I worked at the Tomah VA as a Clinical Pharmacy Specialist from July 2008 to June 2009. I was fired after refusing to fill several narcotic prescriptions prescribed by Dr. Houlihan that I believed to be unsafe. I filed a whistle blower complaint with the Office of Special Counsel, which was denied, and later the Merit System Protection Board. The VA requested federal mediation. I settled out of court in 2010. I was fully reinstated, my service computation date was moved back six months, and I received a monetary settlement.

The whole basis for my whistle blower complaint was that I refused to fill several of Dr. Houlihan's narcotic prescriptions that I did not believe to be safe. I do believe I was terminated for blowing the whistle as I was contacted by DEA and agreed to interview with them. I met with DEA agent Thomas Hill June 2009. I was fired a few weeks later. In my OSC complaint Dr. Houlihan and several others referenced that I turned him into the Inspector General, in which I did not. I believe that played into my termination, however Dr. Houlihan's retaliatory behavior is not the basis of your investigation. I truly believe that Dr. Houlihan is a very dangerous man. What makes him so dangerous is his lack of respect for the medication. Whatever his motives are for prescribing the current doses of medication is almost irrelevant. To this day I still question his motives, whether it be power, monetary gain, negligence, ignorance, or maybe all of the above. The truth of the matter, the quantities of narcotic medications coming out of the Tomah VA facility is irrefutably unsafe. This has been demonstrated by several cases of overdose and deaths. Over 2,000 911 calls from the Tomah VA Medical Center with 24 unexpected deaths over the last five years. There were three unexplained deaths in the Tomah VA parking lot in a matter of four months all Veterans receiving care from Dr. Houlihan just in the year time frame I spent at the Tomah VAMC.

The three questions that need to be asked are simple. First, what makes the Tomah VA patient population so 'complex' as the Tomah Director Mario DeSanctis put in his television debut, that they require the number of narcotics that are being dispensed? I am currently working as a double board certified Clinical Pharmacy Specialist in the Pain Management Clinic at the Des Moines VA. I am the facility lead for the National Opioid Safety Initiative. I can assure you the patients at the Tomah VA are no more complex than the patients we see daily at the Des Moines VA. We have an acute psych ward, a domiciliary with a substance abuse program, post traumatic stress recovery program, as well as several cognitive behavioral therapy recovery programs. We have a long term care facility where Veterans were rejected or denied care elsewhere just as those at the Tomah VA, and we are not prescribing even one fourth of the current narcotics they are. Specifically as the VHA directive is to limit morphine equivalents (MEQ) to less than 200mg/day and limit the combination of opioids and benzodiazepines due to increased rate of mortality. I do not believe Tomah would be in compliance with this National Directive as pointed out in Under Secretary Clancy's investigative teams' clinical review. Out of 18 patient reviews the team found "unsafe clinical practices at the Tomah VAMC in areas of pain management and psychiatric care. Six out of 18 cases revealed patient harm attributable to prescribing practices. Nine of 18 lacked evidence of changing the treatment in the face of aberrant behaviors and twelve of 18 demonstrated extensive use of opioids and benzodiazepines. Tomah Veterans were 2.5 times more likely than the national average to be prescribed opioids greater than 400mg of MEQ. The Tomah VA was found to prescribe benzodiazepines in combination with opioids at almost double the

national average." Dr. Houlihan used to reference his own case studies as documentation and justification to why he used benzodiazepines to treat Post Traumatic Stress Disorder which is not currently recommended or standard of care. Use of benzodiazepines in PTSD treatment has been shown to worsen the condition and cause harm. Not only were these Veterans treated inappropriately with benzodiazepines often in doses well above the maximum recommended daily doses, but in combination with opioids which is also not recommended due to the increased mortality rate in combination. I am struggling to understand the variance between what the Under Secretary's Team found and the report that was administratively closed by the Inspector General. It was noted in the Inspector General's report that they "did not substantiate the allegation that opioids were prescribed inappropriately to specific individuals or in inappropriate doses." They did however find that "opioids prescribed by Dr. Houlihan and Deb Frasher in aggregate and to individual patients were at considerable variance compared with most opioid prescribers in VISN 12." Unfortunately for all Veterans receiving care at the Tomah VA, the "considerable variance" wasn't enough to warrant serious consideration by the Inspector General as the investigation was administratively closed leading to continued harm to our nations Veterans.

