

**STATEMENT OF  
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ACTING INSPECTOR GENERAL  
OFFICE OF INSPECTOR GENERAL  
DEPARTMENT OF VETERANS AFFAIRS  
BEFORE THE  
COMMITTEE ON VETERANS' AFFAIRS  
UNITED STATES SENATE  
HEARING ON  
"THE STATE OF VA HEALTHCARE"  
SEPTEMBER 9, 2014**

Mr. Chairman, Ranking Member Burr, and Members of the Committee, thank you for the opportunity to discuss the results of the Office of Inspector General's (OIG) extensive work at the Phoenix VA Health Care System (PVAHCS), as outlined in our report, *Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System* (August 26, 2014). I am accompanied by John D. Daigh, Jr., M.D., Assistant Inspector General for Healthcare Inspections; Ms. Linda A. Halliday, Assistant Inspector General for Audits and Evaluations; Ms. Maureen T. Regan, Counselor to the Inspector General; and Mr. Larry Reinkemeyer, Director, OIG Kansas City Audit Operations Office.

**BACKGROUND**

The OIG reviewed allegations at the Phoenix VA Health Care System (PVAHCS) that included gross mismanagement of VA resources, systemic patient safety issues, possible wrongful deaths, and we are continuing to review possible criminal misconduct by VA senior hospital leadership. We initiated this review in response to allegations first reported through the OIG Hotline. We expanded our work at the request of the former VA Secretary and the Chairman of the House Committee on Veterans' Affairs (HVA) following an HVA hearing on April 9, 2014, on delays in VA medical care and preventable veteran deaths. We also received requests from this Committee, as well as individual Members of Congress.

On May 28, 2014, we published our report, *Review of Patient Wait Times, Scheduling Practices, and Alleged Patient Deaths at the Phoenix Health Care System – Interim Report*, substantiating serious conditions at the PVAHCS. We provided VA leadership with recommendations for immediate implementation to ensure all veterans receive appropriate care.

Our August 26, 2014, report provides more extensive information previously provided in the interim report to reflect the results of our review and includes information on the reviews by OIG clinical staff of patient medical records. We addressed the following questions in our August report:

- Were there clinically significant delays in care?
- Did PVAHCS omit the names of veterans waiting for care from its Electronic Wait List (EWL)?

- Were PVAHCS personnel following established scheduling procedures?
- Did the PVAHCS culture emphasize goals at the expense of patient care?
- Are scheduling deficiencies systemic throughout VHA?

## **SCOPE OF REVIEW**

Due to the multitude and broad range of issues, a multidisciplinary team comprising board-certified physicians, nurses, health care inspectors along with special agents and auditors evaluated the many allegations to determine their validity and assign individual accountability if appropriate. The team interviewed numerous individuals to include the principal complainants: Dr. Samuel Foote, a retired PVAHCS physician, and Dr. Katherine Mitchell, the Medical Director of the PVAHCS Operation Enduring Freedom/Operation Iraqi Freedom/and Operation New Dawn (OEF/OIF/OND) clinic. In addition:

- We obtained and reviewed VA and non-VA medical records of patients who died while on a wait list or whose deaths were alleged to be related to delays in care.
- We reviewed two statistical samples of completed primary care appointments to determine the accuracy of patient wait times based on our assessment of the earliest indication a patient desired care.
- We reviewed over 1 million email messages, approximately 190,000 files from 11 encrypted computers and/or devices, and over 80,000 converted messages from Veterans Health Information Systems and Technology Architecture emails.

### Patient Care Reviews

Board-certified physicians and nurses in the OIG Office of Healthcare Inspections conducted a review of VA medical records for 3,409 veterans to identify delays and/or lapses in providing quality care. We also requested death certificates for 166 veterans and subpoenaed medical records from non-VA facilities for three veterans. We reviewed Medicare and other records to determine whether these veterans received care by non-VA providers.

The delays described in the report show that access barriers resulted in delays in providing quality primary and specialty care at the PVAHCS. In the course of patient case reviews, we also identified other quality of care issues unrelated to delays. These delays and lapses in care may have had or could have had a negative impact on the health and welfare of the veteran. However, we did not conclusively assert that the absence of timely quality care caused the deaths of these veterans.

In conducting our reviews, we did not apply the medical negligence standard applicable to care provided in the State of Arizona. The OIG has no authority or responsibility to make determinations as to whether acts or omissions by VA constitute medical negligence under the laws of any state or to compensate veterans or their families if the veteran suffered an injury as the result of the provision of health care. Making such determinations is a Department program function and the OIG is prohibited by statute from making program decisions to preserve its independence to conduct oversight of

VA's programs and operations. Decisions regarding VA's liability in these matters lie with the Department and the judicial system under the Federal Tort Claims Act.

Dr. Foote first contacted the OIG in September 2013 and met with OIG representatives in December 2013. In February 2014, Dr. Foote alleged that potentially 40 veterans died waiting for an appointment, and these alleged deaths were widely reported in the media. We pursued this allegation and interviewed Dr. Foote, but he was unable to provide us a list identifying by name 40 specific patients. He provided HVAC the names of 17 deceased patients, which we received from the Committee and reviewed. Based on our own review of PVAHCS electronic records, we were able to identify 40 veterans who died while on the EWL during the period April 2013 through April 2014. These veterans were included in the review of records for 3,409 patients derived from multiple sources, which included 293 deaths.

During our review, we were provided with numerous lists of PVAHCS patients. These patient lists were obtained by OIG staff while onsite at PVAHCS; obtained from the PVAHCS Quality Management office and other similar offices; submitted to the OIG Hotline; and obtained from external sources such as the HVAC, other congressional sources, and media reports. In all, OIG Office of Healthcare Inspections physicians and clinical staff examined the electronic health records (EHR) and other information for 3,409 veteran patients on the following lists:

- Veterans Health Administration (VHA) EWL – The EWL was used to list patients waiting to be scheduled for an appointment. It is a VHA-sanctioned list described in a June 9, 2010, Under Secretary for Health Directive. Patients on PVAHCS's EWL could be waiting for scheduling for either primary or specialty care.
- PVAHCS Physician List – Two PVAHCS physicians provided the names of patients for whom substandard care due to scheduling delays was alleged.
- HVAC – On April 9, 2014, the HVAC provided to the OIG a list of 17 PVAHCS patients, all deceased, who allegedly had both excessive and harmful waiting times.
- Hotline List – OIG's Hotline received numerous contacts concerning PVAHCS. Many alleged poor quality of care or harm to individual patients.
- Media – Print and electronic media reported allegations of substandard care at PVAHCS. Many reports identified and described individual patients' issues.
- Schedule an Appointment Consult List – Clinical staff at PVAHCS wanted to ensure that inpatients who did not have a primary care physician (PCP) would have primary care follow-up post-discharge. They began using the system's "Schedule an Appointment" consult function to accomplish this. Usually a clinical consult request is for an additional opinion, advice, or expertise. Emergency Room clinicians and some specialty services staff also adopted this practice.
- Institutional Disclosure List – PVAHCS patients for whom institutional disclosures had been made to patients or their families for any care-related reason. Institutional disclosures include discussions of events not associated with substantial harm. For example, PVAHCS would disclose that a patient's temperature was taken using an oral probe without a protective cover, a minor

surgical procedure had to be interrupted because of a power failure, or an x-ray was performed on the wrong patient.

- Newly Enrolled/Appointment Requested (NEAR) List – During the enrollment application process, a veteran may indicate on the enrollment form that he/she would like to be contacted to schedule an initial appointment. The NEAR list is a tool used by enrollment staff to tell schedulers that a newly enrolled veteran has requested an appointment. The NEAR list is used for initial appointments only.
- Suicides – PVAHCS patients known by either the facility or the Maricopa County, Arizona, Medical Examiner's Office to have committed suicide.
- Backlog Never Completed – 544 patients who were to be scheduled through the new patient backlog redistribution process but who never received an appointment.
- Urology Service – Partial list of patients from the closed consult and paper lists.
- Helpline Paper Printouts – From March–April 2014, patients who called the PVAHCS's Helpline requesting an appointment were placed on a paper screenshot.
- Helpline Paper Printouts – Paper screenshots found by an employee in June 2014.

The OIG examined the EHRs and other information for the 3,409 veteran patients, including the 40 patients we found on the EWL who were deceased, and identified 28 instances of clinically significant delays in care associated with access or scheduling. Of these 28 patients, 6 were deceased. In addition, we identified 17 cases of care deficiencies that were unrelated to access or scheduling. Of these 17 patients, 14 were deceased. During our review of EHRs, we considered the responsibilities and delivery of medical services by PCPs versus specialty care providers (such as urologists, endocrinologists, and cardiologists). Our analysis found that the majority of the patients were on official or unofficial wait lists and experienced delays accessing primary care, although in some cases, patients were receiving specialty care through VA or non-VA providers for pressing clinical issues. For example, a patient was being seen by a VA cardiologist, but was also on the wait list to see a PCP at the time of death. The 45 cases discussed in the report reflect unacceptable and troubling lapses in follow-up, coordination, quality, or continuity of care.

The review process included an evaluation of the medical records of 3,409 patients from the sources discussed above. The OIG staff who conducted the reviews are physicians and clinicians. Reviewers used clinical judgment to determine whether, in their professional opinion, an identified delay resulted in a harmful outcome or a potentially harmful outcome. OIG physicians reviewed 743 patients. If a physician's review of the records identified deficiencies in the quality of care provided to the patient, the case was reviewed by a second OIG physician. If the two physicians agreed, the case was included in the report. Information on the qualifications of the OIG physicians who conducted these reviews can be found in the attached curricula vitae.

Several patients in cases reviewed opted for non-VA care at critical junctures. As needed, but not in all cases, we obtained and reviewed the relevant private sector

medical records. For 166 deceased patients reviewed in a second-level physician review, we requested death certificates from Maricopa County and the State of Arizona, whom we would like to acknowledge for their cooperation and expedience in meeting our requests. Supplementing the data gathered from the EHR, we also analyzed information, when available, from sources that included Medicare, non-VA health records, death certificates, media reports, and interviews with VA staff. Approximately 23 percent of the patients we reviewed received private sector medical care funded by Medicare or Medicaid, and 35 percent had insurance coverage beyond VA.

## **OBSTACLES TO CARE**

We identified several patterns of obstacles to care that resulted in a negative impact on the quality of care provided by PVAHCS. Patients recently hospitalized, treated in the emergency department, attempting to establish care, or seeking care while traveling or temporarily living in Phoenix often had difficulty obtaining appointments. Furthermore, although we found that PVAHCS had a process to provide access to a mental health assessment, triage, and stabilization, we identified problems with continuity of mental health care and care transitions, delays in assignment to a dedicated health care provider, and limited access to psychotherapy services.

### Panel Size

Primary care was one important medical service that was not able to keep up with demand. A primary care provider's target panel size is locally determined as it is dependent on such factors as disease complexity, number of support staff, number of clinic rooms available for a provider's use, whether a provider is a new hire, and time available for direct patient care versus other activities. When a provider's panel size exceeds a clinic's target panel size, the capacity to add new patients becomes limited. Constrained panel capacity can lead to increases in the length of time it takes new patients to get an appointment. While onsite, we obtained individual provider appointment grids and panel assignments and the targeted panel capacities for April 2014. The target panel size at the PVAHCS is 1,260 patients. For the PVAHCS as a whole, the aggregate primary care panel capacity used was 98 percent. When PCPs left VA employment and their unassigned patients were factored in, aggregate panel capacity used was greater than 100 percent.

The number of unassigned patients represents a demand for established clinic spaces and panel capacity that is masked when these patients remain unassigned for extended periods. If a new provider has been hired and is known to be coming on-board within a tenable time frame, this may be practical. However, in situations where recruiting is difficult and on-boarding fairly lengthy, or for other reasons (e.g., a series of provider medical illnesses) primary care clinics routinely have substantial numbers of unassigned patients, access and continuity of patient care suffer.

Actions that can be taken to increase primary care access include increasing the number of providers, increasing target panel size, optimizing the match between variations in appointment demand and supply, expanding clinic hours, and increasing the use of non-VA purchased care. Increases in staff or panel size may be contingent

on having necessary space, the ability for providers to simultaneously use multiple exam rooms, efficient scheduling processes, sufficient support staff, or other process changes such as support for streamlining medical record documentation. For example, in several primary care clinics, available space at the PVAHCS is only able to support 1 room per clinician while the VHA recommended target panel size (1,200) assumes the availability of 3 rooms per provider.

