeniak to Special Agent Greg Porter[819]

Porter, Greg (OIG)

From: Humeniak, Suzanne (OIG)
Sent: Tuesday, May 22, 2012 10:07 AM
To: Porter, Greg (OIG)
Subject: RE: Pharmacy databases
Attachments: [redacted] - Comprehensive Report - 2012-05-22.pdf

Greg,
I added the SSN to the list below, just in case you need it in the future. Also, I have attached [redacted]'s TLO report. [redacted] is driving a new [redacted] Chevy [redacted]...interesting.

From: Porter, Greg (OIG)
Sent: Monday, May 21, 2012 2:57 PM
To: Brooks, John (OIG)
Cc: Humeniak, Suzanne (OIG)
Subject: FW: Pharmacy databases

These are the vets and they all are patients of Houlihan, Frasher or both

On May 23, 2012, Special Agent Porter received another email from the DEA diversion investigator with information relating to the Tomah VAMC. In this email, the DEA investigator attached a 2002 press release from the Iowa Board of Medical Examiners regarding the charges against Dr. Houlihan.[820] The DEA investigator wrote: "I'll be happy to share any information I

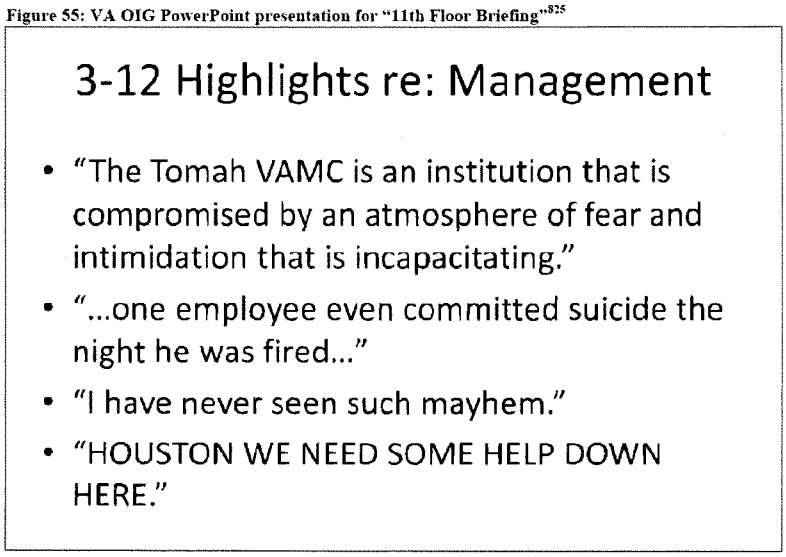
[815] Porter Transcribed Interview, at 38.
[816] E-mail from Greg Porter, VA OIG, to John Brooks & Susanne Humeniak, VA OIG (May 21, 2012, 2:57 PM), at OIG 10605.
[817] E-mail from Suzanne Humeniack, VA OIG, to Greg Porter, VA OIG (May 22, 2012, 10:07 AM), at OIG 10605.
[818] Porter Transcribed Interview, at 43.
[819] E-mail from Suzanne Humeniack, VA OIG, to Greg Porter, VA OIG (May 22, 2012, 10:07 AM), at OIG 10605.
[820] E-mail from Diversion Investigator, DEA, to Greg Porter, VA OIG (May 23, 2012, 11:19 AM), at OIG 10610.

have discovered on [redacted]."[821] During his transcribed interview with Chairman Johnson's staff, Special Agent Porter said that he believed this email showed that the DEA was aware of Dr. Houlihan's disciplinary history in the state of Iowa.[822]

31. May 22, 2012: VA OIG inspectors briefed senior VA OIG leadership

During the pendency of the VA OIG's Tomah VAMC health care inspection, majority staff became aware of at least one high-level briefing that occurred for senior VA OIG leadership. According to documents and statements, preparation for this high-level briefing began in late April or early May of 2012. On May 1, 2012, Dr. Wesley asked Dr. Mallinger if he was "ready for the [Dr. Daigh] briefing on Tomah."[823] In his transcribed interview with Chairman Johnson's staff, Dr. Wesley explained that this request was connected to "the 11th floor briefing" at the VA OIG's headquarters.[824]

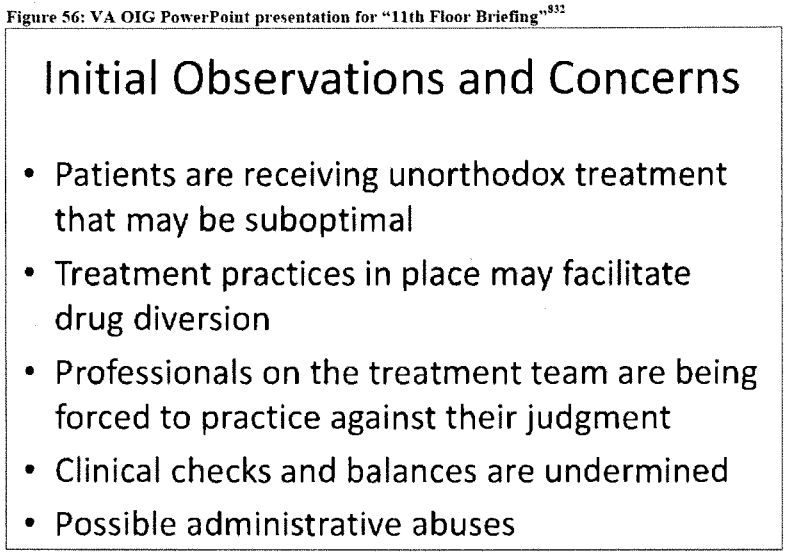
Figure 55: VA OIG PowerPoint presentation for "11th Floor Briefing"[825]



[821] *Id.*
[822] Porter Transcribed Interview, at 29.
[823] E-mail from George Wesley, VA OIG, to Alan Mallinger, VA OIG (May 1, 2012, 11:40 AM), at OIG 10993; *see also* Wesley Transcribed Interview, at 174–75.
[824] Wesley Transcribed Interview, at 174–75.
[825] PowerPoint Presentation Part 1, VA OIG Hotline Referral, OIG 12021, at OIG 12035.

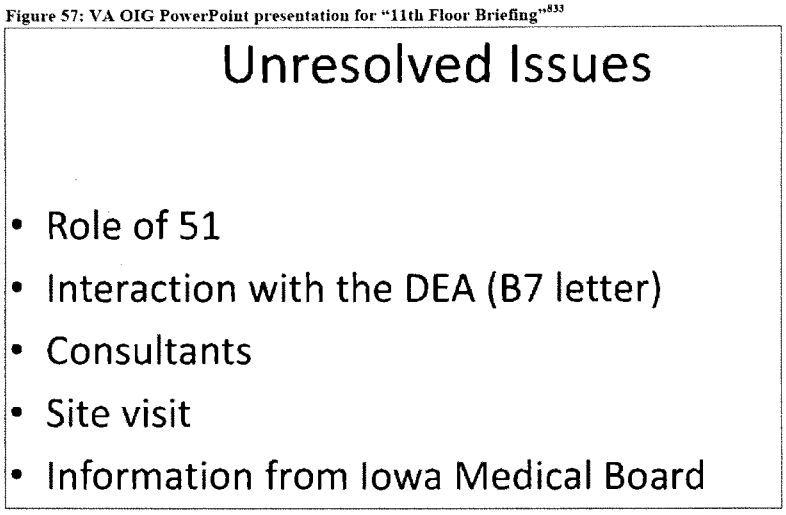
In planning for the briefing, the inspection team, led by Dr. Mallinger, prepared a 23-page PowerPoint presentation.[826] During his transcribed interview with Chairman Johnson's staff, Dr. Mallinger explained that the PowerPoint "was sort of the biggest structured thing we did, and that was in the spring before the site visit."[827] The 23-page Tomah PowerPoint[828] reviewed the "history of multiple complaints" that all involved Dr. Houlihan, alleged mis-prescribing and diversion of opiate drugs, alleged abuse of administrative authority, and various other types of allegations.[829] The PowerPoint summarized some of OIG's "Initial Observations and Concerns," along with a slide labeled, "Unresolved Issues."[830] Among the VA OIG's initial concerns were potential practices that facilitated drug diversion, unorthodox treatments that "may be suboptimal," and pressure on professionals to "practice against their judgment."[831]

Figure 56: VA OIG PowerPoint presentation for "11th Floor Briefing"[832]



[826] Mallinger 4/21/2016 Transcribed Interview, at 330.
[827] *Id.*
[828] The VA OIG Tomah PowerPoint is VA OIG Bates numbers 12021-12041 and 12050-12052.
[829] PowerPoint Presentation Part 1, VA OIG Hotline Referral, OIG 12021, at OIG 12022.
[830] PowerPoint Presentation Part 2, VA OIG Hotline Referral, OIG 12050, at OIG 12052.
[831] *Id.* at OIG 12050.
[832] *Id.*

Figure 57: VA OIG PowerPoint presentation for "11th Floor Briefing"[833]



During his transcribed interview with Chairman Johnson's staff, Dr. Wesley spoke about the 11th floor briefing about the Tomah VAMC. He explained that it occurred "in the first half of 2012" and "before the site visit" to the facility. He stated:

> A: Other things I remember, but not necessarily in chronologic order. I know 51 [the VA OIG's criminal investigations division] attended the site visit, which occurred in August of 2012. I recall that we had a large meeting on the 11th floor in which we discussed the case with 51, 54 [the VA OIG's health care inspections division], and Mr. Griffin. And so—
>
> Q: Do you recall—
>
> A: Let me just—
>
> Q: Sure. Sorry.
>
> A: They were aware of our work. To what degree I can't testify to.

[833] *Id.* at OIG 12052.

Q: Do you recall when that meeting with 51 and 54 and Mr. Griffin occurred?

A: Only generally. I believe in the first half of 2012.

Q: So before the site visit?

A: Before the site visit.[834]

The meeting was scheduled for May 22, 2012,[835] and many senior VA OIG officials were invited to attend. When Chairman Johnson's staff asked Dr. Wesley which OIG employees attended this meeting, his private attorney interjected to assert a privilege on behalf of the VA OIG. She stated:

Q: Can you speak about who attended this meeting and what the meeting was actually about?

Witness Attorney: Can I—Maureen [Regan, Counselor to the VA Inspector General] was at this meeting, it would appear. I am concerned that this may go into areas that the agency would assert a privilege over. This specific meeting they haven't talked to me about, but it sounds within potentially the areas where they've asked me to assert privilege. I think we would need to call Roy [Fredrikson, Deputy Counselor to the VA Inspector General]. And, again, if counsel instructs Dr. Wesley after, he's their—[836]

Documents, however, show that a number of Senior Executive Service (SES) OIG employees were notified about the meeting. The list included Maureen Regan, the Counselor to the Inspector General; James O'Neill, the former Assistant Inspector General for Investigations; and John Daigh, the Assistant Inspector General for Healthcare Inspections.

[834] Wesley Transcribed Interview, at 167.
[835] E-mail from Lisa Seibert, VA OIG, to VA OIG Employees (May 21, 2012, 9:45 AM), at OIG 10313.
[836] Wesley Transcribed Interview, at 170.

Figure 58: Email from Lisa Seibert to VA OIG Employees re "Schedule meeting VAMC Tomah"[837]

Yang, Robert (OIG)

From:	Seibert, Lisa J (OIG)
Sent:	Monday, May 21, 2012 9:45 AM
To:	Seibert, Lisa J (OIG); O'Neill, James J. (SES) (51-OIG); Daigh, John (SES) (OIG); Regan, Maureen T (SES) (OIG); Sullivan, Joe (SES) (OIG); Valiowe, Joseph (SES) (OIG); Christ, Patricia (SES) (OIG); Perkins, Darlene (OIG); Brooks, John (OIG); Wesley, George (SES) (OIG); Mallinger, Alan (OIG); Shepherd, Michael L, MD (OIG); Yang, Robert (OIG)
Subject:	Schedule meeting VAMC Tomah

Room 1105 has been reserved for the meeting at 3:00 pm on Tuesday, May 22. Thank you

During a transcribed interview with Chairman Johnson's staff, Dr. Wesley explained that the high-level meeting with senior OIG executives was not typical for hotline allegations. He stated:

> Q: Was this type of meeting with these individuals in their positions within the IG typical for a hotline?
>
> A: No.
>
> Q: No?
>
> A: Correct. No.[838]

Dr. Wesley said that he believed the meeting with Deputy Inspector General Griffin occurred on May 22, 2012, because it was uncommon for the VA OIG to use a PowerPoint projector in such a meeting.[839] Because of the VA OIG's refusal to cooperate with Chairman Johnson's investigation, the precise details of the briefing—other than the PowerPoint presentation— remain unknown. However, in general, Dr. Daigh explained that Deputy Inspector General Griffin was briefed "on all of the hotlines in our inventory on a regular basis, and Tomah was clearly one of the hotlines that we briefed."[840]

32. May 29, 2012: The VA OIG subpoenaed a Wisconsin Chevrolet dealership

The possibility that a female veteran allegedly involved in an inappropriate relationship with Dr. Houlihan purchased a new car caught the attention of the VA OIG.[841] The VA OIG

[837] E-mail from Lisa Seibert, VA OIG, to VA OIG Employees (May 21, 2012, 9:45 AM), at OIG 10313.
[838] Wesley Transcribed Interview, at 170–71.
[839] *Id.* at 176.
[840] Daigh Transcribed Interview, at 32.
[841] Porter Transcribed Interview, at 43.

successfully verified the vehicle purchase through "a public search database that law enforcement typically has [with] a little deeper access into public records."[842]

Around May 29, 2012, the VA OIG issued a subpoena to a Chevrolet dealership in eastern Wisconsin.[843] Special Agent Porter completed an IG Subpoena Request form,[844] which explained the relevant facts that led to the request for a subpoena.[845] He cited the "numerous hot line complaints regarding Dr. David J. Houlihan of the Tomah VAMC, an interview was conducted with a confidential Tomah VAMC employee on 03/28/12 who suspected PTSD patient/veteran [redacted] is visiting Dr. Houlihan excessively, and possible involved in an intimate personal relationship with him."[846]

The document sheds some light on the events that led to the OIG subpoena. In late May 2012, the same Tomah VAMC employee who spoke with law enforcement in March 2012 told a Tomah Police Department investigator that Dr. Houlihan "may have recently purchased, or assisted [redacted] in the purchase of a vehicle."[847] On the same day, May 22, 2012, the OIG's subpoena request noted that "public record database searches revealed [redacted] owns a [redacted] Chevy (valued at approximately $43,000) financed by [redacted]."[848] The VA OIG inquired with an unknown number of dealers around Wisconsin before finding the dealership.[849] After locating the dealership, an employee at the dealership advised the OIG that the purchase information could be obtained via subpoena.[850] Agent Porter believed the subpoena would "help verify or refute the claim that Dr. Houlihan may have purchased or assisted in the purchase of the above mentioned vehicle."[851]

[842] *Id.* at 41; TLO Report, OIG 10539–91.
[843] The VA OIG subpoena is VA OIG Bates number OIG 10594 and is redacted; *see also* VA OIG, Affidavit of Compliance with Subpoena, OIG 10515.
[844] Agent Porter explained that this IG Subpoena Request is reviewed and approved by his superiors. Porter Transcribed Interview, at 63.
[845] VA OIG, IG Subpoena Request, OIG 10516.
[846] *Id.*
[847] *Id.*
[848] *Id.* The TLO report was produced by VA OIG heavily redacted. TLO Report, OIG 10539 –91.
[849] VA OIG, IG Subpoena Request, OIG 10516.
[850] *Id.*
[851] *Id.*

Figure 59: VA OIG Subpoena Request Form relating to Tomah VAMC inquiry[852]

Department of Veterans Affairs
Office of Inspector General

IG SUBPOENA REQUEST

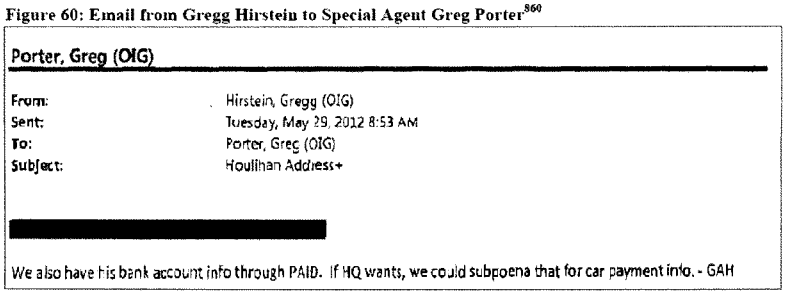
1. Case Agent: Gregory J. Porter	2. Case Number: 2011-04212-DC-0252
3. Requesting Field Office or Resident Agency: 51CH	4. Statute(s) believed to have been violated: N/A

During a transcribed interview, Special Agent Porter summarized what the VA OIG found from information received pursuant to the subpoena. He stated: "I sent the subpoena to the car dealership for the purchase records for the vehicle, and it didn't have any connection to Dr. Houlihan at all."[853] According to a May 29, 2012, email between Special Agent Porter and an employee at the dealership, the down payment for the vehicle was $25,000.[854] Chairman Johnson's staff asked Special Agent Porter if the down payment was paid in cash and he recalled: "As I remember it, there was a cash down payment and then the rest financed."[855]

On the same day, but before the dealership responded to the VA OIG's subpoena, VA OIG personnel discussed the possibility of accessing Dr. Houlihan's bank account information.[856] Specifically, the VA OIG employees considered whether it could get Dr. Houlihan's bank account through a system called PAID.[857] Agent Porter explained the PAID system in his transcribed interview with Chairman Johnson's staff. He stated: "It's like a personnel database. It'll show, like, a person's pay grade, the address of record, and things like that."[858] However, he said that he could not recall whether he ultimately accessed Dr. Houlihan's information via PAID.[859]

[852] *Id.*
[853] Porter Transcribed Interview, at 62.
[854] E-mail to Greg Porter, VA OIG (May 29, 2012, 2:12 PM), at OIG 10613.
[855] Porter Transcribed Interview, at 65.
[856] *Id.* at 87.
[857] E-mail from Gregg Hirstein, VA OIG, to Greg Porter, VA OIG (May 29, 2012, 8:53 AM), at OIG 10611.
[858] Porter Transcribed Interview, at 86.
[859] *Id.* at 87.

Figure 60: Email from Gregg Hirstein to Special Agent Greg Porter[860]



Porter, Greg (OIG)

From: Hirstein, Gregg (OIG)
Sent: Tuesday, May 29, 2012 8:53 AM
To: Porter, Greg (OIG)
Subject: Houlihan Address+

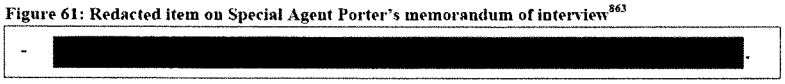
[redacted]

We also have his bank account info through PAID. If HQ wants, we could subpoena that for car payment info. - GAH

33. Spring 2012: The VA OIG Criminal Investigations Division surveilled Dr. Houlihan

During the March 28, 2012 interview of the anonymous Tomah VAMC employee, Special Agent Porter learned of the allegation that Dr. Houlihan was having an inappropriate relationship with a patient.[861] The allegation was part of the memorandum that Special Agent Porter prepared following the interview, but the VA OIG redacted this allegation from the document when it was produced pursuant to Chairman Johnson's subpoena.[862]

Figure 61: Redacted item on Special Agent Porter's memorandum of interview[863]



- [redacted].

During Agent Porter's transcribed interview with Chairman Johnson's staff, however, he confirmed that the redacted portion of his memorandum referenced the allegation that Dr. Houlihan was having an inappropriate relationship with a patient. He stated:

> A: There's an item that's completely redacted. I'm trying to figure out what that is.
>
> Q: We are, too.
>
> A: The—one of the—one of the allegations that was—
>
> Q: Just for the record, this is the second dash on 10592.

[860] E-mail from Gregg Hirstein, VA OIG, to Greg Porter, VA OIG (May 29, 2012, 8:53 AM), at OIG 10611.
[861] VA OIG Criminal Investigations Div., Greg Porter, Memorandum of Interview of Tomah VAMC Employee (Mar. 28, 2012), OIG 10592, at OIG 10592–93.
[862] *Id.*
[863] *Id.* at 10592.

A: The second dash. It's completely redacted. Basically, there was an allegation that Dr.—one of the allegations was Dr. Houlihan was having an inappropriate relationship with a female veteran. That was—in addition, that veteran was also rumored to be one of the veterans who was heavily overprescribed. So, from that point, we—myself and another agent from my office, Fred Lane, L-a-[n-]e, decided to attempt to surveil this veteran patient as well as Dr. Houlihan.

Q: All right. When you say inappropriate relationship, is this a financial relationship, sexual relationship? What type of relationship was it?

A: It was stated to be a romantic and/or a sexual relationship.[864]

Special Agent Porter said that after he learned of this allegation, he sought to understand the circumstances surrounding the female patient.[865] He began exploring residential addresses where the female patient was known to live.[866] He also had the description of the patient's type of vehicle as well, but he was ultimately unsuccessful in locating this patient.[867]

Due to the VA OIG's inability to locate the patient, Special Agent Porter explained that he "switched gears and went and began surveilling Dr. Houlihan."[868] When asked what he found in surveilling Dr. Houlihan, Special Agent Porter replied, "[n]othing. Nothing to substantiate any of the allegations."[869] The surveillance was not extensive. Special Agent Porter said that it lasted "[a] couple days, two days. Not around the clock, just—I believe it was two days. I'd kind of have to refresh my memory . . . ."[870] He also described how he condueted the surveillance. He stated:

Q: Can you describe, without going into law enforcement methods, how you surveil someone in a small town like Tomah?

A: It's difficult. It's—it was vehicle surveillance. I mean, we weren't crawling around in the bushes or anything like that. We just, you know, sit down the street in the car, hope that you could find the vehicle first. Hopefully, you know, in an ideal situation, they'd come out, get in the vehicle and go somewhere, and you'd just follow them. With two people, two agents, each in their own vehicle, it's

[864] Porter Transcribed Interview, at 22.
[865] *Id.* at 25.
[866] *Id.*
[867] *Id.*
[868] *Id.*
[869] *Id.*
[870] *Id.* at 26.

challenging to do that in a small town, but, I mean, that's what we did.[871]

The VA OIG has not produced documents describing Special Agent Porter's surveillance of Dr. Houlihan or the female patient. Special Agent Porter described these actions as a "preliminary investigation," and said that the determination to generate paperwork on surveillance activities "depends on the type of case and . . . what stage of the case you're in."[872] In addition, the precise dates of when the surveillance occurred are unclear due to the absence of documentation and because Special Agent Porter could not recall the dates of surveillance during his transcribed interview with Chairman Johnson's staff.[873]

34. Spring 2012: The VA OIG declined to fully pursue the female patient

Surveillance of Dr. Houlihan was not the only option open to the VA OIG. The VA OIG knew the identity of the female patient alleged to be engaged in an improper relationship with Dr. Houlihan, and had even subpoenaed records about her car purchase. Yet, the VA OIG did not fully pursue this lead in its investigation.

Although the VA OIG's interview with the anonymous Tomah VAMC employee in March 2012 yielded a number of allegations, Special Agent Porter explained that he only examined the claims involving the inappropriate relationship and the vehicle purchase. He stated:

Q: So did you investigate any of those allegations?

A: Yes.

Q: Specifically to drug diversion and pill selling by veterans at the Tomah VAMC?

A: No, not necessarily in regards to that. When you have all these different entities approaching this date, it was—you know, you can't—basically you're way better served having the appropriate entity handle that particular part of things. We didn't really have a lot of—as I said before, a lot of stake in the game as far as—you know, as far as the prescriptions and the diversion angle. That's DEA's thing, so we're going to let them do their thing.

[871] *Id.* at 25–26.
[872] *Id.*
[873] *Id.* at 29–30.

> As far as the prescribing practices of doctors or nurse practitioners, that's Office of Healthcare. That's their thing, and we're going to let them do their thing. What I determined was—for this particular case, my thing—all I really had that I could take a couple shots at trying to develop further was the inappropriate relationship with the patient and, you know, there was additionally an allegation that Dr. Houlihan had bought this female patient a vehicle. And so, you know, those are the items that I chose to focus on, because the other items were being looked at by the other entities.[874]

Despite focusing on only those two allegations—both of which involved the female patient—the VA OIG did not pursue the matter. Special Agent Porter stated he did not seek to interview the female veteran who was alleged to have a relationship with Dr. Houlihan because he "didn't want to ruin any potential case for the police," and "I didn't want to tip her off." In his transcribed interview with Chairman Johnson's staff, Special Agent Porter stated:

> Q: In general—did you interview the—the female veteran who was alleged to have a relationship with Dr. Houlihan?
>
> A: No.
>
> Q: Why not?
>
> A: Because she was also a suspect. Well, I should say she was one of the people named as being a—the recipient of large amounts of prescription medication. So I chose not to interview her because I didn't want to—if—if she is involved, if the potential exists for, you know, her involvement in a drug diversion ring or sales, or she's doing that, I didn't want to ruin any potential case for the police or for any other entity that would be investigating. I didn't want to tip her off.[875]

Special Agent Porter could not provide a precise time frame of when he decided not to interview the female patient, other than to say that it occurred generally in the 2012 period.[876] However, a Tomah VAMC hotline status report dated August 29, 2012, referred to the coordination between the Office of Healthcare Inspections and the Criminal Investigations Division, identifying the patient by the initials "KR."[877]

---

[874] *Id.* at 54–56.
[875] *Id.* at 92.
[876] *Id.* at 93–94.
[877] Tomah Hotline Status as of Aug. 29, 2012, at OIG 12928.

Figure 62: Tomah Hotline Status Report (August 29, 2012)[878]

Coordination with 51:

Further investigation of patient KR for drug diversion or inappropriate relationship.

Identification of police officer and/or patient who were subjects of complaint.

35. June 2012: The VA OIG scheduled a site visit of the Tomah VAMC

In the summer of 2012, the VA OIG began planning to conduct a site visit of the Tomah VAMC. According to documents and statements, in the lead up to the visit, Dr. Mallinger and Dr. Shepherd had a phone conversation with the Tomah VAMC Director Mario DeSanctis.[879] The VA OIG had apparently sought to have a conversation with Director DeSanctis about the Tomah VAMC allegations earlier, but due to a number of reasons—including a visit by the Joint Commission to the facility—the conversation did not occur until June 2012.[880]

Figure 63: Email from Dr. Alan Mallinger to Dr. Michael Shepherd and Dr. Robert Yang[881]

From: Mallinger, Alan (OIG)
Sent: Monday, June 11, 2012 2:17 PM
To: Shepherd, Michael L., MD (OIG); Yang, Robert (OIG)
Subject: meeting

Hi Mike and Robert,

Could we have a meeting tomorrow at 10 to discuss the next step(s) with Tomah?

Regards,
Alan

Dr. Mallinger and Dr. Shepherd had a 15-minute phone call with Director DeSanctis on June 19, 2012.[882] Dr. Mallinger and Dr. Shepherd explained the origins of the VA OIG's inspection and the allegations involving Dr. Houlihan and Deborah Frasher.[883] They informed Director DeSanctis that the allegations involved opiate prescribing practices, the dosing of

[878] *Id.*
[879] VA OIG Interview with Mario DeSanctis, in Tomah, Wis. (June 19, 2012), OIG 6075 [hereinafter 6/19/2012 VA OIG Interview of DeSanctis].
[880] E-mails between Michael Shepherd, VA OIG, and Mario DeSanctis, Tomah VAMC (May 17–22, 2012), OIG 10870, at OIG 10870–74.
[881] E-mails between Michael Shepherd, Alan Mallinger, and Robert Yang, VA OIG (June 11, 2012), at OIG 10842.
[882] 6/19/2012 VA OIG Interview of DeSanctis, at OIG 6075.
[883] *Id.*

opiates, the appropriateness of the prescribing of opiates.[884] They also told him that other allegations involved "the administrative style of Dr. Houlihan," and the belief that Dr. Houlihan is "a bully."[885]

Figure 64: Excerpt of VA OIG's conversation with Mario DeSanctis[886]

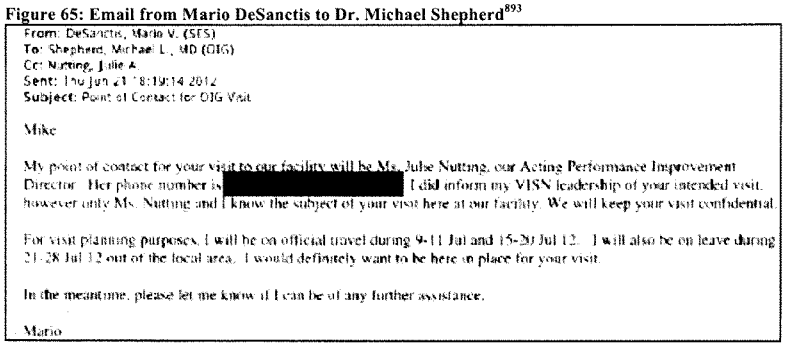
DR. SHEPHERD: The letter, you know, the complainant's letter kind of implies that he's a bully, they say he thinks he's unstoppable, basically it questions kind of his administrative style if you will, and so that's kind of so essentially, we've been asked to look at this, you know. We look at these

In the conversation, Dr. Shepherd described the goal of the VA OIG's inspection as "to kind of try to figure out if there's merit to these allegations or not."[887] According to a transcript of the conversation, Director DeSanctis was the only Tomah VAMC official involved in the conversation, as requested by the OIG.[888]

During the same phone call, Dr. Shepherd advised Director DeSanctis that the VA OIG would likely conduct a site visit at the facility in the near future.[889] According to the transcript, Director DeSanctis sought to facilitate the OIG's visit.[890] The parties agreed on a Tomah point of contact, who was assigned to assist the OIG on the logistical matters of the site visit.[891] Two days after the phone call, Director DeSanctis emailed Dr. Shepherd informing him that Julie Nutting would be the point of contact for the OIG's site visit.[892]

[884] *Id.*
[885] *Id.*
[886] *Id.*
[887] *Id.* at OIG 6076.
[888] *Id.*
[889] *Id.*
[890] *Id.*
[891] *Id.* at OIG 6077.
[892] E-mail from Mario DeSanctis, VA OIG, to Michael Shepherd, VA OIG (Aug. 13, 2012, 4:15 PM), at OIG 10671.

Figure 65: Email from Mario DeSanctis to Dr. Michael Shepherd[893]



From: DeSanctis, Mario V. (SES)
To: Shepherd, Michael L., MD (OIG)
Cc: Nutting, Julie A.
Sent: Thu Jun 21 18:19:14 2012
Subject: Point of Contact for OIG Visit

Mike

My point of contact for your visit to our facility will be Ms. Julie Nutting, our Acting Performance Improvement Director. Her phone number is [redacted]. I did inform my VISN leadership of your intended visit, however only Ms. Nutting and I know the subject of your visit here at our facility. We will keep your visit confidential.

For visit planning purposes, I will be on official travel during 9-11 Jul and 15-20 Jul 12. I will also be on leave during 21-28 Jul 12 out of the local area. I would definitely want to be here in place for your visit.

In the meantime, please let me know if I can be of any further assistance.

Mario

36. Summer 2012: The VA OIG prepared for the Tomah VAMC site visit

After the phone conversation with Director DeSanctis, the VA OIG team began to prepare for the Tomah VAMC site visit—planning which inspectors would attend, who they would interview, and when they would travel to Tomah. According to documents and statements, it appears Dr. Mallinger and Dr. Shepherd were the primary inspectors who assembled the interview list and other logistical matters.

During July 2012, members of the inspection team exchanged emails in preparation for the site visit. On July 16, 2012, Dr. Shepherd advised Dr. Mallinger of his schedule for the month of August, indicating that the middle to the later part of the month would work best for him for the visit.[894] Ultimately, however, Dr. Shepherd did not make the trip up to the Tomah VAMC due to an illness.[895]

[893] *Id.*
[894] E-mail from Michael Shepherd, VA OIG, to Alan Mallinger, VA OIG (July 16, 2012, 2:04 PM), at OIG 10745.
[895] Shepherd 1/27/2016 Transcribed Interview, at 108–09.

Figure 66: Email from Michael Shepherd to Alan Mallinger[896]

Mallinger, Alan (OIG)

From: Shepherd, Michael L, MD (OIG)
Sent: Monday, August 20, 2012 9:06 AM
To: Mallinger, Alan (OIG)

Hi Alan: I am feeling pretty under the weather today. Very sore throat, a little wheezy, post-nasal drip, low energy, rhinitis, and annoying cough that kept me up till 2:45 am. Not particularly feeling up to traveling. Started yesterday by doctor at prompt care on antibiotics. Unsure how you want to proceed. Let's touch base after morning meeting.

Thanks.

Mike

In addition, Special Agent Greg Porter of the VA OIG's criminal investigations unit notified Dr. Mallinger of his availability "to accompany" the health care inspection team to Tomah.[897] During his transcribed interview with Chairman Johnson's staff, he explained his role of joining the team on the site visit. He stated:

> Q: So running up and getting to the August 2012 time frame, and Dr. Mallinger and his team coming up to the Tomah facility and you joining them, was there any parameters on what you could ask in the interviews, or any—was there any things that—were you allowed to basically ask what you needed to ask from your standpoint as a criminal investigator with the VA IG during these interviews?
>
> A: Yes. I—I—I pretty much could have asked anything. There was no—no one put any—any parameters on me. I—I—the—I—I guess the—the only parameter would be that they're talking about medically related stuff and I'm not a doctor, so, you know, if—if a lot of the stuff that they were talking about and the questions they were asking pertaining to medically related stuff, prescription related stuff, I just wouldn't have had a knowledge base to go from, to work from.[898]

Later in his transcribed interview, Special Agent Porter explained his understanding of why he was asked to be at the Tomah site visit. He stated:

> I was—my understanding is that I was asked to be there in case anyone made any kind of utterance of—of criminal activity or anything like that. That was, you know, what I was told, and—and, you know, my purpose for—for being there, and that didn't happen.[899]

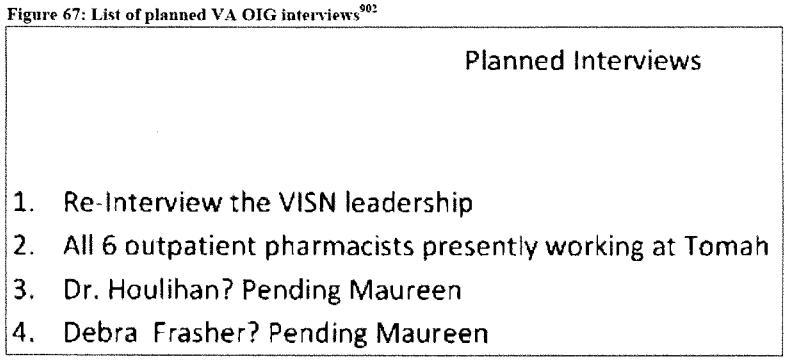
[896] E-mail from Michael Shepherd, VA OIG, to Alan Mallinger, VA OIG (Aug. 20, 2012, 9:06 AM), at OIG 10655.
[897] E-mail from Greg Porter, VA OIG, to Alan Mallinger, VA OIG (July 27, 2012, 12:14 PM), at OIG 10685.
[898] Porter Transcribed Interview, at 96–97.
[899] *Id.* at 98.

Dr. Wesley considered attending the site visit and, during his transcribed interview with Committee staff, he explained why he considered attending the site visit.[900] He stated:

> Q: Why would you have—why did you consider attending the site visit?
>
> A: The hotline was getting more and more complex. As you recall, I'm sort of the old hand at this. Dr. Mallinger was still relatively new. So for all those reasons, we talked about my going.[901]

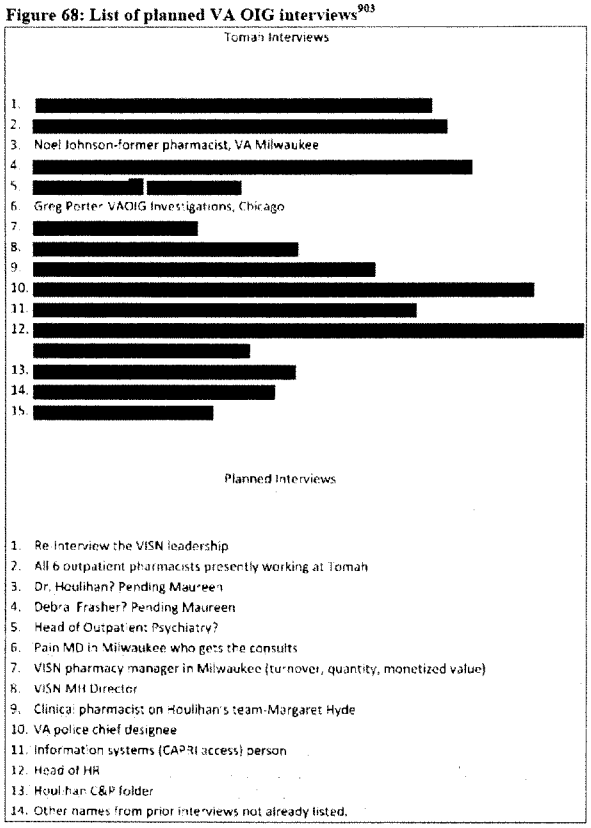
Documents illustrate that the VA OIG team considered conducting interviews with a number of different individuals. The lists of individuals lack dates but they do provide an insight into how the scope of the site visit changed over time. According to a draft interview list, the inspection team needed the approval from Counselor to the Inspector General, Maureen Regan, to set up interviews with Dr. Houlihan and Deborah Frasher.

Figure 67: List of planned VA OIG interviews[902]



[900] Wesley Transcribed Interview, at 194.
[901] *Id.*
[902] List of Planned VA OIG Interviews, at OIG 12214.

Figure 68: List of planned VA OIG interviews[903]



During his transcribed interview with Chairman Johnson's staff, Dr. Shepherd recalled speaking to other OIG employees about "people we were going to interview" and described the development of the interview list as a "dynamic process."[904] He remembered suggesting at the time that "it was important we talk to some front-line psychiatrists . . . ."[905] Dr. Shepherd

[903] *Id.*
[904] Transcribed Interview with Michael Shepherd, in Washington, D.C., at 7 (Feb. 9, 2016) [hereinafter Shepherd 2/9/2016 Transcribed Interview].
[905] *Id.* at 7.

thought this process would allow the OIG to get the "viewpoint from people on the front line, not just people who were, like, in leadership or, you know, or beholden to the leadership . . . ."[906]

Because the draft interview lists do not have dates, it is difficult to reconstruct a timeline of how the VA OIG determined who to interview during its Tomah VAMC site visit. From information available, however, it appears that several different versions of a draft interview list were exchanged. On July 31, 2012, a few weeks before the site visit, Dr. Shepherd sent an email to Dr. Mallinger with an attachment and an explanation that the list would need to be revised and updated. A few weeks later, on August 13, Dr. Shepherd again emailed Dr. Mallinger a document labeled "Tomah Interviews 7-31-2012."[907] Just 18 minutes later, Dr. Shepherd sent another email with a document attached labeled "Planned Interviews Tomah."[908]

Figure 69: Email from Dr. Michael Shepherd to Dr. Alan Mallinger[909]

Mallinger, Alan (OIG)

From:	Shepherd, Michael L, MD (OIG)
Sent:	Tuesday, July 31, 2012 3:42 PM
To:	Mallinger, Alan (OIG)
Subject:	Tomah Interviews
Attachments:	Tomah Interviews.docx

Hi Alan: This was the list. However, I think we need to re-vise and update. I will give you a call after hotline meeting.

Thanks,

Mike

Figure 70: Email from Dr. Michael Shepherd to Dr. Alan Mallinger[910]

Mallinger, Alan (OIG)

From:	Shepherd, Michael L., MD (OIG)
Sent:	Monday, August 13, 2012 3:55 PM
To:	Mallinger, Alan (OIG)
Subject:	Tomah Interviews 7-31-2012
Attachments:	Tomah Interviews 7-31-2012.docx

[906] *Id.* at 7.
[907] E-mail from Michael Shepherd, VA OIG, to Alan Mallinger, VA OIG (Aug. 13, 2012, 3:55 PM), at OIG 10675.
[908] E-mail from Michael Shepherd, VA OIG, to Alan Mallinger, VA OIG (Aug. 13, 2012, 4:13 PM), at OIG 10673.
[909] E-mail from Michael Shepherd, VA OIG, to Alan Mallinger, VA OIG, (July 31, 2012, 3:42 PM), at OIG 10692.
[910] E-mail from Michael Shepherd, VA OIG, to Alan Mallinger, VA OIG (Aug. 13, 2012, 3:55 PM), at OIG 10675.

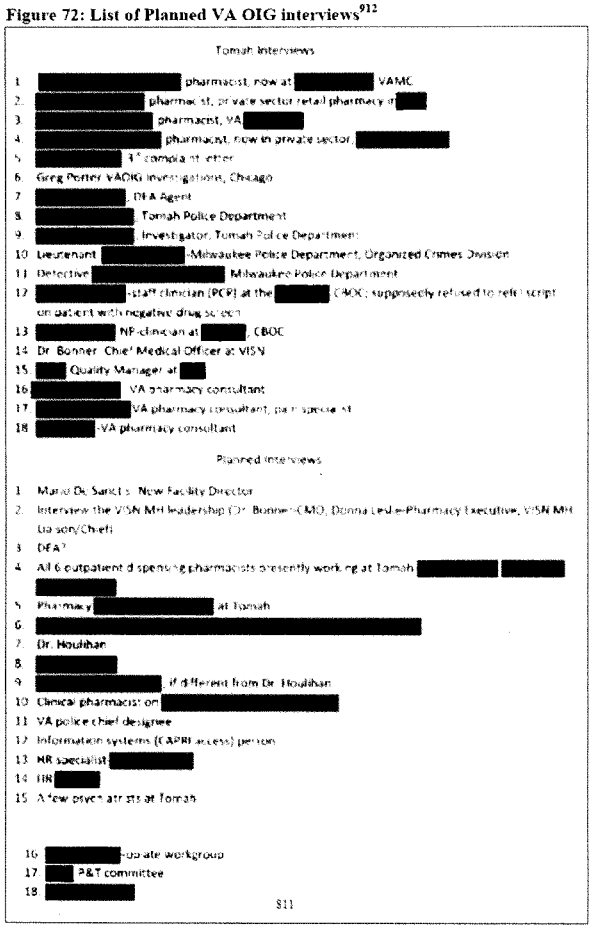
Figure 71: Email from Dr. Michael Shepherd to Dr. Alan Mallinger[911]

Mallinger, Alan (OIG)

From:	Shepherd, Michael L., MD (OIG)
Sent:	Monday, August 13, 2012 4:13 PM
To:	Mallinger, Alan (OIG)
Subject:	Planned Interviews Tomah
Attachments:	Planned Interviews Tomah.docx

[911] E-mail from Michael Shepherd, VA OIG, to Alan Mallinger, VA OIG (Aug. 13, 2012, 4:13 PM), at OIG 10673.

Figure 72: List of Planned VA OIG interviews[912]



Later on August 13, 2012, Dr. Mallinger emailed Dr. Shepherd and another OIG employee, Cynthia Gallegos, a list of individuals that the team intended to interview.[913] He

[912] List of Planned VA OIG Interviews, OIG 12929, at OIG 12929–30.

asked Ms. Gallegos to connect with the team's point of contact at the Tomah VAMC, Julie Nutting, to set up the interviews for August 21 and 22, 2012.[914] The list included Director DeSanctis, Dr. Houlihan, Deborah Frasher, and Margaret Hyde, among others.[915]

Figure 73: Email from Dr. Alan Mallinger to Cynthia Gallegos[916]

Mallinger, Alan (OIG)

From:	Mallinger, Alan (OIG)
Sent:	Monday, August 13, 2012 6:15 PM
To:	Gallegos, Cynthia (OIG)
Cc:	Shepherd, Michael L., MD (OIG)
Subject:	RE: DC on Thursday

Tracking:

Recipient	Read
Gallegos, Cynthia (OIG)	Read: 8/14/2012 7:25 AM
Shepherd, Michael L., MD (OIG)	Read: 8/13/2012 6:56 PM

Hi Cyn,

Julie Nutting is the POC for our visit. We have not yet contacted her, i.e., they don't know we are coming. Would you be able to set up the interviews for Wednesday and Thursday August 21-22? These are the intended interviewees:

1. Mario De Sanctis- Facility Director (should have an entrance interview on arriving and exit interview at the end)
2. Head of information systems (want this to be ASAP after our interview with Mr. DeSanctis)
3. All outpatient dispensing pharmacists presently working at Tomah (to include Darlene Krock, Yiu Ibekwe, David Hughes, even if they are in different roles now)(should be about six total)
4. Pharmacy Director (Ron Pelham)
5. Director of Pharmacy Operations/Service Line Manager (Jeff Evanson)
6. Chief of Staff, Dr. David Houlihan (want to meet with him twice, near the beginning and near the end)
7. Nurse Practitioner, Debra Frasher
8. Chief of Mental Health
9. Clinical pharmacist, Margaret Hyde
10. Chief VA police
11. HR specialist-David Dechand
12. HR Director
13. A few outpatient psychiatrists at Tomah
14. Dr. Whiteway- Director opiate workgroup
15. Chair P&T committee
16. Clinical pharmacist, Laureen Chambers

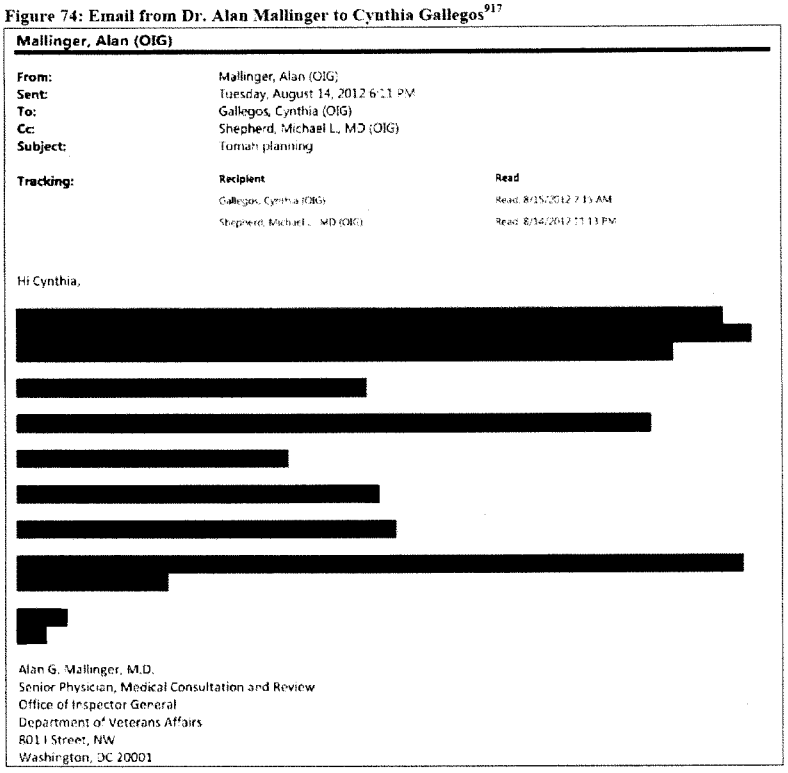
Let me know when you will be available in DC and hopefully we can get together for a bit. Also, feel free to call any time with questions.

Best regards,
AGM

The next day, Dr. Mallinger sent another email to Ms. Gallegos, with the subject "Tomah Planning." The VA OIG, however, redacted the contents of the email when producing it pursuant to Chairman Johnson's subpoena.

[913] E-mail from Alan Mallinger, VA OIG, to Cynthia Gallegos, VA OIG (Aug. 13, 2012, 6:15 PM), OIG 13674, at 13674.
[914] *Id.*
[915] *Id.*
[916] *Id.*

Figure 74: Email from Dr. Alan Mallinger to Cynthia Gallegos[917]



Mallinger, Alan (OIG)

From: Mallinger, Alan (OIG)
Sent: Tuesday, August 14, 2012 6:21 PM
To: Gallegos, Cynthia (OIG)
Cc: Shepherd, Michael L, MD (OIG)
Subject: Tomah planning

Tracking:

Recipient	Read
Gallegos, Cynthia (OIG)	Read: 8/15/2012 7:15 AM
Shepherd, Michael L., MD (OIG)	Read: 8/14/2012 11:13 PM

Hi Cynthia,

[redacted]

Alan G. Mallinger, M.D.
Senior Physician, Medical Consultation and Review
Office of Inspector General
Department of Veterans Affairs
801 I Street, NW
Washington, DC 20001

On August 16, 2012, Dr. Shepherd emailed Julie Nutting at the Tomah VAMC to confirm that Ms. Nutting "was able to liaison" with Ms. Gallegos to arrange the site visit interview schedule.[918] It appears that Ms. Nutting apprised Director DeSanctis of Dr. Shepherd's email, because Director DeSanctis responded on the same day.[919] In his response, Director DeSanctis confirmed that the planned interview schedule was received from Ms. Gallegos and

[917] VA OIG Bates number OIG 10665.
[918] E-mail from Michael Shepherd, VA OIG, to Julie Nutting, VA (Aug. 16, 2012, 4:33 PM), at OIG 10659.
[919] E-mail from Mario DeSanctis, VA OIG, to Julie Nutting, VA (Aug. 16, 2012, 5:35 PM), at OIG 10658.

that his office was working to confirm staff availability.[920] Director DeSanctis told Dr. Shepherd that he was concerned about "rumors" or "unnecessary disruption," and asked him "to keep this confidential" in an effort to not "tip off the staff."[921] During his transcribed interview with Chairman Johnson's staff, Dr. Shepherd said that contacting Director DeSanctis before the site visit was a normal action taken by the OIG.[922] He explained that OIG does not send out a "general notice to the entire facility" but "typically tell[s] the director."[923]

Figure 75: Email from Mario DeSanctis to Dr. Michael Shepherd[924]

-----Original Message-----
From: DeSanctis, Mario V. (SES)
To: Shepherd, Michael L., MD (OIG)
Subject: Schedule for Next Week
Sent: Aug 16, 2012 5:35 PM

Mike-

We did receive your planned interview schedule for next week from Ms. Gallegos. We are checking to see who will be available from your requested list and we will get back with you shortly. I have told my point of contact for your visit, Julie Nutting, not to lock in the times until late Monday or Tuesday. I do not want to keep this confidential and tip off the staff about this any earlier to avoid any rumors or unnecessary disruption. Please let me know if you would like me to proceed differently. Thanks-

R/Mario

The next day, on August 17, 2012, Julie Nutting responded to Dr. Shepherd's email as well. Ms. Nutting alerted Dr. Shepherd that three individuals who were included on the OIG's

[920] *Id.*
[921] *Id.* Dr. Shepherd forwarded the email to Dr. Mallinger. *Id.*
[922] Shepherd 1/27/2016 Transcribed Interview, at 110–11.
[923] *Id.*
[924] E-mail from Mario DeSanctis, VA OIG, to Julie Nutting, VA (Aug. 16, 2012, 5:35 PM), at OIG 10658. Even though the text reads "I do not want to keep this confidential . . . ." Dr. Shepherd agreed that Director DeSanctis meant to say, "I want to keep this confidential . . . ." Shepherd 1/27/2016 Transcribed Interview, at 107.

interview list would not be at the facility during the two-day OIG site visit.[925] The Tomah VAMC Chief Information Officer (CIO), Chad Babcock, was on leave during the week of the site visit.[926] The outpatient dispensing pharmacist, David Hughes, separated from the facility on August 17, 2012—the same day as Ms. Nutting's email.[927] The third individual, Jeff Evanson, who was the Tomah VAMC's Service Line Manager,[928] was away from the facility that week on "travel."[929]

Figure 76: Email from Julie Nutting to Dr. Michael Shepherd[930]

From: Nutting, Julie A.
Sent: Friday, August 17, 2012 12:28 PM
To: Shepherd, Michael L., MD (OIG)
Subject: RE:

Good Morning Dr. Shepherd,

Yes, Ms. Gallegos has been in communication with me. I have confirmed that all of the staff the team has requested to meet with will be working next Wednesday or Thursday (or both) with the exception of the following.

- Chad Babcock, CIO is on leave next week
- David Hughes, outpatient dispensing pharmacist has separated from the VA effective today
- Jeff Evanson, Service Line Manager is on travel next week

Dr. Whiteway, Director for Opiate Workgroup, is stationed at one of our CBOCs. Is a telephone interview with him acceptable? Please let me know if you have additional questions. I tried to touch base with Ms. Gallegos today, but I think she may be off today.

Thank you,
Julie

Julie Nutting, MSN, RN
Acting Performance Improvement Director/Risk Manager
Tomah VA Medical Center

Chairman Johnson's staff interviewed Mr. Evanson on December 17, 2015. During his interview, he explained that he did not interact with the VA OIG any time between 2011 and 2014.[931] He said:

[925] E-mail from Julie Nutting, VA, to Alan Mallinger, VA OIG (Aug. 17, 2012, 3:07 PM), OIG 10651, at OIG 10652.
[926] The Tomah VAMC offered the acting CIO to the OIG. *Id.* The majority staff is not aware of the OIG interviewing him at a later date.
[927] *Id.*
[928] According to Jeffrey Evanson, the Service Line Manager position no longer exists at the Tomah VAMC. Mr. Evanson described the duties as "the overall manager of all the departments, multiple supervisors reporting through that position. Contract oversight, administrative responsibilities . . . ." Transcribed Interview with Jeffrey Evanson, in Tomah, Wis., at 8 (Dec. 17, 2015) [hereinafter Evanson Transcribed Interview].
[929] E-mail from Julie Nutting, VA to Alan Mallinger, VA OIG (Aug. 17, 2012, 3:07 PM), OIG 10651, at OIG 10652.
[930] *Id.*
[931] Evanson Transcribed Interview, at 26.

Q: Did you interact with the Inspector General at all when they were here [in Tomah, Wisconsin]—

A: No.

Q: —between '11 and '14?

A: No.

Q: So you were never interviewed by–

A: No.

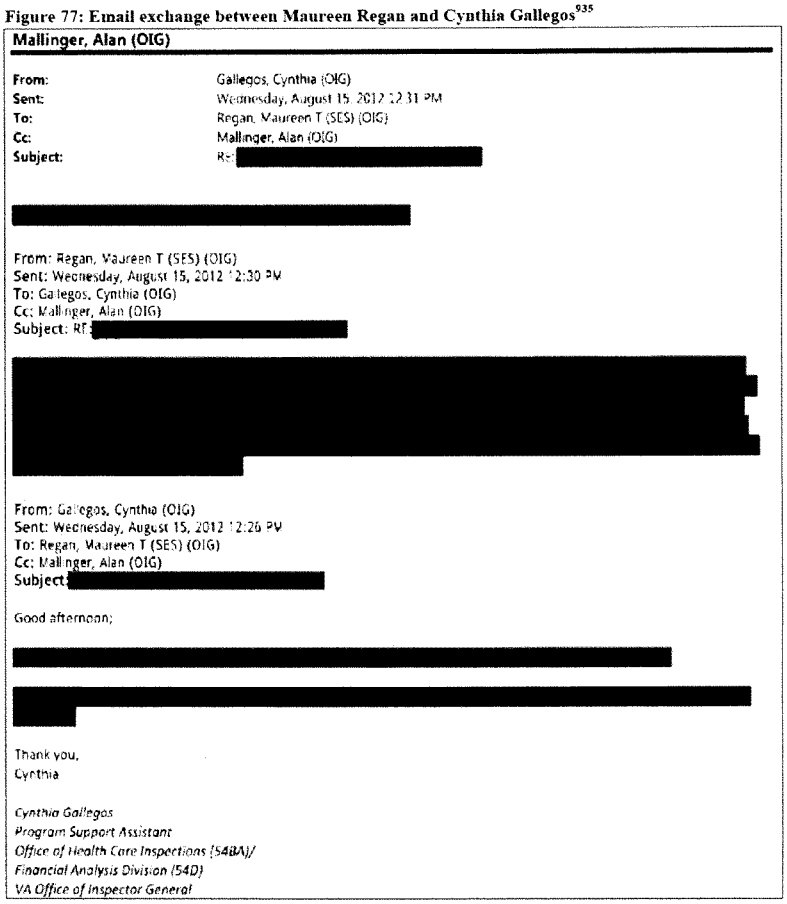
Q: —the Inspector General?

A: No.[932]

About one week before the Tomah VAMC site visit, on August 15, 2012, Cynthia Gallegos sent an email to the Counselor to the Inspector General, Maureen Regan.[933] The email, on which Dr. Mallinger was copied, is almost completely redacted.[934] The VA OIG even redacted the subject of the email. The majority staff can only assume it is pertinent to the investigation based on the VA OIG's production of the email pursuant to Chairman Johnson's subpoena and the parties included on the email.

[932] *Id.* at 26.
[933] E-mails from Cynthia Gallegos, VA OIG, to Maureen Regan, VA OIG (Aug. 15, 2012), at OIG 10662.
[934] *Id.*

Figure 77: Email exchange between Maureen Regan and Cynthia Gallegos[935]



Mallinger, Alan (OIG)

From: Gallegos, Cynthia (OIG)
Sent: Wednesday, August 15, 2012 12:31 PM
To: Regan, Maureen T (SES) (OIG)
Cc: Mallinger, Alan (OIG)
Subject: Re: [redacted]

[redacted]

From: Regan, Maureen T (SES) (OIG)
Sent: Wednesday, August 15, 2012 12:30 PM
To: Gallegos, Cynthia (OIG)
Cc: Mallinger, Alan (OIG)
Subject: RE: [redacted]

[redacted]

From: Gallegos, Cynthia (OIG)
Sent: Wednesday, August 15, 2012 12:26 PM
To: Regan, Maureen T (SES) (OIG)
Cc: Mallinger, Alan (OIG)
Subject: [redacted]

Good afternoon;

[redacted]

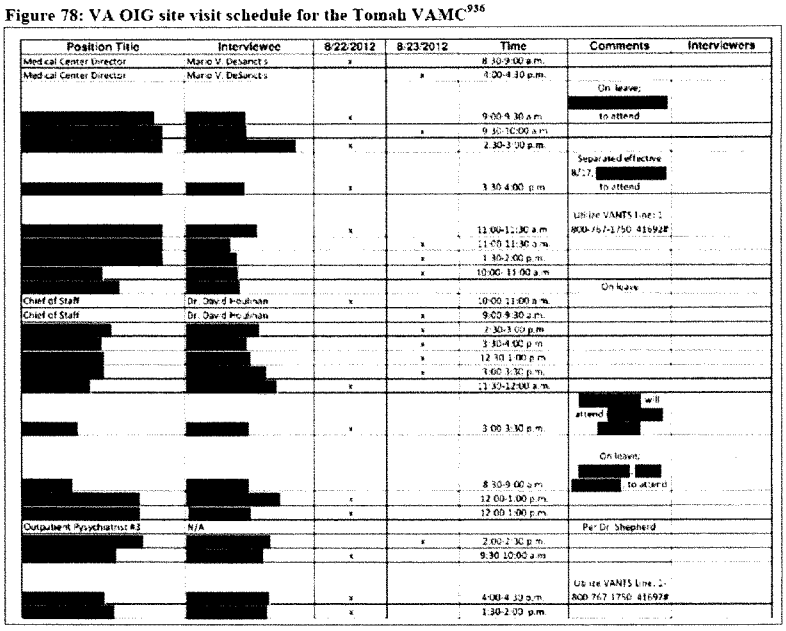
Thank you,
Cynthia

Cynthia Gallegos
Program Support Assistant
Office of Health Care Inspections (54BA)/
Financial Analysis Division (54D)
VA Office of Inspector General

According to internal VA OIG documents, it appears the OIG prepared multiple versions of a Tomah VAMC site visit schedule. Both schedules are heavily redacted and undated, but they suggest that the OIG team planned to interview Director DeSanctis and Dr. Houlihan twice.

[935] *Id.*

Figure 78: VA OIG site visit schedule for the Tomah VAMC[936]



Position Title	Interviewee	8/22/2012	8/23/2012	Time	Comments	Interviewers
Medical Center Director	Marie V. Desanctis	x		8:30-9:00 a.m.		
Medical Center Director	Marie V. DeSanctis		x	9:00-9:30 a.m.	On leave; to attend	
		x		9:30-10:00 a.m.		
		x		2:30-3:30 p.m.		
		x		3:30-4:00 p.m.	Separated effective 8/27; to attend	
		x		11:00-11:30 a.m.	Utilize VANTS Line 1 800-767-1750 41692#	
			x	11:00-11:30 a.m.		
			x	1:30-2:00 p.m.		
			x	10:00-11:00 a.m.		
Chief of Staff	Dr. David Houlihan	x		10:00-11:00 a.m.	On leave	
Chief of Staff	Dr. David Houlihan		x	9:00-9:30 a.m.		
			x	2:30-3:00 p.m.		
			x	3:30-4:00 p.m.		
			x	12:30-1:00 p.m.		
			x	3:00-3:30 p.m.		
		x		11:30-12:00 a.m.		
		x		3:00-3:30 p.m.	will attend	
			x	8:30-9:00 a.m.	On leave; to attend	
		x		12:00-1:00 p.m.		
		x		12:00-1:00 p.m.		
Outpatient Psychiatrist #3	N/A				Per Dr. Shepherd	
			x	2:00-2:30 p.m.		
		x		9:30-10:00 a.m.		
		x		4:00-4:30 p.m.	Utilize VANTS Line 1- 800.767.1750 41692#	
		x		1:30-2:00 p.m.		

[936] VA OIG Tomah VAMC Site Visit Schedule for August 22–23, 2012, at OIG 11739.

Figure 79: VA OIG site visit schedule for the Tomah VAMC[937]

Tomah Veterans Affairs Medical Center (VAMC)
Interview Schedule August 22-23, 2012

TIME	WEDNESDAY- AUGUST 22, 2012	THURSDAY- AUGUST 23, 2012
0830-0900	Entrance Interview with the Director. Mario V. DeSanctis, FACHE	[redacted]
0900-0930	Interview with the [redacted]	Chief of Staff Interview, Dr. David Houlihan
0930-1000	[redacted]	[redacted]
1000-1100	Chief of Staff Interview, Dr. David Houlihan	[redacted]
1100-1130	[redacted], [redacted] (via VANTS) 1-800-767-1750 Code: 41692	[redacted]
1130-1200	[redacted]	LUNCH
1200-1230	Outpatient Psychiatrists 60 minute group interview (404/3462): [redacted]	Open time slot
1230-1300	Group Interview Continued	[redacted]
1300-1330	LUNCH	[redacted]
1330-1400	[redacted]	Open time slot
1400-1430	Open time slot	[redacted]
1430-1500	[redacted]	[redacted]
1500-1530	[redacted]	[redacted]
1530-1600	[redacted]	[redacted]
1600-1630	[redacted] (via VANTS) 1-800-767-1750 Code: 41692	Exit Interview with the Director Mario V. DeSanctis, FACHE

Both schedules indicate Director DeSanctis was scheduled to participate in an entrance interview at 8:30 a.m. on August 22, 2012, and an exit interview on August 23, 2012.[938] Dr. Wesley provided an explanation of what an entrance interview involved in his transcribed interview with Chairman Johnson's staff. He stated:

> I'll start by saying remember our investigations are inspections. They're not criminal investigations. And when you go on a VA medical center, we try to show a lot of respect to the medical center. It's almost like going on a military base. And, therefore, when we make a site visit, we begin all site visits by having an entrance conference with anyone that the Director chooses. It can be the Director alone, or it can be 50 people. I'm exaggerating there. It can be anyone such as the Director alone or it could be a dozen people. And it's to give him or her the courtesy of letting them know we're there and, likewise, letting them know why we're there. Usually, we share allegations at the entrance conference. I'll say one other thing. We also—in the same vein of respect, we also do an exit conference.[939]

[937] *Id.* at OIG 11740.
[938] *Id.*
[939] Wesley Transcribed Interview, at 184–85.

However, the OIG team never had an opportunity to interview Director DeSanctis while at the facility. On the morning of August 23, 2012, Director DeSanctis emailed Dr. Shepherd, who did not make the trip up to Tomah due to illness, to alert the OIG that he was "out sick." He wrote to Dr. Shepherd that he had "been out sick since Tuesday and [has] not been able to meet the IG team or participate in the visit."[940]

Figure 80: Email from Mario DeSanctis to Dr. Michael Shepherd[941]

----- Original Message -----
From: DeSanctis, Mario V. (SES)
Sent: Thursday, August 23, 2012 07:49 AM
To: Shepherd, Michael L., MD (OIG)
Subject: Out Sick

Mike- just wanted to let you know I have been out sick since Tuesday and have not been able to meet the IG team or participate in the visit. This G illness has totally taken me down. I feel very weak. I feel bad I couldn't be in the office for it. Let me know if you would still like to interview me once I feel better. Sounds like the visit is going well according to Julie Nutting. Again, I apologize for not being there.

Mario

Dr. Shepherd responded to Director DeSanctis, "No problem. Hope you feel better soon. We can touch base with you by phone next week when you are feeling better."[942] Dr. Shepherd forwarded the email to Dr. Mallinger and Monika Gottlieb,[943] a Senior Physician in the OIG's Medical Consultation Review who had joined Dr. Mallinger on the site visit.[944] It is unclear whether Director DeSanctis knew at the time he emailed Dr. Shepherd that Dr. Shepherd was also ill and not in Tomah. Chairman Johnson's staff asked Dr. Shepherd why Director DeSanctis emailed him and not Dr. Mallinger:

> Q: Can you explain why Mr. DeSanctis was emailing you directly and not Alan Mallinger?
>
> A: The only—I can't, other than, for some reason, either——for some reason, I was able to get hold of him somehow better. For some reason, it fell on me to get a hold of him. In other words, I don't remember if Alan was having an issue getting a hold of him and I was able to do it, or if Alan asked me to, or if I said, you know, hey, I'll get

[940] E-mail from Mario DeSanctis, Tomah VAMC, to Michael Shepherd, VA OIG (Aug. 23, 2012, 7:49 AM), at OIG 10643.
[941] *Id.*
[942] E-mail from Michael Shepherd, VA OIG, to Mario DeSanctis, Tomah VAMC (Aug. 23, 2012, 8:03 AM), at OIG 10643.
[943] Shepherd 1/27/2016 Transcribed Interview, at 112.
[944] E-mail from Michael Shepherd, VA OIG, to Alan Mallinger & Monika Gottlieb, VA OIG (Aug. 23, 2012, 8:08 AM), at OIG 10643.

> a hold of the director. Somehow, it ended up in my bailiwick to get this guy, to get a hold of this guy, and so I did.[945]

37. August 2012: The VA OIG conducted a site visit of the Tomah VAMC

In August 2012, a year after the VA OIG received hotline allegations involving the Tomah VAMC, Dr. Mallinger led a group of OIG employees to Tomah, Wisconsin. The OIG interviewed 26 individuals during the two-day site visit.[946] The OIG team also "inspected the pharmacy pick up and dispensing areas" at the Tomah VAMC.[947] The Tomah VAMC Director, Mario DeSanctis was not interviewed during the site-visit due to illness.[948] The VA OIG instead conducted an "entrance" interview with Sandra Gregar,[949] who was the Associate Director of the facility at the time. [950]

On August 22, 2012, Dr. Mallinger and his OIG colleagues interviewed Ms. Gregar at the facility.[951] According to a subsequent report of contact, Ms. Gregar told the OIG she had "only became aware of this yesterday" and she offered to "facilitate" the OIG's investigation.[952] Dr. Mallinger provided Ms. Gregar with some background on the OIG's purpose for visiting the Tomah VAMC and described the allegations involving prescribing problems, drug diversion, and administrative abuses.[953] Ms. Gregar told the OIG she had "been aware, peripherally, of this as a member of the Quadrad."[954] She explained that "[o]ne of the things is that the [chief of staff] is a Psychiatrist at the facility and manages some of the most difficult patients. He's asked to take on the difficult patients from the staff when nothing else has worked or when the staff doesn't know what else to do."[955] Ms. Gregar believed Dr. Houlihan's willingness to take on "difficult patients" made "him more of a target for some of the staff that wonder about his practices."[956]

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[945] Shepherd 1/27/2016 Transcribed Interview, at 113.
[946] VA OIG, Tomah Summary, OIG 12935, at OIG 12936.
[947] *Id.*
[948] E-mail from Mario DeSanctis, Tomah VAMC, to Michael Shepherd, VA OIG (Aug, 23, 2012, 7:49 AM), at OIG 10643.
[949] Sandra Gregar retired from the Tomah VAMC in October 2012. *Gregar Retiring after 36 Years at VA*, TOMAH JOURNAL (Oct. 29, 2012), http://lacrossetribune.com/tomahjournal/news/local/gregar-retiring-after-years-at-va/article_d50f415e-21df-11e2-8323-001a4bcf887a html; Press Release, Dep't of Veterans Affairs, *Sandy Gregar Retires from Tomah VAMC after 36 Years*, (Oct. 23, 2012), http://www.wrjc.com/wp-content/uploads/2012/10/Gregar-Press-Release.pdf.
[950] Sandra K. Gregar was appointed as the Associate Director of the Tomah VAMC on December 7, 2008. *Senior Management Biographies*, http://www.tomah.va.gov/tomahvaleadership.pdf. Chairman Johnson's office reached out to interview Sandra Gregar but did not connect. E-mail from Staff, HSGAC (Apr. 13, 2016).
[951] Memorandum of Interview of Sandra Gregor (Aug. 22, 2012), at OIG 5911.
[952] *Id.* at OIG 5911.
[953] *Id.* OIG 5912.
[954] *Id.*
[955] *Id.*
[956] *Id.*

She spoke about Dr. Houlihan thinking "outside of the box" when it came to treating patients and that she had heard patients say to him: "you saved my life."[957]

Ms. Gregar told the VA OIG team how the "anonymous statements" and "questions about how Dr. Houlihan practices" hurt the facility. She said "[i]t's been a very difficult time when stuff like this keeps bubbling up."[958] When Dr. Mallinger asked how long these complaints have persisted, Ms. Gregar responded: "Much beyond 2011."[959]

According to the report of contact, Ms. Gregar served as the Acting Director at the Tomah VAMC for a short period between 2008 and 2009, and she recalled "discussions" about these issues occurring in December of 2008.[960] She described an incident in 2009 in which "a pharmacist [. . .] challenged his prescribing practices."[961] The pharmacist is not named in the report of contact.

When Dr. Mallinger asked Ms. Gregar why individuals were complaining to the OIG in 2011, Ms. Gregar responded the "IG was involved then, too," and she "was aware of these issues when I came back in 2008/2009."[962] During the interview, Dr. Mallinger asked her whether she thought Tomah is "polarized" because of these issues. Ms. Gregar responded:

> From my perspective, it's been fairly new clinical Pharm. D's [*sic*] who have a different or lack of understand [*sic*] of VA pain mgmt policies/pain directives and not really understanding what those are and how they could/should be applied in VA hospitals. There's been some misunderstanding on that and moving the pain mgmt forward in this facility and addressing the pain.[963]

Ms. Gregar also described the role of the Tomah VAMC union and how it affected the facility's environment. Ms. Gregar described it as "an extremely difficult polarizing union" and the union creates "a polarizing environment between [management] and staff."[964] She added that the "union has had significant issues with leadership and management style of Dr. Houlihan in the past."[965] When questioned about why the complaints mainly focused on Dr. Houlihan, Ms. Gregar responded that "they target all of leadership."[966]

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[957] *Id.*
[958] *Id.*
[959] *Id.*
[960] *Id.*
[961] *Id.*.
[962] *Id.*
[963] *Id.* at OIG 5912–13.
[964] *Id.* at OIG 5913.
[965] *Id.*
[966] *Id.*

During the interview, a member of the OIG team requested Ms. Gregar "keep this discussion confidential and do not discuss this with anyone during and after" the site visit.[967] Ms. Gregar, according to the document, agreed to the OIG's request for confidentiality, but questioned if she should brief Director DeSanctis since "he would not have the perspective" and only began working at the Tomah VAMC in February 2012.[968] The OIG's report of contact does not indicate how the OIG responded.

When Chairman Johnson's staff interviewed Linda Ellinghuysen, the Tomah VAMC union president, she described Ms. Gregar as ruling "with an iron fist and she did not respect the police department" at the facility.[969] Ms. Ellinghuysen further believed Ms. Gregar was a loyalist of Dr. Houlihan's.[970] Ms. Ellinghuysen agreed, however, that the Tomah VAMC union took issue with Dr. Houlihan's leadership and management style. She stated:

> Q: In the paragraph right above it, it says, Dr. Mallinger asked her, you're saying maybe this issue is underlying, a polarizing environment? Sandy Gregar says, "Union has had significant issues with leadership and management style of Dr. Houlihan in the past." Seems to be an accurate statement, no?
>
> A: That is accurate and we have questioned Dr. Houlihan publicly, publicly on e-mail, and we've put Dr. Murawsky on those e-mails back then. I did that. I have a copy of that e-mail, and it was about a patient abuse case where Dr. Houlihan was not treating a veteran appropriately. And the Union addressed that. The Union addressed Dr. Houlihan with Noelle Johnson. We addressed Dr. Houlihan when he fired Dr. Saddiqui, so it didn't matter if it was Sandra Gregar, Dr. Houlihan or Joe Smith. If they violated a law, reg or contract, the Union was going to step in.[971]

38. August 22, 2012: The VA OIG conducted its initial interview of Dr. Houlihan at the Tomah VAMC

The VA OIG scheduled two interviews with Dr. Houlihan during its August 2012 site visit.[972] A number of VA OIG employees participated in the interview in person and over the

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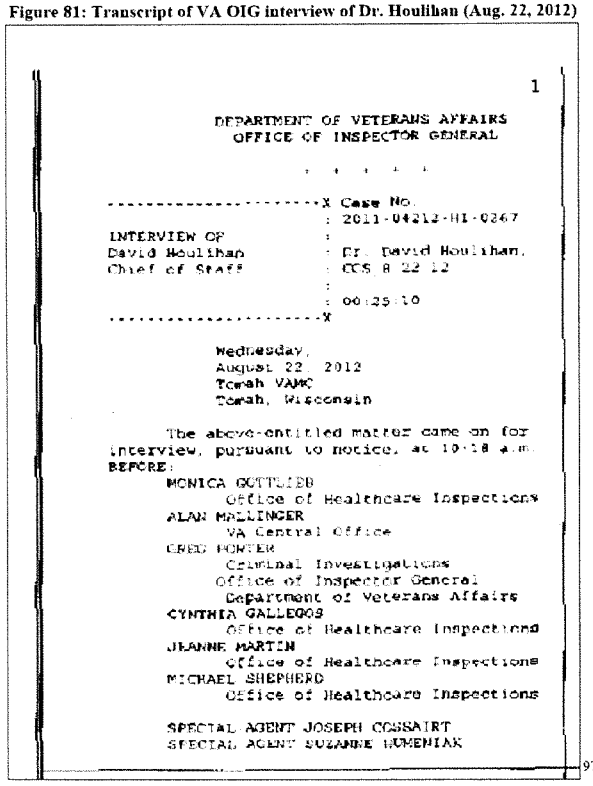
[967] *Id.* at OIG 5914.
[968] *Id.*
[969] Ellinghuysen Transcribed Interview, at 47–48.
[970] *Id.* at 48.
[971] *Id.* at 148–49.
[972] Dr. Houlihan was interviewed by the VA OIG on August 22, 2012 and August 23, 2012. VA OIG Interview with David Houlihan (Aug. 22, 2012), OIG 5423 [hereinafter 8/22/2012 VA OIG Interview of Houlihan]; VA OIG Interview with David Houlihan (Aug. 23, 2012), OIG 5396 [hereinafter 8/23/2012 VA OIG Interview of Houlihan].

phone.[973] The first interview occurred on the morning of August 22, 2012, and lasted around 25 minutes.[974]

Figure 81: Transcript of VA OIG interview of Dr. Houlihan (Aug. 22, 2012)



1

DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

. . . . .

