STATEMENT OF
RICHARD J. GRIFFIN
ACTING INSPECTOR GENERAL
OFFICE OF INSPECTOR GENERAL
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
HEARING ON
"SCHEDULING MANIPULATION AND VETERAN DEATHS IN PHOENIX: EXAMINATION OF THE OIG'S FINAL REPORT"
SEPTEMBER 17, 2014

Mr. Chairman, Ranking Member Michaud, 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). Our August 26, 2014, report, *Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System*, expands upon information previously provided in our May 2014 interim report and includes the results of the reviews by OIG clinical staff of patient medical records. 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.

Our recent report cannot capture the personal disappointment, frustration, and loss of faith of individual veterans and their family members with a health care system that often could not respond to their physical and mental health needs in a timely manner. Although, we did not apply the standards for determining medical negligence during our review, our findings and conclusions in no way affect the right of a veteran or, if the veteran is deceased, his or her family, from filing a complaint under the Federal Tort Claims Act with VA. Decisions regarding VA's potential liability in these matters lie with the Department, Department of Justice, and the judicial system under the Federal Tort Claims Act.

WHY WE DID THIS REVIEW

We initiated this review in response to allegations first reported through the OIG Hotline on October 24, 2013, from Dr. Samuel Foote, the now-retired PVAHCS physician who alleged gross mismanagement of VA resources, criminal misconduct by VA senior hospital leadership, systemic patient safety issues, and possible wrongful deaths at PVAHCS.

We would like to thank all the individuals including Dr. Foote and Dr. Katherine Mitchell, the Medical Director of the PVAHCS Operation Enduring Freedom/Operation Iraqi Freedom/and Operation New Dawn clinic, who brought forward their allegations about issues occurring at PVHACS and other VA medical facilities to the attention of the OIG,

the Congress, and the Nation. What these individuals demonstrated are the actions the Secretary recently said he wanted—to hear VA employees' ideas for improving the Department and for employees to bring to their managers and his attention their concerns and significant issues, so VA can make necessary changes to improve its organization. On November 26, 2013, our Office of Healthcare Inspections initiated a review of the Hotline allegations. At the request of the Chairman, Subcommittee on Oversight and Investigation, U.S. House Committee on Veterans' Affairs, on August 19, 2014, we submitted a timeline of our actions and efforts from September 2013 through April 2014. This information is presented in Exhibit A.

On April 9, 2014, the U.S. House Committee on Veterans' Affairs held a hearing during which VA officials were questioned about delays in VA medical care and preventable veteran deaths at PVHACS and across VA medical facilities. We expanded our work at the request of the Chairman, U.S. House Committee on Veterans' Affairs, and the former VA Secretary, as well as other Members of Congress. Later in the afternoon after the hearing we received an email from the Subcommittee on Oversight and Investigations that provided additional documents. One of the documents included the names of 17 veterans who died awaiting an appointment at PVAHCS and stated that potentially 40 additional veterans died waiting for an appointment. This same document stated that Subcommittee on Oversight and Investigations staff needed access to the VA's Computerized Patient Record System to "unequivocally prove" that all 40 deaths were related to delays in care. The email and document are presented in Exhibit B.

RESULTS OF OUR REVIEW

After the April 9th hearing our team of healthcare inspectors was expanded to include a multidisciplinary team composed of board-certified physicians, special agents, auditors, and additional healthcare inspectors to expand our evaluation of the allegations at PVAHCS. We examined the medical records and other information for 3,409 veteran patients, which included 293 deceased patients, 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. The qualifications of the OIG physicians who conducted these reviews are presented in the curricula vitae in Exhibit C.

The 45 cases discussed in our report reflect unacceptable delays and troubling lapses in coordination, follow-up, quality, or continuity of care. The identities of these 45 veterans have been provided to VA.

We identified several patterns of obstacles to care that resulted in a negative effect on the quality of care provided by PVAHCS. 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' official electronic wait list. 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' official electronic wait list. 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 interim 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 these veterans the care they needed.

During our review, it became clear that the Urology Service at PVAHCS was in turmoil during the 2012 to 2014 timeframe and was unable to keep up with the demand for services. PVAHCS experienced a number of urology physician staffing changes, delays in the procurement of non-VA purchased care consults for urology, and difficulties coordinating urologic care. As a result, the OIG has an ongoing review of the PVAHCS Urology Service where we are working from a list of 3,526 patients who potentially received poor urologic care.

From interviews of 79 PVAHCS employees involved in the scheduling process, we identified scheduling practices not in compliance with VHA policy. PVAHCS executives and senior clinical staff were aware that their subordinate staff were using inappropriate scheduling practices. Further, 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 had not complied with VHA's scheduling policy as of July 7, 2014. Specifically, according to VISN 18 staff, PVAHCS had not completely trained its clerks or established electronic wait lists 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" 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 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.

LACK OF ACCOUNTABILITY TO ADDRESS WAIT TIME AND ACCESS ISSUES

Since July 2005, the OIG published 20 oversight reports on VA patient wait times and access to care, yet the Veterans Health Administration (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 called for immediate action to review scheduling practices and eliminate all inappropriate practices. In June 2010, VHA issued a directive reaffirming outpatient scheduling processes and procedures. In July 2011 an annual certification of wait times was

mandated. However, in May 2013, VHA waived the 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. Clearly, there was a failure to hold VA officials accountable for ensuring that inappropriate scheduling practices were not in use.

OIG INVESTIGATIONS AT OTHER VA MEDICAL FACILITES

The OIG Office of Investigations opened investigations at 93 sites of care in response to allegations of wait time manipulations. To date, we have completed 12 investigations. After conferring with Federal prosecutors who determined that no prosecution would be initiated on substantiated allegations involving alleged violations of law, we provided our investigative reports and related documents to VA for any administrative action it deems appropriate. Cases without proof of alleged criminal conduct would not be referred to prosecutors for prosecutive opinions. To maintain our statutory independence, and to ensure that employee due process rights are protected, the OIG cannot and does not recommend any specific administrative action against individuals. The remaining 81 investigations remain active and are being coordinated with the Department of Justice and the Federal Bureau of Investigation, as appropriate. These investigations are further confirming that wait time manipulations were prevalent throughout VHA.