Secondly, exactly what type of 'pain' is the Tomah VA treating that they are prescribing these dangerous quantities and dosages of opioids published in the most recent investigations. Studies show there is no proven long term benefit of opioid medications let alone at the significant doses being prescribed. As a pain specialist I can assure you if someone is actually taking that amount of opioids they would have serious side effects including respiratory depression and constipation. Many would be experiencing hyperanalgesia due to overloading the Mu receptor which leads me to believe that Veterans are not taking all of the prescribed medications and are at high risk for diversion. This was a "substantiated" finding by the Inspector General. They substantiated the allegation that negative urine drug screens (UDS) were not acted on and that controlled substances were still prescribed in the face of negative urine drug screen. They found that for some patients, when a UDS was performed and showed absence of prescribed medication, documentation in progress notes did not always acknowledge this or indicate what, if any, clinical intervention or change in treatment was initiated with the patient. For example they found in a selected case a Veteran had multiple negative UDS that did not show the presence of prescribed medications that was not acted on. 52 out of 56 patients had a UDS performed at least one time in three years. It is standard of care and part of the Opioid Safety Initiative to obtain a UDS at least annually if not more frequently in the face of aberrant drug related behavior. The remaining four Veterans had no UDS performed during the time frame spanning more than three years, although all were treated chronically with opioids during that time period. Of the 52 Veterans, there were five patients who were being prescribed opioids at the time of the negative urine drug screen. This is indicative of aberrant drug related behavior, misuse, abuse, or diversion. These were the findings for a urine drug screen obtained once over a three year time period. What would the numbers have been if the providers actually followed the standard of care and obtained them at least annually? Yet again the investigation was administratively closed.

The 3rd issue that needs to be considered is why is a psychiatrist prescribing opioid pain medications at the Tomah VA facility? The psychiatrist at the Des Moines VA would not dream of prescribing these medications as it is beyond their scope of practice. Even if Dr. Houlihan was prescribing these medications because he was the Chief of Staff, he has no specialty training or credentialing in pain management. That would be equivalent to Dr. Houlihan prescribing Oncology medications to a cancer patient. Either way it is beyond the scope of standard practice.

I am tremendously disappointed in our federal system and the current authoritative figures that are to be our governing agencies set in place to protect our Veterans and employees. I have interviewed with the DEA three times and had a thorough interview with the Inspector General. I am extremely disappointed with Dr. Daigh, Dr. Mallinger, Mr. Griffen and the whole Inspector General investigative team. Of the 32 allegations that were investigated, many were "unsubstantiated." What is disturbing is that I lived that torture and saw the unsafe practice daily. I can attest to several of the 32 allegations and believe the majority should have been "substantiated." The Inspector General's investigation did "substantiate" several allegations, however they still "did not find any conclusive evidence affirming criminal activity, gross clinical incompetence, or negligence, or administrative practices that were illegal or violated personnel policies." This is unfathomable for the reasons outlined above and following:

I can advise that I alerted and/or questioned Dr. Houlihan on a few different narcotic scripts which is outlined in the Office of Special Counsel complaint. All are very concerning for safety reasons, however the one that concerns me the most is the Oyxcontin that the local medical doctor was tapering and discontinuing due to testing inappropriately positive for methadone which he was not prescribed by either the local provider or Dr. Houlihan. This Veteran was double dipping Oxycontin from local medical doctor and the VA with refill dates only a week or two apart for 30 day supplies. In addition to the inappropriate urine drug screen obtained by the local medical doctor and abuse of opioids, the patient left his cell phone in pharmacy. When the pharmacist, Dave Dettle picked up the phone the person on the other end was asking to buy medication from this Veteran. All this was documented in the chart and despite the information provided Dr. Houlihan decided to re-write the prescription for Oxycontin three times daily. This was an increase in the frequency prescribed. I do not understand why a provider would do that. This supports the "substantiated" findings of Dr. Clancy's team. As expressed above Veterans were still prescribed narcotics in the face of aberrant drug related behavior. From a clinical stand point I am unclear why Dr. Houlihan prescribes the medications in the manner of which he does. My clinical opinion is irrelevant. What matters is the standard of care set in place for providing safe and effective care to our Veterans. For example the 1,080 immediate release morphine tablets that were dispensed. When confronted, Dr. Houlihan refused to change this patient to long acting medication which would have been standard of care or add something non-narcotic to treat his neuropathic pain. In addition he continued to prescribe 36 tablets a day to a known substance abuser who was overusing his morphine while in the hospital. I understand that you would need to taper if you were going to do that, however that was never the plan, nor was addressing the patients 'pain' with the standard of care. Another example is of a prescription for 1,447mg of MEQ per day that Dr. Houlihan and Dr. Hyde worked on together. That patient dangerously increased his own medication which in my pain clinic would be grounds for discontinuation due to the inability to safely take opioid medications. They gave this patient