	Case No.
	: 2011-04212-HI-0267
INTERVIEW OF	:
David Houlihan	: Dr. David Houlihan,
Chief of Staff	: CCS 8 22 12
	:
	: 08:25:10

Wednesday,
August 22, 2012
Tomah VAMC
Tomah, Wisconsin

The above-entitled matter came on for interview, pursuant to notice, at 10:18 a.m.
BEFORE:
MONICA GOTTLIEB
Office of Healthcare Inspections
ALAN MALLINGER
VA Central Office
CHED PORTER
Criminal Investigations
Office of Inspector General
Department of Veterans Affairs
CYNTHIA GALLEGOS
Office of Healthcare Inspections
JEANNE MARTIN
Office of Healthcare Inspections
MICHAEL SHEPHERD
Office of Healthcare Inspections

SPECIAL AGENT JOSEPH COSSAIRT
SPECIAL AGENT SUZANNE HOMENIAK

975

According to a transcript of the interview produced by the VA OIG pursuant to Chairman Johnson's subpoena, the first interview began with Dr. Mallinger noticing the University of Pittsburgh on Dr. Houlihan's curriculum vitae. Dr. Houlihan said that he had trained at the

[973] Dr. Michael Shepherd participated in both of the Dr. Houlihan interviews via phone. 8/22/2012 VA OIG Interview of Houlihan, at OIG 5423; 8/23/2012 VA OIG Interview of Houlihan, at OIG 5399.
[974] 8/22/2012 VA OIG Interview of Houlihan, at OIG 5423.
[975] *Id.*

University of Pittsburgh; Dr. Mallinger explained how he was a faculty member at the university and "wondered if our paths had ever crossed."[976] Dr. Houlihan confirmed that he attended the university in "the early 90's" and commented that Dr. Mallinger's name "look[ed] quite familiar."[977] The initial conversation continued with Dr. Houlihan making the comment that "combat PTSD" was his specialty "for the most part."[978]

After this opening dialogue, Dr. Mallinger explained the reasons why the VA OIG was at the Tomah VAMC. He told Dr. Houlihan that the OIG received a "series of allegations about kind of a number of issues, some of which had to do with treatment practices . . . ."[979] Dr. Houlihan acknowledged he had "heard about a lot of them firsthand."[980] Dr. Mallinger described that the OIG "at this point, really have to take a look and see what's going on. And so really our reason for coming to Tomah here is to try to understand the situation a little better and hopefully get to know you a little better and your treatment practices a little bit better."[981]

Dr. Houlihan told the OIG he had been dealing with many of the allegations for "a long time" and specifically described a time-frame of "seven, eight years."[982] Dr. Houlihan mentioned an earlier OIG complaint involving him and that he became aware of it via a contact with the VISN regional office.[983] Dr. Mallinger asked Dr. Houlihan to explain his opinion on using opiates as treatment for PTSD and depression.[984] Dr. Houlihan responded by telling the OIG he was "in the process of publishing" a paper involving "five or six veterans."[985] It is unclear whether Dr. Houlihan published any work after this August 2012 period.

During his transcribed interview, Chairman Johnson's staff asked Dr. Mallinger about his takeaways after the first interview with Dr. Houlihan.[986] Dr. Mallinger responded, "I was just there to gather information from him and hear his side of the story."[987] When asked for further thoughts about Dr. Houlihan, Dr. Mallinger called his treatment practices "unorthodox," saying that "they do not reflect the mainstream way" that "a typical psychiatrist would approach treating patients."[988] He stated:

> Q: So what did you learn about his treatment practices after these interviews?

[976] 8/22/2012 VA OIG Interview of Houlihan, at OIG 5424. Dr. Alan Mallinger was a professor at the University of Pittsburgh from 1975 through 2003. Mallinger 3/8/2016 Transcribed Interview, at 9.
[977] 8/22/2012 VA OIG Interview of Houlihan, at OIG 5424.
[978] *Id.* The "Male Participant" in the OIG interview transcript is Dr. Alan Mallinger.
[979] *Id.*
[980] *Id.*
[981] *Id.*
[982] *Id.*
[983] *Id.* at OIG 5426.
[984] *Id.* at OIG 5427.
[985] *Id.*
[986] Mallinger 4/6/2016 Transcribed Interview, at 300.
[987] *Id.* at 300.
[988] *Id.* at 302.

A: Well, I can tell you that my impression of Dr. Houlihan is that he believes that he's being very genuinely helpful to veterans and is, at least from what he says, very committed to caring for veterans.

Q: Anything more about his prescription practices?

A: Well, that's a complicated—you know, the whole thing is a very complicated issue. You know, as I've said before, it's the—it's trying to sort out the whole risk-benefit equation. And, you know, from my perspective, I only know what he tells me. I can't know whether what he tells me is true or not, so I have to use all the evidence available to me.

I think that he has kind of set himself up to be the one who takes care of the very difficult patients. He's made it very clear to, you know, other doctors who work there, as they indicated to us, that, you know, when they have patients that are too difficult to feel comfortable taking care of, that, you know, they should feel very free to refer those patients to him. And I think that he kind of prides himself on having a practice of very difficult to treat patients.

His treatment practices are—you know, I've searched around for the right word to describe his treatment practices for a long time, and the word that I came up with was "unorthodox." And I think it's absolutely true that his treatment practices are unorthodox. They do not reflect the mainstream way that, you know, a typical psychiatrist would approach treating patients.

The other side of that equation is that the patient population that he has taken on for treatment is very different from the patient population that mainstream psychiatrists treat in that, you know, they have very serious mental illness, they have—you know, as I said before, most of the ones that find their way to him have substance use disorders. Many of them have chronic pain.

They are the kinds of patients who are often not successfully treated. One of the hardest things with patients like this is actually retaining them in treatment.

* * *

Certainly I've talked with pharmacists who were prescribing-fearful when they were, you know, resisting filling prescriptions for patients. These are some seriously difficult people, and I think they challenge

> all of us in terms of our humanity because they really are the kind of people you like to forget about.
>
> But they're people, and they deserve to be treated. And, you know, if his unorthodox methods can offer some hope to people like that, then—then that would be a good thing. The problem is knowing whether that's what's actually happening there. But that's the picture that he paints. And there's some evidence, particularly when you consider the patients' perspective, that that indeed—that there may indeed be some truth to that. It's a real dilemma.
>
> You know, on the one hand, you know, he's putting these people on addictive drugs, which is not necessarily a good thing in psychiatry in the mainstream. On the other hand, they do seem to be coming back—and, you know, you can embrace that whole dilemma, put somebody on an addictive drug, they come back. It's a bad thing. It's good that they come back. It's a bad thing if that's why they're coming back. And we don't really know the answer to that.[989]

During the same interview, Dr. Mallinger confronted Dr. Houlihan about being called the "Candy Man." Dr. Houlihan responded, "It's Candy Land."[990] When interviewed by Chairman Johnson's staff, Dr. Mallinger expressed little concern about the meaning of monikers, stating: "Well, again, you know, I would say to you what does it mean? I mean, it's just name-calling. If he knows it's called 'Candy Land,' you know, the little girl in the fifth grade knew she was being called 'Cootie.' You know, what does it—what does it mean? What did it mean to her? Nothing."[991] Dr. Mallinger further said that the "Candy Land" moniker was of little evidentiary value to the VA OIG's inspeetion, stating: "Well, you know, again, you know, people are name calling, and he's aware of it, obviously, which is what I wanted to know. What I object to is using that as evidence. I mean, what is that evidence of?"[992] In light of the little weight given to the "name-calling," Chairman Johnson's asked Dr. Mallinger why he raised the moniker "Candy Man" with Dr. Houlihan at all. He responded:

> Q: So you just wanted to know if he knew that people called him "Candy Man."
>
> A: Well, you know, I was doing a few things with Dr. Houlihan. One is that I was trying to establish some rapport with him. And, two, I was kind of feeling him out for his attitudes and his beliefs and his

[989] *Id.* at 301–04; 8/23/2012 VA OIG Interview of Houlihan, at OIG 5431, at 33–34.
[990] Mallinger 4/6/2016 Transcribed Interview, at 304.
[991] *Id.* at 305.
[992] *Id.*

> approaches. And, you know, I don't remember, but, you know, most likely I wanted to know how he felt about that label.[993]

Under further questioning about the monikers "Candy Man" and "Candy Land", Dr. Mallinger acknowledged that one "can understand why staff would call him names. He's not a nice guy. He's mean to the staff."[994] Yet, Dr. Mallinger believed these feelings and the monikers "just doesn't prove wrongdoing."[995] In the same discussion with Chairman Johnson's staff, Dr. Mallinger described Tomah as a "polarized atmosphere" and "there's a lot of hostility and animosity" at the facility.[996] He called the Tomah VAMC a "dysfunctional system" and equated the facility to "a dysfunctional family and people are—you know, everybody's upset with everybody else, and that's kind of like what it is there."[997]

39. August 23, 2012: The VA OIG conducted its second interview of Dr. Houlihan at the Tomah VAMC

The first day of the VA OIG's site visit included interviews with other individuals at the facility. Nearly 24 hours after speaking with Dr. Houlihan, the OIG team again sat down with him. According to the interview transcript, the interview on August 23, 2012 lasted for over an hour.[998] In the interview, Dr. Mallinger said the OIG's first day of interviews at the Tomah VAMC as "interesting."[999] Dr. Mallinger described complaints that the OIG team received about "a lack of professional autonomy."[1000] This statement led into a discussion of "building a consensus" regarding early refills at the facility. Dr. Houlihan argued that he was working on building a consensus and talking with employees.[1001] Dr. Mallinger apparently did not see the progress, telling Dr. Houlihan bluntly: "Well, it's kind of like not happening, you know."[1002]

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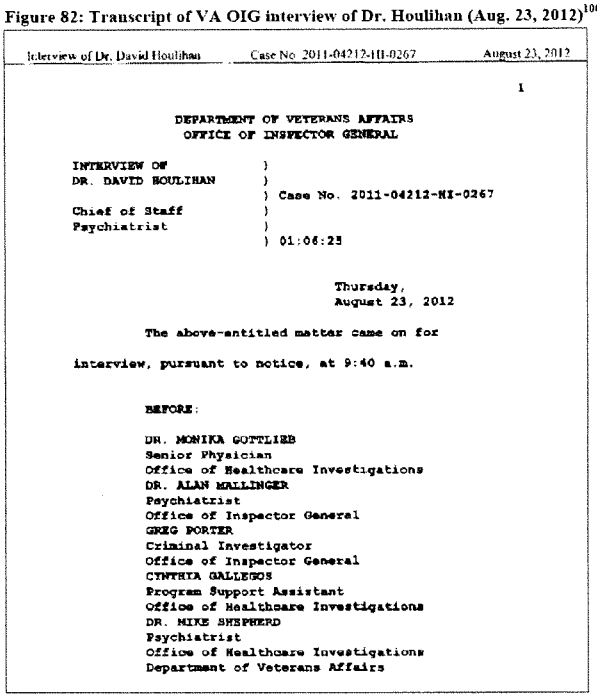
[993] *Id.* at 305–06.
[994] *Id.* at 306.
[995] Mallinger 4/6/2016 Transcribed Interview, at 307.
[996] *Id.* at 307.
[997] *Id.*
[998] 8/23/2012 VA OIG Interview of Houlihan, at OIG 5396.
[999] *Id.* at OIG 5397
[1000] *Id.* at OIG 5403.
[1001] *Id.* at OIG 5404.
[1002] *Id.*

Figure 82: Transcript of VA OIG interview of Dr. Houlihan (Aug. 23, 2012)[1003]



Interview of Dr. David Houlihan Case No. 2011-04212-HI-0267 August 23, 2012

1

DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

INTERVIEW OF)
DR. DAVID HOULIHAN)
) Case No. 2011-04212-HI-0267
Chief of Staff)
Psychiatrist)
) 01:06:25

Thursday,
August 23, 2012

The above-entitled matter came on for

interview, pursuant to notice, at 9:40 a.m.

BEFORE:

DR. MONIKA GOTTLIEB
Senior Physician
Office of Healthcare Investigations
DR. ALAN MALLINGER
Psychiatrist
Office of Inspector General
GREG PORTER
Criminal Investigator
Office of Inspector General
CYNTHIA GALLEGOS
Program Support Assistant
Office of Healthcare Investigations
DR. MIKE SHEPHERD
Psychiatrist
Office of Healthcare Investigations
Department of Veterans Affairs

During the interview, Dr. Mallinger attempted to better understand how breakdowns in communication contributed to Dr. Houlihan's poor relationship with the Tomah VAMC pharmacy. Dr. Houlihan explained, "what happens is, you know, I hear about the chatter. And so let's try and clear the air with the chatter." Dr. Mallinger responded, "So the fire has already started there." Dr. Houlihan retorted: "Well, the fire has been there for like about seven years."[1004]

[1003] *Id.* at OIG 5396.
[1004] *Id.* at OIG 5405.

Figure 83: Transcript of VA OIG interview of Dr. Houlihan (Aug. 23, 2012)

DR. HOULIHAN: -- special -- well, yeah. It's that it was around -- it was around the issues that -- what happens is, you know, I hear about the chatter. And so let's try and clear the air with the chatter.

DR. MALLINGER: So the fire has already started there.

DR. HOULIHAN: Well, the fire has been there for like about seven years.

DR. MALLINGER: Yeah.

DR. HOULIHAN: It's that the issue that we've had is what can we do to get people at a level of comfort, and --

During the Tomah VAMC site visit, VA OIG Special Agent Greg Porter accompanied the health care inspection team. In a transcribed interview with the Committee, Special Agent Porter was asked about how he makes a determination to interview a particular witness or suspect. He explained that he did not interview a particular female patient during the spring of 2012 because she was "a suspect" and he "didn't want to tip her off."[1005] Chairman Johnson's staff asked Special Agent Porter whether he had any similar concerns about interviewing Dr. Houlihan in August of 2012. Agent Porter responded:

> Q: I think you mentioned earlier about you were not the creator of the interview list for the August 2012 visit by [Office of Healthcare Inspections] and you joining them. I think you also mentioned, you know, from an operational standpoint in an—in an investigation, you might not want to tip off certain people. Correct?
>
> A: Correct.
>
> Q: So was the decision to interview Dr. Houlihan in August of 2012 a smart decision, from your view?
>
> A: It was—well, it was part of their health care review, so to sit and—and ask him specific questions about specific people, or about, you know, specific crimes or—or, you know, for example, "Doctor, are you diverting drugs" or "Doctor, are you getting kickbacks from veterans?"

[1005] Porter Transcribed Interview, at 92.

> "Doctor, are you doing this?" that would have been probably a poor choice at that point.
>
> But there—as far as—I think I did ask a couple of questions of Dr. Houlihan. I—I kept pretty quiet for most of the interviews. I think I—I asked Dr. Houlihan a question or two. I don't really recall what questions they were.
>
> But I think, at that point, the—the purpose of those interviews were more for the healthcare inspection purposes than they were for—for criminal. I was—my understanding is that I was asked to be there in case anyone made any kind of utterance of—of criminal activity or anything like that. That was, you know, what I was told, and—and, you know, my purpose for—for being there, and that didn't happen.[1006]

According to the transcript of the VA OIG's August 23, 2012 interview, Special Agent Porter asked Dr. Houlihan a series of questions about any potential relationships with any individuals who work in the supply chain of the narcotics to the Tomah VAMC pharmacy.[1007] Dr. Houlihan responded, "No."[1008] Special Agent Porter also asked Dr. Houlihan about whether he provided any financial or personal assistance to a patient, which he denied.[1009] Special Agent Porter then asked Dr. Houlihan about the "perception that the kind of word around the campfire so to speak is that if you need narcotics, go to Dr. Houlihan." Dr. Houlihan responded, "I don't think – I think that that might be over-zealous, quite frankly . . . ."[1010]

40. August 29, 2012: The VA OIG created a post-site visit "Tomah Hotline Status" document with a draft report date of October 2012

After the VA OIG team concluded its two-day site visit of the Tomah VAMC, Dr. Mallinger returned to Washington, D.C. and provided his supervisor, Dr. Wesley, with a briefing. In a transcribed interview with Chairman Johnson's staff, Dr. Wesley confirmed that the team briefed him when they came back from Tomah.[1011] Shortly after their return, the OIG produced a "Tomah Hotline Status" document, dated August 29, 2012, which identified specific areas in the hotline that had yet to be completed. The document included a goal to "[c]omplete [an] initial draft" of the report "by the end of October" 2012.[1012] Dr. Mallinger did not recall this document, but offered a long response detailing what OIG did after the site visit. He stated:

[1006] *Id.* at 97–98.
[1007] 8/23/2012 VA OIG Interview of Houlihan, at OIG 5410.
[1008] *Id.*
[1009] *Id.* at OIG 5410–11.
[1010] *Id.* at OIG 5411.
[1011] Wesley Transcribed Interview, at 196.
[1012] Tomah Hotline Status as of Aug. 29, 2012, at OIG 12928.

Q: And then at the bottom it says, "Report. Complete all data collection analysis by end of September." And then, "Complete initial draft by end of October." Do you recall if an initial draft was completed by October of 2012?

A: You know, I don't recall, you know. I know that the final draft was completed somewhat later than that. I think that this plan, you know, is as of the end of August, and I would say that the—you know, we did things—we didn't necessarily follow this plan. And, in particular, you know, if I look at the specifics, I mean, we did—we certainly did some additional interviews by telephone. The pharmacy data review turned out to be much more extensive than we had initially envisioned it. And, you know, I'm not sure if it was justified or not, although ultimately it produced what was really our main finding, which was the high rate of prescribing.

But, you know, one of the problems ongoing in this whole inspection had been that we were coming up with so little that we kept pushing into new areas trying to find, you know, that smoking gun, if you will. And the pharmacy data request was—you know, I don't think it was even fulfilled by the end of September. We asked for quite a bit more than we had initially envisioned asking for. And the first things that we reviewed from the pharmacy led us then to ask for additional things. It became a process, and it turned out to be kind of a bigger undertaking than we had initially envisioned, which, like I say, ultimately, you know, produced, you know, kind of the core finding of the report, although it, you know, wasn't a damning finding.

So I don't know. I think maybe, you know, we were trying as hard as we could to pursue everything that was stated in the allegations, and so it took us in a direction of opening up yet another can of worms, if you will.

The email investigation also, you know, I mean, that took some time to put together. There were—there was some trouble retrieving some of the files that had been stored on people's individual computers. And we, you know—ultimately, we got those files, but it took some time to get those. So we got a little bit of a later start with that than we had wanted to.

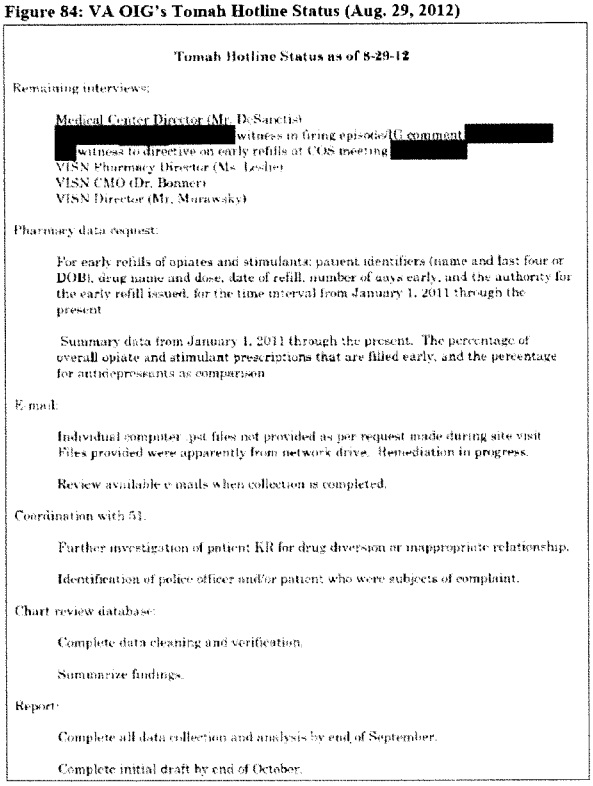
The chart review database, you know, the data cleaning and verification, when we finally got around to writing the report, you know, after doing all these things, we really—we really did the—that's

the structured chart reviews I'm talking about here. We did the data verification kind of concert with the writing of the report. So that—that was actually a process that took about 7 weeks just by itself. You know, we would write something, and then we would look into the structured chart review to see what we could reliably count on from that review to support it, and that would require then going through this process of verification, and then we would go back to writing. So that was about a 7-week process there.

And so that is really—you know, I'm not sure—you know, as I look back on it, you know, from the perspective of, you know, a long time later, end of August, complete the initial draft by end of October, it's September, so 2 months, not really a very realistic perspective considering the work that we ultimately did.[1013]

[1013] Mallinger 4/21/2016 Transcribed Interview, at 327–30.

Figure 84: VA OIG's Tomah Hotline Status (Aug. 29, 2012)



Tomah Hotline Status as of 8-29-12

Remaining interviews:

Medical Center Director (Mr. DeSanctis)
[redacted] witness in firing episode/IG comment [redacted]
[redacted] witness to directive on early refills at COS meeting [redacted]
VISN Pharmacy Director (Ms. Leslie)
VISN CMO (Dr. Bonner)
VISN Director (Mr. Murawsky)

Pharmacy data request:

For early refills of opiates and stimulants: patient identifiers (name and last four or DOB), drug name and dose, date of refill, number of days early, and the authority for the early refill issued, for the time interval from January 1, 2011 through the present

Summary data from January 1, 2011 through the present. The percentage of overall opiate and stimulant prescriptions that are filled early, and the percentage for antidepressants as comparison

E mail:

Individual computer .pst files not provided as per request made during site visit. Files provided were apparently from network drive. Remediation in progress.

Review available e mails when collection is completed.

Coordination with 51:

Further investigation of patient KR for drug diversion or inappropriate relationship.

Identification of police officer and/or patient who were subjects of complaint.

Chart review database:

Complete data cleaning and verification.

Summarize findings.

Report:

Complete all data collection and analysis by end of September.

Complete initial draft by end of October.

41. September 2012: The VA OIG conducted a phone interview with Tomah VAMC Director Mario DeSanctis

The VA OIG team was unable to interview the Tomah VAMC Director, Mario DeSanctis, during their site visit to the facility because the director was ill. As the August 29, 2012, Tomah Hotline Status document illustrated, the OIG team listed Mario DeSanctis as one of the remaining witnesses to interview.[1014] On September 10, 2012, the OIG team conducted a

[1014] Tomah Hotline Status as of Aug. 29, 2012, at OIG 12928.

phone conference with Director DeSanctis. The phone call lasted nearly one hour,[1015] and concerned what the OIG team witnessed during their site visit.[1016] The concerns about Dr. Houlihan and the "fear" that had gripped the facility were some of the topics discussed. At the end of the phone call, the OIG decided to "go off the record" to alert Director DeSanctis about their site-visit observations of Dr. Houlihan and Deborah Frasher.[1017]

Figure 85: Transcript of VA OIG interview of Mario DeSanctis

DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

* * * * *

	Case No.
	2011-04213-HI-0267
INTERVIEW OF	
MARIO DeSANCTIS	Mr. Mario DeSanctis,
DIRECTOR	Director_9 10 12
	00:56:17

Monday,
September 10, 2012
Tomah VAMC
Tomah, Wisconsin

The above-entitled matter came on for interview, pursuant to notice, at 10:33 a.m. BEFORE:

ALAN MALLINGER
VA Central Office
GREG PORTER
Criminal Investigations
Office of Inspector General
Department of Veterans Affairs
CYNTHIA GALLEGOS
Office of Healthcare Inspections
MICHAEL SHEPHERD
Office of Healthcare Inspections

This transcript produced from audio provided by Department of Veterans Affairs Office of Inspector General.

[1015] The entire Mario DeSanctis OIG phone interview transcript can be found at VA OIG Bates number OIG 6084-6103.
[1016] VA OIG Interview with Mario DeSanctis, in Tomah, Wis. (Sept. 10, 2012), OIG 6084 [hereinafter 9/10/2012 VA OIG Interview of DeSanctis].
[1017] *Id.* at OIG 6095–96; Handwritten Note from Alan Mallinger (Sept. 10, 2012), at OIG 12364.

During the interview with Director DeSanctis, Dr. Mallinger explained the complaints received by the VA OIG, including "allegations that a lot of these drugs are being misused for criminal purposes, that people would either be abusing drugs that they get or reselling them, which amounts to drug trafficking."[1018] He sought Director DeSanctis' "sense" of the situation at the Tomah VAMC, because Director DeSanctis had not been at Tomah "very long." The director responded that he was aware of the "sense of friction between the Pharmacy and the Chief of Staff" but that his involvement had been "somewhat inconsistent unfortunately."[1019]

Director DeSanctis referenced the allegations received by the OIG in March 2011 and referred to VISN 12, and how he "got an indication" about the complaints while he was at the VISN for training.[1020] He also recalled an OIG Combined Assessment Program (CAP) inspection, in which there was an anonymous allegation involving "the over-prescribing of meds to psych patients."[1021] Director DeSanctis told the OIG that he "asked Dr. Houlihan to look into" the anonymous allegation and requested a response by June 2012.[1022] According to Director DeSanctis, he was provided a response and "thought it was good," but thought "we could do more than that."[1023]

Dr. Mallinger explained his impressions of the Tomah VAMC, saying: "I was very impressed with the, you know, the quality of the people, but also the—you know, they really do seem to have the best interests of the veterans at heart."[1024] Despite that impression, Dr. Mallinger described a "sort of dichotomous, polarized situation has arisen" and he asked Director DeSanctis his thoughts on those diverging realties. Director DeSanctis responded:

> I think over time there's some fear there, and I think it's been based on Dr. Houlihan's personality, and I think it's been because he was the acting director before, and I think we may have lost some objectivity. And I'm trying, and I want to re-establish the objectivity in all of this. So I think I can break the tie, you know, or this polarization that you talked about.[1025]

Director DeSanctis continued with discussing the "fear" that had taken root at the Tomah VAMC, particularly with the pharmacists and technicians at the facility. In passing, he

---

[1018] 9/10/2012 VA OIG Interview of DeSanctis, OIG 6085.
[1019] *Id.*
[1020] *Id.* at OIG 6086, at 10.
[1021] *Id.* at OIG 6086. Every three years, the VA OIG Office of Health Care Inspection reviews every VA Hospital through its CAP reviews. The CAP reviews ensure compliance with appropriate protocols and typically include a survey of the staff of each hospital.
[1022] *Id.*
[1023] *Id.*
[1024] *Id.* at OIG 6088.
[1025] *Id.*

mentioned the firing of Dr. Noelle Johnson and how that "has had a lasting effect on the pharmacy, to where I think even the technicians work[] in fear."[1026]

During his interview of Director DeSanctis, Dr. Mallinger raised concerns about the ability for the VA Police handling patients who had some criminal issues connected to drugs. Director DeSanctis responded that he did not hold that concern, but cited that the Tomah VAMC has "had gaps" in the chief of police position. He also explained, "I don't have a sense of the criminal world, although I have met with John Brooks, you know, Special Investigator for our area, and he has told me that there's some drug trafficking going on in this area."[1027]

Dr. Mallinger raised other concerns about the Tomah VAMC's role in the drug trade. Specifically, Dr. Mallinger told Director DeSanctis that the VA OIG had received information from the Tomah Police Department about "specific individuals who are basically getting their drugs at Tomah."[1028] He described a perception "that Tomah has put itself in sort of the role as a drug supplier" for the area, and that "there seems to be genuine concern about what harm might be being done to the community."[1029] In response, Director DeSanctis opined: "I really think if they suspect something like that, they need to act on it and you know, to follow through."[1030]

[1026] *Id.*
[1027] *Id.* at OIG 6089–90.
[1028] *Id.* at OIG 6092.
[1029] *Id.*
[1030] *Id.*

Figure 86: Transcript of VA OIG interview of Mario DeSanctis[1031]

DR. MALLINGER: But it's also true that we've gotten information from the Tomah Police Department that you know, the municipal police department that you know, that they have concerns about specific individuals who are basically getting their drugs at Tomah, so --

MR. DeSANCTIS: I really think if they suspect something like that, they need to act on it and you know, to follow through on it.

DR. MALLINGER: Well, I'm sure they

36

do, but you know, just based on what their informants tell them, you know, I mean they certainly do seem to be pursuing their law enforcement agenda, but there is this perception, even by some of the pharmacists, that Tomah has put itself in sort of the role as a drug supplier, and there seems to be some genuine, you know, a lot of the people who work at Tomah are part of the Tomah community.

MR. DeSANCTIS: Yes.

DR. MALLINGER: And there seems to be genuine concern about what harm might be being done to the community.

MR. DeSANCTIS: Yea.

[1031] 9/10/2012 VA OIG Interview of DeSanctis, OIG 6092.

At the end of the phone interview with Director DeSanctis, Dr. Mallinger raised a concern about "very significant Union problems" that he heard during the OIG's interview with Associate Director Sandy Gregar. Dr. Mallinger questioned Director DeSanctis about what he knew about the Tomah union. Director DeSanctis replied that he was meeting with the union every other week and was developing a "good partnership" with the union.[1032] He described what he knew about the union, saying "I think there's just been some friction in the past" going "back many years, so that's a big part of the culture here too."[1033]

Dr. Mallinger concluded the interview by telling Director DeSanctis that the VA OIG still had work to do on the inspection, but that a report would be prepared and "it will have specific recommendations in it."[1034] Of course, the OIG's eventual final product—the eleven-page administrative closure—made no recommendations. Instead, the administrative closure included five "suggestions" for Director DeSanctis.[1035]

42. September 2012: VA OIG Special Agent in Charge John Brooks contacted Tomah VAMC Director Mario DeSanctis about the DEA's inquiry

On September 10, 2012, the Special Agent in Charge (SAC) of the VA OIG's Criminal Investigation Division Chicago field office contacted Director DeSanctis seeking information about the DEA's actions at the Tomah VAMC.[1036] SAC John Brooks asked Director DeSanctis, "Any word regarding the DEA Privacy Act request?"[1037] Director DeSanctis responded, "John-not yet. Will forward to you as soon as I find out more."[1038] This inquiry about the DEA occurred on the same day Director DeSanctis had a phone call with Dr. Mallinger, Special Agent Porter and other OIG inspectors.[1039] According to the OIG interview transcript, the DEA was not a topic of conversation.[1040]

[1032] *Id.* at OIG 6094.
[1033] *Id.* at OIG 6095.
[1034] *Id.* at OIG 6093.
[1035] VA OIG TOMAH VAMC ADMINISTRATIVE CLOSURE, at 10-11.
[1036] E-mail from John Brooks, VA OIG, to Mario DeSanctis, Tomah VAMC (Sept. 10, 2012, 1:50 PM), OIG 11507, at OIG 11508–09. John Brooks has since retired as the Special Agent in Charge of the Chicago OIG office. Porter Transcribed Interview, at 23, 24, 69.
[1037] E-mail from John Brooks, VA OIG, to Mario DeSanctis, Tomah VAMC (Sept. 10, 2012, 1:50 PM), OIG 11507, at OIG 11508–09.
[1038] E-mail from Mario DeSanctis, Tomah VA, to John Brooks, VA OIG (Sept. 10, 2012, 4:22 PM), OIG 11507, at OIG 11508.
[1039] 9/10/2012 VA OIG Interview of DeSanctis, OIG 6084.
[1040] *Id.* at OIG 6084–6103.

Figure 87: Email exchange between John Brooks and Mario DeSanctis[1041]

From: DeSanctis, Mario V. (SES)
Sent: Monday, September 10, 2012 04:22 PM
To: Brooks, John (OIG)
Subject: Re:

John- not yet. Will forward to you as soon as I find out more.

R/Mario

From: Brooks, John (OIG)
Sent: Monday, September 10, 2012 01:50 PM
To: DeSanctis, Mario V. (SES)
Subject:

Director M. DeSanctis,

Any word regarding the DEA Privacy Act request?

VR,

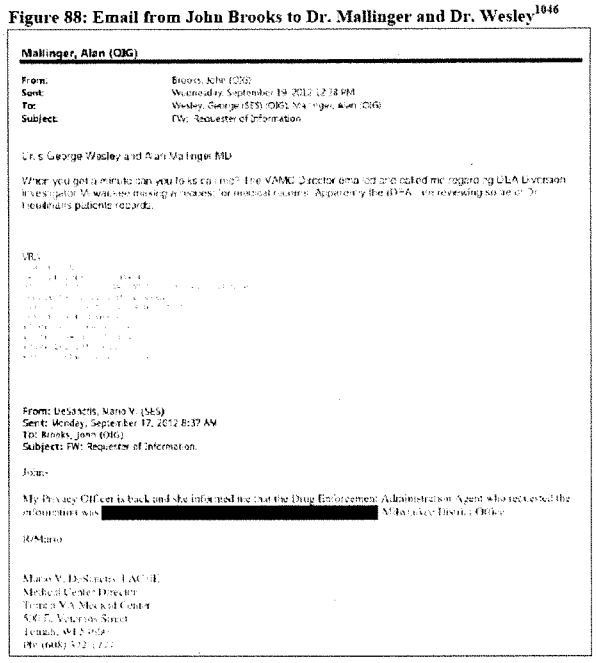
JOHN N. BROOKS
SPECIAL AGENT IN CHARGE
UNITED STATES DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL
CRIMINAL INVESTIGATION DIVISION
CHICAGO FIELD OFFICE
(708) 202-2566 Direct
(708) 557-2197 Mobile 2197
(708) 202-2256 FAX

The email communication between SAC Brooks and Director DeSanctis continued. On September 13, 2012, Director DeSanctis notified SAC Brooks that the Tomah VAMC Privacy Officer was on leave and would not return until September 17, 2012.[1042] On September 17, 2012, Director DeSanctis wrote to SAC Brooks: "My Privacy Officer is back and she informed me that the Drug Enforcement Administration Agent" requested information and the agent was from the "Milwaukee District Office."[1043]

[1041] E-mails between John Brooks, VA OIG, and Mario DeSanctis, Tomah VA (Sept. 10, 2012), OIG 11507, at OIG 11508–09.
[1042] E-mail from Mario DeSanctis, Tomah VA, to John Brooks, VA OIG (Sept. 13, 2012, 12:13 PM), OIG 11507, at OIG 11508.
[1043] E-mail from Mario DeSanctis, Tomah VA, to John Brooks, VA OIG (Sept. 17, 2012, 8:37 AM), at OIG 11507.

Two days later, on September 19, 2012, SAC Brooks sent an email to Dr. Wesley and Dr. Mallinger in Washington, D.C. asking to speak.[1044] SAC Brooks wrote "[t]he VAMC Director emailed and called me regarding DEA Diversion Investigator Milwaukee making a request for medical records. Apparently the (DEA) are reviewing some of Dr. Houlihans [*sic*] patients [*sic*] records."[1045]

Figure 88: Email from John Brooks to Dr. Mallinger and Dr. Wesley[1046]



Mallinger, Alan (OIG)

From: Brooks, John (OIG)
Sent: Wednesday, September 19, 2012 12:30 PM
To: Wesley, George (SES) (OIG); Mallinger, Alan (OIG)
Subject: FW: Requester of Information

Dr.s George Wesley and Alan Mallinger MD

When you get a minute can you folks call me? The VAMC Director emailed and called me regarding DEA Diversion Investigator Milwaukee making a request for medical records. Apparently the (DEA) are reviewing some of Dr. Houlihans patients records.

VR,

From: DeSanctis, Mario V. (SES)
Sent: Monday, September 17, 2012 8:39 AM
To: Brooks, John (OIG)
Subject: FW: Requester of Information

John-

My Privacy Officer is back and she informed me that the Drug Enforcement Administration Agent who received the information was [redacted] Milwaukee District Office

R/Mario

Mario V. DeSanctis, FACHE
Medical Center Director
Tomah VA Medical Center
500 E. Veterans Street
Tomah, WI 54660
Ph: (608) 372-1721

[1044] E-mail from John Brooks, VA OIG, to George Wesley & Alan Mallinger, VA OIG (Sept. 19, 2012, 12:30 PM), at OIG 11507.
[1045] *Id.*
[1046] *Id.*

43. Unknown date in 2011 or 2012: The Drug Enforcement Administration visited VISN 12 to discuss the Tomah VAMC

During this period, the VA OIG was not the only investigative agency examining the Tomah VAMC. The DEA conducted several investigations relating to the Tomah VAMC from 2009 to 2015.[1047] At some point in 2012, the DEA also visited VISN 12 headquarters in Chicago.

Ms. Oshinski, Deputy Director for VISN 12, said that she recalled the DEA appearing at the VISN 12 offices at some time during 2011 or 2012.[1048] She recalled that the DEA spoke with VISN 12 Network Director Dr. Murawsky at that time. Ms. Oshinski was not invited to the meeting but explained that "one day we had a big party of people come" and "we don't normally get a lot of suits . . . in the VISN office."[1049] After the meeting, Ms. Oshinski said that she was curious about why the DEA had come to meet with Dr. Murawsky, then-VISN 12 Network Director. She asked, and Dr. Murawsky told her it was "something I can't talk to you about."[1050] At some later point in time, Dr. Murawsky disclosed to Ms. Oshinski the reason for the DEA's visit—"it was DEA looking at Tomah."[1051]

Ms. Oshinski told Chairman Johnson's staff that she was not contacted by the DEA during its visit to the VISN 12 headquarters and that she has never been interviewed by the DEA.[1052] Although they were not interviewed by the DEA, at least two VISN employees continued to monitor Dr. Houlihan's prescription practices after the DEA's visit to VISN headquarters.[1053]

C. The VA OIG's administrative closure of its health care inspection of the Tomah VAMC

On or about March 12, 2014, the VA OIG administratively closed its health care inspection of the Tomah VAMC. Dr. John Daigh, Assistant Inspector General for Healthcare Inspections, signed the administrative closure. The VA OIG initially did not make public its report, although it alleged that the report was "available" to the public if an individual filed a

[1047] 1/28/2015 Letter from Chairman Johnson, HSGAC, to Administrator Leonhart, DEA; 3/3/2015 Letter from Chairman Johnson, HSGAC, to Administrator Leonhart, DEA, at 1–2; S. COMM. ON HOMELAND SEC. & GOVERNMENTAL AFFAIRS, MAJORITY STAFF REPORT: TRAGEDY AT TOMAH: INITIAL FINDINGS 14 (2015).
[1048] Oshinski Transcribed Interview, at 93–95.
[1049] *Id.* at 93–94.
[1050] *Id.* at 94.
[1051] *Id.*
[1052] *Id.* at 94–95.
[1053] *Id.* at 93.

Freedom of Information Act (FOIA) request.[1054] The VA OIG has accurately pointed out that it lists the number of administrative closures in its semiannual report to Congress.[1055] However, the semiannual reports only list the number of administrative closures without any context or details and thus an individual would have to know that an administrative closure of an investigation at a particular facility exists in order to submit a FOIA request for the document.[1056] Under the VA OIG's view of transparency, an interested individual would have to know that the OIG conducted a health care inspection of the facility before he or she could submit a FOIA request for the document.

The VA OIG has also disputed when its Tomah health care inspection was made public. The VA OIG has asserted that its inspection of the Tomah VAMC was public as of August 29, 2014—the date on which it provided a copy of the closure to Senator Tammy Baldwin in response to her FOIA request.[1057] At that point, however, the VA OIG did not publish the Tomah VAMC administrative closure on its website or make the report available to other members of the Wisconsin congressional delegation. In reality, the VA OIG Tomah VAMC inspection was not made public until it was linked in the *Center for Investigative Reporting*'s article posted on January 8, 2015.[1058] The VA OIG did not publish the Tomah VAMC administrative closure on its website until February 6, 2015.[1059]

At only eleven pages in length, the VA OIG's administrative closure significantly understated the breadth of the inspection, the time invested in the inspection, and the resources dedicated to the inquiry. The report made no mention of the DEA and VA OIG criminal division investigations that occurred concurrent to its health care inspection of the facility. The administrative closure completely omitted some aspects of the VA OIG's investigation and ignored some facts and documents. The VA OIG provided no analysis or insight into how it determined whether to substantiate the allegations it reviewed, and the VA OIG did not explain why it chose to administratively close the inspection.

[1054] Shepherd 2/9/2016 Transcribed Interview, at 142–43; *see also* Donovan Slack, *Newly Released VA Reports Include Cases of Veteran Harm, Death*, USA TODAY (April 29, 2015), http://www.usatoday.com/story/news/politics/2015/04/29/newly-released-va-reports/26594353/.

[1055] 1/27/2015 Letter from Deputy Inspector General Griffin, VA OIG, to Chairman Johnson, HSGAC.

[1056] Slack, *Newly Released VA Reports Include Cases of Veteran Harm, Death*, USA TODAY (April 29, 2015).

[1057] Letter from Richard J. Griffin, Deputy Inspector General, Dep't of Veterans Affairs, to Hon. Ron Johnson, Chairman, S. Comm. on Homeland Sec. & Governmental Affairs, at 2 (Jan. 27, 2015) [hereinafter 1/27/2015 Letter from Deputy Inspector General Griffin, VA OIG, to Chairman Johnson, HSGAC]; Shepherd 2/9/2016 Transcribed Interview, at 142–43.

[1058] Glantz, *Opiates Handed out Like Candy*, REVEAL NEWS (Jan. 8, 2015).

[1059] *Report Summary: Healthcare Inspection – Alleged Inappropriate Prescribing of Controlled Substances and Alleged Abuse of Authority, Tomah VA Medical Center, Tomah, Wisconsin*, DEP'T OF VETERANS AFFAIRS, OFFICE OF INSPECTOR GENERAL (Feb. 6, 2015), http://www.va.gov/oig/publications/report-summary.asp?id=3283.

1. The scope of the VA OIG's inspection

As described in the VA OIG's eleven-page administrative closure, the scope of the VA OIG's inspection:

> included the assessment of the practice patterns and controlled substance prescribing habits of [Dr. Houlihan][1060] and [Deborah Frasher][1061] as well as the administrative interactions of [Dr. Houlihan] with subordinates and his approach to clinical leadership, specifically as these related to issues around the prescribing of controlled substances.[1062]

In addition, the VA OIG looked for "any concerns by federal and municipal law enforcement authorities or other signals of drug diversion related to the practices of [Dr. Houlihan] and [Deborah Frasher]."[1063] The VA OIG health care inspection team also reviewed "allegations of criminal activity" and "their efforts throughout the inspection were closely coordinated with the OIG's Criminal Investigation Division."[1064] These two references are the only mention of potential drug diversion or possible criminal activity in the VA OIG's report.

2. Complaints reviewed by the VA OIG

As explained in this staff report, the VA OIG reviewed multiple complaints from multiple sources over the course of multiple years during its health care inspection of the Tomah VAMC. The administrative closure specifically noted that the VA OIG compiled "various allegations" from a number of sources, including:

- A complaint made in March, 2011 by a facility social worker (with a corresponding VISN response in June, 2011 and a September, 2011 report from the VISN Chief Medical Officer (CMO) on remedial actions taken).
- Anonymous complaints made in August, 2011, via a letter sent to the OIG and Congressman Ron Kind of the U.S. House of Representatives.
- A physician at the facility in March, 2012, while the inspection was actively ongoing.
- Several anonymous respondents to an [employee] survey in May, 2012, that was conducted prior to a regularly scheduled [. . .] inspection [of the facility].[1065]

[1060] Identified as "Dr. Z" in the administrative closure.
[1061] Identified as "NP Y" in the administrative closure.
[1062] VA OIG TOMAH VAMC ADMINISTRATIVE CLOSURE, at 1.
[1063] *Id.*
[1064] *Id.* at 2.
[1065] *Id.* at 1.

3. Documents reviewed by the VA OIG

The VA OIG's administrative closure also listed the documents it reviewed during its health care inspection. As listed in the administrative closure, the VA OIG reviewed the following documents:

- Statement of Charges, Settlement Agreement and Final Order from [Iowa Board of Medical Examiners] concerning charges brought against [Dr. David Houlihan] shortly after his date of appointment to the VA.
- Letters from the [VISN 12] Director and the VISN 12 CMO.
- Five peer reviews, and correspondence from [Dr. Houlihan] to the Peer Review Oversight Committee and the VISN 12 regarding allegations made in March, 2011, and subsequent actions by VA management.
- Scope of practice documents and routine peer reviews for [nurse practitioner Deborah Frasher].
- OIG Master Case Index records of 19 cases at Tomah VAMC since 2009.
- Ten peer reviews of [Dr. Houlihan's] practice performed in November, 2009, along with minutes of a subsequent special session of the Peer Review Committee, and related correspondence between [Dr. Houlihan] and the Committee.
- Tomah VAMC police reports of overdoses/suspected overdoses over a three-year period.
- Reports on adverse drug reactions in patients treated by [Dr. Houlihan] and [Ms. Frasher] compiled by the Tomah VAMC pharmacy.
- Documents related to the suicide of a Tomah VAMC mental health professional [Dr. Kirkpatrick] immediately following termination of employment (memoranda, e-mail messages, Sheriff's Department reports, union representation records and related internal union correspondence).
- Documents related to the appeal of a terminated Tomah VAMC pharmacist [Dr. Noelle Johnson] to the [MSPB] (appellant's brief for MSPB jurisdiction, narrative of [Dr. Johnson's] experiences, supporting materials for decisions).
- Relevant [Tomah VAMC] [m]emoranda on pain management, chronic opioid use, and adverse drug event surveillance.
- VA/DoD Clinical Practice Guideline on Management of Opioid Therapy for Chronic Pain (May 2010).
- [The VA OIG] also requested Tomah VAMC police reports on sales of prescribed or illegal drugs on the Tomah VAMC campus in the preceding three years, but were told there have been no Uniform Offense Reports of such activities.[1066]

According to the administrative closure, the VA OIG queried its Master Case Index—the OIG's repository for case information—and reviewed 19 cases at the Tomah VAMC since

[1066] *Id.* at 2–3.

2009.[1067] As a part of Chairman Johnson's investigation, his staff asked the OIG to identify the 19 cases reviewed by the OIG during the Tomah VAMC inspection.[1068] The OIG Deputy Counselor Roy Fredrikson responded:

> When the Counselor's office reviewed these 19 cases, we discovered the complaints involved matters that were completely unrelated to the Committee's investigation. The topics of these cases include, threats of violence from Veterans, theft of property, pornography, potential loss or theft of patient medications during shipment, allegations of sexual assault, misappropriation of a Veteran's benefits by a family member, off campus misconduct, and quality of care (unrelated to the subject of the investigation), to name a few. None of these cases related to the opioid prescription practices at Tomah, or the conduct of Dr. Houlihan, or any other party connected with the OHI Administrative Closure. As the cases did not fall within Committee's stated scope of investigation, the inappropriate prescribing of controlled substances or abuse of authority at the Veterans' Affairs Medical Center in Tomah, we determined this material was not responsive.
>
> Please note, write-ups on MCI cases that were responsive to the scope identified by the Committee were provided at Bates 1389-1400. Also, the case above involving quality of care was accepted by OHI, and reported out under Case No. 10-02355-242 (September 8, 2010), which is available on our website.[1069]

When Chairman Johnson's staff interviewed Dr. John Daigh, the Assistant Inspector General for Healthcare Inspections, he described the OIG Master Case Index and the 19 Tomah cases. He stated:

> Q: Going back to the [administrative] closure, and page 2 specifically, there's 12 bulleted items of documents that OHI reviewed pursuant to this inspection.
>
> A: Mm-hmm.
>
> Q: Number 5 lists, "OIG master case index records of 19 cases at Tomah VAMC since 2009." Are those 19 cases all published reports and documents? Or is that just you've had 19 different allegations or hotlines come in and your team checked up—checked them at the OIG master case index file?

[1067] *Id.* at 2. The OIG Master Case Index is a corporate management information system that serves as a repository for OIG case files. *About the Office of Investigations*, DEP'T OF VETERANS AFFAIRS, OFFICE OF INSPECTOR GENERAL, http://www.va.gov/oig/about/investigations.asp.
[1068] E-mails between Majority Staff, HSGAC, and Staff, VA OIG (Mar. 16, 2016) (on file with the Committee).
[1069] *Id.*

A: I think that I'm going to—you'd have to ask [Dr.] Alan [Mallinger], who wrote this, but I think this is the number of cases on the various hotlines we've got, starting with the one that we sent out to the VISN that came back. I mean, that had a whole series of names attached. I don't remember how many cases were on that. And then there were cases attached with the couple of other hotlines we got about the same time that we decided to open the one that resulted in the admin closure. I think it's a summary of those names, is what I think it is. But you'd have to talk to Alan on that.[1070]

4. Patient charts and pharmacy information reviewed by the VA OIG

The VA OIG health care inspectors conducted two types of chart reviews: "general chart reviews" and "structured chart reviews."[1071] As described in the eleven-page administrative closure, the VA OIG team conducted "general chart reviews" based on the following metrics:

- Patients who were specifically identified in complainants' allegations.
- Patients who were included in June 2011 peer reviews of [Dr. Houlihan's] practice.
- A patient of [Deborah Frasher] who was identified by an informant to Tomah municipal police as being involved in drug diversion.
- Selected individuals from a list of the 100 patients at Tomah VAMC receiving the highest doses of opioids.[1072]

In addition, the VA OIG inspection team also conducted "structured chart reviews" based on the following metrics:

- All patients in the care of [Dr. Houlihan] and/or [Deborah Frasher] who were among the 100 patients at Tomah having the highest doses of opioids (32 cases).
- Patients on a list provided by the Tomah municipal police department of individuals suspected of drug crimes, who were receiving prescriptions for controlled substances from any provider at Tomah (24 cases; 15 were patients of [Dr. Houlihan] and/or [Deborah Frasher]).[1073]

During Chairman Johnson's investigation, his staff inquired about the difference between general chart reviews and structured chart reviews.[1074] Dr. Mallinger, the lead OIG inspector assigned to the health care inspection, explained that a general chart review entailed "going

[1070] Daigh Transcribed Interview, at 154-55.
[1071] VA OIG TOMAH VAMC ADMINISTRATIVE CLOSURE, at 3.
[1072] *Id.*
[1073] *Id.*
[1074] Mallinger 4/6/2016 Transcribed Interview, at 162–64.

through the chart and reading . . . the entries in the chart kind of in relation to the allegations [that] were made, trying to see if what's in the chart fits the allegations."[1075] The charts reviewed in the general chart review were "selected from a variety of sources."[1076] Dr. Mallinger explained:

> We had compiled a list of the 100 patients at Tomah who had the highest doses of opioids, and we took some patients that seemed like it might be fruitful to review their charts. There were some cases that had previously been reviewed by the VA Medical Center, and so we looked at some of those.[1077]

Conversely, in the structured chart reviews, Dr. Mallinger and Dr. Shepherd developed a list of questions and criteria that reviewers would answer with the data from the charts of Tomah VAMC veterans.[1078] The health care inspection team then solicited the assistance of other VA OIG personnel to review the charts and answer the questions with the data from the charts.[1079] Dr. Mallinger developed the questions with Dr. Shepherd to "get some specific information that we felt would be pertinent to the allegations" received by the VA OIG.[1080] The VA OIG health care inspectors devised the structured chart reviews as "a way we could get a team involved" to "address some specific aspects of the allegations."[1081] Dr. Mallinger and Dr. Shepherd "trained several staff members" who "basically went through the charts and . . . addressed the specific items that were in our questionnaire."[1082]

The VA OIG had two sources of patients for the structured chart reviews. One source was a "list of people that we got from the Tomah police, which is people who were suspected of being involved in drug crimes."[1083] VA OIG health care inspectors reviewed that list and "found the ones who were actually patients at the VA and who were actually taking prescribed opioids."[1084] The second source of patients came from a subset of the 100 top opioid recipients at the Tomah VAMC. Of those 100 patients, the VA OIG "pulled out all of the people on that list who were patients of either Dr. Houlihan or [Deborah Frasher]."[1085] Roughly one-third of those 100 patients "were attributable to one of those two physicians" and "20-some" charts were from the "police source."[1086] In total, the VA OIG reviewed approximately 46 charts as part of the structured chart reviews.[1087]

[1075] *Id.* at 162.
[1076] *Id.* at 163.
[1077] *Id.* at 163.
[1078] *Id.* at 162.
[1079] *Id.*
[1080] *Id.* at 163.
[1081] *Id.* at 162.
[1082] *Id.* at 162–63.
[1083] *Id.* at 163.
[1084] *Id.*
[1085] *Id.* at 163–64.
[1086] *Id.* at 164.
[1087] *Id.*

In addition, the VA OIG reviewed spreadsheets of pharmacy records from the Tomah VAMC. Specifically, the health care inspection team reviewed the following data:

- Early refills of controlled substances and antidepressants (for comparison) at Tomah VAMC over the period of January 1, 2011 to September 12, 2012.
- Total morphine equivalent amounts of opioids dispensed during FY 2012 in all VISN 12 facilities by site, provider, and patient.[1088]

5. Emails collected as a part of the VA OIG's health care inspection

The VA OIG health care inspection team also received emails from the Tomah VAMC and VISN 12 employees. As explained in the eleven-page administrative closure, the VA OIG "collected an e-mail dataset for review consisting of 227,532 unique e-mail messages and 859 associated files originating from 17 individuals."[1089] The administrative closure noted that the health care inspection team "searched terms that could signal potential drug seeking behavior, such as those related to early refills and urine drug screens, in order to assess what was being communicated about these topics, as well as what advice or instructions were being given."[1090] In addition, the VA OIG team "reviewed messages pertaining to specific individuals in cases where administrative/supervisory conflicts were reported to exist."[1091]

6. The VA OIG's site visit to the facility, interviews conducted, and consultants engaged

On August 22 and 23, 2012, VA OIG health care inspectors conducted a site visit at the Tomah VAMC. While on site, the health care inspectors "toured the outpatient pharmacy to assess security issues" alleged in the complaints received.[1092] The VA OIG team also met with the Tomah VAMC's Acting Chief Information Officer to "discuss obtaining e-mail files" that the VA OIG could not retrieve remotely.[1093]

VA OIG health care inspectors also conducted multiple interviews of Tomah VAMC and VISN 12 personnel as part of their inspection. Prior to the site visit, the VA OIG team conducted telephonic interviews, including:

[1088] VA OIG TOMAH VAMC ADMINISTRATIVE CLOSURE, at 3.
[1089] *Id.*
[1090] *Id.*
[1091] *Id.*
[1092] *Id.* at 4.
[1093] *Id.*

- The complainant in the case where he/she was not anonymous.[1094]
- Tomah and Milwaukee municipal police officials; a Diversion Investigator from the [DEA], United States Department of Justice.
- Current and former Tomah VAMC staff who were identified by complainants as having key information, including a nurse practitioner, a physician, and four pharmacists.
- The newly appointed Director of Tomah VAMC.[1095]

The administrative closure explained that during the VA OIG's site visit in August 2012, the health care inspectors interviewed the following individuals:

- The Tomah VAMC Associate Director Sandra Gregor (interviewed in place of the director, Mario DeSanctis, because he was ill);
- The "Chair of the Pharmacy and Therapeutics Committee";
- The "Director of the facility's Opioid Workgroup";
- Chief Roberto Obong;
- The Tomah VAMC's "Pharmacy Director";
- The "Outpatient Pharmacy Supervisor";
- "[T]wo clinical pharmacists";
- "[S]ix outpatient staff pharmacists";
- "[O]ne contract dispensing pharmacist";
- "[T]hree psychiatrists";
- "Two primary care physicians";
- "[A] physician's assistant";
- "[A] Human Resources specialist";
- Dr. David Houlihan; and
- Deborah Frasher.[1096]

Following the site visit, the VA OIG health care inspectors interviewed the "Medical Center Director, the Director of Human Resources, and the VISN Pharmacy Executive."[1097]

Throughout its health care inspection of the Tomah VAMC, the VA OIG also "engaged the assistance of three pharmacist consultants to assist [the VA OIG] in evaluating the clinical and administrative aspects of [Dr. Houlihan's] interactions with pharmacy staff and the staff's roles in facilitating patient safety and appropriately dispensing controlled substances."[1098] The

[1094] Some of the complainants that made allegations to the VA OIG hotline that formed the basis of the VA OIG's Tomah VAMC health care inspection made their complaints anonymously. In those cases, the VA OIG could not interview those complainants because they did not know their identities.
[1095] VA OIG TOMAH VAMC ADMINISTRATIVE CLOSURE, at 4.
[1096] *Id.*
[1097] *Id.*
[1098] *Id.*

consultants based their analyses on their review of the recordings of VA OIG interviews with four pharmacists who had previously left the Tomah VAMC.[1099]

D. The findings of the VA OIG's health care inspection

All told, as mentioned in the VA OIG's administrative closure, "[a] total of 32 specific allegations were made by [the VA OIG's] sources, several of which came to light at various points while the inspection was underway."[1100] The chart below summarizes the allegations the VA OIG reviewed as part of its health care inspection and indicates whether the VA OIG substantiated the allegation:

Allegation reviewed by the VA OIG	Substantiated or Unsubstantiated
"Tomah municipal and Milwaukee police departments made complaints about drug trafficking at the Tomah VAMC"[1101]	Unsubstantiated[1102]
"[A]t least five outpatient pharmacy staff left the facility in recent years."[1103]	Substantiated[1104]
"[Dr. Houlihan] was mismanaging a patient with complex regional pain syndrome by attempting to arrange an inappropriate above the knee amputation."[1105]	Unsubstantiated[1106]
"[A]buse of authority, intimidation and retaliation when staff question controlled substance prescription practices."[1107]	Unsubstantiated[1108]
"[N]egative urine drug screens (UDS) are not acted on and that controlled substances are still prescribed in the face of a negative UDS."[1109]	Substantiated[1110]

[1099] *Id.*
[1100] *Id.* at 1.
[1101] *Id.* at 4.
[1102] The VA OIG did note that the "Tomah police department reported suspicions that certain Tomah VAMC patients were misusing their prescribed controlled substances in various ways including drug diversion." *Id.* at 4-5.
[1103] *Id.* at 5.
[1104] The administrative closure highlighted why the pharmacists left the facility. *Id.*
[1105] *Id.*
[1106] *Id.*
[1107] *Id.*
[1108] The VA OIG explained that it did not substantiate the allegations "in the context of having obtained multiple contradictory facts and statement during the course of this inspection, often based on second or third hand accounts." The VA OIG added that while it did not substantiate this allegation, it found that "these are widely held beliefs and concerns among most pharmacy staff and some other staff." *Id.*
[1109] *Id.* at 6.

Allegation reviewed by the VA OIG	Substantiated or Unsubstantiated
"[O]pioid contracts are not being 'encouraged' by [Dr. Houlihan]."[1111]	Unsubstantiated[1112]
"Several allegations dealt with general over prescription of narcotics at the facility, and specifically alleged over prescription by [Dr. Houlihan] and [Deborah Frasher]."[1113]	Unsubstantiated "allegations that opioids were prescribed inappropriately to specific individuals or in inappropriate doses."[1114]
"'Opioids are contraindicated for PTSD, but this is part of [[Dr. Houlihan's]] treatment plan.'"[1115]	Unsubstantiated[1116]

The VA OIG's health care inspection of the Tomah VAMC either substantiated or unsubstantiated eight of the 32 allegations it analyzed.[1117] While the VA OIG made other findings, which are summarized below, its eleven-page administrative closure did not provide a clear summary of the allegations received and analyzed as part of the inspection. The other findings, for which the VA OIG offered no analysis, include:

[1110] The VA OIG found that of the 56 patients they reviewed in the structured chart review, 52 of them had at least one UDS between January 2009 and April 2012. The remaining four patients had no UDS done on that time, although all four of them were prescribed opioids. Of the 52 patients that did receive a UDS in that time period, there were 5 patients that received opioids in the face of a negative UDS. The VA OIG noted that in a general chart review of one of Deborah Frasher's patients, it found that "multiple negative UDS (i.e., UDS that did not show presence of prescribed medications) were not acted on." *Id.* Medical professionals give their patients on opioids and other potentially dangerous medications UDS to examine whether the patients are actually taking their prescribed medication(s). If a patient has a negative UDS, it may be indicative that they are not taking their prescribed medications. A negative test can influence how a doctor treats their patient, as well as may be an indication of potentially dangerous activities like drug diversion.

[1110] The VA OIG found that "48 of 56 patients in the structured medical record review had an opioid contract. Of the patients lacking opioid contracts, [Dr. Houlihan] was a primary prescriber of opioids for none, and [Deborah Frasher was the primary prescriber of opioids for two." *Id.*

[1111] *Id.*

[1112] The VA OIG found that "48 of 56 patients in the structured medical record review had an opioid contract. Of the patients lacking opioid contracts, [Dr. Houlihan] was a primary prescriber of opioids for none, and [Deborah Frasher was the primary prescriber of opioids for two." *Id.*

[1113] *Id.*

[1114] The VA OIG noted that the "appropriateness of prescribing opioids to a particular patient or the appropriateness of a particular dose utilized is a complex matter that must take into account the patient's history, current medical and psychiatric status, social situation and other factors. The clinical decision making underlying this process is based on the practitioner's clinical judgment and other factors that vary from patient to patient." It was in this context that the VA OIG unsubstantiated the allegations with respect to opioid over prescription. *Id.* at 6–7.

[1115] *Id.* at 9.

[1116] The VA OIG's review of patient records, emails, and interviews "did not find documentation that opioids were being used to treat PTSD. In each case, medical record review indicated a history of a pain related condition and use of opioids for treatment of pain." *Id.* at 9.

[1117] *See id.*

- The Tomah VAMC Chief of Pharmacy reported to Dr. Houlihan "by virtue of his [Dr. Houlihan's] administrative leadership position.[1118]
- "[S]ome patients at Tomah VAMC had a pattern of early refill requests, which can be a potential risk behavior for substance abuse. Pharmacists expressed a reluctance to question such early refills."[1119]
    - A review of pharmacy data showed that Dr. Houlihan, Deborah Frasher and other clinicians at the Tomah VAMC "provided more than 7 days early controlled substance refills."[1120]
    - Prior to April 12, 2012, the Tomah VAMC had a policy that did not allow exceptions to the facility's "no early refill rule." However, the policy in place when the VA OIG investigated the Tomah VAMC did not forbid exceptions to the no early refill rule, nor did it "provide practical guidance, parameters, or processes by which to approach early refills or navigate the clinical complexity of such exceptions."[1121]
- The amounts of opioids prescribed by Dr. Houlihan and Deborah Frasher "in aggregate and to individual patients were at considerable variance compared with most opioid prescribers in VISN 12."[1122]
- "Although the allegations dealing with general overuse of narcotics at the facility may have had some merit, they do not constitute proof of wrongdoing."[1123]
- The VA OIG "did not find any conclusive evidence affirming criminal activity, gross clinical incompetence or negligence, or administrative practices that were illegal or violated personnel policies."[1124]
- "It would seem more clinically appropriate" for complex patients on "unconventional" treatment regimens "to be treated by a specialist or subspecialist in their particular condition, rather than a nurse practitioner or physician's assistant."[1125]
- The VA OIG noted "concern" over the "dysfunction of multidisciplinary collaboration in patient care," especially between the pharmacy and Dr. Houlihan. The OIG found that the Tomah VAMC "appeared to be at a functional impasse with respect to such collaboration."[1126]
    - The Tomah VAMC pharmacists interviewed by the OIG "uniformly indicated that they were reluctant to question any prescription ordered by [Dr. Houlihan] or any aberrant behavior by his patients (for example, frequent requests for early refills)

[1118] *Id.* at 6.
[1119] *Id.*
[1120] *Id.*
[1121] *Id.*
[1122] *Id.* at 7.
[1123] *Id.* at 9
[1124] *Id.*
[1125] The VA OIG added that effective collaboration between providers and pharmacists "provides a system of checks and balances that reduces medication errors and enhances general patient safety, and is especially important in this setting [the Tomah VAMC] given the quantities and dosage of opioids that are being utilized in seriously ill patients." *Id.* at 9–10.
[1126] *Id.* at 10.

because they feared reprisal, even though most of them could not give a first-hand account of negative actions toward them by [Dr. Houlihan]."[1127]

- The fact that the Tomah VAMC Chief of Pharmacy reported to Dr. Houlihan, as Tomah VAMC Chief of Staff, "may complicate the perception that "[Dr. Houlihan] misuses his authority to compel acquiescence with his clinical decisions."[1128]
- On the other hand, Dr. Houlihan "complained that pharmacists (except for one) were unwilling to approach him with problems or concerns and were uninterested in learning more about his treatment approach and rationale."[1129]

The VA OIG offered five "suggestions that should be brought to the attention of the facility Director and VISN management . . . ." The VA OIG's suggested:

- The facility Director should implement a vehicle by which clinicians and staff can openly and constructively communicate concerns and rationale when disagreements arise concerning dispensing of opioid prescriptions.
- The facility Director should review the reporting structure in the context of safeguarding bi-directional clinical discourse from actual or perceived administrative constraint.
- The facility Director should ensure development of guidance, parameters, processes, or a specialty clinic based mechanism to assist clinicians and staff with managing complex patients requesting early opioid refills.
- The facility Director should consider some variant of the tumor board model as one potential avenue by which to foster collaborative interdisciplinary management when presented with very complex clinical pain cases.
- The VISN should conduct further evaluation and monitoring of relative and case-specific opioid prescribing at Tomah V AMC on both a facility and individual clinician level.[1130]

E. Deficiencies in the VA OIG's health care inspection of the Tomah VAMC and its administrative closure

1. The VA OIG appears to have no clear standards for substantiating allegations

i. The findings of the VA OIG's health care inspection of the Tomah VAMC

The VA OIG's analysis of the problems at the Tomah VAMC demonstrates that the VA OIG lacks clear standards for substantiating allegations. Throughout interviews with Chairman

[1127] *Id.*
[1128] *Id.*
[1129] *Id.*
[1130] *Id.* at 10–11.

Johnson's staff, VA OIG officials were unable to articulate a clear and straightforward standard for substantiation. The result is an arbitrary process that threatens to limit OIG independence.

During a transcribed interview of Dr. Daigh, Chairman Johnson's staff asked him about the standard for substantiating an allegation reviewed by the VA OIG Office of Healthcare Inspection. Dr. Daigh was unable to provide a concise answer on how the office substantiates allegations. Instead, Dr. Daigh answered the question by applying the amorphous standards to the Tomah VAMC inspection. When Chairman Johnson's staff tried to get a clear answer on the substantiation standards, VA OIG counsel interjected and again spoke about the Tomah VAMC allegations. VA OIG counsel later objected to subsequent efforts by Chairman Johnson's staff to understand how the Office of Healthcare Inspections substantiated allegations. Dr. Daigh stated:

Q: What is the standard for substantiating an allegation in [the Office of Healthcare Inspections]?

A: Well, you have to—I mean, if—so in this particular—let's talk about this particular case. We reviewed—Alan reviewed medical records for a good number of cases, reviewed the peer reviews for those cases, talked to providers about those cases, and came to the conclusion that the practice, as written down on those cases, was within the standard. So if you're going to talk about—I mean, you have to have some evidence to support that Johnny committed suicide because—because his boss wasn't nice to him. Is there any evidence to support that? We couldn't find any evidence to support that. I mean, when we look in the record, was—was there, in fact, a plan to cut off a gentleman's leg because he had pain? We couldn't find any evidence to support that allegation.

When people said there was a possible crime, Alan went to the end of the world to find those people who might be able to provide data to support that a drug transaction went down here or there or that somebody was doing this or that, and it just was all rumor, it just never materialized into anything that we could get our hands on.

When I talked—and I—when I talked—well, so we were unable to get any hard evidence for the many, many things that we heard were said to be wrong and associated with Candy Man. Had we been able to, we would have some evidence.

Q: So when you're deciding whether or not to substantiate an allegation, is more likely than not to have occurred the standard or is it a higher standard than that?

A: It's some hard evidence that is believable that an event occurred. So if somebody just says something happened, that would not likely be enough to support it unless multiple people in the conversation agreed that that's what happened.

Q: Can you put a number, a percentage of certainty?

A: I would—well, it's—I've never really thought about it in those terms, but it has to—it has to have—there has to be at least some meat on the bones to suggest that there is data to support what's being said. And so we looked at emails, we talked to DEA, we talked to all the police officers up there, right? Tomah police, VA Tomah police, the Milwaukee police. We heard people talk about things; you know, citizens made allegations. We go to talk to people who are supposed to be part of those transactions, and everything melts away. So we had a lot of rumors, but after rumor, I couldn't go beyond rumor.

Q: So—

VA OIG
Attorney: Can I ask one quick clarifying question? Maybe we can just get to the—you're trying to get to a level of evidence or something—that's what it seems to me. I would ask: Was there any evidence of the allegations, of the salacious allegations that you're talking about, cutting the legs off, a drug transaction—I think we were talking about an extramarital affair. Did you find any evidence to support that?

Q: I'm not asking that. I'm asking the operations of the Office of Healthcare Inspections. You guys review a lot of hotlines—

A: We do.

Q: —that include a lot of allegations.

A: Right.

Q: And I'm trying to figure out what the standard of the office is to substantiate or not substantiate an allegation.

VA OIG
Attorney: You asked for a percentage, which suggested that you were looking at was it a close call. And I think the question was, was it even a close call in this case, which would be a little bit different than—standards are—standards are all—you know, you can have preponderance of the

evidence. You can have another one. But it's still a judgment call in the end. So you were asking him what percentage, and I think there's a difference between it was 49-51, or, you know, 50-50 versus there wasn't any. So I think that's why [VA OIG Attorney] asked the question.

A: It's usually not a difficult call. It's usually straightforward. Right? I mean, you have an allegation. We can almost always find data to support the allegation was true or is not true. This hotline was extremely difficult, and it took a great deal of time, because everyone we talked to—or not everyone. Many of the people we talked to said things that, when you actually said, "Okay, if that's true, let me go see this," it all just melted away.

So would it be that when people said a transaction occurred we could find evidence of it, would it be that the police had provided something, would it be that the DEA had said something, would it be that we had something—a fact—that I could write about, then we would have written about it. But we really could not find the evidence to support these things. And so—so that's why I made the decision I did.

Q: And so—so everything is—determining whether or not to substantiate an individual allegation is your decision when these hotlines come in and a product is developed?

A: I would say that it's usually pretty straightforward. The person who writes the report—I mean, you've read the admin closure. The admin closure, you know, basically doesn't support the allegations that were made. And in the same way a draft would lay out data, an argument by which you would decide yes or no, and then you'd say we support it or we don't support it, or there's not enough data to support it. They're sort of the three possibilities. And in this report, there was not the data to support those allegations.

Q: Did Dr. Mallinger substantiate any allegations in this first draft that were then unsubstantiated in the final admin closure?

A: I don't know the answer to that.

VA OIG Attorney: And we would object to that because now you're getting into the deliberative process. We already talked about—we've already said on

a number of occasions we're not going to discuss drafts and what was in drafts.[1131]

During his transcribed interview, Dr. Wesley also provided an equally imprecise answer on what standards the Office of Healthcare Inspections uses when deciding whether to substantiate an allegation. Dr. Wesley stated that when he is looking whether to substantiate an allegation, he looks for "solid evidence." Of course, "solid evidence"—like Dr. Daigh's use of the term "hard evidence"—is a subjective and means different things to different people. Dr. Wesley stated:

Q: Dr. Wesley, just a couple questions. One thing we've been trying to get a little bit more information on is the standard that the IG's office uses for substantiating allegations. We've interviewed Dr. Mallinger and other folks at the IG's office, and we've heard, you know, it's a high standard; we've heard a number of different things. I'm just wondering, from your perspective, is there a set standard at the IG's office for substantiating allegations? Or from your perspective, what is the standard?

A: Sure. First of all, it's not a court, so we don't think in terms of beyond a reasonable doubt or even 51 percent in preponderance of the evidence.

Having said that, when I ask my staff to do these, I think—I do think in terms of is there solid evidence that substantiates something—I look for solid evidence. I don't think there's a scale like in a court case, but if there's solid evidence that affirms or proves an allegation, that's the standard I use.

Q: From your knowledge, is that standard in writing anywhere? We've also heard mixed things. Is that in the handbook? Is that clearly communicated to the doctors? For example, did Dr. Mallinger know in this case what the standard was for substantiating allegations? That's two questions. Sorry.

A: Did Dr. Mallinger know? I don't know. It's—it's communicated more by, again, is there solid evidence, and that's certainly made clear to—I certainly make that clear to all of my physicians and all of the regional offices. Because I've done this so long, I teach this. I've trained a couple generations on how to do these hotlines. I would say the standard is find—lay out all the evidence, but, A, is there solid

[1131] Daigh Transcribed Interview, at 96–101.

evidence? I suppose if there's a battle between evidence, I would go towards preponderance of the evidence.

In general—well, I'll tell you, in practical, real terms, you tend to either find evidence that says yea or find evidence that refutes the allegation. That's how it works in practical terms. It ends up being fairly black and white once you're out in the field and once you do these cases.

Q: Is this in writing anywhere, what you just kind of laid out, within the office—

A: There may be some better descriptions in writing. I don't have them at my fingertips.

Q: Okay. Do you have any—if it's not in writing, would there be any objection to having kind of a formal policy that talks about standards of evidence in writing at the—

A: Not at all, and as I say, there may well be. If there are, I'm just not—I'm not as conversant as I—I'm not conversant in it.[1132]

Likewise, Chairman Johnson's staff questioned Dr. Mallinger about the VA OIG's standards for substantiating allegations. Dr. Mallinger was new to the Office of Healthcare Inspections when he was assigned the Tomah VAMC inspection. Prior to joining the VA OIG, he had spent years in academia, conducting research to further his scholarship in psychiatry. Dr. Mallinger spoke to about the differences in conducting scientific research versus substantiating allegations at the VA OIG. He explained:

As far as, you know, what I learned, well, you know, what we do in health care inspections is very different from the way things are done in the world of medicine and science, if you will. And there's some actually very fundamental differences.

For example, as a scientist—and I spent quite a bit of my career doing this—when we do research and we talk about our results, we talk about them in terms of 95 percent certainty, and we do statistical analyses that sort of establish that. So any given piece of scientific research that you see, even if you read about it in the *New York Times*, there's really a one out of 20 chance that it's totally wrong. And in science, the way that's dealt with is through a process that we call replication; that is—and this is one of the problems. You know, like the health—you read the

[1132] Wesley Transcribed Interview, at 204–06.

newspaper, and you find out, you know, what's going on in health care, and it changes every—well, this is why, because you do one study and it's 95 percent certain. It requires what we call replication. It requires another group to do a similar study and to come up with comparable findings. And then you can start to believe things basically as being true.

So that's kind of one way of collecting data and analyzing data. It's very different in the IG. It's—you know, we approach things much more the way attorneys would approach them. You know, we gather evidence. We use the evidence to establish facts, and we basically apply reasoning to those facts and draw conclusions. So it's a totally different process, and that was a process that I had learned it had existed and then learned how to do it.

So another way that's very different is, you know, like in science, you know, we feel pretty good if we are 95 percent certain that something is right. We'll go to a meeting and talk about it and present it and be very enthusiastic. And in the IG, it's very different. You know, we're held to a much higher standard of evidence. So, you know, that evidence and those facts and that reasoning all have to be very airtight and have to—you know, I don't know that there's such a thing as 100 percent certainty, but they have to be as certain as it's possible to be, because nobody's going to replicate our work. It has to be right the first time, so the standard of evidence is much higher.[1133]

Because Dr. Mallinger explained that within the VA OIG, health care inspectors needed a "much higher" standard of evidence than the 95 percent certainty in the scientific and academic worlds, Chairman Johnson's staff asked what metrics the VA OIG uses to substantiate an allegation. In response, Dr. Mallinger also spoke about challenges he faced when he first joined the VA OIG in properly assessing the office's standards for substantiating allegations. He stated:

Q: You got into this a little bit earlier. Can you quantify what percentage of certainty you would need to substantiate an allegation? So you said—you talked about having an academic role in science, you know, your findings and your research is done within a 95 percent chance of—you know, percent chance of certainty. What percentage threshold do you have to cross to substantiate an allegation?