### Urology Service

Urology Service was also unable to keep up with the demand for services. During our review, it became clear that the Urology Service at PVAHCS was in turmoil during the 2012 to 2014 timeframe. There were a number of urology physician staffing changes, delays in the procurement of non-VA purchased care consults for urology, and difficulties coordinating urologic care. The OIG is currently working from a list of 3,526 patients who may be at risk for having received poor quality urologic care. As a result, urology services at PVAHCS is the subject of an ongoing review. In addition, non-urology cases whose evaluation could not be completed within the time constraints of the August 2014 report will be included in the upcoming final review.

### Mental Health Services

We found that PVAHCS had a process to provide access to a mental health assessment, triage, and stabilization. However, we identified problems with continuity of mental health care and care transitions, delays in assignment to a dedicated health care provider, and limited access to psychotherapy services. When a facility becomes reliant on a walk-in clinic structure to increasingly provide daily routine or ongoing mental health services because of diminished access to the regular outpatient mental health clinic, issues with provider continuity, care transitions, and provider assignment arise. Since coming to PVAHCS in October 2013 from outside the VA system, the Chief of Psychiatry has taken several steps to address these issues. Thirteen additional mental health prescribing clinicians were recently hired to provide the ability to assign patients to a mental health provider and increase the availability of new and established patient appointments. The mental health clinic has recently been re-organized to help improve both access to and continuity of care.

We identified prolonged waits for access to types of individual psychotherapies. In April 2014, 105 patients were waiting to be seen by a non-VA provider; as of September 4, 2014, 24 patients are waiting to be seen.

### Patients Waiting for Care

As of April 22, 2014, we identified about 1,400 veterans waiting to receive a scheduled primary care appointment who were appropriately included on the PVAHCS EWL. However, as our work progressed, we identified over 3,500 additional veterans, many of whom were on what we determined to be unofficial wait lists, waiting to be scheduled for appointments but not on PVAHCS's official EWL. These veterans were at risk of never obtaining their requested or necessary appointments. PVAHCS senior administrative and clinical leadership were aware of unofficial wait lists and that access delays existed but did not effectively address these issues. Throughout the course of our review, we

promptly provided PVAHCS leadership the names of all veterans we identified as being on an unofficial wait list to enable them to take the necessary actions to get veterans the care they needed.

### Inappropriate Scheduling Practices in Use at PVAHCS

From interviews of 79 PVAHCS employees involved in the scheduling process, we identified the following types of scheduling practices not in compliance with VHA policy. Some schedulers identified multiple inappropriate scheduling practices.

- Thirty staff stated they used the wrong desired date of care, resulting in appointments showing a false 0-day wait time.
- Eleven staff stated they “fixed” or were instructed to “fix” appointments with wait times greater than 14 days. They did this by rescheduling the appointment for the same date and time but with a later desired date.
- Twenty-eight staff stated they either printed out or received printouts of patient information for scheduling purposes. Staff said they kept the printouts in their desks for days or sometimes weeks before the veterans were scheduled an appointment or placed on the EWL.

PVAHCS executives and senior clinical staff were aware that their subordinate staff were using inappropriate scheduling practices. In January 2012 and later in May 2013, the Veterans Integrated Service Network (VISN) 18 Director issued two reports that found PVAHCS did not comply with VHA’s scheduling policy. Our review also determined PVAHCS still did not comply with VHA’s scheduling policy. Specifically, according to VISN 18 staff, PVAHCS had not completely trained their clerks or established EWLs in the clinics. As a result of using inappropriate scheduling practices, reported wait times were unreliable, and we could not obtain reasonable assurance that all veterans seeking care received the care they needed.

The emphasis by Ms. Sharon Helman, the Director of PVAHCS, on her “Wildly Important Goal” (WIG) effort to improve access to primary care resulted in a misleading portrayal of veterans’ access to patient care. Despite her claimed improvements in access measures during fiscal year (FY) 2013, we found her accomplishments related to primary care wait times and the third-next available appointment were inaccurate or unsupported. After we published our interim report, the Acting VA Secretary removed the 14-day scheduling goal from employee performance contracts.

### **HISTORY OF VHA SCHEDULING AND DATA RELIABILITY PROBLEMS**

Since July 2005, OIG published 20 oversight reports on VA patient wait times and access to care yet VHA did not effectively address its access to care issues or stop the use of inappropriate scheduling procedures.

When VHA concurred with our recommendations and submitted an action plan, VA medical facility directors did not take the necessary actions to comply with VHA’s program directives and policy changes.

In April 2010, in a memorandum to all VISN Directors, the then-Deputy Under Secretary for Health for Operations and Management (DUSHOM) called for immediate action to review schedule practices and eliminate all inappropriate practices. The memorandum stated that in order to improve scores on assorted access measures, certain facilities have adopted the use of inappropriate scheduling practices that were not in line with patient-centered care.

In May 2013, the then-DUSHOM waived the FY 2013 annual requirement for facility directors to certify compliance with the VHA scheduling directive, further reducing accountability over wait time data integrity and compliance with appropriate scheduling practices. This annual certification requirement was initiated in January 2011. Additionally, the breakdown of the ethics system within VHA contributed significantly to the questioning of the reliability of VHA's reported wait time data.

### **NATIONWIDE SYSTEMIC PROBLEM**

Inappropriate scheduling practices were a nationwide systemic problem. We identified multiple types of scheduling practices in use that did not comply with VHA's scheduling policy. These practices became systemic because VHA did not hold senior headquarters and facility leadership responsible and accountable for implementing action plans that addressed compliance with scheduling procedures.

Since the PVAHCS story first appeared in the national media, we received approximately 225 allegations regarding PVAHCS and approximately 445 allegations regarding manipulated wait times at other VA medical facilities through the OIG Hotline, from Members of Congress, VA employees, veterans and their families, and the media.

The OIG Office of Investigations opened investigations at 93 sites of care in response to allegations of wait time manipulations. The investigations focused on whether management ordered schedulers to falsify wait times and EWL records or attempted to obstruct OIG or other investigative efforts. Investigations continue, in coordination with the Department of Justice and the Federal Bureau of Investigation. While most are still ongoing, these investigations are confirming that wait time manipulations were prevalent throughout VHA.

As of August 2014, among the variations of wait time manipulations, our ongoing investigations at the 93 sites have, thus far, found many medical facilities were:

- Using the next available date as the desired date to "0-out" appointment wait times.
- Canceling appointments and rescheduling appointments to make wait times appear to be less than they actually were. We substantiated that management at one facility directed schedulers to do this.
- Using paper wait lists rather than official EWLs.
- Canceling consultations (consults) without appropriate clinical review.
- Altering clinic utilization rates to make it appear the clinic was meeting utilization goals.



Wherever we confirm potential criminal violations, we will present our findings to the appropriate Federal prosecutor. If prosecution is declined, we will provide documented results of our investigation to VA for appropriate administrative action. We will do the same if our investigations substantiate manipulation of wait times but do not find evidence of any possible criminal intent. Finally, we have also kept the U.S. Office of Special Counsel apprised of our active criminal investigations as they relate to their numerous referrals to VA of whistleblower disclosures of allegations relating to wait times and scheduling issues.

Prior to our work at PVAHCS, we initiated an audit of the Health Eligibility Center. Soon after, the OIG Hotline received complaints that the Health Eligibility Center purged over 10,000 veterans' health care applications to improve performance metrics. The same complaint also identified that VHA had a backlog of over 600,000 unprocessed enrollment applications. We have expanded our work to assess the merits of these allegations, as processing veterans' applications for enrollment in VA health care is a first and important step to ensuring access to care is available and meeting veterans' needs.

## **CONCLUSION**

The VA Secretary has acknowledged the Department is in the midst of a serious crisis and has stated VA must work to get veterans off wait lists, address cultural and accountability issues, and use their resources to consistently deliver timely health care. The VA Secretary concurred with all 24 recommendations and submitted acceptable corrective action plans.

Our findings and conclusions provide VA a major impetus to re-examine the entire process of setting performance expectations for its leaders and managers. Along with a rigorous follow up to ensure full implementation of all corrective actions, we plan on initiating a series of reviews based upon allegations received of appointment scheduling irregularities, barriers to access to care, and other issues that affect medical care, quality, and productivity. These reviews will provide us the opportunity to determine whether senior VA medical facility officials have implemented the Secretary's action plan.

If headquarters and facility leadership are held accountable for fully implementing VA's action plans, VA can begin to regain the trust of veterans and the American public. Employee commitment and morale can be rebuilt, and most importantly, VA can move forward to provide timely access to the high-quality health care veterans have earned—when and where they need it.

Mr. Chairman, this concludes our statement and we would happy to answer any questions you or other Members of the Committee may have.

## CURRICULUM VITAE

### NAME:

John David Daigh Jr.

### EDUCATION:

#### NON MEDICAL:

United States Military Academy  
West Point, NY  
B.S. 1974

University of Maryland, University College  
B.S. (Accounting) 1998

American University  
Masters in Taxation, 2000

#### MEDICAL:

University of Texas Health Science Center  
Southwestern Medical School  
Dallas, Texas  
MD 1978

### POSTGRADUATE EDUCATION:

#### PEDIATRIC INTERNSHIP:

Fitzsimons Army Medical Center  
Denver, Colorado  
1978-79

#### PEDIATRIC RESIDENCY:

Fitzsimons Army Medical Center  
Denver, Colorado  
1979-80

### CHILD NEUROLOGY FELLOWSHIP:

Daigh, JD

University of Texas - Dallas, Southwestern Medical School  
Parkland and Dallas Children's Hospitals  
Dallas, Texas  
1980-83

**BOARD CERTIFICATION:**

American Board of Pediatrics 1984  
American Board of Psychiatry and Neurology 1986

**LICENSE:**

Physician Maryland D30048  
CPA Maryland # I026445

**PROFESSIONAL EXPERIENCE:**

Assistant Inspector General For Healthcare Inspections, Office of the  
Inspector General, Department of Veterans Affairs 1/04 to present

Associate Director, Medical Consultation and Review, Department of  
Veterans Affairs, Office of the Inspector General 02/02 to 1/04

Director, Program Budget & Execution, TRICARE Management Activity  
12/99 to 02/02

Senior Budget Analyst, TRICARE Management Activity 12/98-12/99

Chief, Department of Neurology, Walter Reed Army Medical Center 8/96-  
12/98

Chief Child Neurology, WRAMC 7/94 to 8/96

Assistant Chief of Child Neurology 7/93 to 7/94

Assistant Chief Neurology, Walter Reed Army Medical Center 7/92 to 8/96

Staff Neurologist Fitzsimons Army Medical Center 7/91 to 7/92

Assistant Chief Child Neurology WRAMC 1983 to 7/1991

Assistant Professor of Neurology  
Assistant Professor of Pediatrics

Uniformed Services University of the Health Sciences, Bethesda, Maryland  
1984 to 02/02

Assistant Program Director, Neurology Residency WRAMC 8/93 to 12/98

#### MILITARY SERVICE:

Retired from Active duty 02/02

#### EXAMINER

American Board of Psychiatry and Neurology Oral Boards 1990, 1991,  
1995, 1998, 1999

#### COMMITTEES

American Academy of Neurology Committee on Government Affairs  
1993- 1997

National Tuberos Sclerosis Society, Professional Advisory Board  
Member, 1994-1996

#### AWARDS

Presidential Rank Award for Meritorious Service 2007

#### PUBLICATIONS:

1. Jabbari B, Gunderson CH, Wippold F, Citrin C, Sherman J, Bartoszek D, Daigh JD, Mitchell MH. Magnetic Resonance Imaging in Partial Complex Epilepsy. Arch Neurology 1986;43:869-72.
2. Young RSK, Osbakken D, Alger PM, Ramer, Weidner, Daigh JD: Nuclear Magnetic Resonance imaging of childhood leukodystrophies. Ped Neurology 1985 Jan-Feb 1:(1):15-9
3. Lipps DC; Jabbari B; Mitchell MH; Daigh JD Jr: Nifedipine for intractable hiccups. Neurology 1990 Mar; 40:531-2

4. McAdams H.P., Geyer C.A., Done S.L., Daigh David, Mitchell M, Ghaed V; CT and MR Imaging of Canavan Disease; American Journal of Neuroradiology 11:397-399 March/April 1990

5. Stephen Metraux, PhD, Limin X. Clegg, PhD, John D. Daigh, MD, Dennis P. Culhane, PhD, and Vincent Kane, MSS ; Risk Factors for Becoming Homeless Among a Cohort of Veterans Who Served in the Era of the Iraq and Afghanistan Conflicts, Am J Public Health. 2013; 103:S255–S261.

#### PRESENTATIONS:

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2. Cook JD, Daigh JD, Henderson-Tilton AC et al: A forme fruste of Schwartz-Jampel Syndrome without the epiphyseal dysplasia. American Academy of Neurology, April 1984

3. Young RSK, Osbakken D, Alger PM, Daigh JD: Nuclear Magnetic Resonance imaging of childhood leukodystrophies. Ann Neurol 16:408 1984.

