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

---

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.

---

[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

[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.

---

[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.