A: Well, so here's the thing: When I say 95 percent certainty, I can say that with certainty because the appropriate statistical analyses have been done, and, you know, by agreement of people who've developed these mathematical models, we can say that we—we basically establish that ourselves. We test the data in such a way that we only

[1133] Mallinger 3/8/2016 Transcribed Interview, at 14–16 (emphasis added).

draw a conclusion if it might be wrong one out of 20 times. So I can say that exactly—

Q: A quick clarifying question. So 95 percent certainty is sort of a best practices developed within scientific and academia world as—

A: That's the standard in the scientific world.

Q: —as acceptable—okay. Sorry. Continue. Thank you for that clarification.

A: Sure. Not to say you wouldn't like to have it better, and sometimes it is better. But, generally, if it's below 95 percent, it's hard to make the argument. We don't have—I can't tell you that. You know, I don't have a statistical test that tells me how certain I am of the information to the IG. I can just tell you that it's—you know, we have to be as sure as you can be.

Q: So as a senior physician within the Office of Healthcare Inspections, when you're doing the inspection, you're the one that's substantiating or not substantiating the allegations. Correct?

A: Well, not the one. This is a process of the group working together with a lot of supervision.

Q: So what standards do you implement then to determine whether or not an allegation is substantiated or not?

A: Well, I have to feel that the facts that have been established conclusively show that the allegation is true.

Q: Are we talking more likely than not?

A: No. We are talking a much higher standard than that.

Q: Okay. And would you be able to put a number on it to quantify a percentage?

A: I don't know how I would. Like where would the number come from? I would have to make it up.

Q: Well, right. I'm just trying to figure out what sort of threshold, you know, you as a person that does this established for yourself to

determine where you feel comfortable substantiating an allegation or—

A: Well, it's kind of like—it doesn't really work like that. You know, it's—you know, these are things that we discuss versus a team, and then depending on the case, with the various levels of supervision, and so, you know, through a process of—in other words, if I think something is either substantiated or not substantiated, I have to present it to—again, depending on the case, it could be to Dr. Wesley. It could be at the staff meeting to Dr. Daigh. It could be to Dr. Shepherd. And we have to discuss it. And then, you know, ultimately, when we had an IG, that person had to approve it, too. It's—it's—I guess you could say it's a process of consensus more so than being able to apply—you can't calculate a number like you could with a statistical model.

Q: Is there any guidance from a central office within the IG on sort of establishing those best practices to substantiate allegations? Or is it more done on a case-by-case, allegation-by-allegation basis?

A: I think it's case-by-case. And I have to tell you, when I started in the IG, I was more inclined to kind of believe things were established and had to learn how high the standard of evidence was. That was part of the learning process. It's a very high standard of evidence that's applied in the IG.

Q: What do you mean by learning—you believe—

A: Through the process of consensus to presenting it to my bosses and having them say, "Well, are you sure?" You know, "Why are you sure?"

Q: I was more referring to—you said you were more likely to believe that things were established. I'm paraphrasing here. Can you kind of elaborate on what you mean by that?

A: I guess what I would say is, again, this is—my personal inclination might have been to accept a lower standard of evidence.

Q: Understood.

A: But as I—through this process of learning how to do my job, I came to understand what a high standard of evidence is.[1134]

As these excerpts demonstrate, the standard for substantiation within the VA OIG Office of Healthcare Inspection is very unclear. Three separate employees of VA OIG—at three separate levels—were unable to clearly articulate what standards the office uses to substantiate an allegation. The differing standards, depending on the inspector, range from a mere preponderance of evidence supporting the allegation to a standard upward of 95 percent certainty. This lack of clarity allows for the apparent arbitrary application of subjective standards that can be molded depending on the inspection. As a result, complainants can potentially receive unequal analysis of their complaints when they refer matters to the VA OIG.

ii. The findings of the VA OIG's health care inspection into the death of Thomas Baer

The VA OIG's selective and arbitrary substantiation of allegations is also illustrated in its health care inspection into the care that veteran Thomas Baer received at the Tomah VAMC in January 2015. In January 2015, Candace Delis contacted Chairman Johnson's staff regarding the treatment of her father, Thomas Baer, at the Tomah VAMC on January 12, 2015. Ms. Delis informed Chairman Johnson's staff that she brought her father to the Tomah VAMC urgent care facility on January 12, 2015. The family waited over two hours to be seen by a physician and during that time, Mr. Baer suffered a stroke in the Tomah VAMC urgent care center. After the first stroke, Mr. Baer underwent an electrocardiogram and a chest x-ray, but the facility's CT scan machine was unavailable because it was undergoing "routine, preventative maintenance."[1135] Soon after, Mr. Baer suffered a massive stroke.

Tomah VAMC staff informed Ms. Delis that the hospital lacked the necessary equipment to properly treat Mr. Baer and that he would be transported to another hospital. There was no helicopter available to transport Mr. Baer and he was transported roughly 45 minutes via ambulance to Gundersen Lutheran Medical Center in La Crosse, Wisconsin.[1136] At Gundersen, Mr. Baer underwent emergency surgery to remove a blood clot in his artery.[1137] Mr. Baer never regained consciousness and he passed away on January 14, 2015.[1138]

[1134] *Id.* at 17–21.
[1135] Letter from Dr. Carolyn M. Clancy, Interim Under Secretary for Health, Dep't of Veterans Affairs, to Hon. Ron Johnson, Chairman, S. Comm. on Homeland Sec. & Governmental Affairs, at 3 (Mar. 9, 2015) [hereinafter 3/9/2015 Letter from Dr. Clancy, VA, to Chairman Johnson, HSGAC].
[1136] VA OIG, Office of Healthcare Inspections, Report No. 15-02456-396, Healthcare Inspection: Care of an Urgent Care Clinic Patient Tomah VAMC, at 15 (2015) [hereinafter VA OIG Report: Thomas Baer].
[1137] *Tomah VAMC: Examining Quality, Access, and Culture of Overreliance on High-Risk Medications, Joint Field Hearing Before S. Comm. on Homeland Sec. & Governmental Affairs & H. Comm. on Veterans Affairs* 114th Cong. (2015) (statement of Candace Delis, daughter of Thomas Baer, at 2).
[1138] *Obituary: Thomas P. Baer*, LEGACY.COM, http://www.legacy.com/obituaries/marshfieldnewsherald/obituary.aspx?pid=173936994.

Pursuant to a request by Chairman Johnson and Senator Baldwin, the VA OIG conducted a health care inspection of Mr. Baer's treatment at the Tomah VAMC.[1139] The VA OIG's inspection largely cleared the medical center of any wrongdoing.[1140] However, the VA OIG separated out the allegations in a manner that allowed it to take a selective and literal interpretation of the allegations.

For example, the VA OIG's review of Mr. Baer's care did not substantiate the allegation that Mr. Baer "waited 3 hours to be seen."[1141] The report noted that Mr. Baer was not seen by a doctor for a considerable period of time—approximately 2 hours and 16 minutes after he was checked in to the urgent care clinic.[1142] However, because this otherwise lengthy period fell 46 minutes short of the precise 3-hour period alleged by Mr. Baer's family, the VA OIG did not substantiate the allegation.[1143]

Likewise, the VA OIG did not substantiate the Baer family's allegation that the CT scanner at the Tomah VAMC was "broken" on January 12, 2015.[1144] The VA OIG found, instead, that the CT scanner was "unavailable for use due to routine maintenance at the time . . . ."[1145] The VA OIG, again, in taking an overly literal interpretation of the allegations, discounted criticism about the facility. Whether the CT scan machine was "broken" or "unavailable . . . due to routine maintenance," the tool was not operational when Mr. Baer needed it.

In addition, the OIG separated out Ms. Delis and her mother's account of how the Tomah VAMC staff reacted to Mr. Baer's first stroke into three separate allegations. In breaking out the allegation in this manner, the VA OIG ultimately concluded "that, overall, the [urgent care center] staff acted appropriately in the face of a patient experiencing a sudden and unexpected acute ischemic stroke while waiting for a mental health evaluation in a rural hospital that is not equipped to treat a health problem of this magnitude."[1146]

The Baer family filed an administrative claim against the VA for the care Mr. Baer received at the Tomah VAMC. As part of their claim, the family hired Dr. Lisa Nee, an interventional cardiologist, to provide an expert evaluation of Mr. Baer's care at the Tomah VAMC. Dr. Nee has "extensive experience and training in the diagnosis, treatment and intervention of cerebral vascular disease including acute ischemic stroke."[1147] Dr. Nee identified significant concerns with both Mr. Baer's treatment at the Tomah VAMC and with the VA

[1139] VA OIG Report: Thomas Baer, at i.
[1140] *Id.*
[1141] *Id.* at 16.
[1142] *Id.*
[1143] *Id.*
[1144] *Id.* at 18.
[1145] *Id.*
[1146] *Id.* at 25.
[1147] Lisa Nee, Krause Law, PLLC, Report on Thomas Baer Stroke, Expert Opinion, at 1 (Oct. 30, 2015) [hereinafter Nee Expert Opinion].

OIG's evaluation of Mr. Baer's treatment at the Tomah VAMC urgent care center. The findings of Dr. Nee call into question the VA OIG's standards for substantiating allegations.

Dr. Nee's analysis raises serious concerns with how the Tomah VAMC's initial triage of Mr. Baer may have contributed to his fatal outcome. As the VA OIG report and Dr. Nee's analysis note, the Baer family called the Tomah VAMC at approximately 9:00 a.m. on January 12, 2015.[1148] A member of the Baer family allegedly informed the nurse at the Tomah VAMC that Mr. Baer "generally was not feeling or sleeping well, had balance problems, shortness of breath, and disorientation."[1149] The nurse, however, told the VA OIG that she "had no recollection of being told of respiratory distress, and stated that had she been so informed, she would not have directed the family to take the patient to Tomah VAMC."[1150] The note in Mr. Baer's medical files that document the 9:20 a.m. phone call apparently made no mention of Mr. Baer's respiratory distress or balance problems.[1151]

This factual dispute is vital in determining the potential culpability of the Tomah VAMC in Mr. Baer's care. It appears that the VA OIG, for unknown reasons, credited the account of the nurse and the medical record over the statements of the Baer family. If the Baer family did inform the Tomah VAMC nurse on the phone of Mr. Baer's difficulty breathing and balance issues, Dr. Nee noted that the nurse would have violated the Tomah VAMC policy of referring patients with "acute illness and difficulty breathing" to the nearest emergency department.[1152]

Both the VA OIG and Dr. Nee noted that in the approximately 90-minute drive from the Baer family home to the Tomah VAMC, Mr. Baer's condition deteriorated.[1153] When the family arrived at the facility, Mr. Baer required a wheelchair to get into the urgent care clinic.[1154] Both the VA OIG and Dr. Nee noted that the Baer family informed the "clerical employee" at check in that Mr. Baer was presenting the symptoms of "generally not feeling well, balance problems, shortness of breath, disorientation, and insomnia."[1155] Dr. Nee's opinion states that "this acute change in neurologic status should have signaled to medical staff that the patient required immediate assessment and emergent physician evaluation. This event is in all likelihood Time Zero for symptom onset of Acute Ischemic Stroke (AIS)."[1156]

[1148] VA OIG Report: Thomas Baer, at 11; Nee Expert Opinion, at 5.
[1149] VA OIG Report: Thomas Baer, at 11.
[1150] *Id.*
[1151] *Id.*
[1152] Nee Expert Opinion, at 5.
[1153] VA OIG Report: Thomas Baer, at 11; Nee Expert Opinion, at 6.
[1154] Nee Expert Opinion, at 6.
[1155] VA OIG Report: Thomas Baer, at 11
[1156] Nee Expert Opinion, at 6. "Time Zero" refers to the last known time where the patient's neurological status was normal. *Step 2: ACLS Stroke Protocol*, ACLS-ALGORITHMS.COM, https://acls-algorithms.com/adult-stroke-algorithm/acls-stroke-protocol-step-2/.

Dr. Nee wrote that after Mr. Baer arrived at the Tomah VAMC urgent care clinic, he "waited 60 minutes for triage."[1157] She added that "there is no documentation from Tomah VAMC records that any neurologic assessment was conducted at this time."[1158]

According to Dr. Nee, the Tomah VAMC's failure to initially determine the neurological issues with Mr. Baer created a domino effect in which subsequent ineffective triage and treatment methods delayed the treatment of Mr. Baer's stroke-like symptoms.[1159] Dr. Nee wrote that "the combination of improper triage and lack of recognition of urgent clinical symptomatology resulted in delay of care for this patient displaying symptoms concerning for AIS."[1160] Dr. Nee explained:

> The OIG Report states the patient checked in at the UCC front desk at 11:09 AM with symptoms of weakness (requiring a wheelchair) shortness of breath and new onset disorientation. Each of these symptoms requires further investigation; collectively they are a red flag for an acute neurological event. There is no further investigation into these symptoms by either a medical nurse or physician and no neurologic exam is noted in the record. Due to the fact the patient had neurologic deviations from his baseline upon presentation to the UCC, Time Zero (T0) for the subsequent AIS [major stroke] will be determined to be 11:09 AM for the remainder of this report. **Nothing in the record indicates Tomah VAMC attempted to ascertain "Time Zero" at any point.** Some VAMC facilities utilize tools like the Cincinnati Prehospital Stroke Scale (CPSS) when a patient arrives with similar symptoms as Mr. Baer's. Failing to ascertain Time Zero is a deviation from the standard of care and puts any patient at unnecessary risk of permanent injury or death from stroke
>
> Because there was improper triage and failure to diagnose a possible acute neurologic event, the patient was assigned Emergency Severity Index 4 (ESI Level 4). His vital signs were documented at 12:11 PM and never repeated until 3:15 PM, however they were copied and pasted into multiple notes, which is a violation of VHA documentation policy. It also violates the Tomah VAMC Memorandum which states ESI Level 4 patients should have monitoring and documentation hourly by an RN. **Vitals were not taken every hour as required.** Given the symptoms indicated in the EHR [electronic health record] by 12:11 PM, the patient should have received an ESI Level 2, which would have accelerated the speed of his case and resources available to him.[1161]

[1157] Nee Expert Opinion, at 6.
[1158] *Id.*
[1159] *See id.* at 6–7.
[1160] *Id.* at 11.
[1161] *Id.*

Dr. Nee also noted concerns with the Tomah VAMC's scheduled maintenance of the facility's only CT scanner during Mr. Baer's time in the urgent care clinic. She explained that "maintenance records show that at 1:30 PM, Tomah VAMC contractors started their preventative maintenance on the CT machine, originally scheduled for January 2, 2015."[1162] Mr. Baer suffered his first episode, the "mini" or "warning" stroke, *five minutes before* maintenance began on the CT machine.[1163] As she noted, a correct diagnosis of Mr. Baer's mini stroke "likely would have resulted in Mr. Baer being rushed to get a stat CT scan before the machine was shut down for scheduled maintenance."[1164]

Dr. Nee's expert opinion provides valuable insight on whether Mr. Baer's treatment at the Tomah VAMC on January 12, 2015 met the standard of care. Her perspective as a medical professional with experience in treating stroke and other related ailments levies concerns with the VA OIG's medical conclusions in its review of Mr. Baer's care. The VA OIG's review of Mr. Baer's care shows how the OIG applied an overly literal reading of allegations to unsubstantiate claims relating to a deficient standard of care.

2. The VA OIG selectively focused its inspection and seemed to ignore other potential problems found during the course of the inspection

The VA OIG narrowly and selectively focused on the allegations it received, sometimes to the exclusion of other issues it uncovered during the course of the inspection. It appears that the VA OIG did not pursue issues it uncovered during the course of the inspection unless the issue was directly on point with the precise language of an allegation it received in the hotline. Leads were not followed up on, and opportunities for improvement were missed.

i. The VA OIG appears to not have fully examined allegations of potential drug use by Tomah VAMC medical providers

During its site visit to the Tomah VAMC, VA OIG officials interviewed both Dr. Houlihan and Deborah Frasher. During the interviews, both OIG physicians and Special Agent Porter of the VA OIG's criminal division observed that Dr. Houlihan and Ms. Frasher appeared to be impaired. Documents show that the VA OIG health care inspectors noted their concerns to their superiors and the Counselor to the Inspector General Maureen Regan. They also informed the facility director, Mario DeSanctis, of their concerns. Despite these observations, the VA OIG failed to follow up with Tomah VAMC management about their concerns, and the eleven-page administrative closure made no reference to the observations that Dr. Houlihan and Ms. Frasher were impaired at the time of their interviews with the VA OIG.

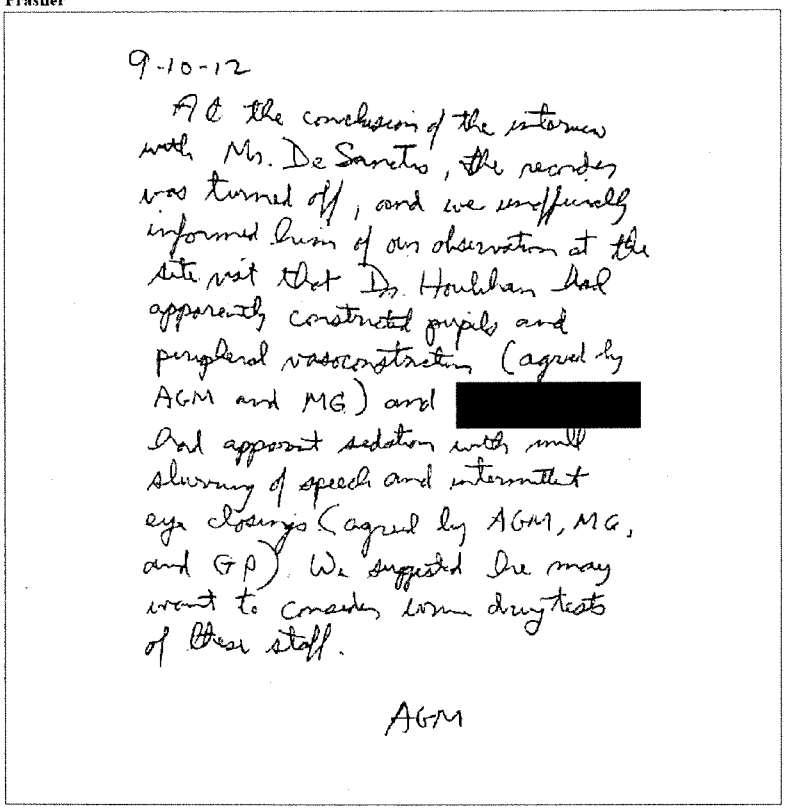
[1162] *Id.* at 6.
[1163] *Id.*
[1164] *Id.* at 6–7.

As a part of Chairman Johnson's requests for documents, the Committee received a handwritten note penned by Dr. Mallinger and dated September 10, 2012. The note read:

> At the conclusion of the interview with Mr. DeSanctis, the recorder was turned off, and we unofficially informed him of our observation at the site visit that Dr. Houlihan had apparently constricted pupils and peripheral vasoconstriction (agreed by AGM and MG) and [Redacted] had apparent sedation with small slurring of speech and intermittent eye closings (agreed by AGM, MG, and GP). We suggested he may want to order some drug tests of the staff.[1165]

[1165] Handwritten Note from Alan Mallinger (Sept. 10, 2012), at OIG 12364.

Figure 89: Dr. Mallinger's handwritten note about potential impairment of Dr. Houlihan and Ms. Frasher[1166]



9-10-12

At the conclusion of the interview with Ms. De Sanctis, the recorder was turned off, and we unofficially informed them of our observation at the site visit that Dr. Houlihan had apparently constricted pupils and peripheral vasoconstriction (agreed by AGM and MG) and [redacted] had apparent sedation with mild slurring of speech and intermittent eye closure (agreed by AGM, MG, and GP). We suggested she may want to consider urine drug tests of these staff.

AGM

During the Committee's interview with Special Agent Porter, Maureen Regan, Counselor to the VA Inspector General, confirmed to Chairman Johnson's staff that the redacted individual in Dr. Mallinger's handwritten note was Nurse Practitioner, Deborah Frasher.[1167]

Chairman Johnson's staff asked both Special Agent Porter and Dr. Mallinger about their observations of Dr. Houlihan and Ms. Frasher. In their interviews, both Special Agent Porter

[1166] *Id.*

[1167] Porter Transcribed Interview, at 112.

and Dr. Malinger downplayed the seriousness of their observations of Dr. Houlihan and Ms. Frasher. For example, Special Agent Porter stated:

> Q: Do you recall having these discussions about the—the signs that—that Dr. Houlihan and Deb Frasher appeared to be under the influence of some sort of drugs?
>
> A: Yes, I do recall that.
>
> Q: Can you elaborate on—on what those discussions were?
>
> A: Sure. It—I don't know who brought it up, if it was Dr. Mallinger or Dr. Gottlieb. One of the two suggested that they thought one or both may be under the influence—currently under the influence of drugs or alcohol. I don't know specifically which they said. I remember saying—concurring that maybe, you know, it was, who knows, maybe it was a possibility. Having said that, nothing during the course of their interviews stood out to me, and I've been a police officer and given DUIs and—and have extensive training in—in recognizing signs and symptoms of drug and alcohol usage, and that did not occur to me during the interview at all.
>
> Q: Did—did you share this information with the DEA or local law enforcement, that, you know, Dr. Mallinger and other medical professionals made these observations?
>
> A: No.
>
> Q: Did you act in any other way on this information at all?
>
> A: No.[1168]

Later in his transcribed interview, Special Agent Porter stated that he could not recall why he concurred with Dr. Mallinger's observation with respect to Ms. Frasher. He stated:

> Q: So do you recall having a discussion about the appearance that Dr. Houlihan and Deb Frasher were—
>
> A: I recall having a—a brief discussion with Doctors Mallinger and Gottlieb about—and, again, I don't remember which posed the issue, but, you know, saying that they thought one or both of them, I don't

[1168] *Id.* at 112–13.

remember, were under the influence of something, and I—I seem to remember saying, "Well, you know, it's possible." I don't know. I didn't—but—but as I sit here today, I don't recall their interviews and thinking anything along those lines at all.

Q: Right. This, Dr. Mallinger's note on [the handwritten note], notes that apparent sedation with slurring of speech and intermittent eye-closing, agreed by Alan Mallinger and Monika Gottlieb and Greg Porter.

VA OIG Attorney: That was Deb Frasher's interview, the second one. In other words, when you look at the initials, the first one was Dr. Houlihan's, and that appears to be Monika Gottlieb and Alan Mallinger. Correct?

Q: Yes.

VA OIG Attorney: And then the second one is Deb Frasher, and that's where you have Mr. Porter's initials.

Q: Understood.

VA OIG Attorney: Okay.

Q: So you don't remember anything from your interview of Deb Frasher that would be an indicia that she may have been under the influence of drugs.

A: I do not.

Q: Okay. Did you report this to anybody up the chain in the Criminal Division?

A: No.

Q: And you said earlier that you didn't report this to the DEA. Did you report this to local law enforcement?

A: No.[1169]

[1169] *Id.* at 116–17.

During his transcribed interview with Chairman Johnson's staff, Dr. Mallinger explained why he wrote the note. With respect to Dr. Houlihan, he explained:

> So during the interview, Dr. Gottlieb and I made some observations with Dr. Houlihan regarding his physiological appearance, if you will. We felt that his pupils were quite small, and we had what I wrote in the note here as peripheral vasoconstriction. What that basically means is that, you know, when you shook hands with him, his hands were very cold, and his skin was very white.
>
> So we, because of all the, you know, stuff going on there, we did not want to leave those observations unattended to, if you will.[1170]

Chairman Johnson's staff further inquired about what Dr. Mallinger and Dr. Gottlieb's observations meant. Dr. Mallinger stated:

Q: Are Dr. Houlihan's symptoms indicative of illicit drug use?

A: Well, it's really impossible to know. You know, first of all, you could have those kinds of physiological signs from what's called sympathetic nervous system stimulation, adrenaline in your system, if he was very nervous about the interview, or if he were in some other ways having the kind of flight-or-fight response. Those are signs that could—the peripheral vasoconstriction particularly could be a sign of that. It could be a sign of taking other things, allergy medicine or other kinds of medications that, you know, might have been taken for some, you know, appropriate medical purpose, the same with the nurse practitioner. Or it could have been illicit drug use. We had no way to know that.

Q: Did you think it was more likely than not it was illicit drug use?

A: No. We were simply in the frame of mind of pursuing every lead, if you will, and leaving no stone unturned. And we had some observations. We felt they should be followed up on. And, you know, the—you know, we discussed with Dr. Wesley what to do about it, and he recommended contacting the hospital director, and the hospital director could, you know—you know, we can't do drug tests on people, but the hospital director could.

Q: Did he?

[1170] Mallinger 4/6/2016 Transcribed Interview, at 308.

A: I don't know.

Q: So you wrote this note down detailing these symptoms. Were you concerned that Dr. Houlihan was using illicit drugs?

A: I was concerned about the possibility, and, you know, because of that, you know, that's—that was what we decided, the way we decided to handle it.[1171]

Dr. Mallinger explained that his observations of Ms. Frasher's appearance were more concrete. He stated:

> So in her case—I think in her case it was actually much more obvious that she was—she appeared to be sedated, that she was practically falling asleep during the interview in that, you know, her eyes were closing, seemingly she had trouble controlling that, that her speech was slightly slurred. Mr. Porter agreed with us on that one. He didn't feel comfortable talking about the other signs just because that's not consistent with his training, but because of his police training, he felt that he could comment on sedation. It's kind of like sobriety, you know, and he agreed with us about the findings about the nurse practitioner.[1172]

After recording their observations of Dr. Houlihan and Ms. Frasher during the Tomah VAMC site visit, Dr. Mallinger and his colleagues took two courses of action. First, on August 31, 2012, Dr. Gottlieb emailed Maureen Regan, Counselor to the Inspector General, requesting a meeting to "discuss a concern regarding possible impaired interviewee(s) during a recent site visit."[1173] The VA OIG did not provide Ms. Regan's response to this request.

[1171] *Id.* at 309–10.
[1172] *Id.* at 308–09.
[1173] E-mail from Monika Gottlieb, VA OIG, to Maureen Regan, VA OIG (Aug. 31, 2012, 1:07 PM), at OIG 11671.

Figure 90: Email from Dr. Gottlieb to Maureen Regan requesting to meet about possible impaired interviewees[1174]

Mallinger, Alan (OIG)

From: Gottlieb, Monika (OIG)
Sent: Friday, August 31, 2012 1:07 PM
To: Regan, Maureen T (SES) (OIG)
Cc: Daigh, John (SES) (OIG); Mallinger, Alan (OIG); Shepherd, Michael J., MD (OIG)
Subject: Legal guidance

Hi Maureen,
We would like to meet with you to discuss a concern regarding possible impaired interviewee(s) during a recent site visit.
Do you have time available Tuesday, September 4th?
Regards,
Monika

Monika Gottlieb, MD, SFHM
Senior Physician
Office of Healthcare Inspections
VA Office of Inspector General
Medical Consultation and Review

Second, the Tomah VAMC health care inspection team informed their supervisor, Dr. Wesley, of their observations.[1175] Dr. Wesley advised the team to document the observation and inform the Tomah VAMC facility director, Mario DeSanctis.[1176] VA OIG health care inspectors spoke with Mr. DeSanctis on two occasions—on June 19, 2012 and again on September 10, 2012.[1177] At the conclusion of the September 10, 2012, interview, the health care inspection team informed Mr. DeSanctis of their observations from the August site visit and Dr. Mallinger drafted the hand-written note summarizing their observations.[1178]

The VA OIG conducted no additional follow-up beyond informing Mr. DeSanctis of the observations. The VA OIG also did not inform VISN 12 personnel of the observations. When asked by Chairman Johnson's staff why the VA OIG did not take additional action, Dr. Wesley explained:

> There are about 20 different medicines that cause constricted pupils. So it wasn't for us to determine why Dr. Houlihan had constricted pupils. It wasn't for us to determine why the other individual may have been drowsy. Maybe he or she was up all night. That was for Mr. DeSanctis to figure out.[1179]

When asked why the VA OIG did not inform VISN 12 officials of the observations, Dr. Wesley replied, "that's a fundamental responsibility of a medical center Director. They're an SES head

[1174] *Id.*
[1175] Mallinger 4/6/2016 Transcribed Interview, at 312–13.
[1176] Wesley Transcribed Interview, at 197–98.
[1177] 6/19/2012 VA OIG Interview of DeSanctis, OIG 6075; 9/10/2012 VA OIG Interview of DeSanctis, OIG 6084.
[1178] Handwritten Note from Alan Mallinger (Sept. 10, 2012), at OIG 12364.
[1179] Wesley Transcribed Interview, at 200–01.

of a major installation. If they can't handle something like that, then they shouldn't be a Director."[1180]

Dr. Wesley also stated that because the health care inspection team's observations were not part of the hotline, the allegations were not part of the VA OIG's review. He explained:

> This was not the hotline. The hotline wasn't about Dr. Houlihan's pupils or whether the other individual was falling asleep. The hotline was about Dr. Houlihan's prescription practices and the culture of fear, and so on and so forth. So when I have a team going on site and they observe this, though, I can't let it go, nothing happens about it, so share it with the Director or share it up the chain, but it's not really—at least the way I analyze it, it wasn't part of the essential hotline. It was—if this—if these were impaired individuals, that's a different issue.[1181]

Dr. Wesley is correct that potential drug use by Tomah VAMC personnel was not part of the "essential hotline" review.[1182]

The VA OIG criminal investigations division, however, did receive allegations that Ms. Frasher was under the influence of drugs while at work at the Tomah VAMC. On March 28, 2012, Special Agent Greg Porter, two DEA Investigators from Milwaukee, and a detective from the Tomah Police Department interviewed an "anonymous Tomah VAMC employee" at the Tomah Police Department for approximately one hour and fifteen minutes.[1183] Special Agent Porter outlined the details of this interview in a Memorandum of Interview that was produced to the Committee pursuant to Chairman Johnson's subpoena.[1184]

The anonymous Tomah VAMC employee, referred to as "A.S." in the document is a "full-time employee at the Tomah VAMC having regular and familiar contact with Dr. David Houlihan and [redacted]."[1185] The employee informed law-enforcement officials that it was "widely believed, through word of mouth at the Tomah VAMC, that veterans who need certain prescribed opiates and/or other pain killers go directly to Houlihan or [redacted], who typically prescribe medications freely and without many questions."[1186] In a transcribed interview, Special Agent Porter initially claimed he did not know the identity of the redacted individual referenced in the Memorandum of Interview. However, after VA OIG counsel told him that he could disclose the identity, Special Agent Porter confirmed that the redacted individual referred to was Deborah Frasher:

[1180] *Id.* at 201.
[1181] *Id.* at 198–99.
[1182] *Id.*
[1183] VA OIG Criminal Investigations Div., Greg Porter, Memorandum of Interview of Tomah VAMC Employee (Mar. 28, 2012), OIG 10592, at OIG 10592–93.
[1184] *Id.* at OIG 10592–93.
[1185] *Id.* at OIG 10592.
[1186] *Id.*

Q: So, this Tomah employee, you interviewed—you, two DEA investigators. This individual says some pretty serious things, you know, that they—just recounting the document here, you know, veterans who need to be prescribed certain opiates and/or painkillers go directly to Houlihan or redacted. To your knowledge, is the redacted individual Deborah Frasher?

A: I don't know.

Q: Well, were you investigating the prescribing practices of Deb Frasher?

A: No, I was not.

VA OIG
Attorney: You can go ahead and say who—go ahead.

A: Okay. Yes. Yes, Deborah Frasher.[1187]

Special Agent Porter's Memorandum of Interview continued to noted that "A.S." informed law-enforcement personnel, "[redacted] is often 'stoned' while at work, meaning [redacted] is incoherent, and many believe [redacted] may have dependency issues involving alcohol and/or pain killers."[1188] Chairman Johnson's staff asked whether the redacted "stoned" individual Special Agent Porter mentioned in the Memorandum of Interview was Deborah Frasher. He confirmed that it was, stating:

Q: So, Tomah veterans here are saying that they go to Houlihan and Frasher—or Frasher, who prescribed medications freely and without questions, if they want to seek drugs.

The third bullet down, "redacted" is often stoned while at work, meaning blank is incoherent and many believe that "redacted" may have dependency issues involving alcohol and/or painkillers. Do you recall who that individual is?

A: Yes.

Q: Who is that individual?

[1187] Porter Transcribed Interview, at 18–19.
[1188] VA OIG Criminal Investigations Div., Greg Porter, Memorandum of Interview of Tomah VAMC Employee (Mar. 28, 2012), at OIG 10592.

A: Deb Frasher.[1189]

Special Agent Porter's report also noted that "several employees, to include pharmacists, have raised issues about Houlihan and [Frasher] over-prescribing painkillers for veterans."[1190] He wrote that "Houlihan has been known to openly 'brag' about the fact that OIG 'Can't touch him' and that the VA Police cannot contact OIG without his permission."[1191]

[1189] Porter Transcribed Interview, at 19.
[1190] VA OIG Criminal Investigations Div., Greg Porter, Memorandum of Interview of Tomah VAMC Employee (Mar. 28, 2012), at OIG 10592–93.
[1191] *Id.* at OIG 10593.

Figure 91: Memorandum of Interview of Anonymous Tomah VAMC Employee[1192]

Department of Veterans Affairs
Office of Inspector General
Criminal Investigations Division

MEMORANDUM OF INTERVIEW

APPR: GAH

CASE FILE: 2011-04212-DC-0252
DATE: 03/28/12
TIME: 1645 Hrs
PLACE: Tomah Police Department, 805 Superior Ave., Tomah, WI

INTERVIEWEE: Anonymous Tomah VAMC Employee

INTERVIEW BY: SA Greg Porter (VA OIG), Detective [redacted] (Tomah PD), Investigator [redacted] (DEA- Milwaukee), and Investigator [redacted] (DEA-Milwaukee)

WRITTEN BY: SA Greg Porter, 4/25/2012

On 03/28/2012, an employee of the Tomah VA Medical Center (VAMC) was interviewed at the Tomah Police Department. The employee wished to remain an anonymous source, and will hereafter be referred to as "A.S."

A.S. is a full-time employee at the Tomah VAMC having regular and familiar contact with Dr. David Houlihan and [redacted]. In summary, A.S provided the following information regarding Houlihan and [redacted]:

- Dr. Houlihan was the acting VAMC Director and Chief of Staff at the Tomah VAMC prior to the recent appointment of Director Mario DeSanctis.
- [redacted]
- It is widely believed, through word of mouth at the Tomah VAMC, that veterans who need certain prescribed opiates and/or other pain killers go directly to Houlihan or [redacted], who typically prescribe medications freely and without many questions.
- [redacted] is often "stoned" while at work, meaning [redacted] is incoherent, and many believe [redacted] may have dependency issues involving alcohol and/or pain killers.
- Several VAMC employees, to include pharmacists, have raised issues about

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[1192] *Id.* at OIG 10592–93.

Figure 92: Memorandum of Interview of Anonymous Tomah VAMC Employee (page 2)[1193]

> Houlihan and [redacted] over-prescribing painkillers for veterans, often noting that the same veterans would receive several prescriptions in a short amount of time. Many of the employees who have complained have been "forced-out" or intimidated by Houlihan to the point that they resigned or transferred from the Tomah VAMC.
>
> - Houlihan has been known to openly "brag" about the fact that OIG "Can't touch him" and that the VA Police cannot contact OIG without his permission.
> - Houlihan has lost his license to practice medicine in the State of Iowa.
>
> A.S. concluded the interview by stating Houlihan and [redacted] are at the root of drug diversion / pill-selling by veterans at the Tomah VAMC and they have created a culture of fear within the Tomah VAMC, to which employees are afraid to step forward and/or speak their minds.
>
> The interview was terminated at approximately 1800 hrs.

The VA OIG redacted in its entirety the second bullet point on the first page of the document. Chairman Johnson's staff inquired about what Special Agent Porter wrote on that redacted portion of the Memorandum of Interview. Special Agent Porter explained "there was an allegation that Dr.—one of the allegations was Dr. Houlihan was having an inappropriate relationship with a female veteran. That was—in addition, that veteran was also rumored to be one of the veterans who was heavily overprescribed."[1194]

Based on this allegation, Special Agent Porter subsequently surveilled the female veteran, subpoenaed a car dealership, and coordinated efforts with federal and local law-enforcement entities.[1195] While Special Agent Porter's investigation resulted in no written work product and was not mentioned anywhere in the administrative closure, his subsequent investigation reveals a deficiency with how the VA OIG health care inspection team addressed their observations that Dr. Houlihan and Deborah Frasher were potentially impaired.

The different reactions of the two different components of the VA OIG involved with the Tomah VAMC are stark. Whereas the VA OIG criminal investigators engaged in surveillance and issued a subpoena after receiving an allegation of impairment in the workplace, the VA OIG health care inspectors did not pursue potential drug use by Dr. Houlihan and Deborah Frasher because it was not part of the "essential hotline,"[1196] and because those types of allegations were

[1193] *Id.*
[1194] Porter Transcribed Interview, at 22.
[1195] Part III.B. 29, *supra*.
[1196] Wesley Transcribed Interview, at 198–99.

the responsibility of the facility director.[1197] The Office of Healthcare Inspections' narrow focus to only the allegations it received through the hotline impeded the flexibility of the inspection and led the team to ignore potentially dangerous issues. Even when the health care inspectors personally observed evidence that could have potentially corroborated evidence the VA OIG learned from an anonymous Tomah VAMC employee in March of 2012, the emphasis on the hotline allegations meant that the VA OIG did not address those concerns.[1198]

In their transcribed interviews with Chairman Johnson's staff, the VA OIG health care inspectors noted the potential patient safety concerns that come with the prospect of practitioners providing care under the influence of drugs. Dr. Mallinger stated:

> A: And this is why we notified Mr. DeSanctis, as a patient safety concern. And we trust that Mr. DeSanctis did, you know, something appropriate with that. But this was not—this was collateral to our inspection, but potentially involved patient safety and, therefore, we felt needed some sort of an immediate intervention, and this was the intervention that, in consultation with Dr. Wesley, we decided to make.
>
> Q: And did your team conduct any additional—or take any additional action besides alerting Director DeSanctis?
>
> A: No, we did not.[1199]

VA OIG officials confirmed that Dr. Houlihan and Ms. Frasher continued to see patients at the Tomah VAMC throughout the health care inspection.[1200] In light of the potential patient safety concerns that accompany the possibility of an impaired medical provider, Chairman Johnson's staff asked whether the VA OIG considered trying to place Dr. Houlihan and Ms. Frasher on administrative leave while these allegations were investigated. Dr. Wesley stated:

> Q: Was there ever any consideration to place these individuals on leave or take away their ability to see patients while this inspection was ongoing?
>
> A: Yeah, I'd like to make two comments on that. One is that was the whole purpose of—the most important, that was the whole purpose of

[1197] *Id.* at 201.
[1198] Majority staff inquired with Dr. Mallinger whether their observations of Dr. Houlihan at the site visit were connected to the allegations that were levied against him by the Iowa Board of Medical Examiners in 2002/2003, considering he was accused of possessing patient medications in his home. Dr. Mallinger stated that he viewed the Iowa allegations as potential "boundary" violations with a patient, and not a drug issue. Thus, in Dr. Mallinger's view, the observations at the site visit were unrelated to the Iowa allegations. *See* Mallinger 4/6/2016 Transcribed Interview, at 311–12.
[1199] *Id.* at 312–13.
[1200] Wesley Transcribed Interview, at 200.

> telling the Director. That's the Director's decision. If he—if the Director has an impaired practitioner, he's got to decide what to do. We have no authority there whatsoever. And in telling Mr. DeSanctis, that problem was placed squarely at his feet.[1201]

Thus, the only action the VA OIG took in relation to its inspectors' observations at the site visit was to alert Director DeSanctis informally of the observations. The VA OIG conducted no additional follow-up with Director DeSanctis to determine whether he took any action with the VA OIG's referral, even though their observations potentially raised concerns about patient safety. It is unclear what Director DeSanctis did with the information he received from the VA OIG.

ii. The VA OIG's focus solely on opioids missed larger issues with prescriptions at the Tomah VAMC

As the VA OIG explained in its administrative closure, the health care inspection team conducted both structured and general chart reviews of specific Tomah VAMC patients.[1202] Through those chart reviews, the VA OIG identified concerns with the lack of action in the face of negative urine drug screens at the facility.[1203] Through those chart reviews, the VA OIG also unsubstantiated the allegation that "opioid contracts are not being 'encouraged' by [Dr. Houlihan]."[1204] After reviewing patient charts, the VA OIG ultimately concluded that it could not substantiate allegations that "opioids were prescribed inappropriately to specific individuals or in inappropriate doses."[1205] The VA OIG's narrow analysis of just opioid prescription practices of providers at Tomah VAMC may have overlooked the potentially dangerous combination of other drugs with opioids.

The VA OIG received allegations about prescription practices at the Tomah VAMC that were not isolated to just the prescription of opioids. For example, the VA OIG received allegations in March 2011 that raised concerns about Dr. Houlihan's use of benzodiazepines and stimulants in concert with opioids.[1206] In fact, the March 2011 complainant alleged that Dr. Houlihan was conducting "his research into benzodiazepine, Ritalin and opiates for healing PTSD" at the Tomah VAMC.[1207] The email described the "cocktail of medications" veterans received and the health problems that veterans experienced after receiving the cocktail of medications.[1208] While the VA OIG referred those allegations to VISN 12 for review, the VA OIG was well aware of the concerns about the use of drugs other than opioids. From the text of

[1201] *Id.* at 200.
[1202] VA OIG TOMAH VAMC ADMINISTRATIVE CLOSURE, at 3.
[1203] *Id.* at 6.
[1204] *Id.*
[1205] *Id.* at 7.
[1206] E-mail to Representative 99, VA OIG Hotline (Mar. 14, 2011, 11:51 PM), OIG 5696, at OIG 5696–97.
[1207] *Id.* at OIG 5697.
[1208] *Id.* at OIG 5697–700.

the administrative closure, it is not clear whether the VA OIG reviewed or analyzed how the opioids prescribed at the Tomah VAMC interacted with the other drugs.

As the news reports illustrated, drugs other than opioids played a role in the deaths of veterans, or other traumatic events. For example, when Jason Simcakoski died, he was found to have a "cocktail" of multiple drugs in his system and the cause of death was identified as "mixed drug toxicity."[1209] In addition, according to news reports, Marine Corps veteran and Tomah VAMC patient Brian Witkus was "stoned on painkillers and tranquilizers" when he crashed his car into an Amish horse and buggy carriage, killing six-week old Ada Mae Miller in 2009.[1210] In addition, Chairman Johnson's investigation found that Kraig Ferrington was on seven different medications, including an opioid and tranquilizers when he died of "poly medication overdose" after receiving care of the Tomah VAMC in 2007.[1211]

Indeed, the VA OIG's own chart reviews identified concerns with prescription practices at the Tomah VAMC that were not isolated to just opioid prescription practice. For the structured chart reviews, Dr. Mallinger and Dr. Shepherd developed a list of criteria by which the team reviewed the charts of Tomah VAMC patients.[1212] A team of VA OIG personnel—including Karen McGoff-Yost, a licensed clinical social worker—used these criteria to review the charts.[1213] Pursuant to his subpoena, Chairman Johnson obtained a copy of the document Ms. McGoff-Yost drafted in which she recorded her analysis of the charts she reviewed. In this document, Ms. McGoff-Yost noted some concerns about the mixture of drugs veterans at the Tomah VAMC received.[1214]

Ms. McGoff-Yost reviewed the charts of eight Tomah VAMC veterans.[1215] Of the eight patient charts she reviewed, all were prescribed opiates. Five of the patients received opioids from Deborah Frasher, two received opioid prescriptions from Dr. Houlihan, and one received an opioid prescription from a physician's assistant.[1216] Of those eight patients, six were also prescribed a benzodiazepine in addition to the opioid.[1217] In addition, three patients were prescribed "amphetamine-like substances (Ritalin)."[1218] She noted that the charts indicated that the order for the stimulant was to treat Attention Deficit Disorder (ADD).[1219]

[1209] Glantz, *Opiates Handed out Like Candy*, REVEAL NEWS (Jan. 8, 2015).
[1210] Aaron Glantz, *Devastating Effects of 'Candy Land' Reach Beyond Veterans*, REVEAL NEWS (Mar. 16, 2015), http://lacrossetribune.com/news/local/devastating-effects-of-candy-land-reach-beyond-veterans/article_68dd85d0-88fa-5d4a-b9cc-0fd46110bd19 html.
[1211] Part II.A.1, *supra*.
[1212] Karen McGoff-Yost, VA OIG, Tomah Hotline: Electronic Health Record Review (Apr. 23, 2012), at OIG 12197; *see also* Mallinger 4/6/2016 Transcribed Interview, at 162–63.
[1213] *Id.*
[1214] *Id.*
[1215] *Id.*
[1216] *Id.*
[1217] *Id.*
[1218] *Id.*
[1219] *Id.*

Ms. McGoff-Yost highlighted additional concerns she identified through her chart reviews. Ms. McGoff-Yost "noted two documented instances of Dr. H using himself as a reference when he wrote the justification for why he ordered certain meds. The reference refers published case studies on the use of Ritalin for PTSD."[1220] She wrote that "[o]rder entered into CPRS [the patient's medical record] for the Ritalin says it is for ADD but seems that Dr. H is using this off label for PTSD."[1221] Finally, she wrote that she identified "A LOT [*sic*] of polypharmacy – patients on both uppers and downers, would really love to have a pharmacist look at some of these drug combos."[1222]

During a transcribed interview with Dr. Mallinger, Chairman Johnson's staff inquired about Ms. McGoff-Yost's observations. Dr. Mallinger downplayed the concerns about polypharmacy and other mixtures of medications as they were not part of the allegations they received. He explained:

Q: Moving on, Bullet 7, "Three patients are prescribed amphetamine-like substances (Ritalin). Order indicates this is for ADD. Two ordered by NP F and one ordered by Dr. H." If you move down the page, about the bottom third, another bullet there says, "Noted two documents instances of Dr. H using himself as reference when he wrote the justification for why he ordered certain meds. The reference refers to public case studies on use of Ritalin for PTSD." The chart notes say that the Ritalin was prescribed for ADD, and he's sort of providing justification of prescribing Ritalin to treat PTSD, as the notes indicate. Did that—that doesn't match up, does it?

A: Well, I don't know that she's talking about the same patients here.

Q: Okay. Did any of the charts indicate that these patients were prescribed Ritalin for PTSD?

A: I actually don't know the answer to that. **You know, the allegation that we had was that he was using opioids to treat PTSD, and that was the allegation that we looked at.**

Q: But there was an allegation about a potential research project that he may have been doing—Dr. Houlihan—with Ritalin, correct? Or was that the March 2011 hotline—

A: I don't know of any allegation. He had published a small case series on some use of stimulants—I don't remember if it was Ritalin or

[1220] *Id.*
[1221] *Id.*
[1222] *Id.*

whatever; it was some stimulant—in the treatment of PTSD. And at times he did cite that study in his notes. But I don't really remember the exact—

Q: But he was citing himself, again, in that instance?

A: He was citing himself. I remember—again, you know, just from doing the general chart reviews or for looking in charts—I don't even remember from which—I was—I remember that he cited his own work in his notes, yeah.

Q: We could get into that work, too, later. Another—

A: Again, that wasn't really something we were—**we were charged with determining whether he was treating PTSD with opioids.**[1223]

While it is unknown which patients were on certain drugs, Ms. McGoff-Yost's analysis appears to highlight the potentially dangerous mixture of opiates, benzodiazepines, and stimulants among at least a subset of Tomah VAMC veterans. Dr. Mallinger's statements show that the VA OIG health care inspectors narrowly interpreted the scope and the mission of the health care inspection. The literal and strict analysis of allegations did not give the health care inspectors the flexibility to address other issues that arose over the course of an inspection or investigation—namely the potentially dangerous mixture of opioids and benzodiazepines with Tomah VAMC veterans.

Dr. Shepherd, another VA OIG physician who participated in the inspection, also talked about Dr. Houlihan's penchant for citing his own work. Dr. Shepherd expressed concern that Dr. Houlihan was citing himself as justification for his prescribing practices.[1224] He stated:

Q: Would you generally cite medical articles that you, yourself, had written as—

A: No.

Q: —backing it up?

A: No.

Q: Do you know or have you been made aware of that potentially Dr. Houlihan did do that?

[1223] Mallinger 4/6/2016 Transcribed Interview, at 172–73 (emphasis added).
[1224] Shepherd 1/27/2016 Transcribed Interview, at 90.

A: Yes. Well, not the absolute, not that there was an absolute contraindication, that, umm, Dr. Mallinger had a discussion at one point where the discussion was essentially about Dr. Houlihan citing his own stuff to, you know, in a sense, to back him—to justify some of his stuff up. I think it was on a peer review. And part of that conversation or the piece I recall was Dr. Mallinger and I were pretty—pretty under—you know, I mean, I don't know how to say this—basically, underwhelmed by his—you know, we didn't put credence into his citing himself. We thought that was, you know—

Q: Did he solely cite himself, or did he provide any additional documentation?

A: **I don't—that, I don't recall. But, basically, we thought that was crap**, I mean, that you would cite yourself. I mean, you know, like, you would want to cite, like, a major journal—[1225]

Chairman Johnson received two research documents authored by Dr. Houlihan. The first piece is a letter to the editor published in *Psychotherapy and Psychomatics* entitled "Episodic Rage Associated with Primary Aldosteronism Resolved with Adrenalectomy."[1226] The second piece is a short article published in the *Journal of Psychopharmacology* entitled "Psychostimulant treatment of combat-related posttraumatic stress disorder."[1227] This article was a case study of three veterans with PTSD at the Tomah VAMC. Dr. Shepherd explained that case studies like this one are "lower down" on the hierarchy of acceptable medical research.[1228] Dr. Shepherd also said that he was familiar with this article as evidence Dr. Houlihan used to support his clinical practices.[1229]

The objective of Dr. Houlihan's case study was to "describe three cases of combat-related posttraumatic stress disorder (PTSD), largely refractory to standard medication treatment, who responded well to psychostimulant treatment."[1230] The paper summarized a case study of how veterans with combat-related PTSD, who had not responded well with traditional treatments for PTSD, responded well to psychostimulants, like Ritalin and Adderall. The report noted that other than this study, "the literature on psychostimulant use treating PTSD is limited to a single case report."[1231] This report summarized the treatments of three Tomah VAMC veterans and

[1225] *Id.* at 90 (emphasis added).
[1226] David Houlihan, *Episodic Rage Associated with Primar Aldosteronism Resolved with Adrenalectomy*, 80 PSYCHOTHERAPY & PSYCHOSOMATICS 306 (2011), OIG 330, at OIG 330–31.
[1227] David Houlihan, *Psychostimulant Treatment of Combat-related Posttraumatic Stress Disorder*, 25 J. OF PSYCHOPHARMACOLOGY 1568 (2011), OIG 332 [hereinafter Houlihan, *Psychostimulant Treatment of Combat-related PTSD*].
[1228] Shepherd 2/9/2016 Transcribed Interview, at 64.
[1229] *Id.* at 56–57.
[1230] Houlihan, *Psychostimulant Treatment of Combat-related PTSD*, at OIG 332.
[1231] *Id.* at OIG 334

noted improvements in the veterans' mental and physical state since they were placed on Ritalin.[1232]

Chairman Johnson's staff asked Dr. Shepherd whether the VA OIG health care inspectors were concerned about Dr. Houlihan's reliance on this study to support his clinical practice in light of allegations of over-prescription. Dr. Shepherd said that he was concerned throughout the inspection that Dr. Houlihan and other providers at the Tomah VAMC were potentially documenting in the medical charts that they were prescribing certain medications for the acceptable medical reasons, but were really prescribing the medications in a matter that furthered their own research. He explained:

> Q: During that interview, and you were on the phone with Dr. Houlihan, did you guys question the fact that he was citing his own work to back up his clinical practice?
>
> A: Umm, that, I don't recall. I just don't remember. You know, you'd have to—I don't remember. I just don't remember.
>
> Q: But, would it be fair to say that when this revelation and Dr. Mallinger having this conversation with you about being underwhelmed by Dr. Houlihan citing his own work to back up his clinical practice, I mean, that's—that's something that you guys need to look into, no?
>
> A: I'm not sure what you're asking, because, again, I'd ask for clarification, because to clarify my comment to make sure it's in context. You know, we were looking at allegations independently, and what I'm saying is in looking at allegations independently, we—just because Houlihan cited himself doesn't mean we're, like, oh, okay, that's great. You know, we were—had appropriate skepticism about him citing himself, you know, in pursuing the allegations from an independent, objective standpoint. You know, that's really the point I was making, is just because he had written it in response to something doesn't mean that we gave it credence, meaning that we thought that was, like, oh, yeah. You know, we—you kind of, like, well, we were going to look independently. Is this guy prescribing—do we see evidence that he's prescribing opiates for PTSD, et cetera.
>
> Q: And what did you find?
>
> A: Well, the chart reviews, we couldn't—we couldn't find that he—that documentation that seemed to support that he was prescribing opiates

[1232] *See generally id.* at OIG 332–33.

for PTSD, because what we found was all—most of his patients—all of them—that the patients also had pain issues, and he—and, so—so, in other words, his documentation, these people have pain issues which you would also treat with opiates, and so you could—and he—we had—Dr. Mallinger and I had a discussion at one point where we basically discussed that if he were doing that, meaning if he were, he certainly—

Q: Doing what?

A: If, for some reason—if there was an intention to prescribe opiates for PTSD, he certainly—it certainly wasn't in the documentation, meaning these patients had pain problems, so they had another reason to be on opiates and we couldn't find, like, notes saying, you know, I've started him on Ritalin or this—I mean, I've started him on this opiate for PTSD.

* * *

A: —and some other, and there were some patients who were neither of theirs, but they were people who had—Alan had put together a list based on things like who was getting the highest doses and stuff like that. We couldn't find notes that—documentation that seemed to indicate that he was prescribing the opiates for the PTSD. And a lot of these patients had pain conditions for which you would—

Q: Was Dr. Houlihan prescribing the opioids for pain?

VA OIG Attorney: Let him finish his answer, okay.

A: **However, you know—however, you know, we did—you know, we did have a conversation where, umm, one of us raised the potential that, you know, this guy may be a guy who's, in a sense, quote-unquote, "smart enough"—in other words we were, you know, that skepticism you should have as a, you know, investigator or whatever, or inspector, you know, hey, maybe is this guy just smart enough or whatever that he makes sure not to document. Do you know what I'm saying, like—**

Q: Right, because you said there's no clinical purpose of prescribing opioids for PTSD.

A: Not that I'm aware of.

Q: Was he the main identifier or diagnose of the opioid for pain purposes?

A: Now, like I said, the charts that were in our chart review, there were—there were other providers. It was several Houlihan charts, several Frasher charts, but then there were some other providers, because of the list that Alan [Mallinger] had put together, some of those were patients who—you know, it was based on, like, dosage, like, they were higher-dose patients. Some of them were because they were names that came up in his interviews with other people, like the e-mail you showed me here. You know, it might have been some names that came up from that—that he got. So, they weren't all Houlihan patients. They were Houlihan, Frasher, and a couple other—[1233]

None of these concerns about the potential for prescribing medication to advance research were addressed in the VA OIG's administrative closure. Because the VA OIG has refused to provide copies of drafts of the original document the office intended to publish, or drafts of the administrative closure, the majority staff has no way of knowing whether the Office of Healthcare Inspections considered addressing these issues at any time. The VA OIG, by limiting its review to opioid prescription practices, appears to have avoided the issues of mixed drug interactions altogether.

iii. The VA OIG ignored firsthand accounts of the poor state of affairs in the Tomah VAMC pharmacy

The Tomah VAMC pharmacy has been a significant area of concern at the facility for many years. Pharmacists raised concerns about prescription practices at the Tomah VAMC throughout the years and there was a strained relationship between pharmacists and providers, like Dr. Houlihan, at the facility. This strained relationship was further complicated by the fact that the Tomah VAMC Chief of Pharmacy reported to Dr. Houlihan as the Tomah VAMC Chief of Staff. In the instances in which a pharmacist questioned a doctor's prescription, the pharmacist was essentially challenging the clinical judgment and practices of their top-line supervisor. These problems created an inherent conflict of interest when resolving concerns over prescriptions that created administrative headaches and may have compromised veteran care.

The VA OIG examined the conflicts between the pharmacy and Dr. Houlihan during its health care inspection of the Tomah VAMC. In the administrative closure, the VA OIG found that "the Chief of Pharmacy reports to [Dr. Houlihan] by virtue of [Dr. Houlihan's] administrative leadership position."[1234] The VA OIG also substantiated that "at least five

[1233] Shepherd 1/27/2016 Transcribed Interview, at 98–102 (emphasis added).
[1234] VA OIG TOMAH VAMC ADMINISTRATIVE CLOSURE, at 6.

outpatient pharmacy staff left the facility in recent years."[1235] However, the health care inspection did not substantiate allegations of "abuse of authority, intimidation and retaliation when staff question controlled substance prescription practices."[1236] The administrative closure explained that the VA OIG did not substantiate these allegations "in the context of having obtained multiple contradictory facts and statements during the course of this inspection, often based on second or third hand accounts."[1237] In addition, the VA OIG added that although it did not substantiate the allegation, it found that perceptions of abuse of authority and intimidation with respect to the questioning of prescriptions were "widely held beliefs and concerns among most pharmacy staff and some other staff."[1238]

The VA OIG interviewed several Tomah VAMC pharmacists during its health care inspection. Every pharmacist interviewed by the VA OIG "expressed concerns regarding the facility's (and ultimately [Dr. Houlihan's]) expectations for dispensing opioids and other controlled substances."[1239] The administrative closure summarized the pharmacists' concerns as follows:

- One pharmacist, a new employee, was not retained by the facility at the conclusion of his/her initial employment period. This individual reported that on three occasions he/she had refused to fill prescriptions for controlled substances due to concerns about patient safety and/or drug diversion.
- A second clinical pharmacist who left the Tomah VAMC reported feeling inappropriately blamed by [Dr. Houlihan] for the suicide of a patient.
- A dispensing pharmacist, relatively new to the facility, reported that he believed there were 40-50 patients who were regularly presenting to the outpatient pharmacy for early refills of opioids, and that pharmacists were told by [Dr. Houlihan] they had to fill the prescriptions. He feared this would place his license at risk.
- A clinical pharmacist who had been hired in a supervisory capacity reported that when some of the pharmacists expressed discomfort with dispensing high doses of opioids to patients, [Dr. Houlihan] would become angry and would insist that this pharmacist discipline the other pharmacists under his supervision.[1240]

The VA OIG ultimately unsubstantiated allegations of abuse of authority and intimidation by Tomah VAMC management against pharmacists because their allegations were formed on the basis of "second or third hand accounts."[1241] However, a review of the transcripts of VA OIG interviews with Tomah VAMC pharmacists shows that on multiple occasions, Tomah VAMC pharmacists told health care inspectors of first-hand accounts in which they

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[1235] *Id.* at 5
[1236] *Id.*
[1237] *Id.*
[1238] *Id.*
[1239] *Id.*
[1240] *Id.*
[1241] *Id.*

refused to fill certain prescriptions and of instances in which they were forced by Tomah VAMC management to practice against their judgment. In many instances, these pharmacists detailed specific negative interactions with Tomah VAMC management when they expressed concerns about questionable prescriptions. In addition, they also referenced specific patients or instances in which they believed prescription regimes were potentially unsafe. They also told OIG inspectors about how their inability to raise concerns about potential patient harm led to an apparent culture of fear at the facility.

a. Dr. Noelle Johnson described to the VA OIG her first-hand accounts of abuse and questionable prescription practices at the Tomah VAMC

On May 10, 2012, VA OIG inspectors—Dr. Wesley, Dr. Mallinger, Dr. Shepherd and Dr. Yang—interviewed Dr. Noelle Johnson over the telephone. Dr. Johnson had worked at the Tomah VAMC pharmacist from July 2008 to June 2009.[1242] During her interview with the VA OIG, she raised significant, first-hand accounts of abuse from her time at the facility. According to a VA OIG transcript of the interview, Dr. Johnson told the VA OIG inspectors: "I was warned day one when I got there that whatever I did, don't question him [Dr. Houlihan] because I will be fired if I did or at least make my life very difficult. . . ."[1243]

Dr. Johnson also described pharmacy security procedures at the Tomah VAMC that did not properly safeguard controlled substances. She informed the OIG staff that when she started at the facility, the door to the vault of the pharmacy—where all of the controlled substances were stored—was "left open all day long."[1244] She added that "anybody and everybody had access to those controlled substances."[1245] Dr. Mallinger expressed concern about Dr. Johnson's revelation about the lax security procedures within the pharmacy:

VA OIG: Okay. But the message I'm getting is that security wasn't as tight there [Tomah VAMC] as other places you worked.

Johnson: No, no. So that was very, very different all in itself that, first of all, a pharmacist had enough C2s [controlled substances] to do all day long. There—

VA OIG: Oh, that's unusual?

Johnson: Well, it was as far as I was concerned.

[1242] *Tomah VAMC: Examining Quality, Access, and Culture of Overreliance on High-Risk Medications, Joint Field Hearing Before S. Comm. on Homeland Sec. & Governmental Affairs & H. Comm. on Veterans Affairs* 114th Cong. (2015) (statement of Dr. Noelle Johnson).
[1243] VA OIG Interview with Noelle Johnson (May 10, 2012), OIG 5935, OIG 5939, at 14.
[1244] *Id.* at OIG 5940, at 20.
[1245] *Id.*

VA OIG: Okay. You know, none of us are pharmacists, so this is all sort of new, new ground for us.[1246]

Dr. Johnson raised three specific prescriptions to VA OIG health care inspectors that she refused to fill because she felt they were unsafe. One prescription came up during her conversation with the VA OIG health care inspectors about the lax security procedures of the Tomah VAMC pharmacy vault. She explained:

VA OIG: Right. So basically it's—there was a circumvention of the internal controls of the pharmacy.

Johnson: Yes, absolutely. By being the vault pharmacist, that's where I encountered the trouble. The reason I was fired, I believe, was because I chose to refuse to fill three prescriptions. They were all written by Dr. Houlihan, and the first one was for an immediate release morphine and it was 1,080 immediate release morphine tablets for a 30-day supply. [1247]

Dr. Johnson explained to the VA OIG health care inspectors her concerns about this particular patient and prescription. The particular veteran was apparently prescribed 36 tablets of 15 milligram immediate release morphine.[1248] Dr. Johnson was concerned that the veteran was prescribed all immediate release tablets. She explained that based on her experience with pain medication, "you don't most often treat current pain management with strictly immediate release prescription."[1249] Dr. Johnson also noted that the patient was diagnosed with "neuropathic pain" and 36 tablets of 15 milligram immediate release morphine was "not the medicine [she] would be trying to use to treat a neuropathic pain . . . ."[1250] She added that the veteran "wasn't on any type of other adjunct therapy" and emphasized that "the fact that it was all short-acting was concerning."[1251] VA OIG health care inspectors asked Dr. Johnson who this veteran was and when this prescription was issued.[1252] She recalled that the issue came up in November 2008, but she did not recall the veteran's name.[1253]

Dr. Johnson told the VA OIG health care inspectors that she approached Dr. Houlihan with this prescription and had a phone conversation about converting the patient. Dr. Johnson explained that the conversation "didn't go over well."[1254] The conversation "ended up in a

[1246] *Id.* at OIG 5941, at 22.
[1247] *Id.* at OIG 5941, at 25.
[1248] *Id.* at OIG 5942, at 26.
[1249] *Id.* at OIG 5942, at 28.
[1250] *Id.*
[1251] *Id.*
[1252] *Id.* at OIG 5942.
[1253] *Id.*
[1254] *Id.* at OIG 5942, at 29.

screaming match, him yelling at me profanities and throwing the scripts in the air, threatening to punch me."[1255] She added that Dr. Houlihan yelled at her "you don't have a right to question me. You will [f*****g] fill this if I say you will . . . ."[1256] Dr. Johnson refused to fill the prescription because she believed it was unsafe.[1257] Her supervisor ultimately filled the prescription.[1258]

According to her interview with VA OIG inspectors, Dr. Johnson refused to fill another prescription because the veteran in that case was prescribed a potentially dangerous combination of drugs. Dr. Johnson told the VA OIG that "almost every patient that came through that was Dr. Houlihan's patient was getting some sort of not only narcotic but stimulants, and they were getting large doses."[1259] She said that her concern with this prescription was "not only are we giving a stimulant to a patient who has no diagnosis of any type of ADHD or anything like that in his chart."[1260] She added:

> Dr. Houlihan at this point may have told me that he likes to use stimulant medications for PTSD, which I do work in a mental health clinic at this moment and I do see some stimulants come through, very small amounts of stimulant. But I wouldn't say that as far as my knowledge goes that large stimulants are first line for PTSD therapy.[1261]

In this instance, Dr. Johnson explained that the veteran was prescribed 120 milligrams a day of a stimulant.[1262] Dr. Johnson told the VA OIG that in her training as a clinical pharmacist, she knew that the maximum dose of stimulant is 60 milligrams per day.[1263] She informed the VA OIG inspectors that she reviewed the veteran's chart to determine why the veteran was prescribed double the maximum dose of stimulant.[1264] She told the VA OIG:

> So then I start looking through the chart to see—look for documentation why the patient is getting above the max dose, because we don't know. I mean, sometimes we do operate above those.
>
> So I look over the documents for that, and then I start looking through the problems or the diagnosis as far as why the patient is even getting it because obviously for certain drugs an indication of the dosage is different based on the indication.

[1255] *Id.*
[1256] *Id.* at OIG 5943, at 32.
[1257] *Id.* at OIG 5942, at 27, OIG 5944, at 34.
[1258] *Id.* at OIG 5944, at 34.
[1259] *Id.* at OIG 5948, at 50.
[1260] *Id.* at OIG 5948, at 51.
[1261] *Id.*
[1262] *Id.* at OIG 5948, at 53.
[1263] *Id.* at OIG 5948, at 51–52.
[1264] *Id.*

> So, um, at this patient, I also looked into his cardiac history that 120 milligrams of a stimulant, I was concerned that the patient would have some kind of cardiac issue, such as tachycardia. So, and this particular patient did, which even concerned me more. So I felt it wasn't safe for the patient to be taking this. Um, at this point, after my first altercation with Dr. Houlihan, I was told I couldn't contact him.[1265]

Dr. Johnson told the VA OIG team that her immediate manager, Jeff Everson, and the interim Chief of Pharmacy, Erin Narus, told her that Dr. Houlihan "cannot control his temper" and that she was "not to contact him for any recommendations or questions."[1266] Instead, she was instructed to fax her concerns to Dr. Houlihan.[1267] Dr. Johnson told the VA OIG that when she faxed her concerns to Dr. Houlihan, he replied that the patient was "large" and instructed her to fill the prescription.[1268] Ultimately, Dr. Johnson still felt that the prescription was unsafe and transferred the prescription to her supervisor, who filled the prescription.[1269]

Dr. Johnson also described to the VA OIG the potentially dangerous prescriptions of benzodiazepines at the Tomah VAMC. She explained:

> Dr. Houlihan was always writing benzodiazepines over the max doses. We're talking Alprazolam (inaudible) everything. But he would be six—six milligrams, eight milligrams of Alprazolam. Isn't that a little extreme? You guys are psychiatrists, right? So we'd be going benzo—everybody got benzodiazepine, and Alprazolam was a favorite, which I think is ironic because we hardly rate for that at our VA [the VA facility in Iowa where Dr. Johnson is currently employed].
>
> But they always for a benzodiazepine, and they were all on a stimulant, all of them. And they were always on above max doses. I've never in any other—both VAs that I've been to have ever been even presented with a prescription above a max dose for a stimulant. I mean there's reasons. There are safety issues around that, and there's reasons there are max doses.[1270]

The third specific prescription that Dr. Johnson told the VA OIG she refused to fill was around June 2009 for oxycodone that amounted to "1447 milligrams of morphine-equivalent per day."[1271] Dr. Johnson explained to the inspectors her concerns about this prescription. She said:

[1265] *Id.* at VA OIG 5948, at 52–53.
[1266] *Id.* at OIG 5948–49, at 53–54.
[1267] *Id.* at OIG 5949, at 54.
[1268] *Id.* at OIG 5949, at 54–55.
[1269] *Id.* at OIG 5949, 54–56.
[1270] *Id.* at OIG 5964, at 116–17. The "inaudible" notation was included on the transcript as produced by the VA OIG pursuant to Chairman Johnson's subpoena.
[1271] *Id.* at OIG 5950, at 58.

> Johnson: So I started looking to the chart, and, there was a note faxed in that—you know once you had faxed it in, you can scan it in, and it goes to medical records, and it gets scanned in. And there was a note from an outside provider saying that the patient had tested positive for methadone in addition—
>
> VA OIG: Oh, geez.
>
> Johnson: —and no oxycodone. So he tested positive for methadone, but no oxycodone. And so therefore, he [the outside provider] was going to be tapering the patient off the medication, and he—and that was it. He was not taking any more narcotics. Um, so that was scanned in.[1272]

Dr. Johnson explained that Dr. Houlihan told her that the veteran got the methadone from the VA, but that her review of the medical record showed that the veteran had "never, ever gotten methadone from the VA."[1273] Dr. Johnson refused to fill the prescription and informed the VA OIG inspectors that she brought her concerns to her supervisor, who ultimately filled the prescription.[1274]

Dr. Johnson explained to the VA OIG in general why she refused to fill prescriptions she believed to be dangerous:

> I guess it's not that I am high and mighty, but also—I have more advanced clinical experience. I went through a pain clinic. I knew the difference between safe and unsafe and right and wrong. And I chose at that time to—even if he was going to fire me or make my life difficult, what people would say hell, I was going to let them—let him do it.
>
> I wanted to make sure that the veterans got put first and that their safety was of utmost importance. But just I couldn't, I couldn't do it. I couldn't sleep at night, and I couldn't, I couldn't let them go through so [. . .] I made the decision I guess to refuse to fill them.[1275]

In addition, Dr. Johnson told the VA OIG inspectors about another negative interaction she had with Dr. Houlihan. Dr. Johnson explained that she received a prescription for a controlled substance from Dr. Houlihan on a paper that was not the required prescription pad.[1276] When she approached Dr. Houlihan to have the prescription written on the correct form, Dr. Johnson recalled that Dr. Houlihan "came flailing out of his office, screaming and hollering

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[1272] *Id.* at OIG 5950, at 59–60.
[1273] *Id.* at OIG 5950, at 60–61.
[1274] *Id.* at OIG 5949, at 56, OIG 5950, at 58.
[1275] *Id.* at OIG 5949–50, at 57–58.
[1276] *Id.* at OIG 5952, at 66.

profanities at me that he hates these [f*****g] pharmacists and just F this and F that. He put his fist up in the air like he was going to hit me."[1277] She told the VA OIG inspectors that she was frightened at this exchange.[1278]

Dr. Johnson also spoke to the VA OIG about common early refills for controlled substances, and how she was removed from the Tomah VAMC pain committee, even though she had an educational background in pain management.[1279] Dr. Johnson recalled her firsthand accounts with Deborah Frasher and her propensity to prescribe potentially dangerous mixtures of drugs. She explained:

> VA OIG: Okay. Uh, did you have any, uh, interactions with Deborah Frasher?
>
> Johnson: Deb Frasher was just kind of coming on the—I would like to say the Houlihan train when I was leaving. Um, sbe—I had one interaction with her, and I don't—it wasn't anything significant. I guess I'm just trying to remember exactly why we were talking. But it had to do with the pain committee and the pain clinic and somebody was saying why I had questions about why I couldn't be on this, you know, kicked off. And somebody told me that she had a complaint.
>
> So I confronted her and said, you know, I heard you had a problem or complaint. You know, is there something I did wrong, or could we talk about this? And she said no, she didn't have any problem with me.
>
> So I do remember having issues her seeing prescriptions sent to her. **Everything she prescribed, she had an upper, a downer, a stimulant. So everybody gets a benzo, everybody gets a stimulant, everybody gets some kind of narcotic, and everybody gets some kind of antipsychotic. And she told me that she has a cocktail for these people.**[1280]

Dr. Johnson also talked to the VA OIG inspectors about her interactions with the DEA and Dr. Houlihan's nickname among veterans at the Tomah VAMC as the "Candy Man." She recalled:

> Johnson: I did not talk to the inspector general myself. I had talked to the DEA. A DEA agent actually had contacted me and come to my house.

[1277] *Id.* at OIG 5952, at 66.
[1278] *Id.* at OIG 5953, at 70.
[1279] *See id.* at OIG 5944, at 35, OIG 5945, at 39–41.
[1280] *Id.* at OIG 5954, at 75–76 (emphasis added).

VA OIG: I'm sorry. You say the DEA had contacted you?

Johnson: Yes.

* * *

VA OIG: And what was the DEA's concern?

Johnson: Diversion. Many of our patients were not testing like—first of all, we were told by Dr. Houlihan we were not supposed to be drug testing our patients because we were liable when they didn't test positive and then we wrote the order. Yet I know he forced other providers to write the order when their patients didn't test positive.

* * *

Johnson: So my concern was, I mean, the patients that would go down the hallway—Dr. Houlihan's name is the Candy Man. I would hear the patients in the hallway talk about him and call him the Candy Man. **I would hear them say things like, well, I went to my primary care doctor and she took me off my pain medicines, but I went to Dr. Houlihan and he put me back on, so he's the guy you need to go to.**[1281]

As the transcript of her interview with VA OIG inspectors demonstrates, Dr. Johnson relayed concerns about a litany of issues that arose during her tenure at the Tomah VAMC. She described to the VA OIG specific, firsthand experiences and observations about patient safety and administrative abuses at the Tomah VAMC. The transcript of her interview undercuts the VA OIG's assertion that the allegations they received about the Tomah VAMC pharmacy were based on second and third-hand accounts. The VA OIG health care inspectors interviewed other Tomah VAMC pharmacists who also relayed first-hand accounts of abuses at the Tomah VAMC.

b. First-hand accounts given by other pharmacists to the VA OIG about abuse and questionable prescription practices at the Tomah VAMC

In addition to Dr. Noelle Johnson, the VA OIG interviewed other Tomah VAMC pharmacists during their review of the Tomah VAMC. Each pharmacist relayed specific instances of abuse or questionable prescription practices at the Tomah VAMC. The VA OIG provided the transcripts of their interviews with the Tomah VAMC pharmacists

[1281] *Id.* at OIG 5954–55 at 75–79 (emphasis added).

pursuant to Chairman Johnson's subpoena. However, the OIG redacted the names of the pharmacists and other information.

For example, one pharmacist informed the VA OIG health care inspectors of a specific patient, a young male Iraq war veteran, that she believed was abusing his drugs. She explained:

Witness: There's like certain patients that you see that you know are abusing the drugs. There's a [redacted] that's no longer in our—[redacted] that's no longer being treated here. I think he went to [redacted] and ended up not—if you look in the files there, you'll find that [redacted] was a pharmacist.

He had come to this place a couple times on a narcan drip overdose. He lost his meds all the time. That was back when I said I first started doing non-formularies.[1282]

OxyContin we did not . . . . I mean [another Tomah VAMC pharmacist] and I were just—we didn't let anyone get it. We put brakes on it. No, no, no. More whatever. And Houlihan walked down. One time I disapproved it. He walked down and said "you will approve it."

Now I had seen this kid because I'm in the military and I'm a veteran. He had one of the—when you first came back, and I was there in '03, '04, those black—I don't know, are you a vet? No.