IMPACT OF MEDIA COVERAGE

In February 2014, Dr. Foote alleged in a letter to the OIG Hotline that 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 a list identifying 40 specific patients. He provided the U.S. House Committee on Veterans Affairs the names of 17 deceased patients, which we received from the Committee on April 9, 2014, and reviewed. However, we conducted a review of PVAHCS electronic records and 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, which included 293 deaths, whose names were derived from multiple sources.

Prior to issuance of the OIG's final report on August 26, 2014, over 800 news stories appeared that cited 40 veterans' deaths at PVAHCS, with much of this reporting indicating that the 40 deaths were confirmed rather than the allegations were under review. We treated these allegations as just that—allegations. We proceeded to analyze information found in medical and other relevant records to determine if we could substantiate specific allegations. As I cautioned in my May 15, 2014, testimony before the U.S. Senate Committee on Veterans' Affairs, it is one thing to be on a waiting list and it is another thing to conclude that being on a waiting list caused death. The pervasiveness of the 40 deaths in media reports—reports that reached tens of millions of Americans—was the crucial factor leading to the OIG's decision to insert the reference to 40 veterans' deaths in a revision to the original draft report.

INDEPENDENCE AND INTEGRITY OF THE OIG REPORT

On August 19, 2014, the Chairman, Subcommittee on Oversight and Investigations, sent a letter to the OIG requesting the original copy of our draft report, prior to VA's comments and adopted changes to the report. A Committee staff member made the same request on September 2, 2014, on behalf of the Chairman, U.S. House Committee on Veterans' Affairs. These concerns seem to come from our inclusion of the following sentence in the final report that was not in the first draft report we submitted to VA.

> *"While the case reviews in this report document poor quality of care, we are unable to conclusively assert that the absence of timely care caused the deaths of these veterans."*

This sentence was inserted for clarity to summarize the results of our clinical case reviews. It replaced the sentence *"The death of a veteran on a wait list does not demonstrate causality."* This change was made by the OIG strictly on our own initiative; neither the language nor the concept was suggested by anyone at VA.

On July 28, 2014, we provided VA our draft report. As a standard procedure, we included a transmittal letter that provided specific instructions to VA on the necessity to safeguard the contents of the draft report and that the contents of the draft report were subject to revision prior to issuance of the final report. We also invited VA staff to discuss any questions about the contents of the report with us. After providing VA with our draft report, we provided four additional revised drafts that had minimal changes that were made solely for purposes of accuracy and clarity that were supportable by credible factual evidence. Many of the changes were made after long, deliberate discussions among OIG senior staff who continued to review the facts and refine the language in the draft report after it was released to VA for comment until the time the final report was published. For example, VA requested we remove five cases. We did not remove the cases. We did correct one date, one set of blood pressure numbers, and consolidated our recommendations involving VHA's ethics program into one broader recommendation. In all instances, the OIG, not VA, dictated the findings and recommendations that appear in our final report.

The deliberative nature of the draft report review and comment process is a long-standing practice consistent with the principle of Inspectors General as independent and objective units of Government and long-standing practice across the Inspector General community. This process gives VA the opportunity to provide comments to ensure that the facts and findings are accurate, to obtain concurrence with recommendations, and have VA submit a plan to implement the recommendations. During this process, VA has the opportunity to raise factual issues and other concerns. To ensure each report is accurate and complete, we have an obligation to review the issues raised by VA and determine whether to make changes to the report or not. However, VA has no authority to demand that changes be made or impede the issuance of a report unless changes are made. Further, VA's response to each of our reports is included in the final report. When deemed necessary, we provide a rebuttal to information provided. This process

ensures that VA is aware of the findings and held accountable to correct any deficiencies identified in the reports through our follow-up program.

In the last 6 years, we have issued between 235 and 350 reports annually. This same draft review and comment process has been used effectively throughout OIG history to provide the VA Secretary and Members of Congress with independent, unbiased, fact-based program reviews to correct identified deficiencies and improve VA programs. These reports have served as the basis for 67 congressional oversight hearings, including 48 hearings before the U.S. House Committee on Veterans' Affairs. Noteworthy, our decision to issue an interim report was to ensure veterans receive needed health care services. This report was issued without concern that the report could potentially lead to significant changes in VA leadership as it ultimately did.

The August 19, 2014, letter from the Chairman, Subcommittee on Oversight and Investigations, requested that we include certain information regarding the standard of care in our soon-to-be published report. Among the matters he asked us to incorporate in our report was the application of VA's use of a greater than 50 percent or "more likely than not" standard for determining service-connected conditions. He believed that the same standard should be used to determine whether a veteran's death was caused by extensive delays in care related to placement on an appointment wait list. In addition, he asked us to provide him with specific information, such as whether someone in VA attempted to persuade us not to use the greater than 50 percent standard. Later that day, we received VA's comments and action plan. A copy of the August 19, 2014, letter is presented as Exhibit D.

I replied to the Chairman's letter on August 22, 2014, and again on September 4, 2014. Among the issues I addressed was that we did not undertake these reviews to make service-connection decisions or medical malpractice decisions because that is not the role of the OIG. The standard posited in the Chairman's questions is one for application in the legal system, and in fact is lower than the "unequivocally prove" standard plainly stated as the standard to apply in the Subcommittee's own analysis if given access to patient medical records, which was described in material provided by his Subcommittee staff on April 9, 2014. Details of the Chairman's request for information to be included in our final report and my two replies to him and the Chairman, U.S. House Committee on Veterans' Affairs, are presented as Exhibits E, F, and G.

CONCLUSION

The VA Secretary has acknowledged the Department is in the midst of a serious crisis and has stated that VA must work to get veterans off wait lists, address cultural and accountability issues, and use its 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 effectively implemented the VA Secretary's action plan and stopped the use of inappropriate scheduling practices.

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 be happy to answer any questions you or other Members of the Committee may have.

EXHIBIT A

TIMELINE FOR OIG PHOENIX HEALTH CARE SYSTEM REVIEW

OIG Office of Healthcare Inspections
Phoenix Health Care System Timeline

November 26, 2013 — Case referral reviewed by Office of Healthcare Inspections (OHI)

- 16-page letter, dated "Sept 1 – 18, 2013," with multiple attachments addressing:
  - 10 patients died while on the EWL (*no names or other specific details provided*)
  - Behavior of new director and focus on wildly important goal
  - Short staffing
  - Increased panel sizes
  - Appointment delays, possible shredding of data, manipulation of wait times data
  - Canceled consult
- Attachments included a 4/1/13 letter to the OIG addressing personnel issues.
- OHI Disposition— Opened as a hotline case—assigned to San Diego OHI (OHI SD)

December 3–4, 2013 — Email between Dr. Foote and OHI SD Inspector arranging interview time. Inspector provides Dr. Foote with fax number for any documents he would like to send.