a 30 day supply of medication when he was supposed to be admitted to the inpatient facility the following week. Based on the calculation of his current supply even with the increased dose he would have had enough medication to get through until admission so why was he dispensed 30 day supply of a high risk medication that he was currently abusing. The Veteran just got done dangerously increasing his own dose, and Dr. Houlihan gave him more to take on his own despite the dose being at considerable variance compared to the recommended VHA Opioid Safety Initiative dose limit of 200mg of MEQ per day. That is how you have accidental or non- accidental overdoses in your parking lot. I retrospectively reviewed the Veterans profile the following week and he was not admitted according to the plan of care. When I went to the MSPB mediation and the documents were brought to discovery there was a progress note from Dr. Hyde's husband (Rod Hyde - PA in Tomah – not involved with this particular patients care) discussing an admission for this particular Veteran. It is my belief the records were altered. This concern has been brought forth by several others, some that continue to work at the Tomah VA. My experience with Dr. Hyde was somewhat limited, as I was only at the Tomah VA for one year, however she had no prior pain management experience yet she seemed to do exactly what Dr. Houlihan asked despite evidence of patient harm. I was kicked off the new pain committee and opioid work group that I had been appointed to by the Quality and Safety director by Dr. Houlihan who promptly replaced me with Dr. Hyde, which I do not believe to be a coincidence. Dr. Hyde is now being investigated by the Wisconsin Department of Safety and Professional Services. I had very little interaction with Deb Frasher. The only thing I heard her say is that she believed that every patient needed a 'cocktail' which consisted of an opioid, benzodiazepine, stimulant, and sleeping medication. The one question I would address about Deb Frasher is that if she is seeing patients for mental health then why is she prescribing 5.3 million mg of MEQ? What is she treating? When did it become acceptable or the standard of care to treat 'psychological pain' with opioids. This finding was "unsubstantiated" by the Inspector General, however I saw this indication for opioids in several charts.

I shared my concerns of Dr. Houlihan's over prescribing of narcotic medications, and I say narcotics, not just opioids as he over prescribes benzodiazepines as well as stimulants and other antipsychotic medications inappropriately. I saw several benzodiazepine scripts prescribed above the max doses. I also saw several stimulant prescriptions such as Methylphenidate and Dextroamphetamine prescribed at double the maximum recommended dosage set forth by the manufacture and Federal Drug Administration. The Veterans in the Tomah VA appeared significantly overmedicated. Several Veterans appeared to be suffering with extreme extrapyramidal side effects due to the unsafe combination of medications being prescribed. After reviewing the interview with MSNBC and Fox News the list of medications the Tomah VA prescribed Jason Simcakoski did not follow evidence based guidelines or the standard of care. For example a weak opioid was prescribed with suboxone which should never be done. Diazepam was prescribed at 60mg per day with the maximum dose allowed being 40mg per day. Jason was being prescribed duplicate therapy with the benzodiazepine diazepam and temazepam which is dangerous and not the standard of care. He was also on several other interacting medications including several medications that affect serotonin which put him at high risk for serotonin syndrome which can be lethal and unfortunately was. As a pharmacist I would not have dispensed these medications in combination or the dosages and frequencies in which they were prescribed. One of my concerns regarding the care provided by the staff at the Tomah VA in regards to Jason's care is that the

mixed drug toxicology that eventually led to his death likely did not occur overnight. I would have suspected the Veteran would have displayed signs and symptoms of over sedation, respiratory depression, CNS depression, and cognitive impairment. If this was the case, was there evidence of gross clinical incompetence and negligence? This should have been identified by the medical team and acted on. This Veterans death was a preventable tragedy. Had the Inspector General done their due diligence and reported their findings despite the administrative closing of the investigation, the outcome could have been a very different one.

Majority of my clinical colleagues with the exception of Dr. Hyde agreed with my safety concerns. I alerted my Chief of Pharmacy Dr. Erin Narus who ordered me to illegally partial a Methylphenidate script prescribed by Dr. Houlihan as neither of us concurred with the current dosing regimen as it was prescribed above the maximum recommended dosage and frequency. Dr. Narus asked me to illegally change the script and the directions without the provider's approval and only provide a seven day supply until further clarification from Dr. Houlihan. I told my Service Line Chief Jeff Evanson and his response to me being asked to do something illegal was "why are you trying to cause trouble? Why are you throwing Erin under the bus, if Dr. Houlihan wants you to fill that medication than you have no right to say no." I reported my concerns to the President of the Union, the VISN pharmacy leaders, the DEA, and later the Inspector General, as well as the WI board of pharmacy. The WI Board of Pharmacy could not be bothered to return my phone call after several attempts. I alerted my licensing agency, the Iowa Board of Pharmacy, who advised me not to fill the prescriptions and bring the matter to local authorities as I was 50% liable for those medications being dispensed. I was not going to be responsible for another death in the parking lot or contribute to suspected medication diversion. The unfortunate part of all of this, is that despite all who knew, nothing has been done. The true tragedy is that more Veterans had to die because the OSC determined "my clinical opinion" was different than Dr. Houlihan.