4. Vincent J, Bash M, Shanks D, Daigh JD, Moriarty R, Fisher ,: Neurologic Symptoms as the Initial Presentation of HIV Infection in Pediatric Patients. V International Conference on AIDS, 1989

5. Director, Conference on Tuberos Sclerosis, Fall 1993, Washington, DC

6. Director, AMEDD Neurology “Current Topics in Neurology”, Fall 1994, Washington, DC

7. Herbers, Jerome; Wesley, George B.; Daigh, John D. Nocardia Meningitis in a Marine Injured in Iraq. Poster Presentation at the 2<sup>nd</sup> Federal Interagency Conference on Traumatic Brain Injury: Integrating Models of Research and Service Delivery, March 9-11, 2006 Bethesda, MD

August 2014

## CURRICULUM VITAE

Jerome E. Herbers, Jr., MD, MBA, FACP

### EDUCATION

Primary and Secondary, Memphis, Tennessee	
B.A., Johns Hopkins University, Baltimore, MD	1975
M.D., University of Tennessee, Memphis, TN	1979
M.B.A., Johns Hopkins University, Baltimore, MD	2006

### POSTGRADUATE TRAINING

Internship, Categorical Diversified in Psychiatry, Walter Reed Army Medical Center, Washington, DC	1979-1980
Residency, Internal Medicine, Walter Reed	1980-1982
Fellowship, General Internal Medicine, Walter Reed and Uniformed Services University of the Health Sciences (USUHS), Bethesda, MD	1985-1987

### BOARD CERTIFICATION

American Board of Internal Medicine (# 85441)	1982
Added Qualifications in Geriatric Medicine (# 085441)	1994
Renewed	2004
Meeting Maintenance of Certification Requirements	

### MEDICAL LICENSURE

Maryland # D42675  
District of Columbia # MD034542

### PROFESSIONAL POSITIONS

Staff Internist, Walter Reed Army Medical Center, Washington DC	1985-1995
Chief, Internal Medicine Clinic	1990-1992
Chief, General Medicine Service	1992-1995
Associate Professor of Clinical Medicine, USUHS	1993-1998
Assistant Chief, Medical Service, Department of Veterans Affairs Medical Center (VAMC), Washington DC	1995-2004
Associate Professor of Medicine, Georgetown University, Washington DC	1996-2004
Adjunct Associate Professor of Medicine, Howard University	2001-2004

-2- Curriculum vitae: Jerome E. Herbers, Jr., M.D.

Adjunct Associate Professor of Clinical Medicine, USUHS	1998-present
Associate Director, Medical Consultation and Review VA Office of the Inspector General, Washington DC (Senior Executive Service)	2004-present
Volunteer physician, Mobile Medical Care, Inc., Bethesda, MD	2007-present

### CLINICAL TEACHING (most recent)

Preceptor and Attending, 3rd year clinical clerkship, USUHS	1986-2006, 2009-present
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### SOCIETY MEMBERSHIPS

Association of Program Directors in Internal Medicine	1996-2004
Society of General Internal Medicine	1985-2012
American College of Physicians (ACP) Fellow, 1992	1984-present
American Geriatrics Society	2014-present

### PUBLICATIONS IN CRITICALLY REFEREED JOURNALS; INVITED CHAPTERS

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Roy MJ, Herbers JE, Seidman A, Kroenke K. Improving patient satisfaction with the transfer of care: a randomized controlled trial. J Gen Intern Med. 2003;18:364-9.

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-3- Curriculum vitae: Jerome E. Herbers, Jr., M.D.

Amarasingham R, Diener-West M, Weiner M, Lehmann H, Herbers JE, Powe NR. Clinical information technology capabilities in four U.S. hospitals: testing a new structural performance measure. Medical Care. 2006;44:216-224.

Herbers JE, Zarter S. Prevention of venous thromboembolism in Department of Veterans Affairs hospitals. J Hospital Med. 2010;5:E21-E25.

## SELECTED REPORTS, VA OFFICE OF INSPECTOR GENERAL

Review of Quality of Care, James A. Haley Medical Center, Tampa, Florida. June 1, 2005.

<http://www.va.gov/oig/54/reports/VAOIG-05-00641-149.pdf>

This was a review of care provided for a marine who was seriously wounded in Iraq, treated initially in military facilities, and died after transfer to a VA hospital for rehabilitation.

Health Status of and Services for Operation Enduring Freedom/Operation Iraqi Freedom Veterans after Traumatic Brain Injury Rehabilitation, July 12, 2006.

<http://www.va.gov/oig/54/reports/VAOIG-05-01818-165.pdf>

Assessment of Legionnaire's Disease Risk in Veterans Health Administration Inpatient Facilities, June 20, 2007. <http://www.va.gov/oig/54/reports/VAOIG-07-00029-151.pdf>

Hospitalized Community-Dwelling Elderly Veterans: Cognitive and Functional Assessments and Follow-up after Discharge, March 4, 2010.

<http://www.va.gov/oig/54/reports/VAOIG-09-01588-92.pdf>

Management of Osteoporosis in Veterans with Fractures, July 13, 2010.

<http://www.va.gov/oig/54/reports/VAOIG-09-03138-191.pdf>

Primary Care Services for Women Veterans: Accessibility and Acknowledgment of Test Results, August 4, 2010. <http://www.va.gov/oig/54/reports/VAOIG-08-03299-217.pdf>

Radiation Safety in Veterans Health Administration Facilities. March 10, 2011.

<http://www.va.gov/oig/54/reports/VAOIG-10-02178-120.pdf>

Informed Consent and Prevention of Disease Progression in Veterans with Chronic Kidney Disease. December 19, 2011. <http://www.va.gov/oig/54/reports/VAOIG-07-00029-151.pdf>

Foot Care for Patients with Diabetes and Additional Risk Factors for Amputation. January 17, 2013. <http://www.va.gov/oig/pubs/VAOIG-11-00711-74.pdf>

Prevention of Legionnaires' Disease in VHA Facilities. August 1, 2013.

<http://www.va.gov/oig/54/reports/VAOIG-07-00029-151.pdf>



**Curriculum Vitae**  
**Thomas W. Jamieson, MD**

**CURRENT POSITION:**

Senior Physician, Medical Consultation and Review, United States Department of Veterans Affairs, Office of Inspector General, Office of Healthcare Inspections, Washington, DC; [January 2011 to present]

**Prior Position:**

Director, Medical Student Ambulatory Education, VA Boston Healthcare System (Medicine), Boston, MA; Hospitalist Ward Attending, Medicine Consult Attending, and Primary Care Outpatient Medicine; [April 2008 to January 2011]

**ACADEMIC TRAINING:**

1972 B.S.      University of Notre Dame, South Bend, IN  
1976 M.D.     St. Louis University School of Medicine, St. Louis, MO  
1998 J.D.      American University Washington College of Law, Washington, DC

**POSTDOCTORAL TRAINING:**

1976-77      Intern, University of Missouri/Kansas City, Kansas City, MO  
1977-79      Resident (Medicine), Cleveland Clinic Foundation, Cleveland, OH  
1982-84      Fellow in Rheumatology, University of Kansas, Kansas City, KS

**ACADEMIC APPOINTMENTS:**

2006-08      Clinical Assistant Professor of Medicine,  
Brown Medical School, Providence, RI  
1992-2005    Associate Professor of Medicine,  
Uniformed Services University School of Health Sciences,  
Bethesda, MD  
1986-92      Assistant Professor of Medicine,  
Uniformed Services University School of Health Sciences,  
Bethesda, MD  
1984-85      Assistant Professor of Medicine,  
University of Kansas School of Medicine,  
Kansas City, KS

## **HOSPITAL APPOINTMENTS:**

2008 Staff Physician/Attending,  
Veterans' Affairs Boston Healthcare System, Boston, MA

2006-08 Staff Physician/ Hospitalist/Attending,  
Veterans' Affairs Medical Center, Providence, RI

2003-06 Staff Physician/ Hospitalist,  
Newport Hospital, Newport, RI

1985-2003 Staff Physician/Attending,  
National Naval medical Center, Bethesda, MD

1984-85 Staff Physician/Attending,  
University of Kansas Medical Center, Kansas City, KS

1979-82 Staff Physician/Attending,  
Naval Medical Center, Portsmouth, VA

## **HONORS:**

2006 U.S. Navy Commendation Medal (Second Award)  
Naval Health Care New England

2005 Global War on Terrorism Expeditionary Medal/ Operation Iraqi Freedom  
U.S. Military Hospital, Kuwait

2005 Global War on Terrorism Service Medal/Operation Iraqi Freedom

2004 Meritorious Unit Commendation (Second Award)  
National Naval Medical Center

2003 Defense Meritorious Service Medal  
Uniformed Services University of Health Sciences, Bethesda, MD

2000 Customer Service "Hero" Award for Patient Care  
National Naval Medical Center, Bethesda, MD

1995 Naval Unit Commendation, for service aboard USS Lasalle, Persian Gulf

1992 Kuwait Liberation Medal

1992 U.S. Navy Commendation Medal, Force Medical Officer  
U.S. Navy Central Command (forward deployed), Persian Gulf

1992 U.S. Navy Marksman Ribbon

1992 U.S. Navy Sea Service Ribbon, USS LaSalle

1992 Southwest Asia Service Medal,  
U.S. Navy Central Command, Persian Gulf

1991 Meritorious Unit Commendation  
National Naval Medical Center/Desert Storm

1991 National Defense Service Medal

1988 Letter of Commendation  
U.S. Naval Hospital, Naples, Italy

1983 Fellows Award for Clinical Research (Total Lymphoid Irradiation  
Intervention in Experimental Collagen-Induced Arthritis in Rats)  
American Rheumatism Association, Central Region, Chicago, IL

1981 Teacher-of-the-Year Award for General Internal Medicine

Naval Medical Center, Portsmouth, VA

**LICENSES and CERTIFICATION:**

1979 Commonwealth of Virginia, License #0101030880  
1976 National Board of Medical Examiners, #172347  
1980 American Board of Internal Medicine, #77322  
1986 Subspecialty Certification in Rheumatology, #77322

**DEPARTMENTAL and UNIVERSITY COMMITTEES:**

2009 Narcotic Review Committee, VA Boston Healthcare System  
2008 Education Leadership Group, VA Boston Healthcare System  
2008 Patient Safety Committee, VA Boston Healthcare System  
1992-2003 Chair, Committee for the Evaluation of Competence of Internal Medicine  
House Officers, National Naval Medical Center, Bethesda, MD  
1992-2003 Education Committee, Uniformed Services University of  
Health Sciences, Bethesda, MD

**TEACHING EXPERIENCE and RESPONSIBILITIES:**

2008-09 VA Boston Healthcare System (affiliations: Harvard Medical School,  
Boston University School of Medicine), 3 months inpatient ward  
attending, 3 months inpatient consult attending;  
Group Leader-Introduction to Clinical Medicine,  
2006-08 VA Providence, RI (affiliation: Brown Medical School) Monthly lectures  
(noon conference format, topics: general medicine, rheumatic diseases,  
legal issues);  
6-8 months/year as inpatient ward attending for Brown Medical School  
teaching team;  
1985-2003 National Naval Medical Center, Bethesda, MD, Bi-monthly lectures for  
housestaff, semi-monthly moderator for Medicine morning report;  
2 months/year as ward attending for National Naval Medical Center  
teaching team, also precepting students, residents in outpatient clinic  
setting;  
1984-85 University of Kansas Medical Center, 2 months ward attending, 3 months  
consult attending (rheumatic diseases);  
1979-82 Naval Medical Center, Portsmouth, Virginia, 4 months/year as ward  
attending teaching team;

**MAJOR ADMINISTRATIVE RESPONSIBILITIES:**

2008-2011 Director, Ambulatory Medical Student Education,  
VA Boston Healthcare System, Boston, MA;

- 1999-2003 Clerkship Director, Third-Year Medicine Clerkship, Uniformed Services University of Health Sciences, Bethesda, MD;  
1992-99 Assistant Clerkship Director, Third-Year Medicine Clerkship, Uniformed Services University of Health Sciences, Bethesda, MD;

**OTHER PROFESSIONAL ACTIVITIES:**

**MILITARY SERVICE/RANK CHRONOLOGY:**

- 1991 Captain, United States Navy  
1986 Commander, United States Navy  
1980 Lieutenant Commander, United States Navy  
1976 Lieutenant, United States Navy  
1972 Ensign, United States Naval Reserve