Okay, there's a certain jacket you have, a black fleece was the under thing. Are you military?

VA OIG: Yes

Witness: The black . . . . the Army had the black first—yes, first time they were issued were out in Iraq. And so, not everyone had it at the time, and I saw this young kid walking around with it, and I was like, "oh he looks like my nephew." A nice, young, blond-haired kid.

He had to have OxyContin, and the kid was literally jumping up and down going I wasn't going to approve it, but I disapproved it. Houlihan walks in, and says, 'you will approve it." And so I said,

[1282] *See* Paul Pinsonault, *When Your Drug Is Not on Formulary*, PHARMEXEC.COM (June 1, 2002), http://www.pharmexec.com/when-your-drug-not-formulary.

"okay." He told him, "You're going to get it." Houlihan walked down the hallway and the kid goes. "Yeah, you're the man Houlihan."

Now, if he's got a bad back that needs OxyContin?

VA OIG: I guess it was working well.

Witness: He hadn't gotten it yet.

VA OIG: Okay

VA OIG: So he did that in the presence of--

Witness: In the hallway, where the old outpatient pharmacy used to be. And like I said, I had watched the kid because I was like "I had one of those jackets." I had it issued to me when I was out in Iraq, because you . . . you couldn't buy them. And so it was like, you know, you know that person is a recent vet and just got back.

And so, that kid? Read about him. Just a big druggie. He had problems, his [redacted] said. They'll be notes, the nurses were writing notes. Look at the 402 notes and stuff on him.

VA OIG: So you had to approve it because it was sustained release.

Witness: **I had to approve it because Houlihan told me.**[1283]

The same pharmacist recounted a meeting during which Dr. Houlihan yelled at her and accused Dr. Johnson of turning him into the VA OIG. She explained:

VA OIG: According to some reports that I've heard, there was a meeting held during that time in early 2009, and at that meeting, Dr. Houlihan talked about Noel [*sic*] [Johnson] turning him in to the IG.

Witness: Oh, was that a medsec (phonetic) meeting? Because he yelled at me at one of those.

VA OIG: That's all I know about the meeting.

Witness: There was a meeting where Tom Jaeger at the time and I went to and I got a report on PNT (phonetic) because I the secretary for the PNT for

[1283] VA OIG Interview of Tomah VAMC Pharmacist 1 (Aug. 23, 2012), OIG 6050–51, at 12–15 (emphasis added).

a while. And I specifically—I mean the room kind of was like this. Houlihan was going to be up front and Tom Jaeger and I both sat against the wall like right up there.

He joined and just yelled. I mean he was just wild. He was like—you can tell the whole time he was like this until—and he just goes, "somebody from the pharmacy turned me into the IG." And I just like—I just looked at him and I said "it wasn't me, and it is nobody in pharmacy that I know of" turned him in.

VA OIG: And what was it about?

Witness: I—I don't. He was just mad about it.

VA OIG: No. I mean what was he turned in for?

Witness: I don't know. I assume excessive narcotic prescribing.

VA OIG: Because I think actually nobody turned him into the IG.

Witness: I don't think so. I think the union told me that they did something but it was—the union came and told me that they had done something and it wasn't Noel [*sic*]. But he was adamant that it was pharmacy. I said, "it wasn't me or anybody that I know."[1284]

Another pharmacist, who was relatively new to the Tomah VAMC, also brought up specific concerns about high narcotic prescriptions at the facility in a conversation with VA OIG inspectors. The pharmacist explained:

Witness: I just started and um, yes, when I got here—it seemed very outrageous what I saw here with the narcotics and all that stuff.

VA OIG: Did that compare to like previous jobs you've had?

Witness: Yeah, because I—to me—

VA OIG: Where did you used to work?

Witness: I used to work at Walgreens.

VA OIG: Here in Tomah?

[1284] *Id.* at OIG 6052, at 17–18.

Witness: No, in [redacted]

VA OIG: Oh, okay.

Witness: I'm from [redacted]. We moved out here. And, um, to me, high doses were like 240 tablets of Percocet and I'm coming over here, and I'm seeing, wow, okay, 400 and something for a month Oxycodones, (inaudible), you know, stuff like that, and I'm like, "Okay, isn't that excessive?"

In the beginning I would check out the records, well they've been getting this for a while now, um, you know, ask my coworkers, "Oh that's—that's okay, it's normal."

So you know, you don't question too much, if I do feel that something is too high I would go to my supervisor . . . .[1285]

The same pharmacist spoke about how early refills were common at the Tomah VAMC pharmacy and recounted a specific instance in which a veteran requested an early refill for a controlled substance prescription. The pharmacist stated:

Witness: Um, well I can say my—my first experience I think was probably, what, my first month-and-a-half. I came into contact with um, I was in the window and I think her name is, [redacted].

Um she came in with—with her order for a C-2, I believe it was Oxycodone, and um, it was early—it was an early fill, and I told her straight out, you know, "we're going to talk with your doctor and see if it's okay," cause you know we have to, um document.

VA OIG: Did she give you a reason why she was there early?

Witness: Um, I don't believe so. I really—I really don't remember.

VA OIG: Okay.

Witness: Um, she said, "No its due today." She points out to the paper, "the date" and I'm like, "Yeah the date says its due in maybe three days or four days," I really don't remember.

[1285] VA OIG Interview with Tomah VAMC Pharmacist 2 (Aug. 23, 2012), OIG 5122–23 at 5–6.

But you know, "we'll call the doctor and we'll see what happens. You know, just let me talk to Jack."

VA OIG: And Jack is the supervisor?

Witness: Yeah.

VA OIG: Okay.

Witness: So you know, "all right, let him handle it," and that's the way it happened.

VA OIG: And then what happened?

Witness: Um, I believe it got filled.[1286]

It is unclear whether the VA OIG reviewed this veteran's chart after the Tomah VAMC pharmacist identified her as a veteran that received an early refill. Nevertheless, this account is yet another example of a firsthand experience that a Tomah VAMC pharmacist told to VA OIG health care inspectors.

Dr. Wesley and Dr. Mallinger interviewed another Tomah VAMC pharmacist on April 26, 2012. This pharmacist worked at the Tomah VAMC or at a Community-Based Outreach Clinic near the Tomah VAMC for over three years.[1287] The pharmacist told the VA OIG health care inspectors of a specific incident in which Dr. Houlihan blamed the pharmacist for the suicide of a veteran.

The pharmacist gave the veteran's name to the VA OIG and explained that the veteran was being treated at a clinic for anticoagulation.[1288] The veteran committed suicide after the pharmacist refused to fill his prescription because his pill box smelled of marijuana and the veteran could not perform a drug test. The veteran's wife claimed that the veteran killed himself because "the pharmacist wouldn't give him his pills."[1289] Because the veteran killed himself within 24 hours of seeing a VA physician, the VA conducted a root cause analysis and peer reviews of the individuals involved with the treatment of the veteran.[1290]

[1286] *Id.* at OIG 5123, at 6–7.
[1287] VA OIG Interview with Tomah VAMC Pharmacist 3 (Apr. 26, 2012), at OIG 5042.
[1288] *Id.* at OIG 5043, at 13.
[1289] *Id.* at OIG 5047, at 27.
[1290] *Id.*

The pharmacist was cleared of any wrongdoing but Dr. Houlihan apparently blamed the pharmacist for the veteran's suicide. The pharmacist described the interaction to VA OIG inspectors:

Witness: You know I was found, you know, not to be at fault for anything or whatever. I mean, nothing ever—nothing ever else came out of that, but, I mean, I was like—that like was one of the worst things that has ever happened to me in my career, and I still get upset by it, and Dr. Houlihan to this day tells people that I killed this patient and that because of me the patient killed himself.

* * *

I have no idea what happened, but the bottom line is that [the veteran] killed himself and that Dr. Houlihan has held me accountable for that because he said I did not dispense his medication, which is not true. Umm, the facility themselves had to do an [Root Cause Analysis]—

VA OIG: Who did he say that to?

VA OIG: We'll find out. So, umm, could—

Witness: And—pardon me?

VA OIG: I'm—I'm just wondering, how it was that you found out that Dr. Houlihan was—did Dr. Houlihan say these things to you directly?

Witness: Oh, he—he told the chief of staff. He's told Donna Leslie. Umm, or not chief of staff. I'm sorry, Chief of Pharmacy. He's told everyone.

VA OIG: And how do you know that?

Witness: I mean people have said Dr. Houlihan has said that this patient killed themselves because [the pharmacist] did not give him his medications.

VA OIG: So, umm, can you tell—I guess the first question is did—did he ever express that to you directly?

Witness: No, because I—I tried to stay as far away removed from him because of what Noel [*sic*] Johnson went through with him, the pharmacist he fired over her refusing to fill narcotic prescriptions.

VA OIG: Okay. We can get to that.

Witness: I mean, I was scared as hell of Houlihan.[1291]

The same pharmacist provided the VA OIG inspectors, Dr. Mallinger and Dr. Wesley, with names of individuals who were told that this pharmacist was responsible for the veteran's suicide.[1292] A review of the transcripts of subsequent VA OIG interviews does not show that VA OIG health care inspectors followed up with those individuals about the veteran's suicide or what Dr. Houlihan said about the pharmacist's culpability. Instead of conducting follow-up about this incident, the VA OIG did not substantiate the allegations of administrative abuse. The VA OIG's only reference to this incident is a passing mention in the administrative closure that a "clinical pharmacist who left the Tomah VAMC reported feeling inappropriately blamed by [Dr. Houlihan] for the suicide of a patient."[1293]

iv. The VA OIG did not heed warnings of pharmacy consultants

As referenced in the VA OIG's administrative closure, and explained in the majority staff's interim report from June 2015, the VA OIG selected three VA pharmacists from outside of the Tomah VAMC to act as consultants in the OIG's inspection.[1294] The administrative closure noted that the VA OIG used the pharmacy consultants to assist the health care inspectors in "evaluating the clinical administrative aspects of [Dr. Houlihan's] interactions with pharmacy staff and the staff's roles in facilitating patient safety and appropriately dispensing controlled substances."[1295] The inspection team provided the consultants with recordings of four interviews conducted of Tomah VAMC pharmacists.[1296] Based on a review of those interviews, the pharmacy consultants provided their feedback of the issues within the Tomah VAMC pharmacy. Despite receiving significant concerns about the clinical and administrative operations of the Tomah VAMC pharmacy in relation to Tomah VAMC management, the administrative closure made no mention of what the consultants found.[1297]

The VA OIG health care inspection team called on the pharmacy consultants because they did not have a pharmacist on the inspection team and the health care inspectors sought to gain a better understanding of the "guidelines and processes that are used" in situations where pharmacists feel uncomfortable filling certain prescriptions.[1298] In his transcribed interview with Chairman Johnson's staff, Dr. Mallinger explained the consultants' role. He stated:

[1291] *Id.* at OIG 5047–48, at 27–30.
[1292] *Id.* at OIG 5050, at 38.
[1293] VA OIG TOMAH VAMC ADMINISTRATIVE CLOSURE, at 5.
[1294] *Id.* at 4.
[1295] *Id.*
[1296] *Id.*
[1297] *See id.*
[1298] Shepherd 1/27/2016 Transcribed Interview, at 162.

> And we tasked these pharmacists with telling us basically whether the way these pharmacists dealt with their experiences were, you know, reasonable and appropriate. You know, basically we asked them to consider this from the context of the usual policies and procedures that pharmacists adhere to in the course of doing their jobs, and kind of the usual role expectations that you would have from a pharmacist in applying those policies and procedures. So they were kind of our quality check, if you will, on the—you know, the evaluation of the experiences that the pharmacists reported to us.[1299]

In total, the VA OIG solicited the opinions of three VA pharmacists from outside the Tomah VAMC: Dr. Nick Beckey, Dr. Mitchel Nazarrio, and Dr. Janelle Wormuth. Dr. Beckey and Dr. Wormuth provided written feedback to the VA OIG health care inspectors, and Dr. Nazarrio informed the VA OIG of his analysis orally during a phone call.[1300] All three pharmacists identified serious concerns with prescribing practices and management at the Tomah VAMC.

After reviewing the audio recordings of the VA OIG's interviews with the Tomah VAMC pharmacists, Dr. Beckey found "several concerns" that present "a significant risk" to the facility. Dr. Beckey identified as follows:

1. The Tomah VAMC pharmacy was at risk of having its DEA controlled substance license either revoked or suspended "due to the lack of sufficient effort to decrease the potential for diversion, abuse, and overdose after several red flags were raised";
2. The Tomah VAMC pharmacy was at risk of having its Joint Commission accreditation revoked or changed to partial accreditation; and
3. The Tomah VAMC a showed high potential risk of litigation by former or current employees.[1301]

Dr. Beckey found that there were "several concerning practices at [the Tomah VAMC] that were not only condoned by the Chief of Staff [Dr. Houlihan], but were insisted on by him when concerns were raised by pharmacists and other physicians."[1302] In particular, Dr. Beckey noted that (1) veterans were prescribed excessive doses of controlled substances; (2) veterans were prescribed an excessive amount of short-acting narcotics with no long-acting agents; and (3) providers exhibited a lack of due diligence when issues were raised about patients who demonstrated behaviors of abuse or diversion of medications.[1303]

[1299] Mallinger 4/6/2016 Transcribed Interview, at 265.
[1300] Nick Beckey, OIG Consultation, Tomah VAMC, OIG 1547 [hereinafter Nick Beckey Consultation]; Memorandum from Janelle Wormuth, PharmD, Chief, Pharmacy Service, VA Nebraska Western Iowa Health Care System, to OIG Review Team & Alan Mallinger (July 12, 2012), OIG 1943 [hereinafter Wormuth Memo]; Transcribed Interview with Mitchell Nazarrio, in West Palm Beach, Fla., at 30–31 (Dec. 1, 2015).
[1301] Nick Beckey Consultation, at OIG 1547.
[1302] *Id.*
[1303] *Id.*

With respect to the third finding relating to a lack of due diligence addressing concerns of potential drug abuse or diversion behavior, Dr. Beckey noted:

> The interviews were full of examples of patients who received high doses of controlled substances with negative urine drug screens for those agents and patients being given numerous replacements for controlled substances that were either lost or overused. Each time these issues were raised the decision was made by the Chief of Staff to insist on the replacement prescription, with no warning or follow up of the patients behavior. Additionally, a meeting was called by the Chief of Pharmacy that included concerned pharmacists and the Chief of Staff told them that nothing could be done about these cases, they were to fill the replacement prescriptions as written.[1304]

Dr. Beckey also noted that "more than one" individual at the Tomah VAMC told him that Dr. Houlihan was nicknamed the "Candy Man" by the patients "due to the ease in which [Dr. Houlihan] prescribed controlled substances."[1305] Dr. Beckey further identified "concerns that were raised by local police officers" and "more than one" overdose that occurred in the parking lot of the Tomah VAMC.[1306] For each of these points, Dr. Beckey wrote that "[i]t appears that there was also no action taken by senior leadership to address these concerns."[1307] Dr. Beckey also advised the VA OIG that based on his review, the Tomah VAMC was at risk of losing its Joint Commission accreditation and posed an increased risk of litigation relating to the termination of Tomah VAMC pharmacists.[1308]

Dr. Janelle Wormuth is Chief of Pharmacy Service at a Midwest VA facility and provided consultation for the VA OIG based on her review of VA OIG interviews with Tomah VAMC pharmacists.[1309] She described the prescriptions written by the Chief of Staff, Dr. Houlihan, as "extreme in quantity and dose."[1310] With respect to the Tomah VAMC pharmacy, Dr. Wormuth noted that "safety would be a concern of mine as well."[1311] Dr. Wormuth raised significant concerns about the relationship between pharmacists and providers at the Tomah VAMC. She wrote:

> The environment to practice pharmacy at the Toma [*sic*] VA does not seem safe. It is unacceptable, in my opinion, for an environment to exist that an entire team (PACT model of care) is not utilized to care for the patient. Every member of the team is valued in what they provide for the care of the patient. Pharmacists at the Toma [*sic*] VA have not been provided an environment to give optimal patient

[1304] *Id.*
[1305] *Id.* at OIG 1548.
[1306] *Id.*
[1307] *Id.*
[1308] *Id.*
[1309] Wormuth Memo, at OIG 1943.
[1310] *Id.*
[1311] *Id.*

> care. These 4 interviewed pharmacists no longer work at the Toma [*sic*] VA due to their perception that pharmacy practice is not supported. In my opinion, that perception is real. The Chief of Staff is not providing an environment where pharmacy practice is respected for the safety of patients. In addition, Pharmacy leadership has been inconsistent. Given the information on the 4 tapes, I would say the Chief of Staff is the reason the environment is hostile at the Toma [*sic*] VA.[1312]

Dr. Wormuth also wrote that she "support[s] a pharmacist refusing to fill a prescription for a patient if the safety of the patient is at risk."[1313] Her "expectations" before a pharmacist refuses to fill a prescription are that the pharmacist and provider have a discussion with each other and review the patient's prescription history.[1314]

In a transcribed interview with Chairman Johnson's staff, Dr. Beckey discussed his expectation that a provider and pharmacist would openly discuss any disagreement over a prescription. He spoke of the importance of a dialogue between providers and the dangers evident when pharmacists are afraid to speak up about questionable prescriptions. He stated:

> I did just a little presentation for the staff on civility and the dangers associated with being afraid of a provider, let's say, or there's a lot of medical errors that may occur because somebody just doesn't want to deal with a difficult nurse or a difficult provider, so what will happen is, the staff, instead of being yelled at by a physician, will choose not to call that physician when normally they would have called that physician on something, and so that has been an area of concentration for kind of like in the medical error community kind of to be able to speak up, you know. They'll say, you know, "Stop the line" kind of thing is a—is one of the things that is trying to be brought up in medicine. "No matter who you are, if you see something wrong during a surgery, you should speak up," so it's trying to get that kind of culture at this medical center or at any medical center is something that people are trying to do within the healthcare field.
>
> So that was kind of the biggest thing that you seem to obviously have pharmacists that were afraid or disgusted because they were speaking up over things that was concerning to them, the excessive doses of narcotics, the excessive dose of narcotics combined with a stimulant, so, you know, it seems that those all tended to be true once they actually looked at the numbers, and the average dose was much higher at Tomah, I believe, than at other sites, so that was my biggest—the biggest thing that was alarming was the fact that it was, it was brought up and it didn't seem to have been acted on by that site.[1315]

[1312] *Id.*
[1313] *Id.*
[1314] *Id.*
[1315] Transcribed Interview with Nick Beckey, in West Palm Beach, Fla., at 26–27 (Dec. 1, 2015).

During Dr. Mallinger's transcribed interview, Chairman Johnson's staff asked why the VA OIG only provided the consultants with the audio recordings of the four departed Tomah VAMC pharmacists. Dr. Mallinger stated:

> Q: Is there a particular reason why they only just received interview transcripts—or recordings, excuse me?
>
> A: Well, because what we wanted from them was to tell us—in other words, a pharmacist tells you a story, and they say, "I couldn't do this because it was the wrong thing to do." And I don't know whether all pharmacists are taught that that's the wrong thing to do or whether this particular person, you know, missed pharmacy school that day and didn't know it was okay. So we needed a check on the appropriate professional behavior of a pharmacist in response to certain situations, and they provided us with that check.[1316]

Ultimately, however, the VA OIG did not use any of the information that the consultants offered. The VA OIG's administrative closure provided no mention of the consultants' findings, nor were the consultants' concerns raised anywhere in the administrative closure. Dr. Mallinger explained that the consultants' opinions and analysis were rendered useless because the VA OIG health care inspection team did not corroborate the statements that the departed Tomah VAMC pharmacists made in the four interviews that the consultants reviewed. He stated:

> A: Now, you know, it's obviously—you know, you can have an opinion about these things from the story, but we wanted someone with real expertise. We were actually hoping, when we started this, that they would, you know, make us—enable us to use the pharmacists' interviews in a very authoritative way in our inspection. The problem got to be that we weren't unable—we were unable to corroborate a lot of things that the pharmacists were telling us, and so it had become less material. I mean, it made a lot of sense at the time, but then when we were not getting such consistent stories, it—you know, their—what they said was still useful, but it wasn't—you know, we couldn't use it to substantiate allegations because we didn't have the consistency of the evidence.
>
> Q: If I could turn your attention to Exhibit 33, OIG Bates 1547, this is Dr. Beckey's analysis. He writes here, "After listening to the testimony from the four pharmacists interviewed, I"—meaning Dr. Beckey—"have several concerns related to senior management at this VA. In

[1316] Mallinger 4/6/2016 Transcribed Interview, at 266.

particular, I believe these actions place the medical center at significant risk of the following: risk of having DEA license either revoked or suspended due to lack of a sufficient effort to decrease potential for diversion, abuse, and overdose after several red flags were raised." This is a pretty serious finding, no?

A: Well, here's the thing. The consultant was telling us what they were telling us from the perspective of the departed pharmacists. They didn't have any other information about Tomah at all. And so they were speaking strictly, you know, about these consequential things. They were speaking strictly from the perspective of the departed pharmacists. He makes that very clear in his write-up. You know, he says, if you look down on the third bullet point there at the last sentence, he says, you know, "From the interviews it appears that"—and most of what he writes through here is similarly qualified as, you know, representing the point of view of the interviewee. And all of these things may be true from the point of view of the interviewee, but if we couldn't corroborate what the interviewee told us, then they have much less credibility, I guess would be the word.

Q: And so is it fair to say that since the team couldn't subsequently corroborate what the departed pharmacists were saying, that the consultations your team received from folks like Dr. Beckey and the other pharmacy consultants was not very valuable to the inspection? Is that fair to say?

A: It was not valuable in terms of supporting allegations.[1317]

Because the VA OIG did not provide the consultants with additional information beyond the recordings of four interviews, the VA OIG essentially set these consultants up for failure. By arbitrarily narrowing the scope of the consultants' review, the VA OIG ignored the potentially dangerous elements of the Tomah VAMC pharmacy that the consultants found. The consultants' candid assessments of the risks at the Tomah VAMC paint a startling picture of the potentially dangerous prescription practices and toxic management at the Tomah VAMC. The VA OIG's willingness to discredit the consultants' assessment because the OIG could not corroborate the statements of the departed pharmacists prevented an opportunity to improve accountability at the Tomah VAMC.

[1317] *Id.* at 266–68.

3. VA OIG staff drafted the Tomah VAMC report as a public document, but management made a decision to administratively close the case

Dr. Mallinger, the lead inspector on the VA OIG's Tomah VAMC health care inspection team, originally drafted the results of the Tomah inspection as a report that would be published on the VA OIG's website. However, Dr. Daigh, the VA OIG's Assistant Inspector General for Healthcare Inspections, decided to administratively close the Tomah VAMC health care inspection. The decision to administratively close the health care inspection not only meant that the report was not originally published, but it also limited the VA OIG's ability to follow through on its suggestions to improve care at the Tomah VAMC.

Dr. Mallinger and Dr. Shepherd were the primary drafters of the administrative closure of the VA OIG's inspection of the Tomah VAMC. By February 2013, Dr. Mallinger was in the "very early" drafting stages of the Tomah VAMC report.[1318] On February 26, 2013, Dr. Mallinger emailed Dr. Wesley and Dr. Shepherd, writing "in anticipation of our conference call tomorrow, I am sending you my working draft of the Tomah report in which the Background section is completed. Hopefully this can provide a starting place for our discussion/planning."[1319] Dr. Mallinger confirmed that as of February 26, 2013, he was drafting the document with the understanding that the document would be a published report.[1320] In other words, as of late February 2013, the decision to administratively close the inspection with a nonpublic report had not been made.

Two days later, February 28, 2013, Dr. Mallinger emailed Dr. Wesley with the subject "Tomah report."[1321] The entire contents of the email were redacted by the VA OIG.[1322] During a transcribed interview with Dr. Mallinger, Chairman Johnson's staff inquired about how Dr. Mallinger worked with his superior, Dr. Wesley, in the drafting process. Dr. Mallinger explained:

> Well, Dr. Wesley generally will read things, and he may suggest things for us to change, or he may actually, you know, write some of the changes. It really varies from report to report. But he's sort of the next level of editing. In other words, I'd produce sort of the rougher document, and then he—when I talked about that pre-publication editing process that takes place, he's sort of the first element in that.[1323]

[1318] Mallinger 4/21/2016 Transcribed Interview, at 339.
[1319] E-mail from Alan Mallinger, VA OIG, to Michael Shepherd & George Wesley, VA OIG (Feb. 26, 2013, 5:43 PM), at OIG 11381.
[1320] Mallinger 4/21/2016 Transcribed Interview, at 340.
[1321] E-mail from Alan Mallinger, VA OIG, to George Wesley, VA OIG (Feb. 28, 2013, 6:20 PM), at OIG 11372.
[1322] *Id.*
[1323] Mallinger 4/21/2016 Transcribed Interview, at 345.

Dr. Mallinger explained that he and Dr. Shepherd interacted only with Dr. Wesley on the drafting of the Tomah report.[1324] Dr. Mallinger said that he and Dr. Shepherd were unaware of whether their superiors made subsequent edits to the document after they transmitted it to Dr. Wesley.[1325]

On March 1, 2013, Dr. Mallinger emailed Dr. Wesley and Dr. Shepherd with the subject "Tomah draft."[1326] He wrote: "Enclosed is the current draft with Scope and Methodology completed. 1 will start work on the Inspection Results – would appreciate some discussion on classifying the issues."[1327] A portion of the email was redacted by the VA OIG.[1328] Dr. Mallinger did not recall which of the allegations the team had decided to substantiate or unsubstantiated at this point in the drafting process.[1329] He did confirm that as of March 1, 2013, the Tomah VAMC inspection was planned to be completed in a report that would be published.[1330]

A month later, on April 3, 2013, Dr. Mallinger emailed Dr. Wesley about the Tomah VAMC report. His email read, "[e]nclosed is the draft Tomah report at long last. Thank you for your patience and support. I still need to condense case example #1, so you may want to limit your reading of that to the last seven paragraphs."[1331] The email had an attachment entitled "Tomah draft 4-3-13.doc."[1332] Dr. Mallinger subsequently emailed Dr. Wesley and Dr. Shepherd on April 23, 2013 with the subject "slightly revised Tomah draft per discussion" and the attachment "Tomah draft 4-23-13.doc."[1333] The VA OIG has withheld these drafts from Chairman Johnson and the Committee.

When Chairman Johnson's staff inquired about the "discussion" referenced in Dr. Mallinger's April 23rd email, VA OIG counsel interrupted on multiple occasions and prevented Dr. Mallinger from answering the questions.

> Q: This is Exhibit 50. Exhibit 50 is an email marked OIG Bates 11240 from Dr. Mallinger to Dr. Wesley, cc Dr. Shepherd, email sent Tuesday, April 23, 2013; subject line: slightly revised Tomah draft for discussion; with an attachment, Tomah draft 4-23-13.doc. Do you recall the discussion that led to this slightly revised—

[1324] *Id.* at 347.
[1325] *Id.*
[1326] E-mail from Alan Mallinger, VA OIG, to George Wesley & Michael Shepherd, VA OIG (Mar. 1, 203, 5:45 PM), at OIG 11370.
[1327] *Id.*
[1328] *Id.*
[1329] Mallinger 4/21/2016 Transcribed Interview, at 355–56.
[1330] *Id.* at 355–57.
[1331] E-mail from Alan Mallinger, VA OIG, to George Wesley, VA OIG (Apr. 3, 2013, 9:45 PM), at OIG 11280.
[1332] *Id.*
[1333] E-mail from Alan Mallinger, VA OIG, to George Wesley, VA OIG (Apr. 23, 2013, 2:45 PM), at OIG 11240.

VA OIG
Attorney: That would be deliberative.

Q: —draft?

VA OIG
Attorney: That would be deliberative. If we're doing revisions on the draft, that is per se deliberative.

Q: Dr. Mallinger, would you like to answer the question?

A: I honestly don't have any recollection of it anyway, so—these would—you know, it was a long time ago.

Q: Understood. Do you recall what changed between the version you sent to him on April 3rd—

VA OIG
Attorney: Again, objection. That's deliberative.

Q: Can I finish my question, please?

VA OIG
Attorney: You're asking about a change in a draft, but go ahead.

Q: Do you recall what changed between the draft you sent to him on April 3rd and this draft of April 23rd?

A: No, I really don't.

Q: Do you recall if this is a full and complete draft of the report?

A: Again, I really—I don't know.

Q: Do you recall whether the decision had been made to administratively close this document or inspection had been made at this point?

A: It had not been made at that point.[1334]

On May 3, 2013, Dr. Mallinger sent another email to Dr. Wesley with the subject, "Tomah current version."[1335] Three days later, on May 6, 2013, Dr. Mallinger again transmitted

[1334] Mallinger 4/21/2016 Transcribed Interview, at 362–64.
[1335] E-mail from Alan Mallinger, VA OIG, to George Wesley, VA OIG (May 3, 2013, 10:29 PM), OIG 11235.

another draft to Dr. Wesley.[1336] According to the transmittal email, this draft included "validated" chart review data.[1337] On May 15, 2013, Dr. Mallinger sent another draft to Dr. Wesley.[1338] The subject of that email was "Latest Tomah draft as discussed" and included an attachment labeled "Tomah draft 5-15-13.doc."[1339] The VA OIG has not produced any of these drafts to Chairman Johnson or the Committee.

Sometime between the email of May 15, 2013, and January 9, 2014, Dr. Daigh decided to administratively close the Tomah VAMC health care inspection.[1340] On January 9, 2014, Dr. Mallinger emailed Dr. Wesley with the subject line, "Tomah administrative closure" and an attachment entitled "Tomah Administrative Closure draft 1-8-14.docx."[1341] Dr. Mallinger's use of the term "administrative closure" to refer to the document, instead of the previously-used "report" suggests that by January 9, 2014, Dr. Daigh decided to administratively close the VA OIG's Tomah VAMC health care inspection. Dr. Mallinger explained to Chairman Johnson's staff that his email to Dr. Wesley on January 9, 2014, was when his "input" on the Tomah VAMC health care inspection ended.[1342]

Chairman Johnson's staff attempted to explore the differences between the versions Dr. Mallinger prepared as a published report in 2013 and the drafts of the administrative closure Dr. Mallinger prepared and ultimately sent to Dr. Wesley in January 2014. Again, VA OIG counsel interrupted the staff's questioning and directly ordered Dr. Mallinger not to answer questions from Chairman Johnson's staff:

Q: So was this version you sent up to Dr. Wesley in January the final version you worked on?

A: So that was—right. That was when my input to it ended. So I was giving her [*sic*]—to the best of my recollection, I was giving her [*sic*] the most up-to-date copy of it.

Q: So just to clarify, you did not work on the draft—the drafting of the Tomah administrative closure after mid-January of 2014?

A: Not to my recollection.

Q: Was the version that was the final closure significantly--

[1336] E-mail from Alan Mallinger, VA OIG, to George Wesley, VA OIG (May 6, 2013, 5:41 PM), OIG 11230.
[1337] *Id.*
[1338] E-mail from Alan Mallinger, VA OIG, to George Wesley, VA OIG (May 15, 2013, 1:23 PM), OIG 11226.
[1339] *Id.*
[1340] Daigh Transcribed Interview, at 96.
[1341] E-mail from Alan Mallinger, VA OIG, to George Wesley, VA OIG (Jan. 9, 2014, 12:09 PM), OIG 11224.
[1342] Mallinger 4/21/2016 Transcribed Interview, at 371.

VA OIG
Attorney: I'm going to object to that.

Q: Can I finish my question, please?

VA OIG
Attorney: No, he—

VA OIG
Attorney: Let him ask the question and then you can object, and—

VA OIG
Attorney: Don't answer before my objection, but please continue.

Q: Was the version that was the final administrative closure significantly different from the version you submitted to Dr. Wesley in January of 2014?

VA OIG
Attorney: And I object to the question because you're now asking about versions of draft reports, which is deliberative.

Q: Dr. Mallinger, please feel free to answer the question if you'd like.

VA OIG
Attorney: Dr. Mallinger, do not answer that question.[1343]

The VA OIG claims that the Tomah VAMC administrative closure was finalized on March 12, 2014.[1344] During his transcribed interview with Chairman Johnson's staff, Dr. Daigh explained why he decided to administratively close the Tomah VAMC health care inspection. He stated:

> Tomah created the other problem, and the problem that Tomah created with—was that I do not publish reports that contain a repetition—so our standard report repeats the allegations that were given to us. So I do not publish reports that repeat salacious allegations that I can't support. So to write a report with all sorts of accusations that I can't support and throw that into a small community destroys the community and destroys the VA.

[1343] *Id.* at 370–71.
[1344] *Tomah VAMC: Examining Quality, Access, and Culture of Overreliance on High-Risk Medications, Joint Field Hearing Before S. Comm. on Homeland Sec. & Governmental Affairs & H. Comm. on Veterans Affairs* 114th Cong. (2015) (statement of John Daigh, Jr.).

So in this report, we had allegations that—we had the whole panoply of sort of Candy Man allegations, right? You had allegations of people—of criminal activities. You had allegations of misuse of narcotics. You had allegations of all sorts of misbehavior among folks. And after we had interviewed people, after we had looked at all the emails, after we had talked to the DEA, after we had done all that work, there would be an allegation, and then I would say I don't have any data to support it.

The second allegation that was out there that was extremely important was that Dr. Houlihan was practicing substandard medicine and specifically that he was treating PTSD with narcotics. Alan [Mallinger] came to the conclusion that he was not treating PTSD with narcotics, that these patients had very complex medical history, often involving risk of suicide and other significant behaviors. So Alan came back and the other doctors supported that this guy was at the edge of what was normal, but we could not say that his practice was not within standard. So, again, I would have allegations:

Allegation: VA is treating patients with narcotics for PTSD. Not supported.

Allegation: VA is going to cut the leg off of a patient because he has chronic pain. Not supported.

Allegation: A gentleman committed suicide because his boss was unkind to him. We looked into that. Unsupported.

Then there would be in the last paragraph of the report, there would be—there would be a statement of what we could support, and that would be that there was a lack of trust and some managerial issues between the pharmacist and Dr. Houlihan or the chief of staff, which, frankly, is an extremely common finding that we have, you know, between different parts of hospitals frequently.

So I thought that those allegations, unsupported by us, was an inappropriate publication. I did, though, believe that even though we didn't have the data to support these allegations, we believed that there were issues there, and so we wrote suggestions. And I insisted that Alan and George Wesley meet with the director and go over what we had as issues formally, although as you can see from what you've already seen, they're aware of the issues. From the CAP report, we briefed them. They knew we were there talking to who we were talking to. We talked to the VISN director. And at those meetings, they came forward and told us the changes they'd already put into place to deal with the issues that we had identified.

So, you know, I think—so that was the reasoning. It was—if I don't—if I can't support the essential things, I think that repeating salacious allegations is not in

> the best interest of the Government or the hospital or the veterans in that community.[1345]

There is a significant difference between an administrative closure and a published report of a VA OIG health care inspection. Reports of health care inspections are published on the VA OIG's website. Administrative closures are not. Instead, the VA OIG merely lists the number of Office of Healthcare Inspections administrative closures it completed in its semiannual reports to Congress. Dr. Daigh stated that the VA OIG has "always" made administrative closures "freely available when asked."[1346] Of course, a congressional office—or even a concerned citizen, for that matter—would have to know of the existence of an inspection and administrative closure in order to request information pertaining to that inspection. That type of information is currently impossible to obtain from the VA OIG's practice of merely publishing the number of administrative closures in its semiannual reports to Congress.

Published reports go in-depth into the allegations that the VA OIG Office of Healthcare Inspections reviewed and provide evidence to support the office's findings. Conversely, administrative closures are "brief documents" that are "summar[ies] of the initial evidence" and are supposed to be one or two pages.[1347] Administrative closures are drafted in a different manner than published reports.[1348] Published reports also contain recommendations that require follow-up from the facility that the VA OIG reviewed.[1349] According to Dr. Mallinger, an administrative closure "won't normally contain recommendations," and the Tomah VAMC administrative closure contained a number of "suggestions"—rather than recommendations—for the facility to implement.[1350] Dr. Mallinger explained the significance of the differences between recommendations in published reports and suggestions contained in administrative closures.[1351] With respect to the Tomah VAMC inspection, Dr. Mallinger acknowledged that an administrative closure was his "big concern" because the suggestions differed in weight from OIG recommendations.[1352]

When Chairman Johnson's staff inquired whether the "suggestions" that appeared in the administrative closure were originally written as "recommendations" in initial drafts of the Tomah document, VA OIG counsel again objected and refused to allow Dr. Mallinger to answer the question.

> A: So recommendations are part of the standard kind of way we deal with reports. And as I've said before, you know, we—you know, in a sense they're the focus of the report. They're the things that we've identified

[1345] Daigh Transcribed Interview, at 93–95.
[1346] *Id.* at 95.
[1347] Mallinger 4/21/2016 Transcribed Interview, at 344; Daigh Transcribed Interview, at 96.
[1348] Mallinger 4/21/2016 Transcribed Interview, at 342–43.
[1349] *Id.* at 379–80.
[1350] *Id.* at 344.
[1351] *Id.* at 379–80.
[1352] *Id.*

that need to be changed, that we want the VA to change. And those get sent to the VA, along with the report, of course, pre-publication. And then they have to either concur or not concur with them. And our job is to make it so that they want to concur because, as I said, we don't run the VA, and if they don't agree, they're not going to do it. So we're trying to get them to make these changes.

So that's what we do, and those recommendations are then followed up on. We have like a separate office that follows up on the recommendations and, when they've been completed, basically closes them out. So it's a very formalized process.

Suggestions, you know, we don't have—in an administrative closure, we don't have a defined process like that. So—and this was actually one of the things we—the only—you know, once I heard this was going to be an administrative closure, this was my big concern. We had things to tell the VA, how are we going to do this? So the way that we decided to do it was through having suggestions. So we basically made the recommendations as suggestions. And they don't have the same formal follow-up process, and they don't require concurrence from the VA. But other than that, they're basically what had been the recommendations.

Q: So were these four or five suggestions in an earlier draft actually recommendations?

VA OIG Attorney: Objection, deliberative process. We're not talking about earlier drafts.[1353]

The difference between the OIG offering recommendations or mere suggestions appears to have had a direct effect on how the VA responding to the Tomah VAMC inspection. In the summer of 2014, VA OIG employees—including Dr. Mallinger, Dr. Shepherd, and Dr. Wesley—briefed Tomah VAMC Director Mario DeSanctis, then-VISN 12 Quality Management Officer Victoria Brahm, and VISN 12 Director Dr. Jeffrey Murawsky about the administrative closure's findings and suggestions.[1354] According to Dr. Mallinger, Director DeSanctis informed him at some time following the briefing that he chose not to implement one of the OIG's suggestions. Dr. Mallinger stated:

[1353] *Id.*

[1354] VA OIG Office of Healthcare Inspections, Alan Mallinger, Report of Contact with Jeffrey Murawsky, Network Director, VISN 12 (July 16, 2014, 1:30 PM), VA OIG 13814; VA OIG Office of Healthcare Inspections, Report of Contact with Mario DeSanctis, Victoria Brahm, & Julie Nutting (July 3, 2014), OIG 13651.

Q: And do you understand—from your understanding, did Director DeSanctis implement those changes after receiving this administrative closure?

A: Well, Mr. DeSanctis did make some changes, and he did contact me later and tell me that he wasn't going to make one of the changes, that he had decided. And so we kind of took it to the next level, to the VISN Director. So I think that, you know, it was two people involved here, the facility Director and the VISN Director. And I think, again, if you go through the specifics, you know, there were some things he said he did change. And so there were some—as I said, he contacted me later, and he said there was one thing he wasn't going to change. And—

Q: And what was that thing that he wasn't going to change?

A: It had to do with who the Director of the pharmacy reports to. We had—one of the problems that we identified structurally at Tomah—and, you know, as I kind of said, and said in the report, you know, there was kind of a dysfunctional system at Tomah. And part of the dysfunction we felt could be helped by not having the Pharmacy Director report to the Chief of Staff because—

Q: Who was—who was the Chief of Staff?

A: Dr. Houlihan.

Q: So Director DeSanctis called you after this June 2014 phone call and advised you that he was not going to change that process?

A: I don't know if he called me or emailed me or—but he—we—our recommendation was that the Pharmacy Director should report to him because, you know, there was already this conflict between Dr. Houlihan and the pharmacists. And if you have the Pharmacy Director, you know, basically under the Chief of Staff, then he—then there's no balance there. The pharmacists are totally at the mercy of whatever the Chief of Staff tells them. But if the Pharmacy Director points—reports to someone higher, then there's at least a chance for there to be balance if there's a disagreement as to how things should be done. So that was one of the structural things we felt.

Q: And Director DeSanctis advised you he was not changing Dr. Houlihan's role of overseeing the pharmacy?

A: That's my recollection. I'm trying to see what he said about it in this interview. But my recollection of it is that he contacted me separately and said that that was one change that he didn't feel comfortable making.

Q: Did he provide you a reason of why he wasn't comfortable making that change?

A: My recollection is he said he was too busy to have another person reporting to him. But I'm not totally sure that's correct.[1355]

Had the VA OIG's work product on its Tomah VAMC health care inspection been a published report rather than an administrative closure, the facility would have been required to work with the VA OIG to either concur or not concur with the recommendations and explain its decision. The published report would have ensured greater transparency with how the VA and the OIG addressed the problems at the Tomah VAMC. The VA would have had to explain why it agreed or disagreed with the VA OIG's recommendations to change the pharmacy reporting structure. The published report and recommendations would have also ensured accountability on the part of the VA to explain its reasoning for accepting or rejecting the Inspector General's recommendations. The facility's failure to act in this instance would have been well-documented and the public would not bave had to wait the many months for changes to actually be made.[1356]

Because the VA OIG continues to withhold drafts of the administrative closure—and Dr. Mallinger's earlier drafts prepared as a public report—Chairman Johnson and the majority staff cannot assess the substantive differences between the versions. It is clear, nonetheless, from the available information, that line-level VA OIG employees initially prepared the final product as a public report, a vast difference both substantively and procedurally from the nonpublic administrative closure.

4. The VA OIG understated the degree to which Dr. Houlihan's and Deborah Frasher's prescription practices were outside the norm

The VA OIG's analysis in its administrative closure downplayed the seriousness of prescription irregularities at the Tomah VAMC. The administrative closure concluded that "[a]lthough the allegations dealing with general overuse of narcotics at the facility may have had merit, they do not constitute proof of wrongdoing."[1357] However, the administrative closure also noted:

[1355] Mallinger 4/21/2016 Transcribed Interview, at 376–78.
[1356] Currently, the Chief of Pharmacy reports directly to the Associate Director of the Tomah VAMC. The Acting Associating Director of the Tomah VAMC is Jeffrey Evanson. Evanson Transcribed Interview, at 63.
[1357] VA OIG TOMAH VAMC ADMINISTRATIVE CLOSURE, at 9.

> Our inspection raised **potentially serious concerns** that should be brought to the attention of VISN 12 management for further review. In particular, we noted that the amounts of opioid equivalents prescribed by [Dr. Houlihan and Nurse Practitioner Frasher], both in the aggregate and per individual patient, were at **considerable variance** compared with most opioid prescribers in VISN . . . .[1358]

Standing alone, these comments seem to suggest rather serious allegations that are juxtaposed within a report that constitutes "no proof of wrongdoing." The administrative closure included charts and other data illustrating the outliers in the amount of opioids that were prescribed at the Tomah VAMC.

Figure 93: VA OIG Tomah VAMC Administrative Closure, Comparison of Opioid Prescriptions[1359]

Table 1. Morphine Equivalents Prescribed by each VISN 12 VAMC Station in FY 12.

Station	Total Morphine Equivalents	Unique Patients with Opioid Prescriptions	Total Morphine Equivalents/Unique Patients with Opioid Prescriptions	Average Daily Morphine Equivalents Dispensed (Total Morphine Equivalents/365 days)
676[2]	36,845,093	3171	11,619	100,945
585	28,974,019	3570	8,116	79,381
578	66,814,245	9144	7,307	183,053
607	42,341,117	5893	7,185	116,003
556	21,668,793	3390	6,392	59,367
695	51,990,679	9888	5,258	142,440
537	42,127,193	8662	4,863	115,417

In Figure 93 above, "station 676" refers to the Tomah VAMC. As is apparent, the Tomah VAMC has the smallest number of patients on opioids in all of VISN 12, but had the fifth-highest total prescribed morphine equivalent. This chart also shows that although the Tomah VAMC had the fewest patients in the VISN on opioids, the patients that were prescribed opioids received the highest dosages of opioids in the entire VISN.

[1358] *Id.* (emphasis added).
[1359] *Id.* at 7.

Figure 94: VA OIG Tomah VAMC Administrative Closure, Comparison of Clinician Prescribers[1360]

Table 2. Ten highest individual VISN 12 clinician prescribers (by morphine equivalents) in FY 12

Equivalence Determined by Total Quantity Dispensed in FY12				
Station	TotalMorphEquiv	UniquePats	TotalMorphineEquiv	AveDailyMeqDispensed
			Total Morph Eq/Unique Rx Pts	Total Morph Eq/365 Days
676 (NP Y)	5,326,011	182	29,264	14,592
585	4,213,089	366	11,511	11,543
578	4,162,684	271	15,360	11,405
537	3,810,090	311	12,251	10,439
676 (PA)	3,734,272	332	11,248	10,231
585	3,489,265	340	10,263	9,560
676 (Dr Z)	3,218,188	128	25,142	8,817
578	3,159,204	50	63,184	8,655
556	2,721,641	107	25,436	7,457
695	2,427,161	270	8,989	6,650

In Figure 94 above, Deborah Frasher is identified as "NP Y", Dr. Houlihan is identified as "Dr. Z" and an unnamed physician's assistant at the Tomah VAMC is marked as "PA." As the VA OIG noted in its administrative closure, Ms. Frasher was the highest prescriber of opiates in VISN 12 out of "3206 providers who wrote prescriptions for opioids."[1361] Dr. Houlihan was the "seventh highest opioid prescriber in VISN 12" and the unnamed physician's assistant was the "fifth highest prescriber" of opioids in all of VISN 12.[1362] All told, Dr. Houlihan, Ms. Frasher, and the physician's assistant at Tomah accounted for one-third "all morphine equivalents prescribed at Tomah VAMC" in fiscal year 2012.[1363] Ms. Frasher prescribed the second-most opioids per patient out of all VISN 12 providers.[1364] Dr. Houlihan prescribed the fourth-most opioids per patient out of VISN 12 providers.[1365]

The administrative closure noted that the opioid prescription practices at the Tomah VAMC were at "considerable variance compared with most opioid prescribers in VISN 12" but ultimately found no wrongdoing.[1366] The administrative closure downplayed or ignored other data about questionable prescriptions practices at Tomah VAMC. For example, in fiscal year 2012, Tomah VAMC prescribers accounted for 6 of the top 20 highest prescribing providers and nine of the top 30 highest prescribing providers in total morphine equivalent units dispensed.[1367]

[1360] *Id.* at 8.
[1361] *Id.*
[1362] *Id.*
[1363] *Id.*
[1364] *Id.*
[1365] *Id.*
[1366] *Id.* at 9.
[1367] Spreadsheet, Equivalence Determined by Total Quantity Dispensed in FY12, OIG 1947 (showing that Station 585 has 2 clinicians in the top 10 and 6 in the top 30, which is fully 10 percent less than Tomah VAMC's statistics).

The data that the VA OIG collected for fiscal year 2012 also showed the average daily morphine equivalent per specific patients.[1368] The data showed that a number of patients at the Tomah VAMC were prescribed less than 10 morphine equivalents per day. However, the data also showed outliers in both Dr. Houlihan and Ms. Frasher's prescription practices. For example, Ms. Frasher has 31 patients with a daily average greater than 100 morphine equivalents,[1369] and one patient had an average daily morphine equivalent of 2,185.[1370] Dr. Houlihan had 20 patients with daily morphine equivalents average over 100,[1371] and one patient with an average daily morphine equivalent of 1,614.[1372] While the administrative closure correctly noted that their prescription practices were at "considerable variance" with the rest of VISN 12, that statement does not capture the extent to which these professionals' prescription practices were outliers.[1373]

When opioids are prescribed with such frequency, it is important that the facility have in place proper safeguards to ensure that the drugs are used only for their proper purpose. One way to monitor and prevent improper drug use is to conduct urine drug screens (UDS). Providers give patients UDS to ensure that they are actually taking the drugs they are prescribed and not diverting them for illegal purpose. If veterans have negative UDS, it may be indicative that they are not taking the drugs they are prescribed and the drugs may potentially be diverted. The VA OIG found that at the Tomah VAMC, "negative [UDS] are not acted on and that controlled substances are still prescribed in the face of a negative UDS."[1374] The combination of high opioid prescriptions with non-action on negative UDS may result in the potential widespread diversion of drugs and may have contributed to the Tomah VAMC's perception in the community as "Candy Land." Had the VA OIG published its findings in a public report, instead of administratively closing the case, the VA could have been forced to respond to the findings and address these issues.

5. With the information available, it is difficult to assert that the VA OIG's email collection and review was adequate

The VA OIG reviewed emails collected from Tomah VAMC and VISN 12 employees during its health care inspection of the facility. In its administrative closure, the VA OIG wrote that it "collected an e-mail dataset for review consisting of 227,532 unique e-mail messages and 859 associated files originating from 17 individuals."[1375] The administrative closure noted that the health care inspection team "searched terms that could signal potential drug seeking behavior, such as those related to early refills and urine drug screens, in order to assess what was

[1368] *See* Spreadsheet, Average Daily Morphine Equivalent per Patient, OIG 2879–4122.
[1369] *See generally id.* at OIG 3188–91.
[1370] *See id.* at OIG 3189.
[1371] *See generally id.* at 3303–05.
[1372] *See id.* at OIG 3304.
[1373] *See* VA OIG TOMAH VAMC ADMINISTRATIVE CLOSURE, at 8–9.
[1374] *See id.* at 6.
[1375] *Id.* at 3.

being communicated about these topics, as well as what advice or instructions being given."[1376] In addition, the VA OIG team "reviewed messages pertaining to specific individuals in cases where administrative/supervisory conflicts were reported to exist."[1377]

These quoted excerpts are the only mention of email collection in the entire administrative closure. The VA OIG did not identify whose emails it collected or why it chose those individuals. It does not explain how long staff reviewed emails, or what information the inspectors learned from the emails.

Notably, the VA OIG did not provide Chairman Johnson and the Committee with all of the emails it collected as part of its inspection, as required pursuant to the Chairman's subpoena.[1378] Instead, the VA OIG provided Chairman Johnson with only a redacted subset of emails that were "tagged" as indicating that the VA OIG health care inspectors viewed the email.[1379] In a subsequent transcribed interview, a VA OIG attorney explained that the "tagged" emails were the emails that the health care inspectors marked as relevant to their inspection.[1380] Further, the attorney informed Chairman Johnson's staff that not all of the emails collected were necessarily part of the VA OIG's case file relating to the Tomah VAMC inspection.[1381] The VA OIG health care inspectors had to take the extra step of "tagging" the email as potentially relevant to their inspection in order for the email to qualify as part of the Tomah VAMC case file.[1382] One VA OIG employee who reviewed emails as part of the health care inspection recalled tagging "less than a handful" of emails.[1383]

The number of emails cited in the administrative closure is misleading in terms of the scope of the VA OIG's email search. The health care inspection team may have very well collected in excess of 227,000 emails, but it likely only reviewed a small fraction of that total that were "tagged" as potentially relevant. In addition, it appears that the VA OIG ignored emails it collected from individuals that could have shed light on administrative abuses and other issues at the Tomah VAMC.

The VA OIG health care inspectors solicited the assistance of the VA OIG criminal division to procure the emails of Tomah VAMC and VISN 12 employees.[1384] To obtain the emails, Dr. Robert Yang, a physician in the VA OIG's Office of Healthcare Inspections, wrote memoranda to the Director of Computer Crimes and Forensics Laboratory within the VA OIG's

[1376] *Id.* at 3.
[1377] *Id.* at 3.
[1378] Yang Transcribed Interview, at 131–32.
[1379] *Id.* at 130–31.
[1380] *Id.* at 131.
[1381] *Id.* at 132.
[1382] *Id.*
[1383] *Id.* at 140.
[1384] Memoranda from Robert Yang, VA, to Director, Computer Crimes and Forensics Laboratory (May 17, 2012), OIG 13676–78.

criminal division.[1385] The memoranda included the identity of the employee whose emails the VA OIG health care inspectors sought, the sources for the email pull (whether it was from the network drive, local computer or both) and whether the emails needed to be decrypted.[1386] Brian Tullis, Assistant Special Agent in Charge and Director of the Computer Crimes and Forensics division of the VA OIG's Criminal Investigations unit, facilitated the production of emails to the health care inspection team.[1387]

Dr. Yang sent two request memoranda for emails of Tomah VAMC and VISN 12 employees. Dr. Yang sent the first request via email to Mr. Tullis on May 17, 2012.[1388] He sent the second request memorandum on August 30, 2012.[1389] In total, the VA OIG health care inspection team reviewed the emails of the following individuals:

- Dr. David Houlihan, Tomah VAMC Chief of Staff;
- Deborah Frasher, Nurse Practitioner, Tomah VAMC;
- Thomas Jaeger, Pharmacist, Tomah VAMC;
- Margaret Hyde, Pharmacist, Tomah VAMC;
- Mary Forslund, Nurse Practitioner, Tomah VAMC;
- Dr. Zakia Amling (Siddiqi), Physician, Minneapolis VAMC (formerly Tomah VAMC);[1390]
- Dr. Christopher Kirkpatrick, Psychologist, Tomah VAMC;
- Linda Ellinghuysen, Patient Safety Nurse, AFGE 007 President, Tomah VAMC;
- Dr. Gary Loethen, Psychologist, Tomah VAMC;
- Cindy Gile, Physician Assistant, Tomah VAMC;
- Angela Cournoyer, Pharmacist, Tomah VAMC;
- Craig Otting, Pharmacist, Tomah VAMC;[1391]
- Jerald Molnar, Director, Tomah VAMC;
- Donna Leslie, VISN 12 Pharmacy Executive, VISN 12 Office;
- Ron Pelham, Chief of Pharmacy, Tomah VAMC;
- John H. Edwards, Psychiatrist, Madison VAMC;
- Dr. Dean Whiteway, Physician, Tomah VAMC; and[1392]

[1385] *Id.*
[1386] *Id.*
[1387] *Id.*; E-mail from Brian Tullis, VA OIG, to Robert Yang & Alan Mallinger, VA OIG (July 5, 2012, 8:26 AM), OIG 10348.
[1388] Memorandum from Robert Yang, VA, to Director, Computer Crimes and Forensics Laboratory (May 17, 2012), OIG 13676; Memorandum from Robert Yang, VA, to Director, Computer Crimes and Forensics Laboratory (May 17, 2012), OIG 13677; Memorandum from Robert Yang, VA, to Director, Computer Crimes and Forensics Laboratory (May 17, 2012), OIG 13678.
[1389] Memorandum from Robert Yang, VA, to Director, Computer Crimes and Forensics Laboratory (Aug. 30, 2012), OIG 10351.
[1390] Memorandum from Robert Yang, VA, to Director, Computer Crimes and Forensics Laboratory (May 17, 2012), OIG 13676.
[1391] Memorandum from Robert Yang, VA, to Director, Computer Crimes and Forensics Laboratory (May 17, 2012), OIG 13677.

- Roberto Obong, Chief of Police, Tomah VAMC.[1393]

Dr. Yang explained that the VA OIG "reviewed the emails over the course of several days. Again, three separate days, we sat down and went through them for about—I'm thinking anywhere between 2 and 4 hours at a time."[1394] Dr. Mallinger estimated that the total time reviewing emails would "probably be a week of work."[1395]

Dr. Mallinger explained to Chairman Johnson's staff during a transcribed interview why the VA OIG collected the emails of certain employees. In particular, the VA OIG chose to collect emails from Lin Ellinghuysen, the president of the local Tomah employees union, although the VA OIG opted not to interview Ms. Ellinghuysen as a part of its inspection. When discussing these decisions with Chairman Johnson's staff, Dr. Mallinger stated:

A: So in the Juneau County sheriff's investigation, there were several individuals who were named. And, again, we wanted to look more carefully at this because there were allegations that somehow he had been critical of Dr. Houlihan's prescribing practices and had been fired because of that. And so these people listed below his name—Linda Ellinghuysen, as I said, had represented him, Gary Loethen was his supervisor, and Cindy Gile was a physician's assistant who supposedly he made these comments to about Dr. Houlihan's practice. And so we wanted to see whether, you know, we could get any further information about any potential administrative abuse that might have taken place by looking through these records to basically see if, you know, they were sent emails or, you know, that they sent emails that would shed further light on that.

Q: And what did you find? Did you confirm the allegations? Or were those unsubstantiated?

A: Well, there weren't allegations about Dr. Kirkpatrick directly in the allegations we received, except for this—you see he's mentioned here in the EAR survey. I think it was in the EAR survey. No, I guess not. I guess he was mentioned in an interview. I know I saw him go by today. But, you know, basically there were—you know, there weren't, strictly speaking, allegations but, again, we were looking for administrative abuse, and, you know, we have a little latitude to go,

[1392] Memorandum from Robert Yang, VA, to Director, Computer Crimes and Forensics Laboratory (May 17, 2012), OIG 13678.
[1393] Memorandum from Robert Yang, VA, to Director, Computer Crimes and Forensics Laboratory (Aug. 30, 2012), OIG 10351.
[1394] Yang Transcribed Interview, at 140.
[1395] Mallinger 4/21/2016 Transcribed Interview, at 335.

you know, take a look at things that turn up in the leads that we develop. So that's really what we were doing here, is we were trying to determine whether there was any evidence for administrative abuse that arose out of this situation. And, basically, frankly, we were trying to understand the situation a little bit better—

Q: Did have a sit-down interview with Linda Ellinghuysen during this inspection?

A: I don't think so.

Q: Why not?

A: Well, because we didn't really feel that the situation with Dr. Kirkpatrick led anywhere. We thought it was another—you know, one of many sort of thing that we followed that didn't take us to a productive conclusion.

Q: So did you review Linda Ellinghuysen's emails? And during that review were there emails that illustrated her concerns about the facility?

A: Well, actually, you know, several of her emails were in the Juneau County sheriff's report, and whether we got additional fruitful emails I'm not really—it's a little hard to remember specifically.

Q: Do you recall discussions about potentially having a sit-down, in-person interview with Linda Ellinghuysen?

A: We may have discussed it. I really don't recall any specific discussions.[1396]

The Juneau County Sheriff's report on Dr. Kirkpatrick's suicide contained several emails between Ms. Ellinghuysen, Dr. Kirkpatrick, and other union officials.[1397] The emails discussed Dr. Kirkpatrick's concerns about overmedicated patients and his belief that he had "every reason to be afraid of Dr. Houlihan" for raising those concerns to others at the Tomah VAMC.[1398] In addition, Ms. Ellinghuysen told Chairman Johnson's staff that she had raised concerns to the VA OIG about prescription practices and potential retaliation at the Tomah VAMC in January

[1396] Mallinger 4/6/2016 Transcribed Interview, at 256–58.
[1397] E-mail exchange between Chris Kirkpatrick, M.D., U.S. Dep't of Veterans Affairs, Dianne Streeter, VA Chief Steward, AFGE Local 1882, and Linda Ellinghuysen, Executive V.P., AFGE Local 1882, at 1-5 (Apr. 23, 2009) *in* JUNEAU COUNTY SHERIFF'S DEPARTMENT, CHRIS KIRKPATRICK DEATH INVESTIGATION REPORT 40, at 40-44 (2009).
[1398] *Id.* at 42-43.

2009.[1399] Even in light of these multiple concerns, it does not appear that VA OIG health care inspectors carefully reviewed Ms. Ellinghuysen's emails, nor did they attempt to interview her.

Chairman Johnson's also tried to determine whether the VA OIG interviewed other individuals whose emails it collected; however, the VA OIG refused to provide the names of the individuals it interviewed. For example, the VA OIG staff collected the emails of Dr. Zakia Siddiqi, a former physician at the Tomah VAMC.[1400] Dr. Mallinger explained that the VA OIG had pulled Dr. Siddiqi's emails because investigators "had concerns about the possibility of retaliation."[1401] A report of contact completed by Dr. Mallinger on April 4, 2012, detailed his conversation with a DEA diversion investigator.[1402] The report of contact identified potential sources of information to further the VA OIG's investigation. One of those sources read:

> [Redacted] (current married name [redacted]). This is a physician currently employed at the [redacted], who works in [redacted]. Reportedly she was "fired" by Dr. Houlihan for refusing to write an oxycodone prescription for a patient with a negative drug screen. This was reported by a former VA pharmacist.[1403]

A subsequent Report of Contact completed by Dr. Mallinger on April 17, 2012, recounted a conversation with a doctor and that Dr. Mallinger "had gotten her name from DEA Agent [redacted] (see ROC 4-4-12)."[1404] The Report of Contact noted that the individual was "defensive throughout the conversation" and "did not want to talk with the IG."[1405]

During a transcribed interview, Chairman Johnson's staff asked Dr. Mallinger whether the individual referenced in the reports of contact was Dr. Siddiqi. VA OIG counsel interrupted the Committee's questioning and ordered Dr. Mallinger not to answer the question:

> Q: Is that individual, Dr. Siddiqi, the individual—
>
> VA OIG Attorney: He's not going to answer that question because we said we redacted it.
>
> Q: Well, I'm going to ask it anyways.
>
> VA OIG

[1399] Ellinghuysen Transcribed Interview, at 69–72.
[1400] Memorandum from Robert Yang, VA, to Director, Computer Crimes and Forensics Laboratory (May 17, 2012), OIG 13676.
[1401] Mallinger 4/6/2016 Transcribed Interview, at 254.
[1402] VA OIG Office of Healthcare Inspections, Alan Mallinger, Report of Contact with Diversion Investigator, DEA, (Apr. 4, 2012), OIG 5896
[1403] *Id.*
[1404] VA OIG Office of Healthcare Inspections, Alan Mallinger, Report of Contact with Staff Physical (Apr. 17, 2012), OIG 5899.
[1405] *Id.*

Attorney: Okay.

Q: But on Exhibit 25, paragraph 2—

VA OIG
Attorney: It's redact—you're not going to answer anything about redacted names.

Q: So you pulled Dr. Siddiqi's emails. Is what is mentioned in Exhibit 25 in paragraph 2, did you find anything of that in Dr. Siddiqi's emails?

VA OIG
Attorney: He's not going to admit that it's Dr. Siddiqi, so—

Q: Would you like to answer, Dr. Mallinger?

VA OIG
Attorney: No, don't answer.

VA OIG
Attorney: He can't answer that.[1406]

The VA OIG's obstruction on the identity of the people it interviewed presented challenges in determining whether the office interviewed the individuals whose emails they collected. Nevertheless, the recitation in the VA OIG's administrative closure of total number of emails collected in a misleading number that does not represent the number of emails actually reviewed. Even in a case where the VA OIG collected an individual's email, it did not conduct interviews with them. With the limited information available, it is difficult to know with certainty whether the VA OIG's email collection was adequate to assess the allegations.

6. There is conflicting information about the date of the VA OIG's closure of the Tomah VAMC inspection

From documents and other information available to the Committee, there is a degree of uncertainty as to when the VA OIG closed its inspection of the Tomah VAMC. The VA OIG informed Chairman Johnson through multiple letters and statements that Dr. Daigh administratively closed the Tomah VAMC health care inspection on March 12, 2014.[1407] However, VA OIG's Master Case Index (MCI)—the VA OIG's case management and tracking

[1406] Mallinger 4/6/2016 Transcribed Interview, at 254–55.
[1407] *Tomah VAMC: Examining Quality, Access, and Culture of Overreliance on High-Risk Medications, Joint Field Hearing Before S. Comm. on Homeland Sec. & Governmental Affairs & H. Comm. on Veterans Affairs* 114th Cong. (2015) (statement of John Daigh, Jr.).

system—indicates that the Tomah VAMC administrative closure was not closed until August 2014.[1408]

Dr. Daigh testified during the Committee's field hearing in March 2015 that he administratively closed the Tomah VAMC health care inspection on March 12, 2014.[1409] Internal email correspondence from the VA OIG also shows that Dr. Daigh signed the administrative closure on March 12, 2014. On the morning of March 12, 2014, Dr. Daigh received an email informing him that "[t]he adjusted copy of the Tomah Admin Closure is uploaded to your box in SharePoint as well as attached. Edna is preparing a printed copy for your signature."[1410] Later that afternoon, of March 12, 2014, Dr. Daigh replied, "Thanks… signed and provided to Edna."[1411]

In a transcribed interview with Chairman Johnson's staff, Dr. Daigh explained that his signing and dating of an administrative closure marks the conclusion of a health care inspection.[1412] He also reiterated that the Tomah VAMC health care inspection was closed on March 12, 2014.[1413]

Page 11 of the VA OIG's administrative closure about the Tomah VAMC bears Dr. Daigh's signature and a date marking the end of the closure.[1414] The date appears to read "3/12/14"; however, the "3" appears to have additional markings that would seem to be unnecessary for an ordinary marking of the numeral. These additional markings appear to suggest that the "3" may have been altered in some form, and could have been an "8" at some time. The numeral "8"—for August—would seem to match the information in the VA OIG's Master Case Index.

[1408] *See* VA OIG Healthcare Transaction Report, MCI # 2011-04212-HI-0267 (May 1, 2015, 11:46 AM), OIG 1394, at OIG 1394–96; VA OIG Hotline Input Transaction, MCI # 2011-04212-HL-1068 (May 1, 2015, 11:48 AM), OIG 1397.

[1409] *Tomah VAMC: Examining Quality, Access, and Culture of Overreliance on High-Risk Medications, Joint Field Hearing Before S. Comm. on Homeland Sec. & Governmental Affairs & H. Comm. on Veterans Affairs* 114th Cong. (2015) (statement of John Daigh, Jr.).

[1410] E-mail from Natalie Sadow, VA OIG, to John Daigh, VA OIG (Mar. 12, 2014, 11:41 AM), OIG 10304.

[1411] E-mail from John Daigh, VA OIG, to Natalie Sadow, VA OIG (Mar. 12, 2014, 1:20 PM), OIG 10304.

[1412] Daigh Transcribed Interview, at 132.

[1413] *Id.* at 132–33.

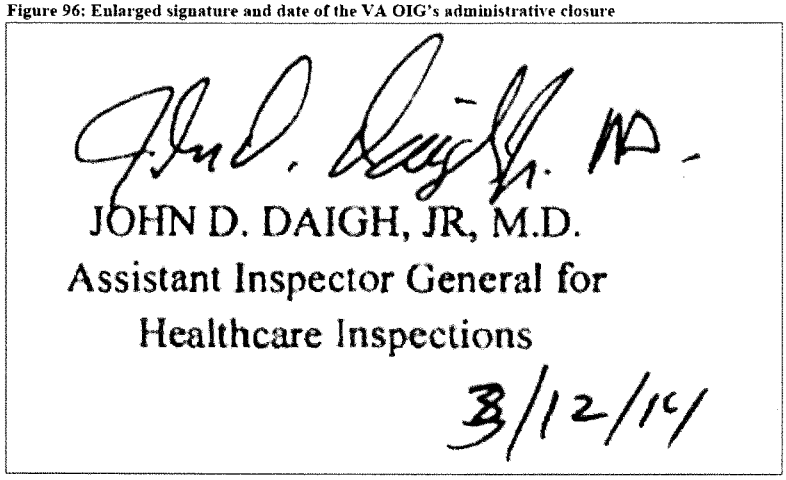
[1414] *Id.* at 129.

Figure 95: Page 11 of the VA OIG's administrative closure[1415]

Based on our review, I am administratively closing this case.

JOHN D. DAIGH, JR, M.D.
Assistant Inspector General for
Healthcare Inspections
3/12/14

Figure 96: Enlarged signature and date of the VA OIG's administrative closure



When Chairman Johnson's staff interviewed Dr. Daigh about the date of the administrative closure, he said that he did not recall signing the document. He stated:

> Q: This is an unredacted copy of the administrative closure the Committee received pursuant to a request letter from Chairman Johnson. The title of the document is "Administrative Closure,

[1415] VA OIG TOMAH VAMC ADMINISTRATIVE CLOSURE, at 11.

Alleged Inappropriate Prescribing of Controlled Substances and Alleged Abuse of Authority, Tomah VA Medical Center, Tomah, Wisconsin, MCI 25 2011-04212-HI-0267." Dr. Daigh, if I could turn your attention to the last page, please?

A: Sure.

Q: Is that your signature on that page there?

A: Yes.

Q: What is the date of this document?

A: I think it says 3/12/14.

Q: Do you recall dating it when you closed it and signed it?

A: I typically do, yes.

Q: But do you recall in this instance?

A: No.[1416]

Pursuant to the Chairman Johnson's subpoena, the Committee received the VA OIG's MCI file document for the Tomah VAMC Inspection. The VA OIG gives each hotline a unique identifier number to mark its progress in the MCI file. The MCI documents for each hotline summarize the allegations the hotline received, marked the dates the VA OIG received the allegation, as well as milestones as the team progressed through the health care inspection. In addition, the MCI notes when the VA OIG closes each inspection.

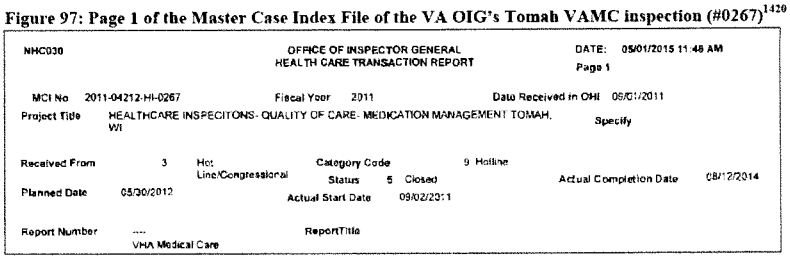
There are two hotline numbers and MCI input documents that refer to the Tomah VAMC health care inspection. The VA OIG's administrative closure identified the Tomah health care inspection as MCI # 2011-04212-HI-0267.[1417] The VA OIG bundled the hotline it received from Congressman Kind in August 2011 with the same inspection that the health care inspection team was already conducting. The referral from Congressman Kind was marked with the MCI # 2011-04212-HL-1068.[1418]

Chairman Johnson's staff reviewed the MCI tracking documents for both of those hotlines. The VA OIG's case tracking and management system for MCI# 2011-04212-HI-0267

[1416] Daigh Transcribed Interview, at 128–29.
[1417] VA OIG TOMAH VAMC ADMINISTRATIVE CLOSURE, at 1.
[1418] VA OIG Hotline Input Transaction, MCI # 2011-04212-HL-1068 (May 1, 2015, 11:48 AM), OIG 1397.

shows that the "actual completion date" and the "publication date" of the VA OIG's Tomah VAMC health care inspection was August 12, 2014.[1419]

Figure 97: Page 1 of the Master Case Index File of the VA OIG's Tomah VAMC inspection (#0267)[1420]



NHC030 — OFFICE OF INSPECTOR GENERAL, HEALTH CARE TRANSACTION REPORT — DATE: 05/01/2015 11:46 AM, Page 1

MCI No 2011-04212-HI-0267 — Fiscal Year 2011 — Date Received in OHI 09/01/2011

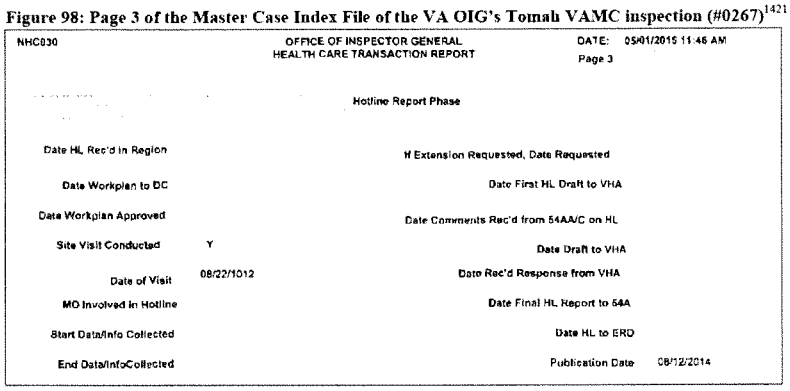
Project Title: HEALTHCARE INSPECITONS- QUALITY OF CARE- MEDICATION MANAGEMENT TOMAH, WI — Specify

Received From: 3 Hot Line/Congressional — Category Code: 9 Hotline — Status: 5 Closed — Actual Completion Date: 08/12/2014

Planned Date: 05/30/2012 — Actual Start Date: 09/02/2011

Report Number: --- — ReportTitle: VHA Medical Care

Figure 98: Page 3 of the Master Case Index File of the VA OIG's Tomah VAMC inspection (#0267)[1421]



NHC030 — OFFICE OF INSPECTOR GENERAL, HEALTH CARE TRANSACTION REPORT — DATE: 05/01/2015 11:46 AM, Page 3

Hotline Report Phase

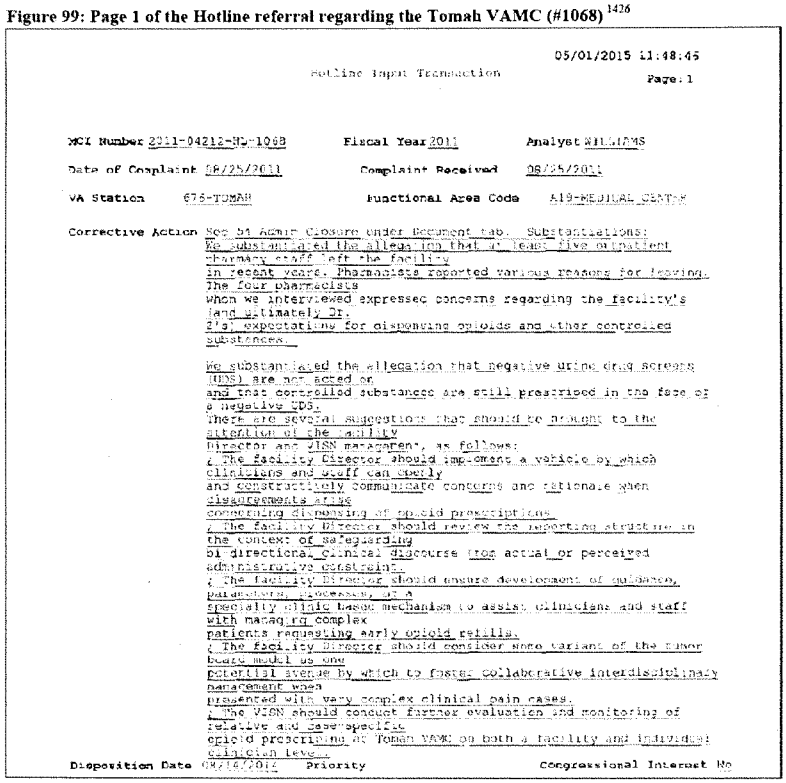
Date HL Rec'd in Region		If Extension Requested, Date Requested	
Date Workplan to DC		Date First HL Draft to VHA	
Date Workplan Approved		Date Comments Rec'd from 54AA/C on HL	
Site Visit Conducted	Y	Date Draft to VHA	
Date of Visit	08/22/1012	Date Rec'd Response from VHA	
MO Involved in Hotline		Date Final HL Report to 54A	
Start Data/Info Collected		Date HL to ERD	
End Data/InfoCollected		Publication Date	08/12/2014

In addition, the MCI information from the hotline referred by Congressman Kind— MCI # 2011-04212-HL-1068—similarly indicates that the referral was also closed in August 2014. The first page of the case-tracking document summarized what the VA OIG found in the administrative closure and notes the "disposition date" as August 14, 2014.[1422] Likewise, page two of the document summarized the allegations and displayed the date of the "response received" as August 14, 2014.[1423] The third page of the MCI information for the Tomah VAMC hotline showed that the hotline was administratively closed on August 14, 2014. The "analyst

[1419] VA OIG Healthcare Transaction Report, MCI # 2011-04212-HI-0267 (May 1, 2015, 11:46 AM), OIG 1394, at OIG 1394–96.
[1420] *Id.* at OIG 1394.
[1421] *Id.* at OIG 1396.
[1422] VA OIG Hotline Input Transaction, MCI # 2011-04212-HL-1068 (May 1, 2015, 11:48 AM), OIG 1397.
[1423] *Id.* at OIG 1398.

notes" on page three also showed that the administrative closure was "received" on August 14, 2014.[1424] It further indicated that the case was "closed partially substantiated" and that "Cathy"—likely VA OIG Congressional Relations Officer Catherine Gromek—was given "a copy for her congressional case" on August 14, 2014.[1425]

Figure 99: Page 1 of the Hotline referral regarding the Tomah VAMC (#1068)[1426]



05/01/2015 11:48:45
Hotline Input Transaction
Page: 1

MCI Number 2011-04212-HQ-1068 Fiscal Year 2011 Analyst WILLIAMS

Date of Complaint 08/25/2011 Complaint Received 08/25/2011

VA Station 676-TOMAH Functional Area Code A19-MEDICAL CENTER

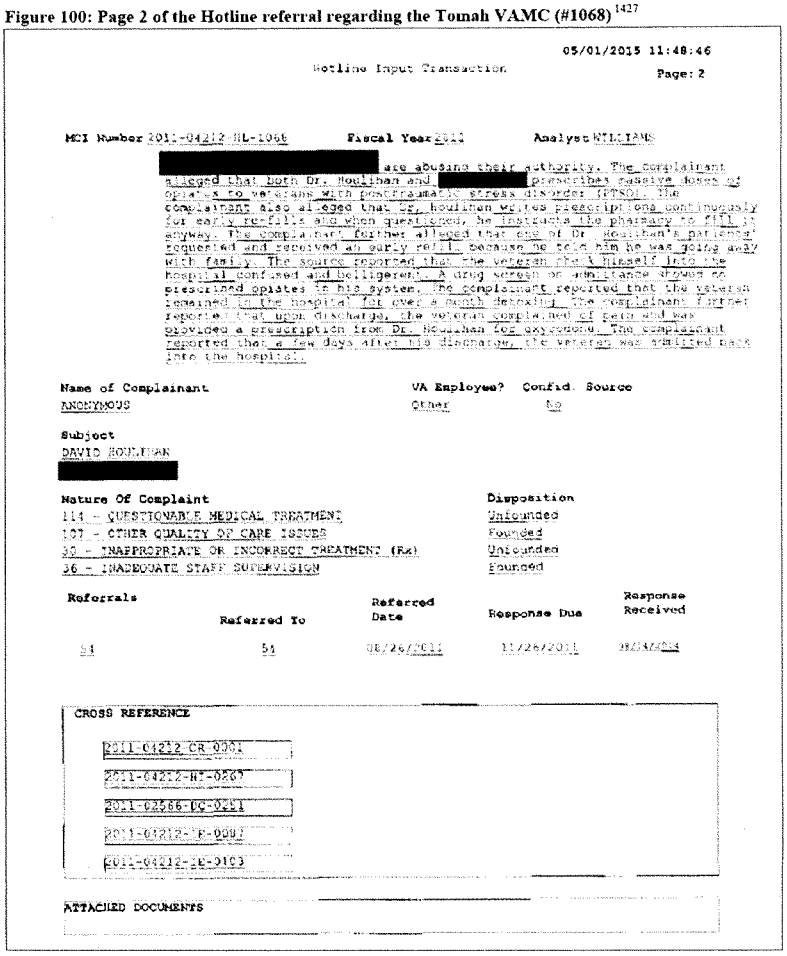
Corrective Action See 01 Admin Closure under Document tab. Substantiations:
We substantiated the allegation that at least five outpatient
pharmacy staff left the facility
in recent years. Pharmacists reported various reasons for leaving.
The four pharmacists
whom we interviewed expressed concerns regarding the facility's
lend ultimately Dr.
P's] expectations for dispensing opioids and other controlled
substances.