December 6, 2013 — Telephone Interview of Dr. Foote by OHI SD:

- Reports that 21 patients have died waiting for care but tells inspectors he cannot get the names
- Provides inspectors with the last names/last 4 SSN of 6 veterans who experienced delays in care (not all deceased).
- Described concerns about the Schedule an Appointment consult system – "alert to print" function disabled, possible deletion of consults.

December 8, 2013 — Follow-up email from Dr. Foote to OHI SD inspector:

- No new details; repeats concerns about facility directors (past and present).

December 10, 2013 — Follow-up email from Dr. Foote to OHI SD inspector:

- Describes briefly his theory as to why the "alert to print" function for Schedule an Appointment consults doesn't work.
- Requests an additional fax number or notification that OHI SD fax line is repaired.

December 16, 2013 — OHI SD Inspector responds to Dr. Foote's email that fax is repaired; requests he sends any documents he wanted to send. (No documents received.)

December 16–18, 2013 — Phoenix onsite visit:

December 18, 2013 — Email from Dr. Foote to OHI SD inspector:

- Reports that there are three EWLs that he knows of ("One at the SE Clinic, one at the Main Center and one for the subspecialty clinics.") Provides a contact name for more information.
- Provides emails from Chief of Primary Care and Chief of Staff.
- Thanks OIG team for coming to Phoenix.

December 19, 2013 — Email from Dr. Foote to OHI SD inspector:

- Shares his thoughts on specialty clinic wait lists and how denied consults are managed (i.e., come back to primary care).

December 21, 2013 — Email from Dr. Foote to OHI SD inspector:

- Reports that his retirement party was yesterday.
- Discusses "fake vesting appointments."
- Refers to "Prime suspect."

January 2, 2014 – OHI SD receives list of Schedule an Appointment Consult (SAAC) from OHI data staff (over 4,000 patients)

January 8, 2014 — Two emails from Dr. Foote to OHI SD Director and inspector:

- First email reports that "someone in the COS office in Phoenix is discontinuing consults on pts that have died in the Schedule an Appt consult package." No details provided.
- Second email reports the name of the person assigned to discontinue the consults.

January 9, 2014 — Email from Dr. Foote to OHI SD Director and inspector:

- Reports that staff person is "administratively closing the consults of those who have died by order of the COS on the schedule an appt clinic consult package."
- Reports that he has a list of 6 patients with last 4 SSN. Offers to fax.
- No list received.

January 10, 2014 — Email from Dr. Foote to OHI SD Director and inspector:

- Reports that he has 10 more names of patients from the schedule an appointment consult list who died (for a total of 16 names).
- States that he had two prior names plus 22 names on the "Electronic List" and that it "brings the count on the Electronic list and this one to Forty pts." Offers to "forward it somewhere or mail it . . ."
- No list received.

January 27, 2014 – OHI SD receives list of patients on Electronic Waiting List (EWL) from OHI data staff (over 3,000 patients)

February – March 2014 — Medical record review tool for SAAC:

- OHI SD drafts medical record review tool for SAAC.
- OHI SD works with SharePoint team to create database for review tool and tests tool.
- OHI SD receives another SAAC data pull from OHI data staff (over 4,400 patients).

February 12, 2014 – OHI SD receives list from OHI data staff of 17 patients who had died on SAAC/EWL.

February 12, 2014 — Letter to VA OIG Hotline

- Letter from Dr. Foote dated February 2, 2014 to OIG. References his previous contact to OIG.
- States that since his original letter, "I have forwarded to you information regarding 22 people who were placed on the electronic waiting list and died before getting appointments and another 18 patients who suffered the same fate on the schedule an appoint consult list."
- States that "We have informed you that we have the names of those individuals, but you have yet to request that we send them to you."

February 13, 2014 — Information forwarded to OHI SD project team.

February 24, 2014 — Death review (review of patient records) completed by Registered Nurse.

April 4, 2014 — OHI SD meets with assigned OHI physician to discuss how to move forward.

April 9, 2014 — HVAC Hearing

- HVAC staff provides VA OIG "Names and last four of 17 veterans who have died awaiting an appointment at the Phoenix VAMC."

April 24, 2014 — Face-to-face Interview of Dr. Foote (taped) by OIG

- Asked about the 22 patients who died on the wait list and 18 who died on the schedule appointment consult list—responded: "I do not have those names. Congress has those names." Stated that HVAC Chairman Miller has the list. Would be a HIPAA violation to have.
- Asked about the secret wait list—responded that he never saw it.
- Provided 2 patient names and last 4 SSN. (He provided both names during 12/6/13 interview; however, for the second patient, spelling and last 4 SSN were different.)
- OIG staff reported that we have a list (unspecified)—Foote responded, "You do have a list? Oh, okay, good. Oh, okay, good. I thought you'd have a list. But as I'm not an employee, you better believe I don't have it in my possession."
- OIG staff asked where the 40 patients come from—Foote responded, "No, no, no that's the possible number of dead, okay, because we had 22 and 18. That's

40. And since that time we discovered 5 more people that are actually dead. You know that increases the number of potentials now because we don't know who's who." OIG asked, "Do we know all 40 names?" Foote responded, "No, No, No. We have 17 to 18 on one list, we have 7 to 27 on the other. Well, we think we have 7, five for sure. Five of 25 for sure."

EXHIBIT B

APRIL 9, 2014, EMAIL AND ATTACHMENT FROM HVAC OVERSIGHT & INVESTIGATIONS SUBCOMMITTEE

Gromek, Catherine A. (OIG)

From: Hannel, Eric <Eric.Hannel@mail.house.gov>
Sent: Wednesday, April 09, 2014 1:55 PM
To: Gromek, Catherine A. (OIG)
Cc: Rees, Harold; Hodnette, Jon
Subject: [EXTERNAL] Phoenix VAMC Evidence
Attachments: Schedule and appointment Consult List (Names).docx; Wait List - 10 deaths.pdf; Director's Staff Meeting Minutes - October 10 2013.pdf; Ethical Discussion Binder.pdf; FYI APPROPRIATE DISTRUBUTION.PDF; MINUTES SEPT 7 2013 UAV MEETING.doc; Notes to Contents.docx; Notes to FYI APPROPRIATE.docx

Cathy,

Here are most of the documents. I have two more that I hope to send soon.

