TAMMY BALDWIN
WISCONSIN

COMMITTEES:
HEALTH, EDUCATION, LABOR, AND PENSIONS
BUDGET
SPECIAL COMMITTEE ON AGING
COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS
COMMITTEE ON ENERGY AND NATURAL RESOURCES

United States Senate

WASHINGTON, DC 20510

January 27, 2015

The Honorable Carolyn M. Clancy, M.D.
Interim Under Secretary for Health
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Under Secretary Clancy:

I am writing to follow-up on our conversation last week regarding the investigation you are leading into allegations of improper opiate prescribing practices and abuse of administrative authority at the Tomah VA Medical Center. As we discussed, I am pleased that Secretary McDonald agreed to my request to initiate an investigation into these serious allegations and has tasked you—along with Ms. Meghan Flanz of the VA's Office of Accountability Review—to lead it. As you begin your investigation this week in Tomah, I wanted to convey the many serious concerns that have been brought to my attention since I began working on this issue last year so that you can address them in your investigation.

The March 2014 Office of Inspector General (OIG) review, media reports, and constituents have shed light on extremely troubling prescription drug practices and management issues at the Tomah facility as well as with the VA's national prescription drug policy. The March 2014 OIG report, which looked into allegations of extremely high levels of opioid painkiller prescriptions at Tomah, detailed amounts at "considerable variance" compared to other facilities and prescribers within Veterans Integrated Service Network (VISN) 12—the regional VA office that supervises Tomah and other VA facilities in Wisconsin, Illinois, Michigan, and Indiana. Indeed, out of the seven medical centers managed by VISN 12, the Tomah VA had by far the highest per patient dosage rate. It is clear that prescription drug distribution and the overall management at Tomah warrant a full investigation. Additionally, despite these alarming numbers, the OIG did not find evidence of wrongdoing, stating only that "allegations dealing with general overuse of narcotics at the facility may have had some merit." This conclusion seriously calls into question the Department of Veterans Affairs' national standard of care, and I would strongly encourage you to also initiate a national system-wide review of the VA's prescription drug policy to ensure that local VA medical centers—in Wisconsin and across the country—are receiving appropriate direction.

The aforementioned concerns are particularly troubling in light of the tragic death of former Marine Jason Simcakoski who passed away on August 30, 2014. My office received the OIG report on August 29th, 2014, and it did not address Mr. Simcakoski's death because the report was completed five months earlier in March 2014. However, we have since learned about some of the disturbing circumstances surrounding his death, and I believe this deserves your full attention. Accordingly, I

request that your review address the causes and circumstances that led to Mr. Simcakoski's death and include a review of the Tomah VA's investigation of his death.

There also have been extremely alarming allegations raised regarding VISN 12's management of its facilities, management and hiring practices at the Tomah VA, and the VA and the VA OIG's inability to effectively communicate problems identified at VA facilities. Therefore, I would encourage you to address the following in your investigation:

- Reports of veterans becoming addicted to drugs as a result of the prescribing practices at the Tomah VA.
- A comparison of Tomah's mental health treatment programs relative to best practices in mental health treatment programs within the national VA health system.
- The circumstances surrounding the hiring of the Tomah VA Chief of Staff, Dr. David Houlihan, a psychiatrist who reportedly engaged in an inappropriate relationship with a patient while practicing in Iowa.
- VISN 12's oversight of facilities within its jurisdiction.
- How the local and federal VA offices and facilities communicate—and respond to—OIG reports that recommend "administrative closure" but identify problems.
- The concerns raised by current and former Tomah VA employees, patients and their families.
- Allegations of retaliatory behavior against current and former employees at the Tomah VA as well as reports of a culture of fear and intimidation at the facility.
- Whether it would be appropriate for the Tomah VA to be under the direct supervision of a senior VA official from outside VISN 12 until the investigation is complete.
- Whether wrongdoing at the Tomah VA could warrant a criminal investigation.

Finally, I would strongly encourage you and your team to meet with the whistleblowers who have raised many of these concerns and to do so in a manner that allows individuals to be forthcoming. A broad and detailed investigation of both the Tomah VA and relevant aspects of the national VA health system will provide much needed accountability and information that will allow us to decide how we can best improve the delivery of timely and highest-quality care to veterans in Wisconsin and throughout the country. I look forward to working with you toward that goal.

Sincerely,

Tammy Baldwin
United States Senator

Cc: The Honorable Robert McDonald, Secretary, Department of Veterans of Affairs
Ms. Meghan Flanz, Co-Chair, VA Office of Accountability Review