We substantiated the allegation that negative urine drug screens
(UDS) are not acted on
and that controlled substances are still prescribed in the face of
a negative UDS.
There are several suggestions that should be brought to the
attention of the facility
Director and VISN management, as follows:
(The facility Director should implement a vehicle by which
clinicians and staff can openly
and constructively communicate concerns and rationale when
disagreements arise
concerning dispensing of opioid prescriptions.
(The facility Director should review the reporting structure in
the context of safeguarding
bi directional clinical discourse from actual or perceived
administrative constraint.
(The facility Director should ensure development of guidance,
parameters, processes, or a
specialty clinic based mechanism to assist clinicians and staff
with managing complex
patients requesting early opioid refills.
(The facility Director should consider some variant of the Tumor
Board model as one
potential avenue by which to foster collaborative interdisciplinary
management when
presented with very complex clinical pain cases.
(The VISN should conduct further evaluation and monitoring of
relative and case-specific
opioid prescribing at Tomah VAMC on both a facility and individual
clinician level.

Disposition Date 09/16/2011 Priority Congressional Interest No

[1424] *Id.* at OIG 1399.
[1425] *Id.*
[1426] *Id.* at OIG 1397.

Figure 100: Page 2 of the Hotline referral regarding the Tomah VAMC (#1068)[1427]



05/01/2015 11:48:46
Hotline Input Transaction
Page: 2

MCI Number 2011-04212-HL-1068 Fiscal Year 2011 Analyst WILLIAMS

[redacted] are abusing their authority. The complainant alleged that both Dr. Houlihan and [redacted] prescribes excessive doses of opiates to veterans with posttraumatic stress disorder (PTSD). The complainant also alleged that Dr. Houlihan writes prescriptions continuously for early refills and when questioned, he instructs the pharmacy to fill it anyway. The complainant further alleged that one of Dr. Houlihan's patients' requested and received an early refill because he told him he was going away with family. The source reported that the veteran checked himself into the hospital confused and belligerent. A drug screen on admittance showed no prescribed opiates in his system. The complainant reported that the veteran remained in the hospital for over a month detoxing. The complainant further reported that upon discharge, the veteran complained of pain and was provided a prescription from Dr. Houlihan for oxycodone. The complainant reported that a few days after his discharge, the veteran was admitted back into the hospital.

Name of Complainant	VA Employee?	Confid. Source
ANONYMOUS	Other	No

Subject
DAVID HOULIHAN
[redacted]

Nature Of Complaint	Disposition
114 - QUESTIONABLE MEDICAL TREATMENT	Unfounded
107 - OTHER QUALITY OF CARE ISSUES	Founded
30 - INAPPROPRIATE OR INCORRECT TREATMENT (Rx)	Unfounded
36 - INADEQUATE STAFF SUPERVISION	Founded

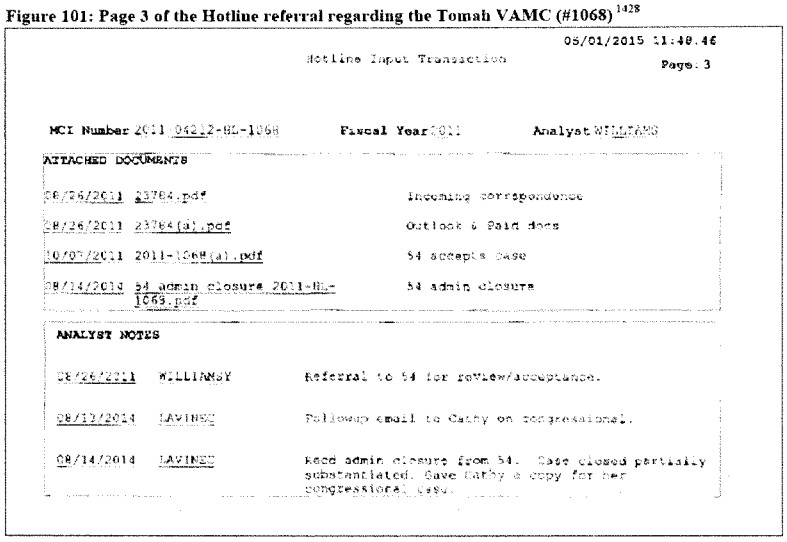
Referrals	Referred To	Referred Date	Response Due	Response Received
54	54	08/26/2011	11/26/2011	09/14/2011

CROSS REFERENCE
2011-04212-CR-0001
2011-04212-HT-0267
2011-02566-DC-0251
2011-01812-IF-0007
2011-04212-IG-0103

ATTACHED DOCUMENTS

[1427] *Id.* at OIG 1398.

Figure 101: Page 3 of the Hotline referral regarding the Tomah VAMC (#1068)[1428]



05/01/2015 11:48.46
Page: 3

Hotline Input Transaction

MCI Number 2011-04212-HI-1068 Fiscal Year 2011 Analyst WILLIAMS

ATTACHED DOCUMENTS

08/26/2011	23764.pdf	Incoming correspondence
08/26/2011	23764(a).pdf	Outlook 6 Paid docs
10/07/2011	2011-1068(a).pdf	54 accepts case
08/14/2014	54 admin closure 2011-HI-1068.pdf	54 admin closure

ANALYST NOTES

08/26/2011	WILLIAMSY	Referral to 54 for review/acceptance.
08/13/2014	LAVINEC	Followup email to Cathy on congressional.
08/14/2014	LAVINEC	Need admin closure from 54. Case closed partially substantiated. Gave Cathy a copy for her congressional case.

When interviewed by Chairman Johnson's staff, Dr. Daigh said that he did not know why the case-tracking system for the Tomah VAMC inspection showed that the inspection was administratively closed on August 12, 2014. He stated:

> Q: For the record, Exhibit 24 is three pages marked OIG Bates 1394, 1395, and 1396. It is an Office of Inspector General Health Care Transaction Report. The MCI number is 2011-04212-HI-0267. It is the same MCI number as the identified number on Exhibit 22, which is the administrative closure for the Tomah health care inspection. Dr. Daigh, if I could turn your attention to the top of 1394 where it says "Actual Completion Date." It reads, "8/12/2014." Do you have any— why would this be different— why is the actual completion date in this hotline input transaction report August 12th when you signed off on it in March?
>
> A: So this is not my computer system. This is something called MCI, and we keep our data in SharePoint, so I have no idea who entered that data.

[1428] *Id.* at OIG 1399.

Q: Who runs MCI?

A: It's an internal data system that tracks all the hotline material, but I don't know.

Q: So you don't know why the actual completion date of this hotline is 8/12/2014?

A: I have no clue.

VA OIG Attorney: Can we clarify? The question is: Can you answer why the actual completion date as reflected in MCI—which he's already said is a separate data system.

Q: How is it a separate data system? What is it separate from?

A: So my office runs off of a SharePoint site, so we get an allegation from hotlines, so a big hotline in the management group at the OIG. And then once we get that, we then manage the further flow of data in our SharePoint system so we have a way to monitor all the allegations that come to us, the decisions that we've made, and then they're processed through OHI. So I don't actually know who enters the data on this particular document, but it—but, you know, so I don't know why that is that way.

VA OIG Attorney: Is the MCI system that one would actually work in? Or is it a database system that records cases?

A: It's a database system that records cases, but we've migrated—again, we've migrated to a different—I don't—I don't know who entered this data. I really don't. So I don't know who did it, I don't know what it reflects.

Q: Does signing an admin closure mark the conclusion of the inspection?

A: For us it does, yes. That's why I dated it and why I signed it.[1429]

Both Dr. Daigh and Maureen Regan, Counselor to the Inspector General who accompanied Dr. Daigh to his interview with Chairman Johnson's staff, also questioned

[1429] Daigh Transcribed Interview, at 131–32.

why the VA OIG's case-tracking system showed the hotline about the Tomah VAMC referred to the VA OIG indicated that the inspection was closed on August 14, 2014. Dr. Daigh said that he did not know why the date for that referral differed from the date on the administrative closure. He stated:

Q: This is a three-page document marked Bates OIG 1397, 1398, and 1399. It is marked MCI number 2011-04212-HI-1068. A synopsis: This is a congressional interest from Congressman Ron Kind delivered to Cathy, and this number marks up with and the allegations mark up with the complaint sent in with Congressman Kind's. If I could turn your attention to 1398, about two- thirds of the way down, the referrals, it says, "Referrals. 54 referred to 54." That would be the Office of Healthcare Inspections, correct?

***

A: Mm-hmm.

Q: It says, "Date Referred August 26, 2011. Response Due November 26, 2011. Response Received August 14, 2014."

A: Mm-hmm.

Q: This synopsis is discussing some of the findings, and if you'll turn to the first page of the document, the findings of the admin closure, it's clear referring to the Tomah inspection at issue here, you know, why—do you have an opinion or thought as to why it says that this wasn't received until August 14, 2014?

A: I really don't know. I signed it on the date I signed it. You are correct in that the closing of the document I stipulated that we needed to meet with the VISN director and the facility director. I then asked days later Alan and George Wesley, "Did you meet with the facility director and the VISN director?" And they told me no. So I told them to get out there and meet with the facility director and the VISN director. So they then did that. So that's why there's a difference in time between when I signed it and when that happened.

The dates here, I really don't know who creates that date or where they get it from. But we see ceased work on this on the day I signed it, and that was the admin closure on our books. So this is—you know, this date actually is not the same date you had before, right? Actual completion date 8/12, and this says 8/14.

* * *

VA OIG
Attorney: Just to clarify, some of the people who put these analyst notes, they all work in Hotline as opposed to Healthcare Inspections?

A: Yeah, I frankly—I just don't know who enters what data on these screens, okay? It's—I don't know.

Q: So if you turn to the last page of the document, OIG 1399?

A: Okay.

Q: Under the box "Attached Documents," it says, "August 26, 2011, incoming correspondence. August 26, 2011, Outlook and Paid docs. October 7, 2011, 54 accepts case. August 14, 2014, 54 admin closure."

In the "Analyst Notes," it says, "August 26, 2011, WILLIAMSY, referred to 54 for review acceptance. August 13, 2014, LAVINEC"--L-A-V-I-N-E-C—"follow-up email to Cathy in Congressional." And then, "August 14, 2014, LAVINEC, received admin closure from 54, case closed, partially substantiated. Gave Cathy a copy for her congressional case."

A: Okay.

Q: Is that what occurred at that time period?

A: So, routinely, you know, if it's a congressional, then Cathy's given a copy of the report, made aware of the report, and so I don't—

Q: What congressional is this note talking about, do you know?

A: It would be this report, which was from our view a congressional from Representative Kind to our—

Q: Just for the record, Dr. Daigh is holding up Exhibit 22, the admin closure.

VA OIG
Attorney: Can I just insert, we could save a lot of time, that this is a record put in by our Hotline Division. It's not done by Dr. Daigh or his staff. These three people on here—Yvonne Williams and Christine Lavine—are hotline, and Christine Lavine was actually a rehired annuitant at the

time, brought back of everything that was coming in and the mess created by the Phoenix issue at this time. So I don't know if he will know whether they had a report and put it in late, but it's not a document that Dr. Daigh or his staff fill in, and none of these people worked for—worked for him. It's just that it's something that happened in Hotline, and the dates are out of his control. We can go around and around in circles forever, but I think you're asking the wrong person, and I'm not sure it's going to be relevant to what Hotline put into the system versus the date he had it signed. You have an email to Edna at some point in 2014, and—

* * *

Q: There's no date marks on here from the March 2014 time frame. Do you routinely send admin closures to this section of OIG?

A: The admin closures, I believe, all eventually get logged into the system that maintains all reports. So the admin closures are then, I believe, kept in MCI someplace as a storage for the reports we've done, and that's managed, again, by 53, the Management Group. So-

Q: So the admin—just so we understand, an admin closure goes from you and your signature—

A: Right.

Q: —to 53 Management. And then Management may send it to this Hotline Group? Is that what you're saying?

A: No. What I'm saying is that reports—so the standard report in the publication process is archived by our internal management group through the standard SOP of how things are published. If you have an admin closure and it's not published, then it goes to—through another route and it gets back to the Management Group for OIG, and they then take a copy of it right here, and they put it in their big database so they have a copy of all the official reports that we did. So the date that it moves from a pile to a pile, I don't really know. But these guys are, I think, logging in our report into their system, and I don't know what these transaction dates mean.[1430]

[1430] *Id.* at 134–40.

Dr. Daigh has been employed by VA OIG since 2002, and has served as the Assistant Inspector General for Healthcare Inspections since 2004.[1431] Ms. Regan has been Counselor to the Inspector General since 1992.[1432] With a combined 36 years of experience in their current positions at the VA OIG, it is surprising that neither Dr. Daigh nor Ms. Regan would know how the cases are logged in the MCI center after the Office of Healthcare Inspections administratively closes a case.

One potential reason for the discrepancy in the date that the administrative closure was finalized is that the administrative closure was not officially closed in the OIG's systems until the VA OIG received a FOIA request for the Tomah VAMC inspection report. Throughout this investigation, the VA OIG has continually disputed claims that the Tomah VAMC administrative closure was not made public until the *Center for Investigative Reporting* article in January 2015.[1433] Deputy Inspector General, Richard Griffin, wrote to Chairman Johnson on February 27, 2015:

> In the third paragraph of the letter [Chairman Johnson's February 25, 2015 letter to Deputy Inspector General Griffin] you state that we "did not publicly release the eleven-page administrative closure at the time of completion and delayed reporting its findings to Congress." As you are aware from various media reports, in June 2014, Senator Tammy Baldwin contacted our office after she received allegations relating to prescription practices at Tomah. She was advised that we had completed work on similar allegations and subsequently requested a briefing. On July 22, 2014, Dr. David Daigh, the Assistant Inspector General for Healthcare Inspections and Dr. Alan Mallinger, a Senior Physician on staff in the Office of Healthcare Inspections, provided Senator Baldwin's staff with a briefing. Dr. Mallinger is Board Certified in Psychiatry. On August 11, 2014, Senator Baldwin requested a copy of the administrative closure under the Freedom of Information Act, which was provided on August 29, 2014. We received no other requests or allegations relating to Tomah until recently.[1434]

Likewise during a transcribed interview, Maureen Regan, the Counselor to the Inspector General, disputed an assertion that the administrative closure was made public in January 2015. She stated:

> [T]hat is completely untrue. In August of 2014, we gave a copy under FOIA to Senator Baldwin. At that point, it became a public document. So, she asked for it

[1431] *John D. Daigh, Assistant Inspector General for Healthcare Inspections*, DEP'T OF VETERANS AFFAIRS, OFFICE OF INSPECTOR GENERAL, http://www.va.gov/oig/about/aig-healthcare.asp.
[1432] *Maureen T. Regan, Counselor to the Inspector General*, DEP'T OF VETERANS AFFAIRS, OFFICE OF INSPECTOR GENERAL, http://www.va.gov/oig/about/bio-counselor.asp.
[1433] Glantz, *Opiates Handed out Like Candy*, REVEAL NEWS (Jan. 8, 2015).
[1434] Letter from Hon. Richard J. Griffin, Deputy Inspector General, Dep't of Veterans Affairs, to Hon. Ron Johnson, Chairman, S. Comm. on Homeland Sec. & Governmental Affairs, at 1–2 (Feb. 27, 2015) [hereinafter 2/27/2015 Letter from Deputy Inspector General Griffin, VA OIG, to Chairman Johnson, HSGAC].

under FOIA. She got it under FOIA. And then it was after that when allegations came out. But it was given out under FOIA when we had a request in August of 2014.[1435]

According to the VA OIG, it received a FOIA request for the administrative closure one day before its own case-management document shows that the office administratively closed the Tomah Inspection. Dr. Daigh initially denied that the Tomah VAMC administrative closure was signed and dated in response to a FOIA request from Congress.[1436] When asked again by staff whether a FOIA request could be the reason for the discrepancy in the dates, Dr. Daigh first said he was unsure:

Q: If you go to OIG 1396 [the hotline input transaction page for the VA OIG Tomah VAMC health care inspection] of this document, the last page of it, midway down on the right, it says "Publication Date August 12, 2014."

A: Like I said, I don't know.

Q: It might be the person entering it in from the FOIA request. No?

A: I have no idea.

Q: Isn't that kind of another guess?

A: I'm not going to guess. I don't know. I don't routinely see these reports. I don't usually—this information is—I'm not sure how it gets to this report. It's—the other spread sheets you've showed me are internal documents for my office and how we've dealt with it. This is outside my office.

Q: Is this a headquarters document then?

A: This would be a management tracking system for the IG, so I'm sure that they got—so there are aspects of data that I'm sure they get from Yohannes and the other names you've seen on these emails. But who actually put that data on there, I don't know.

Q: What constitutes for the IG a publication? Is it when it's either FOIA'd or actually released on your website?

[1435] Shepherd 2/9/2016 Transcribed Interview, at 142–43.
[1436] Daigh Transcribed Interview, at 129.

A: So we consider a publication to be on the website, and then the one caveat to that is admin closures are publicly notified to the Hill through the SAR, but they are not in general published to the Web.[1437]

A review of VA OIG's case tracking system clearly shows that internally, the VA OIG case-monitoring mechanism did not register the Tomah VAMC health care inspection as closed until August 2014—either one or three days after the FOIA request, depending on the hotline. VA OIG personnel interviewed could not provide an explanation as to why the discrepancies in the dates exist. Given the confusion in the date as it is written in the administrative closure and the VA OIG's refusal to provide drafts and other documents relating to the drafting of the Tomah VAMC administrative closure, it is difficult to determine with certainty when the VA OIG administratively closed its review of the Tomah VAMC.

F. Subsequent administrative reviews found different outcomes than the VA OIG's Tomah VAMC health care inspection

The VA OIG's multi-year inspection and corresponding criminal investigation of the Tomah VAMC largely cleared providers of any wrongdoing. However, since the *Center for Investigative Reporting* article brought the longstanding problems to light, three subsequent investigations into the Tomah VAMC found, among other problems, inappropriate and unsafe prescription practices at the Tomah VAMC.[1438] These investigations, largely spurred on by public awareness and transparency to the problems at the facility, have finally begun to lead to some accountability for wrongdoers at the Tomah VAMC.

The VA's Undersecretary for Health released a report in March 2015 that found that patients at the Tomah VAMC received high-dose opioid prescriptions that potentially jeopardized patient safety.[1439] The review team stated the need for an in-depth evaluation of the providers' clinical practices.[1440] Additionally, the VA produced a draft March 2015 report authored by the Chief Medical Officer of VISN 12 that found that Dr. Houlihan had failed to meet the standard of care in 92 percent of cases reviewed and that Ms. Frasher failed to meet the standard of care in 80 percent of cases reviewed.[1441] Finally, at the request of Chairman Johnson and Senator Baldwin, the VA OIG Office of Healthcare Inspections released a report in August 2015 that found that the prescribing psychologists failed to discuss the risks of off-label drug use

[1437] *Id.* at 132–33.
[1438] VA Central Office (VACO), VACO Clinical Review Visit Report, Tomah VA Medical Center (Mar. 4, 2015) [hereinafter Interim VHA Report]; Veterans Health Admin., Draft VISN 12 Focused Clinical Review Report—Tomah VAMC (Mar. 26, 2015) [hereinafter Draft VISN 12 Report]; VA OIG Office of Healthcare Inspections, Report No. 15-02131-471, Healthcare Inspection: Unexpected Death of a Patient During Treatment with Multiple Medications, Tomah VAMC (Aug. 6, 2015) [hereinafter VHA Healthcare Inspection Report].
[1439] Interim VHA Report.
[1440] *Id.*
[1441] Draft VISN 12 Report, at 3.

with Jason Simcakoski before his death, and that the facility staff failed to adequately and promptly respond when they found Mr. Simcakoski unresponsive.[1442]

1. The March 2015 memorandum from the VA's Under Secretary for Health largely substantiated allegations about over-prescription and a culture of fear at the Tomah VAMC

In January 2015, after the public reporting about the Tomah VAMC, the VA's interim Under Secretary for Health, Dr. Carolyn Clancy, convened a nine-person clinical review team to assess the practice patterns and prescribing habits at the facility.[1443] The team reviewed internal documents and interviewed 18 employees, including facility leadership.[1444] The team submitted a report on March 4, 2015, and emphasized "the need for an in-depth evaluation of the clinical practices among providers . . . ."[1445] In the course of two months, the VA substantiated allegations that the VA OIG could not substantiate after years of examination.

The review team found that although fewer patients at the Tomah VAMC received opioid medication than the national veteran patient population (11.5 percent versus 14.6 percent),[1446] patients at the Tomah VAMC received higher dosages of opioids and more frequently received opioids and benzodiazepines concomitantly.[1447] Specifically, patients at the Tomah VAMC received opioid dosages greater than 400 morphine equivalents per day, 2.5 times as frequently as the national veteran patient population (1.08 percent versus 0.42 percent),[1448] and received opioid dosages between 200 and 300 morphine equivalents per day more frequently than the national veteran patient population (1.53 percent versus 1.2 percent).[1449] Additionally, Tomah VAMC patients received benzodiazepines and opioids concomitantly—a discouraged practice due to risks of complications—almost twice as frequently as the national veteran patient population (20.4 percent versus 11.7 percent).[1450]

[1442] VHA Healthcare Inspection Report, at 13.
[1443] Interim VHA Report at 3–4. The team visited the Tomah VAMC from January 27–January 29, 2015. *Id.* at 3–4.
[1444] *Id.* at 5–6. The team interviewed the following individuals: Mario DeSanctis, Medical Center Director, Katherine Pica, Acting Chief of Staff, Carlo Piraino, Associate Director Patient Care Services/Nurse Executive, Paul Gardetto, Associate Medical Center Director, David Houlihan, Chief of Staff, and Lin Ellinghuysen, AFGE President. *Id.* The team also interviewed three supervisory staff members and nine frontline staff members, whose names were withheld upon employee request. *Id.*
[1445] *Id.* at 11.
[1446] Memorandum from Carolyn M. Clancy, Interim Under Secretary for Health, Dep't of Veterans Affairs, to Secretary, Dep't of Veterans Affairs (Mar. 10, 2015) [hereinafter 3/10/2015 Memo from Carolyn Clancy to VA Secretary]; Interim VHA Report, at 6–7.
[1447] Interim VHA Report, at 8.
[1448] 3/10/2015 Memo from Carolyn Clancy to VA Secretary; Interim VHA Report, at 7.
[1449] 3/10/2015 Memo from Carolyn Clancy to VA Secretary; Interim VHA Report, at 7.
[1450] 3/10/2015 Memo from Carolyn Clancy to VA Secretary; Interim VHA Report, at 8.

A review of 18 patients' medical records "suggested unsafe clinical practices in areas such as pain management and psychiatric care,"[1451] including the following findings:

- Six of 18 cases revealed patient harm, such as patient falls, that could be at least partially attributable to prescribing practices.[1452]
- Nine of 18 cases lacked evidence of treatment plan change despite aberrant behaviors such as early refill requests and both positive and negative urine drug screen results.[1453]
- Twelve of 18 cases demonstrate extensive use of opioids and benzodiazepines concomitantly.[1454]

Finally, the report found that "an apparent culture of fear" at the facility compromised patient care and impacted staff satisfaction and morale.[1455] A staff member in a leadership position stated, regarding opioid prescribing practices, "Tomah is different from any place I have ever been; someone's going to die."[1456] Another staff member reported that "the Chief of Staff, patient advocates, and/or Nurse Practitioner frequently '*demand*' that prescriptions be ordered by providers and filled by pharmacists."[1457] Other staff members described the negative workplace environment, explaining, "There is a lot of hopelessness (at Tomah VAMC) . . . things are so disjointed,"[1458] and "You are at risk; you keep your head down."[1459] Regarding Dr. Houlihan, staff members reported that he "has a passion for control"[1460] and voiced concerns that "there is no ability to review or question Dr. Houlihan's cases."[1461] One staff member stated, "thou shall not document things in CPRS that embarrass Dr. Houlihan."[1462]

The review team was unable to "directly substantiate[]" the staff's "culture of fear," but found "evidence that the Chief of Staff directed patient care through unsolicited comments in the patient record. . . . includ[ing] recommendations for patient care that conflicted with the treatment plans developed by other providers and might be viewed as intimidating."[1463]

[1451] Interim VHA Report, at 5.
[1452] *Id.* at 10; 3/10/2015 Memo from Carolyn Clancy to VA Secretary.
[1453] Interim VHA Report, at 10; 3/10/2015 Memo from Carolyn Clancy to VA Secretary.
[1454] Interim VHA Report, at 10; 3/10/2015 Memo from Carolyn Clancy to VA Secretary.
[1455] Interim VHA Report, at 5; 3/10/2015 Memo from Carolyn Clancy to VA Secretary.
[1456] Interim VHA Report, at 10.
[1457] *Id.*
[1458] *Id.* at 9.
[1459] *Id.*
[1460] *Id.*
[1461] *Id.*
[1462] *Id.*
[1463] *Id.* at 10.

Figure 102: Memorandum on the Clinical Review Findings of the Tomah VAMC[1464]

DEPARTMENT OF VETERANS AFFAIRS

Memorandum

Date: March 10, 2015

From: Interim Under Secretary for Health

Subj: Summary of Phase One Clinical Review Findings, Tomah, WI

To: Secretary

Thru: Deputy Secretary

1. In January 2015 you directed me to lead a comprehensive review of medication prescription practices at the Tomah VA Medical Center (VAMC) and to report back in 30 days.

2. On January 23, 2015, I convened a clinical review team consisting of nine clinicians and other subject matter experts from across VHA to " assess the practice patterns, controlled substance prescribing habits, and administrative interactions with subordinates and clinical leadership as related to prescribing practices" at the Tomah VAMC.

3. The team submitted a report summarizing its findings on March 4, 2015. Based on a review of computerized medical records of eighteen (18) patients, the team found unsafe clinical practices at the Tomah VAMC in areas such as pain management and psychiatric care. More specifically, six of 18 cases revealed that patient harm (examples of falls) that could be at least partially attributable to prescribing practices (multiple CNS depressants and/or high dose opioids); nine of 18 lacked evidence of changing the treatment plan in the face of aberrant behaviors; and twelve of 18 demonstrated extensive use of opioids and benzodiazepines.

4. The team made specific findings relating to overall opioid utilization at Tomah and other VHA facilities, noting that 11.5% of Tomah patients receive opioid medications as compared to 14.6% of patients VA wide. The team also found that Tomah patients were 2.5 times more likely than the national average to be prescribed opioids greater than 400 morphine equivalents per day (1.08% vs. 0.42%), and were also more likely than the national average to be prescribed opioid doses between 200-300 morphine equivalents per day (1.53% vs. 1.2%). With respect to the use of benzodiazepines and opioids concomitantly, which is discouraged due to risks of complications, the team found that Tomah VAMC was almost double the national average (20.4% vs. 11.7%).

5. The team also found that an apparent culture of fear at the facility compromised patient care and impacted staff satisfaction and morale. Based on these preliminary findings, the team recommended that VHA consider a more in-depth evaluation of the clinical and administrative practices at the Tomah VAMC. That additional review is now ongoing.

Carolyn M. Clancy, MD

[1464] Interim VHA Report, at 5.

Chairman Johnson's staff presented the VA's summary memorandum to VA OIG personnel during transcribed interviews in order to obtain their perspective on the VA's findings. In particular, Chairman Johnson's staff sought to understand how the VA OIG's a multi-year health care inspection could differ so drastically from the VA's own three-month-long clinical review of the same facility.

When Chairman's Johnson staff presented the document to Dr. Wesley, he claimed that the VA was well-aware of the issues at the Tomah VAMC and did little, if anything, to address the issues at the facility before the media reports about the facility. He explained:

A: It's very—from a technical point of view, I have no problem with it. It's very distressing, though, because of the date, which is March 10, 2015. As I said, I've taught hotlines for a long time, and one of the things I've always worked very hard at is that the IG should not know something that VHA [Veterans Health Administration] doesn't. In other words, I worry about patient safety. So I don't want to have medical facts or information about a patient that VHA doesn't.

So as we're doing this and as we're crunching numbers and as we're going through things, I don't think there's anything we knew that VHA either didn't know or didn't have very quick access to. And, in fact, after we released the administrative closure, we briefed both Mr. DeSanctis and Dr. Murawsky in depth. And when I briefed Mr. Murawsky in particular, he seemed to know—know it all, if you will. There was nothing unfamiliar to him. Likewise, he wrote that early response, and so he was extremely conversant with the issues.

And so the reason this bothers me is that up until the Aaron Glantz story of January 2015, VHA really did very little, if anything. Suddenly, you have a major media story, and then you see a memo like this from the—

Witness Attorney: All right. So I'm going to caution you here. That's an honest response, but—

A: Okay.

Witness Attorney: —you don't know—what you know is that you informed VA—VHA about what you had found about the administrative closure. You don't exactly know--

A: **My professional opinion is throughout the inspection, VHA knew what we knew, and so you asked me my reaction.**

Witness Attorney: Right.

A: And my reaction is I find this professionally disturbing because—because of the date.[1465]

Chairman Johnson's staff also presented the memorandum to both Dr. Daigh and Dr. Mallinger. Both doctors claimed that the VA's findings were not all that different than what the VA OIG found in the administrative closure. The doctors went paragraph-by-paragraph to compare the VA's findings to what the administrative closure found.

Paragraph one of the VA's memorandum summarized that in January 2015, Secretary McDonald directed Dr. Clancy to conduct a "comprehensive review of medication prescription practices at the Tomah [VAMC] . . . ."[1466] With respect to this paragraph, Dr. Daigh noted that the review "would be after we [the VA OIG] had provided our administrative closure and discussed with VA our findings at Tomah."[1467]

Paragraph two of the VA's memorandum explained that Dr. Clancy "convened a clinical review team consisting of nine clinicians and other subject matter experts from across VHA to 'assess the practice patterns, controlled substance prescribing habits and administrative interactions with subordinates and clinical leadership as related to prescribing practices' at the Tomah VAMC."[1468] With respect to paragraph two, Dr. Daigh responded:

> Paragraph 2, so it all seems appropriate. They put together a team to look at prescribing patterns. I would say that by this time frame in our administrative closure we highlighted that there was substantial use of narcotics at Tomah, and I think in the data, we provided VISN data as it related to Tomah as a facility and also as to some of the prescribers.
>
> Contemporaneous with this, we had published and reported to the Senate Veterans' Affairs Committee a nationwide review of narcotic usage, and we found that outrageous amounts of narcotics were being used across VA, at essentially every VA hospital you looked at.[1469]

[1465] Wesley Transcribed Interview, at 207–09 (emphasis added).
[1466] 3/10/2015 Memo from Carolyn Clancy to VA Secretary.
[1467] Daigh Transcribed Interview, at 147–48.
[1468] 3/10/2015 Memo from Carolyn Clancy to VA Secretary.
[1469] Daigh Transcribed Interview, at 148. The review Dr. Daigh referred to was a 2014 nation-wide review of take-home opioid prescription patterns across the VA. *See* VA OIG, Office of Healthcare Inspections, Report No. 14-00895-163, Healthcare Inspection—VA Patterns of Dispensing Take-Home Opioids and Monitoring Patients on Opioid Therapy (May 14, 2014), *available at* http://www.va.gov/oig/pubs/VAOIG-14-00895-163.pdf.

Paragraph three of the VA's memorandum summarized the findings of chart reviews of 18 Tomah VAMC patients. The memorandum noted that the clinical review team:

> found unsafe clinical practices at the Tomah VAMC in areas such as pain management and psychiatric care. More specifically, six of 18 cases revealed that patient harm (examples of falls) that could be at least partially attributable to prescribing practices (multiple CNS [Central Nervous System] depressants and/or high dose opioids); nine of 18 lacked evidence of changing the treatment plan in the face of aberrant behaviors; and twelve of 18 demonstrated extensive use of opioids and benzodiazepines.[1470]

Dr. Daigh noted that the VA's findings in paragraph three may not reflect the same data that the VA OIG examined in its health care inspection, but that the VHA's findings in this paragraph were "reasonable." He explained:

> A: So when you get down here to number three, VA then looked at a series of patients, and they found that the care didn't meet standard. And so I understand also that, at least from the news—it may not be accurate—that Wisconsin looked at Dr. Houlihan's cases or some cases of his and came to the same conclusion. So that's fine. I think that—I think Alan [Mallinger] did an expert job in looking at the cases he looked at and dealing with the issues that they were, you know, confronted with at Tomah. I think his opinion is a reasonable one. I think this is also a reasonable one. I don't know if they looked at the same 18 cases we looked at, or different cases.
>
> I am aware of sort of the peer reviews that were done during this period of time, so I am aware that VA's findings, you know, earlier were not so critical of his care but more in line with what we had found in those issues. But—
>
> Q: So the data from this time period is different from the data that was being reviewed—
>
> A: Yes. I think so. I mean, these 18 cases I think are more—are a little more recent. And, you know, during this time period there has been just a tremendous shift in how society views the treatment of patients with opioid dependence. We've gone from pain is, what, the fourth or fifth vital sign after the Institute of Medicine study to now, you know, CDC is coming out with recommendations about how to not use pain

[1470] 3/10/2015 Memo from Carolyn Clancy to VA Secretary.

> medicines, and DOD is about to come out with some—DOD VA is coming out with new recommendations where the data doesn't support the use of narcotic like it has been used for the last 30 years. So I think there's a big emotional shift. People are trying to get their head around that. So part of that shift is occurring during this time frame.[1471]

Paragraph four of the VA's memorandum highlighted potentially dangerous prescription practices at the Tomah VAMC. The VA found:

> The team made specific findings relating to overall opioid utilization at Tomah and other VHA facilities, noting that 11.5% of Tomah patients receive opioid medications as compared to 14.6% of patients VA wide. The team also found that Tomah patients were 2.5 times more likely than the national average to be prescribed opioids greater than 400 morphine equivalents per day (1.08% vs. 0.42%), and were also more likely than the national average to be prescribed opioid doses between 200-300 morphine equivalents per day (1.53% vs. 1.2%). With respect to the use of benzodiazepines and opioids concomitantly, which is discouraged due to risks of complications, the team found that Tomah VAMC was almost double the national average (20.4% vs. 11. 7%).[1472]

When Dr. Daigh analyzed the VA's findings in paragraph four, he talked about how the findings are more in line with national trends and did not discuss how it differed from the administrative closure. The VA OIG's administrative closure did not analyze the parallel prescription of opioids and benzodiazepines at the Tomah VAMC. With respect to paragraph four, Dr. Daigh stated:

> And then the data that—paragraph four essentially talks about the use of narcotic at Tomah not unlike the data we presented. We found that VA across the system was giving both benzos and narcotic to the same patients. It puts providers in a little bit of a box because many patients who have substance use disorder problems who are very seriously ill also have anxiety disorder where they act out. . . .
>
> The Tomah data, you know, we just looked at the VISN look, but when we looked at the national look, I mean, I think you could take this data and you could have gone to 50 places and find people who were prescribing at the levels they're finding that, I mean, I think, if you look at our national data out there, just the average amount given. And if you look at the top providers, then you've got psychiatrists dealing—you have basically addiction psychiatry, and you're out there on the very most difficult patients to take care of in psychiatry. So it's—to the general surgeon, it's the tumor case that no one else will operate on, you can

[1471] Daigh Transcribed Interview, at 149–50.
[1472] 3/10/2015 Memo from Carolyn Clancy to VA Secretary.

> always find someone to operate on. In psychiatry, it's the guy that's been addicted to narcotic—take the Simcakoski case and some of these other cases—for years, you know? People are trying to do the best for them. Sometimes it's better, sometimes it's worse. They're just very difficult to care for.
>
> So, again, when—you know, it's not just a VA problem. If you watch the news and you see that the most recently advertised drug, which I have to laugh about, is to cure constipation in people who are addicted to opioids. When I first saw that, I just started laughing because, I mean, the only data I really have is VA data. But when a drug company can make money on the receptor in the gut for opioids and then sell it to the general population, that's just a total failure of government policies on how to manage patients with pain. And so we're trying to swing back.[1473]

Dr. Mallinger also rendered an opinion about how the VA's findings in paragraph four differed from the VA OIG's administrative closure. He noted that the VA's review of opioid prescriptions at Tomah reached similar conclusions as the administrative closure—notably that prescribers at the Tomah VAMC prescribed high levels of opioids. Dr. Mallinger's explanation about how the VA's analysis of parallel prescription of opioids and benzodiazepines differs from the OIG's inspection further illustrates the office's narrow interpretation of allegations it received. He stated:

> So as far as number 4 goes, so they found, you know, more or less a similar percentage of patients at Tomah on opioids as compared to VA-wide, but that they were more likely to be prescribed, you know, high doses. They'd look at that in terms of both the more than 400 morphine equivalents per day and also the 200 to 300 range of morphine equivalents per day. And, again, this agrees with what we had in our report, that, you know, there was as high level of prescribing of opioids at Tomah.
>
> * * *
>
> **And the last part of this sentence, use of benzodiazepines and opioids concomitantly, here I would say that we didn't really have any allegation about that, and we didn't really look at that in our, you know, report**. But, again, it's higher than the national average. It's 20 percent. But, you know, they themselves are saying that the national average of doing this is, you know, 11.7 percent, say one out of 10. So what we're talking about is if you go to any VA medical center in the country and you round up 100 patients on opioids, 10 of them will be on this combination.[1474]

[1473] Daigh Transcribed Interview, at 150–52.
[1474] Mallinger 4/21/2016 Transcribed Interview, at 395–96 (emphasis added).

Paragraph five of the VA's review of the Tomah VAMC addressed the culture of fear at the facility. It stated:

> The team also found that an apparent culture of fear at the facility compromised patient care and impacted staff satisfaction and morale. Based on these preliminary findings, the team recommended that VHA consider a more in-depth evaluation of the clinical and administrative practices at the Tomah VAMC. That additional review is now ongoing.[1475]

Dr. Mallinger talked about the VA's findings with respect to paragraph five were actually not all that different than the VA OIG's administrative closure. He stated:

> You know, I think 5 basically agrees with what we had in our report, that, you know, as we talked about, you know, we didn't really substantiate, if you want to call it "administrative abuse" or whatever, but that, you know, there was a widely held perception that administrative abuse occurred, and that perception is essentially the same as the culture of fear . . . . So I thought, you know, that really pretty much agrees with what we said in the report.

Dr. Daigh expressed similar sentiments on the VA's finding that there was a culture of fear at the Tomah VAMC. He said:

> The last one, again, apparent culture of fear and compromised care, again, that's what they found. I'm not going to dispute that. We certainly have heard people vociferously make complaints like that when we were there. I'll just say that when we went to look at interpersonal interviews and we went to look at the official records we could find, we didn't see the kind of, you know, behind-the-scenes email traffic and other data to support that. There were some people that were unhappy, but whether it was as pervasive as they found it, we didn't see that. But we did see a problem there. We note that in the report.[1476]

These statements are puzzling. Not only did the VA OIG not substantiate the "allegations of abuse of authority, intimidation and retaliation when staff question controlled substanee prescription practices," but the administrative closure did not link the problems to patient care at the facility. At most, the administrative closure made a passing reference on how the perceptions of administrative abuse can lead to breakdowns in communication and prevent people from coming forward to report wrongdoing.[1477] Although the VA OIG suggested that the Tomah VAMC director should "implement a vehicle by which clinicians and staff can openly and constructively communicate concerns and rationale when disagreements arise concerning

[1475] 3/10/2015 Memo from Carolyn Clancy to VA Secretary.
[1476] Daigh Transcribed Interview, at 152–53.
[1477] VA OIG TOMAH VAMC ADMINISTRATIVE CLOSURE, at 10.

dispensing of opioid prescriptions,"[1478] this "suggestion" was non-binding and there was no required follow-up from either the VA OIG or the VA.

Despite the VA OIG's protestations that its health care inspection arrived at the same conclusions as the VA's subsequent review, the VA found serious problems at the Tomah VAMC where the VA OIG did not. Most notably, with respect to the concomitant prescription of medications and administrative abuse at the facility, the VA went further than the OIG in identifying areas of serious concern.

2. A March 2015 draft report by the VISN 12 Chief Medical Officer substantiated allegations about improper opioid prescription

In December 2014, the Chief Medical Officer of VISN 12 directed an external clinical team to conduct a review of Dr. David Houlihan's and Deborah Frasher's patient care and prescribing practices.[1479] The review team focused on patients who received opioids or suboxone.[1480] The VISN 12 draft report is dated March 26, 2015.[1481]

The review team found that "Dr. Houlihan did not meet the standard of care in 92% of the cases reviewed and Ms. Frasher did not meet the standard of care in 80% of cases reviewed."[1482] In a significant number of cases, "the care provided was not appropriate and documentation was not adequate to support care provided."[1483] Reported problems included:

- Inappropriate use of opioids, suboxone, and stimulants;
- Unsafe combinations of drugs prescribed, including high doses of benzodiazepines with opioids and use of multiple benzodiazepines concomitantly;
- High doses of opiates and benzodiazepines for patients with substance abuse disorders;
- Lack of oversight of urine drug screens;
- Inappropriate management of chronic pain; and
- Early refills of controlled substances despite ongoing illicit drug use.[1484]

The draft report concluded that "[a]ll of these findings can pose increased risk to patients."[1485]

[1478] *Id.*
[1479] Draft VISN 12 Report, at 3. The external clinical review team consisted of four physicians and a nurse practitioner. *Id.* at 4.
[1480] *Id.* at 3.
[1481] *Id.* It is unknown if this VISN 12 document was finalized.
[1482] *Id.* at 3.
[1483] *Id.*
[1484] *Id.* at 3, 8.
[1485] *Id.* at 11.

3. An August 2015 report by VA OIG on Jason Simcakoski's death substantiated hazardous prescription practices

From February to June 2015, at the request of Chairman Johnson and Senator Baldwin, the VA OIG Office of Healthcare Inspections conducted an inspection into the death of Jason Simcakoski during his treatment at the Tomah VAMC.[1486] The OIG released a report in August 2015, finding deficiencies in prescription practices and the facility staff's emergency response. The OIG reported that the medical examiner found, and a consultant forensic toxicologist agreed, that the findings in Mr. Simcakoski's case "were sufficient to conclude that the cause of death was mixed drug toxicity."[1487]

The OIG found that the prescribing psychiatrists failed to comply with the VHA's requirement of obtaining written informed consent when administering hazardous drugs, including buprenorphine.[1488] The report referred to two psychiatrists who treated Mr. Simcakoski: Psychiatrist 1 and Psychiatrist 2. The Committee has learned that Psychiatrist 1 in this inspection was Ronda Davis and that Psychiatrist 2 was Dr. Houlihan.[1489] The OIG did not find evidence of written information consent for buprenorphine treatment, and both psychiatrists acknowledged that they did not discuss the risks inherent in off-label use with Mr. Simcakoski.[1490]

Additionally, the OIG reported deficiencies in the facility staff's emergency response.[1491] The OIG found that that the facility's Short Stay Mental Health Recovery unit did not have medication available to use in emergency situations to reverse the effects of possible drug overdose.[1492] Flumazenil, which is used to reverse benzodiazepine overdose, was administered 33 minutes after Mr. Simcakoski was found unresponsive.[1493] Furthermore, the OIG found that there was confusion among the unit staff regarding emergency response responsibilities.[1494] Specifically, unit staff discontinued CPR efforts when facility firefighters arrived, believing that the firefighters would take over CPR efforts.[1495] However, the facility firefighters were not paramedics or emergency medical technicians and were not designated as first-line staff to provide hands-on emergency care.[1496] Finally, the OIG found that there were delays in

[1486] VHA Healthcare Inspection Report, at *i*.
[1487] *Id.* at 8.
[1488] *Id.* at *i*, 10–11.
[1489] E-mail from Tomah VAMC Whistleblower to Committee (Nov. 12, 2015) (on file with Comm.); Briefing with VA (Nov, 12, 2015); *see also* Bobby Caina Calvan, *Wisconsin Veterans Hospital's Former Director No Longer on VA Payroll*, REVEAL NEWS (Sept. 2, 2015), https://www.revealnews.org/article/wisconsin-veterans-hospitals-former-director-no-longer-on-va-payroll/.
[1490] VHA Healthcare Inspection Report, at *i*, 10–11.
[1491] *Id.* at *i*, 11.
[1492] *Id.* at *i*.
[1493] *Id.* at 12.
[1494] *Id.* at *i*, 12.
[1495] *Id.* at 12.
[1496] *Id.*

"initiating cardiopulmonary resuscitation, calling for medical emergency assistance both within the unit and from facility emergency response staff, and applying defibrillator pads to determine cardiac rhythm for possible intervention."[1497]

* * *

Of all the federal entities that examined the Tomah VAMC, the VA OIG was perhaps best suited to identify and rectify the problems at the facility. When it first received a complaint in March 2011, it opted to refer the matter to the VA's regional office for their review. When the VA OIG received a second complaint in August 2011, and then a congressional request shortly thereafter, it finally took action.

Over the course of the subsequent two-plus years, the VA OIG conducted—to its credit—a sizeable amount of work inspecting the Tomah VAMC. It collected emails from facility employees, interviewed witnesses, surveilled Dr. Houlihan, and issued at least one subpoena. The work product that the VA OIG produced at the culmination of this inspection simply did not match the effort that went into the inquiry. The manner in which the VA OIG closed the report also obscured transparency and public accountability in the Tomah VAMC and the VA OIG.

Chairman Johnson's investigation offers some explanation for the VA OIG's failure at the Tomah VAMC. According to statements received by Chairman Johnson's staff, the VA OIG lacks clear standards for substantiating allegations—making it difficult to arrive at conclusive findings. The VA OIG did not do enough in response to observations about the potential impairment of Dr. Houlihan and Deborah Frasher and limited its inquiry to ignore concerns about the interaction between opioids and other prescribed medication. The office discounted statements from Tomah VAMC pharmacists about abuses and understated the variance in Dr. Houlihan's prescription practices. Notably, while the VA OIG failed to substantiate the allegations after its lengthy inspection, the VA independently substantiated similar allegations after only three months.

The leadership at the helm of the VA OIG during the course of its health care inspection of the Tomah VAMC is gone. Chairman Johnson is hopeful that the new Inspector General Michael Missal, will restore trust and accountability in this important office. A transparent and effective VA OIG is vital for protecting and support veterans across the nation.

[1497] *Id.* at *i*.

IV. Whistleblower retaliation and a culture of fear at the Tomah VAMC

Chairman Johnson's investigation into the Tomah VAMC shows that the allegations of opioid over-prescription, abuse of authority, drug diversion, and more were allowed to fester because a "culture of fear" within the facility. Concerned employees were afraid to speak out for fear of retaliation. Some employees who raised questions—like Dr. Noelle Johnson or Dr. Christopher Kirkpatrick—were fired from their jobs.

Sadly, the retaliation was not limited to within the Tomah VAMC. The VA OIG—the Department's independent watchdog—also retaliated against Tomah VAMC whistleblowers. In an unsolicited white paper—which, at 13 pages, was longer than the VA OIG's administrative closure—the VA OIG defended its work at the facility by attempting to discredit the whistleblowers. The VA OIG implied that Dr. Kirkpatrick was a drug dealer and stated that Dr. Johnson had "poor interpersonal skills"—facts that have no bearing on the merits of their allegations.[1498]

It is unfortunate the VA OIG ignored these whistleblowers and dismissed the retaliation they faced as "gossip, rumor, and hearsay."[1499] In early 2015, the VA found that "an apparent culture of fear at the [Tomah VAMC] compromised patient care and impacted staff satisfaction and morale."[1500] The VA review team interviewed a number of staff members who expressed concerns about the culture at the facility. One employee was quoted as stating "you are at risk; you keep your head down" and said that staff must "tolerate the oppression which is waxing and waning."[1501] The VA's review team concluded that the employee statements "appear[ed] to support concerns related to a culture of fear among Tomah VAMC staff."[1502]

A. The sad state of whistleblower protections within the VA

Federal whistleblower laws have existed in some form since the early Twentieth Century. In 1978, Congress passed the Civil Service Reform Act, which for the first time provided an enforceable right for federal employees to petition Congress.[1503] The Act also created the Office of Special Counsel (OSC) and the Merit Systems Protection Board.[1504] In 1989, Congress passed the Whistleblower Protection Act, which provided protections for federal employees who

[1498] *See* VA OIG, *Whitepaper: Analysis of the Evidence Supporting the Findings of the VA Office of Inspector General, Office of Healthcare Inspections Administrative Closure of its Inspection of Complaints Regarding the Tomah, Wisconsin, VA Medical Center* 9 (June 4, 2015) [hereinafter VA OIG Whitepaper].
[1499] *Id.* at 10.
[1500] 3/10/2015 Memo from Carolyn Clancy to VA Secretary.
[1501] Interim VHA Report, at 9.
[1502] *Id.*
[1503] Pub. L. 95-454, 92 Stat. 1111 (1978).
[1504] *Id.*

disclosed illegal or improper government actions.[1505] Most recently, Congress passed the Whistleblower Protection Enhancement Act of 2012, which augmented whistleblower protections and expanded the powers of OSC to prevent retaliation.[1506]

Data shows that the VA, as a whole, is not friendly to whistleblowers. The Office of Special Counsel investigates and prosecutes whistleblower claims brought by federal employees.[1507] During a hearing held by Chairman Johnson in September 2015, Special Counsel Carolyn Lerner testified that VA cases made up approximately 35 percent of OSC's entire retaliation case load in 2015.[1508] In 2014, more VA employees alleged retaliation than Department of Defense (DOD) employees, even though the DOD has twice the number of civilian employees as the VA.[1509] Special Counsel Lerner similarly testified before the Senate Committee on Appropriations that the volume of VA cases is "overwhelming" her agency.[1510]

The whistleblower community has also identified significant concerns with the VA OIG's treatment of VA whistleblowers. The Project on Government Oversight (POGO), a non-profit organization that promotes good government, highlighted the shortcomings of the VA OIG's posture towards whistleblowers. In testimony to the Committee, POGO's Executive Director, Danielle Brian, explained:

> The perception that an acting IG lacks adequate independence can have a chilling effect on the office's natural allies: agency employees and other insiders who are in a position to blow the whistle on agency wrongdoing. One former VA employee recently stated that the IG's office is "not trusted by most employees and usually used in the VA as retaliation" . . . .[1511]

Other VA whistleblowers have been more direct in their criticism of the VA OIG, calling the office a "joke" for its refusal to properly protect whistleblowers.[1512]

[1505] Pub. L. 101-12, 103 Stat. 16 (1989).
[1506] Pub. L. 112-155, 126 Stat. 1465 (2012).
[1507] *About*, U.S. OFFICE OF SPECIAL COUNSEL, https://osc.gov/Pages/about.aspx.
[1508] *Improving VA Accountability: Examining First-Hand Accounts of Department of Veterans Affairs Whistleblowers, Hearing Before S. Comm. on Homeland Sec. & Governmental Affairs*, 114th Cong. (2015) (statement of Carolyn Lerner, Special Counsel, U.S. Office of Special Counsel).
[1509] *Id.*
[1510] *Review of Whistleblower Claims at the Department of Veterans Affairs, Hearing Before Subcomm. on Military Construction, Veterans Affairs, & Related Agencies on the S. Comm. on Appropriations*, 114th Cong. (2015) (statement of Carolyn Lerner, Special Counsel, U.S. Office of Special Counsel).
[1511] *Watchdogs Needed: Top Government Investigator Positions Left Unfilled for Years, Hearing Before S. Comm. on Homeland Sec. & Governmental Affairs*, 114th Cong. (2015) (statement of Danielle Brian, Director, Project on Gov't Oversight).
[1512] *Improving VA Accountability: Examining First-Hand Accounts of Department of Veterans Affairs Whistleblowers, Hearing Before S. Comm. on Homeland Sec. & Governmental Affairs*, 114th Cong. (2015) (statement of Christopher SheaWilkes, VA Truth Tellers).

The Tomah VAMC is a microcosm of both the VA's cultural problems with respect to whistleblower retaliation and the VA OIG's disregard for whistleblowers. Former employees of the Tomah VAMC—Dr. Christopher Kirkpatrick and Dr. Noelle Johnson—were fired from the facility after they raised concerns about mismanagement at the facility. In addition, they faced attacks from the VA OIG when the OIG issued a "white paper" defending its investigation of the Tomah VAMC and disparaging the whistleblowers who took the courageous step to speak out. These individuals' stories and subsequent character assassination at the hands of the VA OIG illustrate the severe cultural problems within the VA and the VA OIG with respect to protecting whistleblowers.

B. Dr. Christopher Kirkpatrick

Dr. Christopher Kirkpatrick was a clinical psychologist at the Tomah VAMC who was fired after expressing his belief that some of his patients were overmedicated. On the same day of his termination from the Tomah VAMC, Dr. Kirkpatrick took his own life. Despite the tragedy of his firing and death—and in the face of reports of broader overmedication and employee retaliation at the facility—Chairman Johnson's staff has learned that the VA did not examine the circumstances that led to Dr. Kirkpatrick's termination. In addition, Chairman Johnson's staff has learned that the VA OIG examined Dr. Kirkpatrick's termination and suicide as part of its review of the Tomah VAMC and did not find anything improper with Dr. Kirkpatrick's removal from the facility.

1. The circumstances surrounding Dr. Kirkpatrick's termination

Dr. Kirkpatrick was hired at the Tomah VAMC in September 2008 as a clinical psychologist. In the spring of 2009, he began raising concerns that his patients appeared to be overmedicated in their group meetings. He first spoke with a physician's assistant about patients they both treated and raised concerns that these veterans were overmedicated. According to documents, the physician's assistant reported Dr. Kirkpatrick's comments to the facility's Chief of Staff, Dr. Houlihan, who initiated disciplinary actions against Dr. Kirkpatrick.

On April 30, 2009, Dr. Kirkpatrick received a "written counseling" from his immediate supervisor.[1513] The "written counseling" noted that on April 20, 2009, Dr. Kirkpatrick's supervisor "spoke with psychologist Chris Kirkpatrick, Psy.D. regarding information [the supervisor] received from [Dr. Houlihan] stating that Dr. Kirkpatrick had been criticizing the Physician Assistant (PA) assigned to the Residential Program."[1514] The written counseling

[1513] Memorandum from Gary Loethen, M.D., U.S. Dep't of Veterans Affairs, to Chris Kirkpatrick, M.D., U.S. Dep't of Veterans Affairs (Apr. 30, 2009), *in* JUNEAU COUNTY SHERIFF'S DEPARTMENT, CHRIS KIRKPATRICK DEATH INVESTIGATION REPORT, at 24 (2009).
[1514] *Id.*

"cautioned [Dr. Kirkpatrick] about engaging in any further criticisms of the PA and . . . counseled that he should avoid advising on medications as it is not in his scope of practice."[1515]

Emails between Dr. Kirkpatrick and his union representatives shed light on to why Dr. Kirkpatrick confronted the PA about their patients. Dr. Kirkpatrick understood that the written counseling was ordered because he was "inappropriate somehow in discussing medications that patients we both see are prescribed."[1516] He wrote to his union representatives: "I have had words with [the PA] inquiring about medications and possible side effect/adverse reactions they were experiencing but these conservations happened months ago. These situations put me into an ethical dilemma. Why this comes up as an issue now is open to interpretation."[1517] Dr. Kirkpatrick implored the union for assistance: "Based on what others have told me, I have every reason to be very afraid of Dr. Houlihan. I have sacrificed a lot to move up here and do the kind of work I excel at and help people in. I need help."[1518]

On May 13, 2009, Dr. Kirkpatrick responded in writing to the written counseling. He wrote:

> I was quite surprised to hear of the accusations made by Chief of Staff (COS) in your Memorandum of April 30, 2009 as there has been no discussion between the Physician Assistant (PA) and myself about medications for a period of at least six weeks. Previously, soon after our PA had joined the team, I and several other staff had asked questions about medications after noticing changes in demeanor in our patients. I do not presume to prescribe medications but think it is important there be a dialogue between providers so as to best serve our patients. Patients have occasionally asked questions about their medications for which I refer them to their physician or other provider.[1519]

Two months later, on July 14, 2009, Dr. Kirkpatrick was fired from the Tomah VAMC.

Chairman Johnson's staff interviewed Linda Ellinghuysen, the Tomah VAMC employee union president who represented Dr. Kirkpatrick in his termination proceedings. Ms. Ellinghuysen talked about Dr. Kirkpatrick's discussion of prescription practices with the PA. She stated that the PA "worked closely with Dr. Houlihan" and that "Dr. Houlihan, for the most

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[1515] *Id.*

[1516] E-mail from Chris Kirkpatrick, M.D., U.S. Dep't of Veterans Affairs, to Dianne Streeter, VA Chief Steward, AFGE Local 1882, and Linda Ellinghuysen, Executive V.P., AFGE Local 1882, (April 23, 2009) *in* JUNEAU COUNTY SHERIFF'S DEPARTMENT, CHRIS KIRKPATRICK DEATH INVESTIGATION REPORT 40, at 43 (2009).

[1517] E-mail from Chris Kirkpatrick to Dianne Streeter and Linda Ellinghuysen (April 23, 2009) *in* JUNEAU COUNTY REPORT 40, at 43 (2009).

[1518] *Id.*

[1519] Letter from Chris Kirkpatrick, M.D., U.S. Dep't of Veterans Affairs, to Gary Loethen, M.D., U.S. Dep't of Veterans Affairs (May 13, 2009), *in* JUNEAU COUNTY SHERIFF'S DEPARTMENT, CHRIS KIRKPATRICK DEATH INVESTIGATION REPORT, at 23 (2009).

part, cosigned her medication orders."[1520] When Dr. Kirkpatrick spoke to the PA about their shared patients appearing overmedicated, Ms. Ellinghuysen felt the PA "went to the Chief of Staff that Chris Kirkpatrick was questioning the medication orders. And that, that – that can't be done here, asking [the] Chief of Staff that."[1521]

Ms. Ellinghuysen also recounted discussions with Dr. Kirkpatrick about a threat he received from a patient in April or May 2009. She said that a patient threatened to do bodily harm to Dr. Kirkpatrick and his dog and based on that threat, Dr. Kirkpatrick spoke with his interdisciplinary team about removing the patient from Dr. Kirkpatrick's care.[1522] Ms. Ellinghuysen explained that Dr. Kirkpatrick was disturbed by the threat so he "took a long weekend" and expected the patient to be discharged from his team.[1523] When Dr. Kirkpatrick returned to work, the patient was not discharged. Ms. Ellinghuysen said that she, "as a union rep, did not hear of a plausible explanation" about why the patient was not discharged.[1524]

On July 14, 2009, Dr. Kirkpatrick called Ms. Ellinghuysen and told her that "his bosses wanted to speak with him and human resources" and asked Ms. Ellinghuysen if she would represent him.[1525] She agreed and accompanied him to the meeting. Also present at the meeting were Dr. Kirkpatrick's immediate supervisor and the Tomah VAMC Human Resources Coordinator.

In documents Ms. Ellinghuysen provided to the Juneau County Sherriff's Office after Dr. Kirkpatrick's suicide in 2009, she described the meeting as "gruesome" and that "[i]t was apparent the COS [Chief of Staff, Dr. David Houlihan] was behind the termination."[1526] Ms. Ellinghuysen said that the reason given by the Tomah VAMC management for Dr. Kirkpatrick's termination was "very vague."[1527] In the meeting and in the document terminating Dr. Kirkpatrick, Tomah VAMC management explained "performance issues" were the reason for his termination.[1528] According to Ms. Ellinghuysen, Tomah VAMC management "could not specify he [Dr. Kirkpatrick] had a specific performance issue. In fact, his two bosses, throughout the hour we were there, his two bosses praised him on his performance and his work with veterans."[1529]

[1520] Ellinghuysen Transcribed Interview, at 92.
[1521] *Id.*
[1522] *Id.* at 92–93.
[1523] *Id.* at 93.
[1524] *Id.*
[1525] *Id.* at 94.
[1526] Memorandum by Linda Ellinghuysen, Executive V.P., AFGE Local 1882, at 1 (2009), *in* JUNEAU COUNTY SHERIFF'S DEPARTMENT, CHRIS KIRKPATRICK DEATH INVESTIGATION REPORT 34(2009).
[1527] Ellinghuysen Transcribed Interview, at 95.
[1528] Memorandum from David P. Dechant, Manager, Great Lakes Human Resources Mgmt. Serv., to Chris Kirkpatrick, M.D., U.S. Dep't of Veterans Affairs (July 14, 2009), *in* JUNEAU COUNTY SHERIFF'S DEPARTMENT, CHRIS KIRKPATRICK DEATH INVESTIGATION REPORT 49 (2009); *see also* Ellinghuysen Transcribed Interview, at 95.
[1529] *Id.* at 95.

Based on documentation and statements from Ms. Ellinghuysen, it appears the Tomah VAMC fired Dr. Kirkpatrick for two reasons. The first issue surrounds Dr. Kirkpatrick's leave patterns.[1530] The second reason management cited was an incident in which Dr. Kirkpatrick brought his dog into work and another VAMC employee had to clean up after the dog.[1531]

On the issue of leave, management cited an incident in which Dr. Kirkpatrick reportedly requested vacation leave from 2:30 p.m. to 4:00 p.m. on one day, but actually left early at 1:00 p.m.[1532] The second issue cited by management concerned a request that Dr. Kirkpatrick correct how he logged his leave time. Even after he was asked to correct the record, Dr. Kirkpatrick still apparently logged his leave time inaccurately.[1533] Management also noted that Dr. Kirkpatrick took a vacation day on a Friday and then called in sick on the proceeding Monday.[1534]

According to Ms. Ellinghuysen, Dr. Kirkpatrick replied to the question of leave that he "didn't have a bank of comp time and [leadership] didn't have budget money for overtime."[1535] Because Tomah VAMC management was not approving either compensatory time or overtime, Dr. Kirkpatrick marked that he was leaving at 2:00, but really left at 1:00 because he had worked late one night earlier in the week and needed to ensure that he worked exactly 40 hours that week.[1536] According to Ms. Ellinghuysen, this type of time-management practice is common in the federal government and at the Tomah VAMC.[1537]

Ms. Ellinghuysen further explained that the time management system in pace at the time was "complex" and that Dr. Kirkpatrick was a "new employee."[1538] Mistakes with filing leave time in the new system were common amongst Tomah VAMC employees. "We all mess it up," Ms. Ellinghuysen said.[1539]

Tomah VAMC management disagreed with Dr. Kirkpatrick's explanations. Ms. Ellinghuysen stated, and documents show, that Tomah VAMC management cited a "pattern of leave" with Dr. Kirkpatrick's leave schedule.[1540] According to Ms. Ellinghuysen, Dr.

[1530] Memorandum by Linda Ellinghuysen, at 2 (2009), *in* JUNEAU COUNTY REPORT 34, at 35 (2009).
[1531] *Id.*
[1532] Memorandum by Linda Ellinghuysen, at 1-2 (2009), *in* JUNEAU COUNTY REPORT 34, at 34-35 (2009).
[1533] Memorandum by Linda Ellinghuysen, at 2 (2009), *in* JUNEAU COUNTY REPORT 34, at 35 (2009).
[1534] *Id.*
[1535] Ellinghuysen Transcribed Interview, at 96. The "bank of comp time" refers to a time management system that is common in the federal government. Federal employees work 40 hours per week and overtime or compensatory time must be approved by a manager. For example, if an employee works two hours late on Monday, she can receive two hours of compensatory time or she can leave work two hours early one day that week—so long as her weekly hours worked equal 40. According to Ms. Ellinghuysen, employees kept track of their own hours in this practice. *Id.* at 96–97.
[1536] *Id.* at 97.
[1537] Memorandum by Linda Ellinghuysen, at 1-2 (2009), *in* JUNEAU COUNTY REPORT 34, at 34-35 (2009).
[1537] Ellinghuysen Transcribed Interview, at 97.
[1538] *Id.*
[1539] *Id.*
[1540] Memorandum by Linda Ellinghuysen, at 2 (2009), *in* JUNEAU COUNTY REPORT 34, at 35 (2009).

Kirkpatrick informed Tomah VAMC management that it was the first time he had heard about a leave problem but that he would ensure he was present on Tuesday through Thursdays when he ran his group counseling sessions.[1541]

During the meeting, Dr. Kirkpatrick explained why he thought he was being terminated. Dr. Kirkpatrick told Tomah VAMC management that he was being fired because he placed a note in the chart of the veteran that threatened him.[1542]

According to Ms. Ellinghuysen, it became clear that Tomah VAMC management was "not going to give this young man another chance."[1543] Tomah VAMC management terminated Dr. Kirkpatrick on July 14, 2009. Tragically, Dr. Kirkpatrick was found dead in his apartment that evening from a self-inflicted gunshot wound.

2. There was no VA inquiry into Dr. Kirkpatrick's termination and death

On April 20, 2015, Chairman Johnson wrote to VA Secretary McDonald inquiring whether the VA conducted any inquiry into Dr. Kirkpatrick's termination and suicide.[1544] The Chairman noted the circumstances surrounding Dr. Kirkpatrick's termination and death and asked for information and documents surrounding these events. The VA notified the Chairman that it did not investigate Dr. Kirkpatrick's suicide—even though Dr. Kirkpatrick reported receiving patient threats—because Dr. Kirkpatrick had announced his intention to resign before he committed suicide.

In a May 29, 2015 letter to Chairman Johnson, VA Deputy Secretary Sloan Gibson confirmed that the "VA did not conduct an investigation into Dr. Kirkpatrick's termination and suicide."[1545] Deputy Secretary Gibson elaborated:

> Tomah VAMC management did not investigate [Dr. Kirkpatrick's] suicide because during the July 14, 2009, meeting where Dr. Kirkpatrick was notified that his temporary appointment would be terminated effective July 28, 2009, he indicated his intention to resign prior to the termination effective date. Tomah VAMC management did not receive a resignation letter from Dr. Kirkpatrick prior to his death.[1546]

[1541] Ellinghuysen Transcribed Interview, at 97; *see also* Memorandum by Linda Ellinghuysen, at 1-2 (2009), *in* JUNEAU COUNTY REPORT 34, at 34-35 (2009).
[1542] Ellinghuysen Transcribed Interview, at 98–99; *see also* Memorandum by Linda Ellinghuysen, at 1-2 (2009), *in* JUNEAU COUNTY REPORT 34, at 34-35 (2009).
[1543] Ellinghuysen Transcribed Interview, at 98.
[1544] 4/20/2015 Letter from Chairman Johnson, HSGAC, to Secretary McDonald, VA, at 1.
[1545] 5/29/2015 Letter from Deputy Secretary Gibson, VA, to Chairman Johnson, HSGAC, at 1.
[1546] *Id.*

Deputy Secretary Gibson explained, "[t]he VA Police Service does not have the jurisdiction to investigate an employee or a recently-terminated employee's suicide that occurred off VA property."[1547]

Deputy Secretary Gibson explained that the VA Police Service is responsible for addressing reported patient threats.[1548] He added that the Tomah VAMC has a committee that considers "risk factors and recommendations on flagging patients" consistent with VA regulations.[1549] With respect to the patient that allegedly threatened Dr. Kirkpatrick, Deputy Secretary Gibson wrote:

> A review of Dr. Kirkpatrick's records identified one Veteran as possibly being the Veteran who may have threatened Dr. Kirkpatrick. However the Tomah VAMC is not aware of any action taken against this patient regarding threats against Dr. Kirkpatrick.[1550]

3. The VA OIG's inquiry into Dr. Kirkpatrick's suicide

The VA OIG asserted that it examined Dr. Kirkpatrick's termination and suicide as part of its Tomah VAMC health care inspection. However, the only mention of Dr. Kirkpatrick's termination and suicide appears on page two of the OIG's 11-page administrative closure where the VA OIG listed the documents it reviewed as part of its inspection. The reference reads:

> 9. Documents related to the suicide of a Tomah VAMC mental health professional immediately following termination of employment (memoranda, e-mail messages, Sheriff's Department reports, union representation records and related internal union correspondence).[1551]

The majority staff has learned that the VA OIG pulled Dr. Kirkpatrick's emails as part of its review of the facility.[1552] However, the administrative closure made no findings about Dr. Kirkpatrick's termination or suicide.

During transcribed interviews, Chairman Johnson's staff asked VA OIG personnel whether the VA OIG investigated Dr. Kirkpatrick's termination and suicide as part of either its health care inspection or a separate criminal investigation. Staff presented the Juneau County Sheriff's report of Dr. Kirkpatrick's suicide. Dr. Mallinger described the VA OIG's inquiry into Dr. Kirkpatrick's suicide, stating:

[1547] *Id.*
[1548] *Id.*
[1549] *Id.*
[1550] *Id.*
[1551] VA OIG TOMAH VAMC ADMINISTRATIVE CLOSURE, at 2.
[1552] Memorandum from Robert Yang, VA, to Director, Computer Crimes and Forensics Laboratory (May 17, 2012), at OIG 13677.

> So Dr. Kirkpatrick was a psychologist at the Tomah VA who committed suicide, and some information about him came to our attention, specifically an investigation into his death by the Juneau County Sheriff's Department and we reviewed a lot of—and you probably have a copy of that, but there was a lot of VA material considered in that investigation that had been supplied by a union representative who had represented Mr. Kirkpatrick.[1553]

He explained further what the health care inspection team found in reference to Dr. Kirkpatrick:

> [B]asically there were—you know, there weren't, strictly speaking, allegations but, again, we were looking for administrative abuse, and, you know, we have a little latitude to go, you know, take a look at things that turn up in the leads that we develop. So that's really what we were doing here, is we were trying to determine whether there was any evidence for administrative abuse that arose out of this situation. And, basically, frankly, we were trying to understand the situation a little bit better—[1554]

Ultimately, the team "didn't really feel that the situation with Dr. Kirkpatrick led anywhere. We thought it was another—you know, one of many sort of things that we followed that didn't take us to a productive conclusion."[1555]

In May 2012, Special Agent Greg Porter of the VA OIG's criminal investigation unit received an email from a DEA diversion investigator with a copy of the Juneau County Sherriff's report.[1556] The DEA investigator opined, "I think the best parts are the attachments and email correspondence, but you may find something I've missed regarding controlled substances."[1557] Special Agent Porter did not conduct any additional follow-up beyond reading the Juneau County Sheriff's report.[1558] He could not recall his reaction to the document, but he did not believe its contents were relevant to his investigation. He explained:

> Q: Do you recall reviewing this and can you recall your reaction to reviewing these 58 pages?
>
> A: No, I cannot. I would look at—as I sit here looking at it, the first thing I would look at is when this happened, and this happened three years

[1553] Mallinger 4/6/2016 Transcribed Interview, at 255.
[1554] *Id.* at 257.
[1555] *Id.* at 258.
[1556] E-mail from Diversion Investigator, DEA, to Greg Porter, VA OIG (May 21, 2012, 3:02 PM), OIG 10598.
[1557] *Id.*
[1558] Porter Transcribed Interview, at 82–83.

> prior to my investigation at the Tomah, and it was a suicide by gunshot. So I wouldn't have given much credence to this as being relevant to my investigation.[1559]

Chairman Johnson's staff inquired further whether Special Agent Porter found any connection to his investigation in the contents of the suicide investigation report. Specifically, staff pointed to information contained in the report about potential whistleblower retaliation at the Tomah VAMC, allegations surrounding concerns about credentialing, the prescription of large quantities of narcotics, and use of the moniker "Candy Man."[1560] Special Agent Porter did not find that those documents were relevant and candidly informed the Committee that all he learned from the document was that Dr. Kirkpatrick committed suicide and "may have been a drug user himself." He stated:

> Q: My question is: From reviewing this document and interviews preceding this May 2012 time frame, did you become aware that similar allegations had been raised in earlier years?
>
> A: **By reading this report, I learned that a doctor had shot himself in the head, and there was--as I recall, there were other pieces of information to where, you know, he may have been a drug user himself**, as I recall it. I don't—this report per se didn't influence my investigation at all, and I didn't—[1561]

This exchange underscores the VA OIG's disregard for Dr. Kirkpatrick's whistleblower allegations. Similar to the VA OIG's white paper that attacked the Tomah VAMC whistleblowers, Special Agent Porter refused to concede that Dr. Kirkpatrick was raising concerns about overmedication and abuse of authority at the Tomah VAMC. Instead, all he apparently gleamed from the Sherriff's report of Dr. Kirkpatrick's death was that Dr. Kirkpatrick was a drug user who "shot himself."