Best regards,

Eric Hannel, PhD (c)
Marine (ret)
Staff Director
Subcommittee on Oversight and Investigations
House Committee on Veterans' Affairs
335 Cannon House Office Building
Washington, D.C. 20515
(202) 225-3569

Schedule and appointment Consult List

O&I analysis: The following list provides the names and last four of 17 Veterans who have died awaiting an appointment at the Phoenix VAMC. To date, there are potentially 40 Veterans who have died awaiting an appointment with delays upwards of one year. In order to unequivocally prove that these deaths (all 40) are related to delays in care, O&I needs access to VA's Computerized Patients Record System (CPRS) to pull up these Veteran's files or request if from VA.

1.	8784
2.	6633
3.	4076
4.	0516
5.	0691
6.	6449
7.	2097
8.	1286
9.	5525
10.	2431
11	7734
12.	5861
13.	7559
14.	2659
15.	2657
16.	2878
17.	8604

EXHIBIT C

OIG PHYSICIANS' CURRICULA VITAE

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:

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 Tuberous 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:

1. Cook JD, Henderson-Tilton AC, Daigh JD, Oliver YP:Beneficial response to a Ca channel antagonist in myotonic syndromes. American Academy of Neurology, April 1984

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 Tuberous 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 2nd 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

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

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

Herbers JE, Noel GL, Cooper G, Harvey J, Pangaro L, Weaver M. How accurate are faculty evaluations of clinical competence. J Gen Intern Med. 1989;4:202-8.

Herbers JE, Noel GL. Diagnostic tests and clinical decisions. In: Moore WT, Eastman RC, eds., Diagnostic Endocrinology, 2nd Ed. St. Louis: Mosby, 1996.

Noel GL, Herbers JE, Caplow MP, Cooper GS, Pangaro LN, Harvey J. How well do internal medicine faculty members evaluate the clinical skills of residents? Ann Intern Med. 1992;117:757-765.

Kroenke K, Lucas CA, Rosenberg ML, Scherokman B, Herbers JE, Wehrle PA, Boggi JO. Causes of persistent dizziness: a prospective study of 100 patients in primary care. Ann Intern Med. 1992;117:898-904.

Birdwell B, Herbers J, Kroenke K. Evaluating chest pain: The patient's presentation style alters the physician's diagnostic approach. Arch Intern Med. 1993;153:1991-1995.

Reed WW, Herbers JE, Noel GL. Cholesterol-lowering therapy: what patients expect in return. J Gen Intern Med. 1993.

Landry FJ, Pangaro L, Kroenke K, Lucey C, Herbers J. A controlled trial of a seminar to improve medical student attitudes, knowledge and use of the medical literature. J Gen Intern Med. 1993;9:436-439.

Kroenke K, Lucas C, Rosenberg ML, Scherokman B, Herbers JE. One-year outcome for patients with a chief complaint of dizziness. J Gen Intern Med. 1994;9:684-689.

Roy MJ, Kroenke K, Herbers JE. When the physician leaves the patient: predictors of satisfaction with the transfer of care in a primary care clinic. J Gen Intern Med. 1995;10:206-210.

Wei GS, Jackson JL, Herbers JE. Ethnic disparity in the treatment of women with established low bone mass. J Am Med Womens Assoc. 2003;58:173-7.

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.

Herbers JE, Wessel L, El-Bayoumi J, Hassan SN, St. Onge JE. Pelvic examination training for interns: a randomized controlled trial. Academic Medicine. 2003;78:1164-1169.

Wei GS, Herbers JE. Reporting elder abuse: a medical, legal, and ethical overview. J Am Med Womens Assoc. 2004;59:248-254.

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 18th 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 Erythematous. 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, 3rd 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 VITAE

BIOGRAPHICAL

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 TRAINING

Undergraduate:

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

Graduate:

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

Post-Graduate:

Dates:	Institution:	Program:	Discipline:
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:

Dates:	Institution:	Title:
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)

Dates:	Institution:	Title:
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:

Dates:	Institution:	Position:
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)

Dates:	Institution:	Position:
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)

Dates:	Institution:	Position:
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

Date:	Organization:
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

Dates:	Institution:
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

Date:	Title of Award:
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 tranylcypromine 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 tranylcypromine 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 tranylcypromine: 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.

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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)

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

TEACHING (National Institutes of Health):

Activity:	Program:	Content:
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):

Courses Directed:	Department:	Content:
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 pharmaco-therapy in outpatient practice.

TEACHING (University of Pittsburgh): (continued)

Courses Directed:	Department:	Content:
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):

Date:	Title:	Source:
January-December, 1975	In vitro studies of lithium metabolism by erythrocytes of depressed patients.	Fluid Research Program Western Psychiatric Institute and Clinic University of Pittsburgh Pittsburgh, Pennsylvania
January, 1976-December, 1977	Erythrocytic lithium and electrolyte transport in depressive illness.	Pharmaceutical Manufacturers Association Foundation 1155 Fifteenth St., NW Washington, D.C.
April, 1976-March, 1977	Lithium and electrolyte 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 transport 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)

Date:	Title:	Source:
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)

Date:	Title:	Source:
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):

Date:	Title:
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):

Date:	Title:
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)

Date:	Title:
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_{1A} 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):

Date:	Title:
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:

Date:	Description:	Agency:
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
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)

Date:	Description:	Agency:
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:

Date:	Description:
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)

Date:	Description:
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 (www.healthtalk.com), Seattle, WA.

SERVICE: (continued)

Community: (continued)

Date:	Description:
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, 55th 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, 56th 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.

4. Young, Peg, Connell, Alastair M., and Wesley, George, "Using Forecasting Techniques or Quality Control: A Case Study in the Health Care Industry," Program Book, ISF 94 - The Fourteenth Annual International Symposium on Forecasting, Stockholm, Sweden, June 12 - 15, 1994.

5. Wesley, George, "A Bibliographic Database As A Health Care Forecasting Tool," The Seventh Annual Federal Forecasters Conference, Arlington, Virginia, November 15, 1994.

6. Wesley G, Miller S, and Young P, "A Study Of Veteran Inpatients' Awareness Of The Identity Of Their Attending Physician," Thirteenth Annual HSR&D Service Meeting, Department of Veterans Affairs, Washington, D.C. February 28 - March 2, 1995.