**OPERATIONAL MILITARY SERVICE:**

- 2004 Deployed, U.S. Military Hospital Kuwait/environs, in support of Operation Iraqi Freedom  
2003 Operational Platform, USNS Comfort (Hospital Ship)  
1992 Force Medical Officer for Commander, United States Naval Forces Central Command (Fifth Fleet), USS LaSalle, Persian Gulf  
1991-92 Mobile Medical Augmentation Readiness Team, National Naval Medical Center, Bethesda, MD  
1988-92 Consultant to the White House, Washington, DC, for Rheumatic Diseases  
1988 Staff Internist, Naval Hospital, Naples, Italy

**PROFESSIONAL SOCIETIES:**

- 2009-current Physicians Committee for Responsible Medicine  
1992-2003 Clerkship Directors in Internal Medicine  
1995-2008 American Medical Association  
1995-2003 American College of Rheumatology

**INVITED REVIEWER:**

- 1999-2003 Academic Medicine

**MAJOR COMMITTEE ASSIGNMENTS:**

**Federal Government**

- 1993-98 NIH Advisory Board on Musculoskeletal Diseases

## **INVITED LECTURES and PRESENTATIONS**

- 2003 Grand Rounds (Polymyalgia Rheumatica)  
Newport Hospital, Newport, Rhode Island
- 2002 Teaching and Evaluation of Medical Students: A New Look  
Ottawa Meeting on Medical Education, Ottawa, Ontario
- 2002 Grading Responsibility, The First Amendment and the Essential Freedoms of the  
Public University in the United States  
Ottawa Meeting on Medical Education (Poster Presentation), Ottawa, Ontario
- 2002 Legal Issues in Medical Education, Presentation for Graduate Medical Education  
Committee  
Madigan Army Medical Center, Fort Lewis, Washington
- 2002 National Capital Consortium for Program Directors (Legal Issues)  
Uniformed Services University of Health Sciences, Bethesda, Maryland
- 2001 Navigating the Legal Waters: What Every Clerkship Director Needs to Know  
Clerkship Directors in Internal medicine, National Meeting, Tucson, Arizona
- 2001 Legal Theories of Recourse for Failed Medical Students in the United States  
Association for Medical Education in Europe International Mtg., Berlin, Germany
- 2000 Medical Educators Due Process Obligations to Students (Poster Presentation)  
Clerkship Directors in Internal Medicine, National Meeting, Washington, DC
- 1998 Post-Course on Problem Students (Legal Issues)  
Clerkship Directors in Internal Medicine, National Meeting, Denver, Colorado
- 1995 Lecture Series: Inflammatory Arthritis; Serology in Rheumatic Diseases;  
Shoulder/Knee Syndromes;  
U.S. Army 18<sup>th</sup> Medical Command Health Education Conference, Seoul, Korea
- 1993 Navy Medicine in the Middle East  
Grand Rounds, Department of Medicine  
National Naval Medical Center, Bethesda, Maryland
- 1989 Complications of Necrotizing Vasculitis  
Grand Rounds, Department of Medicine  
National Naval medical Center, Bethesda, Maryland

- 1988 Pulmonary Hypertension in Systemic Lupus Erythematosus  
American Rheumatism Association Central Region Meeting, Chicago, Illinois
- 1987 Rheumatoid Arthritis Diagnosis and Management; Spondyloarthropathies;  
United States Medical-Surgical Congress Postgraduate Seminar  
Garmisch, Germany

### **Bibliography:**

#### **Original, Peer Reviewed Articles:**

1. Chute J, Hoffmeister K, Cotelingam J, Davis T, Frame J, Jamieson T. Aplastic Anemia As the Sole Presentation of Systemic Lupus Erythematosus. *Amer J Hem.* 1996
2. Lindsley HB, Jamieson TW, Desmet AA, Kimler BF, Cremer MA, Hassanein K. Total Lymphoid Irradiation Retards Evolution of Articular Erosions in Collagen-Induced Arthritis. *J Rheum* 1988
3. Jamieson TW. Corticosteroids in Rheumatic Diseases-Therapeutic Approach. *Postgrad Med* 1986
4. Jamieson TW. Corticosteroids in Rheumatic Diseases-Pharmacology and Physiology. *Postgrad Med* 1986.
5. Jamieson TW, Desmet AA, Cremer MA, Kage KL, Lindsley HB. Collagen-Induced Arthritis in Rats: A Radiographic Analysis. *Investigative Radiol* 1985

#### **Case Reports, Reviews, Chapters and Editorials/Letters**

##### **Letters**

1. Hemmer PA, Jamieson TW, Pangaro LN. Reliable, Valid, and Educational Medical Student-in-Training Evaluation Overlooked. *Acad Med* 2000
2. Jamieson TW. Medical Students Need More Medicolegal Education. *Acad Med* 1999

##### **Reviews**

1. Jamieson TW, Desmet AA, Stechschulte DJ. Erosive Arthritis in Scleromyxedema. *Skeletal Radiol* 1985

### **Textbook Chapters**

1. Jamieson TW, Hemmer PA, Pangaro LN. Legal Aspects of Failing Grades. Guidebook For Clerkship Directors, 3<sup>rd</sup> edition, Alliance for Clinical Education University of Nebraska Press 2005
2. Jamieson TW. Bursitis, Tendonitis, Myofascial Pain, and Fibromyalgia. Conn's Current Therapy, WB Saunders Co., Philadelphia 2000
3. Jamieson TW. Osteoarthritis. Manual of Rheumatology and Outpatient Disorders. Little, Brown, & Co., Boston 1993
4. Jamieson TW. Fibrositis, Bursitis, and Tendonitis. Conn's Current Therapy, WB Saunders Co., Philadelphia 1992

### **Case Reports**

1. Gregory, M, Mersfelder, TL, Jamieson, TW. Accidental Overdose of Tiotropium in a Patient with Atrial Fibrillation. Ann Pharmacol 2010
2. Jamieson TW, Curran JJ, Desmet AA, Cotelingam JD, Kimmich H. Bilateral Pigmented Villonodular Synovitis of the Wrist. Orthopaedic Rev 1990
3. Curran JJ, Jamieson TW. Dermatomyositis-like Syndrome Associated with Phenylbutazone Therapy. J Rheum 1987
4. Jamieson TW. Adult Still's Disease Complicated by Cardiac Tamponade. JAMA 1983

### **FORENSIC CONSULTING:**

Personal injury/medical malpractice/product liability (plaintiff/defense)

Julie Kroviak, M.D.

EDUCATION:

1991-1995 BS Spanish Language and Literature, Georgetown University, Washington D.C.

1996-2000 MD, University of Alabama School of Medicine, Birmingham, AL

POST-GRADUATE  
EDUCATION:

2000-2001 Intern, Internal Medicine, Georgetown University Medical Center, Washington, DC

2001-2003 Resident, Internal Medicine, Georgetown University Medical Center, Washington, DC

BOARD CERTIFICATION: Internal Medicine 2003

ACTIVE LICENSES: Virginia

PRACTICE:

Feb 2014- present:  
Senior Physician, Office of the Inspector General, Veterans Affairs, Office of Healthcare Inspections

2003- 2014:  
Medical Team Leader, Department of Veterans Affairs, Washington DC and Fort Belvoir Community Clinic

I directly supervised a staff of four physicians, two NP's, 1 PA as well as directing the operations of seven subspecialty clinics with which we were co-located.

During my ten + years with the VA I worked to transform a small community based clinic serving under 400 veterans into one of the three DOD/VA cooperative arrangements in the nation that serves over 6,000 veterans. Beyond managing clinical staff, and serving as the lead liaison with DOD, I was also responsible for maintaining standards to meet JCAHO and JTF standards of accreditation. As the medical director of this clinic, I also organized and led weekly team management meetings, directly handled all patient complaints and congressional inquiries, and worked closely with hospital administration to ensure that patient care needs continued to be met despite limited resources.

References available upon request



CURRICULUM VITAEBIOGRAPHICAL

NAME: Alan Gary Mallinger

BUSINESS ADDRESS: DVA Office of Inspector General  
Office of Healthcare Inspections  
801 I Street, NW  
Washington, DC 20001

BUSINESS PHONE: 202-461-4684 FAX: 202-495-5858

EDUCATION AND TRAININGUndergraduate:

<u>Dates:</u>	<u>Institution:</u>	<u>Degree:</u>	<u>Major:</u>
1965-1969	College of Arts and Sciences University of Pittsburgh Pittsburgh, Pennsylvania	Bachelor of Science, 1969	Biophysics and Microbiology

Graduate:

<u>Dates:</u>	<u>Institution:</u>	<u>Degree:</u>	<u>Discipline:</u>
1969-1973	School of Medicine University of Pittsburgh Pittsburgh, Pennsylvania	Doctor of Medicine, 1973	Medicine

Post-Graduate:

<u>Dates:</u>	<u>Institution:</u>	<u>Program:</u>	<u>Discipline:</u>
1973-1974	Western Psychiatric Institute & Clinic University of Pittsburgh Pittsburgh, Pennsylvania	Internship- Residency	Medicine- Psychiatry
1974-1975 1979-1981	Western Psychiatric Institute & Clinic University of Pittsburgh Pittsburgh, Pennsylvania	Residency	Psychiatry

APPOINTMENTS AND POSITIONS

Academic:

<u>Dates:</u>	<u>Institution:</u>	<u>Title:</u>
2014-present	School of Medicine Uniformed Services University of the Health Sciences Bethesda, Maryland	Clinical Professor in Psychiatry
2012-present	School of Medicine University of Pittsburgh Pittsburgh, Pennsylvania	Adjunct Professor of Psychiatry
2011-2012	Division of Intramural Research Programs National Institute of Mental Health Bethesda, Maryland	Special Volunteer Experimental Therapeutics and Pathophysiology Branch
2003-2012	School of Medicine University of Pittsburgh Pittsburgh, Pennsylvania	Clinical Professor of Psychiatry
2010-2011	Division of Intramural Research Programs National Institute of Mental Health Bethesda, Maryland	Research Psychiatrist Experimental Therapeutics and Pathophysiology Branch
2006-2010	Division of Intramural Research Programs National Institute of Mental Health Bethesda, Maryland	Unit Chief, Outpatient Research Clinic Mood and Anxiety Disorders Program
2007-2008	School of Medicine Johns Hopkins University Baltimore, Maryland	Visiting Scientist in Psychiatry
1999-2003	School of Medicine University of Pittsburgh Pittsburgh, Pennsylvania	Professor of Psychiatry and Pharmacology
1987-1999	School of Medicine University of Pittsburgh Pittsburgh, Pennsylvania	Associate Professor of Psychiatry and Pharmacology
1985-1987	School of Medicine University of Pittsburgh Pittsburgh, Pennsylvania	Associate Professor of Psychiatry and Assistant Professor of Pharmacology

APPOINTMENTS AND POSITIONS (continued)

Academic: (continued)

<u>Dates:</u>	<u>Institution:</u>	<u>Title:</u>
1979-2003	School of Medicine University of Pittsburgh Pittsburgh, Pennsylvania	Member of the Graduate Faculty
1976-1985	School of Medicine University of Pittsburgh Pittsburgh, Pennsylvania	Assistant Professor of Psychiatry and Pharmacology
1975-1976	School of Medicine University of Pittsburgh Pittsburgh, Pennsylvania	Instructor in Psychiatry and Pharmacology

Non-Academic:

<u>Dates:</u>	<u>Institution:</u>	<u>Position:</u>
May, 2014-present	Office of Inspector General Department of Veterans Affairs Washington, DC	Senior Physician (Senior Level) Medical Consultation and Review
May, 2011-May, 2014	Office of Inspector General Department of Veterans Affairs Washington, DC	Senior Physician Medical Consultation and Review
July, 2010-May, 2011	Division of Intramural Research Programs National Institute of Mental Health Bethesda, Maryland	Staff Clinician Experimental Therapeutics and Pathophysiology Branch
July, 2006-July, 2010	Division of Intramural Research Programs National Institute of Mental Health Bethesda, Maryland	Staff Clinician Mood and Anxiety Disorders Program
July, 2003- December, 2006	Private Practice (full time) Pittsburgh, Pennsylvania	Psychiatrist
October, 2001- June, 2003	Private Practice (part time) Pittsburgh, Pennsylvania	Psychiatrist

APPOINTMENTS AND POSITIONS (continued)Non-Academic: (continued)