4. The VA OIG's whitepaper on Dr. Kirkpatrick

On June 4, 2015, VA OIG Deputy Inspector General Richard Griffin sent an unsolicited letter to Chairman Johnson that included a "white paper" that purported to support the VA OIG's health care inspection.[1562] The letter and white paper were sent to 38 separate Senators and Congressmen—many of whom had no involvement whatsoever with the Committee's

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[1559] *Id.*
[1560] *Id.* at 84.
[1561] *Id.* at 84–85.
[1562] Letter from Richard J. Griffin, Deputy Inspector General, Dep't of Veterans Affairs, to Hon. Ron Johnson, Chairman, S. Comm. on Homeland Sec. & Governmental Affairs, at 3 (June 4, 2015) [hereinafter 6/4/2015 Letter from Deputy Inspector General Griffin, VA OIG, to Chairman Johnson, HSGAC].

investigation or any connection to the Tomah VAMC. On June 18, 2015, the VA OIG issued a press release highlighting the white paper and issued at least five separate tweets promoting the document.[1563]

The VA OIG's whitepaper attacked the victims and whistleblowers of the Tomah VAMC. The document and its unsolicited attacks were particularly alarming because they came from the VA OIG—the very office that should protect whistleblowers.[1564] Even Dr. Kirkpatrick, who had passed away nearly six years earlier, fell into the VA OIG's crosshairs. Dr. Kirkpatrick was not in a position to defend himself and it is repulsive that the VA OIG went to such lengths to retaliate against him.

The VA OIG's white paper references evidence found in Dr. Kirkpatrick's suicide report that is irrelevant to Dr. Kirkpatrick's concerns about overmedicated patients at the Tomah VAMC, his termination, or his suicide. In the white paper, the VA OIG "strongly" recommended that readers undertake a "thorough" review of the Juneau County Sheriff's report documenting law enforcement's investigation of Dr. Kirkpatrick's suicide.[1565] The VA OIG specifically noted the "voluminous amounts and types of marijuana and what appears [*sic*] to be other illegal substances found in Dr. Kirkpatrick's residence." The VA OIG added:

> **The evidence indicates that Dr. Kirkpatrick was likely not only to have been using but also distributing the marijuana and other illegal substances**. The Sheriff's report also lists large amounts of various prescription drugs found onsite, some of which were lying around loose with no indication whether they were prescribed for Dr. Kirkpatrick and, if so, when and by what provider.[1566]

Nothing in the VA OIG's white paper makes any reference to the actual substance of Dr. Kirkpatrick's whistleblowing—the appearance of overmedicated patients at the Tomah VAMC. The very same Sheriff's report that the VA OIG cites contained documents referring to the Tomah VAMC and Dr. Houlihan as "Candy Land" and "Candy Man," and highlighted Dr. Kirkpatrick's concerns about over prescription of narcotics at the facility.[1567] The VA OIG white paper ignored those facts.

[1563] Letter from Hon. Ron Johnson, Chairman, S. Comm. on Homeland Sec. & Governmental Affairs, to Linda Halliday, Deputy Inspector General, Dep't of Veterans Affairs, at 2 (July 8, 2015) [hereinafter 7/8/2015 Letter from Chairman Johnson, HSGAC, to Deputy Inspector General Halliday, VA OIG].

[1564] *See generally* Whistleblower Protection Act, Pub. L. 101-12, 1-3 Stat. 16; Pub L. 103-424, 108 Stat. 4361 (codified, as amended, in various sections of Title 5 U.S.C.).

[1565] VA OIG Whitepaper, at 8.

[1566] *Id.* at 9 (emphasis added).

[1567] Memorandum from Linda Ellinghuysen, Executive V.P., AFGE Local 1882, to Ben Balkum, President, AFGE Local VA Medical Center, Iron Mountain, MI, at 2–3 (Apr. 17, 2009), *in* JUNEAU COUNTY SHERIFF'S DEPARTMENT, CHRIS KIRKPATRICK DEATH INVESTIGATION REPORT 50, at 51-52 (2009).

Figure 103: VA OIG white paper (pages 8 and 9)

> The only specific death brought to our attention during the inspection was that of a psychologist, Christopher Kirkpatrick, who committed suicide after being terminated from his temporary position at the Tomah medical center on July 14, 2009. We did not find any evidence that Dr. Houlihan was in any way responsible for Dr. Kirkpatrick's death, although the Vice President of the local chapter of the American Federation of Government Employees (AFGE) expressed this opinion in documents she provided to the Juneau County Sheriff's Department who was responsible for investigating the suicide. I strongly recommend a thorough review of the in-depth Sheriff's report, a publicly available document, that is included in the documents produced, Records produced, pp. 5795-5851, with specific attention to the pages detailing the voluminous amounts and types of marijuana and what appears to be other illegal substances found in Dr. Kirkpatrick's residence as well as other items, including a scale and used devices containing marijuana residue. The evidence indicates that Dr. Kirkpatrick was likely not only to have been using but also distributing the marijuana and other illegal substances. The Sheriff's report also lists large amounts of various prescription drugs found onsite, some of which were lying around loose with no indication whether they were prescribed for Dr. Kirkpatrick and, if so, when and by what provider.

On July 8, 2015, Chairman Johnson sent a letter to VA Deputy Inspector General, Linda Halliday,[1568] responding to the VA OIG's attacks against the Tomah VAMC whistleblowers. Chairman Johnson wrote:

> It is beyond belief that the VA OIG could perform a "thorough" review of the Sheriff's investigative file, seemingly ignore the evidence with any actual merit to the subject of its inspection, and instead focus solely on information to attempt to discredit a deceased witness. Both the administrative closure and the white paper acknowledged the fact that the VA OIG reviewed material relating to Dr. Kirkpatrick's death during the health care inspection at the Tomah VAMC. However, the only analysis of this information, which the VA OIG offers with scant evidence, appears to consist of blaming Dr. Kirkpatrick and implying drug use contributed to his death. Nowhere does the VA OIG discuss the actual evidence in the Juneau County Sheriff's file relevant to the subject matter of its inspection of the Tomah VAMC.[1569]

At a Committee hearing held on September 22, 2015, Chairman Johnson questioned Deputy Inspector General Halliday on why the VA OIG would retaliate against Dr.

[1568] Deputy Inspector General Griffin retired from federal service on July 4, 2015. Donovan Slack, *Embattled VA Watchdog Stepping Down*, USA TODAY (June 30, 3015). http://www.usatoday.com/story/news/politics/2015/06/30/va-inspector-general-to-resign-this-week-in-face-of-criticism/29525497/.

[1569] 7/8/2015 Letter from Chairman Johnson, HSGAC, to Deputy Inspector General Halliday, VA OIG, at 6.

Kirkpatrick.[1570] When asked who prepared the white paper, Deputy Inspector General Halliday testified that she had not prepared the document and said she would need to take the question for the record.[1571] She testified:

> **Chairman Johnson:** Were you at all involved in the writing of that white paper?
>
> **Ms. Halliday:** I was not.
>
> **Chairman Johnson:** Were you aware it was being written and issued?
>
> **Ms. Halliday:** I was not.
>
> **Chairman Johnson:** It strikes me as, quite honestly, reprehensible. . . . I want assurances that this will be corrected, that amends will be made for this reprehensible reprisal. Ms. Halliday?
>
> **Ms. Halliday:** As I stated, I did not prepare that document. I—
>
> **Chairman Johnson:** Who did? Do you know the individuals within the Office of Inspector General that wrote this? Who did this? I want to know. This Committee wants to know who is involved in this.
>
> **Ms. Halliday:** The prior—
>
> **Chairman Johnson:** I want to know every individual who was involved in writing this report.
>
> **Ms. Halliday:** I would have to take that for the record.[1572]

Chairman Johnson followed up his request from the hearing with a letter to Deputy Inspector General Halliday on September 29, 2015, asking for "all documents and communications referring or relating to the drafting or publication of the VA OIG's Tomah VAMC white paper . . . ."[1573] The Chairman requested all drafts of the white paper, and all

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[1570] *Improving VA Accountability: Examining First-Hand Accounts of Department of Veterans Affairs Whistleblowers, Hearing Before S. Comm. on Homeland Sec. & Governmental Affairs*, 114th Cong. (2015).
[1571] *Improving VA Accountability: Examining First-Hand Accounts of Department of Veterans Affairs Whistleblowers, Hearing Before S. Comm. on Homeland Sec. & Governmental Affairs*, 114th Cong. 106–09 (2015) (hearing transcript).
[1572] *Id.*
[1573] Letter from Hon. Ron Johnson, Chairman, S. Comm. on Homeland Sec. & Governmental Affairs, to Linda Halliday, Deputy Inspector General, Dep't of Veterans Affairs, at 2 (Sept. 29, 2015) [hereinafter 9/29/2015 Letter from Chairman Johnson, HSGAC, to Deputy Inspector General Halliday, VA OIG].

emails between VA OIG employees concerning the drafting or publication of the white paper.[1574] The letter requested the VA OIG produce this information by October 6, 2015.[1575]

On October 6, 2015, Deputy Inspector General Halliday responded to Chairman Johnson's letter. The letter reiterated Ms. Halliday's position from her September 22 testimony. Ms. Halliday wrote:

> As I stated at the Committee's hearing on September 22, 2015, I had no role in drafting this document or the decision to release it as I was not the Deputy Inspector General at the time. I would emphasize that all staff were operating under the direction of the former Deputy Inspector General [Richard Griffin], who is the responsible official who directed, signed, and issued the document.[1576]

Ms. Halliday refused to provide the requested information and said that the drafts were part of the agency's deliberative process. She also cited concerns that producing this material would somehow jeopardize the independence of the VA OIG. She concluded:

> In consideration of these actions and the need to preserve the independence and integrity of the deliberative proves across the Inspector General community, I respectfully ask that you withdraw your request for documents described [in the letter].[1577]

Chairman Johnson has not withdrawn his request, which remains outstanding. The VA OIG has not asserted a privilege over this material, but merely claimed that the requested documents could include deliberative materials. Even more troubling is the VA OIG's decision to avoid accountability for its reprisal against Dr. Kirkpatrick. The VA OIG's callous attacks on the Tomah VAMC whistleblowers and its hinting at legal privilege to avoid public scrutiny of its decisions are unbecoming of a member of the inspector general community.

[1574] *Id.*
[1575] *Id.*
[1576] Letter from Linda Halliday, Deputy Inspector General, Dep't of Veterans Affairs, to Hon. Ron Johnson, Chairman, S. Comm. on Homeland Sec. & Governmental Affairs, at 1 (Oct. 6, 2015) [hereinafter 10/6/2015 Letter from Deputy Inspector General Halliday, VA OIG, to Chairman Johnson, HSGAC].
[1577] *Id.* at 2.

Figure 104: Letter from VA Deputy Inspector General Linda Halliday to Chairman Johnson

In consideration of these actions and the need to preserve the independence and integrity of the deliberative process across the Inspector General community, I respectfully ask that you withdraw your request for the documents described in paragraphs a and b.

I am confident that, under your leadership, the Committee and the OIG can forge a new relationship, based on mutual respect, cooperation, and a shared mission of ensuring veterans receive the care they have earned through their service to our Nation. I appreciate your consideration of this request.

Sincerely,

LINDA A. HALLIDAY
Deputy Inspector General

C. Dr. Noelle Johnson

Dr. Noelle Johnson was a clinical pharmacy specialist at the Tomah VAMC from July 2008 to June 2009.[1578] Dr. Johnson often served as the "hot seat" pharmacist at the facility's pharmacy, in which she would act as the final reviewer of prescriptions before they were dispensed to veterans.[1579] On multiple occasions through her tenure in the pharmacy, Dr. Johnson refused to fill prescriptions because she believed they were unsafe. She was removed from the Tomah VAMC just weeks before the conclusion of her probationary employment period. She challenged her removal before the Merit Systems Protection Board (MSPB) and subsequently reached a settlement with the VA that fully reinstated her employment. Dr. Johnson currently works at a VA facility in Iowa.

Dr. Johnson testified about her experiences in the Tomah VAMC pharmacy during the Committee's March 30, 2015 field hearing in Tomah, Wisconsin.[1580] She confirmed that the facility was known among the veteran population as "Candy Land" and that veterans referred to Dr. Houlihan as the "Candy Man":

[1578] *Tomah VAMC: Examining Quality, Access, and Culture of Overreliance on High-Risk Medications, Joint Field Hearing Before S. Comm. on Homeland Sec. & Governmental Affairs & H. Comm. on Veterans Affairs* 114th Cong. (2015) (statement of Noelle Johnson).
[1579] Noelle A. Johnson v. Dep't of Veterans Affairs, MSPB Docket No. CH-1221-10-0036-W-1, Tab 1 at 1 (Dr. Johnson's narrative of the events).
[1580] *Tomah VAMC: Examining Quality, Access, and Culture of Overreliance on High-Risk Medications, Joint Field Hearing Before S. Comm. on Homeland Sec. & Governmental Affairs & H. Comm. on Veterans Affairs* 114th Cong. (2015) (statement of Noelle Johnson).

> The "Candy Man" statement the *CIR* [*Center for Investigative Reporting*] reference is legitimate. I heard more than one Veteran reference Dr. Houlihan as this. I heard a particular [Tomah VAMC] patient in the hall way say "my primary care doctor took me off of my narcotics, you need to see Dr. Houlihan because he will put you back on them just like he did me."[1581]

She testified about specific instances in which she refused to fill prescriptions that she believed to be unsafe.[1582] Dr. Johnson also highlighted instances of other Tomah VAMC employees either leaving the facility or facing discipline for questioning potentially unsafe prescriptions.[1583]

In addition to speaking about her efforts to address the issue of overmedication internally within the Tomah VAMC, Dr. Johnson testified about how she contacted multiple entities to potentially initiate an outside review of the Tomah VAMC.[1584] She testified that she called the Wisconsin Pharmacy Board, the Iowa Board of Pharmacy, and the Drug Enforcement Administration (DEA), and that she filed a whistleblower claim with the Office of Special Counsel.[1585]

As the majority staff's interim report discussed, the DEA interviewed Dr. Johnson as part of an investigation it conducted on the Tomah VAMC in 2009. According to documents filed as part of Dr. Johnson's MSPB appeal, she was interviewed by a DEA investigator on June 19, 2009.[1586] During the interview, Dr. Johnson showed the DEA investigator approximately ten examples of patients under Dr. Houlihan's care who received narcotic prescriptions that in her opinion were either too high in dosage or too long in length.[1587] Dr. Johnson informed the DEA investigator of three "unexplained suicides" of Dr. Houlihan's patients at the Tomah VAMC during her employment.[1588] At the conclusion of the two-hour interview, the DEA investigator informed Dr. Johnson that federal prosecutors would be in touch with her and he advised her not to fill any prescriptions she felt were unsafe.[1589] Federal law-enforcement officials never followed up with Dr. Johnson.

Like it did to Dr. Kirkpatrick, the VA OIG attacked Dr. Johnson's claims and creditability in its white paper. The VA OIG argued that Dr. Johnson had no "personal

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[1581] *Id.* at 6.
[1582] *Id.*
[1583] *Id.* at 6.
[1584] *Id.* at 5.
[1585] *Id.* at 1, 5.
[1586] Noelle A. Johnson v. Dep't of Veterans Affairs, MSPB Docket No. CH-1221-10-0036-W-1, Tab 1 at 6 (Dr. Johnson's narrative of the events). Dr. Johnson also confirmed that she was interviewed by the DEA in 2009 in her written testimony for the Committee's Field Hearing in Tomah on March 30, 2015. Noelle Johnson statement at 1.
[1587] Noelle A. Johnson v. Dep't of Veterans Affairs, MSPB Docket No. CH-1221-10-0036-W-1, Tab 1 at 6 (Dr. Johnson's narrative of the events).
[1588] *Id.*
[1589] *Id.*

knowledge of the facts and circumstances as they existed during [the OIG's] inspection."[1590] The VA OIG also downplayed the retaliation Dr. Johnson suffered, saying that she was terminated in part because she had "poor interpersonal skills," "repeated negative interactions," and had "unsatisfactory" performance.[1591] The VA OIG implied that because Dr. Johnson was "only a probationary employee" who "had just completed her training and [the Tomah VAMC] was her first position as a pharmacist," her perception that some of Dr. Houlihan's prescriptions were unsafe and her belief that she was fired because she questioned those prescriptions was somehow inaccurate.[1592]

Nowhere in the white paper, or the actual administrative closure for that matter, did the VA OIG actually examine on the merits of Dr. Johnson's allegations. As explained in Chairman Johnson's letter to the VA OIG in response to the white paper, the VA OIG failed to acknowledge Dr. Johnson's credentials as a pharmacist, or any other facts that paint Dr. Johnson in a positive light.[1593] The VA OIG ignored Dr. Johnson's firsthand accounts of abuse and over-prescription because they did not occur during the time of the OIG's inspection. The VA OIG ignored the twelve separate letters of support signed by Tomah VAMC employees who interacted with Dr. Johnson during her tenure at the Tomah VAMC.[1594] The VA OIG overlooked Dr. Johnson's "fully successful" performance ratings from her service line manager.[1595] Most significantly, the VA OIG failed to acknowledge that Dr. Johnson entered into a settlement agreement with the VA in 2010 that fully reinstated her to VA employment. Instead, the VA OIG focused solely on cherry-picked documents and information that painted Dr. Johnson in a negative light in an effort to discredit her.

D. Ryan Honl

Ryan Honl served as a secretary in the Tomah VAMC mental health unit. He is a disabled combat veteran of Operation Desert Storm and a graduate of the United States Military Academy at West Point, New York.[1596] Mr. Honl began raising concerns about the over-prescription of narcotics at the Tomah VAMC, as well as potential scheduling manipulation at the facility.[1597] Mr. Honl made complaints to both the VA OIG and the Office of Special

[1590] VA OIG Whitepaper, at 3.
[1591] *Id.* at 9–10.
[1592] *Id.* at 10.
[1593] 7/8/2015 Letter from Chairman Johnson, HSGAC, to Deputy Inspector Halliday, VA OIG, at 3-4.
[1594] Noelle A. Johnson v. Dep't of Veterans Affairs, MSPB Docket No. CH-1221-10-0036-W-1, Attachment T, at 1-12 (letters of support).
[1595] Noelle A. Johnson v. Dep't of Veterans Affairs, MSPB Docket No. CH-1221-10-0036-W-1, Attachment N (Dr. Johnson's performance appraisals).
[1596] *Tomah VAMC: Examining Quality, Access, and Culture of Overreliance on High-Risk Medications, Joint Field Hearing Before S. Comm. on Homeland Sec. & Governmental Affairs & H. Comm. on Veterans Affairs* 114th Cong. (2015) (statement of Ryan Honl at 1).
[1597] *Id.*

Counsel (OSC) about the issues he observed at the Tomah VAMC. After he made his disclosures, he faced several forms of retaliation.

On the same day that Mr. Honl made a disclosure to the VA OIG, Tomah VAMC management "stripped Mr. Honl of his job duties, locked him out of his office, and isolated him from his co-workers."[1598] Shortly after the abuse began, Mr. Honl resigned. With the assistance of the OSC, Mr. Honl settled with the VA and received "several corrective actions, including the removal of negative information from his personnel file and monetary damages."[1599]

Like Dr. Johnson, Mr. Honl testified during the Committee's March 2015 field hearing in Tomah, Wisconsin. He highlighted additional examples of retaliation that he faced at the Tomah VAMC after coming forward to reporting wrongdoing. Mr. Honl testified:

> After requesting a patient access report of my medical records, I discovered that a half dozen Tomah employees had accessed my electronic medical records after I left the facility over a supposed mix up in Secretary McDonald's office concerning a complaint about my prescriptions. Although I had never received care or prescriptions from the Tomah VA, there were half dozen Tomah non-pharmacy employees in my records. [1600]

Mr. Honl also testified about how Tomah VAMC personnel disclosed and publicized his diagnosis of PTSD in an attempt to discredit his whistleblowing. He testified:

> I had originally informed my supervisor, Lisa Noe, that I had a PTSD diagnosis since I was in vocational rehabilitation and my counselor in Indiana needed to know information about my employment at the Tomah VA. I asked that this remain in confidence. However, as soon as I blew the whistle, I started hearing about my instability from other employees. Ultimately, the most troubling [*sic*] occurred since everything came out in the media in January. Dr. Houlihan's attorney sent a letter to me threatening a lawsuit for defamation. In an interview with the *Milwaukee Journal Sentinel*, his attorney alluded to my mental health status. Shortly after while VA investigators were in the Tomah VA, Police Chief Huffman directed that a police report be done on me by my former supervisor, Lisa Noe, and two coworkers, Leesha Dukes and Rachel Fleming, four months after I resigned over a supposed "threatening incident" that took place while I was an employee before I resigned. . . . In one part of the police report, I'm accused of

[1598] Press Release, U.S. Office of Special Counsel, *OSC Secures Relief for Additional VA Whistleblowers* (July 22, 2015), https://osc.gov/News/pr15-15.pdf.
[1599] *Id.*
[1600] *Tomah VAMC: Examining Quality, Access, and Culture of Overreliance on High-Risk Medications, Joint Field Hearing Before S. Comm. on Homeland Sec. & Governmental Affairs & H. Comm. on Veterans Affairs* 114th Cong. (2015) (statement of Ryan Honl at 2).

> acting "crazy." Clearly, my mental health diagnoses are being used by those I reported in order to discredit me.[1601]

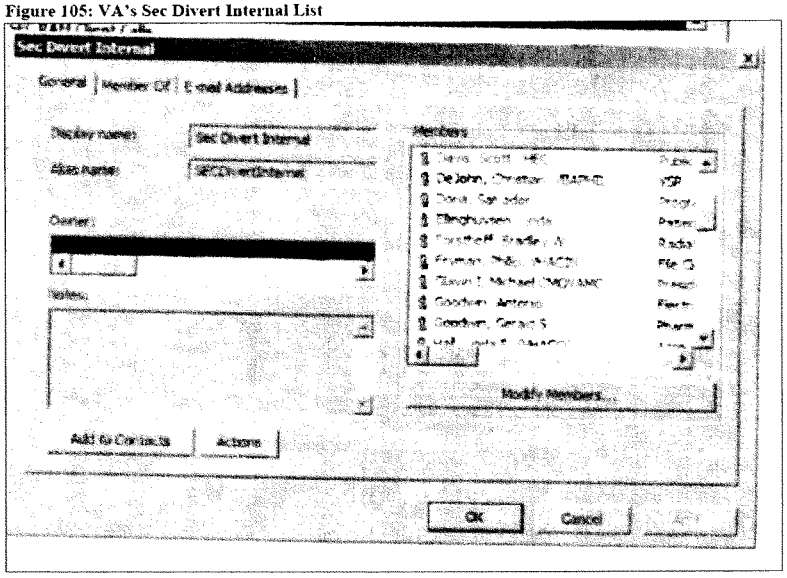
Like Dr. Kirkpatrick and Dr. Johnson, the VA OIG attempted to attack Mr. Honl's creditability as a whistleblower in its white paper, arguing that Mr. Honl had no personal knowledge of narcotic over-prescription at the Tomah VAMC.[1602] However, Mr. Honl's tenure at the Tomah VAMC gave him a firsthand view of the whistleblower retaliation at the facility and the culture of fear at the Tomah VAMC—an issue that the VA OIG examined in its health care inspection. As Chairman Johnson explained in his response to the VA OIG, "[t]o discount [Mr.] Honl's testimony on such narrow grounds indicates a tainted and slanted perspective within the VA OIG."[1603]

E. Lin Ellinghuysen

On January 21, 2016 the *Washington Examiner* published an article revealing complaints that the Department of Veterans Affairs was "spying on whistleblowers by diverting their emails to the secretary's office in Washington, D.C."[1604] The list, titled "Sec Divert Internal" includes VA whistleblowers throughout the country. According to the *Examiner*, "emails from those workers are being sent to VA secretary's office in Washington, D.C."[1605] Lin Ellinghuysen, the president of AFGE Local 0007 who had been raising concerns about over-medication and administrative abuse at the Tomah VAMC for years, appears on the Sec Divert Internal list.[1606]

[1601] *Id.* at 2–3.
[1602] VA OIG Whitepaper, at 3.
[1603] 7/8/2015 Letter from Chairman Johnson, HSGAC, to Deputy Inspector Halliday, VA OIG, at 7.
[1604] Pete Kasperowicz, *House Probes Claim the VA is Spying on Whistleblower Emails*, WASHINGTON EXAMINER (Jan. 21, 2016), http://www.washingtonexaminer.com/house-probes-claim-the-va-is-spying-on-whistleblower-emails/article/2581072.
[1605] *Id.*
[1606] *Id.*; *see also* Memo by Linda Ellinghuysen, President, AFGE Local 0007 (Feb. 2014).

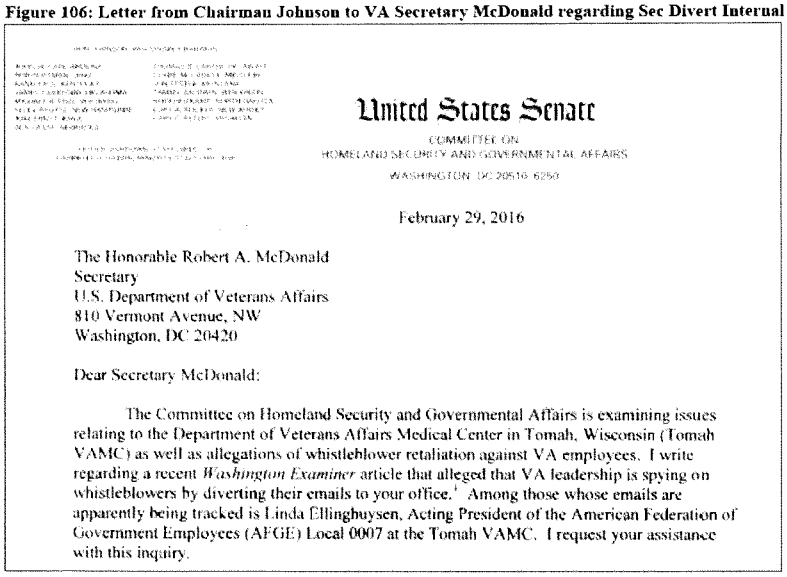
Figure 105: VA's Sec Divert Internal List



On February 29, 2016, Chairman Johnson wrote to VA Secretary McDonald inquiring why Ms. Ellinghuysen appeared on the "Sec Divert Internal" list of emails that were being diverted.[1607] In the letter, Chairman Johnson noted that in a February 2016 meeting between his staff and AFGE union officials, Ms. Ellinghuysen informed the staff that she was unaware that she was included on such a list.[1608] Ms. Ellinghuysen noted, however, that she noticed a mysterious woman's name—a name she did not recognize—included in some group emails she had sent in 2015 since the public became aware of the tragedies at the Tomah VAMC.[1609]

[1607] Letter from Hon. Ron Johnson, Chairman, S. Comm. on Homeland Sec. & Governmental Affairs, to Hon. Robert McDonald, Secretary, Dep't of Veterans Affairs, at 2 (Feb. 29, 2016) [hereinafter 2/29/2016 Letter from Chairman Johnson, HSGAC, to Secretary McDonald, VA].
[1608] *Id.*
[1609] *Id.*

Figure 106: Letter from Chairman Johnson to VA Secretary McDonald regarding Sec Divert Internal list



United States Senate

COMMITTEE ON
HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS
WASHINGTON, DC 20510-6250

February 29, 2016

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

Dear Secretary McDonald:

The Committee on Homeland Security and Governmental Affairs is examining issues relating to the Department of Veterans Affairs Medical Center in Tomah, Wisconsin (Tomah VAMC) as well as allegations of whistleblower retaliation against VA employees. I write regarding a recent *Washington Examiner* article that alleged that VA leadership is spying on whistleblowers by diverting their emails to your office.[1] Among those whose emails are apparently being tracked is Linda Ellinghuysen, Acting President of the American Federation of Government Employees (AFGE) Local 0007 at the Tomah VAMC. I request your assistance with this inquiry.

Chairman Johnson's letter explained that the existence of a list like the "Sec Divert Internal" list raises significant concerns about VA employees' ability to blow the whistle on waste, fraud, abuse, and misconduct by VA management.[1610] VA employees need to have confidence to raise concerns at their facilities to ensure that veterans receive the care they deserve. Chairman Johnson requested material about the purpose and origins of the list.[1611] Chairman Johnson requested that the VA produce this material by March 18, 2016.[1612] To date, the VA has not produced any material responsive to this request and they do not have a timeline on when the agency anticipates providing a response to Chairman Johnson's inquiry.

* * *

By most accounts, the VA is not a friendly environment for whistleblowers. Witnesses from across the country who were invited by Chairman Johnson to testify at a September 2015 Committee hearing described their experiences. The VA put Brandon Coleman, a veteran and VA employee in Phoenix, Arizona, on leave and closed his drug rehabilitation program after Mr.

[1610] *Id.* at 1.
[1611] *Id.* at 3.
[1612] *Id.*

Coleman raised concerns about patient suicides.[1613] Shea Wilkes, a VA employee from Shreveport, Louisiana, testified that the VA OIG began to investigate him for accessing VA records after Mr. Wilkes discovered a secret patient wait list for care at the Shreveport facility.[1614] Joseph Colon, a credentialing support specialist with the VA Caribbean Health System in San Juan, Puerto Rico, testified about the retaliation he faced after he blew the whistle about quality of care issues and misconduct by the director of his facility.[1615]

Sean Kirkpatrick, the brother of Dr. Christopher Kirkpatrick, also testified during that hearing. He told Chairman Johnson and the Committee the story of his brother, who raised concerns about over-prescription at the Tomah VAMC and was later fired.[1616] The story of Dr. Kirkpatrick was unfortunately familiar to other Tomah VAMC employees. Witnesses described a culture of fear at the Tomah VAMC. The VA OIG, the entity that is supposed to protect VA whistleblowers, attacked the Tomah VAMC whistleblowers—attempting to discredit their allegations through character and *ad hominen* attacks.

The Tomah VAMC is an unfortunate case study of the poor state of whistleblower protection within the VA. Because employees and others were afraid to speak out, the problems at the facility continued unabated. In this way, the whistleblower retaliation and culture of fear at the Tomah VAMC contributed to the tragedy.

[1613] *Improving VA Accountability: Examining First-Hand Accounts of Department of Veterans Affairs Whistleblowers, Hearing before S. Comm. on Homeland Sec. and Governmental Affairs*, 114th Cong. (2015) (statement by Brandon Coleman at 3).
[1614] *Id.* (statement by Shea Wilkes at 11).
[1615] *Id.* (statement by Joseph Colon).
[1616] *Id.* (statement by Sean Kirkpatrick).

V. Attempts at stonewalling Chairman Johnson's investigation

Throughout the course of the investigation, Chairman Johnson has received cooperation from agencies—such as the Merit Systems Protection Board and the Office of Special Counsel—that have been forthcoming with information. Their forthright assistance has greatly aided the Committee's fact-finding. Other entities, however, have resisted efforts to obtain information about what happened at the Tomah VAMC. By and large, the entities centrally involved in investigating abuses at the Tomah VAMC declined to cooperate completely with Chairman Johnson's investigation. This posture unnecessarily delayed the fact-finding and prevents Congress and Wisconsin veterans from understanding the truth of what really happened at the Tomah VAMC.

A. Congress has a right to information from the executive branch and other entities

The United States Constitution vests Congress with certain enumerated powers, including the exclusive right to legislate. Article 1 of the Constitution authorizes Congress:

> To make all laws which shall be necessary and proper for carrying into execution the foregoing powers, and all other powers vested by this Constitution in the government of the United States, or in any department or officer thereof.[1617]

Implicit in this delegation is the authority of Congress to gather facts and to ensure that laws passed by Congress were faithfully executed. As early as 1792, Congress used its investigative power to obtain records and papers relating to the Battle of Wabash in the Northwest Territory.[1618]

For nearly 100 years, the Supreme Court has explained that Congress's lawmaking authority necessarily includes a right to information from the executive branch. In *Eastland v. U.S. Servicemen's Fund*, the Supreme Court explained that "[t]his Court has often noted that the power to investigate is inherent in the power to make laws because '[a] legislative body cannot legislate wisely or effectively in the absence of information respecting the conditions which the legislation is intended to affect or change.'"[1619] In *Barenblatt v. United States*, the Court elaborated:

> The power of inquiry has been employed by Congress throughout our history, over the whole range of the national interests concerning which Congress might

[1617] U.S. Const. art. I, § 8, cl. 18.
[1618] 3 ANNALS OF CONG. 490-93 (1792).
[1619] *Eastland v. U.S. Servicemen's Fund*, 421 U.S. 491, 504 (1975) (citing *McGrain v. Daugherty*, 273 U.S. 135, 175 (1927)).

> legislate or decide upon due investigation not to legislate; it has similarly been utilized in determining what to appropriate from the national purse, or whether to appropriate.[1620]

The Supreme Court has continually emphasized the breadth of Congress' investigative power. "The scope of the power of inquiry," the Court explained in 1959, "is as penetrating and far-reaching as the potential power to enact and appropriate under the Constitution."[1621] While this investigative power must be exercised "in aid of the legislative function"[1622]—in other words, "there is no congressional power to expose for the sake of exposure"[1623]—this focus does not restrict "the power of Congress to inquire into and publicize corruption, maladministration or inefficiency in agencies of the Government."[1624]

Congress's broad authority to conduct investigations includes the ability to compel the production of information and materials. In *Eastland*, the Supreme Court explained that the "[i]ssuance of subpoenas . . . has long been held to be a legitimate use by Congress of its power to investigate."[1625] The Court reasoned that "where the legislative body does not itself possess the requisite information—which not infrequently is true—recourse must be had to others who do possess it."[1626] The congressional "power of inquiry—with process to enforce it—is an essential and appropriate auxiliary to the legislative function."[1627] Moreover, committees of Congress exercise on behalf of the Congress the power to compel information: "It also has been held that the subpoena power may be exercised by a committee acting, as here, on behalf of one of the Houses."[1628]

The Senate Committee on Homeland Security and Governmental Affairs serves as the Senate's chief oversight and investigative committee. The Standing Rules of the Senate authorize the Committee to investigate "the efficiency and economy of operations of all branches and functions of the Government."[1629] In addition, the Senate has specifically authorized the Committee to examine "the efficiency and economy of all branches of the Government including the possible existence of fraud, misfeasance, malfeasance, collusion, mismanagement,

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[1620] *Barenblatt v. United States*, 360 U.S. 109, 111 (1959).
[1621] *Id.*; see also *Eastland v. U.S. Servicemen's Fund*, 421 U.S. 491, 501 n.15 (1975).
[1622] *Kilbourn v. Thompson*, 103 U.S. 168, 189 (1880).
[1623] *Watkins v. United States*, 354 U.S. 178, 200 (1957).
[1624] *Watkins v. United States*, 354 U.S. 178, 200 n.33 (1957). Similarly, lower federal courts have recognized Congress's right to information, including material from the executive branch. In *Murphy v. Department of the Army*, the Court of Appeals for the District of Columbia noted that "Congress, whether as a body, through committees, or otherwise, must have the widest possible access to executive branch information if it is to perform its manifold responsibilities effectively." *Murphy*, 613 F.2d 1151, 1158 (D.C. Cir. 1979).
[1625] *Eastland*, 421 U.S. at 504 n. 15.
[1626] *McGrain v. Daugherty*, 273 U.S. 135, 174-75 (1927).
[1627] *Id.*
[1628] *Eastland*, 421 U.S. at 503-05.
[1629] S. Rule XXV(k); *see also* S. Res. 445, 108th Cong. (2004).

incompetence, corruption, or unethical practices . . . ."[1630] Chairman Johnson is investigating allegations relating to the Tomah VAMC pursuant to this authority.

In short, if Congress is to develop laws to fix problems within the executive branch, it must first possess all necessary information to identify the root causes of the problems. This right to information from the executive branch is rooted in the Constitution and reaffirmed by the Supreme Court. In the course of this investigation, however, executive branch entities have failed to honor fully Chairman Johnson's requests for material. The stonewalling and lack of transparency unreasonably delayed the investigation and hindered accountability for the tragedies at the Tomah VAMC.

B. The VA Office of Inspector General

At the outset of the investigation, Chairman Johnson's staff contacted the VA OIG to seek its assistance in understanding the allegations concerning the Tomah VAMC. In early February 2015, Chairman Johnson's staff received a briefing from the VA OIG employees who conducted the Tomah VAMC health care inspection about their work. When Chairman Johnson's staff asked for the original source material supporting the VA OIG's health care inspection, the VA OIG balked and took on an increasingly confrontational tone. Chairman Johnson sent four letters to the VA Deputy Inspector General Richard Griffin in spring 2015 in an effort to secure its voluntary cooperation, and the Chairman's staff engaged in a number of discussions with VA OIG staff.[1631] Chairman Johnson also met personally with Deputy Inspector General Griffin on March 2, 2015, to try to reach an accommodation on the production of documents.[1632]

The VA OIG's refusal to aid the Chairman Johnson's investigation led to the highly unusual—and reluctant—issuance of a subpoena to Deputy Inspector General Griffin for documents relating the VA OIG's inspection.[1633] Although the VA OIG produced some documents, its overall posture toward the investigation has not changed since the issuance of the subpoena. The VA OIG continues to withhold documents from Chairman Johnson.

[1630] S. Res. 73 § 12, 114th Cong. (2015).

[1631] Letter from Hon. Ron Johnson, Chairman, S. Comm. on Homeland Sec. & Governmental Affairs, to Richard J. Griffin, Deputy Inspector General, Dep't of Veterans Affairs, at 2 (Feb. 25, 2015); Letter from Hon. Ron Johnson, Chairman, S. Comm. on Homeland Sec. & Governmental Affairs, to Richard J. Griffin, Deputy Inspector General, Dep't of Veterans Affairs, at 2 (Mar. 11, 2015); Letter from Hon. Ron Johnson, Chairman, S. Comm. on Homeland Sec. & Governmental Affairs, to Richard J. Griffin, Deputy Inspector General, Dep't of Veterans Affairs, at 1-2 (Mar. 17, 2015); Letter from Hon. Ron Johnson, Chairman, S. Comm. on Homeland Sec. & Governmental Affairs, to Richard J. Griffin, Deputy Inspector General, Dep't of Veterans Affairs, at 2 (Apr. 20, 2015).

[1632] Meeting between Hon. Ron Johnson, Chairman, S. Comm. on Homeland Sec. & Governmental Affairs, and Richard J. Griffin, Deputy Inspector General, VA OIG (Mar. 2, 2015).

[1633] Deputy Inspector General Richard Griffin was the most senior official at the VA OIG due to a vacancy in the position of the Inspector General. Under Chairman Johnson's leadership, attorney Michael Missal was confirmed as the VA Inspector General on April 19, 2016.

1. Chairman Johnson's efforts to secure the VA OIG's voluntary cooperation

On February 4, 2015, Chairman Johnson's staff met with employees from the VA OIG to discuss the VA OIG's health care inspection of the Tomah VAMC. During this meeting, staff learned that the VA OIG had compiled and still possessed a comprehensive investigative file gathered during its almost three-year inspection of the Tomah VAMC.[1634] Chairman Johnson's staff requested that the VA OIG provide the file to assist with Chairman Johnson's investigation.[1635] Following the meeting, Chairman Johnson's staff and VA OIG staff discussed the production on the phone and by email on February 11, 2015,[1636] and February 13, 2015,[1637] under the belief that the VA OIG would produce the file. In one email, VA OIG staff represented to Chairman Johnson's staff:

> We are going through the documents—of which there are many (we tend to gather a lot of information)—so let me discuss with our Release of Information Office staff about what a reasonable timeline could be for getting you the documents.[1638]

From the outset of these communications with the VA OIG, Chairman Johnson and his staff continually sought to accommodate concerns about patient privacy and narrowed their requests accordingly. On February 11, 2015, Chairman Johnson's staff wrote to Catherine Gromek, the VA OIG's Congressional Relations Officer, to express Chairman Johnson's willingness to resolve the concerns:

> We understand that there may be sensitivities surrounding particular documents—and we're certainly willing to work with you to resolve those matters—but we requested the VA OIG investigative file to inform our oversight work. Without the entire investigative file, the Committee may not be able to assess effectively or fully the situation in Tomah. As a starting point for further discussions about the investigative file, it would be helpful for us to know how many documents need to be reviewed by your staff and precisely what restrictions the VA OIG believes apply to these documents.[1639]

[1634] 2/25/2015 Letter from Chairman Johnson, HSGAC, to Deputy Inspector General Griffin, VA OIG, at 2. Committee investigators met with Dr. John Daigh, the Assistant Inspector General for Healthcare Inspections, and Dr. Alan Mallinger, Senior Physician in the Office of Healthcare Inspections. *Id.*

[1635] 2/25/2015 Letter from Chairman Johnson, HSGAC, to Deputy Inspector General Griffin, VA OIG, at 3.

[1636] *Id.* at 2; Email from Catherin Gromek, VA OIG, to Comm. Staff, HSGAC (Feb. 11, 2015).

[1637] Email from Catherine Gromek, VA OIG, to Comm. Staff, HSGAC (Feb. 13, 2015).

[1638] Email from Catherine Gromek, VA OIG, to Comm. Staff, HSGAC (Feb. 11, 2015).

[1639] Email from Comm. Staff, HSGAC, to Catherine Gromek, VA OIG (Feb. 11, 2015); Letter from Hon. Ron Johnson, Chairman, S. Comm. on Homeland Sec. & Governmental Affairs, to Richard J. Griffin, Deputy Inspector General, Dep't of Veterans Affairs, at 2 (Mar. 11, 2015) [hereinafter 3/11/2015 Letter from Chairman Johnson,

In a subsequent letter to Mr. Griffin, Chairman Johnson reiterated that "the Committee seeks to work with the VA OIG to protect sensitive patient information," and stated that "[t]he Committee will accept *in camera* review of this material, as well as appropriate redactions for patient-sensitive information."[1640]

On February 18, 2015, VA OIG attorneys met with Chairman Johnson's staff and indicated that the VA OIG would *not* produce the investigative file.[1641] Specifically, Maureen Regan, Counselor to the Inspector General, told staff that the VA OIG had no obligation to report to Congress outside of its semiannual report and even questioned Chairman Johnson's authority and purpose for reviewing the VA OIG's inspection.[1642] Ms. Regan refused to elaborate on the VA OIG's position and refused to discuss or provide a list of the types of documents contained in the investigative file, despite possessing such a list at the meeting and even referring to it during the conversation.[1643]

Following these unsuccessful discussions with the VA OIG, Chairman Johnson wrote a letter to Mr. Griffin on February 25, 2015, formally requesting "the VA OIG's entire investigative file pertaining to the Tomah VAMC."[1644] Mr. Griffin responded on February 27, 2015, declining to produce the material and asserting without citing any legal precedent that Chairman Johnson had to justify his request by explaining "why [he] believes [his] needs are legitimate."[1645]

Over the next several months, Chairman Johnson's staff continued to seek an accommodation on the production of documents from the VA OIG. Staff offered to accommodate the VA OIG's by accepting rolling productions, redactions of sensitive veterans' health information, and other means to address the VA OIG's stated concerns.[1646] The VA OIG, however, refused to articulate any particularized concerns about specific documents, and instead asserted broad and generalized concerns about the documents as a whole. The VA OIG continuously reiterated its perceived barriers to compliance without proposing any path toward accommodation.[1647] During one phone call, in fact, Ms. Regan summarized the VA OIG's

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HSGAC, to Deputy Inspector General Griffin, VA OIG]; Letter from Hon. Ron Johnson, Chairman, S. Comm. on Homeland Sec. & Governmental Affairs, to Richard J. Griffin, Deputy Inspector General, Dep't of Veterans Affairs, at 2 (Apr. 20, 2015) [hereinafter 4/20/2015 Letter from Chairman Johnson, HSGAC, to Deputy Inspector General Griffin, VA OIG] ("The Committee will accept production of the case file with limited, appropriate redactions for sensitive veterans' health information.").

[1640] 3/11/2015 Letter from Chairman Johnson, HSGAC, to Deputy Inspector General Griffin, VA OIG, at 6.

[1641] 2/25/2015 Letter from Chairman Johnson, HSGAC, to Deputy Inspector General Griffin, VA OIG, at 2.

[1642] *Id.*

[1643] *Id.*

[1644] *Id.* at 3.

[1645] 2/27/2015 Letter from Deputy Inspector General Griffin, VA OIG, to Chairman Johnson, HSGAC, at 3 (quoting 13 Op. O.L.C. 153 (1989)).

[1646] 3/11/2015 Letter from Chairman Johnson, HSGAC, to Deputy Inspector General Griffin, VA OIG, at 2.

[1647] 2/27/2015 Letter from Deputy Inspector General Griffin, VA OIG, to Chairman Johnson, HSGAC.

contempt for Chairman Johnson's investigation, claiming: "technically [the VA OIG] doesn't have to do anything to a Chairman's letter."[1648]

Chairman Johnson's months-long attempts to secure the VA OIG's voluntary production of all documents relating to its Tomah VAMC health care inspection ultimately proved unsuccessful. Even with Chairman Johnson's offers to accommodate the VA OIG's concerns and seek a mutually agreeable resolution, the VA OIG declined to produce any material about the inspection. Chairman Johnson, left with no choice, issued a subpoena to Mr. Griffin for documents relating the VA OIG's work at the Tomah VAMC. Chairman Johnson issued the subpoena on April 29, 2015, with the consent of Ranking Member Tom Carper.[1649]

2. The VA OIG has not complied with Chairman Johnson's subpoena

Chairman Johnson's subpoena required the VA OIG to produce "[a]ll documents and communications obtained, received, reviewed, created, or relied upon by the [VA OIG] during its health care inspection of the [Tomah VAMC], or in preparation for its" report of the investigation.[1650] The subpoena also compelled the production of communications among VA OIG personnel about its Tomah VAMC health care inspection.[1651]

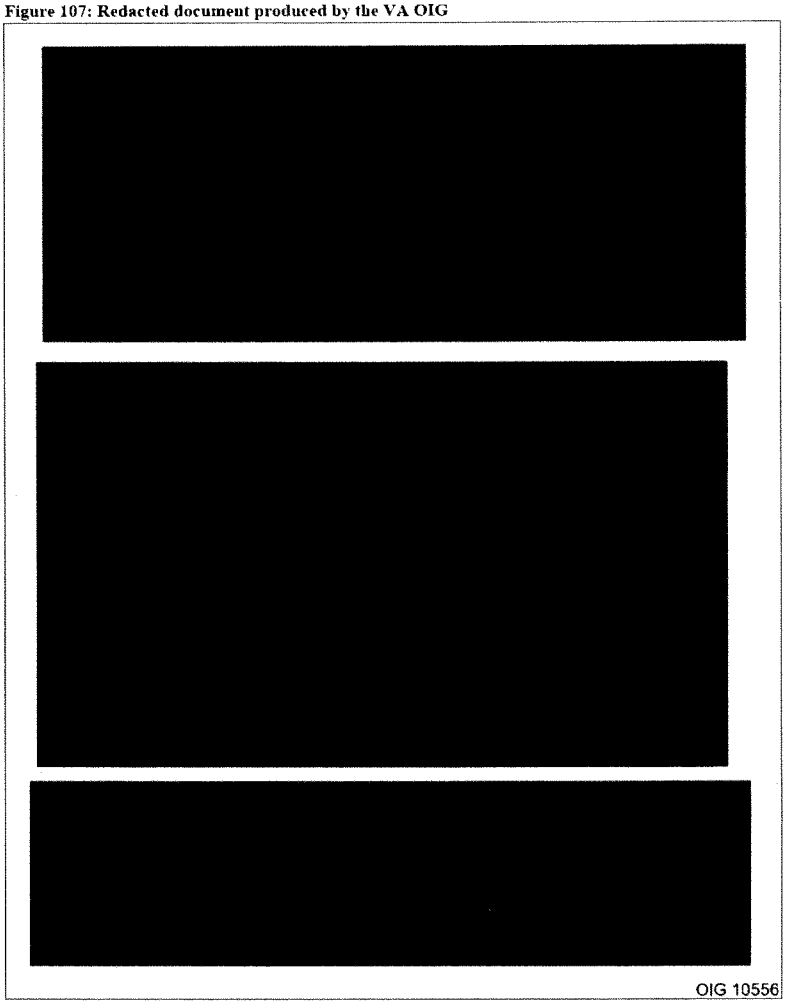
Despite Chairman Johnson's subpoena, the VA OIG continues to stonewall Chairman Johnson's investigation by making inappropriate redactions to material produced and by outright refusing to produce other documents. On May 27, 2015, Roy Fredrikson, the Deputy Counselor to the Inspector General, certified to the Committee that the VA OIG had completed the production of all documents responsive to Chairman Johnson's subpoena.[1652] In the same communication, Fredrickson acknowledged—despite his certification—that the VA OIG has redacted information broader than agreed to by the Committee and has knowingly withheld at least 1,812 pages of subpoenaed material.[1653]

The VA OIG has applied excessive and improper redactions to the documents it produced pursuant to Chairman Johnson's subpoena. Although the subpoena stipulated that the Committee would accept limited redactions of patient-specific medical information,[1654] the VA

[1648] Telephone Meeting between Comm. staff and VA OIG staff (March 24, 2015).
[1649] *See* Letter from Hon. Ron Johnson, Chairman, and Hon. Thomas R. Carper, Ranking Member, S. Comm. on Homeland Sec. & Governmental Affairs, to Richard J. Griffin, Deputy Inspector General, Dep't of Veterans Affairs, at 2 (Apr. 29, 2015) [hereinafter 4/29/2015 Letter from Chairman Johnson and Ranking Member Carper, HSGAC, to Deputy Inspector General Griffin, VA OIG].
[1650] Subpoena of Richard J. Griffin, Deputy Inspector General, Dep't of Veterans Affairs, issued by Hon. Ron Johnson, Chairman, S. Comm. on Homeland Sec. & Governmental Affairs, at Schedule A, § 1 (Apr. 29, 2015).
[1651] *Id.* at Schedule A, § 4.
[1652] E-mail from Roy Fredrikson, Deputy Counselor, Office of Inspector General, Dept. of Veterans Affairs, to Staff, HSGAC (May 27, 2015, 9:16 AM) [05/27/2015 Email VA OIG Deputy Counselor Fredrikson to HSGAC staff].
[1653] *Id.*
[1654] *See* Subpoena of Richard J. Griffin, Deputy Inspector General, Dep't of Veterans Affairs, issued by Hon. Ron Johnson, Chairman, S. Comm. on Homeland Sec. & Governmental Affairs, at Schedule A.

OIG redacted information that goes well beyond patient-specific information. The VA OIG has either refused to produce documents or applied redactions to documents for the following reasons: (1) deliberative process privilege; (2) attorney-client privilege; (3) privacy statutes; (4) Office of Legal Counsel opinions; and (5) assurances of confidentiality to individuals the office interviewed as part of its Tomah inspection. The VA OIG has asserted these privileges and claims generally and vaguely, without specifying which privilege or concerns attach to which documents withheld.

Figure 107: Redacted document produced by the VA OIG



i. Despite requirements of Chairman Johnson's subpoena, the VA OIG has not provided a privilege log of withheld material

In response to Chairman Johnson's subpoena, the VA OIG produced a self-selected subset of documents and withheld others. In such circumstances, the instructions of the subpoena require the VA OIG to provide a detailed list of the withheld material to assist in resolving the dispute. Despite this requirement, the VA OIG refused to provide a detailed basis for its privilege claims or to produce a privilege log. Mr. Fredrikson, Deputy Counselor to the Inspector General, merely represented in an email to bipartisan Committee staff:

> Additionally, draft reports and communications between IG employees addressing the course of the inquiry or the interpretation of evidence has [*sic*] been redacted under the deliberative process privilege. Likewise, all communications by and between OIG counsels and OIG personnel has [*sic*] been withheld under both the attorney client and deliberative process privileges. It should be noted that few of these communications related to the actual inspection, and none related to the findings or the decision to administratively close the inspection.[1655]

The VA OIG's broad assertion of privileges has hindered Chairman Johnson's ability to determine the nature of the information withheld or redacted by the VA OIG. Because of the VA OIG's noncooperation, Chairman Johnson's staff has been forced to present redacted documents to witnesses to determine the context and nature of the documents. Only then did Mr. Fredrikson interject and explain why the VA OIG redacted a particular document.[1656] In those instances, Mr. Fredrikson or Ms. Regan ordered the VA OIG witnesses not to answer questions relating to the document.

Without more information or a privilege log, Chairman Johnson is unable to assess the validity of the VA OIG's privilege claims or to determine the nature of the information that the VA OIG is withholding. The VA OIG's petulant refusal to cooperate—even in this small way—with Chairman Johnson's investigation needlessly obstructs the inquiry and prevents Wisconsin veterans from understanding all the facts.

ii. The Deliberative Process Privilege and the Attorney-Client Privilege do not absolutely shield the VA OIG's documents from production

The VA OIG has withheld documents from Chairman Johnson based on assertions of deliberative process privilege and the attorney-client privilege. Although these privileges may

[1655] 05/27/2015 E-mail VA OIG Deputy Counselor Fredrikson to HSGAC staff. On May 18, 2016, new VA Inspector General Michael Missal offered to allow Committee staff to review drafts of the report and administrative closure *in camera* in the offices of the VA OIG. Given the lateness of this offer, the drafts could not be reviewed prior to the issuance of this staff report.

[1656] *See e.g.*, Porter Transcribed Interview, at 19; *see also* Mallinger 4/21/2016 Transcribed Interview, at 358.

attach under certain circumstances, they are not an absolute shield from the congressional investigative power. The VA OIG has not provided sufficient information to allow Chairman Johnson to assess whether the privileges apply in this context.

a. The Deliberative Process Privilege

The VA OIG's claims of deliberative process privilege—a form of executive privilege—to avoid compliance with Chairman Johnson's subpoena are unfounded. The VA OIG has declined to provide an adequate explanation of its reliance on the deliberative process privilege or to provide a privilege log of material withheld on the basis of deliberative process.

The deliberative process privilege may be invoked to shield some disclosure of executive branch material. The purpose of the deliberative process privilege is to protect the "decision making processes of government agencies"[1657] and to "'prevent injury to the quality of agency decisions' by allowing government officials freedom to debate alternative approaches in private."[1658] The privilege applies to documents "reflecting advisory opinions, recommendations and deliberations comprising part of a process by which governmental decisions and policies are formulated."[1659]

The material in question must be (1) "predecisional," meaning it must be "antecedent to the adoption of agency policy," and (2) "deliberative," meaning, "it must actually be related to the process by which policies are formulated."[1660] The privilege does not apply to factual material or post-decisional explanative material. A federal court that examined the privilege explained:

> The deliberative process privilege does not shield documents that simply state or explain a decision the government has already made or protect material that is purely factual, unless the material is so inextricably intertwined with the deliberative sections of documents that its disclosure would inevitably reveal the government's deliberations."[1661]

[1657] *Nat'l Labor Relations Bd. v. Sears, Roebuck & Co.*, 421 U.S. 132, 150 (1975) (quoting *Tennessean Newspapers, Inc. v. Fed. Hous. Admin.*, 464 F.2d 657, 660 (6th Cir. 1972)).
[1658] *In re Sealed Case (Espy)*, 121 F.3d 729, 737 (D.C. Cir. 1997) (quoting *Nat'l Labor Relations Bd. v. Sears, Roebuck & Co.*, 421 U.S. 132, 151–53 (1975)).
[1659] *Nat'l Labor Relations Bd. v. Sears, Roebuck & Co.*, 421 U.S. at 150 (quoting *Carl Zeiss Stiftung v. V.E.B. Car Zeiss, Jena*, 40 F.R.D. 318, 324 (D.D.C. 1966)).
[1660] *E.g.*, *Nat'l Wildlife Fed'n v. U.S. Forest Serv.*, 861 F.2d 1114, 1117 (9th Cir. 1988) (quoting *Jordan v. U.S. Dep't of Justice*, 591 F.2d 753, 774 (D.C. Cir. 1978); *Envtl. Prot. Agency v. Mink*, 410 U.S. 73 (1973); and *Texaco P.R., Inc. v. Dep't of Consumer Affairs*, 60 F.3d 867, 884 (1st Cir. 1995)).
[1661] *In re Sealed Case (Espy)*, 121 F.3d at 737; *Texaco P.R., Inc. v. Dep't of Consumer Affairs*, 60 F.3d at 884–85 ("[F]actual statements or post-decisional documents explaining or justifying a decision already made are not shielded." (citing *Nat'l Labor Relations Bd. v. Sears, Roebuck & Co.*, 421 U.S. 132, 151–52 (1975); *Envtl. Prot. Agency v. Mink*, 410 U.S. 73, 88 (1973))).

In other words, the deliberative process privilege is not an absolute or unqualified protection against congressional inquiries.

More recently, a federal court provided more detail on the limits of the deliberative process privilege. In *Committee on Oversight and Government Reform v. Holder*, the U.S. District Court for the District of Columbia found that the deliberative process privilege may be invoked in response to a congressional subpoena.[1662] The court noted that "the executive branch could properly invoke the deliberative process privilege in response to a legislative demand."[1663] However, the court explained that the deliberative process privilege "can be overcome by a sufficient showing of need."[1664] In such a dispute, the court explained that it must:

> balance the competing interests on a flexible, case by case, ad hoc basis, considering such factors as the relevance of the evidence, the availability of other evidence, the seriousness of the litigation or investigation, the harm that could flow from disclosure, the possibility of future timidity by government employees, and **whether there is reason to believe that the documents would shed light on government misconduct**, all through the lens of what would advance the public's—as well as the parties'—interests.[1665]

The court emphasized that the showing of need required to overcome the deliberative process privilege "is a lower threshold to overcome than the privilege that covers Presidential communications."[1666]

Other federal courts have consistently explained that "where there is reason to believe the documents sought may shed light on government misconduct, 'the privilege is routinely denied'" regardless of whether the materials qualify as predecisional and deliberative.[1667] Courts reason

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[1662] *Comm. on Oversight and Gov't Reform v. Lynch*, 2016 WL 225675, *5 (Jan. 19, 2016).
[1663] *Id.* at *5 (citing Order on Mot. for Summ. J. at 3). The Court cited the D.C. Circuit Court's opinion in *Espy*, which stated that "[s]ome aspects of the [deliberative process] privilege, for example the protection accorded the mental processes of agency officials, have roots in the constitutional separation of powers." Order on Mot. for Summ. J. at 2.
[1664] *Comm. on Oversight and Gov't Reform v. Lynch*, 2016 WL 225675, at *5 (citing Order on Mot. for Summ. J. at 3).
[1665] *Comm. on Oversight & Gov't Reform, U.S. House of Representatives v. Lynch*, Civil Action No. 12-1332 (ABJ), 2016 WL 225675, at *9 (D.D.C. Jan. 19, 2016) (emphasis added) (citing *In re Sealed Case (Espy)*, 121 F.3d 729, 737–38 (D.C. Cir. 1997)).
[1666] *OGR v. Holder*, at *5 (Jan. 19, 2016) (citing Order on Mot. for Summ. J. at 3). The Court stated, "[c]ongressional or judicial negation of the presidential communications privilege is subject to greater scrutiny than denial of the deliberative privilege." Order on Mot. for Summ. J. at 3 (quoting *Espy* at 745).
[1667] *In re Sealed Case (Espy)*, 121 F.3d 729, 738 (D.C. Cir. 1997) (quoting *Texaco P.R., Inc. v. Dep't of Consumer Affairs*, 60 F.3d 867, 885 (1st Cir. 1995)); *Singer Sewing Mach. Co. v. Nat'l Labor Relations Bd.*, 329 F.2d 200, 208 (4th Cir. 1964) ("Thus, we conclude, where a prima facie case of misconduct is shown, justice requires that the mental process rule be held inapplicable.").

that "shielding internal government deliberations in this context does not serve 'the public's interest in honest, effective government.'"[1668]

In this case, the VA OIG's claim of privilege does not absolutely shield its documents from production to the Committee. There are allegations of misconduct and mismanagement at the Tomah VAMC. The VA OIG's inspection of the Tomah VAMC examined similar issues and many of the same individuals, and its investigative file presumably includes informative material on these topics. Because there is reason to believe that the VA OIG's documents could inform potential misconduct, the VA OIG's insistence on the privilege does not serve the public's interest in an honest, effective executive branch. In addition, there are concerns about the quality and scope of the VA OIG's inspection of the facility—concerns that can only be fully assessed with the VA OIG's own documents. Indeed, in this case, all of the relevant factors—the relevance and availability of the evidence, the seriousness of the investigation, the harm from disclosure, and belief that the documents would disclose potential misconduct—all weigh in favor of production pursuant to Chairman Johnson's subpoena.

b. The Attorney-Client Privilege requires an attorney to be providing legal advice, presenting a complicated assertion for in-house attorneys

The VA OIG has also withheld documents from Chairman Johnson on the basis of attorney-client privilege. The VA OIG informed bipartisan Committee staff in an email: "Likewise, all communications by and between OIG counsels and OIG personnel has [*sic*] been withheld under both the attorney client and deliberative process privileges."[1669] Although congressional proceedings are not bound by the parameters of common law, the Committee may choose to accept a valid assertion of the attorney-client privilege.[1670] However, here, the VA OIG's attorney-client privilege claim is problematic because the VA OIG declined to provide a detailed basis for its privilege claim or a privilege log.

A valid assertion of the attorney-client privilege requires the cumulative presence of several factors in the interaction. "To prove that the attorney-client privilege should apply, the

[1668] *In re Sealed Case (Espy)*, 121 F.3d 729, 738 (D.C. Cir. 1997) (quoting *Texaco P.R., Inc. v. Dep't of Consumer Affairs*, 60 F.3d 867, 885 (1st Cir. 1995)); *see Bank of Dearborn v. Saxon*, 244 F. Supp. 394, 401–03 (E.D. Mich. 1965), *aff'd*, 337 F.2d 496 (6th Cir. 1967) ("[A] prima facie case of sham and subterfuge had been made out. It would seem that the real public interest under such circumstances is not the agency's interest in its administration but the citizen's interest in due process. . . . The authorities do not support the application of the privilege claimed to the facts before us.").

[1669] 05/27/2015 Email VA OIG Deputy Counselor Fredrikson to HSGAC staff.

[1670] "In congressional proceedings, a committee may determine, on a case-by-case basis, whether to accept common law testimonial privileges. It can deny a witness' request to invoke privilege when the committee concludes it needs the information sought to accomplish its legislative functions. In practice, however, congressional committees have followed the courts' guidance in assessing the validity of a common law privilege claim." When Congress Comes Calling at 39 (citing Glenn A. Beard, *Congress v. The Attorney-Client Privilege: A 'Full and Frank' Discussion*, 35 Am. Crim. L. Rev. 119 (1997); CRS Report 95-464, *Investigative Oversight: An Introduction to the Law, Practice and Procedure of Congressional Inquiry*.

person claiming the privilege must establish: (1) a communication, (2) made in confidence, (3) to an attorney, (4) by a client, and (5) for the purpose of seeking or obtaining legal advice."[1671] In other words, as one commentator on congressional investigations explained, "the mere fact that an individual communicates with an attorney does not make the communication privileged."[1672] This limitation applies particularly for in-house attorneys whose dual responsibilities may overlap. In such circumstances, communications may be sheltered by the attorney-client privilege "only upon a clear showing that [in-house counsel] gave [advice] in a professional legal capacity."[1673]

The VA OIG's assertion of the attorney-client privilege is complicated by the fact that the VA OIG's attorneys serve dual roles as in-house counsel for the VA Inspector General. It is easy to fathom a category of documents—for instance, communications about staffing or timing of the inspection—on which a VA OIG attorney could comment without offering advice in a professional legal capacity. These communications would not qualify for protection under the privilege. However, because the VA OIG refused to provide a detailed explanation for its assertion of privilege or a privilege log, Chairman Johnson is unable to understand the nature of the documents withheld on the basis of the attorney-client privilege. The VA OIG has made no "clear showing" that the documents contain advice provided by an attorney in a professional legal capacity. Without making such a showing, the VA OIG should not claim attorney-client privilege as a basis to withhold documents.

iii. The VA OIG relied on statutes that expressly allow disclosure to Congress

The VA OIG also cited to several federal statutes—the Privacy Act, the Inspector General Act (IG Act), 38 U.S.C. § 5701, and 38 U.S.C. § 5705—as bases for withholding material about its health care inspection of the Tomah VAMC case file from Chairman Johnson.[1674] However, each of those statutes contains an express exemption allowing for the disclosure of material to Congress.[1675]

The VA OIG claimed that the Inspector General Act limits the information that an AG may share with Congress.[1676] However, the Act provides inspectors general with discretionary

[1671] When Congress Comes Calling at 39 (citing *In re Grand Jury Investigation No. 83-2-35*, 723 (F.2d 447, 450–51 (6th Cir. 1983).
[1672] When Congress Comes Calling at 39 (citing *In re Grand Jury Subpoena Duces Tecum*, 112 F.3d 910 (8th Cir. 1997).
[1673] When Congress Comes Calling at 39 n.252 (citing *e.g., Colton v. United States*, 306 F.2d 633, 636, 638 (2d Cir. 1962).
[1674] 4/20/2015 Letter from Chairman Johnson, HSGAC, to Deputy Inspector General Griffin, VA OIG, at 4-5.
[1675] *Id.* at 5.
[1676] 2/27/2015 Letter from Deputy Inspector General Griffin, VA OIG, to Chairman Johnson, HSGAC, at 5 ("In response to a specific request for all records relating to interviews conducted, particularly with current or former employees, Ms. Regan noted that the IG Act itself prohibits the disclosure of the identity of individuals who submit complaints or provided information to the IG.").

authority as to what information they may disclose. In fact, the Act expressly states that nothing in the Act "shall be construed to authorize or permit the withholding of information from Congress, or from any committee or subcommittee thereof."[1677] As Chairman Johnson explained to Mr. Griffin, other inspectors general have recognized Congress's authority to receive such information, including material with "Executive Branch confidentiality interests."[1678]

Additionally, the VA OIG cited statutes specific to veterans' medical information, including 38 U.S.C. §§ 5701, 5705, and 7332, as reasons to withhold information from Chairman Johnson.[1679] Of note, citing these statutes, the VA OIG withheld peer reviews of Tomah VAMC providers it received during its health care inspection. The peer reviews provide important information on whether the provider reviewed provided proper care to the patient in the incident that was peer reviewed. The majority staff requested the peer review material not to learn the identity of the veterans whose care was reviewed, but because the peer reviews could add to the staff's understanding about instances in which Tomah VAMC providers provided substandard care to veterans. The VA OIG still has not produced peer reviews; however, on May 3, 2016, the VA separately produced some peer review material.[1680]

Two of these statutes cited by the VA OIG contain express exemptions that permit disclosures to Congress.[1681] Specifically, 38 U.S.C. § 5705(b)(4) states, "[n]othing in this section shall be construed as authority to withhold any record or document from a committee of either House of Congress or any joint committee of Congress, if such record or document pertains to any matter within the jurisdiction of such committee or joint committee."[1682] Chairman Johnson's committee has jurisdiction pursuant to Rule XXV of the Standing Rules of the Senate and Senate Resolution 73 (114th Congress). Likewise, 38 U.S.C. § 5701(b)(3) allows the disclosure of records "[w]hen required by any department or other agency of the United States Government."[1683] Moreover, Chairman Johnson and his staff repeatedly emphasized their willingness to "work collaboratively with [the VA OIG] to identify with precision patient-sensitive information and limit access to that material appropriately."[1684]

The VA OIG also claimed that the VA OIG could not disclose records covered by these statutes because these statutes place this authority with the Secretary of the VA.[1685] The IG Act

[1677] 5 U.S.C. § 5(e)(3); 3/11/2015 Letter from Chairman Johnson, HSGAC, to Deputy Inspector General Griffin, VA OIG, at 5.
[1678] 3/11/2015 Letter from Chairman Johnson, HSGAC, to Deputy Inspector General Griffin, VA OIG, at 5 (quoting 2/27/2015 Letter from Deputy Inspector General Griffin, VA OIG, to Chairman Johnson, HSGAC).
[1679] 2/27/2015 Letter from Deputy Inspector General Griffin, VA OIG, to Chairman Johnson, HSGAC, at 4.
[1680] *See* Letter from Robert D. Snyder, Dep't of Veterans Affairs, to Hon. Ron Johnson, Chairman, S. Comm. on Homeland Sec. & Governmental Affairs (May 3, 2016).
[1681] 38 U.S.C. §§ 5705(b)(4), 4701(b)(3); 3/11/2015 Letter from Chairman Johnson, HSGAC, to Deputy Inspector General Griffin, VA OIG, at 6.
[1682] 38 U.S.C. § 5705(b)(4).
[1683] 38 U.S.C. § 5701(b)(3).
[1684] 3/11/2015 Letter from Chairman Johnson, HSGAC, to Deputy Inspector General Griffin, VA OIG, at 7.
[1685] *Id.* at 6.

makes clear that inspectors general are separate entities from the agencies they oversee,[1686] and Chairman Johnson was seeking material from the VA OIG that is in the possession of the OIG. The VA OIG need not require approval of the VA to disclose to Chairman Johnson material that is in the custody and control of the VA OIG.[1687] In any event, even assuming the VA OIG needed the VA's approval, VA General Counsel Leigh Bradley informed Deputy Inspector General Linda Halliday in August 2015 that VA Secretary McDonald had no objections to disclosing the peer review material to Chairman Johnson.[1688] Even still, the VA OIG has withheld this material.

[1686] 5 app. U.S.C. §§ 2, 6; 4/20/2015 Letter from Chairman Johnson, HSGAC, to Deputy Inspector General Griffin, VA OIG, at 5.
[1687] 4/20/2015 Letter from Chairman Johnson, HSGAC, to Deputy Inspector General Griffin, VA OIG, at 5.
[1688] Email from Leigh A. Bradley, General Counsel, Dep't of Veterans Affairs, to Linda Halliday, Deputy Inspector General, Dep't of Veterans Affairs Off. of Inspector General (Aug. 7, 2015).

Figure 108: Email from Leigh Bradley, VA General Counsel, to Deputy IG Linda Halliday

Halliday, Linda (OIG)

From:	Bradley, Leigh A.
Sent:	Friday, August 07, 2015 3:02 PM
To:	Halliday, Linda (OIG)
Cc:	Regan, Maureen T. (OIG); Donaghy, Maryanne T; Miranda, Bonnie
Subject:	Congressional subpoena for records

Dear Lynn: We received your memorandum to the Secretary, dated August 4, 2015, regarding the Congressional request for medical quality assurance records that OIG reviewed in connection with its healthcare inspection of the Tomah, Wisconsin VAMC. OIG's counsel, Maureen Regan, provided me the peer review materials that the OIG collected during its inspection—documents governed by Title 38 U S C. Section 5705. We understand that the OIG has determined that these materials are responsive to the April 29, 2015 subpoena issued to the OIG by the Senate Committee on Homeland Security and Governmental Affairs. Per your request, I have consulted the Secretary who has no objection to OIG's production of these Section 5705 materials in response to the subpoena.

For your consideration, the following is language that the Department generally uses when producing confidential information. We recommend that you consider using similar language in OIG's transmission of these materials to the Committee.

> "The enclosed information includes highly confidential information which, if publicly disclosed, could cause harm not only to important processes that ensure continuous quality review and improvement, but most important, to the families of Veterans who may have significant interests in protecting their private information. The enclosed materials may be protected under the Privacy Act, 5 U.S.C. § 552a, the Health Insurance Portability and Accountability Act Privacy and Security Rule, 45 C.F.R. Parts 160 and 164 (HIPAA) and may also include sensitive diagnoses protected from disclosure under 38 United States Code (U.S.C.) Section 7332. Title 38 U.S.C. Section 7332(b)(2)(C)(ii) prohibits any re-disclosure of the existence or substance of the information. We request that the Committee keep the record in a secure location, limit its use to those purposes consistent with the Committee's stated oversight purpose, and ensure no further disclosure. Further, it is our expectation that confidential information included in this production not be released or disclosed without prior consultation with the Department to ensure that important confidentiality and privacy interests are not violated."

I hope this is helpful. Don't hesitate to call me if you have follow-up questions

Leigh A. Bradley
General Counsel
U.S. Department of Veterans Affairs
[redacted]

Upon receiving a copy of the above email from Deputy Inspector General Halliday, Chairman Johnson's staff contacted the VA OIG to facilitate the production of peer review material.[1689] The Deputy Counselor to the VA Inspector General, Roy Fredrikson, refused to provide the requested material, even after the Secretary authorized the disclosure of documents protected under the statute. In an email to Chairman Johnson's staff, he wrote:

[1689] Email from Maj. Staff to VA OIG, March 4, 2016 (10:12 AM).

> With respect to the attached email, I responded immediately to Ms. Bradley that as the 5705 material belonged to the VA, we felt it was their obligation to vet and release this material. I note that we neither report nor answer to the Secretary of the VA, and any scenario where it appears we are acting on the Secretary's authority could be seen as an impediment to our independence. As we noted during the last interview with Dr. Yang, during a subsequent discussion between OGC and OIG on August 25, 2015, concerning the legal authorities to produce this material, the General Counsel advised that irrespective of the Secretary's earlier statement, the 5705 material would, nonetheless, need redactions. This only strengthened our resolve that the VA needed to examine and redact its material, not the OIG. Accordingly we supplied the VA with compact discs containing all of the 5705 material associated with the Tomah inspection on two separate occasions, Aug 4, and again in late December 2015, to accomplish the necessary redactions and respond to Congress. The OIG's position on this matter remains consistent. The information in question belongs to the VA, and the VA needs to complete its own examination of the information and release as it deems appropriate.[1690]

In a further attempt to facilitate the production of the subpoenaed material, Chairman Johnson's staff asked Mr. Fredrikson to provide the communications between the VA and the VA OIG about the release of the peer review material pursuant to Chairman Johnson's subpoena.[1691] Chairman Johnson's staff noted the importance of having "the full record of communications between the VA and VA OIG" with respect to the" documents in question so that it could obtain the documents that are responsive to Chairman Johnson's subpoena.[1692] The VA OIG did not respond to this request.

Finally, the VA OIG cited to the Privacy Act as a barrier toward compliance with the Chairman Johnson's request.[1693] However, the Privacy Act also contains an express exemption for disclosing records to Congress. The statute reads:

> No agency shall disclose any record which is contained in a system of records by any means of communication to any person, or to another agency . . . unless disclosure of the record would be—
>
> . . .

[1690] Email from Roy Fredrikson to Comm. Staff, March 4, 2016. Email from Roy Fredrikson, Deputy Counselor, Office of Inspector General, Dept. of Veterans Affairs, to Staff, HSGAC (March 4, 2016) [03/4/2016 Email VA OIG Deputy Counselor Fredrikson to HSGAC staff].
[1691] Email from Maj. Staff to VA OIG staff, March 4, 2016 (2:27 PM).
[1692] *Id.*
[1693] 2/27/2015 Letter from Deputy Inspector General Griffin, VA OIG, to Chairman Johnson, HSGAC, at 4.