7. Wesley, George and Young, Peg, "Forecasting Physician Demand in the Department of Veterans Affairs," Program Book, ISF 95 - The Fifteenth Annual International Symposium on Forecasting, Toronto, Canada, June 12 - 15, 1995.

8. Christ P, Wesley G, Trowell-Harris I, Levy F, Miranda N, Rowland W, Schweitzer A, Willis S, Stevens C, Young P, and Connell A, "The Appropriateness of Acute Care Designations in VA Medical Centers," Association of Military Surgeons of the United States, 102nd Annual Meeting, Anaheim, California, November 4 - 5, 1995.

9. Christ P, Wesley G, Trowell-Harris I, Levy F, Miranda N, Rowland W, Schweitzer A, Willis S, Stevens C, Young P, and Connell C, "A Review of the Appropriateness of Level of Care Assignments in VA Hospitals," Fourteenth Annual HSR&D Service Meeting, Department of Veterans Affairs, Washington, D.C. February 28 - March 1, 1996.

10. Nadal R, Trowell-Harris I, and Wesley G, "A Retrospective Analysis of Three Years of Healthcare Related Hotline Complaints Inspected By VA's OIG," Association of Military Surgeons of the United States, 105th Annual Meeting, San Antonio, Texas, November 9 - 13, 1998.

11. Trowell-Harris I and Wesley G, "A Review Of VA's Office Of Healthcare Inspections," Association of Military Surgeons of the United States, 105th Annual Meeting, San Antonio, Texas, November 9 - 13, 1998.

12. Nadal R, Miranda N, Trowell-Harris I, and Wesley G, "Analysis And Forecast Of Health Care Services Required By Patients With Traumatic Brain Injury (TBI) Cared For By The Defense And Veterans Head Injury Program (DVHIP)," Association of Military Surgeons of the United States, 106th Annual Meeting, Anaheim, California, November 8, 1999.

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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.

Robert K Yang MD, MHA

Current Position

Senior Physician
Medical Consultation and Review, Office of Healthcare Inspections
Department of Veterans Affairs, Office of Inspector General
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

University of North Carolina 2005 - 2008
Masters in Healthcare Administration (MHA)

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

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

Honors and Awards

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

Board Certification

American Board of Physical Medicine and Rehabilitation	2001 – 2021
American Board of Medical Acupuncture	2005 – 2015

Medical Licenses

Iowa	2006 - present

Professional Memberships and Services

American Academy of Physical Medicine and Rehabilitation	1997 – present
Health Policy and Legislation Committee	2006 – 2012
Delegate to the American Medical Association YPS	2006 - 2010
Membership Marketing Committee	2001 – 2006

Presentations

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

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 5th 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 Assocation 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
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March 2003	Persistent Symptoms of Rotator Cuff Arthropathy: A Case Report and Review of the Literature A.J Locketz and R.K Yang Association of Academic Physiatrists Ft. Lauderdale, Florida
January 2003	Acupuncture - An Overview Manual Medicine Course Rochester, Minnesota
January 2002	Acupuncture for Low Back Pain: Critical Review of the Current Literature Mayo Spine Center Conference Scottsdale, Arizona
October 2001	Worker's Compensation in Chronic Low Back Pain, Patient Counseling, and Return to Work Issues Mayo Clinic Spine Center Physicians' Retreat Scottsdale, Arizona
September 1999	Neural Network Analysis of Outcomes in ACL Repair Case Presentation: Neck Pain with History of Transverse Myelitis Third National Conference of Rehabilitation Medicine for the Young Nanjing, People's Republic of China

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EXHIBIT D

CHAIRMAN COFFMAN'S LETTER DATED AUGUST 19, 2014,TO ACTING INSPECTOR GENERAL

U.S. House of Representatives
COMMITTEE ON VETERANS' AFFAIRS
ONE HUNDRED THIRTEENTH CONGRESS
335 CANNON HOUSE OFFICE BUILDING
WASHINGTON, DC 20515
http://veterans.house.gov

August 19, 2014

The Honorable Richard J. Griffin
Acting Inspector General
U. S. Department of Veterans Affairs
810 Vermont Avenue NW
Washington, DC 20420

Dear Acting Inspector Griffin,

As we near the final release of the Office of the Inspector General (OIG) report, I request the following information be included in the published report. The VA uses a greater than 50% or "more likely than not" standard for determining service connected conditions. As such, the same standard should be used to determine whether a Veteran's death was caused by extensive delays in care related to placement on an appointment wait list.

1. I would like to know from the OIG how many cases there were where, "more likely than not," the death was related to the wait. It is not necessary for your office to conclude to a 100% certainty, an unrealistic standard that is not that used by VA and will assuredly overlook Veterans who more than likely died from delays in care.

2. Did someone within VA attempt to persuade the OIG not to use the greater than 50% standard? If so, who was that person?

3. Additionally, were there cases that did not meet the greater than 50% threshold but the reviewers concluded that the wait may have contributed to the death? If so, how many were there?

4. Similarly, in how many cases that you reviewed was the standard of care not met? How many patients "more likely than not" died because of that?

5. How many total cases did you review? Within this answer, please break down the response into how many included patients waiting for new appointments and how many for patients waiting for return appointments.

I am also concerned that OIG investigators were provided numerous lists with patient names, including a report that showed that 22 veterans on those lists died. It is my understanding that you were provided two of those names.

6. We would like the report to explain if you were able to recover those 22 names and review those cases. If you were able to review them, please explain your findings. If you were not able to recover them, please explain why you were not able to do so.

7. Did you suspect that the Phoenix VA staff shredded the names or erased them from the computer? Please account for what you think happened to those patients.

According to whistleblowers, 18 patients died on the appointment consult list in Phoenix of which you were given 17 of the 18 names. You stated that you found 18 additional patients that died out of the 1700 patients that you found in various locations. Including the 22 patients referenced above, that would bring the total to 57. You were also given the names of five additional cases from the Electronic Wait List where the clerks called and found out that the patients had died. That would bring the total up to 62 plus the additional cases that we sent you for review, not counting duplicates, which would top out around 70 deceased patients.

8. Please account for all of these deaths.

9. Dr. Sam Foote disclosed issues regarding alternate wait lists to the OIG in December 2013, and then, according to the IG's interim report, it opened an investigation into those issues. Please explain, in detail, the progress of the investigation from that original disclosure up to the request by the Committee for the OIG to open an investigation in April 2014.