The depths of this tragedy are far reaching. I recently received a pain management consult for a Veteran at the Des Moines VA. This Veteran was a prior Tomah patient who was treated by Dr. Houlihan and Deb Frasher. This particular Veteran had a long standing history of substance abuse with alcohol and narcotics. The patient was previously taken off of opioids due to aberrant drug behavior and overdose. The Veteran was placed on suboxone by Dr. Houlihan, which the patient reports he never took to only be placed back on large doses of opioids and benzodiazepines by Dr. Houlihan. The patient has since had two more admissions for overdoses within the past 2 months. He is currently being taken off all his opioids and benzodiazepines. If this Veteran's family had not sought care elsewhere and the patient continued to receive care by Dr. Houlihan and Deb Frasher would his second and third overdoses been enough for them to finally take this veteran off of such a dangerous medications? I am unclear how the Inspector General could not "substantiate" these findings or "find no conclusive evidence of gross clinical incompetence or negligence." Veterans have lost their lives because of this prime example of gross clinical incompetence and negligence.

I have personally dealt with the repercussions of administrative practices that were illegal and that violated all sorts of personnel policies. I was asked to do something illegal, refused, blew the whistle on this gross clinical incompetence and negligence outlined above, and was fired for standing up and

doing what was safe and right for the Veteran. The Inspector General did find that, “pharmacy staff uniformly indicated that they were reluctant to question any prescription ordered by Dr. Houlihan or any aberrant behavior by his patients because they feared reprisal.” This was eventually “unsubstantiated” by the Inspector General despite findings of consistent, documented early refills, inappropriate urine drug screens, unsafe narcotic dosages, quantities, and dosage frequencies, as well as other drug related aberrant behavior. If all these findings were “unsubstantiated” why have so many clinicians left the Tomah VA? The one pharmacist who was brave enough to stand up and question those prescriptions for our Veterans safety was fired. The precedence of “what not to do if you value your job” was set.

My second Chief of Pharmacy Tom Jaeger reported he was coerced into writing his falsified personal statement that helped lead to my termination . He agreed to take it back, he then resigned two days after I was terminated. He then wrote another report of contact which stated he would not recant his statement. My clinical colleague Heather Asthmus and Rebecca Bell were pulled into Dr. Houlihan’s office where he essentially told them if they value their job they would not question him like I did. Shortly before my termination Dr. Zakia Siddiqi resigned in lieu of termination after refusing to write for an opioid that a veteran did not test positive for in his urine drug screen, indicating aberrant drug behavior. In addition I was told in a pain committee meeting that we were not to be drug testing our patients as when they did not test positive for the substance prescribed and we continued to prescribe the medication we were liable. I do believe that is the point of urine drug testing to substantiate use and misuse of high risk medications for the safety of the Veterans and public. This was a “substantiated” finding by the Inspector General. Dr. Houliahn proceeded to tell Union Steward Dianne Streeter that there would never be a pain clinic at the Tomah VA and if pharmacy took over pain management then patients would start dying, after which they would bring their guns to pharmacy and start shooting. The “Candy Man” statement the CIR references is legitimate. I heard more than one Veteran reference Dr. Houlihan as this. I heard a particular 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.”

I continue to have grave concerns about the clinical abilities of several providers at the Tomah VA, including concerns ignored or “unsubstantiated” by the Inspector General. What will it take for those in a position of authority to take significant action? 911 was called more than 2,000 times over the last five years reporting 24 unexpected deaths. How many Veterans lives need to be lost? We are to be taking care of these Soldiers’ returning from war, not creating a war they will not survive. What happened to the doctors oath of “First Do No Harm?” It is all of our responsibility to stand up for those Veterans safety and not contribute to the tragedy that has cost so many lives. The leadership at all levels; Tomah, VISN, VACO, and Inspector General need to be held accountable or true change will never prosper and Veterans will continue to suffer the ultimate sacrifice. Those Veterans deserve the highest quality of care afforded. I urge and encourage you to deeply consider and investigate all allegations against the Tomah VA and their providers.