> (9) to either House of Congress, or, to the extent of matter within its jurisdiction, any committee or subcommittee thereof, any joint committee of Congress or subcommittee of any such joint committee.[1694]

The Privacy Act's exemption contains no limitation on the purpose or use of the records. But nonetheless, as detailed above, Chairman Johnson and his Committee have a specific and important need for the VA OIG's investigative file.

iv. The VA OIG relied on Office of Legal Counsel opinion to justify withholding information from Chairman Johnson's subpoena

The VA OIG cited to an opinion issued by the Justice Department's Office Legal Counsel (OLC) in 1989 as an additional barrier to compliance with Chairman Johnson's request for the Tomah VAMC investigative file.[1695] The VA OIG claimed that the OLC opinion addressed "the duty of Congress to justify its requests" and "requires that each branch explain to the other why it believes its needs are legitimate."[1696] The VA OIG claimed—despite substantial formal and informal communications—that Chairman Johnson and his staff had not sufficiently clarified "the specific oversight purpose for the request."[1697]

Contrary to the VA OIG's claims, Chairman Johnson and his staff explained, in numerous forms of correspondence, the relevance and necessity of the documents to the investigation.[1698] In a March 11, 2015 letter to Mr. Griffin, Chairman Johnson explained:

> [T]his Committee is the chief investigative committee of the Senate and it is examining the circumstances surrounding the recent public reports of malfeasance and misfeasance at the Tomah VAMC. The healthcare inspection conducted by your office, examining similar issues and many of the same individuals, is highly relevant to the Committee's work.
>
> The need for congressional oversight and potential legislative action necessitates the Committee's request for the Tomah VAMC case file. The family of at least one veteran who passed away after neglect and delay at the Tomah VAMC has said publicly that she would not have taken her father to the Tomah VAMC for

[1694] 5 U.S.C. § 552a.
[1695] 2/27/2015 Letter from Deputy Inspector General Griffin, VA OIG, to Chairman Johnson, HSGAC, at 3.
[1696] *Id.* at 3 (citing *Congressional Requests for Confidential Executive Branch Information*, 13 Op. O.L.C. 153 (1989)).
[1697] 2/27/2015 Letter from Deputy Inspector General Griffin, VA OIG, to Chairman Johnson, HSGAC, at 3 ("During the meeting with your staff on February 18, 2015, the Counselor to the Inspector General and the Chief Information Release Officer attempted to obtain further clarification of the specific oversight purpose for the request. None was forthcoming. The Committee staff . . . merely cited their authority to investigate and that gave the Committee the power to obtain any records they wanted.").
[1698] *See* 3/11/2015 Letter from Chairman Johnson, HSGAC, to Deputy Inspector General Griffin, VA OIG, at 4.

> treatment had she known about the problems in the Tomah VAMC. In addition, another veteran died of a narcotic opioid drug overdose at the Tomah facility five months after the VA OIG administratively closed its inspection. This veteran received treatment from some of the same healthcare providers that your office reviewed in its healthcare inspection.
>
> Although you believe the VA OIG has been transparent in its inspection of the Tomah VAMC, the fact remains that the VA OIG administratively closed its inspection of the Tomah VAMC in March 2014 and the report was not posted on the VA OIG website until February 2015. According to VA OIG staff, the decision to close the inspection rested with the Assistance Inspector General for Healthcare Inspections and was never raised to [Mr. Griffin] or Ms. Regan's attention. If whistleblowers had not contacted Congress, it is likely that Congress would have never learned that the VA OIG conducted a nearly three-year review of the opioid practices at the Tomah VAMC. These circumstances compel thorough and careful congressional attention.[1699]

Chairman Johnson further explained the relevance and necessity of the documents to 'his investigation in an April 20, 2015 letter to Mr. Griffin. He wrote:

> The Committee is investigating allegations of veteran deaths at the Tomah VAMC, retaliation against whistleblowers, and a culture of fear among the employees at the facility that date back almost a decade. In the course of this work, the Committee has become aware that the VA OIG conducted a multi-year inspection of the facility, examining similar issues and many of the same individuals. This inspection was administratively closed without publication and apparently without [Mr. Griffin's] knowledge or approval. Given these circumstances, robust congressional oversight is needed to bring transparency and accountability to the Tomah VAMC, the VA, and the VA OIG.[1700]

Despite a clear and repeated statement by Chairman Johnson of the investigative file's relevance to his investigation, the VA OIG continues to refuse to produce the file. Chairman Johnson and his staff have continually offered to work with the VA OIG to find a mutually acceptable resolution that allows Chairman Johnson to obtain all the documents necessary for a full and complete understanding of the Tomah VAMC. Under the leadership of former Deputy Inspector General Griffin, current Deputy Inspector General Linda Halliday, and Counselor to the Inspector General Maureen Regan, the VA OIG has resisted transparency and accountability in its work. The majority staff is hopeful that new Inspector General Michael Missal will restore trust in the VA OIG and produce all documents subpoenaed by Chairman Johnson.

[1699] *Id.*

[1700] 4/20/2015 Letter from Chairman Johnson, HSGAC, to Deputy Inspector General Griffin, VA OIG, at 1.

C. The Drug Enforcement Administration

The Drug Enforcement Administration (DEA) declined requests from Chairman Johnson and his staff for information about the DEA's work at the Tomah VAMC. The DEA did not articulate a protected legal interest in refusing to comply with Chairman Johnson's investigation, other than to assert ongoing law-enforcement sensitivities. The DEA declined to cooperate, despite evidence suggesting that it had conducted at least three inquiries concerning the Tomah VAMC since 2009.[1701] Chairman Johnson's investigation has also revealed information that suggests that the DEA did not request information from the Tomah VAMC about allegations of drug diversion until after Chairman Johnson's request to the DEA.

As part of its investigation, the Committee obtained the Merit Systems Protection Board case file concerning former Tomah VAMC pharmacist, Dr. Noelle Johnson, who brought suit against the VA after she was terminated from the facility.[1702] Documents in the file indicate that DEA investigators interviewed Dr. Johnson on June 19, 2009, as part of a DEA criminal investigation. During the interview, Dr. Johnson reportedly showed the DEA investigator examples of multiple patients that, in her clinical opinion, received unsafe narcotic prescriptions.[1703] In addition, Dr. Johnson reportedly told the DEA investigator about three "unexplained suicides" of Dr. Houlihan's patients at the Tomah VAMC during her employment at the facility.[1704] At the conclusion of the interview, the DEA investigator informed Dr. Johnson that federal prosecutors would soon contact her and advised her that she should not fill any prescriptions that she believed were unsafe.[1705]

The second DEA inquiry into potential drug diversion at the Tomah VAMC was apparently ongoing in or around 2011 and 2012 and was referenced in the VA OIG's healthcare inspection report of the Tomah VAMC.[1706] VA OIG documents revealed that as of August 2011, DEA drug diversion investigators in Milwaukee had initiated an investigation into Dr. Houlihan and the Tomah VAMC.[1707] DEA apparently launched its diversion investigation based on anonymous complaints that Dr. Houlihan and another medical professional at the Tomah VAMC were "excessively prescribing opiate medications to patients with PTSD."[1708] On March 28, 2012, DEA diversion investigators, the VA OIG investigator, and local law enforcement interviewed a Tomah VAMC employee.[1709] The employee told law enforcement that "[Dr.]

[1701] S. COMM. ON HOMELAND SEC. & GOVERNMENTAL AFFAIRS, MAJORITY STAFF REPORT: TRAGEDY AT TOMAH: INITIAL FINDINGS 14 (2015).
[1702] Noelle A. Johnson v. Dep't of Veterans Affairs, MSPB Docket No. CH-1221-10-0036-W-1, Tab 1 at 6 (Dr. Johnson's narrative of the events).
[1703] *Id.*
[1704] *Id.*
[1705] *Id.*
[1706] VA OIG TOMAH VAMC ADMINISTRATIVE CLOSURE, at 5 n.1.
[1707] VA OIG MCI Search Results, MCI # 2011-04212-DC-0252 (May 1, 2015, 11:23 AM), OIG 1392.
[1708] *Id.*
[1709] *Id.*; *see also* VA OIG Criminal Investigations Div., Greg Porter, Memorandum of Interview of Tomah VAMC Employee (Mar. 28, 2012), OIG 10592-93.

Houlihan and [Deborah Frasher] are the root of drug diversion/pill-selling by veterans at the Tomah VAMC."[1710] The employee also told investigators that particular patients of Dr. Houlihan frequently requested early refills in conjunction with their high prescription rates of narcotics.[1711] In a meeting between a VA OIG investigator and DEA drug diversion investigators on March 13, 2012, DEA diversion investigators confirmed that "they had initiated a diversion investigators in regards to the Tomah VAMC and local area veterans in Tomah, and that they would cooperate with the VA OIG investigation."[1712]

With respect to its most recent work at the Tomah VAMC, the DEA has confirmed that it is currently performing an investigation involving the Tomah VAMC.[1713] In addition, whistleblowers have told Chairman Johnson's staff that DEA investigators were present at Tomah VAMC over the course of several months in 2015. The status of the DEA's ongoing Tomah investigation—as well as the results of its earlier investigations—is unknown.

1. Chairman Johnson's efforts to secure the voluntary cooperation from the DEA

For months, Chairman Johnson's staff attempted to gain the DEA's voluntary cooperation in assisting the Committee's investigation. On January 28, 2015, Chairman Johnson wrote to then-DEA Administrator Michele Leonhart requesting information, documents, and a staff briefing about the DEA's involvement in Tomah.[1714] At the time of this request, Chairman Johnson's staff was only aware of a joint investigation by the DEA and the VA OIG into the Tomah VAMC in 2011 and 2012. Chairman Johnson's letter requested the responsive information and documents by February 11, 2015.[1715]

On February 9, 2015, a DEA congressional liaison informed Chairman Johnson's staff that, after consulting with the Justice Department's Office of Legislative Affairs, the DEA had chosen to not provide a briefing with specific information about its work at the Tomah VAMC.[1716] He stated the DEA chose not to provide the specific information, although he expressly acknowledged the DEA was not claiming that any of the information was privileged.[1717] Later that day, another DEA official informed Chairman Johnson's staff that the

[1710] VA OIG Criminal Investigations Div., Greg Porter, Memorandum of Interview of Tomah VAMC Employee (Mar. 28, 2012), OIG 10592-93 (Deborah Frasher's name is redacted from this document, but during interviews the Committee was told it was her name under the redaction).
[1711] VA OIG MCI Search Results, MCI # 2011-04212-DC-0252 (May 1, 2015, 11:23 AM), OIG 1393.
[1712] *Id.*
[1713] *See* 3/17/2015 Letter from Deputy Chief Akers, DEA, to Chairman Johnson, HSGAC ("DEA has an ongoing investigation regarding the VAMC-Tomah facility.").
[1714] 1/28/2015 Letter from Chairman Johnson, HSGAC, to Administrator Leonhart, DEA.
[1715] *Id.* at 3.
[1716] Phone Conference between DEA and Maj. Staff (Feb. 9, 2015); Email from Matt Strait, DEA, to Maj. staff (Feb. 9, 2015).
[1717] Phone Conference between DEA and Maj. Staff (Feb. 9, 2015); Email from Matt Strait, DEA, to Maj. staff (Feb. 9, 2015).

DEA would not provide information responsive to his request, but refused to explain the reasons for the DEA's noncooperation.[1718]

The DEA failed to provide a formal response to the requests in Chairman Johnson's initial letter by the date requested. Following the DEA's nonresponse, Chairman Johnson's staff attempted to engage the DEA in a discussion to better understand the agency's law-enforcement interests and to accommodate these concerns in a manner that still satisfied the Chairman's requests for information.[1719] The DEA refused. On February 13, 2015, Gary Owen, the Acting Chief of DEA's Office of Congressional and Public Affairs, emailed Chairman Johnson's staff that "the existence of an ongoing investigation severely limits what DEA is able to provide at this time. We will respond in the greatest extent possible consistent with existing policy and guidelines (Linder Letter), and at the earliest possible opportunity—without jeopardizing any ongoing investigative work."[1720] Mr. Owen did not provide any documents or information in response to Chairman Johnson's request.

On March 3, 2015, Chairman Johnson wrote again to Acting DEA Administrator Leonhart reiterating his request for material and a briefing about the DEA's involvement at the Tomah VAMC.[1721] The Chairman explained to Administrator Leonhart that the Committee was conducting its investigation pursuant to its authority under the Constitution and the Standing Rules of the Senate, and that the DEA had not asserted a statutory or constitutional basis for refusing to comply with the Committee's investigation.[1722]

On March 17, 2015, Chairman Johnson received a response letter from the DEA. The DEA notified Chairman Johnson that "[p]ursuant to longstanding Department of Justice policy, we are not in a position to provide non-public details of our investigation at this time."[1723] The letter, however, did not specify the particular "longstanding policy" or provide any regulation or statute that codified the policy. The DEA offered to brief Chairman Johnson's staff on general information about the process for examining allegations of drug diversion.[1724] As an accommodation to the DEA, and in an effort to move forward with the investigation, Chairman Johnson's staff accepted this offer.[1725] The briefing, which occurred on March 27, 2015, was extremely limited in scope, and the DEA expressly refused to answer any questions about the DEA's work relating to the Tomah VAMC.[1726] The DEA also refused to answer questions about its closed investigations concerning the facility.[1727]

[1718] Phone Conference between DEA and Maj. Staff (Feb. 9, 2015); Email from Deputy Chief Eric Akers, DEA, to Maj. staff (Feb. 9, 2015).
[1719] Email from Maj. staff to Gary Owen, DEA (Feb 12, 2015).
[1720] Email from Gary Owen, DEA, to Maj. Staff (Feb. 13, 2015).
[1721] 3/3/2015 Letter from Chairman Johnson, HSGAC, to Administrator Leonhart, DEA.
[1722] *Id.* at 2.
[1723] *See* 3/17/2015 Letter from Deputy Chief Akers, DEA, to Chairman Johnson, HSGAC, at 1.
[1724] *Id.* at 2.
[1725] Email from Maj. staff to Deputy Chief Eric Akers, DEA (Mar. 20, 2015).
[1726] Briefing between DEA and Maj. Staff (Mar. 27, 2015).
[1727] *Id.*

With questions still outstanding following the briefing and the DEA's response letter, Chairman Johnson's staff attempted to contact DEA personnel directly involved in the investigations of the Tomah VAMC. A DEA congressional liaison interceded and offered to facilitate a "conversation" between Chairman Johnson's staff and DEA officials involved in the agency's work concerning the Tomah VAMC.[1728] When Chairman Johnson's staff suggested a date, the DEA revoked its offer and declined to allow the staff to speak with the investigators. The DEA congressional liaison wrote: "[I]n keeping with longstanding DOJ and DEA policy, we cannot provide additional information regarding this ongoing investigation. Further, it is DEA's and DOJ's policy not to provide line agents and investigators for congressional interviews."[1729]

Chairman Johnson's staff sought clarification about the DEA's refusal to allow DEA personnel to speak with the staff.[1730] In an attempt to understand and accommodate the DEA's concerns, staff also asked the DEA congressional liaison to provide a statute or regulation that prevents the DEA from cooperating with Chairman Johnson's investigation.[1731] The liaison denied ever making an offer to facilitate a conversation between Chairman Johnson's staff and DEA personnel—despite his earlier email offering to facilitate a "conversation." Instead, he provided a letter dated January 27, 2000, from Robert Raben, then-Assistant Attorney General for the Office of Legislative Affairs, to former Congressman John Linder, then-Chairman of the House Rules Committee, Subcommittee on Rules and Organization of the House of Representatives ("Linder letter"). The DEA cited this letter as the authority for refusing to cooperate with the investigation.

On July 29, 2015, in a continuation of the majority staff's attempts to gain the DEA's voluntary cooperation, Chairman Johnson's staff contacted the DEA seeking one specific document: a 2012 memorandum between the DEA and the VA OIG that authorized the DEA to review patient charts of Tomah VAMC veterans.[1732] Chairman Johnson's staff had learned of the existence of this document in course of the investigation and determined that it could be relevant to understanding the work of both the DEA and the VA OIG in the years leading up to the death of Jason Simcakoski. Again, the DEA declined to provide the requested information.[1733] The DEA's congressional liaison wrote:

> As we advised the Chairman in our March and July letters, as well as in phone calls and e-mails with you and Committee staff, DEA is actively conducting an investigation at the Tomah VAMC. The memo that your e-mail is requesting is indeed part of this ongoing investigation. Consistent with longstanding

[1728] Email from Matt Strait, DEA, to Maj. staff (May 21, 2015).
[1729] Email from Matt Strait, DEA, to Maj. staff (June 3, 2015).
[1730] Email from Maj. Staff to Matt Strait, DEA (June 3, 2015).
[1731] *Id.*
[1732] Email from Maj. Staff to Department of Justice (July 29, 2015).
[1733] Email from Matt Strait, DEA, to Maj. staff (Aug. 7, 2015).

> Department of Justice policy prohibiting us from discussing ongoing matters, it would not be appropriate to provide the requested memo.[1734]

The DEA's response contained some troubling implications. First, the response referenced a July letter—when the DEA had only provided a response letter in March 2015. Upon further clarification, it became apparent that the DEA was referring to a July 27, 2015, letter from Assistant Attorney General for Legislative Affairs, Peter Kadzik, in response to a separate letter Chairman Johnson wrote to the United States Attorney for the Western District of Wisconsin—*not* a request to the DEA. The inclusion of this July letter as a basis for declining the Chairman's information requests echoes the DEA's initial representation in February 2015 that the DOJ had advised it not to cooperate with Chairman Johnson's investigation. Second, the DEA's response implied that the 2012 memorandum sought by Chairman Johnson's staff was somehow part of an ongoing law enforcement investigation in 2015. The DEA never provided clarity on this point, and it is difficult to understand the connection because the DEA has declined to articulate the scope or contours of its ongoing law-enforcement work. Finally, the DEA's response to this request demonstrated its blanket refusal to produce *any* documentation to Chairman Johnson—even a narrowly tailored request for a specific document drafted three years earlier and transmitted between two separate agencies.

In sum, Chairman Johnson and his staff have made extensive and reasonable efforts to obtain the DEA's voluntary cooperation in providing information necessary for the Committee's investigation. Thus far, the DEA has refused to cooperate with these efforts. The DEA has not asserted a claim of privilege, nor has it cited a statutory provision that prohibits its cooperation with the investigation. The only rationale it has provided for its outright refusal to cooperate with the investigation is the non-precedential Linder letter.

2. The DEA's stated rationale for its refusal to cooperate with Chairman Johnson's investigation is without merit

Throughout the Chairman Johnson's staff's interactions with the DEA, the DEA has asserted a "longstanding Department of Justice policy" not to comment or provide any specific information to Congress on potentially ongoing—and even closed—law-enforcement matters.[1735] The DEA, however, has not asserted a claim of privilege on the requested material or identified a federal statute that prohibits its cooperation with Chairman Johnson's investigation. The only authority the DEA has articulated for its noncooperation with the investigation has been the Justice Department's Linder letter. The Linder letter is an insufficient basis for refusing to comply with congressional oversight.

[1734] *Id.*

[1735] *See* 3/17/2015 Letter from Deputy Chief Akers, DEA, to Chairman Johnson, HSGAC, at 1.

As explained, the Supreme Court has long recognized Congress' right—rooted in the Constitution—to oversee and investigate the operations of the executive branch.[1736] By contrast, the Linder letter is neither rooted in the Constitution nor based on any statutes governing the relationship between Congress and the executive branch. The Linder letter is simply that—a letter from an executive branch officer to a congressional Subcommittee Chairman with no precedential authority in and of itself.

The Linder letter cited to opinions from the Justice Department's Office of Legal Counsel (OLC). The OLC is an office charged with providing legal advice to the President and executive branch agencies.[1737] These opinions, as merely advisory documents, carry no precedential weight on how Congress performs its oversight duties, and do not limit or restrict Congress's constitutional right to executive branch material. Instead, the Committee's broad investigative authority, as articulated by the Supreme Court, "encompasses inquiries concerning the administration of existing laws as well as proposed or possibly needed statutes."[1738]

Even assuming that there is an ongoing law-enforcement interest with respect to the DEA's current work at the Tomah VAMC, this fact does not preclude the DEA from providing material to Chairman Johnson about its previous, closed investigations. The Linder letter, in fact, states the Justice Department's policy is "whenever possible to provide information about closed, rather than open, matters."[1739] As an attempt at understanding and accommodating the DEA's concerns, Chairman Johnson's staff has inquired whether the DEA would provide information about its closed investigations into the Tomah VAMC. The DEA refused to provide information even about its closed investigations.

Despite the Linder letter, the Justice Department components have provided information to Congress about ongoing law-enforcement investigations when the components chose to do so. The provision of requested information to Congress does not necessarily compromise an ongoing criminal investigation or potential federal prosecution. For example, the existence of an ongoing law-enforcement investigation did not prevent the Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF) from furnishing information to the House Committee on Oversight and Government Reform and the Senate Judiciary Committee about the Fast and Furious gun running operation.[1740] Throughout the congressional investigation, the ATF provided information to the Committees concerning the ongoing Justice Department investigation into the botched operation, as well as the investigations into the murder of U.S. Customs and Border Patrol Agent Brian Terry.[1741] The cooperation with the Congress' investigation into Operation Fast and Furious did

[1736] 3/3/2015 Letter from Chairman Johnson, HSGAC, to Administrator Leonhart, DEA, at 2.
[1737] U.S. Dep't of Justice, Office of Legal Counsel, "About the Office," http://www.justice.gov/olc.
[1738] *Watkins v. United States*, 354 U.S. 178, 187 (1957).
[1739] Letter from Robert Raben, Assistant Attorney Gen. for the Office of Legislative Affairs, Dep't of Justice, to Rep. John Linder, Chairman of H. Comm. on Rules, Subcomm. on Rules and Organization of the House, at 3 (Jan. 27, 2000) [hereinafter "Linder Letter"].
[1740] H. COMM. ON OVERSIGHT & GOV'T REFORM & S. COMM. ON THE JUDICIARY, FAST AND FURIOUS: THE ANATOMY OF A FAILED OPERATION (2012).
[1741] *Id.*

not affect the executive branch's ability to prosecute the case of one of Agent Terry's killers, Manuel Osorio-Arellanes, who was sentenced to 30 years in federal prison.[1742]

In addition, the Federal Bureau of Investigation (FBI) and the Justice Department's Public Integrity Section delivered information to the House Committee on Oversight and Government Reform about their role in allegations that the Internal Revenue Service targeted conservative groups for enhanced scrutiny when applying for tax exempt status.[1743] Again, this information concerned the FBI's and the Public Integrity Section's involvement in the targeting in 2010 and did not affect the Justice Department's subsequent investigation into the targeting. More recently, after a request from Chairman Johnson, the FBI briefed Chairman Johnson's staff about terrorist attack in San Bernardino, California.[1744]

As shown with the previous instances of Justice Department cooperation with congressional oversight that touches upon criminal investigations, it is not always the case that providing information to Congress will compromise the Justice Department's law-enforcement matters. Contrary to the DEA's position, cooperation with Chairman Johnson's investigation is not a zero-sum-game—the DEA can, as other Justice Department components have in the past, provide information in a manner that does not affect its open investigation.

3. The DEA sent an information-request letter to the VA *after* Chairman Johnson's inquiry

Given the DEA's outright refusal to cooperate with Chairman Johnson's investigation, his staff was forced to piece together the DEA's involvement in Tomah from other sources. Pursuant to a document request that Chairman Johnson sent to the VA in February 2015, the Committee received a letter from the DEA to the Tomah VAMC dated March 23, 2015 in which the DEA requested documents and information about potential criminal activity at the facility.[1745] Specifically, the letter requested substantive information about Tomah VAMC personnel matters, prescription practices, facility protocols, and other issues covering potential drug diversion. This broad document request letter appears to be the type of information-request document that typically begins a law-enforcement investigation.[1746]

The existence of this letter reveals yet another troubling aspect of the DEA's posture toward Chairman Johnson's investigation. The DEA's assertion, since the staff's initial contact,

[1742] Ralph Ellis, *Man gets 30 years in 'Fast and Furious' death of border agent Brian Terry*, CNN (Feb. 12, 2014), http://www.cnn.com/2014/02/10/us/fast-and-furious-sentence.
[1743] H. COMM. ON OVERSIGHT & GOV'T REFORM, THE INTERNAL REVENUE SERVICE'S TARGETING OF CONSERVATIVE TAX-EXEMPT APPLICATIONS: REPORT OF FINDINGS FOR THE 113TH CONGRESS (2014).
[1744] Maj. Staff meeting with FBI (Mar. 31, 2016).
[1745] Letter from DEA to Leah Finch, Privacy Officer, Department of Veterans Affairs Medical Center, Tomah, Wisconsin (Mar. 23, 2015) (on file with Comm.).
[1746] Because this letter pertains to an ongoing criminal law enforcement investigation, the Committee has opted to defer releasing specifics about the request letter.

was that the DEA had an ongoing law-enforcement investigation involving the Tomah VAMC, which has prevented the DEA from producing any information about its previous investigations into the Tomah VAMC. The DEA has refused to even confirm when its current investigation of the Tomah VAMC began.

However, the DEA information-request letter obtained by the Committee was sent *after* Chairman Johnson's letters to the DEA requesting information on the DEA's past involvement in the Tomah VAMC. Without more information from the DEA, this timing suggests that the DEA did not open an investigation into the Tomah VAMC—or at least begin its fact-finding in earnest—until after Chairman Johnson requested information from the DEA. If accurate, it appears that the DEA did not have an ongoing law-enforcement investigation at the time of the Chairman's initial letters and therefore had no reason to withhold material on that basis.

The investigation into the Tomah VAMC gives the Committee the opportunity to paint a clear picture of the more than decade-long history of misconduct, whistleblower retaliation, and veteran deaths at the facility. The DEA's refusal to cooperate with Chairman Johnson's investigation unnecessarily delayed and may have limited the ability to identify problems and propose solutions to the issues facing the Tomah VAMC. Ultimately, out of respect for the law-enforcement equities, the majority staff has not pressed the matter further with the DEA.

D. The Joint Commission

The Joint Commission is a non-profit accreditation organization that reviews and accredits health care organizations. On August 27, 2013, the Joint Commission received an anonymous complaint from a Tomah VAMC employee regarding "medication management and leadership standards." Separately, the Joint Commission received and reviewed nine sentinel events—unexpected deaths or serious injuries—at the Tomah VAMC since 2004. Of those nine events, the Joint Commission is conducting a root cause analysis on three active sentinel event investigations of incidents that occurred at the Tomah VAMC. Although it provided some general information to the Committee, the Joint Commission declined to provide any information on the particular complaints, citing an Illinois state privacy law.

The Joint Commission evaluates approximately 21,000 healthcare organizations and programs throughout the United States, including VA facilities across the country.[1747] The Joint Commission accredits hospitals that meet certain performance standards and offer high-quality care to their patients.[1748] As part of its accreditation process, the organization makes site visits to the facilities under review. The Joint Commission has accredited hospitals for more than 60 years. According to the Joint Commission, it has accredited approximately 4,032 general,

[1747] *About the Joint Commission*, THE JOINT COMMISSION, http://www.jointcommission.org/about_us/about_the_joint_commission_main.aspx.
[1748] *Id.*

pediatric, long term acute, psychiatric, rehabilitation and specialty hospitals, and 361 critical access hospitals, through a separate accreditation program.[1749]

During its investigation, Chairman Johnson's staff learned that the Joint Commission conducted an accreditation site visit at the Tomah VAMC from May 22 to 25, 2012.[1750] This visit coincided with the VA OIG's health care inspection of the Tomah VAMC, and was only three months before the VA OIG conducted its own site visit of the Tomah VAMC. The Joint Commission renewed the Tomah VAMC's accreditation, despite identifying a number of concerns with the quality of care at the Tomah VAMC.

The Joint Commission's review found that the Tomah VAMC was in either "partial" or "insufficient" compliance in the following areas of review: (1) environment of care – equipment use; (2) infection protection and control; (3) leadership – information management; (4) life safety – physical environment; (5) availability of resuscitation services throughout the hospital; (6) human resources – orientation & training; and (7) provision of care, treatment and services – assessment and care/services.[1751]

On December 9, 2015, Chairman Johnson and Ranking Member Carper wrote a letter to Dr. Mark Chassin, President and Chief Executive Officer of the Joint Commission, requesting information and documents relating to the Joint Commission's work accrediting the Tomah VAMC.[1752] In addition, the Chairman and Ranking Member asked why the Joint Commission accredited the Tomah VAMC despite its numerous findings of "partial" or "insufficient" compliance in areas of care.[1753] In particular, the Chairman and Ranking Member also requested:

- Information on whether the Joint Commission has ever received reports or allegations of over prescription or whistleblower retaliation from the Tomah VAMC;[1754]
- Records of all contacts, referrals, or complaints that the Joint Commission had received referring or relating to the Tomah VAMC since 2004;[1755]
- Information and material about "sentinel event" investigations the Joint Commission has conducted at the Tomah VAMC since 2004;[1756] and
- The Joint Commission make the employees who conducted the May 2012 Tomah VAMC site visit available to brief Committee staff.[1757]

[1749] *What is Accreditation?*, THE JOINT COMMISSION, http://www.jointcommission.org/accreditation/accreditation_main.aspx.
[1750] The Joint Commission, Accreditation Survey Review of VA Medical Center – Great Lakes Health Care System, 500 East Veterans Street, Tomah, WI, 54660, Organization Identification Number 2571, 2012 (on file with Comm.).
[1751] *Id.*
[1752] Letter from Hon. Ron Johnson, Chairman, S. Comm. on Homeland Sec. & Governmental Affairs, and Hon. Thomas R. Carper, Ranking Member, S. Comm. on Homeland Sec. & Governmental Affairs, to Mark Chassin, President & Chief Executive Officer, The Joint Commission (Dec. 9, 2015).
[1753] *Id.*
[1754] *Id.*
[1755] *Id.*
[1756] *Id.*

The Joint Commission responded to the Committee's inquiry on January 15, 2016.[1758] On the issue of findings of "partial" and "insufficient" compliance, the Joint Commission wrote that the "Tomah VAMC was accredited after successfully addressing the Requirements for Improvement (RFI) in its Survey Report."[1759] The Joint Commission explained that for hospitals that receive RFIs, their accreditation decision is delayed until the areas noted in RFIs are appropriately addressed. The Joint Commission noted that "observations of 'partial' and 'insufficient' compliance in the survey report indicate that the relevant standard was not fully met and that RFI was cited."[1760] Hospitals that have substandard compliance in areas that directly impact patient care must fix those issues within 45 calendar days.[1761] Hospitals that have substandard compliance in areas that indirectly impact patient care must fix those issues within 60 calendar days.[1762]

The Joint Commission accredited the Tomah VAMC in 2012 because it found that the Tomah VAMC had adequately addressed the problems identified in the May 2012 site visit within the allotted time frame. As of today, the Tomah VAMC is an accredited hospital and Joint Commission staff has "no knowledge of any serious discussions to change Tomah's accreditation status."[1763]

The Joint Commission also informed the Committee that it received an anonymous complaint on August 27, 2013 from a Tomah VAMC employee "related to medication management and leadership standards."[1764] In addition, the Joint Commission informed the Committee that it had conducted reviews of nine separate sentinel events at the Tomah VAMC since 2004. Of those nine reviews, the Joint Commission is conducting root cause analyses on three "active" sentinel event reviews.

The Joint Commission refused to provide any additional specific information or documentation relating to the August 2013 complaint. In addition, the Joint Commission refused to provide information on any of its sentinel event reviews. The Joint Commission cited an Illinois state statute as prohibiting its cooperation with the Committee's investigation.[1765] Article VI of the U.S. Constitution specifies that federal law—and matters controlled by federal law—is supreme to state law. Chairman Johnson's staff has informed the Joint Commission that the

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[1757] *Id.*
[1758] Letter from Mark Chassin, President and Chief Executive Officer, The Joint Commission, to Hon. Ron Johnson, Chairman, S. Comm. on Homeland Sec. & Governmental Affairs, & Thomas R. Carper, Ranking Member, S. Comm. on Homeland Sec. & Governmental Affairs (Jan. 15, 2016).
[1759] *Id.* at 5.
[1760] *Id.*
[1761] *Id.*
[1762] *Id.*
[1763] *Id.*
[1764] *Id.*
[1765] The Joint Commission is headquartered in Illinois and thereby claims to be bound by Illinois state statutes. *See* Illinois Medical Studies Act, 735 ILL. COMP. STAT. 5/8-2101 (2003).

Illinois state statute at issue does not wholly prevent compliance with a congressional investigation. Nevertheless, the Joint Commission has refused to cooperate further with the investigation.

* * *

Chairman Johnson is conducting a robust investigation of the Tomah VAMC, but it has not been without difficulties. In the course of his fact-finding, the VA OIG, the DEA, and other entities have attempted to delay, limit, and withhold information. This noncooperation prevents the majority staff from obtaining all relevant information that bears upon the allegations of over-prescription, abuse of authority, and retaliation at tbe Tomah VAMC. In turn, the actions of these agencies limit the findings and recommendations that can be issued to ensure the problems that occurred in Tomah never happen again. The majority staff will continue to gather information and press these entities to uphold their commitments to public transparency.

VI. Increased accountability since Chairman Johnson's investigation

Since Chairman Johnson launched his investigation into the Tomah VAMC in January 2015, individuals have been held accountable, the VA OIG has become more transparent and is now operating under new leadership, and new legislation has been proposed to enact reforms to the VA and VA OIG. These actions are just the first steps toward increased accountability. More must be done, but the changes in place since January 2015 as a result of increased attention on the Tomah VAMC will help to improve quality of care for all veterans.

A. Personnel changes at the Tomah VAMC and within the VA OIG leadership

The scrutiny on the Tomah VAMC since January 2015 has led to personnel changes at the facility. Dr. Houlihan no longer serves as the chief of staff at the Tomah VAMC. Mario DeSanctis has been replaced as the facility's director. Other providers, such as Deborah Frasher, are no longer treating veterans at the facility. The removal of these individuals has played a large role in the improvement in the relationship between management and line employees.

Chairman Johnson's investigation has also led to greater accountability and independence at the VA OIG. On January 22, 2015, Chairman Johnson wrote to President Obama urging him to appoint a permanent inspector general for the Department of Veterans Affairs.[1766] Chairman Johnson noted concerns over the VA OIG's transparency with respect to its handling of its Tomah VAMC health care inspection.[1767] Through the course of the Chairman's investigation, the majority staff came to be increasingly concerned about the VA OIG's cooperation with the investigation. On April 29, 2015, after months of hostile noncooperation, Chairman Johnson subpoenaed VA Deputy Inspector General Richard Griffin for documents relating to the VA OIG's health care inspection of the Tomah VAMC. Mr. Griffin refused to fully comply with the Committee's subpoena. On June 30, 2015, shortly after the VA OIG issued a white paper that attacked the whistleblowers of the Tomah VAMC, Mr. Griffin retired from federal service.

On October 5, 2015, President Obama heeded Chairman Johnson's nearly year-long call and appointed Michael Missal to serve as the permanent Inspector General for the Department of Veterans Affairs. Mr. Missal was reported favorably by both the Senate Veterans Affairs Committee and the Senate Homeland Security and Governmental Affairs Committee, led by Chairman Johnson. On April 19, 2016, the Senate confirmed Mr. Missal as VA Inspector General. Mr. Missal is the first Senate-confirmed Inspector General at the Department of

[1766] Letter from Hon. Ron Johnson, Chairman, S. Comm. on Homeland Sec. & Governmental Affairs, to Barack H. Obama, President of the United States (Jan. 22, 2015) [hereinafter 1/22/2015 Letter from Chairman Johnson, HSGAC, to President Obama].
[1767] *Id.*

Veterans Affairs since the previous Inspector General, George Opfer, retired on December 31, 2013.

In speaking on the Senate floor in support of Mr. Missal's confirmation as VA Inspector General, Chairman Johnson said "we have a duty to provide the best care for the finest among us, and that begins by having a permanent and independent inspector general in place."[1768] He added:

> Michael Missal is the tip of the spear to restore much-needed transparency and accountability at the VA Office of Inspector General. His presence will go far toward accomplishing our shared goal of providing the highest quality care to our nation's veterans. The VA has been plagued with problems like those at the Tomah facility in my home state, where a veteran died because of a lack of proper care and oversight. We need an IG who will boost the confidence of the American people when it comes to the care of our veterans. I thank Michael Missal for his willingness to serve and look forward to working with him to oversee the VA.[1769]

The majority staff is optimistic that under the new leadership at the VA OIG, the agency will finally comply in full with Chairman Johnson's subpoena. When it does, the new personnel in place at the VA OIG and Tomah VAMC will help to restore transparency and accountability to the VA system.

B. Greater transparency from the VA OIG

The VA OIG's health care inspection of the Tomah VAMC was not published when it was completed because Dr. Daigh administratively closed the inspection. Over the course of the investigation, Chairman Johnson and his staff became aware that the Tomah VAMC administrative closure was just one of 140 administrative closures that the VA OIG had failed to publish since 2006.[1770] On March 17, 2015 Chairman Johnson wrote then-Deputy Inspector General Griffin asking him to release these secret administratively closed health care inspections.[1771] Following Chairman Johnson's letter, the VA OIG began publishing the previously-unreleased health care inspections on its website.

[1768] *Sen. Johnson Speaking on the Senate Floor*, YOUTUBE (Apr. 19, 2016), https://www.youtube.com/watch?v=ASbi_k0y40Q.
[1769] *Id.*
[1770] Donovan Slack, *VA Doesn't Release 140 Vet Health Care Probe Findings*, USA TODAY (March 8, 2015), http://www.usatoday.com/story/news/politics/2015/03/08/probes-of-veterans-health-care-often-not-released-to-public/24525109/.
[1771] Letter from Hon. Ron Johnson, Chairman, S. Comm. on Homeland Sec. & Governmental Affairs, to Richard J. Griffin, Deputy Inspector General, Dep't of Veterans Affairs, at 1-2 (Mar. 17, 2015) [hereinafter 3/17/2015 Letter from Chairman Johnson, HSGAC, to Deputy Inspector General Griffin, VA OIG].

In February 2016, Chairman Johnson learned that the VA OIG was again refusing to publish reports of investigations it conducted.[1772] These investigations involved VA OIG inquiries into excessive wait times at VA facilities.[1773] The VA OIG investigated 73 VA facilities and found scheduling problems in 51 cases.[1774] Although Congress passed a law in December 2015 to require OIGs to publish online all reports that make a "recommendation or suggest a corrective action,"[1775] the VA OIG reasoned the law did not apply to the agency. Catherine Gromek, a VA OIG spokeswoman, explained to the media that because the secret reports were not "issued" and because they did not made a "recommendation" or "suggest a corrective action," the VA OIG was not required to publish them.[1776] On February 29, 2016, Chairman Johnson wrote to Deputy Inspector General Halliday asking her to release these wait times investigations.[1777] The VA OIG began publishing the wait time reports that same afternoon.

C. Legislation proposed to address the problems relating to the Tomah VAMC

Chairman Johnson's investigation of the Tomah VAMC has uncovered significant problems in the VA and VA OIG. He has identified areas for improvement in whistleblower protection laws and opioid prescription both inside and outside the VA. Other members have also proposed measures to begin to address the issues highlighted by the Tomah VAMC.

1. The Christopher Kirkpatrick Whistleblower Protection Act

On September 22, 2015, Chairman Johnson's Committee held a hearing entitled *Improving VA Accountability: Examining First-Hand Accounts of Department of Veterans Affairs Whistleblowers*.[1778] At this hearing, the Committee heard testimony from VA whistleblowers, the Office of Special Counsel, and the Deputy Inspector General of the VA.[1779] One of the witnesses who testified was Sean Kirkpatrick, the brother of Dr. Christopher

[1772] Donovan Slack, *VA Watchdog Sits on Wait-time Investigation Reports for Months*, USA TODAY (Feb. 24, 2016), http://www.usatoday.com/story/news/politics/2016/02/24/va-inspector-general-wait-time-investigation-results/80632212/ [hereinafter Slack, *VA Watchdog Sits on Wait-time Investigation Reports for Months*, USA TODAY (Feb. 24, 2016)].
[1773] *Id.*
[1774] *Id.*
[1775] Consolidated Appropriations Act, Pub. L. No. 114-113 § 239 (2016).
[1776] Slack, *VA Watchdog Sits on Wait-time Investigation Reports for Months*, USA TODAY (Feb. 24, 2016).
[1777] Letter from Hon. Ron Johnson, Chairman, S. Comm. on Homeland Sec. & Governmental Affairs, to Linda Halliday, Deputy Inspector General, Dep't of Veterans Affairs, at 1 (Feb. 29, 2016) [hereinafter 2/29/2016 Letter from Chairman Johnson, HSGAC, to Deputy Inspector General Halliday, VA OIG].
[1778] *Improving VA Accountability: Examining First-Hand Accounts of Department of Veterans Affairs Whistleblowers, Hearing before S. Comm. on Homeland Sec. and Governmental Affairs*, 114th Cong. (2015).
[1779] *Id.*

Kirkpatrick, a clinical psychologist who committed suicide the same day he was fired after raising concerns about prescription practices at the Tomah VAMC. In his testimony, Mr. Kirkpatrick listed a number of recommendations for reforms to better protect VA whistleblowers and offer support to the men and women that provide care to our nation's veterans.

On October 1, 2015, Chairman Johnson, along with Senator Kelly Ayotte, introduced the Dr. Chris Kirkpatrick Whistleblower Protection Act of 2015.[1780] The bill would implement a number of Mr. Kirkpatrick's recommendations and would create additional protections for VA whistleblowers. With respect to Mr. Kirkpatrick's recommendations, the Dr. Chris Kirkpatrick Whistleblower Protection Act:

- Enacts measures to ensure greater accountability and discipline for all federal employees who engage in whistleblower retaliation;[1781]
- Requires the VA to conduct outreach to its employees to make them more aware of any mental health services, including telemedicine options, that are available to them;[1782]
- Requires the VA to ensure that protocols are in place to address threats from VA patients against VA employees who are providing care;[1783]
- Allows probationary employees who are granted stays in their disciplinary proceedings through OSC priority in receiving a transfer while their disciplinary action is pending;[1784]
- Requires all agencies to share information with the OSC about a federal employee who committed suicide if that employee had, prior to his or her death, (1) made any protected disclosure, and (2) had a personnel action taken against him or her by the agency. In such circumstances, OSC is required to examine whether the personnel action was taken because of the disclosure and take appropriate action; and[1785]
- Requires Congress's research arm, the Government Accountability Office, to study the reporting, staffing, accountability, and chain of command structure of the VA police officers at their own medical centers.[1786]

The Dr. Chris Kirkpatrick Whistleblower Protection Act provides additional reforms that address issues that arose over the course of Chairman Johnson's investigation. A Tomah VAMC whistleblower, Ryan Honl, testified during the Committee's field hearing in March 2015 that

[1780] Dr. Chris Kirkpatrick Whistleblower Protection Act of 2015, S. 2127, 114th Cong. (2015), https://www.congress.gov/bill/114th-congress/senate-bill/2127 [herein after Kirkpatrick Act, S 2127].
[1781] *Id.* § 105.
[1782] *Id.* § 202.
[1783] *Id.* § 203.
[1784] *Id.* § 102.
[1785] *Id.* § 106.
[1786] *Id.* § 107.

Tomah VAMC employees improperly accessed his medical records after he blew the whistle.[1787] Because Mr. Honl is a veteran in addition to a VA employee, the VA maintains records about his medical history. Other VA whistleblowers who are both veterans and VA employees—including two witnesses who testified during the Committee's September 2015 hearing, Brandon Coleman and Shea Wilkes—testified that their medical records were also improperly accessed when they reported wrongdoing at their VA facilities.[1788] The Dr. Kirkpatrick Act would codify that accessing another employee's medical records in retaliation for whistleblowing would qualify as a prohibited personnel practice under the law.[1789] Under the proposal, such an action would give the veterans whose files were accessed whistleblower protections, as well as subject the offender who accessed the medical records to potential disciplinary action for whistleblower retaliation.[1790]

The Dr. Chris Kirkpatrick Whistleblower Protect Act would also provide the Office of Special Counsel, the executive branch agency in charge of investigating whistleblower retaliation, with additional tools and access to information to better protect all federal whistleblowers.[1791] On December 9, 2015, Chairman Johnson's Committee unanimously approved the bill and reported it favorably to the full Senate.

2. The Inspector General Empowerment Act

Chairman Johnson's investigation also highlighted significant problems with the operations of the VA Office of Inspector General. In addition to championing the installation of Michael Missal as the first permanent VA Inspector General in nearly two years, Chairman Johnson has worked to enact reforms to enhance the independence and transparency of all inspectors general. Chairman Johnson has worked closely with Senators Charles Grassley and Claire McCaskill to introduce the Inspector General Empowerment Act of 2015.[1792]

On March 4, 2015, Chairman Johnson's Committee unanimously approved Inspector General Empowerment Act of 2015. The measure included an amendment that Chairman Johnson and Senator Tammy Baldwin championed to require all inspectors general to publish on their websites any report or audit within three days of the reports' submission "in final form to the head of the federal agency or head of the designated federal entity as applicable."[1793]

[1787] *Tomah VAMC: Examining Quality, Access, and a Culture of Overreliance on High-Risk Medications, J. Hearing before S. Comm. on Homeland Security and Gov't Affairs and H. Comm. on Veterans' Affairs*, 114th Cong. (2015) (statement of Ryan Honl).
[1788] *Improving VA Accountability: Examining First-Hand Accounts of Department of Veterans Affairs Whistleblowers, Hearing before S. Comm. on Homeland Sec. and Governmental Affairs*, 114th Cong. (2015) (statements by Brandon Coleman and Shea Wilkes).
[1789] Kirkpatrick Act, S. 2127, 114th Cong. § 104.
[1790] *Id.*
[1791] *Id.* § 103.
[1792] Inspector General Empowerment Act of 2015, S. 579, 114th Cong. (2015).
[1793] *Id.*

Chairman Johnson offered a similar amendment to the National Defense Authorization Act of 2015, and advocated for a version of the amendment—that would apply to just the VA OIG—to be included in the Military Construction and Department of Veterans Affairs Appropriations Bill of 2015. Ultimately, Congress adopted less stringent language that required the VA OIG whenever it "issues a work product that makes a recommendation or otherwise suggests corrective action" to pose the work product on the VA OIG's website within three days.[1794]

Chairman Johnson pushed for these reforms because of the VA OIG's repeated failures to publish its work product. Even after Congress demonstrated its strong belief that the VA OIG needs to be more transparent, the VA OIG continued to exploit loopholes in the text of the law. Clearly, stronger language requiring the VA OIG to publish all work products is needed to ensure that the VA OIG is transparent. The nation's veterans and the public deserve to know what VA's watchdog is doing to oversee the operations of the VA.

3. The Ensuring Veteran Safety Through Accountability Act

Chairman Johnson has also worked to expand accountability across the VA. In the case of the Tomah VAMC, it took a congressional investigation and immense pressure from the media to begin to bring accountability to the facility. Following the disturbing reports of veterans dying while waiting for care at the Phoenix VA Health Care System, Congress enacted the Veterans Access, Choice and Accountability Act of 2014 (the Choice Act).[1795] The Choice Act included provisions to enhance accountability by authorizing the VA Secretary to immediately remove senior executives based on poor job performance or misconduct.[1796] The law provided for an expedited appeals process for those individuals through the Merit Systems Protection Board.[1797]

On April 28, 2015, Chairman Johnson, motivated by the tragedies at the Tomah VAMC, introduced the Ensuring Veteran Safety Through Accountability Act of 2015.[1798] The proposal would expand the authority the VA Secretary to remove senior executives for performance or misconduct to include the removal of VA health care professionals. On June 24, 2015, Chairman Johnson presented his legislation to the Senate Committee on Veterans Affairs. In his testimony, Chairman Johnson discussed the deaths of Kraig Ferrington, Dr. Kirkpatrick, Jason Simcakoski, and Thomas Baer. He told the Senate Veterans Affairs' Committee that as of June 2015:

> To date, no one at Tomah has been fired. The medical professionals who prescribed the lethal cocktail of drugs that killed Jason Simcakoski are still collecting a paycheck from the American taxpayer. The events in Tomah make it

[1794] Consolidated Appropriations Act, Pub. L. No. 114-113 § 239 (2016).
[1795] Veterans Access, Choice, and Accountability Act of 2014, H.R. 3224, 114th Cong. (2014).
[1796] Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146, § 128 Stat. 1754, § 707
[1797] *Id.*
[1798] Ensuring Veteran Safety Through Accountability Act of 2015, S. 1117, 114th Cong. (2015).

abundantly clear that there must be more accountability for VA medical professionals.[1799]

The Senate Committee on Veterans Affairs incorporated the objectives of Chairman Johnson's proposal into a bill introduced by Senator Marco Rubio, entitled the Department of Veterans Affairs Accountability Act of 2015.[1800] Senator Rubio's bill, which Chairman Johnson cosponsored, would expand those accountability measures in the Choice Act and Chairman Johnson's proposal to all VA employees. On October 19, 2015, the Senate Veterans' Affairs' Committee favorably reported the Department of Veterans Affairs Accountability Act to the full Senate.

4. The Jason Simcakoski Memorial Opioid Safety Act

The events that occurred at the Tomah VAMC also inspired the introduction of the Jason Simcakoski Memorial Opioid Safety Act by Senator Baldwin.[1801] Chairman Johnson is an original cosponsor of this legislation. The bill would direct the VA and the Department of Defense to jointly update the VA/DOD Clinical Practice Guidelines for Management of Opioid Therapy for Chronic Pain to include guidelines that were apparently overlooked in the prescription of opioids at the Tomah VAMC. The enhanced guidelines would establish best practices for prescribing opioids for outpatient treatment of chronic non-cancer pain, contraindications for opioid therapy, treatment of PTSD and other mental illnesses and explore non-opioid treatment regimens for pain management.

In addition to updating the VA/DOD Opioid guidelines, the bill would require the VA to improve training for VA employees in the area of pain management, implement better tracking and monitoring of opioid practices at VA facilities, upgrade the medical records of veterans to better track opioid prescription practices, conduct a number of studies on the safe prescription of opioids, and better integrate opioid prescription data with the state in which the hospital is located. The bill would also require the VA to establish a Pain Management Board at each VISN and creates the Office of Patient Advocacy within the VA.

D. Safety at the Tomah VAMC's Community Based Outpatient Clinics

On February 10, 2016, Chairman Johnson's staff met with members of the AFGE Local 0007 to hear their perspective on the changes at the Tomah VAMC. At the meeting, AFGE representatives alerted Chairman Johnson's staff of potentially dangerous issues concerning the

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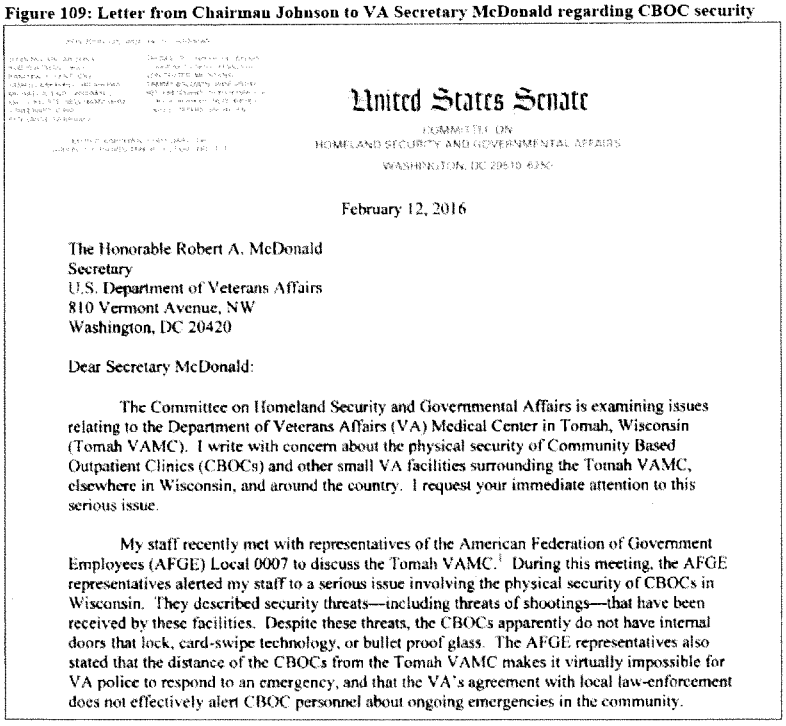
[1799] *Pending Health Care and Benefits Legislation, Hearing before the Senate Committee on Veterans' Affairs*, 114th Cong. (2015) (testimony of Hon. Ron Johnson, Chairman, S. Comm. on Homeland Security & Governmental Affairs).
[1800] Department of Veterans Affairs Accountability Act of 2015, S. 1082, 114th Cong. (2015).
[1801] Jason Simcakoski Memorial Opioid Safety Act, S.1641, 114th Cong. (2015).

physical security of Community Based Outpatient Clinics (CBOCs) that serve veterans in the communities around the Tomah VAMC. The union leaders described security threats—including threats of shootings—that have been received by the staff members of the CBOCs. They informed Chairman Johnson's staff that despite these threats, the CBOCs lack basic security features like internal doors that lock or card-swipe technology. The AFGE representatives explained that the Tomah VAMC's agreement with local law-enforcement authorities does not adequately alert CBOC personnel about ongoing emergencies in the community.

On February 12, 2016, Chairman Johnson wrote to VA Secretary McDonald alerting him of these concerns and asking the VA to take "appropriate steps to ensure that CBOCs and other small VA facilities have adequate safety features in place."[1802] In the letter, Chairman Johnson also requested a briefing about the CBOC security. The VA has not provided a written response to the Chairman's letter or a briefing about measures in place to protect VA employees and veterans at CBOC facilities.

[1802] Letter from Hon. Ron Johnson, Chairman, S. Comm. on Homeland Sec. & Governmental Affairs, to Hon. Robert McDonald, Secretary, Dep't of Veterans Affairs, at 1 (Feb. 12, 2016).

Figure 109: Letter from Chairman Johnson to VA Secretary McDonald regarding CBOC security



United States Senate

COMMITTEE ON
HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS
WASHINGTON, DC 20510-6250

February 12, 2016

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

Dear Secretary McDonald:

The Committee on Homeland Security and Governmental Affairs is examining issues relating to the Department of Veterans Affairs (VA) Medical Center in Tomah, Wisconsin (Tomah VAMC). I write with concern about the physical security of Community Based Outpatient Clinics (CBOCs) and other small VA facilities surrounding the Tomah VAMC, elsewhere in Wisconsin, and around the country. I request your immediate attention to this serious issue.

My staff recently met with representatives of the American Federation of Government Employees (AFGE) Local 0007 to discuss the Tomah VAMC.[1] During this meeting, the AFGE representatives alerted my staff to a serious issue involving the physical security of CBOCs in Wisconsin. They described security threats—including threats of shootings—that have been received by these facilities. Despite these threats, the CBOCs apparently do not have internal doors that lock, card-swipe technology, or bullet proof glass. The AFGE representatives also stated that the distance of the CBOCs from the Tomah VAMC makes it virtually impossible for VA police to respond to an emergency, and that the VA's agreement with local law-enforcement does not effectively alert CBOC personnel about ongoing emergencies in the community.

* * *

The public reporting about over-prescription, abuse of authority, and retaliation at the Tomah VAMC sparked an effort to understand and solve the problems. Since January 2015, Chairman Johnson has been dedicated to this task. Since the beginning of this investigation, the management of the Tomah VAMC has been replaced and the VA Deputy Inspector General has been forced into retirement. Chairman Johnson shepherded the President's nominee to be the permanent Inspector General, Michael Missal, through his committee to confirmation by the Senate. Chairman Johnson has sponsored and supported measures to improve quality of care for veterans, ensure transparency in the inspector general community, and increase accountability for VA employees. There is no doubt that additional work remains, but the measures achieved so far as are building blocks for greater transparency and accountability in the VA.

VII. Recommendations

Chairman Johnson's investigation to date demonstrates the need for reforms in the VA and the VA OIG to improve accountability and transparency. From the available information, there is undoubtedly room for improvement to the VA's quality of care and the OIG's oversight of the VA's clinical practices. Without subject matter expertise, the majority staff has limited its proposed recommendations to managerial and programmatic suggestions.

The majority staff submits the following modest recommendations based on the information available to date:

- The VA should limit the patient loads of chiefs of staff and other leaders at VA medical facilities.
- The VA should alter the reporting structure within its facilities to remove the facility's chief of staff from the reporting chain of the facility's pharmacy department, especially in cases where the chief of staff maintains a heavy patient load.
- The VA should develop procedures by which a VA pharmacist can communicate concerns about prescriptions he or she believes to be unsafe to the prescribing provider.
- The VA should implement safeguards to prevent the unauthorized access of electronic medical records for VA employees who have also received care at a VA facility.
- The VA should develop protocols to address threats made by a patient against a VA provider.
- The VA should ensure the independent reporting structure of VA police services to the VA Central Office, especially when examining allegations against senior facility leadership.
- The VA should ensure annual training for all VA employees on prohibited personnel practices and whistleblower protections.
- The VA should update its guidelines and training relating to pain management and opioid therapy.
- The VA should expand access to the Choice Program to allow veterans a say in their health care decisions.
- If the VA OIG is conducting a health care inspection that examines the quality of care of a particular provider, the VA should consider placing that provider on administrative leave during the course of the OIG's inspection.

- The VA OIG should provide a summary of the substance of its administrative closures in each semiannual report to Congress sufficient to inform the public about the allegations, the facility, and the nature of the OIG's work.

- The VA OIG Office of Healthcare Inspections should develop and implement clear standards for substantiating or unsubstantiating allegations it reviews.

- The VA OIG should develop a memorandum of understanding with the Drug Enforcement Administration that clearly outlines each agency's jurisdiction in investigating allegations of drug diversion that involve VA personnel, VA property, or other VA equities.

- If, during the course of VA OIG activities, there are concerns about the potential impairment of a VA health care provider, the OIG should immediately notify in writing the facility Director, the VISN Director, and the Under Secretary for Health.

- The VA OIG should develop and implement a list of factors for the hotline group to consider in determining how it disposes of a hotline complaint.

- Congress ought to extend whistleblower protections to probationary employees.

- Congress ought to include unauthorized access to a VA employee's medical records as a prohibited personnel practice.

- Congress ought to expand the authority of the VA Secretary to remove VA employees for poor performance or misconduct.

- Congress ought to require all inspectors general to publish all work products that make a recommendation or otherwise suggest corrective action.

VIII. Conclusion

In the fifteen months since the problems of the Tomah VAMC came to light, considerable changes have been made to the facility, the VA, and the VA OIG. New leadership exists at the Tomah VAMC and the VA OIG. The VA has instituted a new opioid therapy tool. The OIG is more transparent. Whistleblowers within the VA are empowered to speak out about waste, fraud, abuse, and mismanagement. These are positive developments sparked by attention from Chairman Johnson, other congressional leaders, and the media.

While improvements are welcome, it is useful and necessary to examine the tragedies at the Tomah VAMC to ensure they do not happen again. What occurred at the facility was preventable, and the fact that the tragedies were not prevented is the result of systemic executive branch failures. For years, veterans and employees sought help, and no entity answered their calls. The VA was aware of variances in the Tomah VAMC's prescription rates, and merely "encouraged" the facility to review its policies. The DEA conducted at least three investigations surrounding the facility, with little to no public results. Jason Simcakoski contacted the FBI several times in November 2013, and an FBI agent left a voicemail on his cell phone—yet the FBI states it has no record of these contacts.

The VA OIG conducted a multi-year inspection of the facility. In the course of its inspection, the VA OIG collected hundreds of thousands of documents, interviewed witnesses and whistleblowers, reviewed patient charts, surveilled Dr. Houlihan, and issued a subpoena to a car dealership in Western Wisconsin. But its final work product—the culmination of all this work—was a short eleven-page administrative closure. Because the VA OIG did not publish this closure, other patients of the Tomah VAMC—veterans like Thomas Baer—did not know the facility was at the center of an OIG inspection.

Chairman Johnson is conducting a thorough and robust bipartisan investigation of the Tomah VAMC. He requested documents and information from the VA, the VA OIG, federal law-enforcement agencies, and other entities. Joined by staff from Ranking Member Carper and Senator Baldwin, Chairman Johnson's staff conducted lengthy transcribed interviews with over twenty current and former VA and VA OIG employees. His staff also received information from whistleblowers in and around the Tomah community. This fact-finding is not complete, as the VA OIG is withholding subpoenaed documents and other entities declined to cooperate.

As detailed in this majority staff report, Chairman Johnson's investigation highlights the systemic failures and preventable tragedies of the Tomah VAMC. It also describes the culture of fear and whistleblower retaliation that enabled these tragedies to continue. Chairman Johnson has undertaken this effort to identify the problems that caused the tragedies of the Tomah VAMC. In this spirit, the majority staff report presents modest recommendations for reform to improve the management and operations of the VA and the VA OIG.

In a nation like the United States, no veteran should find him or herself at the mercy of a troubled VA facility, or forced to take medications that his or her family feels are unsafe. These

men and women fought for Freedom of Speech, Freedom of Religion, and Freedom of Association. When they return from the battlefield, they ought to have the freedom to choose the healthcare of their choice. The Tomah VAMC is a tragic case study of the alternative.

The majority staff presents this report as a necessary first step to understand comprehensively what occurred at the Tomah VAMC and to put forth proposals to cure those ills. This report is not the end of investigation of the Tomah VAMC—not with relevant material still outstanding—nor should it be the end of public attention and accountability on the facility, the VA, and the VA OIG. The seriousness of the issues, the veterans' deaths, and the subsequent heartbreaks deserve continued vigilance.

MEMORANDUM

To: Members of the Senate Homeland Security and Governmental Affairs Committee
From: Ranking Member's Staff of the Senate Homeland Security and Governmental Affairs Committee
Date: May 31, 2016
Re: Ranking Member Staff's supplemental views regarding the Committee's investigation of the Tomah, Wisconsin VA Medical Center

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In 2009, a young psychiatrist committed suicide after being fired from the Veterans Affairs Medical Center (VAMC) in Tomah, Wisconsin. In 2014, a U.S. Marine veteran died while being treated at the facility.

Shortly after an alarming January 2015 report about prescription practices and mismanagement published by the *Center for Investigative Reporting*, the U.S. Senate Homeland Security and Governmental Affairs Committee (HSGAC) began an investigation into allegations of over prescription of opioids, mismanagement, and whistleblower retaliation at the Tomah VAMC.

Minority staff participated thoroughly in the investigation, including in all twenty-two transcribed interviews of current and former Department of Veterans Affairs (VA) and VA Office of Inspector General (VA OIG) staff, and reviewed tens of thousands of documents produced by over a dozen federal and local government agencies and other entities related to the Tomah VAMC.

On May 31, 2016, the HSGAC majority staff released a report titled "The Systemic Failures and Preventable Tragedies at the Tomah VA Medical Center" outlining their findings and recommendations. The purpose of this memorandum is to provide supplemental views concerning the Committee's investigation.

I. Initial efforts to address problems at the Tomah VAMC were not effective.

The record before the Committee suggests that issues related to improper prescription practices, a dysfunctional management environment, and chronic staffing shortages were known to the Tomah VAMC and its regional supervisory office, Veterans Integrated Service Network (VISN) 12.

Then-VISN 12 Network Director Dr. Jeffrey Murawsky appears to have been alerted to concerns regarding prescribing practices, management problems, and staffing issues at the Tomah VAMC. VISN 12 Pharmacy Executive, Ms. Donna Leslie, told the Committee that these concerns were brought to Dr. Murawsky's attention on several occasions.[1] For example, Ms. Leslie identified a conference call between VISN 12 and the Tomah VAMC where then-Chief of Staff Dr. David Houlihan openly questioned the role of pharmacists, stating "he felt like the

[1] Interview of Donna Leslie at 33, 84, 86, 150, 154, 176, and 195 (Dec. 15, 2015).

pharmacists at Tomah were the barriers to proper pain management...."[2] Ms. Leslie brought concerns about this conversation to Dr. Murawsky, but the Committee's record shows that her concerns were dismissed.[3]

Dr. Houlihan's prescribing practices raised concerns amongst certain VISN 12 employees, including Ms. Leslie and Ms. Vicki Brahm (then VISN 12 Quality Management Officer and current Acting Tomah VAMC Facility Director). Mses. Leslie and Brahm made several efforts to investigate and correct instances of overprescription at Tomah VAMC, but were repeatedly rebuffed by senior leadership at both the facility and the regional supervisory office, VISN 12. Mses. Leslie and Brahm sought to have Dr. Houlihan's practices peer reviewed in 2009.[4] When the peer reviews confirmed that, in at least some cases, "most experienced, competent practitioners would have handled the case differently" than Dr. Houlihan did, Mses. Leslie and Brahm recommended an administrative investigation board review -- a formal VA investigation into Dr. Houlihan's prescribing practices which could have subjected Dr. Houlihan to disciplinary actions.[5] Dr. Murawsky and then-Tomah VAMC Facility Director, Jerry Molnar, rejected this recommendation, and instead opted to implement an action plan to re-review the Tomah VAMC's early refill guidance and urine screen policy and practice.[6] Mses. Leslie and Brahm's efforts to implement this action plan ceased, however, when the VA OIG began its healthcare inspection in late 2011, and the VISN 12 employees were told to "stand down and let the IG do their investigation."[7]

Further, and throughout the VA OIG's multi-year inspection of the Tomah facility, the Tomah VAMC Director, Mr. Mario Desanctis, was contacted several times by the VA OIG regarding various aspects of the healthcare inspection. During one interview with the VA OIG, Mr. Desanctis noted that he was aware of the "sense of friction between the Pharmacy and the Chief of Staff" but that his own involvement had been "somewhat inconsistent unfortunately."[8] In the summer of 2014, the VA OIG briefed Mr. Desanctis and others at VISN 12 about the VA OIG's administrative closure's findings and suggestions. During the Committee's transcribed interview of Dr. Alan Mallinger, who was the lead investigator assigned to the VA OIG's healthcare inspection of the facility, it appears that Mr. Desanctis did not implement all of the suggestions outlined in the administrative closure report. Specifically, Dr. Mallinger notes that Mr. Desanctis contacted him and noted that he would not implement the suggestion that the Chief Pharmacist report to the Tomah VAMC's Associate Director rather than the Chief of Staff.[9] The Tomah VAMC senior leadership declined to implement both VISN 12 recommendations (such as conducting an administrative investigative board review for Dr. Houlihan) and VA OIG suggestions aimed at addressing problems at the facility.

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[2] *Id.* at 198.

[3] *Id.* at 199.

[4] Interview of Victoria Brahm at 58-61 (Dec. 16, 2015).

[5] *Id.* at 70-72.

[6] *Id.* at 71-75.

[7] *Id.* at 78-79.

[8] VA OIG Bates number OIG 6085.

[9] Interview of Alan Mallinger at 378 (Apr. 21, 2016).

While the record before the Committee suggests that federal law enforcement agencies were making inquiries related to the Tomah VAMC since 2009, it is unknown when or if the Federal Bureau of Investigation (FBI) or the Drug Enforcement Administration (DEA) began any formal investigations. Consistent with longstanding Department of Justice policy, federal law enforcement agencies are generally unable to provide information about ongoing investigations in order to protect the integrity of those investigations. Thus, the DEA and the FBI were unable to provide information to the Committee regarding any potential ongoing investigations related to the Tomah VAMC. As such, there is no information before the Committee about whether these federal law enforcement agencies had sufficient evidence to prosecute specific criminal activity or were deficient in their activities involving the Tomah VAMC.

Finally, certain efforts to inform congressional offices about problems at the Tomah VAMC were unsuccessful. For example, an April 2009 memorandum regarding opioid overprescription at the Tomah VAMC, authored by Ms. Lin Ellinghuysen, President of the American Federation of Government Employees Local 0007, was not delivered to the Wisconsin delegation as she had intended.[10] In her interview with Committee staff on December 14, 2015, Ms. Ellinghuysen explained that she provided the memo to Ben Balkum, then-president of another local union chapter, and asked that he give the memorandum to Wisconsin's congressional delegation during an upcoming trip he was taking to Washington, DC.[11] Ms. Ellinghuysen told the Committee staff that, at the time, she had assumed the memorandum had been delivered.[12] She later learned the memorandum was not delivered.[13]

II. The VA and the VA OIG have implemented corrective actions aimed at improving quality of care and management practices, but more improvements are needed

The VA removed the former Director and former Chief of Staff from their positions at the Tomah VAMC. The VA immediately put in place an interim Director, Mr. John Rohrer, who took a series of management steps to restore the trust of veterans and employees at the facility. Mr. Rohrer met with dozens of Tomah VAMC employees to assess the extent of the facility's problems and took action to mend broken lines of communication between management and staff at the facility.

The facility's current Acting Director Ms. Brahm is continuing that work through initiatives intended to address many of the issues raised at the Tomah VAMC. These include the recently concluded 100-day plan, a multi-pronged approach to addressing communication and

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[10] Interview of Linda Ellinghuysen at 133 (December 14, 2015).

[11] *Id.*

[12] *Id.* at 134.

[13] Ms. Ellinghuysen told the Committee: "I called Ben Balkum about this. I said Ben, did you hand deliver – think back, Ben. Did you hand deliver, and I explained the letter to Congressman Kind and Senator Feingold? He said, no. I didn't hand-deliver anything to any of them." (*Id.* at 133.)

quality of care issues at the facility.[14] Leadership at the facility is also addressing concerns with staff shortages through an aggressive effort to recruit qualified physicians to serve veterans at the Tomah VAMC. The VA OIG has also begun to address transparency concerns by publishing the Tomah VAMC administrative closure report along with dozens of other previously-unreleased healthcare inspections.

Nationally, the VA is also taking steps to address issues surrounding pain management and the overprescribing of opiate drugs. The VA launched a system-wide opioid safety initiative in 2013 whose objective is to make the totality of opioid use visible at all levels in the organization. In March 2015, the VA launched a new Opioid Therapy Risk Report tool, which is intended to give providers detailed information on the risk status of veterans taking opioids. Finally, the VA launched a psychotropic drug safety initiative with the aim of improving the safety and effectiveness of the use of these drugs across the VA.[15]

The new leadership team at the Tomah VAMC has taken several corrective actions to provide veterans and employees at the facility with enhanced access to leadership and an environment that fosters communication between veterans, employees, and leadership. The VA nationally has several initiatives intended to support higher quality care for veterans and better pain management.

Finally, in Congress, legislation sponsored by Senators Baldwin and Johnson would address chronic pain management issues across the VA by establishing best practices for prescribing opioids and through exploring non-opioid treatment regimens for pain management. In addition, the Senate confirmed a new VA Inspector General, Mr. Michael Missal, who has committed to improving transparency and addressing the lack of oversight that allowed the Tomah VAMC to continue to be mismanaged after the VA OIG's healthcare inspection of the facility.

While these improvements are essential to address the failures at the Tomah VAMC, continued oversight by the VA, the VA OIG and Congress is needed to ensure that the facility is held accountable and that our veterans receive the quality care and attention they deserve.

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[14] U.S. Department of Veterans Affairs. *Tomah VAMC 100-Day Plan.* (Accessible at http://www.tomah.va.gov/docs/Tomah%20100-Day%20Plan.pdf).

[15] *Tomah VAMC- Examining Patient Care and Abuse of Authority: Hearing Before the Senate Committee on Homeland Security and Governmental Affairs, 114th Congress (2016)* Statement of Sloan Gibson, Deputy Secretary of Veterans Affairs.

Post-Hearing Questions for the Record
Submitted to Hon. Sloan Gibson regarding
"Tomah VAMC: Examining Patient Care and Abuse of Authority"

Homeland Security and Governmental Affairs Committee
United States Senate
May 31, 2016

FROM CHAIRMAN JOHNSON

QUESTION 1: Was former Tomah VAMC Director, Mario DeSanctis, terminated from VA employment, or did he enter into a settlement with the VA that allowed him to resign in lieu of termination? How much money did Director DeSanctis receive in his settlement with the VA?

Response: The Department of Veterans Affairs (VA) proposed removal of former Tomah Medical Center Director Mario DeSanctis. Mr. DeSanctis appealed his removal with the Merit Systems Protection Board. His appeal was settled by an agreement that Mr. DeSanctis would voluntarily resign his position and waive all appeal rights in exchange for a one-time, lump-sum payment of $88,000.00.

QUESTION 2: How long was Dr. Houlihan on administrative leave for before he was terminated from VA employment? Why?

Response: Dr. Houlihan was on Authorized Absence from March 10, 2015, through November 9, 2015. During this time, multiple clinical reviews were completed by providers outside of Veterans Integrated Service Network 12 to assess Dr. Houlihan's clinical practice. Once the reviews were received, the medical bylaws required a hearing by the Medical Staff Executive Committee where this information was presented. Following that hearing, charges were developed, termination was proposed, and a subsequent decision to uphold the termination was made. Multiple legal reviews were conducted to ensure appropriate human resources regulations were followed to ensure that there was no opportunity to overturn the termination on procedural grounds.

QUESTION 3: The Veterans Access, Choice, and Accountability Act of 2014 (Choice Act) authorized the Secretary to seek the removal or transfer of Senior Executives based on poor performance or misconduct:

a. **Since implementation, how many Senior Executives have been transferred under this provision of the Choice Act? For each Senior Executive that has been transferred under this provision, please provide their name, the**

reason for transfer, what VA facility the Senior Executive was transferred from, and what VA facility the Senior Executive was transferred to.

Response: Diana Rubens – Veterans Benefits Administration (VBA) Regional Office (RO) Director Philadelphia to RO Assistant Director-Houston for Failure to Exercise Sound Judgment; and Kimberly Graves - VBA Area Director-Ann Arbor to RO Assistant Director-Phoenix for Failure to Exercise Sound Judgment. Both cases were overturned by Merit System Protection Board (MSPB).

b. Since implementation, how many Senior Executives have been terminated under this provision of the Choice Act? For each Senior Executive that has been terminated under this provision, please provide their name, the reason for termination, and what VA facility the Senior Executive was terminated from.

Response:

Removals:

- Sharon Helman; Phoenix VA Medical Center (VAMC); Lack of Oversight (not sustained by the MSPB); Conduct Unbecoming a Senior Executive; and Failure to Report Gifts. Note: Ms. Helman has appealed her removal to the Federal Circuit.
- James Talton-Central Alabama; Neglect of Duty
- Therese Wolf; Pittsburg VAMC; Conduct Unbecoming a Senior Executive and Wasteful Spending
- Mario DeSanctis-Tomah; Conduct Unbecoming a Federal Employee
- Japhet Rivera-Danville; Conduct Unbecoming a Senior Executive, Providing Misleading Information during an Administrative Investigation, Failure to Make Timely Payment on a Government Credit Card

Removal reversed by MSPB (currently in litigation):

- Linda Weiss-Albany; Failure to Take Timely Action
  Weiss was removed from federal service for failing to take timely action to remove a clinical provider from patient care following Weiss' receipt of reports indicating the provider's interactions with patients were unsafe. Ms. Weiss appealed her removal to the Merit Systems Protection Board and her case is currently being litigated.

FROM SENATOR BALDWIN

QUESTION 1: At the hearing, you stated that the Committee report was the first time you heard that Dr. Houlihan and Ms. Frasher were possibly impaired or intoxicated during their interviews with the VA IG team.

a. What is VA's protocol for handling cases of potential impairment of its employees, specifically healthcare providers?

Response: The Department of Veterans Affairs (VA) regulations, 38 C.F.R. § 1.218(a)(7), prohibit the possession or use of alcoholic beverages or any narcotic drug, hallucinogen, marijuana, barbiturate, and amphetamine (unless prescribed by a phyisician) on VA property. The regulation also states that "[e]ntering [VA] property under the influence of any narcotic drug, hallucinogen, marijuana, barbiturate, amphetamine, or alcoholic beverage (unless prescribed by a physician) is prohibited." Employees who fail to follow this regulation may be disciplined in accordance with VA Handbook 5021.