10. Lastly, please provide this Committee with the original draft copy of the OIG report, prior to VA's comments and adopted changes to the report by your office.

If you have any questions, please contact Mr. Eric Hannel, Staff Director of the Subcommittee on Oversight and Investigations, at (202) 225-3569.

Sincerely,

Mike Coffman

MIKE COFFMAN
Chairman
Subcommittee on Oversight and Investigations

MC/ch

EXHIBIT E

ACTING INSPECTOR GENERAL'S LETTER DATED AUGUST 22, 2014, TO CHAIRMAN COFFMAN

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

AUG 22 2014

The Honorable Mike Coffman
Chairman, Subcommittee on Oversight
and Investigations
Committee on Veterans' Affairs
U. S. House of Representatives
Washington, DC 20515

Dear Chairman Coffman:

This is in response to your letter dated August 19, 2014, requesting that the forthcoming Office of Inspector General (OIG) report on patient deaths, waiting times, and scheduling practices at the Phoenix Health Care System address a series of nine questions. You also requested a copy of the original OIG draft report provided to VA along with any changes that were adopted.

On August 21, 2014, the OIG's Congressional Liaison contacted your staff to advise that our report has been finalized and will be published on August 27, 2014. Arrangements were also made for OIG senior officials to brief your staff and other congressional staff on the report at 9:00 am prior to release of the report later that same day. I believe the briefing and report will address your questions regarding the scope, methodology, and findings of our review. If after reading the report you have further questions, OIG subject-matter experts will be made available.

The deliberative nature of the draft report review and comment process is consistent with the principle of Inspectors General as independent and objective units of Government and long-standing OIG practice. I can assure you that minimal changes were made to the draft report following receipt of VA's comments and that changes were made solely for purposes of clarity, and in no way altered the substance of the report.

Sincerely,

RICHARD J. GRIFFIN
Acting Inspector General

EXHIBIT F

ACTING INSPECTOR GENERAL'S LETTER DATED SEPTEMBER 4, 2014, TO CHAIRMAN COFFMAN

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

SEP 4 2014

The Honorable Mike Coffman
Chairman, Subcommittee on Oversight
and Investigations
Committee on Veterans' Affairs
U. S. House of Representatives
Washington, DC 20515

Dear Chairman Coffman:

This is in further response to your letter dated August 19, 2014, wherein you suggest that a greater than 50 percent standard or "more likely than not standard" be used to determine whether a veteran's death was caused by delays in care related to placement on an appointment wait list. My earlier response was emailed to your staff on August 22, 2014.

In regard to your Questions 1, 3, and 4, the tenor of these questions assumes that, in making our determinations in case reviews of clinical care provided to 3,409 veterans by the Phoenix Health Care System, the OIG is bound by a VA standard for determining service-connected conditions. Let me correct that misunderstanding. The OIG did not undertake these reviews to make service-connection decisions or medical malpractice decisions because that is not the role of the OIG. We addressed this matter in our response to Question 1 in the OIG's "Questions and Answers" provided at the August 26th briefing to congressional staff:

> This report includes case reviews of 45 patients who experienced unacceptable and troubling lapses in follow-up, coordination, quality, and continuity of care. The patients discussed reflect both patients who were negatively impacted by care delays (28 patients including 6 deaths), as well as patients whose care deviated from the expected standard independent of delays (17 patients including 14 deaths).
>
> Our determinations were based on the professional judgment of the OIG's board-certified physician staff. We are unable to conclusively assert that these 20 deaths were caused by delays or sub-standard care. We did not evaluate these cases to make a determination of medical negligence under Arizona State law because that is not the role of the OIG. Federal law applies State tort law to malpractice involving VA care.
>
> The VA Secretary concurred with our very first recommendation to "review the cases identified in this report to determine the appropriate response to possible patient injury and allegations of poor quality of care. For patients with adverse outcomes, the Phoenix VA Health Care System should confer with Regional Counsel regarding the appropriateness of disclosures to patients and families."

We believe that the standard posited in your questions is one for application in the legal system, and in fact is lower than the standard described in material provided by the Subcommittee on Oversight and Investigations (O&I) staff on April 9, 2014, when the OIG was first requested by the Committee to review potentially 40 veterans who died awaiting appointments. The O&I analysis asserts the need to review the medical records of the 17 deaths provided to the OIG "in order to unequivocally prove" that the deaths occurred due to delays in care—a higher and more difficult standard to meet than the 50 percent standard now suggested.

In conducting our case reviews, our physicians drew on their collective experience in practicing internal medicine, psychiatry, physical and rehabilitative medicine, rheumatology, and child neurology to make professional judgments about the quality of care provided to these patients. This is consistent with the establishment of the OIG's Office of Healthcare Inspections in 1991 to fully implement the provisions of Public Law 100-322, which calls for the OIG to oversee, monitor, and evaluate the operations of the Veterans Health Administration's quality assurance programs so as to provide the Secretary and Congress with clear and objective assessments of the effectiveness of those programs and operations.

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.

Although we often opine about the quality of care provided in VA facilities, these are professional judgments made based on our combined experience and expertise and are not intended to be, nor should they be used as, standard of care determinations needed to determine medical negligence in the location in which the care was provided. This has been the consistent past practice of the OIG, including prior OIG reporting where we severely criticized care provided at VA facilities such as Marion, Illinois, Columbia, South Carolina, and Atlanta, Georgia, to name just a few.

In regard to Question 2, no person at VA attempted to persuade the OIG not to use the greater than 50 percent standard or any other standard.

In regard to Question 5, we reviewed 3,409 medical records of veterans. For these 3,409 reviews of medical records, we did not record whether veterans were waiting for new appointments and/or follow-up appointments.

In regard to Question 6 and 8, our report explains that we reviewed 3,409 cases that were identified on the following lists:

- EWL—deceased patients between April 2013 and April 2014
- Former PVAHCS physician list
- HVAC list
- Hotline referrals up to June 1, 2014
- Media list
- Institutional Disclosure List for disclosures made in calendar years 2012 and 2013
- Deceased patients on the NEAR list after January 1, 2012
- Suicides after January 1, 2012

In regard to Question 7, as stated in our August 26th report on pages 36-37, we determined through interviews with Phoenix HCS Health Administration Service staff that they destroyed printouts that contained personally identifiable information. Staff stated they destroyed these printouts after they scheduled the veterans' appointments or placed them on the Electronic Wait List. Because staff destroyed the printouts during the approximate period February 2013 through March 2014, we could not identify those veterans affected by this process or confirm that they were eventually placed on the Electronic Wait List or provided an appointment. Through our interviews with staff in Phoenix, we found no evidence of removal of veterans' records and no staff stated they were aware that records were inappropriately deleted or removed from the VistA scheduling system.

