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.