The Medical Center's Bylaws also provide guidance to medical staff to assist them with meeting facility expectations and complying with VA, the Veterans Health Administration, The Joint Commission, and local facility requirements. The following is the excerpt from the Medical Staff Bylaws template related to Health Status and Impaired Professional Program. VA Facilities are encouraged to maintain this section in their facility-specific Medical Staff Bylaws:

HEALTH STATUS AND IMPAIRED PROFESSIONAL PROGRAM

VHA recognizes its responsibility to assist impaired professionals and collaborate with available programs designed to intervene, monitor, refer to treatment, and advocate for physicians and dentists.

A. Where there is evidence that a physician or dentist's practice is impaired as a consequence of chemical dependence or mental or physical illness, the Chief of Staff's office will be notified. Practitioners are allowed to self-refer to a program for assistance for psychiatric, emotional, or physical problems. Assistance in the self-referral may be obtained from their Service Chief or Chief of Staff.

B. In cases of known or suspected impairment due to mental illness or substance use, the Chief of Staff may request an assessment.

C. In cases of known or suspected impairment due to physical and/or mental illness, the Chief of Staff may request the Director to authorize a Special Physical Examination as authorized VA Handbook 5019, Part II, and applicable hospital policy. The Special Physical Examination will be tailored to the clinical circumstances and may involve a physical examination, imaging studies, neuropsychological testing, or other indicated measures. The fitness for duty examination will be conducted by or under the direction of the Occupational

Health Program or outside medical examiner, which will assess the findings and make a recommendation on the Practitioner's fitness for duty based on such findings. If the determination is unfavorable to the Practitioner, or in cases of uncertainty, the findings will be presented to an ad hoc Physical Standards Board.

D. VA and Facility policies, responsibilities and procedures of the Employee Assistance Program and the VA Drug-Free Workplace Program are applicable for physicians, dentists, and other healthcare professionals.

E. Confidentiality of the Practitioner seeking referral or referred for assistance will be kept, except as limited by law, ethical obligation, or when the safety of a patient is threatened. In all instances, every effort will be made to protect the confidentiality of the individual referred for assistance.

F. The hospital will sponsor periodic educational program regarding illness and impairment issues. Licensed independent Practitioners will be issued written information regarding illness issues at the time of initial appointment and re-appointment to the medical staff.

As stated, the provider may be removed from patient care to ensure the safety of our patients. This may be through the "summary suspension" process for privileged providers or through VA's Human Resource process for non-privileged providers. Reporting to the State Licensing Boards may also be considered in accordance with VHA 1100.18, *Reporting and Responding to State Licensing Boards*.

The Rehabilitation Act of 1973 – Individual with a Disability: Under this Act, an individual with a physical or mental impairment that substantially limits one or more major life activities; has a record of such impairment; or is regarded as having such impairment. Please note: the Americans with Disabilities Act Amendments Act of 2008 has broadened the coverage of what is considered a disability under the Rehabilitation Act of 1973. This means that just about every condition that affects a major life activity will be covered under the Act. The caveat is that a condition lasting six months or less is not covered.

Reasonable Accommodation: An agency is required to make reasonable accommodation to the known physical and mental limitations of an otherwise qualified individual with a disability unless the agency can show that accommodation would cause an undue hardship. In this situation there are two issues to consider: (1) Has the employee requested an accommodation? (2) Has management considered the individual as being disabled? If the answers to the questions are "Yes," then reasonable accommodations generally should be provided.

b. Are facility directors required to take certain actions?

Response: Managers must assess the evidence and determine if action is appropriate to promote the efficiency of the service. If action is appropriate,

management needs to analyze the aggravating and mitigating factors to determine the appropriate level of action to take. The penalties, specified in VA Handbook 5021, part I, appendix A, paragraph 23, range from a reprimand to removal for alcohol-related offenses, and from a suspension to removal for drug-related offenses.

c. Now that you have had time to look into this issue, is there any evidence that Director DeScantis or anyone else at the facility took action to address this matter?

Response: Other than informal conversations about impairment information possibly being contained in VA's Office of Inspector General (OIG) document release, VHA did not have knowledge of the OIG interviewer's allegation until they saw documents that the OIG shared with the Committee and a comment from Senator Baldwin's staffer about impairment information possibly being contained in the OIG document release.

QUESTION 2: The Jason Simcakoski Memorial Opioid Safety Act would require the VA to track and review opioid prescribing rates at each medical facility, including the number of concurrent prescriptions of opioids and benzodiazepines. It would also mandate that the VA *immediately* conduct a full investigation into a provider or facility – and notify Congress – if any of these rates show dangerous or inappropriate outliers that could harm patients.

a. How does the VA currently track opioid prescriptions, including both opioids and benzodiazepines, under the Opioid Therapy Risk Report Tool?

Response: The Opioid Therapy Risk Report (OTRR) does not "track" opioid prescriptions but it allows individual primary care providers to follow, in real time while treating Veterans in the clinic, the key variables that influence risks when taking chronic opioids.

Key considerations and relevant information found in OTRR include:

Documented diagnoses that influence risk
- Post-Traumatic Stress Disorder
- Depression
- Substance Use Disorder
- Obstructive Sleep Apnea

Patient interaction with health Providers
- Last visit date
- Last Pain Clinic visit date
- Last Mental Health visit date

Patient details

- Results of last Urine Drug Test and date
- Patient Pain Scores
- Patient Opioid and Benzodiazepine medication history
  - ALL VA Prescribers; dispensing location; strength; day supply; morphine equivalents
- Status of signed iMedConsent™, required for Opioid Therapy

How this information is used during patient interactions:

- Provides provider specific patient list that enables the clinician or team to quickly view status of key risk factors and treatment milestones. Dramatically reduces the time for data collection to make important clinical decisions.
- Specific patient details can be obtained from the provider patient list, printed, and utilized as a patient education tool during a face-to-face visit to facilitate a conversation around pain management. This has the following benefits:
  - Re-enforces to the patient the doses of current meds
  - Allows conversation concerning early refills
  - Can be used to follow adjustments or tapers over time
  - Provides visual of the relationship between doses of opioids and pain scores

In addition to OTRR, VA has other tools available to assist VHA staff with proactive clinical care of patients receiving outpatient opioid prescriptions or with diagnosed opioid use disorders, and metrics that provide information on implementation of clinical practice guideline recommended practices to improve the safety and efficacy of chronic opioid therapy.

VA will soon be implementing a requirement to consult the state prescription drug monitoring program (PDMP) report where available, prior to initiating a new opioid prescription, and VA is currently uploading its prescribing data to a majority of the state PDMPs.

The Stratification Tool for Opioid Risk Mitigation (STORM) provides clinical decision support for the broader population of opioid-exposed patients, including patients with short-term prescriptions of outpatient opioid analgesics and patients with diagnosed opioid use disorders. STORM incorporates predictive analytics to estimate a patient's risk of adverse events including overdose, suicide-related events, accidents, and falls based on their clinical history and current prescriptions. Risk information is paired with customized, guideline recommended risk reduction strategies and non-medication based pain therapies, along with tracking of the use of these clinical interventions. This tool is designed with multiple views to facilitate individual clinical care encounters, enable proactive implementation of risk reduction strategies in patient panels, and guide facility-level quality and process improvement efforts.

A set of Opioid Therapy Guideline Adherence metrics are used to track facility rates of opioid prescription and implementation of clinical practice guideline recommendations to improve the safety of opioid prescribing and the effectiveness of pain care. These metrics guide quality improvement efforts and document the declining use of opioid analgesics in VHA. Current data show the substantial improvement in use of recommended risk mitigation strategies over the last six years, as well as the comprehensive array of pain care options provided to VA patients who are also receiving opioid analgesics. This includes provision of non-opioid pain pharmacotherapies; rehabilitative treatments, such as physical therapy, occupational therapy, exercise or movement-based therapy, integrated health treatments, and specialty pain clinic services; and psychosocial and behavioral treatments.

b. What is the process for identifying and investigating potentially dangerous prescribers?

Response: Each facility has a Pain Point of Contact (POC) and an Opioid Safety Initiative (OSI) POC (they may be the same person) who track opioid prescribing in their facility and identify potentially unsafe practices, which are then addressed using education and remediation through the Academic Detailing Program and individual consultation with the Pain/OSI POC(s) and pain clinic personnel.

QUESTION 3. The Jason Simcakoski Memorial Opioid Safety Act would also expand the Department's Opioid Safety Initiative, including a requirement that every opioid prescriber receives education and training on the updated opioid guidelines and on screening and coordinating care for patients with substance use disorders.

a. Can you please provide an update on the implementation of the Opioid Safety Initiative in all medical facilities?

Response: Since 2014, the OSI is reporting on opioid use, opioid doses, use of urine drug screens, and co-prescription of benzodiazepines for all Veteran Integrated Service Networks (VISN) and for all medical facilities in VHA. See the summarized information below:

Results of key clinical metrics measured by the OSI:

- From Quarter 4, Fiscal Year (FY) 2012 (beginning in July 2012) to Quarter 2, FY 2016 (ending in March 2016) there are:
  - 151,982 fewer patients receiving opioids (679,376 patients to 527,394 patients, a 22-percent reduction).
  - 51,916 fewer patients receiving opioids and benzodiazepines together (122,633 patients to 70,717 patients, a 42-percent reduction).
  - 94,045 more patients that have had a urine drug screen to help guide treatment decisions (160,601 patients to 254,646, a 37-percent increase).

- 112,846 fewer patients on long-term opioid therapy (438,329 to 316,264, a 28-percent reduction).
- The overall dosage of opioids is decreasing in the VA system as 18,883 fewer patients (59,499 patients to 40,616 patients, a 32-percent reduction) are receiving greater than or equal to 100 Morphine Equivalent Daily Dosing.
- The desired results of OSI have been achieved during a time when VA has seen an overall growth of 107,342 patients (3,959,852 patients to 4,096,796 patients, a 3-percent increase) that have utilized VA outpatient pharmacy services.

b. Can you also describe the opioid-specific training and education part of this new effort?

Response: VHA estimates that as of September 7, 2016, 54.37% of prescribers have been trained in the Talent Management System (TMS). VHA continues to train prescribers on opioid safety and continually updates data to reflect that training.

1) *Academic Detailing:* The Academic Detailing Service has been working closely with VISN Academic Detailing programs and VISN and facility pain leaders to educate providers on the OSI, including the development of the **Opioid Safety Initiative Toolkit**. This toolkit was developed by a multi-disciplinary task force appointed by the National Pain Management Program to provide detailed guidance materials and presentations to standardize safe opioid management across the VHA. Academic Detailing is a service for clinicians by clinicians that provides individualized, evidence-based, educational outreach visits intended to meet the needs of the provider in the context of local operations. This service has been effective in altering prescribing habits in a variety of practice settings.

2) *The two Joint Incentive Fund (JIF) projects*, sponsored by the Pain Management Work Group (PMWG) within the Department of Defense (DoD)/VA Health Executive Council (HEC), as discussed below, have successfully created pain management education and training programs to improve pain management competencies and safe opioid prescribing system-wide.

a) The Joint Pain Education Project (JPEP) aims to provide training of clinical providers and teams across VHA and DoD with a special emphasis on educating clinicians in core concepts and modern approaches to safe and effective pain management, including safe opioid prescribing, as well as providing education to Veterans and their families. JPEP provides system-wide training for clinical educators in general pain management, including Integrative Medicine and psychological and physical therapies, as well as evidence based approaches to opioid prescribing, which will enable them to train interdisciplinary clinical teams in primary care, known as Patient Aligned Care Teams (PACT) and provide education for Veterans and their

families. The JPEP team has identified the following four phases of JPEP development:

- *Phase 1*: Traditional Instructor-Led Training Curriculum with 31 trainings that include evidence-based instructional presentations with facilitator notes;
- *Phase 2:* Traditional Instructor-Led Regional Workshop, showcasing three trainings in the Phase 1 lessons;
- *Phase 3:* Virtual Instructor-Led Professional Development Trainings; these are in progress and include trainings being done in joint DoD/VA Specialty Care Access Network-Extension of Community Healthcare Outcomes (SCAN-ECHO) training sessions; and
- *Phase 4:* Self-Paced Asynchronous web-based trainings; this is in progress and includes promotional videos, one of which is an adaptation of a highly popular video on understanding chronic pain that has been adapted for military service personnel and Veterans.

As part of the JPEP program and in preparation to instruct primary care and pain medicine teams, DoD and VA Pain Champions are being educated about off-the-shelf pain management course content and training materials.

- Specific training modules have been developed by the JPEP team to address needs of OSI for safe opioid prescribing and safe, appropriate medication tapering, as well as to meet the education and training needs of all team members regarding the essential elements of good pain care. Subject matter experts from VA and DoD worked closely together to develop the following four courses that are either in production or completed:
    a) Core curriculum for primary care providers and primary care pain teams which was completed FY 2015;
    b) Core curriculum for patients, families, and caregivers, which was completed and made available in May 2016;
    c) Core curriculum for pain medicine specialty teams which continues to be under development and expected to be completed by end of FY 2016; and
    d) Core curriculum for pain care transitions which was completed in FY 2015.

- The dissemination of the training material will be combined with an ongoing effort to solicit suggestions for further refinements and additions to the courses thereby keeping current with the newest concepts in the rapidly evolving field of pain management.

- JPEP courses are available for use by clinicians for continuing education credits and clinical decision-support. These courses are designed to be used in formal settings, independent study and formal educational programs such as SCAN-ECHO, national Community of Practice calls (occurring on a monthly basis in the PACT, Primary

Care/Pain and Post-Deployment Integrated Care Initiative communities) and Pain Mini-Residency programs.

b) The Tiered Acupuncture Training Across Clinical Settings (ATACS) Project aims to create access in all clinical settings to different levels of acupuncture for Veterans and Servicemembers with pain. The intent of this project is to supplement existing pain management capabilities with an integrated Complimentary Alternative Medicine approach that may reduce providers' and patients' dependency on opioids for treating pain, as well as increase patient choices in a patient-centered, proactive care model.

- The tiered ATACS project plans to build a culture of sustainability within medical centers by establishing a cadre of practicing Battlefield Acupuncture (BFA) providers and medical acupuncture physician faculty throughout DoD and VA health care systems.

- Since formal training sessions began in late 2013, the tiered ATACS project has trained 46 VA medical acupuncturists as BFA Faculty with an additional 23 VA providers enrolled in FY 2016 BFA Faculty courses. These medical acupuncturists have trained over 2,000 BFA providers, who are currently active in VHA and DoD medical centers across the country.

- Distribution of trained BFA providers across the VHA continues to expand, as follows:
    - 1 state has trained over 100 providers
    - 4 states have trained 51-99 providers
    - 6 states have trained 26-50 providers
    - 15 states have trained 1-25 providers

- Distribution of medical acupuncture trainees (300-hour course completion)
    - Completed training: 26 trained in 28 states
    - Currently enrolled in training: 32 in 9 states
    - All VISNs have BFA Faculty for training providers in BFA workshops.

- Clinical support for practicing BFA providers is available through a DoD and VA Collaborative Acupuncture Initiative, with a Community of Practice call biweekly and Defense Connect Online Webinars to advise, educate, and support providers on patient cases and acupuncture techniques. This VA/DoD collaborative effort is staffed by medical acupuncturists with expertise in BFA and supported by the Wounded Warrior Pain Care and National Capital Region Pain Initiatives. In addition, as part of the VA sustainment effort, the VA ATACS staff has developed with the VA Integrative Health Coordinating Committee (IHCC) a social network VA ATACS Pulse site. This site supports VA providers with documentation, teaching

material, frequently asked questions as well as best practice examples. The site is managed by the VA ATACS staff and will continue to be managed upon the expiration of the JIF, through a combined effort with the National Director of Pain, the IHCC and Office of Patient Centered Care and Cultural Transformation.

3) *The PACT Roadmap for Managing Pain*, in early implementation, facilitates the delivery of the Stepped Care Model for pain management in the primary care setting. This roadmap is providing structure and guidance for both leadership and PACTs to transform and deliver an organized approach to comprehensive pain care in the framework of the chronic care model and the six essential elements for pain. It highlights proactive planning, utilizing appropriate resources, services, and strategies to meet the needs of the patient, engaging the Veteran and family in self-care and self-management, and ensuring effective team communication and coordination of care.

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

JUL 2 2 2016

The Honorable Ron Johnson
Chairman
Committee on Homeland Security
and Governmental Affairs
United States Senate
Washington, DC 20510

Dear Chairman Johnson:

Enclosed are the Office of Inspector General's responses to the post-hearing questions from the May 31, 2016, hearing "Tomah VAMC: Examining Patient Care and Abuse of Authority." Thank you for the opportunity to testify and provide the requested additional information.

Sincerely,

MICHAEL J. MISSAL

Enclosure

Copy to: The Honorable Tom Carper, Ranking Minority Member
The Honorable Tammy Baldwin
The Honorable Joni Ernst

OFFICE OF INSPECTOR GENERAL
DEPARTMENT OF VETERANS AFFAIRS
RESPONSE TO
POST-HEARING QUESTIONS FOR THE RECORD
FROM THE
COMMITTEE ON HOMELAND SECURITY
AND GOVERNMENTAL AFFAIRS
UNITED STATES SENATE
MAY 31, 2016 HEARING ON
"TOMAH VAMC: EXAMINING PATIENT CARE
AND ABUSE OF AUTHORITY"

JULY 22, 2016

FROM CHAIRMAN RON JOHNSON

1. **On September 29, 2015, I wrote to your predecessor, Deputy Inspector General Linda Halliday requesting information and material relating to the production of the VA OIG's June 4 "white paper" that defended the office's work in Tomah and attacked whistleblowers from the facility. On October 6, 2015, Ms. Halliday wrote to me, "respectfully requesting" that I withdraw my request for information on who authored the "white paper." I have not withdrawn my request and I ask that you please provide the following information and material with respect to the white paper:**

    a. **Please provide the identities of all individuals that were involved in the drafting and publication of the "white paper."**

    OIG Response: The letter was signed by the then Deputy Inspector, Mr. Richard Griffin. Mr. Griffin resigned on or about July 4, 2015. As the author, he was responsible for the content of the white paper. I have not spoken to him to determine who else he may have relied upon with respect to the drafting of the white paper. I have spoken to all current senior officials of the Office of Inspector General (OIG) and conveyed to them that I do not agree with the tone of the white paper or the gratuitous attacks against individuals made in it. I have not identified any current employee of the OIG who disagrees with this opinion. I am confident that documents produced by this office in the future will meet the highest professional standards.

2. **Recently, an administrative law judge with the State of Wisconsin Division of Hearing and Appeals issued an opinion immediately restoring Dr. Houlihan's license to practice medicine while the Wisconsin Department of Safety and Professional Services continues its investigation into his practice of medicine. In the opinion, the administrative law judge heavily cites the VA OIG's "white paper" as evidence to support her ruling that the suspension of Dr. Houlihan's**

medical license be lifted:

a. **Do you believe that it is appropriate that the administrative law judge cited the VA OIG's "white paper" as evidence in her decision?**
b. **Will the VA OIG issue a formal retraction of the "white paper"?**

OIG Response: The white paper was intended solely to provide information to the Committee. It therefore should not be used for any other purpose. I believe that the white paper was retracted when it was removed from the OIG website.

3. **Please produce all 19 cases involving the Tomah VAMC which is referenced in the Tomah Administrative closure.**

OIG Response: It is my understanding from reading the majority's final report that the underlying interest in these 19 cases is to determine whether any were initiated for the purpose of reviewing allegations concerning prescribing practices at the Tomah VAMC and the conduct of Dr. David Houlihan that were made by a Tomah VA Medical Center (VAMC) union representative in a January 2009 memorandum. None of the 19 cases were related to the allegations raised by the union representative.

On March 16, 2016, OIG staff provided information about the 19 cases in response to a similar request from the majority staff. Specifically, we shared that the 19 cases involved matters that were unrelated to the Committee's investigation and that none of them related to opioid prescription practices at the Tomah VAMC, the conduct of Dr. Houlihan, or any other party connected with the OIG's administrative closure. We also identified the various topics these cases covered, which included threats of violence from veterans, theft of property, access to pornography on a VA computer, potential loss or theft of patient medications during shipment, allegations of sexual assault, misappropriation of a veteran's benefits by a family member, off-campus misconduct, and quality of care (unrelated to the subject of the Committee's investigation). The case involving quality of care was accepted for review by the OIG Office of Healthcare Inspections, and we published our final report to our website on September 8, 2010, where it is available to the public at: http://www.va.gov/oig/54/reports/VAOIG-10-02355-242.pdf.

I am enclosing a summary of each of the 19 cases that is contained in our Master Case Index (MCI) system. Given that none of these cases are related to the Committee's investigation, you may not want further information on them beyond the summaries. However, after reviewing the summary of the cases, please let me know if you would like further information on any of them and we will provide it.

FROM SENATOR TAMMY BALDWIN

1. **The Committee Report notes a provision that was included in last year's appropriations bill and is now law, which I authored with Senator Kirk. This provision would increase transparency at the Inspector General's Office and was intended to ensure that when the VA OIG completes a report, it is promptly shared with the VA Secretary, Congress and the public.**

   Prior to your confirmation, the IG's office took an overly strict interpretation of this language regarding investigative reports on wait time manipulations at VA facilities across the country. I, unfortunately, had to place a hold on your confirmation until the office changed course. Thankfully, the IG began releasing the 77 reports and we have since had productive conversations on this issue.

   a. **Now that you have had some time in your role as IG, what is your reading of the appropriations language?**

   b. **What is your overall approach to transparency with Congress and the public on your office's work?**

   OIG Response: As we previously discussed, I believe it is important for the OIG to be as transparent as possible. Our practice is to release promptly reports to the VA Secretary, Congress, and the public that are not otherwise prohibited from disclosure or would negatively impact law enforcement efforts. All have a right to know about our work, while respecting privacy and law enforcement issues. I believe that this is consistent with the appropriations bill authored by Senator Kirk and you.

2. **Your office maintains a hotline service that receives, screens, and reviews whistleblower complaints within the VA. I have heard repeated frustration from whistleblowers that when they come forward with abuse allegations, they feel like the hotline is a black hole. Whistleblowers have stated their complaints are entered in the hotline, but that there are inconsistent responses back from your office.**

   a. **Can you explain the current response process and what improvements you are looking to make in the hotline process?**

   OIG Response: The OIG takes action on ***all*** contacts made to the OIG Hotline. All contacts submitted to the OIG Hotline are reviewed by OIG staff and are entered into the OIG's system of records. All contacts undergo a preliminary evaluation to determine if they merit further action.

   It should be noted that the OIG counts the number of ***contacts*** made to its Hotline. During FY 2015, the OIG received 38,098 contacts. The terms 'contact' and 'complaint' are not synonymous. A single contact may contain an allegation or

multiple allegations and could be considered a complaint. Conversely, many contacts do not contain any allegations, such as when the caller has contacted the Hotline merely to request directory assistance to another component of VA.

Due to the high volume of contacts received by our Hotline, we are not currently able to notify each person individually if we do not accept their complaint or allegation for further action by our office. We inform individuals in our automated e-mail response, by letter mail, and on our website that they will be contacted again only if we open a case or need additional information. Additionally, these communications inform individuals about the types of complaints the OIG does and does not accept for review, provide points of contact for further assistance on common VA complaints that are not matters within the OIG's purview, and outline what individuals should expect next after submitting a Hotline complaint.

Because the number of allegations we receive each year far exceeds the number we can accept for review, the OIG must be highly selective in the cases we accept. We must use our professional judgment to accept only the allegations that we believe represent the most serious risks to veterans, beneficiaries, and taxpayers.

We receive a large volume of complaints that concern one veteran's health care experience at one VA medical facility. While health care-related complaints fall within the OIG's general purview and we do review a select number of complaints regarding a single veteran's experience, it is not possible to open a case for each complaint involving a single episode of care. By reviewing and logging all complaints, we have the ability to use aggregate data to identify areas that may warrant a large-scale or national review, thereby directing our limited resources to areas that will benefit the largest number of veterans.

After undergoing a preliminary review, all contacts are triaged into one of the following categories:

OIG Case. The OIG conducts an investigation, audit, review, evaluation, or inspection in order to determine the merit of the allegations. When the OIG accepts an allegation for a case, we notify the complainant that an OIG case has been opened and when it closes.

External Referral to VA. External referrals of cases result from allegations submitted through our Hotline that the OIG does not accept for review. For allegations that are not accepted by the OIG but that appear to warrant further review, the OIG makes external referrals to VA in accordance with VA Directive 0701, *Office of Inspector General Hotline Complaint Referrals*. VA Directive 0701 requires that VA review the allegations and submit a written response to the OIG that contains:

- Evidence of an independent review by an official separate from and at a higher management level than the alleged wrongdoer.

- Specific review of all allegations.
- The findings of each allegation, which are clearly identified as either substantiated or unsubstantiated.
- A description of any corrective action taken or proposed as a result of a substantiated allegation, (e.g., change in procedures, disciplinary or adverse action taken, etc.).
- Supporting documentation for the review, such as copies of pertinent documents, a summary report of the board of investigations, etc.
- Designation of a point of contact for additional information.

We keep the external referral open until we are satisfied with VA's review or open an OIG case to review the matter further. When we close an external referral that originated through the Hotline, we contact the complainant in writing to advise them how to request the results through a *Freedom of Information Act* (FOIA) request. Many of these external referrals concern the medical care provided to a specific veteran during a specific episode of care.

Non-Case Referral to VA. The OIG will refer certain Hotline contacts directly to the appropriate VA office if the allegation appears to warrant some action on that facility's part. For example, non-case referrals are made for complaints of staff rudeness or medication refill problems. The OIG does not require a response from the facility after they have reviewed the case.

No Further Action. The OIG takes no further action on matters that are not within VA's or the OIG's jurisdiction; can be addressed in another legal or administrative forum; are not logical, plausible, or supported by available VA records; or are too trivial, stale, or vague to warrant further review. When possible, the OIG refers the complainant to the appropriate VA program office or Federal agency that can provide further assistance on the matter. For example, individuals with complaints regarding claim adjudications for VA disability and pension benefits are advised to contact the Veterans Benefits Administration (VBA); individuals with complaints regarding discrimination are advised to contact VA's Office of Resolution Management (ORM); and individuals with allegations of prohibited personnel practices, including reprisal for whistleblowing, are advised to contact the U.S. Office of Special Counsel (OSC). We also do not review complaints of poor quality of care when the veteran or family has filed an administrative tort claim. Those investigations are the responsibility of VA's Office of General Counsel.

For some contacts, the OIG is able to assess immediately and invalidate the allegation by conducting a review of available VA records. For example, a veteran's neighbor might contact the Hotline to report suspected disability fraud. The neighbor is convinced the veteran is rated 100 percent disabled, yet the veteran is observed regularly performing heavy yard work. The OIG can quickly access the veteran's records, and may determine that the individual is either not receiving any disability compensation or is rated for a condition that would not

preclude him from performing physical labor, such as a mental health condition like post-traumatic stress disorder. In such instances, it is not necessary for the OIG to open a case even though we did take action during the preliminary evaluation to invalidate the complaint.

I recognize the importance and significance of information that we receive through our Hotline, particularly from whistleblowers. Whistleblowers are an important source of information to our program. I am in the process of reviewing current OIG policies, workloads, and priorities with respect to our Hotline and will make any enhancements as appropriate.

FROM SENATOR JONI ERNST

1. **After receiving a complaint to the Office of Inspector General (OIG) Hotline in March 2011 regarding prescription practices at the Tomah VAMC, why did the OIG decide to refer the allegation to the Director, Veterans Integrated Service Network (VISN) 12, VA Great Lakes Health Care System rather than investigate the allegation itself?**

   OIG Response: As discussed in our response to Question 2 from Senator Baldwin, and as more fully explained in our response to your next question below, the OIG receives more allegations than we have the resources to review. With respect to quality of care allegations, the OIG's Office of Healthcare Inspections reviews each one to determine which ones are appropriate for our review. Allegations that are not selected for OIG review may be referred to the appropriate office within the Veterans Health Administration for review and response in accordance with VA Directive 0701, *Office of Inspector General Hotline Complaint Referrals*. With respect to this allegation, it was decided, given the then current workload of the OIG and other considerations, to refer this allegation regarding prescription practices at the Tomah VAMC to the Veterans Integrated Service Network 12 for review and response.

2. **What is the standard used by the OIG in determining whether to investigate allegations itself or refer them to the VA?**

   OIG Response: Since the number of allegations we receive each year far exceeds the number we can accept for review, we must be highly selective in the cases we accept. We analyze each matter and use our professional judgment to accept the allegations we believe represent the most serious risks to veterans, beneficiaries, and taxpayers. Many factors influence this decision making process including the nature, severity, and scale of the allegation, the level of detail provided to explain and/or support the allegation, our ability to contact the complainant for more information, and our resource capacity.

   Of particular concern to the OIG are those contacts alleging substandard quality of care. For example, to determine whether quality of care allegations should trigger a

formal inspection, our team of physicians, nurses, and other clinicians consider multiple factors including risk to patients and resource availability. The risk assessment is particularly important and is informed by the relative scope (the number of patients affected) and severity (the actual or potential impact on patients' health or safety) of the alleged quality of care issues.

Other factors that influence whether an allegation receives further consideration from the OIG is the level of detail provided and whether the complainant has provided contact information. It is critical in most instances that the OIG be able to communicate with the complainant to understand the nature of the complaint so as to address effectively the issue; otherwise, we are often left with a task akin to looking for "a needle in a haystack." For example, if a complainant makes a serious but vague allegation that surgery at a medical center is of poor quality, but does not provide any further information, it is difficult to address the complainant's issues.

3. **What is the standard used by the OIG in determining that an investigation warrants an administrative closure rather than a formal report?**

OIG Response: Reports are the final product resulting when the OIG initiates a planned or mandated oversight project or accepts a case arising from an allegation submitted through our Hotline or a Member of Congress. There are several different types of final reports including administrative investigations, audits, reviews, benefits inspections, healthcare inspections, Combined Assessment Program reviews, and Community Based Outpatient Clinic reviews. We publish the results of our completed work in a final report.

However, there are certain circumstances where it is not possible or practical for the OIG to continue performing a review that will result in a final report, and in these situations we may terminate the investigation, audit, review, evaluation, or inspection without a final report through an "administrative closure." Situations where an administrative closure might be appropriate include when:

- We determine an allegation is the subject of litigation or a claim filed under the *Federal Tort Claims Act*.
- We determine the allegation has already been adequately addressed by VA prior to our review.
- The complainant declines to cooperate or provide critical information, without which the OIG is not able to conduct a thorough review of the allegations.

Prior to 2015, the OIG reported the number of administrative closures issued in its Semiannual Report to Congress, but we did not post the administrative closures on our website as we would with a final report. However, in order to be as transparent as possible and keep the Congress and the public informed about our work, the OIG now publishes all administrative closures that are not specifically prohibited from disclosure by any provision of law.

4. **As you stated in your written testimony, the VA OIG needs to be as transparent as possible in its work. Are there ways to address privacy concerns without withholding administrative reports from the public – for example, by redacting personally identifiable information?**

   In addition, with respect to reputational concerns, why would it not be better for everyone involved if allegations were addressed and dismissed as unsubstantiated in a public report so as to leave no lingering question by the person who made the allegation or anyone contacted during the course of the OIG's investigation?

   OIG Response: There are ways to address privacy concerns and we do publish reports where allegations were not substantiated. As required under the IG Act, all report titles are posted on our website within 3 days of being issued to VA. If the information in the report is not protected under the *Privacy Act* or another confidentiality statute (which it most often is not), the website includes a link to the report. However, if the report contains FOIA protected information, our current practice is to post only the title and a brief summary until we receive a FOIA request for the report. Once we receive three FOIA requests for the report, which generally occurs shortly after the report title and summary are posted, we put the full report on our website. We are reviewing this practice to determine whether we can post reports with protected information more quickly.

   In an effort to release our findings and conclusions publicly, all reports are reviewed by our Information Release Office, which is a component of the OIG's Office of the Counselor to the Inspector General, for a determination as to whether the report can be published on our website in its entirety or whether it contains information, such as personally identifiable information, that needs to be redacted. The OIG works diligently to write reports: 1) with findings and conclusions that are clear and supported, and 2) in such a way that, to the extent possible, they can be made public without redactions.

   With respect to the second part of this question, the OIG does publish reports where allegations were not substantiated. For example, we recently published a report detailing our findings related to allegations that could not be substantiated against a senior VA official. The report is available in an unredacted format on our website at: http://www.va.gov/oig/pubs/VAOIG-15-02747-314.pdf.

5. How many complaints were received by the OIG hotline in 2015? Of those complaints received:

a. How many resulted in an OIG investigation?

b. How many were referred back to the VA?

OIG Response: As noted above, the OIG counts the number of ***contacts*** made to its Hotline. During FY 2015, the OIG received 38,098 contacts. The terms 'contact' and 'complaint' are not synonymous. A single contact may contain an allegation or multiple allegations and could be considered a complaint. Conversely, many contacts do not contain any allegations, such as when the caller has contacted the Hotline merely to request directory assistance to another component of VA.

During FY 2015, the OIG's Office of Investigations, Office of Audits and Evaluations, and Office of Healthcare Inspections collectively opened 225 cases as a result of Hotline contacts. It is important to keep in mind that a single OIG case can often address several complaints from many OIG contacts. For example, we received approximately 225 allegations regarding wait times issues during the course of our review of the 2014 Phoenix VA Health Care System wait times scandal. The overarching issues in these 225 allegations were addressed in one interim report and one final report.[1] The OIG also opens cases as a result of congressional mandates and requests; proactive investigative work; investigative leads from other sources; and planned/discretionary audits, reviews, and inspections.

For an additional 1,764 Hotline contacts, we initiated an external referral to VA under the process outlined in our response to Question 2 from Senator Baldwin. We also made non-case referrals to VA for another 497 Hotline contacts, which are also described in our response to Question 2 from Senator Baldwin. For more than 1,000 additional contacts, the OIG requested but did not receive the necessary consent from the complainant that would have allowed the OIG to take further action on the complaint.

Approximately 33,000 of the FY 2015 contacts to the OIG Hotline required no further action by the OIG because they regarded matters that were: 1) not allegations, 2) unrelated to VA programs or operations or from prolific communicators, 3) outside the OIG's jurisdiction, 4) able to be resolved through other avenues of redress (such as another VA office, Federal agency, or legal or administrative forum), 5) not logical or plausible, 6) too trivial, stale, or vague, 7) unsupported or invalidated by VA record checks, or 8) included as a component of an already open OIG case. Even though the OIG ultimately did not open cases for these contacts, OIG staff took action on every contact made to the Hotline. All contacts were reviewed by OIG staff, were entered into the OIG's system of records, and underwent a preliminary

[1] *Interim Report: Review of VHA's Patient Wait Times, Scheduling Practices, and Alleged Patient Deaths at the Phoenix Health Care System* (May 28, 2014) and *Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System* (August 26, 2014).

evaluation to determine whether the complaint or allegation merited further action. When possible, we also took steps to refer the complainant to the appropriate office or agency that could provide assistance.

6. **If complaints received by the OIG hotline in 2015 did not result in an OIG investigation or were not referred to the VA, what happened to them? Please provide a detailed review of how any remaining complaints were handled by the OIG after coming into the hotline.**

OIG Response: As noted above, the OIG takes some degree of action on ***all*** contacts made to the OIG Hotline. Each of the 38,098 contacts made to the OIG Hotline during FY 2015 was reviewed by OIG staff, entered into the OIG's system of records, and evaluated to determine whether the allegation merited further action. The review and evaluation of Hotline allegations is conducted by professionals in the OIG Hotline, and in many cases, by investigative, audit, and clinical professionals throughout the OIG offices of Investigations, Audits and Evaluations, Healthcare Inspections, and Contract Review.

As discussed in greater detail in response to Question 2 from Senator Baldwin, after the initial evaluation of every contact, the OIG takes no further action on matters that are not within VA's or the OIG's jurisdiction; can be addressed in another legal or administrative forum; are not logical, plausible, or supported by available VA records; or are too trivial, stale, or vague to warrant further review. When appropriate, we redirect complainants to the appropriate VA program office or Federal agency that can provide further assistance on matters not accepted by the OIG. There are also many instances where the OIG is able to immediately assess and invalidate the allegation by conducting a review of available VA records. In such instances, it is not necessary for the OIG to open a case even though we did take action during the preliminary evaluation to invalidate the complaint.

Below is a listing of the more common categories of contacts that receive little to no further action once they are reviewed, logged, and evaluated by OIG staff. As you will see, not all of the contacts were for the purpose of filing a complaint. For those that were making a new complaint, we determined the complaint was either outside the purview of the OIG; not supported by available VA records; or not logical, plausible, substantive, or credible enough to warrant further consideration. When possible, the OIG referred the complainant to the appropriate VA program office or Federal agency that can provide further assistance on the matter. In instances where the complainant was providing additional information for an existing contact or case, that information was reviewed and forwarded to the appropriate OIG staff.

No Complaint/Duplicate Complaint/Request for Information:
- Business Invitation
- Caller Ended Call
- Case Already Opened for Same Matter – No New Information Reported
- Dead Call

- Directory Assistance/Request for Information
- No Allegation – Caller is Merely Voicing Frustration
- Previous Closed Issue – No New Information Reported to Warrant Action
- Providing Additional Information for an Existing Case or Contact
- Request for Status of Case or Contact
- Request to Explain Hotline Process

Outside OIG Purview:

- Beneficiary Travel Reimbursement Claim Dispute
- Complaint is Already the Subject of a Tort Claim
- Department of Defense OIG Matter
- Department of Housing and Urban Development-Veterans Affairs Supportive Housing [HUD-VASH] Dispute
- Department of Labor/Workers' Compensation Claim
- Education Benefits Dispute
- FOIA Requests
- Individual Benefit Dispute
- Local Police Matter
- Non-VA Issue
- National Personnel Record Center Request
- OPM Matter
- ORM/Equal Employment Opportunity Matter
- OSC Matter
- Patient Advocate Matter
- Pension Management Center Issue
- Regional Loan Center Issue
- State Attorney General Matter
- Union/Human Resources Matter
- VA Life Insurance Issue
- VA Police Matter
- VBA Call Center Complaint

Not Logical/Plausible/Substantive/Credible:

- Benefit Fraud (no proof of alleged activity)
- Benefit Fraud (VA records did not support the allegation)
- General/Non-Specific Complaint/For Informational Purposes Only
- Not Credible/Too Old
- Preemptive Reporting
- Third Party Allegations/Hearsay

7. What steps are being taken to increase communication and improve the working relationship between the VA OIG and the Office of the Special Counsel?

OIG Response: One of my immediate priorities has been to understand and resolve the concerns between the OSC and the OIG so that we can maintain a positive and constructive relationship moving forward. I met with the Special Counsel and some of her senior staff within the first two weeks of becoming the Inspector General to listen to their views. I am very optimistic that this was a productive first step towards building a stronger relationship.

Moreover, we have streamlined processes to improve communication and our working relationship with OSC in several important ways. OSC has statutory authority to refer disclosures of information meeting certain criteria to VA for further investigation. OSC does not refer cases directly to the OIG. Before VA acts on these complaints, VA forwards them to the OIG so that the OIG can determine whether or not it has ongoing work that would already address those allegations.

In the past, the OIG did not have a reliable system for tracking these complaints, or for communicating clearly to VA what specific aspects of a case the OIG could address. To improve this process, these complaints are now referred to a single point of contact within the OIG, who reviews the complaints and determines whether there is substantial overlap with ongoing OIG work. If there is, the OIG communicates to VA precisely what specific allegations the OIG will address. This enables VA to determine how to best address any additional concerns contained within the OSC complaint.

The OIG will soon begin holding monthly conference calls to update OSC on the progress of cases which originated with OSC. We are also instituting a process for briefing OSC, similar to the briefings we provide to our congressional stakeholders, on OSC-related cases at the time of report publication.

To date, the OIG has received positive feedback from both OSC and VA on how the new process has been working. We will continue to look for ways to work effectively with OSC, as our office values whistleblowers and their role in improving the economy, efficiency, and effectiveness of VA.

MCI NUMBER	FISCAL YEAR	DATE RECEIVE	CLOSED DATE	TITLE	STATUS
2011-04479-IC-0144	2011	09/21/2011	10/14/2011	[redacted]	Closed

OFFICE ASSIGNED ACTION: IC-Central Fld Investigation (CHI)
FUNCTION CODE
FOIA REQUESTOR
INTEREST
ON BEHALF OF (FOIA

LEAD OIG POC NAME: JONES, JOHN B.

COMPLAINANT/CONGRESSIONAL REQUESTOR:
Name | Street | City | State | Zipcode | Work Phone | Home Phone

SUBJECT:
Name | Street | City | State | Zipcode | Work Phone | Home Phone
[redacted]

676-TOMAH

67-THREATS

REFERRAL:
L-State/Local Licensing Regulatory
Z3-AUSA

OTHER REFERENCE:
2011-04479-DC-0446-

WI
WI

HOTLINE CORRECT ACTION:

REPORT RECOMMENDATION:
REPORT NO | ISSUE DATE | TITLE | RECOMMENDATION

SYNOPSIS:
Investigation initiated based on a referral from the VA Police, VAMC Tomah, WI indicating that at veteran [redacted] made threatening statements to a VA medical triage operator via telephone to the Madison VAMC. [redacted] threatened that he was going to show up to his [redacted] 2011 Tomah VAMC appointment with a submachine gun with the intent that VAPD would kill him, and that if the policewere called, there will be shootout.

[redacted] was interviewed on 9/7/2011 and admitted making the aforementioned phone call, but stated he ha dno intentions to harm anyone or bring weapons to the VA. [redacted] had

SYNOPSIS: [redacted] numerous weapons around his home and presented a business card which purported [redacted] to be an ATF agent. This information was provided information to FBI, ATF, and La Crosse County Sheriff Department regarding [redacted].

The U.S. Attorney's Office of the Western District of Wisconsin declined prosecution for consideration by other authorities.

The Monroe County District Attorney's Office requested a copy of this report and advised they had received a May 2011 Tomah, WI Police Department threat case referral involving statements made by [redacted] to the Tomah VAMC. On 10/13/2011, ADA Kevin Croninger declined prosecution of this case, indicating that his office will address this matter through a pending State of Wisconsin case against [redacted]

MCI NUMBER	FISCAL YEAR	DATE RECEIVE	CLOSED DATE	TITLE	STATUS
2011-04479-DC-0446	2011	09/06/2011	09/21/2011	[redacted]	Closed

OFFICE ASSIGNED ACTION
DC-Central Fld Off Referral (INV/CHI)

FUNCTION CODE

INTEREST
ON BEHALF OF (FOIA

FOIA REQUESTOR

LEAD OIG POC NAME
JONES, JOHN B.

COMPLAINANT/CONGRESSIONAL REQUESTOR
Name Street City State Zipcode Work Phone Home Phone

SUBJECT
Name Street City State Zipcode Work Phone Home Phone
[redacted]

CONGRESS

DIVISION
676-TOMAH

67-THREATS

CROSS REFERENCE
2011-04479-IC-0144-

WI
WI

PHOTO/NE CORRECT ACTION

REPORT RECOMMENDATION
REPORT NO ISSUE DATE TITLE RECOMMENDATION

SYNOPSIS
Tomah VAPD notified CFO that on [redacted] 2011 veteran [redacted] called the Madison VAMC medical triage operator and stated that he was going to show up to his [redacted]/2011 Tomah VAMC appointment with a submachine gun with the intent that the VAPD would kill him. SA Jones and SA Ray Vasil interviewed [redacted] on 9/7/2011 who stated that he had no intentions to follow through with his statements, but was just frustrated. [redacted] had numerous weapons and purported himself to be an ATF agent. Information was shared with FBI, ATF, and La Crosse County Sheriff's Department.

MCI NUMBER	FISCAL YEAR	DATE RECEIVE	CLOSED DATE	TITLE	STATUS
2011-03435-DC-0335	2011	06/24/2011	06/27/2011	[redacted]	Closed

OFFICE ASSIGNED ACTION
DC-Central Fld Off Referral (INV/CHI)

FUNCTION CODE
FOIA REQUESTOR

INTEREST
ON BEHALF OF (FOIA

LEAD OIG POC NAME
PORTER, GREGORY

COMPLAINANT/CONGRESSIONAL REQUESTOR
[redacted]

SUBJECT
[redacted]

CONGRESS
[redacted]

LOCATION
676-TOMAH

PROG
67-THREATS

REFERRAL
[redacted]

CROSS REFERENCE
[redacted]

STATE
WI
WI

HOTLINE/CORRECTIVE ACTION
[redacted]

REPORT/RECOMMENDATION
[redacted]

SYNOPSIS
Tomah VA Police contacted 51CH to advise, for informational purposes only, of a veteran who may pose a public safety threat. Acting VA Police Chief Renay Seals advised that veteran [redacted] who receives care at the Tomah VAMC, was investigated by the Tomah, WI Police after his vehicle was left unattended near a Tomah Bank. Visible within the vehicle were disabled hand grenades, wire, rope and tape. The vehicle was inspected by the Tomah Police and Dane County Bomb Squad, who subsequently determined there was no explosive device within the vehicle. [redacted]ws located, interviewed and released without charge.

I made contact with the VA Police (Officer Johns and Acting Chief Seals) who advised the proper alerts were placed on the subject for monitoring while at the VAMC. I made contact with Lt. Waddell of the Tomah Police and provided him with my contact information should they need any future assistance from OIG.

MCI NUMBER	FISCAL YEAR	DATE RECEIVE	CLOSED DATE	TITLE	STATUS
2011-01995-HL-0491	2011	03/11/2011	05/06/2011		Closed

OFFICE ASSIGNED ACTION	FUNCTION CODE	INTEREST
HL-Hotline	A1B-MEDICAL CENTER	ON BEHALF OF (FOIA

LEAD OIG POC NAME	FOIA REQUESTOR
GAMBLET	

[redacted]

[redacted]

[redacted]

[redacted]

676-TOMAH

[redacted]

30-INAPPROPRIATE OR INCORRECT TREATMENT (Rx)

33-DELAY IN DIAGNOSIS OR TREATMENT

[redacted]

[redacted]

[redacted]

WI

[redacted]

CASE CLOSED/UNFOUNDED

A VHA review determined that the allegations were unfounded. The care provided by the Nurse Practitioner was considered appropriate and correct given the duration and nature of the presenting symptoms and physical findings. There were no actions identified as needed by the Tomah VA Medical Center in response to the investigation of inappropriate or incorrect treatment.

The Tomah VA Medical Center Policy PC-14, "Ordering and Reporting Test Results," states that non-critical, non-emergent, or normal test results will be communicated within seven days. The throat culture was negative. The communication of results was processed within the expected seven day time frame. There would be no reason to call the patient given the negative results; the medications ordered would continue to be appropriate.

There were no delays in treatment due to the response of the Wausau Outpatient Clinic [redacted] chose to seek care in the private sector for reasons unknown to our staff when his symptoms continued. He had previous experience with the VA triage system which resulted in getting an appointment quickly. Rather than going to the emergency room, he could have called Tomah VAMC on Saturday, December 18, 2010, at which time he would have been triaged for care appropriately.

[redacted]

[redacted] alleges that on [redacted], 2010, the VA Outpatient Clinic Wausau, WI failed to properly diagnose his ailments and did not provide proper follow-up care.

[redacted] alleges that he informed his PCP that he was experiencing pain in his esophagus after swallowing and was unable to eat or drink water, and the symptoms did not appear to be associated with the symptoms of strep throat. The PCP did a strep test and also treated him for stomach acid overproduction. [redacted] alleges he received the results seven days later with no follow-up phone call or visit regarding his ailments.

On [redacted], 2010, he went to the emergency room (ER) in an extremely dehydrated state and was diagnosed with a viral infection causing esophagitis and esophageal ulcers.

MCI NUMBER	FISCAL YEAR	DATE RECEIVE	CLOSED DATE	TITLE	STATUS
2011-01068-DC-0083	2011	12/28/2010	12/28/2010	[redacted]	Closed

OFFICE ASSIGNED ACTION
DC-Central Fld Off Referral (INV/CHI)

FUNCTION CODE

INTEREST

FOIA REQUESTOR

ON BEHALF OF (FOIA

LEAD OIG POC NAME
PORTER, GREGORY

COMPLAINANT/CONGRESSIONAL REQUESTOR
[redacted]

SUBJECT
[redacted]

CONGRESS
[redacted]

LOCATION
676-TOMAH

NOC
159-SEXUAL ASSAULT

REFERRAL
[redacted]

CROSS REFERENCE
[redacted]

STATE
WI
WI

ROUTINE/CORRECTACTION
[redacted]

REPORT RECOMMENDATION

REPORT NO	ISSUE DATE	TITLE	RECOMMENDATION
[redacted]			

SYNOPSIS
Tomah VA Police UOR#2010-12-27-0951-4237

On 12/28/10, the Tomah VA Police forwarded a report of an alleged sexual assualt reported by Tomah inpatient [redacted] alleged that on 12/25/10, he was approached by a male subject, who identified himself as [redacted], in the building 400 smoking shelter. After small talk, [redacted] went with [redacted] to a nearby bathroom where [redacted] instructed [redacted] to performed oral sex on [redacted] in a bathroom stall. [redacted] did as instructed. Once completed [redacted] left without incident.

[redacted] initially reported the oral sex act as coerced, however later admitted to VA Police Officers the act was consensual, as he "is gay, and didn't mind at the time". He went on to state he made the report because he was scared he may have been infected with a sexually transmitted disease.

SYNOPSIS: [redacted] is described as a heavy set, large black male with a gray stubbled beard.

The VA Police closed the case with no further leads. No further action is being taken by OIG at this time.

MCI NUMBER	FISCAL YEAR	DATE RECEIVE	CLOSED DATE	TITLE	STATUS
2011-00962-HL-0194	2011	12/16/2010	02/09/2011		Closed

OFFICE ASSIGNED ACTION	FUNCTION CODE	INTEREST
HL-Hotline	A19-MEDICAL CENTER	ON BEHALF OF (FOIA

LEAD OIG POC NAME	FOIA REQUESTOR
SMITHD	

COMPLAINANT/CONGRESSIONAL REQUESTOR

SUBJECT

CONGRESS

LOCATION
676-TOMAH

NOC
101-PROBLEMS WITH FACILITIES AND SERVICES
102-EXCESSIVE WAITING TIME

REFERRAL

CROSS REFERENCE

STATE
WI

ROI/NEC/CORRECTIVE ACTION
A VHA review concluded PTSD patients are experiencing a delay in wait time for follow-up appointments. The review concluded that there is a clinical position open at the CBOC that has not yet been filled. Management has implemented a plan to better serve veterans they are trailing a psychotherapy orientation group at the medical center in the near future. There will be efficiency gained with one or two providers seeing a small group of 4 - 8 veterans. The other gain will be a decrease in the number of "no shows" that a provider experienced.

REPORT/RECOMMENDATION

REPORT NO.	ISSUE DATE	TITLE	RECOMMENDATION

SYNOPSIS
Hotline received a complaint from an anonymous source who alleged that PTSD patients assigned to the Mental Health Care clinics at the medical center and Wausau CBOC, are experiencing a two month delay for scheduled follow-up appointments.

MCI NUMBER	FISCAL YEAR	DATE RECEIVE	CLOSED DATE	TITLE	STATUS
2010-02355-HI-0242 H01	2010	09/08/2010	09/08/2010	Healthcare Inspection Review of Quality of Care Issues Tomah VA Medical Center and William S. Middleton Memorial Veterans Hospital, Tomah and Madison, Wisconsin	Implemented

OFFICE ASSIGNED ACTION
HI-Healthcare

FUNCTION CODE
H01-SECRETARY

INTEREST
ON BEHALF OF (FOIA

LEAD OIG POC NAME

FOIA REQUESTOR

COMPLAINANT/CONGRESSIONAL REQUESTOR
Name Type Street City State Zipcode Work Phone Home Phone

SUBJECT
Name Type Street

CONGRESS

LOCATION
676-TOMAH

NOTES

REFERRAL

CROSS REFERENCE

STATE
WI
WI

ROUTINE CORRECTACTION

REPORT/RECOMMENDATION
REPORT NO ISSUE DATE TITLE RECOMMENDATION

SYNOPSIS
Healthcare Inspection Review of Quality of Care Issues Tomah VA Medical Center and William S. Middleton Memorial Veterans Hospital, Tomah and Madison, Wisconsin

MCI NUMBER	FISCAL YEAR	DATE RECEIVE	CLOSED DATE	TITLE	STATUS
2010-02867-DE-0027	2010	06/30/2010	07/01/2010	[redacted]	Closed

OFFICE ASSIGNED ACTION
DE-Investigation Computer Referrals

FUNCTION CODE

FOIA REQUESTOR

INTEREST
VA OIG Investigation

LEAD OIG POC NAME
STUMME WILLIAM F

ON BEHALF OF (FOIA

COMPLAINANT/CONGRESSIONAL REQUESTOR
Name

SUBJECT
Name

[redacted]

CONGRESS

LOCATION
676-TOMAH

VOL
117-CHILD PORNOGRAPHY VA SYSTEMS
120-ADULT PORNOGRAPHY VA SYSTEMS

REFERRAL

CROSS REFERENCE
2010-02867-DC-0288-

STATE
WI
WI

ROUTINE CORRECTION

REPORT RECOMMENDATION
REFERRAL ISSUE DATE TITLE RECOMMENDATION

SYNOPSIS
Veterar [redacted] was seen viewing adult and child pornography on a VA network computer at the Tomah VAMC. Computer was secured and put into evidence by VAPD on 5/28/2010. SA Jones took possession of the evidence on 6/3/2010.

CCFL review of computer found no indications of viewing/possessing Child Pornographyon the submitted hard disk drive. Drive returned to SA Jones.

MCI NUMBER	FISCAL YEAR	DATE RECEIVE	CLOSED DATE	TITLE	STATUS
2010-02867-DC-0288	2010	06/03/2010	07/29/2010	[redacted]	Closed

OFFICE ASSIGNED ACTION
DC-Central Fld Off Referral (INV/CHI)

FUNCTION CODE

INTEREST

FOIA REQUESTOR

ON BEHALF OF (FOIA

LEAD OIG POC NAME
JONES, JOHN B.

COMPLAINANT/CONGRESSIONAL REQUESTOR

[redacted]

CONGRESS

LOCATION
676-TOMAH

NOC
116-CHILD PORNOGRAPHY (GENERAL)
117-CHILD PORNOGRAPHY VA SYSTEMS
119-ADULT PORNOGRAPHY (GENERAL)
120-ADULT PORNOGRAPHY VA SYSTEMS

REFERRAL

CROSS REFERENCE
2010-02867-DE-0027-

STATE
WI
WI

HOTLINE/CORRECTIVE ACTION

REPORT RECOMMENDATION

REPORT NO	ISSUE DATE	TITLE	RECOMMENDATION

SYNOPSIS
Veteran patient [redacted] was seen viewing adult pornography on www.handjob.com on a VA network computer at the Tomah VAMC. The computer was secured and put into evidence by VAPD on 5/28/2010. A review of the internet history revealed "teen" porn websites were accessed and it was suspected that child pornography may have been viewed. VAPD requested assistance from 51CH. SA Jones took possession of the evidence on 6/3/2010.

[redacted]

On 6/15/2010 SA Jones witnessed Mark Smith (53CH) remove the hard drive from the computer. An Action Lead and the hard drive were sent to 51E for analysis of the hard drive for child pornography on 6/29/2010. CCFL SA Wil Stumme reviewed the hard drive and found no indications of viewing/possessing child pornography. The hard drive was returned to SA Jones on 7/1/2010. The hard drive was reinstalled into the computer by Smith and witnessed by SA Jones on 7/22/2010. All items turned over to SA Jones from VAPD were returned on 7/28/2010.

This matter is closed due to no child pornography on the hard drive.

MCI NUMBER	FISCAL YEAR	DATE RECEIVE	CLOSED DATE	TITLE	STATUS
2010-02355-HI-0299	2010	05/05/2010	09/08/2010	HL MADISON, WI - HEART MEDICATION CHANGE/PATIENT DEATH / Healthcare Inspection - Quality of Care Issues, Tomah VA Medical Center and William S. Middleton Memorial Veterans Hospital, Tomah and Madison, Wisconsin	Closed

OFFICE ASSIGNED ACTION
HI-Healthcare

FUNCTION CODE

INTEREST

LEAD OIG POC NAME
REED, JENNIFER

FOIA REQUESTOR

COMPLAINANT/CONGRESSIONAL REQUESTOR

Name	Street	City	State	Zipcode	Work Phone	Home Phone
DAVID OBEY		WASHINGTON	DC	20515		

SUBJECT

CONGRESS
David R. Obey

LOCATION
607-MADISON
676-TOMAH

AOI
30-INAPPROPRIATE OR INCORRECT TREATMENT (Rx)
33-DELAY IN DIAGNOSIS OR TREATMENT

REFERRAL

CROSS REFERENCE

STATE
WI
WI

POTENTIAL CORRECTIVE ACTION

REPORT RECOMMENDATION

REPORT #	SUBMIT DATE	TYPE	RECOMMENDATION

SYNOPSIS
Rep. David Obey on behalf of [redacted]

The Secretary was contacted by Rep. Obey concerning the death of [redacted] [redacted] alleges that her husband received poor care. The Secretary asked the OIG to review the care provided to [redacted]

[redacted]

Referred to our Chicago Office and Dr. Wesley

Continue w/interviews and the draft report is in process.

6/28/10 preliminary draft report sent to Dr. Wesley.

7/21/10 Report in progress.

7/22/10 Report sent to 54A for review.

7/29/10 Report sent to VISN/Med Center Directors for response due August 13.

8/11/10 Report received from VISN/Med Center Directors.

8/19/10 Final report sent to 54.

8/31/10 Report sent to ERD for publication.

MCI NUMBER	FISCAL YEAR	DATE RECEIVE	CLOSED DATE	TITLE	STATUS
2010-02391-DC-0226	2010	04/30/2010	05/03/2010	[redacted]	Closed

OFFICE ASSIGNED ACTION	FUNCTION CODE	INTEREST
DC-Central Fld Off Referral (INV/CHI)	FOIA REQUESTOR	ON BEHALF OF (FOIA

LEAD OIG POC NAME
JONES, JOHN B.

COMPLAINANT/CONGRESSIONAL/REQUESTOR
[redacted]

SUBJECT
[redacted]

CONGRESS
[redacted]

LOCATION
676-TOMAH

NOC
67-THREATS

REFERRAL
[redacted]

CROSSREFERENCE
[redacted]

STATE
WI
WI

HOTLINE/CORRESPONDENCE
[redacted]

REPORT/RECOMMENDATION

REPORT NO	ISSUE DATE	TITLE	RECOMMENDATION

SYNOPSIS
Iron Moutain VAPD Lt. Brian Boldon contacted the writer that veterar [redacted] had made a threat towards VAPD Chief Roberto Obong of bodily harm. [redacted] had made these statements to a VA doctor based at the Milwaukee VAMC during telemental health treatment. [redacted] was previously arrested for possession at the Tomah VAMC and is now inpatient at Iron Mountain VAMC.

Chief Obong was notified and precautionary actions were taken. This matter is closed.

MCI NUMBER	FISCAL YEAR	DATE RECEIVE	CLOSED DATE	TITLE	STATUS
2010-02355-CR-0044	2010	04/29/2010	09/08/2010	PRESCRIPTION CHANGE	Closed

OFFICE ASSIGNED ACTION	FUNCTION CODE	INTEREST
CR-Congressional Relations	FOIA REQUESTOR	ON BEHALF OF (FOIA

LEAD OIG POC NAME
GROMEK, CATHERINE

COMPLAINANT/CONGRESSIONAL REQUESTOR

DAVID OBEY WASHINGTON DC 20515

SUBJECT

CONGRESS
DAVID OBEY

LOCATION
607-MADISON
676-TOMAH

ROI
107-OTHER QUALITY OF CARE ISSUES

REFERRAL

CROSS REFERENCE

STATE
WI
WI

NOTIFICATION/CORRECTIVE ACTION

REPORT RECOMMENDATION
REPORT ID ISSUE DATE TITLE RECOMMENDATION

SYNOPSIS
Rep. David Obey on behalf of [redacted]

The Secretary was contacted by Rep. Obey concerning the death of [redacted] [redacted] alleges that her husband received poor care. The Secretary asked the OIG to review the care provided to [redacted]

MCI NUMBER	FISCAL YEAR	DATE RECEIVE	CLOSED DATE	TITLE	STATUS
2010-02429-DC-0230	2010	04/21/2010	05/04/2010	VETERAN [redacted] MISSING MEDICATION	Closed

OFFICE ASSIGNED ACTION	FUNCTION CODE	INTEREST
DC-Central Fld Off Referral (INV/CHI)	FOIA REQUESTOR	ON BEHALF OF (FOIA

LEAD OIG POC NAME
WILSON, STEVEN L.

COMPLAINANT/CONGRESSIONAL REQUESTOR
[redacted]

SUBJECT
[redacted]

CONGRESS
[redacted]

DIVISION
676-TOMAH

NOC
66-THEFT OF GOVERNMENT FUNDS OR PROPERTY
22-DIVERSION/SALE OF CONTROLLED PHARMACEUTICALS

REFERRAL
[redacted]

CROSS REFERENCE
[redacted]

STATE
WI
WI

HOTLINE/CORRECTIVE ACTION
[redacted]

REPORT RECOMMENDATION
[redacted]

SYNOPSIS
A referral was received from VAMC Tomah, Wisconsin Police Officer Jennifer Carpenter alleging that an unknown individual stole a veteran's prescription medication before it arrived at his P.O. box. Specifically, on 3/29/2010 veteran [redacted] went to the VAMC police department and reported that he did not receive his prescription for Levitra (vardenafil). [redacted] advised that he checked with the pharmacy and was told that his medication was mailed to his P.O. box on 3/15/2010 and was delivered on 3/18/2010. [redacted] stated that this was the third or fourth package of Levitra he did not receive. [redacted] was told to file a report with the Tomah, WI Police Department. On 3/31/2010 [redacted] advised that he filed a report with the Tomah Police Department regarding his missing medication.

This matter is closed because it has been reported to local authorities. Office Carpenter was notified of same.

MCI NUMBER	FISCAL YEAR	DATE RECEIVE	CLOSED DATE	TITLE	STATUS
2010-02248-OC-0211	2010	04/19/2010	09/02/2010	MISSING OXYCODONE [redacted]	Closed

OFFICE ASSIGNED ACTION
DC-Central Fld Off Referral (INV/CHI)

FUNCTION CODE

INTEREST

FOIA REQUESTOR

ON BEHALF OF (FOIA

LEAD OIG POC NAME
VASIL, RAYMOND P

COMPLAINANT/CONGRESSIONAL REQUESTOR
[redacted]

SUBJECT
[redacted]

CONGRESS

LOCATION
676-TOMAH

NHOC
22-DIVERSION/SALE OF CONTROLLED PHARMACEUTICALS

REFERRAL

CROSS REFERENCE

STATE
WI
WI

ROUTINE/CORRECTIVE ACTION

REPORTS RECOMMENDATION
REPORT NO | ISSUE DATE | TITLE | RECOMMENDATION

SYNOPSIS
Referral from Tomah, WI VA Police who advised that veteran [redacted] contacted them to advise that he recently received his VA prescription of Percocet and was missing 20 tabs. He suspects the UPS driver because the package was opened upon his reciept. The driver told [redacted]'s girlfriend that the package was tore on a nail or screw. I contacted AJ Jackson, the UPS security chief for Wisconsin and advised him of the incident. Jackson advised he was aware of the incident and would advise if they discovered a suspect.

As of 9/2/2010 UPS security has not been able to discover a suspect for the missing drugs. This case is now closed pending UPS finding additional information.

RV 9/2/2010

MCI NUMBER	FISCAL YEAR	DATE RECEIVE	CLOSED DATE	TITLE	STATUS
2010-02303-DC-0217	2010	04/07/2010	04/23/2010	[redacted]	Closed

OFFICE ASSIGNED ACTION	FUNCTION CODE	INTEREST
DC-Central Fld Off Referral (INV/CHI)	FOIA REQUESTOR	ON BEHALF OF (FOIA

LEAD OIG POC NAME
HIRSTEIN, GREGG A.

COMPLAINANT/CONGRESSIONAL REQUESTOR
[redacted]

SUBJECT
[redacted]

CONGRESS
[redacted]

LOCATION
676-TOMAH

NOD
66-THEFT OF GOVERNMENT FUNDS OR PROPERTY
22-DIVERSION/SALE OF CONTROLLED PHARMACEUTICALS

REFERRAL
[redacted]

CROSS REFERENCE
[redacted]

STATE
WI
WI

OTHER CORRECTIVE ACTION
[redacted]

REPORT RECOMMENDATION
[redacted]

SYNOPSIS
This is filed for info only. Per VAPD, on [redacted]/2010 veteran [redacted] received 180 vicodin tablets from the Tomah VAMC. Over the next two days Ditello spent most of his time at a motel and being driven around by [redacted] at various locations outside the VAMC. (At one point [redacted] was taking [redacted] to the VAMC, but [redacted] is not a VA driver per se. They did not get to the VAMC because they got lost.) [redacted] came back to the VAMC on 4/1/10 via a taxi cab for health care treatment. While there [redacted] reported that 169 of his 180 vicodin tablets were missing. While interviewing [redacted] at the VAMC, VAPD noticed items in his possession of obvious value, i.e collectable coins, etc. Tomah PD later contacted VAPD looking for the items which had been taken in a home burglary. Tomah PD came to the VAMC, retrieved the items as evidence, and arrested [redacted] for burglary. Based upon motel and gas receipts [redacted] can show he was with [redacted] but he cannot prove (although he alleges) that [redacted] stole his meds. The disappearance of [redacted] meds will not be addressed by the

[redacted]
VAOIG as it does not appear to have occurred on VA property.

MCI NUMBER	FISCAL YEAR	DATE RECEIVE	CLOSED DATE	TITLE	STATUS
2010-01860-DC-0172	2010	03/15/2010	03/15/2010	[redacted]	Closed

OFFICE ASSIGNED ACTION	FUNCTION CODE	INTEREST
DC-Central Fld Off Referral (INV/CHI)	FOIA REQUESTOR	ON BEHALF OF (FOIA

LEAD OIG POC NAME
VASIL, RAYMOND P

COMPLAINANT/CONGRESSIONAL REQUESTOR

SUBJECT

[redacted] Tomah VAMC
Tomah VAMC
Tomah VAMC

CONGRESS

LOCATION
676-TOMAH

ALLEGATION
159-SEXUAL ASSAULT

REFERRAL

CROSS REFERENCE

STATE
WI
WI

NOTE/RECORRECTION

REFORM RECOMMENDATION
REFERRED TO | DUE DATE | TITLE | RECOMMENDATION

SYNOPSIS
Referral from Tomah VAPD Lt. Boldon who advised VAMC psych patient [redacted] alleged fellow patients [redacted] sexually assaulted him in his room on ward 408b. According to Boldon, [redacted] stated that at approximately 0200hrs on [redacted] 2010 he woke up after [redacted] removed [redacted] pants. [redacted] was able to force [redacted] off of him, [redacted] then attempted to place his "dong" in [redacted] mouth. [redacted] advised that [redacted] was unsuccessful and the two then left. [redacted] believed both [redacted] and [redacted] were "queer" and attempting to make him "queer". When interviewed by VAPD [redacted] advised staff and patients were all "queer" on 408b and he wished to be transferred to another ward. VAPD interviewed both suspects who denied the incident. [redacted] was examined by medical staff and no signs of assault were present. Staff on the ward were interviewed by VAPD and advised that [redacted] suffers from paranoid schizophrenia and routinely reports unsubstantiated attacks. [redacted] room is across from the nurses' station and nurses interviewed advised that they did not see anyone enter [redacted] room

[redacted]
the night of the alleged incident. VAPD and staff believe that this event did not occur and it is either part of [redacted] illness or an attempt by him to get to a less restrictive ward. This case is considered closed but will be re-opened if additional evidence sufaces. RV

MCI NUMBER	FISCAL YEAR	DATE RECEIVE	CLOSED DATE	TITLE	STATUS
2010-00568-HL-0141	2010	11/16/2009	03/30/2010		Closed

OFFICE ASSIGNED ACTION	FUNCTION CODE	INTEREST
HL-Hotline	A01-INPATIENT MEDICAL CARE	ON BEHALF OF (FOIA

LEAD OIG POC NAME	FOIA REQUESTOR
SMITHO	

COMPLAINANT/CONGRESSIONAL REQUESTOR

Name	Street	City	State	Zipcode	Work Phone	Home Phone
CAROLE PEDERSON-WATERS	907 E Monowau Street, Apt. 4	Tomah	WA	54660		

SUBJECT

Name	Street	City	State	Zipcode	Work Phone	Home Phone
[redacted]						

CONGRESS

LOCATION
676-TOMAH

ROI
107-OTHER QUALITY OF CARE ISSUES
38-POOR COMMUNICATIONS WITH PATIENT/FAMILY
107-OTHER QUALITY OF CARE ISSUES
107-OTHER QUALITY OF CARE ISSUES
107-OTHER QUALITY OF CARE ISSUES
107-OTHER QUALITY OF CARE ISSUES
107-OTHER QUALITY OF CARE ISSUES
107-OTHER QUALITY OF CARE ISSUES

REFERRAL

CROSS REFERENCE

STATE
WI

HOTLINE CORRESPONDENCE
A VHA review of patient's medical records concluded he received appropriate care according to his ailments. The review also concluded the medical staff communicated with patient's family according to policy and procedures.

REPORT RECOMMENDATION

REFERENCE	ISSUE DATE	TITLE	RECOMMENDATION

SYNOPSIS: [redacted] reported to Hotline that in April 2007 while on Unit 406A the medical center failed to provide her father [redacted] with proper care in [redacted] 2007.

[redacted] alleged that [redacted]'s health began to deteriorate after he was transferred on [redacted], 2007, to Unit 406A against the family's wishes. [redacted] alleged she presented to the patient advocate concerning the transfer and was advised that if she did not like it, she could take him outside to another facility.

[redacted] alleged that when they inquired about [redacted]'s care [redacted] made the statement "that he is an old man, what do you want me to do."

[redacted] alleged that a request submitted by the family to [redacted]'s physician to continue his therapy after he was transferred to Unit 406A was denied.

[redacted] alleged that staff failed to remove [redacted]'s catheter while he was being treated with antibiotics for a bladder infection.

[redacted] alleged that on numerous occasions she had to make sure [redacted] was getting enough water, because staff would not provide him with any.

[redacted] alleged that [redacted] experienced a delay in staff turning him or placing him in his wheelchair in a timely manner causing him to develop bedsores.

[redacted] also alleged as a result of staff failing to treat [redacted] with antibiotics after he developed an infection, he coded and had to be transferred to Gunderson Lutheran Hospital.

MCI NUMBER	FISCAL YEAR	DATE RECEIVE	CLOSED DATE	TITLE	STATUS
2009-03733-DC-0341	2009	09/21/2009	10/13/2009	[redacted]	Closed

OFFICE ASSIGNED ACTION
DC-Central Fld Off Referral (INV/CHI)

FUNCTION CODE

INTEREST

FOIA REQUESTOR

ON BEHALF OF (FOIA

LEAD OIG POC NAME
JONES, JOHN B.

COMPLAINANT/CONGRESSIONAL/REQUESTOR
[redacted]

SUBJECT
[redacted]

CONGRESS
[redacted]

LOCATION
676-TOMAH

NATURE
159-SEXUAL ASSAULT

REFERRAL
[redacted]

CROSS REFERENCE
[redacted]

STATE
WI
WI

HOTLINE/CORRECTIVE ACTION
[redacted]

REPORT/RECOMMENDATION
[redacted]

SYNOPSIS
Tomah VAPO Chief Brian Boldon referred an allegation that a VA employee had inappropriate contact with a veteran patient. On 6/21/2009 Tomah VAMC veteran patient, [redacted] alleged that VAMC [redacted] would straddle the veteran's leg when taking his vitals and would rub his genitals on the veteran's leg. This occurred on occasion in 2006 and 2008.

[redacted] was previously investigated by an AIB dated [redacted] 2008 for inappropriate behavior with a VA patient off of VAMC grounds. [redacted] befriended veteran patient, [redacted] who [redacted] interacted with socially. After a night of drinking together and sitting on the couch together, [redacted] woke up and found [redacted] with his hand down [redacted] pants. [redacted] proceeded to assault [redacted] and [redacted] Police Department responded to the incident. [redacted] declined to press charges and stated that it was a misunderstanding. [redacted] received medical attention for his injuries. The AIB concluded that [redacted] violated staff/patient boundaries and on [redacted]/2008 [redacted] engaged in a sexual assault of [redacted]. [redacted] was not found to be entirely credible or consistent in his recounting of events and he expressed elements of deception during testimony to the AIB.

[redacted] was interview at his home on [redacted] 2009 and stated that he had resigned from the VAMC on [redacted] 2009 just before the findings from the AIB were released. He was employed at the Tomah VAMC for 6 years. He is currently employed as a [redacted] nursing home. [redacted] stated that he never touched VA patients inappropriately. He would check vitals of patients normally, to which he demonstrated with a simulated patient on a table. [redacted] would stand next to the veteran and there may have been incidental body contact. [redacted] also stated that Snyder had tried to blackmail him. The incident occurred after they both were drinking and had passed out. [redacted] assaulted him and made the statements that [redacted] had put his hand down [redacted] pants. [redacted] stated that the [redacted] PD investigated and the ADA did not file any charges on [redacted]. [redacted] stated that it was possible that he may have touched [redacted], but they were both drunk. [redacted] wanted to move on.

This matter is closed as the allegation could not be substantiated.

MCI NUMBER	FISCAL YEAR	DATE RECEIVE	CLOSED DATE	TITLE	STATUS
2009-03362-IC-0101	2009	09/10/2009	08/24/2010	[redacted]	Closed

OFFICE ASSIGNED ACTION
IC-Central Fld Investigation (CHI)

FUNCTION CODE
FOIA REQUESTOR

INTEREST
ON BEHALF OF (FOIA

LEAD OIG POC NAME
PORTER, GREGORY

COMPLAINANT/CONGRESSIONAL REQUESTOR
[redacted]

SUBJECT
[redacted]

CONGRESS
[redacted]

LOCATION
676-TOMAH

NOC
42-GUARDIANSHIP/FIDUCIARY FRAUD

REFERRAL
Z3-AUSA

CROSS REFERENCE
2009-03362-DC-0313-

STATE
WI
WI

[redacted]

REPORT RECOMMENDATION
[redacted]

SYNOPSIS
Case initiated based on a referral from the Tomah VA Police. Sgt. Brian Boldon upon receipt of information from [redacted] alleging that [redacted] has been misappropriating the funds of her father, incompetent veteran [redacted], an inpatient at the Tomah VAMC. [redacted] is [redacted] court-appointed guardian and VA-appointed fiduciary. [redacted] specifically advised that [redacted] bank account is depleted and he has very low monthly expenses. [redacted] advised she also reported the information to the [redacted] WI Police Department, which was conducting a local investigation of the matter.

SYNOPSIS

VA records inquiries revealed [redacted] was appointed [redacted] VA fiduciary in August 2007, when [redacted] was rated incompetent. From that date to present, [redacted] has been issued approximately $72,000 in VA benefit payments. Chief Dan Burgess, [redacted], WI Police Department, has initiated subpoenas for [redacted] bank records of [redacted] and [redacted].

On 08/25/09, [redacted] was interviewed and she admitted to misusing her father's funds for personal gain and gambling. She provided a voluntary sworn written statement.

This case was referred to the U.S. Attorney's Office the Western District of Wisconsin, but was declined due to the fact that veteran [redacted] has died and suspect [redacted] has inherited his estate. There is no monetary loss to the VA.