<u>Dates:</u>	<u>Institution:</u>	<u>Position:</u>
July, 1995- June, 1999	Western Psychiatric Institute and Clinic University of Pittsburgh Pittsburgh, Pennsylvania	Medical Director, Stanley Center for the Innovative Treatment of Bipolar Disorder
July, 1992- October, 2001	Western Psychiatric Institute and Clinic University of Pittsburgh Pittsburgh, Pennsylvania	Associate Medical Director, Maintenance Psychotherapy in Recurrent Depression Study, Depression Prevention Program
July, 1990- December, 2002	Western Psychiatric Institute and Clinic University of Pittsburgh Pittsburgh, Pennsylvania	Medical Director, Maintenance Therapies in Bipolar Disorder Study, Depression Prevention Program
July, 1990- June, 1995	Western Psychiatric Institute and Clinic University of Pittsburgh Pittsburgh, Pennsylvania	Medical Director Pharmacotherapy Training in Mood Disorders Program
July, 1987- June, 2003	Western Psychiatric Institute and Clinic University of Pittsburgh Pittsburgh, Pennsylvania	Director, Psychopharmacology of Mania and Depression Program
December, 1982- June, 2003	Western Psychiatric Institute and Clinic University of Pittsburgh Pittsburgh, Pennsylvania	Attending Psychiatrist, Mood Disorders Module
July, 1982- June, 1991	Department of Epidemiology Graduate School of Public Health University of Pittsburgh Pittsburgh, Pennsylvania	Consultant Psychiatrist, Systolic Hypertension in the Elderly Program
July, 1981- December, 1982	Western Psychiatric Institute & Clinic University of Pittsburgh Pittsburgh, Pennsylvania	Associate Attending Psychiatrist and Treatment Team Leader, Schizophrenia Module

APPOINTMENTS AND POSITIONS (continued)

Non-Academic: (continued)

<u>Dates:</u>	<u>Institution:</u>	<u>Position:</u>
June-Sept., 1971 June-Sept., 1970	School of Medicine University of Pittsburgh Pittsburgh, Pennsylvania	Pre-doctoral Research Fellow
May-Sept., 1969	Department of Chemistry College of Arts & Sciences University of Pittsburgh Pittsburgh, Pennsylvania	Research Assistant
May-Sept., 1968	Department of Biophysics and Microbiology College of Arts & Sciences University of Pittsburgh Pittsburgh, Pennsylvania	Research Assistant
May-Sept., 1967 May-Sept., 1966	Department of Chemistry College of Arts & Sciences University of Pittsburgh Pittsburgh, Pennsylvania	Laboratory Assistant
June-Sept., 1964	Department of Anatomy and Cell Biology School of Medicine University of Pittsburgh Pittsburgh, Pennsylvania	Research Trainee

CERTIFICATION AND LICENSURE

Specialty Certification:

Board Certified (Psychiatry), 1982  
American Board of Psychiatry and Neurology

Medical Licensure:

1. State of Maryland
2. Commonwealth of Pennsylvania (inactive status)

Diplomate, National Board of Medical Examiners

MEMBERSHIPS IN PROFESSIONAL AND SCIENTIFIC SOCIETIES

<u>Date:</u>	<u>Organization:</u>
2012-present	American College of Psychiatrists
1988-present	Society of Biological Psychiatry
1978-2002	American Psychosomatic Society
1977-2002	Society for Neuroscience
1977-2002	American Society for Clinical Pharmacology and Therapeutics
1976-2002	American Association for the Advancement of Science
1975-2002	American College of Clinical Pharmacology (Fellow, 1982)
1999-2002	International Society for Bipolar Disorders

MEDICAL STAFF APPOINTMENTS

<u>Dates:</u>	<u>Institution:</u>
April, 2007- May, 2011	National Institutes of Health Clinical Center 10 Center Drive Bethesda, Maryland
April, 2008- April, 2010	National Naval Medical Center 8901 Wisconsin Avenue Bethesda, Maryland
July, 1981- June, 2003	Western Psychiatric Institute and Clinic University of Pittsburgh 3811 O'Hara Street Pittsburgh, PA

HONORS

<u>Date:</u>	<u>Title of Award:</u>
1994, 1998	Nominated for Outstanding Teacher Award (Golden Apple) WPIC Residents Graduating Class
1982	Mead Johnson Travel Fellowship (American College of Neuropsychopharmacology)
1981	Laughlin Fellow (American College of Psychiatrists)
-----	
1973	M.D. conferred cum laude
1969	B.S. conferred summa cum laude
-----	
1972	Alpha Omega Alpha
1969	Phi Beta Kappa
1967	Beta Beta Beta
1966	Phi Eta Sigma
-----	
1969-73	Medical Alumni Scholar
1972	Roche Award (academic achievement)
1970	Nu Sigma Nu Award (academic achievement)
1970	Guthrie Award (Medical Physiology)
1970	Stock Award (Medical Microbiology)
1966-69	University Scholar
1969	Phi Eta Sigma Senior Scholar Award

PUBLICATIONS

Refereed Articles:

- Mallinger, A.G., Jozwiak, E.L. and Carter, J.C.: Preparation of boron containing bovine gamma-globulin as a model compound for a new approach to slow neutron therapy of tumors. *Cancer Res.* 32:1947-1950, 1972.
- Mallinger, A.G., Kupfer, D.J., Poust, R.I. and Hanin, I.: In vitro and in vivo transport of lithium by human erythrocytes. *Clin. Pharmacol. Ther.* 18:467-474, 1975.
- Poust, R.I., Mallinger, A.G., Mallinger, J., Himmelhoch, J.M. and Hanin, I.: Pharmacokinetics of lithium in human plasma and erythrocytes. *Psychopharm. Commun.* 2:91-103, 1976.
- Poust, R.I., Mallinger, A.G., Mallinger, J., Himmelhoch, J.M., Neil, J.F. and Hanin, I.: Effect of chlorothiazide on the pharmacokinetics of lithium in plasma and erythrocytes. *Psychopharm. Commun.* 2:273-284, 1976.
- Ratey, J.J. and Mallinger, A.G.: The relationship between extra- and intracellular lithium concentration in human red blood cells: An in vitro study. *Brit. J. Psychiat.* 131:59-62, 1977.
- Himmelhoch, J.M., Poust, R.I., Mallinger, A.G., Hanin, I. and Neil, J.F.: Adjustment of lithium dosage during lithium/chlorothiazide therapy. *Clin. Pharmacol. Ther.* 22:225-227, 1977.
- Chweh, A.Y., Pulsinelli, P.D., Goehl, T.J., Abraham, D.J., Miklos, F., Draus, F. and Mallinger, A.G.: A proposed model for the action of lithium. *Commun. Psychopharm.* 1:363-372, 1977.
- Neil, J.F., Himmelhoch, J.M., Mallinger, A.G., Mallinger, J. and Hanin, I.: Caffeinism complicating hypersomnic depressive episodes. *Compr. Psychiat.* 19:377-385, 1978.
- Mallinger, A.G., Mallinger, J.E., Himmelhoch, J.M., Neil, J.F. and Hanin, I.: Transmembrane distribution of lithium and sodium in erythrocytes of depressed patients. *Psychopharmacology* 68:249-255, 1980.
- Hanin, I., Mallinger, A.G., Kopp, U., Himmelhoch, J.M. and Neil, J.: Mechanism of lithium-induced elevation in red blood cell choline content: An in vitro analysis. *Commun. Psychopharm.* 4:345-355, 1980.
- Mallinger, A.G., Himmelhoch, J.M. and Neil, J.F.: Anergic depression accompanied by increased intracellular sodium and lithium. *J. Clin. Psychiatry* 42:83-86, 1981.
- Mallinger, A.G., Hanin, I., Stumpf, R.L., Mallinger, J., Kopp, U. and Erstling, C.: Lithium treatment during pregnancy: A case study of erythrocyte choline content and lithium transport. *J. Clin. Psychiatry* 44:381-384, 1983.



Refereed Articles: (continued)

- Mallinger, A.G., Mallinger, J., Himmelhoch, J.M., Rossi, A. and Hanin, I.: Essential hypertension and membrane lithium transport in depressed patients. *Psychiatry Res.* 10:11-16, 1983.
- Mallinger, A.G., Kopp, U. and Hanin, I.: Erythrocyte choline transport in drug-free and lithium-treated individuals. *J. Psychiatric Res.* 18:107- 117, 1984.
- Mallinger, A.G., Poust, R.I., Mallinger, J., Himmelhoch, J.M., Neil, J.F., Koo, E. and Hanin, I.: A pharmacokinetic approach to the study of cell membrane lithium transport in vivo. *J. Clin. Psychopharmacol.* 5:78-82, 1985.
- Edwards, D.J., Mallinger, A.G., Knopf, S. and Himmelhoch, J.M.: Determination of tranlycypromine in plasma using gas chromatography- chemical ionization-mass spectrometry. *Journal of Chromatography, Biomedical Applications* 344:356-361, 1985.
- Mallinger, A.G., Edwards, D.J., Himmelhoch, J.M., Knopf, S. and Ehler, J.: Pharmacokinetics of tranlycypromine in patients who are depressed: Relationship to cardiovascular effects. *Clin. Pharmacol. Ther.* 40:444-450, 1986.
- Bunker, C.H., Mallinger, A.G., Adams, L.L. and Kuller, L.H.: Red blood cell sodium-lithium countertransport and cardiovascular risk factors in black and white college students. *J. Hypertension* 5:7-15, 1987.
- Mallinger, A.G., Hanin, I., Himmelhoch, J.M., Thase, M.E. and Knopf, S.: Stimulation of cell membrane sodium transport activity by lithium: Possible relationship to therapeutic action. *Psychiatry Res.* 22:49-59, 1987.
- Thase, M.E., Himmelhoch, J.M., Mallinger, A.G., Jarrett, D.B. and Kupfer, D.J.: Sleep EEG and DST findings in anergic bipolar depression. *Am. J. Psychiatry* 146:329-333, 1989.
- Mallinger, A.G., Himmelhoch, J.M., Thase, M.E., Edwards, D.J. and Knopf, S.: Plasma tranlycypromine: Relationship to pharmacokinetic variables and clinical antidepressant actions. *J. Clin. Psychopharmacol.* 10:176-183, 1990.
- Mallinger, A.G., Himmelhoch, J.M., Thase, M.E., Dippold, C.S. and Knopf, S.: Reduced cell membrane affinity for lithium ion during maintenance treatment of bipolar affective disorder. *Biol. Psychiatry* 27:795-798, 1990.
- Frank, E., Kupfer, D.J., Perel, J.M., Cornes, C., Jarrett, D.B., Mallinger, A.G., Thase, M.E., McEachran, A.B. and Grochocinski, V.J.: Three year outcomes for maintenance therapies in recurrent depression. *Arch. Gen. Psychiatry* 47:1093-1099, 1990.
- Himmelhoch, J.M., Thase, M.E., Mallinger, A.G. and Houck, P: Tranlycypromine versus imipramine in anergic bipolar depression. *Am. J. Psychiatry* 148:910-916, 1991.

Refereed Articles: (continued)

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Poust, R.I., Mallinger, A.G., Mallinger, J., Himmelhoch, J.M., Neil, J.F. and Hanin, I.: Absolute availability of lithium. *J. Pharm. Sci.* 66:609, 1977.

Poust, R.I. and Mallinger, A.G.: Lithium pharmacokinetics. *Eur. J. Clin. Pharmacol.* 13:463-464, 1978.

Himmelhoch, J.M., Neil, J.F., Mallinger, A.G., Poust, R.I. and Hanin, I.: Lithium with diuretics. *Drug Therapy* 3:9-10, 1978.

Soares, J.C. and Mallinger, A.G.: Abnormal phosphatidylinositol (PI) - signalling in bipolar disorder. *Biol. Psychiatry* 39:461-462, 1996.

Moses, E.L. and Mallinger, A.G.: St. John's Wort: Three cases of possible mania induction. *J. Clin. Psychopharmacol.* 20:115-117, 2000.

PROFESSIONAL ACTIVITIES

TEACHING (Uniformed Services University of the Health Sciences)

<u>Activity:</u>	<u>Program:</u>	<u>Content:</u>
Student Preceptor 2013-present	Psychiatry	Weekly precepting of medical students in second/third year clinical clerkship.

TEACHING (National Institutes of Health):

<u>Activity:</u>	<u>Program:</u>	<u>Content:</u>
Writing Seminar 2011-2012	Experimental Therapeutics	Biweekly seminar/workshop for Clinical Fellows on writing for publication.
Journal Club Coordinator 2010-2011	Experimental Therapeutics	Weekly journal club for Fellows and staff.
Seminar Coordinator (Clinical and Research Fellows) 2007-2010	Mood and Anxiety Disorders	Weekly seminars on current psychiatric literature.

