United States Senate

COMMITTEE ON
HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS

WASHINGTON, DC 20510–6250

February 4, 2015

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

Dear Secretary McDonald:

I write to request your assistance in addressing the problems at the Veterans Affairs Medical Center (VAMC) in Tomah, Wisconsin. According to media reports, two veterans who received treatment at the facility for post-traumatic stress disorder died of drug overdoses.[1] I am deeply troubled by these reports and by the allegations of suspected prescription drug diversion and a culture of retaliation against whistleblowers at the Tomah VAMC.[2]

It is important for Congress to get to the bottom of these problems and ensure accountability for the veterans who receive care at the Tomah VAMC. A VA Inspector General (IG) report from March 2014, which was released publically in early January 2015, highlighted many of the alleged abuses at the Tomah VAMC. Over the past few weeks my staff and I have heard from many constituents in Wisconsin who have shared similar concerns about the Tomah VAMC.

One area of concern is the alleged large volume of narcotic painkillers being prescribed by doctors at the Tomah VAMC. According to reports, "in 2004, the Tomah VA dispensed 50,000 oxycodone pills to roughly 25,000 veterans. By 2012, that number had grown to 712,000."[3] Patients received prescribed narcotic painkillers in such large volumes that some veterans labelled the Tomah VAMC "Candy Land."[4] According to one news report, patients called Dr. David J. Houlihan, the hospital's former chief of staff, "Candy Man" for "dop[ing] up" or "zombifi[ing]" patients.[5] This report suggests that the problems at the Tomah VAMC led to the deaths of two veterans.[6]

In order to gain a better understanding about the problems at the Tomah VAMC, I ask that you please provide the following information and material:

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[1] Aaron Glantz, *Opiates handed out like candy to 'doped-up' veterans at Wisconsin VA*, THE CENTER FOR INVESTIGATIVE REPORTING, Jan. 8, 2015, http://www.revealnews.org/article-legacy/opiates-handed-out-like-candy-to-doped-up-veterans-at-wisconsin-va.
[2] *Id.*
[3] *Id.*
[4] *Id.*
[5] *Id.*
[6] *Id.*

1. Was VA leadership in Washington, D.C., aware of the VA IG report dated March 2014 prior to its public release in January 2015? Please explain.

    a. If yes, please fully explain which official(s) were aware of the VA IG report and provide the date(s) on which the official(s) became aware.
    b. If yes, please fully explain what actions, if any, VA leadership in Washington, D.C., took prior to January 2015 to address the concerns highlighted in the VA IG report.

2. Was VA leadership in Washington, D.C., ever aware of concerns about suspected drug diversion at the Tomah VAMC prior to March 2014? If so, please provide the date the concern was raised, the nature of the concern, and VA's actions in addressing the concern.

3. Please identify the date on which employees of the Veterans Health Administration (VHA) first became aware of allegations of overmedication and prescription drug diversion at the Tomah VAMC, including but not limited to the following employees:

    a. Dr. Carolyn M. Clancy, the Interim VA Under Secretary for Health;
    b. The Principal Deputy Under Secretary for Health;
    c. The Deputy Under Secretary for Health for Operations and Management;
    d. The Deputy Under Secretary for Health for Policy and Services;
    e. The Assistant Deputy Under Secretary for Health for Clinical Operations;
    f. The Assistant Deputy Under Secretary for Health for Quality, Safety, and Value;
    g. The Director of the Office of Mental Health Operations; and
    h. Mario DeSanctis, the Director of the Tomah VAMC.

    For each of these employees, please explain how he or she became aware of the allegations of overmedication and prescription drug diversion, and what actions he or she took upon learning of the allegations.

4. Please identify the date on which employee(s) of the VHA Office of the Medical Inspector first became aware of allegations of overmedication and prescription drug diversion at the Tomah VAMC. Please identify the employee(s) who first became aware of these allegations, explain how they became aware, and explain what actions they took upon learning of the allegations.

5. Please identify the date on which employee(s) of the VHA Office of Patient Care Services first became aware of allegations of overmedication and prescription drug diversion at the Tomah VAMC. Please identify the employee(s) who first became aware of these allegations, explain how they became aware, and explain what actions they took upon learning of the allegations.

6. Please identify the date on which employees of the National Center for Patient Safety first became aware of allegations of overmedication and prescription drug diversion at the Tomah VAMC. Please identify the employee(s) who first became aware of these allegations, explain how they became aware, and explain what actions they took upon learning of the allegations.

7. Please identify the date on which employees of the VA Office of the General Counsel first became aware of allegations of overmedication and prescription drug diversion at the Tomah VAMC. Please identify the employee(s) who first became aware of these allegations, explain how they became aware, and explain what actions they took upon learning of the allegations.

8. Please explain the VA's decision to temporarily reassign Dr. David Houlihan. In particular, please answer the following questions:

    a. Why did the VA temporarily reassign Dr. Houlihan on or around January 15, 2015?
    b. Which VA official made the decision to reassign Dr. Houlihan?
    c. What factors and/or considerations did the VA assess in deciding to reassign Dr. Houlihan?

9. Please explain the VA's Department-wide policies and procedures for the prescription of narcotic painkillers. Please produce all such Department-wide policies and procedures.

10. Please explain how, if at all, the policies and procedures for the prescription of narcotic painkillers at the Tomah VAMC differ from the VA's Department-wide policies and procedures. Please produce all Tomah VAMC-specific policies and procedures.

11. Please provide a list of all pharmacies where patients of Dr. Houlihan filled a prescription for opioids. For each pharmacy, please provide:

    a. The date that prescription was filled;
    b. The pharmacist who filled the prescription;
    c. The narcotic that was prescribed; and
    d. The number of refills obtained per prescription.

12. Please produce Dr. David Houlihan's VA employee personnel file.

13. Please produce all documents and communications sent or received by Dr. David J. Houlihan referring or relating to the March 2014 Tomah VAMC IG inspection report.

14. Please produce all documents and communications sent or received by the unknown Nurse Practitioner, labeled "NP Y", referring or relating to the March 2014 Tomah VAMC IG inspection report.

15. Please provide all documents and communications between or among the VA and the DEA referring or relating to suspected drug diversion at the Tomah VAMC.

16. Please provide all documents and communications between or among the VA and the Tomah Police Department referring or relating to suspected drug diversion at the Tomah VAMC.

17. Please provide all documents and communications between or among the VA and the Milwaukee Police Department referring or relating to suspected drug diversion at the Tomah VAMC.

18. Please produce all documents and communications between or among the VA and the Department of Veterans Affairs Office of Inspector General referring or relating to suspected drug diversion at the Tomah VAMC.

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

The Committee on Homeland Security and Governmental Affairs is authorized by Rule XXV of the Standing Rules of the Senate to investigate "the efficiency, economy, and effectiveness of all agencies and departments of the Government."[7] Additionally, S. Res. 253 (113th Congress) authorizes the Committee to examine "the efficiency and economy of all branches of the Government including the possible existence of fraud, misfeasance, malfeasance, collusion, mismanagement, incompetence, corruption, or unethical practices . . . ."[8] For purposes of this request, please refer to the definitions and instructions in the enclosure.

Thank you for your prompt attention to this matter. If you have any questions regarding this letter, please contact Brian Downey or Kyle Brosnan of the Committee staff at (202) 224-4751.

Sincerely,

Ron Johnson
Chairman

cc: The Honorable Thomas R. Carper
Ranking Minority Member

Enclosure

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[7] S. Rule XXV(k); *see also* S. Res. 445, 108th Cong. (2004).
[8] S. Res. 253 § 12, 113th Cong. (2013).