In regard to Question 9, we updated the timeline of the Office of Healthcare Inspections' contacts with Dr. Foote that was provided to the Committee on August 29, 2014. The updated timeline includes details on other work activities related to our Phoenix review up to April 2014 when the Committee requested that the OIG open an investigation.

In regard to Question 10, we are providing the requested draft report under separate cover.

Sincerely,

RICHARD J. GRIFFIN
Acting Inspector General

Enclosure

OIG Office of Healthcare Inspections
Phoenix Health Care System Timeline

November 26, 2013 — Case referral reviewed by Office of Healthcare Inspections (OHI)

- 16-page letter, dated "Sept 1 – 18, 2013," with multiple attachments addressing:
  - 10 patients died while on the EWL (*no names or other specific details provided*)
  - Behavior of new director and focus on wildly important goal
  - Short staffing
  - Increased panel sizes
  - Appointment delays, possible shredding of data, manipulation of wait times data
  - Canceled consult
- Attachments included a 4/1/13 letter to the OIG addressing personnel issues, especially concerns about .
- OHI Disposition— Opened as a hotline case—assigned to San Diego OHI (OHI SD)

December 3–4, 2013 — Email between Dr. Foote and OHI SD Inspector arranging interview time. Inspector provides Dr. Foote with fax number for any documents he would like to send.

December 6, 2013 — Telephone Interview of Dr. Foote by OHI SD:

- Reports that 21 patients have died waiting for care but tells inspectors he cannot get the names
- Provides inspectors with the last names/last 4 SSN of 6 veterans who experienced delays in care (not all deceased).
- Described concerns about the Schedule an Appointment consult system – "alert to print" function disabled, possible deletion of consults.

December 8, 2013 — Follow-up email from Dr. Foote to OHI SD inspector:

- No new details; repeats concerns about facility directors (past and present).

December 10, 2013 — Follow-up email from Dr. Foote to OHI SD inspector:

- Describes briefly his theory as to why the "alert to print" function for Schedule an Appointment consults doesn't work.
- Requests an additional fax number or notification that OHI SD fax line is repaired.

December 16, 2013 — OHI SD Inspector responds to Dr. Foote's email that fax is repaired; requests he sends any documents he wanted to send. (No documents received.)

December 16–18, 2013 — Phoenix onsite visit:

December 18, 2013 — Email from Dr. Foote to OHI SD inspector:

- Reports that there are three EWLs that he knows of ("One at the SE Clinic, one at the Main Center and one for the subspecialty clinics.") Provides a contact name for more information.
- Provides emails from Chief of Primary Care and Chief of Staff.
- Thanks OIG team for coming to Phoenix.

December 19, 2013 — Email from Dr. Foote to OHI SD inspector:

- Shares his thoughts on specialty clinic wait lists and how denied consults are managed (i.e., come back to primary care).

December 21, 2013 — Email from Dr. Foote to OHI SD inspector:

- Reports that his retirement party was yesterday.
- Discusses "fake vesting appointments."
- Refers to "Prime suspect."

January 2, 2014 – OHI SD receives list of Schedule an Appointment Consult (SAAC) from OHI data staff (over 4,000 patients)

January 8, 2014 — Two emails from Dr. Foote to OHI SD Director and inspector:

- First email reports that "someone in the COS office in Phoenix is discontinuing consults on pts that have died in the Schedule an Appt consult package." No details provided.
- Second email reports the name of the person assigned to discontinue the consults.

January 9, 2014 — Email from Dr. Foote to OHI SD Director and inspector:

- Reports that staff person is "administratively closing the consults of those who have died by order of the COS on the schedule an appt clinic consult package."
- Reports that he has a list of 6 patients with last 4 SSN. Offers to fax.
- No list received.

January 10, 2014 — Email from Dr. Foote to OHI SD Director and inspector:

- Reports that he has 10 more names of patients from the schedule an appointment consult list who died (for a total of 16 names).
- States that he had two prior names plus 22 names on the "Electronic List" and that it "brings the count on the Electronic list and this one to Forty pts." Offers to "forward it somewhere or mail it . . ."
- No list received.

January 27, 2014 – OHI SD receives list of patients on Electronic Waiting List (EWL) from OHI data staff (over 3,000 patients)

February – March 2014 — Medical record review tool for SAAC:

- OHI SD drafts medical record review tool for SAAC.
- OHI SD works with SharePoint team to create database for review tool and tests tool.
- OHI SD receives another SAAC data pull from OHI data staff (over 4,400 patients).

February 12, 2014 – OHI SD receives list from OHI data staff of 17 patients who had died on SAAC/EWL.

February 12, 2014 — Letter to VA OIG Hotline

- Letter from Dr. Foote dated February 2, 2014 to OIG. References his previous contact to OIG.
- States that since his original letter, "I have forwarded to you information regarding 22 people who were placed on the electronic waiting list and died before getting appointments and another 18 patients who suffered the same fate on the schedule an appoint consult list."
- States that "We have informed you that we have the names of those individuals, but you have yet to request that we send them to you."

February 13, 2014 — Information forwarded to OHI SD project team.

February 24, 2014 — Death review (review of patient records) completed by Registered Nurse.

April 4, 2014 — OHI SD meets with assigned OHI physician to discuss how to move forward.

April 9, 2014 — HVAC Hearing

- HVAC staff provides VA OIG "Names and last four of 17 veterans who have died awaiting an appointment at the Phoenix VAMC."