TEACHING (University of Pittsburgh):

<u>Courses Directed:</u>	<u>Department:</u>	<u>Content:</u>
Fourth International Conference on Bipolar Disorder, June, 2001	Psychiatry	International meeting of researchers and clinicians, dealing with recent advances in the bipolar disorder area.
Third International Conference on Bipolar Disorder, June, 1999	Psychiatry	International meeting of researchers and clinicians, dealing with recent advances in the bipolar disorder area.
Second International Conference on Bipolar Disorder, June, 1997	Psychiatry	International meeting of researchers and clinicians, dealing with recent advances in the bipolar disorder area.
Pharmacotherapy Training in Mood Disorders Clinic, (PGY-2), 1997-2001	Psychiatry	Longitudinal management of mood disorder cases, with group supervision.
Mood Disorders Seminar (PGY-3), 1995-2001	Psychiatry	Weekly seminar series on psychopathology and pharmacotherapy in outpatient practice.

TEACHING (University of Pittsburgh): (continued)

<u>Courses Directed:</u>	<u>Department:</u>	<u>Content:</u>
Pharmacotherapy Training in Mood Disorders Elective (PGY-3, 4), 1990-2001	Psychiatry	Group supervision and discussion of maintenance pharmacotherapy.
Pharmacotherapy Training in Mood Disorders Course (PGY-3), 1990-1995	Psychiatry	Weekly lecture program and group supervision.

Conducted additional Lectures/Seminars/Mentoring/Supervision/Case Conferences from 1975 to 2006.

RESEARCH:

Grants Received (Principal Investigator):

<u>Date:</u>	<u>Title:</u>	<u>Source:</u>
January- December, 1975	<u>In vitro</u> studies of lithium metabolism by erythrocytes of de- pressed patients.	Fluid Research Program Western Psychiatric Institute and Clinic University of Pittsburgh Pittsburgh, Pennsylvania
January, 1976- December, 1977	Erythrocytic lithium and electrolyte trans- port in depressive illness.	Pharmaceutical Manufacturers Association Foundation 1155 Fifteenth St., NW Washington, D.C.
April, 1976- March, 1977	Lithium and electro- lyte transport in depression. MH28252	National Institute of Mental Health Mental Health Small Grants Program 5600 Fishers Lane Rockville, Maryland
January- December, 1978	Alterations of cell membrane lithium trans- port in depression.	Health Research and Services Foundation 200 Ross Street Pittsburgh, Pennsylvania
April, 1978- June, 1980	Lithium and sodium transport studies in depression. MH31279	National Institute of Mental Health Psychopharmacology Research Branch 5600 Fishers Lane Rockville, Maryland

Grants Received (Principal Investigator): (continued)

<u>Date:</u>	<u>Title:</u>	<u>Source:</u>
January, 1981- December, 1982	Cell membrane transport of lithium and sodium in depression.	Health Research and Services Foundation 200 Ross Street Pittsburgh, Pennsylvania
October, 1983- March, 1985	Pharmacokinetics of tranylcypromine in depressed patients.	Smith Kline and French Laboratories 1500 Spring Garden Street Philadelphia, Pennsylvania
January, 1987- December, 1990	Cell membrane phenomena in affective disorders. MH40478	National Institute of Mental Health Affective and Anxiety Disorders Research Branch 5600 Fishers Lane Rockville, Maryland
July, 1990- June, 1991	Membrane phospholipid turnover and metabolism in bipolar disorder.	Seed Project Mental Health Clinical Research Center for Affective Disorders University of Pittsburgh Pittsburgh, Pennsylvania
July, 1992- December, 1993	A double-blind dose-response study to determine the safety and efficacy of fixed doses of moclobemide in patients with social phobia.	Hoffmann-La Roche, Inc. 340 Kingsland Street Nutley, New Jersey
September, 1994- August, 1999	Pharmacotherapy of treatment-resistant mania. MH50634	National Institute of Mental Health Clinical Treatment Research Branch 5600 Fishers Lane Rockville, Maryland
May, 1995- September, 1999	Double-blind controlled study of oral inositol for lithium-induced side effects.	Stanley Center for the Innovative Treatment of Bipolar Disorder (substudy) University of Pittsburgh Pittsburgh, Pennsylvania

Grants Received (Principal Investigator): (continued)

<u>Date:</u>	<u>Title:</u>	<u>Source:</u>
November, 2000- September, 2002	Brain levels of lithium as a predictor of drug response in depressed women with rapid cycling bipolar disorder: Pilot study N01 MH 80001	National Institute of Mental Health 6001 Executive Boulevard Bethesda, Maryland

NIMH Intramural Research Projects (Principal Investigator):

<u>Date:</u>	<u>Title:</u>
April, 2008- May, 2011	An investigation to determine whether levels of p11 protein in peripheral blood cells correlate with treatment response to citalopram in patients with major depressive disorder.

NIMH Intramural Research Projects (Associate Investigator):

<u>Date:</u>	<u>Title:</u>
December, 2006- May, 2011	The evaluation of patients with mood and anxiety disorders and healthy volunteers (Principal Investigator: Carlos A. Zarate, Jr., M.D.)
December, 2006- February, 2010	Combining a dopamine agonist and selective serotonin reuptake inhibitor for treatment of depression: a double-blind, randomized study (Principal Investigator: Carlos A. Zarate, Jr., M.D.)
December, 2006- May, 2011	An investigation of the antidepressant efficacy of an antiglutamatergic agent in bipolar depression (Principal Investigator: Carlos A. Zarate, Jr., M.D.)
May, 2008- May, 2011	Investigation of the rapid (next day) antidepressant effects of an NMDA antagonist (Principal Investigator: Carlos A. Zarate, Jr., M.D.)
June, 2008- September, 2009	Evaluation of the efficacy of the NK1 antagonist GR205171 in posttraumatic stress disorder (Principal Investigator: Carlos A. Zarate, Jr., M.D.)
June, 2008- May, 2011	An investigation of the antidepressant efficacy of a selective, high affinity enkephalinergic agonist in anxious major depressive disorder (Principal Investigator: Carlos A. Zarate, Jr., M.D.)

NIMH Intramural Research Projects (Associate Investigator): (continued)

<u>Date:</u>	<u>Title:</u>
July, 2008- May, 2011	Psychobiological mechanisms of resilience to trauma (Principal Investigator: James Blair, Ph.D.)
November, 2008- May, 2011	Antidepressant effects on cAMP specific phosphodiesterase (PDE4) in depressed patients (Principal Investigator: Masahiro Fujita, M.D., Ph.D.)
April, 2009- May, 2011	An investigation of the antidepressant effects of a low-trapping mixed NR2A/2B antagonist in treatment-resistant major depression (Principal Investigator: Carlos A. Zarate, Jr., M.D.)
November, 2009 May, 2011-	Imaging serotonin 5-HT <sub>1A</sub> receptors in the high affinity state in brains of patients with major depressive disorder (Principal Investigator: Christina S. Hines, M.D., Ph.D.)
September, 2010- May, 2011	Efficacy and tolerability of riluzole and biomarker of treatment response in treatment-resistant depression (Principal Investigator: Carlos A. Zarate, Jr., M.D.)
October, 2010- May, 2011	Development of functional and structural magnetic resonance imaging techniques for the study of mood and anxiety disorders (Principal Investigator: Allison Nugent, Ph.D.)

Collaborative Research Projects (Walter Reed Army Medical Center):

<u>Date:</u>	<u>Title:</u>
May, 2008- May, 2011	The ViRTICo-BP trial: Virtual reality therapy and imaging in combat veterans with blast injury and posttraumatic stress disorder (Principal Investigator: COL Michael J. Roy, M.D.)

Grant Reviewing:

<u>Date:</u>	<u>Description:</u>	<u>Agency:</u>
February, 1980 October, 1981 May, 1982 (site visit)	Consultant for scientific merit review.	Psychopathology and Clinical Biology Research Review Committee National Institute of Mental Health Rockville, Maryland
October, 1982 (site visit)	Consultant for scientific merit review.	Treatment Development and Assessment Research Review Committee National Institute of Mental Health Rockville, Maryland
December, 1983	Member, Special Review Committee.	National Institute of Mental Health Rockville, Maryland
March, 1985	Member, Ad Hoc Review Committee.	Scientific Review Office National Institute on Aging Bethesda, Maryland
March, 1991 - June, 1994	Member, ADAMHA Reviewers Reserve.	Alcohol, Drug Abuse and Mental Health Administration Department of Health and Human Services Rockville, Maryland
June, 1995 - June, 1998	Member, Merit Review Committee for Mental Health and Behavioral Sciences.	Department of Veterans Affairs Veterans Health Administration Washington, D.C.
February, 1996	Consultant Reviewer.	Molecular, Cellular, and Developmental Neurobiology Review Committee National Institute of Mental Health Rockville, Maryland
May, 1996	Consultant for RFP concept review.	Clinical Treatment Research Branch National Institute of Mental Health Rockville, Maryland
June, 1997 - June, 1998	Chairperson, Merit Review Committee for Mental Health and Behavioral Sciences.	Department of Veterans Affairs Veterans Health Administration Washington, D.C.



Grant Reviewing: (continued)

<u>Date:</u>	<u>Description:</u>	<u>Agency:</u>
June, 1998 December, 1998	Member, Merit Review Council.	Department of Veterans Affairs Veterans Health Administration Washington, D.C.
October, 1999	Ad Hoc Member, Merit Review Committee for Mental Health and Behavioral Sciences.	Department of Veterans Affairs Veterans Health Administration Washington, D.C.
November, 1999	Ad Hoc Member, Interventions Research Review Committee	National Institute of Mental Health Bethesda, Maryland
December, 1999	Consultant Reviewer	Medical Research Council London, U.K.
March, 2000 May, 2000	Ad Hoc Member, Seed Money Review Committee	Mental Health Intervention Research Center for the Study of Mood and Anxiety Disorders University of Pittsburgh Pittsburgh, Pennsylvania
July, 2000 - July, 2002	Member, Seed Money Review Committee	Mental Health Intervention Research Center for the Study of Mood and Anxiety Disorders University of Pittsburgh Pittsburgh, Pennsylvania
February, 2003	Consultant Reviewer	Department of Veterans Affairs Veterans Health Administration Washington, D.C.

Recent Journal Reviewing (since 2006):

Journal of Clinical Psychiatry  
Biological Psychiatry  
American Journal of Psychiatry  
Neuropsychopharmacology  
Bipolar Disorders  
2009 and 2010 NCDEU Meeting submissions  
Case Reports in Medicine  
International Medical Case Reports Journal

SERVICE:

Community:

<u>Date:</u>	<u>Description:</u>
September, 1983	Lecture on mood disorders presented to counselors at the Pittsburgh Pastoral Institute.
September, 1985	Guest Speaker, Depressive Illness Support Group, Pittsburgh, PA.
November, 1985	Lecture on "Depression and its Treatment" presented at the Harmarville Rehabilitation Center.
January, 1987	Lecture on "Depression in the Workplace" presented to Pennsylvania Academy of Family Physicians, Allegheny Chapter.
May, 1987	Lecture on "Management of Clinical Depression" presented at Holy Spirit Hospital, Camp Hill, PA.
January, 1988	Lecture on "Depression" presented at Medical Grand Rounds, St. Francis Hospital, Pittsburgh, PA.
February, 1988	Lecture on "Problems of Modern Psychotherapy" presented at Psychiatric Grand Rounds, St. Francis Hospital, Pittsburgh, PA.
June, 1988	Presentation on "Manic Depressive Illness" to the Alliance for the Mentally Ill of Erie County, Erie, PA.
July, 1988	Lecture on "Depression" presented at Green County Memorial Hospital, Waynesburg, PA.
October, 1988	Guest Discussant on the Al McDowell Show, KDKA radio, Pittsburgh, PA.
May, 1989	Guest Speaker, Depressive Illness Support Group, Pittsburgh, PA.
June, 1989	Lecture on "Treatment of Bipolar Disorder" presented at Psychiatric Grand Rounds, Hamot Hospital, Erie, PA.