April 24, 2014 — Face-to-face Interview of Dr. Foote (taped) by OIG

- Asked about the 22 patients who died on the wait list and 18 who died on the schedule appointment consult list—responded: "I do not have those names. Congress has those names." Stated that HVAC Chairman Miller has the list. Would be a HIPAA violation to have.
- Asked about the secret wait list—responded that he never saw it.
- Provided 2 patient names and last 4 SSN. (He provided both names during 12/6/13 interview; however, for the second patient, spelling and last 4 SSN were different.)
- OIG staff reported that we have a list (unspecified)—Foote responded, "You do have a list? Oh, okay, good. Oh, okay, good. I thought you'd have a list. But as I'm not an employee, you better believe I don't have it in my possession."
- OIG staff asked where the 40 patients come from—Foote responded, "No, no, no that's the possible number of dead, okay, because we had 22 and 18. That's

40. And since that time we discovered 5 more people that are actually dead. You know that increases the number of potentials now because we don't know who's who." OIG asked, "Do we know all 40 names?" Foote responded, "No, No, No. We have 17 to 18 on one list, we have 7 to 27 on the other. Well, we think we have 7, five for sure. Five of 25 for sure."

EXHIBIT G

ACTING INSPECTOR GENERAL'S LETTER DATED SEPTEMBER 4, 2014, TO CHAIRMAN MILLER

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

SEP 4 2014

The Honorable Jeff Miller
Chairman
Committee on Veterans' Affairs
United States House of Representatives
Washington, DC 20515

Dear Chairman Miller:

This is in response to an email message from your staff on September 2, 2014, inquiring whether the Office of Inspector General (OIG) is going to provide the Committee on Veterans' Affairs a written copy of the original (unaltered) draft copy of the report, *Veterans Health Administration – Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System*. This follows a prior request from Chairman Mike Coffman, Chairman, Subcommittee on Oversight and Investigations, requesting the draft report.

As I explained in my letter dated August 22, 2014, to Chairman Coffman, the deliberative nature of the draft report review and comment process is consistent with the principle of Inspectors General as independent and objective units of Government and long-standing practice across the Inspector General community. This process provides VA with the opportunity to provide comments to ensure that the facts and findings are accurate, to obtain concurrence with recommendations, and have VA submit a plan to implement the recommendations. During this process, VA has the opportunity to raise factual issues and other concerns. To ensure each report is accurate and complete, the OIG has an obligation to review the issues raised by VA and determine whether to make changes to the report or not. However, VA has no authority to demand that changes be made or impede the issuance of a report unless changes are made. VA's response to our reports is included in the final report. When deemed necessary, we provide a rebuttal to comments and non-concurrences with recommendations. This process ensures that VA is aware of the findings and held accountable to correct any deficiencies identified in the reports through the OIG's follow-up program.

In the last 6 years, the OIG has issued between 235 to 350 reports annually, and this same draft review and comment process has been utilized effectively to provide the VA Secretary and Members of Congress with factual objective findings and recommendations for improvements in VA programs and services for veterans. These reports have served as the basis for congressional oversight hearings, including many before the Committee on Veterans' Affairs. With a proven track record as an independent oversight organization, the OIG has never in its history received a request for a draft report for the purpose of comparing the draft and final versions until your and Chairman Coffman's requests for the OIG's original Phoenix draft report. In consideration of the extraordinary importance of the OIG's Phoenix report to bring about significant improvements to veterans access to quality health care, I have decided to

provide the original draft report to the Committee so that it can carry out its vital oversight responsibilities with the full assurance of the integrity of the OIG's reporting.

I can assure you that minimal changes were made to the draft report following receipt of VA's comments and that changes were made solely for purposes of clarity, and in no way altered the substance of the report. Many of the changes were made at the suggestion of OIG reviewers and editorial staff, who continued to review the facts and refine the language in the draft report after it was released to VA for comment up until the time the final report was published. In all instances, the OIG, and not VA, dictated the final findings and recommendations.

As you will read, the principal changes occurred in the executive summary with very few revisions to the body of the report. After much internal deliberation, we decided to directly address the potential of 40 deaths of veterans on Electronic Wait Lists in the executive summary and under Question 1, "Were There Clinically Significant Delays in Care?" The rationale was that, while whistleblowers were unable to produce a list with 40 names of veterans who died awaiting care, the allegation of 40 deaths was so pervasive that it could not go unaddressed. This revision added clarity for readers who were exposed to repeated reporting of 40 patient deaths.

We also decided to highlight in the executive summary the 20 patient deaths described later in the 45 case reviews under Question 1 (6 deceased patients who encountered significant clinical delays plus 14 deceased patients who experienced care deficiencies unrelated to access or scheduling). We note that in the material provided by the Subcommittee on Oversight and Investigations (O&I) staff on April 9, 2014, the O&I analysis asserts the need to review the medical records of the 17 deaths provided to the OIG "in order to unequivocally prove" that the deaths occurred due to delays in care. While we could not conclusively establish a causal connection between these patients' deaths and their care or delays in care, nevertheless, because of the serious nature of our findings, we believed the 20 deaths warranted greater prominence in our reporting by including them in the executive summary. All 45 of the veterans in the case reviews were the subject of our first recommendation, "We recommend the VA Secretary direct the Veterans Health Administration to review the cases identified in this report to determine the appropriate response to possible patient injury and allegations of poor quality of care. For patients who suffered adverse outcomes, the Phoenix VA Health Care System should confer with Regional Counsel regarding the appropriateness of disclosures to patients and families."

The 45 case reviews—truly the core of the health care findings in the report— contained minimal minor revisions; for example the blood pressure reading in Case 9 was erroneously inverted and corrected, and "late winter" was changed to "early 2014" in Case 29.

In order to both streamline and strengthen the recommendations related to lapses in organizational ethics, we changed a few recommendations in the draft report. We consolidated Recommendations 22 through 26 in the draft into Recommendation 22 in the published report. The draft recommendations focused more narrowly on the Veterans Health Administration Chief Ethics Officer for Health Care's reporting authority and training, reporting, and coordination responsibilities. The final recommendation broadened the single recommendation to conduct an overall review of the operational effectiveness, and integrity of the VHA Ethics Program. This change not only reduced the number of recommendations from five to one, but also expanded the scope beyond the few delineated areas of the draft recommendations.

The VA Secretary and Acting Under Secretary for Health agreed with our findings and recommendations, and submitted an acceptable implementation plan. We intend to rigorously follow up with VA to ensure that these plans achieve their intended results.

This draft report is provided solely for the Committee's oversight purposes and is not intended for public distribution. It contains protected health information that if released could lead to the identification of the veterans described in the 45 case reviews.

Sincerely,

RICHARD J. GRIFFIN
Acting Inspector General

Enclosure

Copy to:

Ranking Member Mike Michaud, Committee on Veterans' Affairs
Chairman Mike Coffman, Subcommittee on Oversight and Investigations