SERVICE: (continued)

Community: (continued)

<u>Date</u> :	<u>Description</u> :
October, 1989	Guest Speaker, Western Pennsylvania Chapter of the National Depressive and Manic-Depressive Association, Pittsburgh, PA.
September, 1990	Lecture on "Mood Disorders: Acute and Long-Term Management" presented at Psychiatric Grand Rounds, Hamot Hospital, Erie, PA.
December, 1990	Lecture on "Pharmacology of Tricyclic Antidepressants" presented at the Pain Evaluation and Treatment Institute, Pittsburgh, PA.
December, 1990	Guest Discussant on "Holiday Depression", KDKA radio, Pittsburgh, PA.
December, 1992	Guest Discussant on "Depression, Social Phobia, and the Holidays", WMXP radio, Pittsburgh, PA.
September, 1993	Presentation on "Social Butterflies - Social Phobia" at HealthPLACE, Pittsburgh, PA.
May, 1996	Guest Discussant on "Bipolar Disorder", WBZY radio, New Castle, PA.
November, 2002	Presentation on "Depression" at Carnegie Library, Mt. Washington Branch, Pittsburgh, PA.
March, 2003	Presentation on "Depression" at Carnegie Library, Oakland Main Library, Pittsburgh, PA.
March, 2007	Presentation on "An Update on Mood Disorders: Research at NIMH" to Bethesda Beatniks Support Group, Washington, D.C.
July, 2007	Presentation on "Pathophysiology of Affective Disorders and Potential New Treatments for Treatment-Resistant Mood Disorders" to Depression and Bipolar Support Alliance, George Washington University Hospital, Washington, D.C.
November, 2007	Presentation on "New Research on the Causes and Treatment of Mood Disorders" to NAMI, Prince George's County, New Carrollton, MD.
February, 2008	Presentation on "How to Find the Right Meds for Your Bipolar Disorder," webcast on HealthTalk ( <a href="http://www.healthtalk.com">www.healthtalk.com</a> ), Seattle, WA.

SERVICE: (continued)

Community: (continued)

<u>Date</u> :	<u>Description</u> :
April, 2008	Presentation on “Research and Treatment Issues in Unipolar Depression” to Depression and Bipolar Support Alliance, George Washington University Hospital, Washington, D.C.
July, 2008	Informational interview for NAMI Prince George’s County newsletter.
February, 2009	Presentation on “Research and Treatment Issues in Unipolar Depression” to NAMI, Montgomery County, Bethesda, MD.
April, 2009	Psychiatry Grand Rounds presentation: “Monoamine Oxidase Inhibitors: New Lessons from Older Medicines” at Penn State College of Medicine, Hershey, PA.

## Michael L. Shepherd MD, CPA

### **PROFESSIONAL EXPERIENCE**

Office of Inspector General, U.S. Department of Veterans Affairs, Washington, DC  
**Senior Level Physician** 2005-Present

Comprehensive Health Systems, Fishersville, VA  
**Private Practice-Attending Physician** 2004-2005

- Co-Medical Director, inpatient mental health treatment unit. Provided outpatient treatment to patients in private practice and consult/liaison and medical detoxification services for the medical-surgical service at a rural, private, community hospital.

Western State Hospital, Staunton, VA  
**Head of Treatment Team** 2001-2004

- Directed inpatient mental health treatment unit. Led multi-disciplinary team, coordinated treatment planning, and active, recovery oriented care for complex patients with serious mental illness and concomitant medical issues.
- Co-chaired hospital quality assurance and medical staff committees.
- Provided lectures on dementia, delirium, and forensic psychiatry for University of Virginia medical students. Supervised medical and physician assistant students during clinical psychiatry rotation.

University of Virginia Medical Center, Charlottesville, VA  
**Clinical Assistant Professor/Geriatric Psychiatrist** 2001-2004

- Provided on-site geriatric psychiatry consultation and treatment to senior adults residing in long term care facilities. Supervised third year medical students.

University of Virginia Medical Center, Charlottesville, VA  
**Assistant Professor of Psychiatric Medicine** 1999-2001

- Provided outpatient and inpatient adult and geriatric psychiatry evaluation and treatment. Presented at UVA grand rounds and external healthcare conferences. Developed joint on-site, integrated, psychiatric consultation co-located in the Neurology Memory Disorders Clinic. Provided psychiatric consultation liaison services to patients on medical-surgical units.
- Mentored and supervised geriatric psychiatry fellows, resident physicians and medical students. Provided medical student lectures on delirium and dementia.
- In coordination with UVA geriatricians, provided once per week, bedside teaching for family practice residents and geriatric medicine fellows at an affiliated nursing facility.

Riverside Methodist Hospital, Columbus, OH  
**Director of Geriatric Psychiatry Services** 1998-1999

- Led geriatric-psychiatry services at a large, urban hospital. Developed and coordinated implementation of an acute inpatient senior adult mental health treatment unit, partial hospitalization program, and co-located geriatric psychiatry outpatient clinic. Treated adult psychiatry inpatients, and provided psychiatric consult-liaison services to patients on medical surgical units.

### **MEDICAL TRAINING**

**University of Virginia Medical Center**, Charlottesville, VA 1996-1998  
Senior (PL-IV) Psychiatry Resident and Geriatric Psychiatry Fellowship

**The Johns Hopkins Hospital**, Baltimore, MD 1994-1996  
Psychiatry Residency

**Texas Children's Hospital, Baylor College of Medicine**, Houston, TX 1992-1994  
Pediatric Residency

**St. Louis Children's Hospital**, St. Louis, MO 1991-1992  
Pediatric Internship

### **EDUCATION**

**CPA University of Virginia**, Charlottesville, Virginia, 30 Credit Certificate in Accounting 2010  
Certified Public Accountant (CPA) designation

**MD Rutgers University-Robert Wood Johnson Medical School** 1991  
Piscataway, New Jersey, Doctor of Medicine (MD)

**BA Cornell University**, Ithaca, New York, Economics 1987

### **CERTIFICATION and Licensure**

American Board of Psychiatry and Neurology: Board Certification in Psychiatry

Active Medical License in Virginia

Active Certified Public Accountant license in Virginia

### **PUBLICATIONS (NON-OIG)**

Peter D. Mills; Joseph M. DeRosier; Bryan A. Ballot; **Michael Shepherd**; James P. Bagian, *Inpatient Suicide and Suicide Attempts in Veterans Affairs Hospitals*, Joint Commission Journal on Quality and Patient Safety, Joint Commission Resources, 2008; 34 (8): 482-488.

Suzanne Holroyd M.D. and **Michael L. Shepherd M.D.**, *Alzheimer's Disease: A Review for the Ophthalmologist*, Survey of Ophthalmology, Volume 45, Number 6, May-June 2001: 516-524.

Suzanne Holroyd, M.D.; **Michael L. Shepherd M.D.**; and J. Hunter Downs, PhD. *Occipital Atrophy is Associated with Visual Hallucinations in Alzheimer's Disease*, The Journal of Neuropsychiatry and Neurosciences, 2000; 12:25-28.

## **CURRICULUM VITA**

### **GEORGE B. WESLEY, M.D.**

**CURRENT POSITIONS:** Director, Medical Consultation and Review, Office of Inspector General, U.S. Department of Veterans Affairs, 810 Vermont Avenue, N.W., Washington, D.C. 20420 (Grade: SES)

Assistant Professor of Medicine, F. Edward Hébert School of Medicine, Uniformed Services University of the Health Sciences, Bethesda, Maryland 20814

#### **EDUCATION:**

**SECONDARY SCHOOL** – Williston Academy, Easthampton, Massachusetts, 1969-1971

**UNDERGRADUATE** – University of Massachusetts, Amherst, Massachusetts B.S., Zoology-Honors, *summa cum laude*, 1971-1974

**MEDICAL EDUCATION** – University of Rochester School of Medicine and Dentistry, Rochester, New York, M.D., 1974-1978

#### **POSTGRADUATE MEDICAL EDUCATION:**

**INTERNSHIP** – Internal Medicine, St. Luke's Hospital, Denver, Colorado, 1978-1979

**RESIDENCY** – Internal Medicine, St. Luke's Hospital, Denver, Colorado 1979-1981

**FELLOWSHIP** – Laboratory of Microbial Immunity, National Institute of Allergy and Infectious Diseases, National Institutes of Health, Bethesda, Maryland, 1984-1986

#### **OTHER MEDICAL TRAINING:**

National Library of Medicine, National Institutes of Health, Medical Informatics Fellowship, Marine Biological Laboratory, Woods Hole, Massachusetts, June, 1992

#### **MANAGEMENT TRAINING:**

Leadership VA Program, Class of 1990



Government Performance and Results, U.S. Office of Personnel Management, Western Development Center, Aurora, Colorado, August 17–21, 1998

Strategies to Build High Performing Organizations, U.S. Office of Personnel Management, Western Development Center, Aurora, Colorado, August 24–28, 1998

**UNIFORMED SERVICE:**

Senior Assistant Surgeon (O-3), 1981-2 and Surgeon (O-4), 1982-3; National Health Service Corps, United States Public Health Service

**CERTIFICATIONS:**

Diplomate, National Board of Medical Examiners, July 2, 1979

Diplomate, American Board of Internal Medicine, September 16, 1981

**MEDICAL LICENSURE:**

California

## **PROFESSIONAL POSITIONS:**

Medical Officer, Office of Inspector General, Department of Veterans Affairs, December 1989 - Present

Director, Medical Consultation and Review, Office of Healthcare Inspections, Office of Inspector General, Department of Veterans Affairs, December, 2001 - Present

Assistant Professor of Medicine, F. Edward Hébert School of Medicine  
Uniformed Services University of the Health Sciences, Bethesda, Maryland  
1985-86 and 1990 - Present

Medical Advisor to the VA Inspector General, Office of Inspector General, Department of Veterans Affairs, January 2000 - December 2003

Director, Medical Assessment and Consultation Section, Office of Healthcare Inspections, Office of Inspector General, Department of Veterans Affairs, July, 1996 - December, 1999

Director, Research and Program Evaluation Division, Office of Healthcare Inspections, Office of the Inspector General, Department of Veterans Affairs  
July, 1991 - June, 1996

Director, Quality Assurance Review Division and Medical Supervisory Officer, Office of Policy, Planning, & Resources, Office of Inspector General, Department of Veterans Affairs, May, 1989 - June, 1991

Assistant Chief, Ambulatory Care Service, Long Beach, California VA Medical Center, Long Beach, California, May, 1987 - May, 1989

Acting Assistant Chief, Ambulatory Care Service, Long Beach VA Medical Center, Long Beach, California, October, 1986 - May, 1987

Staff Physician, Ambulatory Care Service, Long Beach VA Medical Center  
Long Beach, California, July, 1986 - October, 1986

Faculty Advisor, F. Edward Hébert School of Medicine, Uniformed Services University of the Health Sciences, Bethesda, Maryland 1985 - 1986

Medical Staff Fellow, Laboratory of Microbial Immunity, National Institute of Allergy and Infectious Diseases, National Institutes of Health, Bethesda, Maryland, 1984 - 1986

Staff Internist, St. Luke's Hospital, Denver, Colorado, 1983 - 1984

Staff Internist, 1981 - 1983 and Director, ICU, 1982 - 1983, Prowers Medical Center, Lamar, Colorado

### **SELECTED ASSIGNMENTS/COMMITTEES:**

#### **PROWERS MEDICAL CENTER/NATIONAL HEALTH SERVICE CORPS**

- POW Clinic Coordinator
- Infection Control Committee
- Medical Care Evaluation and Utilization Review Committee
- Chairman, Medical Records Committee
- Emergency Room Committee

#### **LONG BEACH VA MEDICAL CENTER**

- Executive Committee, Ambulatory Care Service
- Credentialing and Privileging Committee, Ambulatory Care Service
- Medical District Peer Review Organization Board Reviewer
- Chairman, Visual Impairment Services Team
- Position Management Subcommittee
- Service Excellence Committee
- Chairman and/or Member, Quality Assurance Investigations
- Chairman, Physical Standards Board

### **SELECTED OIG ASSIGNMENTS**

- Department of Veterans Affairs Office of Inspector General Mission Task Force, 1992
- Office of Healthcare Inspections Strategic Planning Council, July 1996 - November, 1999
- President's Council on Integrity and Ethics/Executive Council on Integrity and Ethics Misconduct in Research Working Group

### **HONORS AND AWARDS:**

#### **WILLISTON ACADEMY**

Graduated Valedictorian, Cum Laude Society, Senior Scientific Award, Achievement in Advanced Mathematics, Best Work in Physics, Bausch & Lomb Honor Science Award, Adelphi Gamma Sigma Award, Best Senior Term Paper, Excellence in Debating Award, Edward L. O'Brien Debating Prize, Dickinson Prize for Sight Reading, J.P. Williston Declamation Prize, Elizabeth Hazeldine Prize

## **UNIVERSITY OF MASSACHUSETTS**

Phi Beta Kappa, Phi Eta Sigma Honor Society, Commonwealth of Massachusetts Scholar

## **UNIVERSITY OF ROCHESTER SCHOOL OF MEDICINE AND DENTISTRY**

Honors Summer Research Fellowship, Tufts University School of Medicine, Boston, Massachusetts, 1975

Honors Summer Research Fellowship, Sidney Farber Cancer Institute, Harvard Medical School, Boston, Massachusetts, 1976

## **OTHER AWARDS**

Letter of Commendation to the Chief of Staff, Long Beach VA Medical Center for a Quality Assurance Investigation chaired by George B. Wesley, M.D., 1989

Selection as VA Office of Inspector General representative to Leadership VA Program, April, 1990

Superior Performance Awards, Office of Healthcare Inspections, Multiple Years

Commendation, Office of Healthcare Inspections 1993 "Report of the Year," November 16, 1993

Honorable Mention, Best Technical Paper, Federal Forecasters Conference 1993

Commendation, Office of Healthcare Inspections 1995 "Report of the Year," December 6, 1995

Letter of Commendation from the Assistant Inspector General/OHI, October 11, 1996

"Special"/Cash Award "In Grateful Appreciation for Your Talents Which Contributed Most Significantly to the Recent Success of a Congressional Hearing and Your Development of the Roster of Medical and Healthcare Advisors," October 15, 1997

"Special Act or Service Award," March 26, 1998, August 24, 1998, and September 18, 1998

"Special Contribution Award," September 1998 and August 1999

"Special," "In Acknowledgment of Your Key Role In Support of the Preparation of the Roll-up Report on Hotline Activities, FY 93 To FY 95" November 4, 1998

Office of Inspector General, Assistant Inspector General, Team Accomplishment of the Year Award, July 2000

Office of Inspector General, Assistant Inspector General, Employee of the Year, July 2000

James J. Leonard Award for Excellence in Teaching Internal Medicine, F. Edward Hébert School of Medicine, Uniformed Services University of the Health Sciences, Bethesda, Maryland, Award for Academic Year 2001 - 2002

The President's Council on Integrity and Efficiency, Award for Excellence, October 21, 2008

IG Distinguished Achievement Award, December 11, 2008

#### **MEMBERSHIPS IN PROFESSIONAL SOCIETIES:**

- Association of Military Surgeons of the United States (Life Member)

#### **CONFERENCE PRESENTATIONS:**

1. "Myasthenia Gravis and Neutropenia," Hematology Ground Rounds, Strong Memorial Hospital, Rochester, New York, July, 1977.
2. Clinicopathologic Conference, St. Luke's Hospital, December, 1980.
3. "Promoting Health in the Arthritic Patient," Lamar, Colorado, Conference: "Promoting Health-Preventing Disease", sponsored by the National Health Service Corps, USPHS; the Southeast Colorado Area Health Education Center, and the Southeast Colorado Health Care Association, August 28, 1982.
4. "Pharmacological Management - Update on Anti-hypertensive Medications," Lamar, Colorado, Symposium of the Colorado Heart Association and the Colorado Department of Health Hypertension Control Program, February 17, 1983.
5. "In Vitro Systems of B-Lymphocyte Generation," Conference at Albuquerque VA Medical Center, Albuquerque, New Mexico, April 9, 1986.
6. "Risk Management In Ambulatory Care," National Orientation for VA Attorneys, VA Western Regional Medical Education Center, Long Beach, California, April, 1987.

7. "Risk Management In Ambulatory Care," National Orientation for VA Attorneys, VA Western Regional Medical Education Center, Long Beach, California, April, 1988.
8. "Address to First Annual VA Quality Assurance Conference," First Annual VA Quality Assurance Conference, New Orleans, Louisiana, September 14, 1989.
9. "The Inspector General and Quality Management Oversight," Conference on the Future of HSRO/QM, Northport VA Regional Medical Education Center, Northport, New York, September 26, 1990.
10. Panelist for the Department of Veterans Affairs, Office of Inspector General Advisory Workshop: Validity and Status of VA Clinical Data, June 17-18, 1992.
11. The 13th International Symposium on Forecasting, "Measuring Interventions in Mortality and Time Series Data," (with Peg Young, Ph.D.), Pittsburgh, Pennsylvania, June 11, 1993.
12. The 6th Annual Federal Forecasters Conference - 1993, "Forecasting As a Tool for Oversight [In Health Care]," (with Peg Young, Ph.D.), Crystal City, Virginia, September 8, 1993.
13. The 7th Annual Federal Forecasters Conference - 1994, "A Bibliographic Database As A Health Care Forecasting Tool," Arlington, Virginia, November 15, 1994.
14. The 15th Annual International Symposium on Forecasting, "Forecasting Physician Demand in the Department of Veterans Affairs," Toronto, Canada, June 4, 1995.
15. "Errors in Health Care," U. S. Department of Veterans Affairs Central Office, Washington, D.C., January 29, 1997.
16. "VA's Office of Healthcare Inspections: An Overview," presented at the Lovelace Institute, Albuquerque, New Mexico, February 26, 1997.
17. Guest Panelist, "Healthy Living: Older Adult Health Risk Appraisal Workshop," Atlanta Technical Institute, March 25, 1998.
18. Guest Panelist, Forensic Medicine Section of the VA OIG's Office of Investigations Annual Senior Staff Retreat, Newport Naval Station, May 1998.
19. Office of Healthcare Inspections Grand Rounds, "An Overview of The Government Results and Performance Act," October 26, 1998.

20. Office of Healthcare Inspections Grand Rounds, "An Overview of Annenberg 2: 'Enhancing Patient Safety and Reducing Errors in Health Care,'" December 23, 1998.

21. Keynote Address: Securing Potential Forensic Evidence in the Hospital Setting, Domestic Violence and Sexual Assault Update, Carl T. Hayden Veterans' Affairs Medical Center and the International Association of Forensic Nurses, Phoenix, Arizona, March 11, 2000.

22. Panelist: Conference: "Unsuspected Poisonings In Suspicious Hospital Deaths," Frederic Rieders Family Renaissance Foundation, National Medical Services, Willow Grove, Pennsylvania, December 7, 2000.

23. "Comments On The Overlap Between Medical Quality Assurance Activities And Forensic Science," American Academy of Forensic Science, 55<sup>th</sup> Annual Meeting, Chicago, Illinois, February 21, 2003.

24. Panelist: "Integrating Forensic Science Into Clinical Care," Department of Veterans Affairs: *Improving Patient Care Through Forensic Science*, San Diego, California, April 22, 2003.

25. Presentation: "Forensic Science in the Health Care Setting: Pitfalls and Promise," American Academy of Forensic Science, 56<sup>th</sup> Annual Meeting, Dallas, Texas, February 20, 2004.

26. Presentation: "Handling Misconduct in Veterans' Healthcare," Misconduct in Research Working Group, National Science Foundation, Arlington, Virginia, December 4, 2008.

#### **ABSTRACTS AND POSTER PRESENTATIONS:**

1. Wesley, George B., Edison L. and Howard M.: "Analysis Of Pre-B Cell Lines," Abstract, Federation Proceedings, 44:5130, 1985.

2. Wesley, George B. and Howard, Maureen: "Mature B Cell Populations Precede the Emergence Of Pre-B Cell Lines In Murine Marrow Culture," Abstract, Federation Proceedings, 45:495, 1986.

3. Wesley, George and Young, Peg, "Measuring Interventions in Mortality and Time Series Data," Program Book, ISF 93 - The Thirteenth Annual International Symposium on Forecasting, Pittsburgh, Pennsylvania.

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#### **CONSULTATIONS AND APPEARANCES BEFORE EXPERT COMMISSIONS:**

1. Testimony and written statement to the Commission on the Future Structure of Veterans' Health Care, Tampa, Florida, December 4, 1990.
2. Appearance before the 102nd Congress of the United States, House of Representatives, Veterans' Affairs Committee, Subcommittee on Health and Hospitals: "Hearing on the Quality of Care Provided at a VA Medical Center," April 24, 1991.
3. Consultant to the Government Accounting Office (GAO) on the report: *The Quality of Care Provided by Some VA Psychiatry Hospitals is Inadequate*, GAO/HRD-92-17, April 1992.

4. Appearance before the 110th Congress of the United States, House of Representatives, Veterans' Affairs Committee, Subcommittee on Health and Hospitals: "U.S. Department of Veterans Affairs Credentialing and Privileging: A Patient Safety Issue," January 29, 2008.

5. Appearance before the 111th Congress of the United States, House of Representatives, Veterans' Affairs Committee, Subcommittee on Oversight and Investigations: "Endoscopy Procedures at the U.S. Department of Veterans Affairs: What Happened, What Has Changed?" June 16, 2009.

6. Appearance before the 112th Congress of the United States, Senate Veterans' Affairs Committee Field Hearing Regarding the Dayton Dental Clinic, Dayton VA Medical Center, Dayton, Ohio, April 26, 2011,

### **U.S. GOVERNMENT OVERSIGHT REPORTS**

Over 150 VA Office of Inspector General public reports.

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### Robert K Yang MD, MHA

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Medical Consultation and Review, Office of Healthcare Inspections  
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12/10 - present

#### Previous Work Experience

Clinical Assistant Professor  
University of Iowa Hospitals and Clinics  
Department of Orthopaedics and Rehabilitation  
01/07 – 11/10  
Director, UI Spine Center (2010)  
Carver College of Medicine

Physiatrist  
Iowa City VA Medical Center  
11/07 – 12/10  
Chair, Spinal Cord Injury and Dysfunction Team  
11/07 – 09/08  
Chair, Amputee Clinic Team  
10/08 – 12/10

Assistant Professor  
Assistant Residency Program Director  
University of North Carolina, Chapel Hill  
Department of Physical Medicine and Rehabilitation  
12/2004 – 12/2006

Senior Associate Consultant  
Mayo Clinic Department of Physical Medicine and Rehabilitation  
07/2000 – 10/2004

Instructor  
Mayo Clinic College of Medicine  
07/2000 – 10/2004

#### Education

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Masters in Healthcare Administration (MHA) 2005 - 2008

Mayo Graduate School of Medicine  
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Chief Resident (1999 – 2000) 1997 – 2000

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Virginia Mason Medical Center Transitional Year	1996
Washington University School of Medicine MD	1992 – 1996
Washington University in St. Louis BA, Biochemistry and Mathematics – Summa cum laude	1988 – 1992
<b>Honors and Awards</b>	
Teaching Excellence Award - University of North Carolina Chapel Hill	2005 – 2006
Excellence in Teaching Award – Mayo Clinic College of Medicine	2000 – 2004
Summer Research Fellowship – Washington University	1993
Summa cum laude – Washington University	1992
Pew Mid-states Science and Mathematics Research Fellowship	1990
<b>Board Certification</b>	
American Board of Physical Medicine and Rehabilitation	2001 – 2021
American Board of Medical Acupuncture	2005 – 2015
<b>Medical Licenses</b>	
Iowa	2006 - present
<b>Professional Memberships and Services</b>	
<i>American Academy of Physical Medicine and Rehabilitation</i>	1997 – present
Health Policy and Legislation Committee	2006 – 2012
Delegate to the American Medical Association YPS	2006 - 2010
Membership Marketing Committee	2001 – 2006
<b>Presentations</b>	
April 2009	Rehabilitation Services for Veterans Iowa Academy of Physical Medicine and Rehabilitation 2009 Iowa City, Iowa
February 2008	Physical Modalities for Low Back Pain Iowa Neurological Association – 2008 Annual Meeting Coralville, Iowa
January 2008	Applications of Medical Acupuncture Palliative Care Ground Rounds University of Iowa Hospitals and Clinics

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- September 2007      Multidisciplinary Team Approach for the Back-Injured Worker  
Chen, JJ Vogel, A Yang, RK
- September 2007      Introduction to Medical Acupuncture  
Rheumatology Journal Club  
University of Iowa Hospitals and Clinics
- June 2007            Medical Acupuncture for Musculoskeletal Pain  
5<sup>th</sup> Annual Physical Medicine and Rehabilitation Symposium  
Department of Orthopaedics and Rehabilitation  
University of Iowa Hospitals and Clinics
- May 2006            Impairment Ratings  
Anesthesiology Grand Rounds  
University of North Carolina  
Chapel Hill, North Carolina
- April 2006           Medical Considerations in Disabling Conditions  
National Association of Disability Evaluating Professionals  
Chapel Hill, North Carolina
- April 2005           Evidence Based Review of Diagnosis and Treatment of Spine  
Disorders  
National Association of Disability Examiners  
Raleigh, North Carolina
- April 2005           Acupuncture Treatment: The Importance of Point Selection  
J.W. Eby and R.K. Yang  
American Academy of Medical Acupuncture, Annual Meeting  
Atlanta, Georgia
- January 2005        Acupuncture for Back Pain  
Mayo Clinic Spine Center Update for Primary Care Physicians  
Scottsdale, Arizona
- April 2003           The Use of Acupuncture as an Adjunct Therapy for Pain Control  
Resulting in Decreased Medication Usage  
E.A. Huntoon and R.K. Yang
- Acupuncture for Discogram-Proven Discogenic Back Pain: A  
Case Report and Literature Review  
R.K. Yang and E.A. Huntoon  
American Academy of Medical Acupuncture  
Baltimore, Maryland

